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# Healthcare for Detained Children in the Philippines: Barriers and Facilitators

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# Abstract

## Background

Children in conflict with the law in the Philippines are often living in extreme poverty, forced to commit crimes to survive. Many of these children are detained in homes which should rehabilitate them. In reality however, the conditions of the home are poor, and children are deprived of their human rights. Instead of receiving care, they suffer from abuse and neglect. These children are vulnerable to a number of health problems, yet they are unable to access adequate healthcare.

## Aim

This study aims to describe the availability, access and utilisation of healthcare amongst detained children in the Philippines, and identify and explore the barriers and facilitators to healthcare.

## Methods

Purposive sampling was used to select eighteen participants, who took part in semi-structured interviews in June 2019. Data was then transcribed and thematical analysis was performed. Ethical approval was granted by the University of Leeds.

## Findings

Adolescents and carers commonly reported an absence of, or, if provided, insufficient healthcare. Five facilitators were recognised: medical missions, law, seeking help, staff attitude and severity. Eight barriers were identified: healthcare workers, financing, resources, overcrowding, absent healthcare system, not seeking help, staff attitude and child awareness. Finally, five improvements were highlighted: increased healthcare provision, staff, resources, budget and law implementation.

## Discussion

Despite the presence of laws which should protect children in the Philippines, DC are deprived of their human rights; forced to live in appalling conditions and suffering from abuse and neglect. They are vulnerable to a number of health problems, but as they are unable to access adequate healthcare, these problems persist and increase throughout their time in detainment. Notwithstanding the recognition of some

facilitators, multiple barriers prevent DC from accessing sufficient HC. These must be addressed and overcome in order to improve the healthcare of DC, requiring a significant system change.

*Disclaimer: This report has been submitted in partial fulfilment of the requirements for award of a degree at the University of Leeds. The statements and opinions presented within are those of the author, and do he not necessarily represent the views of the Nuffield Centre for International Health and Development, or the University of Leeds.*

# Contents

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Finally, I would like to thank my research partner, for her support and kindness, not only during the fieldwork, but throughout the year. She is not only a research partner, but a best friend too.

## Glossary

Detain – To hold a person, with reasonable suspicion of unlawful activity, in custody (USLegal, 2019)

Healthcare – The prevention, treatment, and management of illness and the preservation of mental and physical well-being through the services offered by the medical and allied health professions (The American Heritage® Medical Dictionary, 2007*)*

Offence – A breach of the law; a crime (West's Encyclopedia of American Law, 2008)

## Abbreviations

CICL – Children in Conflict with the Law

DC – Detained Children

FDC – Formerly Detained Children

HCW – Healthcare Worker

LMIC – Low- and Middle-Income Countries

UNCRC – United Nations Committee on the Rights of the Child

NGO – Non-Governmental Organisation

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## Working in a Pair

All data was collected and shared as a pair, but only data on participant demographics will be the same. Our introductions may have aspects of similarity as our participants were the same, and as we collected our data together, our methodology may also be similar. Our projects, although linked, had different focuses: mine on the healthcare of detained children, particularly barriers and facilitators, and my research partner's on their health issues and determinants of health. We alternated who was leading in the interviews, but both asked our own questions which were designed to address our individual objectives. For transcription, we divided the interviews so that we both had equal quantities of data to transcribe. We then began coding the data from the first three interviews, before agreeing on a coding framework to be used. Coding, and subsequent analysis, were then done independently with the finalised coding framework. Emerging themes were also discussed together.

# 1. Introduction

## 1.1. Children in Conflict with the Law (CICL) in the Philippines

The Philippines is a low-and-middle income country (LMIC) located in East Asia (World Bank, 2019b). Despite progress in declining poverty rates, an estimated 21.6 percent of Filipinos were still in poverty in 2015 (World Bank, 2019a). Poverty has been recognised as a key factor in influencing Filipino children to commit crime, with some of them offending to stay alive (Abella, 2016). This is known as survival offending, where offences are committed while carrying out one's livelihood, or as an act of survival. Examples include being or working on the streets and petty thieving. Children in poverty are also at increased risk to domestic violence, resulting in them living away from their homes, and increasing chances of offending (Save the Children, 2004).

CICL are individuals under the age of 18 who come into contact with the criminal justice system after being suspected of or accused of committing an offence (Unicef, 2006). In the Philippines, they are recognised as being particularly vulnerable to health threats, as they are often deprived of a safe and protective environment (Unicef, 2019).

### 1.2. Detaining Children in the Philippines

The Philippines has ratified the Convention on the Rights of the Child, which states that the arrest, imprisonment or detainment of children should be a last resort, with rehabilitation prioritised (Human Rights Watch, 2019). However, from 2001 to 2010, it is reported that nearly 64,000 Filipino children were detained by the government (Salud, 2016). They are put into youth detention centres, referred to as 'houses of hope', for rehabilitation. Official data regarding the number of these institutions is unavailable, and some are still being detained in adult prisons (Watkin, 2019).

Philippine law states a number of rights that DC are entitled to, including the right to be treated with humanity and respect (LAWPHIL, 2006). In reality however, the youth detention centres in the Philippines deprive children of their human rights and keep them in inhumane, dangerous conditions (Preda, 2019b).

### 1.3. Healthcare for Detained Children (DC)

All children in the Philippines have the right to the basic physical requirements for a healthy life, including proper medical attention (Chan Robles, 2019). Furthermore, when a child is detained in the Philippines, they should have a physical and mental

examination by a health officer, and any treatment required should be provided (LAWPHIL, 2006).

However, the United Nations Committee on the Rights of the Child (UNCRC) (2009) has expressed concerns about the lack of adequate social and healthcare for DC in the Philippines. In addition, research into healthcare provision for these children is lacking. The first ever inspection of youth detention facilities by government officials on record, which uncovered numerous health risks, such as poor sanitation, overcrowding and abuse, was only performed in 2016 (Cullen, 2016).

### 1.4. Non-Governmental Organisation (NGO) Involvement with DC

The People's Recovery, Empowerment and Development Assistance Foundation (Preda) is a Philippine NGO which rescues vulnerable Filipino children and rehomes them in Zambales, represented in figure 1, where they are supported emotionally, legally and educationally (Preda, 2019a). The 'jail rescue' team remove young people from detention centres into PREDA's homes (Preda, 2019b).


Figure 1: Map of Zambales and Subic (Gonzales, 2019)

Integritas healthcare (Integritas) is a British NGO which provides healthcare to Filipino prisoners and is is currently exploring the possibility of extending its healthcare provision to DC in the Philippines.

## 2. Aims and Objectives

### 2.1. Aim

To describe the availability, access and utilisation of healthcare amongst detained children in the Philippines, and identify and explore the barriers and facilitators to healthcare.

### 2.2. Objectives

1) To describe the availability, access and utilisation of healthcare for Filipino detained children.
2) To identify and describe the barriers to healthcare for Filipino detained children, as well as facilitating factors.
3) To explore the barriers and facilitators to healthcare for Filipino detained children through the perceptions of formerly detained children and their carers.
4) To explore how healthcare Filipino for detained children can be improved.

## 3. Methods

### 3.1. Sampling

Purposive sampling was used in order to select ‘information-rich’ participants for the interviews who could provide information relevant to the aim and objectives (Palinkas et al., 2015). This was done via two gatekeepers, who were both carers with a good knowledge of the study population. There were 18 participants divided into three participant groups. The first of these was formerly detained children (FDC), which included eight adolescents who had been rescued by Preda and were now living in their homes. Children under the age of 15 were excluded from the study on ethical grounds. Nine carers of these children were also interviewed, all of which had visited detainment centres and had worked with Preda for over 3 months. Finally, one healthcare worker (HCW) in adult prisons in the Philippines was interviewed, who had witnessed children in these prisons.

### 3.2. Study Design

A qualitative method was used in order to explore the beliefs, experiences and attitudes of the FDC, their carers and the HCW (Pathak et al., 2013). Interviews allowed the exploration of the perspectives of the participants (Hammarberg et al., 2016), offering a deeper and more detailed understanding of the topic, which is

especially useful as there is a paucity of research on the healthcare of DC in the Philippines. The simultaneous assessment of the exposures (barriers and facilitators) and the outcomes (healthcare) was supported by a cross-sectional retrospective study (Setia, 2016).

### 3.3. Data Collection

In June 2019, 18 interviews were held, in the private rooms of Preda's care homes and one interview with the HCW in her home. The familiar settings of the interviews ensured the comfort of the participant and supported free discussion. Interviews with the adolescents and one of the carers required interpreters. These interpreters were experienced carers at Preda with good English skills, and so were considered to be appropriate interpreters. A separate interpreter, who is trained by Integritas, also translated, and back translated the information sheets and consent forms. A research colleague, Rosie, was present in all interviews.

For all interviews, an information sheet (appendix 1) and consent form (appendix 2) were provided, and participants were given 15 minutes to consider participation. Simplified versions were available for the adolescents (appendix 3 and 4). Written and verbal consent from participants was required for the interviews, as well as additional consent from carers for the interviews with adolescents. Ethical approval for this study was granted by the University of Leeds.

A question guide was used in the interviews to ensure information to meet the four objectives was collected (appendix 5). The interviews lasted from 10 to 25 minutes, and adopted a semi-structured approach, allowing information considered to be important by the participants, which may not have been regarded by the researcher, to be uncovered (Gill et al., 2008). All participants were allowed 48 hours to withdraw from the study.

Participant demographics are summarised in tables 1 and 2.

| | Age | Sex | Time in detainment | Time with NGO |
|---|---|---|---|---|
| Adolescent 1 | 16 | Male | 1 month | 8 months |
| Adolescent 2 | 15 | Male | 8 months | 3 years |
| Adolescent 3 | 15 | Male | 1 year | 4 months |
| Adolescent 4 | 16 | Male | 7 months | 1 year, 7 months |
| Adolescent 5 | 16 | Male | 1 year | 9 months |
| Adolescent 6 | 16 | Male | 1 week | 1 year, 2 months |
| Adolescent 7 | 17 | Male | 2 months | 9 months |
| Adolescent 8 | 17 | Male | 2 years, 5 months | 2 months |

Table 1: Participant Demographics: Adolescents

| | Age | Sex | Time with NGO |
|---|---|---|---|
| Carer 1 | - | Male | 45 years |
| Carer 2 | 29 | Male | 3 years |
| Carer 3 | 34 | Male | 17 years |
| Carer 4 | 31 | Male | 11 years |
| Carer 5 | 25 | Male | 4 years |
| Carer 6 | 42 | Female | 10 years |
| Carer 7 | 27 | Male | 4 years |
| Carer 8 | 29 | Male | 4 years |
| Carer 9 | 38 | Female | 11 years |
| Healthcare worker | - | Female | 4.25 years |

Table 2: Participant Demographics: Staff members (- represents missing data)

### 3.4. Data Analysis

Transcription of interviews was done naturalistically, ensuring that the interviews were represented as they were spoken, and that information was not already filtered when analysis began (Oliver et al., 2005). Thematic analysis was then performed in order to identify themes within the data. This type of analysis was chosen as it is recognised as a qualitative method which is useful for novice researchers, as well as its flexibility (Maguire and Delahunt, 2017). Transcripts were firstly read through for familiarisation, and then re-read with highlighting and colour-coding to identify a-priori codes and emerging codes (appendix 6). Codes were discussed with the research partner before being inputted into a thematic framework to organise the findings. Reference to the transcript was included to ensure context was retained (appendix 7).

### 3.5. Limitations

Following some problems with communication, there was a delay in commencing research. Extra time was required for the alteration of ethics forms and ethical

approval, as well as the editing and translation of the research documents. This delayed the start of the research by two weeks, and as a result participants were not given the full 24 hours to decide whether they wanted to consent. However, they were given the opportunity to ask any questions, and the option to not participate was stressed to them before interviews commenced.

Using an interpreter who was known to the participants may have created a more relaxed setting for the interviews, increasing the overall comfort of participants. However, this may have also increased social desirability bias, as the answers of participants may have been made more socially acceptable, influenced by the presence of a carer (Grimm, 2010). Furthermore, the interpreters were not experienced, and so, despite instructions to provide literal translations, translations were provided in third-person, and may have been simplified.

As the study was retrospective, recall bias may have also affected the responses of participants, as they may have been unable to remember and recall their experiences accurately (Smith and Noble, 2014). However, access to children whilst they were still in detainment was not possible, due to the closed off nature of centres for child detention in the Philippines.

In addition, despite the acknowledgement of female DC by the carers in the study, female FDC were not included as participants as no female FDC meeting our inclusion criteria were in Preda homes at the time of this study. As a result, the beliefs, experiences and attitudes of female DC in particular are under-represented, and the findings of this study may reflect male DC more.

# 4. Findings

The findings have been organised under thematic headings, starting with healthcare provision, then barriers and facilitators, and finally improvements.

## 4.1. Healthcare Provided

### 4.1.1. Healthcare in Detainment Centres

Seven carers and four adolescents described some kind of healthcare provision for DC within the centres. Three of these carers and two adolescents described medically-untrained staff in the facility providing healthcare themselves.

‘They just give them a paracetamol if they have a fever, you know, when they have colds or flus.’ – Carer 1

Five carers, adolescent 8 and HCW explained that individuals visited the facility to provide healthcare for the children.

‘There are some volunteers also who came, or who goes to those centres, but it’s very like, I think once a year.’ – Carer 4

#### 4.1.2. Outside Healthcare

Four carers explained that DC may be taken outside of the facility to receive healthcare when they are unwell.

‘Only when it gets more serious, they have to bring them for a check-up to the local barangay, clinic, you know, and they see, maybe see a doctor, a nurse there.’ – Carer 1

Adolescent 3 was the only adolescent to experience outside healthcare. He described being taken to a hospital for healthcare when he had collapsed in the facility:

‘He was brought to the hospital by this staff… so that’s the time they found out that he has this heart problem’.

Regarding children in adult provincial jails, HCW also described children being taken out of the facility to access healthcare, explaining a case where an adolescent had been taken to hospital for emergency treatment after he became critically ill.

### 4.2. Facilitators

Five facilitators to DC access healthcare arose, which were divided into systematic facilitators (two) and personal facilitators (three). These are illustrated in figure 2.

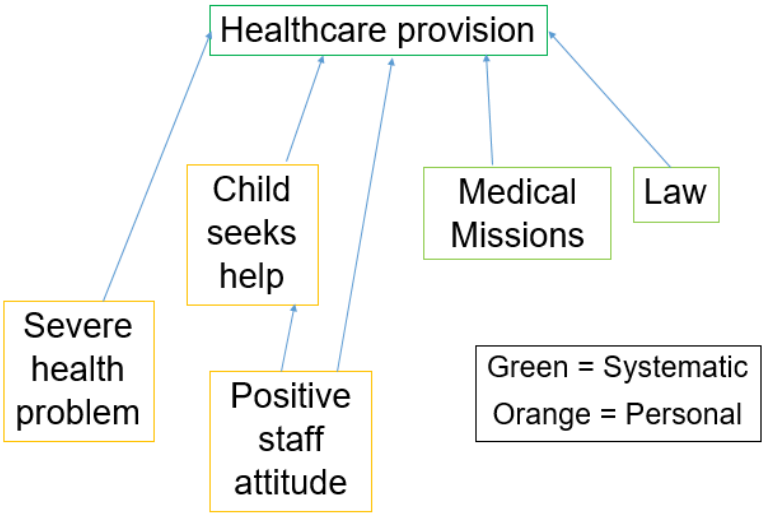


Figure 2: Facilitators

#### 4.2.1. Systematic

**Medical Missions**

Five carers explained that healthcare was provided to DC through medical missions, where volunteers, particularly healthcare staff, visit the facility and offer medical help to the children.

'They are waiting for the free medical missions.' – Carer 2

**Law**

Carer 1 explained that DC may be able to access healthcare because of legal obligations:

'They're also obliged by law, you know, to get help for the child and bring them, you know, for a check-up.'

#### 4.2.2. Personal

**Seeking help**

Seeking help was the most common facilitator to arise. Five adolescents described asking the staff at the detainment centre for help when they had a health problem.

Two carers also commented on DC seeking help when they are unwell.

‘Well yeah, they would call on a social worker and ma’am, you know, I am not feeling good, please give me some medicine, please get me help. They would ask for it, of course.’ – Carer 1

**Staff attitude**

Two carers referred to some kind of positive attitude of the staff in the facility to the children.

‘There are some house parent who really giving their time to take care of them’ – Carer 9

Adolescent 3 also described a positive attitude of staff in the facility towards him:

‘They are quite fair on monitoring them.’

Carer 1 explained that if the head of the centre is ‘a compassionate, understanding person’ they will help the child in detainment to access healthcare.

For children living in prisons with their parents, HCW suggested that prison staff would support healthcare for these children, as ‘very few people are callous enough to like to see children dying’. HCW also described cases of prison staff bringing mentally ill adolescents in adult prisons to visiting healthcare workers, either out of their compassion or through annoyance.

**Severity**

Three carers and one adolescent explained that DC are able to access healthcare when their health problem is considered as serious by staff.

‘Only when it gets more serious, they have to bring them for a check-up to the local barangay, clinic, you know, and they see, maybe see a doctor, a nurse there.’ – Carer 1

### 4.3. Inadequate Healthcare

#### 4.3.1. No Healthcare Provided

Seven carers described an absence of healthcare provision for DC. Five discussed boys with health problems, such as scabies and tuberculosis, unable to access any healthcare throughout their time in detainment.

‘We ask them: “How long have you had this skin disease?”

“Oh, it’s been like half a year.”

“Oh, what did they do?”

“Nothing.”’ – Carer 2

Carer 3 discussed the gradual reduction of visits from an NGO, which provided healthcare to DC, to cessation four years ago.

‘Before it becomes monthly, then every two months, then nowadays we don’t go there.’

Seven adolescents responded ‘No’ when they were asked if their health was ever checked whilst they were in detainment. Three adolescents also described healthcare not being provided when they had health problems.

‘He asked help for the staff, but he was not being listened with his problems.’ – Adolescent 4

Furthermore, HCW discussed an absence of healthcare for physical health problems for children in adult prisons too. When asked if treatment existed for these problems, HCW responded:

‘If the physical ones almost never, no. Scabies so bad so you’re covered bright silver excoriated lichenified skin, that’s horrible when you see children like that. Vitamin deficiencies, no.’

#### 4.3.2. Insufficient Healthcare

Five carers described some healthcare provision for DC, but explained that it was insufficient.

‘Maybe they are giving healthcare for the children, however it’s not that sufficient and not enough for proper healthcare of the children.’ – Carer 7

Three adolescents also expressed healthcare being provided to them in detainment when they had a health problem, but the health problem not being treated effectively. Adolescent 4 described the healthcare he received when he had a hernia whilst he was detained:

‘They just checked physically and then didn’t do anything.’

In addition, after adolescent 3 was taken to a hospital and provided with healthcare, ‘he was given the medicine and afterwards the maintenance was not done.’

HCW also described insufficient healthcare for children in adult prisons, for mental illness in particular:

‘If they are on a reasonably modern drug, it will be on a far too lower dose and nobody reviews it.’

### 4.4. Barriers

Eight barriers to adequate healthcare for DC were distinguished, and divided into systematic barriers (five), and personal barriers (three). These are represented in figure 3.

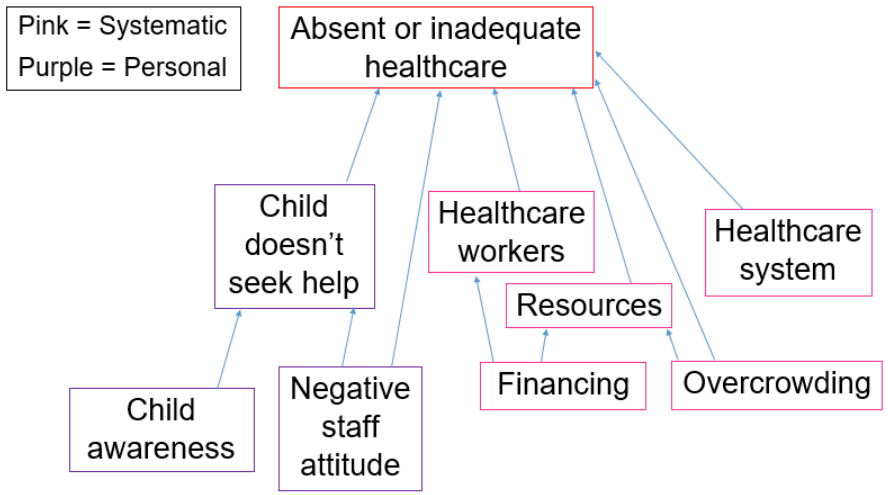


Figure 3: Barriers

#### 4.4.1. Systematic

**Healthcare workers**

Five carers described an absence of healthcare workers in, or visiting, the detainment facility to provide healthcare.

‘There’s no doctor or medical personnel in most of these, so you’d never know what the kid was suffering from.’ – Carer 1

Adolescent 4 explained that there were no healthcare workers involved in his care when he had a hernia.

HCW also reported a lack of healthcare workers in adult prisons where children are also imprisoned:

‘There’s nobody there who is officially there on-duty as the clinical nurse, clinical doctor.’

**Financing**

Two carers suggested that detainment facilities do not have the budgets to provide medicine for children in detainment.

‘They lack funds, that’s why they cannot provide specific things for these children like medicines’. – Carer 7

In addition, HCW explained that even when children are able to access a medical assessment, ‘they would be given a prescription for a drug they could never afford’. She also described the inability of prisons to pay for outside healthcare, and the consequential reliance on NGO input.

**Resources**

Three carers proposed that a lack of resources prevented DC from accessing effective healthcare.

‘Because the resources are very limited, so health condition that was being complained is not being taken care of.’ – Carer 9

Three adolescents described a lack of medicine in the detention centres.

**Overcrowding**

Six carers and three adolescents described overcrowding in the detainment facilities. Two of these carers and adolescent 6 explained that this prevents DC from accessing adequate healthcare.

‘Because there so many. So the people in detention centre, the officer, they cannot, er, entertain everything or every boy that have problem’ – Carer 6

**Healthcare system**

Carer 1 and HCW explained that an absence of a healthcare system for DC, or children in adult prisons, prevented sufficient healthcare provision.

‘There is no functioning offender healthcare system.’ – HCW

#### 4.4.2. Personal

**Not seeking help**

When asked about whether they asked staff in the detention centre for help for their health problems, three adolescents responded that they did not.

Three carers also described DC being hesitant to ask for help when they are unwell.

‘So mostly these children would say that they are hesitant to tell their concerns to the staff because they knew they would not get the proper attention.’ – Carer 4

**Staff attitude**

Eight carers and seven adolescents described negative attitudes of staff in detainment facilities towards the children. This was the most common theme for barriers to healthcare. Five of the nine carers and two adolescents referred specifically to the abuse DC by staff.

‘Some of them are quite abusive. They have guards and so on, they’re inflicting discipline.’ – Carer 1

In addition, HCW explained that the treatment of mentally ill adolescents in adult prisons by prison staff is ‘extremely brutal’.

Two carers and two adolescents explained that this negative attitude stops DC for asking for help when they experience health issues:

‘He doesn’t ask for help because every time that they do ask for help, they get pissed off and most of the staff there were hot-tempered.’ – Adolescent 2

Two carers and four adolescents described children being ignored by staff when they asked for help, therefore preventing access to healthcare.

‘He asked help for the staff, but he was not being listened with his problems.’ – Adolescent 4

**Child awareness**

Carer 6 explained that DC may not seek help for their health problems as they are unaware it is a health problem because of its frequency.

‘They don’t have enough idea about their problem. For them it’s common having a skin problem, maybe because it’s very familiar with their fellows.’

Carer 6 also suggested that the children believe they can deal with the health problems themselves.

### 4.5. Improvements

The five following themes regarding improvements to healthcare arose.

#### 4.5.1. Healthcare Provision

Four carers and three adolescents suggested increasing healthcare provision for DC in order to improve their overall healthcare, making it the most common suggested improvement. Many specifically discussed holding regular check-ups for the children.

‘Weekly or monthly check ups for each boys, for each client in the rehabilitation centre would really help.’ – Carer 4

HCW highlighted the need for the creation of an official healthcare system for detained individuals in the Philippines:

‘It needs to be done officially, and just like with the adults in the Philippines, there needs to develop a formal offender healthcare system.’

#### 4.5.2. Staff

Five carers and one adolescent thought that increasing staffing in the detainment centres could improve healthcare for DC. Four of the carers and the adolescent referred to healthcare staff in particular, such as doctors or nurses.

‘They should have er a nurse or someone that know, have a knowledge on medical aspects. More staff.’ – Carer 5

#### 4.5.3. Resources

Two carers and four adolescents suggested increasing resources as a method to improve healthcare for DC. Three adolescents specifically discussed increasing the availability of medicines in the detainment facilities.

‘He was hoping that they should be able to provide the medicine.’ – Adolescent 1

#### 4.5.4. Budget

Two carers thought that correctly allocating a budget could improve the healthcare of DC.

If they have more budgets and more proper centres I guess it will improve a lot.' – Carer 2

#### 4.5.5. Implementing the Law

Two carers and HCW believed that the laws surrounding healthcare for DC should be implemented properly.

'If the implementation of the laws will be implemented properly, the health issues will be solved' – Carer 9

Carer 1 referred to a specific law concerning healthcare provision for DC:

'Under the law, 9344 law, which is for CICL, the children are supposed to get a daily check-up, and a nurse in the proper home'.

## 5. Discussion

### 5.1. Healthcare for DC

Although DC should, by law, immediately be taken to a medical officer for a mental and physical health examination when they are taken into custody (LAWPHIL, 2006), the findings of this study suggest that this does not occur, and that DC are often unable to access healthcare throughout their detainment. When healthcare is provided, it is insufficient as children are often not assessed by health professionals or provided treatment, and monitoring is not delivered. This confirms the concerns of the UNCRC on the lack of adequate social and healthcare for DC in the Philippines (UNCRC, 2009).

### 5.2. Barriers and Facilitators

Having a medical problem judged as serious by the staff was one of the main facilitators identified by the study, for access to outside healthcare in particular. However, the level of health knowledge of the staff is unknown, and relying on medically-untrained staff to make decisions on the severity of health conditions may result in serious health problems being left untreated, such as the hernia of

adolescent 4. This therefore highlights the importance of DC having access to healthcare professionals.

Medical missions were also identified in the study as helping to provide healthcare to DC. Medical missions involve the travel of healthcare workers in order to undertake short-term projects, normally focussing on infectious diseases or conditions which can be medically treated (Malay, 2017). Despite recognition as valuable in providing healthcare to the developing world (Maki et al. 2008), there have been concerns about the quality and effectiveness of medical missions (Lim, 2012). The findings of this study suggest that the short-term nature of medical missions and their inconsistent visits make them an insufficient provider of healthcare to DC.

Another facilitator identified was DC seeking help for their health problems. Some experiences of positive attitude from staff in the detention centre towards the children were reported, which may encourage DC to seek help. However, the findings suggest that the staff have predominantly negative attitudes towards DC, with abuse and violence reported. These findings echo the existing exposure of abuse of CICL in the Philippines, where children have described being punched, whipped, and having their heads dunked in water (Save the Children, 2004). Furthermore, this negative attitude was linked in the study to DC not asking for help for their health problems, and children who did ask for help were often ignored. Internationally, protecting DC from abuse has involved supervision of detention centres and developing the skills of staff to manage behaviour (Penal Reform International, 2019).

Other barriers identified in the study which reflect the existing literature on conditions in Philippine youth detention centres are a lack of resources and overcrowding (Save the Children, 2004). Overcrowding in prisons has negatively impacted offender healthcare in England and Wales, with delays in both assessment and treatment (Nursing in Practice, 2007). In the Philippine setting, limited resources become scarcer, and staff are unable to offer appropriate attention to each child. In child detention centres in Vietnam, where many of the DC are also street children, these barriers have also been described: resources are lacking, conditions are poor and overcrowded, and DC are regularly abused by staff (Human Rights Watch, 2006).

An absence of healthcare workers in detainment centres, which has not previously been encountered in the literature, was another barrier to adequate healthcare identified by the study, preventing DC from accessing diagnoses, treatment and monitoring. A lack of funding, also recognised as a barrier in the study, may explain the lack of resources and healthcare staff. Local government units in the Philippines are allocated a budget for youth detention centres. However, these centres recognisably lack both resources and funds, preventing them from implementing proper rehabilitation (Abella, 2016).

### 5.3. Improvements

Increasing healthcare provision for DC was the main suggestion for improving the healthcare of DC identified in the study, particularly by introducing regular health check-ups. Having healthcare workers in detention centres was also proposed. In the UK, DC receive physical and mental health screening and assessment from a healthcare professional within two hours of arrival into detention. A healthcare plan is then created for the child, and a lead healthcare professional co-ordinates their care. In addition, all DC have access to a GP, and specialist clinics are provided in-house (British Medical Association, 2014). However, no information regarding healthcare provision to DC in LMIC has been encountered; where issues such as financing, resources and staffing may prevent implementation. Adaptations to this system may therefore be required and further research into feasibility is essential.

### 5.4. Conclusion

Despite the presence of laws which should protect children in the Philippines, DC are deprived of their human rights; forced to live in appalling conditions and suffering from abuse and neglect. They are vulnerable to a number of health problems, but as they are unable to access adequate healthcare, these problems persist and increase throughout their time in detainment. Notwithstanding the recognition of some facilitators, multiple barriers prevent DC from accessing sufficient HC, and these must be addressed and overcome in order to improve the healthcare of DC, and thus, their overall health.

## 6. Recommendations

1) Review the national laws and policies concerning CICL, acknowledging the detainment of children as a last resort and implementing them properly, ensuring that human rights are upheld
    - Minimum standards for facilities
    - Programmes for rehabilitation, including education and counselling
    - Aim to complete within 3 years
2) Utilising research on the health and healthcare of DC, develop a formal healthcare system for these children
    - Same standard as healthcare outside of detainment
    - Involvement of NGOs to provide healthcare within 1 year
    - Full-time nurse in each detainment centre and bi-weekly visits from doctors within 2 years
    - Initial health screening for every child within 3 days of their arrival, within 2 years
    - Quarterly medical check-ups for each child, addressing priority health needs in particular, within 2 years
    - Medical record system within 1 year
3) Conduct further research within detainment centres on healthcare for DC
    - Address both genders and different centres across the Philippines
    - Cross-sectional study within 1 year
    - Longitudinal study within 3 years
4) Conduct inspections every 6 months of all child detention centres in the Philippines by governmental officials, within 1 year
    - Collect statistical data on numbers of DC and staff, as well as official data on the conditions and facilities
    - Evaluate the health and healthcare of DC
    - Report abuse, and hold those who are responsible accountable

## 7. Reflection

### 7.1. Planning

Preparing for the project was extremely daunting: not only was this my first time collecting qualitative research, but it was in a foreign country in an unfamiliar setting. Communication difficulties with our host made this more stressful, but after conversations with my supervisor, I learnt about the unpredictability of research, especially abroad, and I was ready to adapt if change occurred. Despite the unknowns, we prepared as much as possible, and the International Health team were very understanding of our situation. Being adaptable is a skill I will undoubtedly practice throughout my career in medicine, both clinically and undertaking research.

### 7.2. Fieldwork

The opportunity to travel around the Philippines for two weeks before arriving at the research base allowed us to experience and familiarise ourselves with Filipino culture. In particular we were exposed to ‘Filipino time’, where people are often late, and so we were prepared when plans were delayed.

Following communication issues with Preda, we were unable to visit the home and familiarise ourselves with the boys, the staff and the setting prior to data collection. Although this made data collection slightly intimidating, I was excited to get started and meet our participants. I found that as the interviews went on, I became more confident with the process and I was able to judge when it was appropriate to try and gather more information. I also really enjoyed the opportunity to have lunch with the boys and the staff at Preda, as we were able to interact with them in a relaxed environment. I feel that this also helped us to form a positive relationship with our participants.

### 7.3. Writing up

Starting to write up the project as early as possible was a plan I had formed ever since completing project A, as I recognised the scale of the task. When we commenced data collection, the value of starting early was confirmed to me, as I realised the huge amount of information being collected in our interviews. Thematically analysing data was also a daunting task, but reading about it allowed me to revise the process, and I now consider it as a valuable skill that I hold. Presenting my findings concisely and clearly was also challenging, but the organised

structure of my thematic framework and discussions with my research partner helped me to tackle this.

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## 9. Appendices

**Appendix 1: Carer Information Sheet**

Faculty of Medicine and Health, School of Medicine,

Leeds Institute for Health Sciences

UNIVERSITY OF LEEDS

The health status, determinants and barriers to health care of detained children in the Philippines.

Participant information sheet for carers.

Researchers: Miriam Farrant and Rosie Blount

Our names are Miriam and Rosie, we are students studying International Health at the University of Leeds in the UK, and we are carrying out research to identify the health issues, determinants and barriers to healthcare of detained children in the Philippines. This forms part of our university studies. This study has been approved by the Ethics Committee of the University of Leeds, and we are inviting you to participate in this research project. Before you decide it is important for you to understand why the research is being done and what it will involve. This information sheet will tell you more about the project, and what you will be asked to do if you take part. Please read this sheet in full and take some time to consider whether you would like to be involved. Thank you.

**Background**

This study has been proposed to address the lack of knowledge on the health of detained children and their healthcare. There has been some research into the health of vulnerable children in the Philippines, for example street children. However little knowledge exists on the health and healthcare provision of detained children in particular due to difficulties in accessing the 'children's homes'. By investigating this, local NGOs can prioritise health interventions for these children, and provide specific long term care.

**Why have you been chosen?**

We think it would be valuable to investigate the opinions of the children's carers in order to identify the most common health issues the children face, as well as gain insight into how these children receive healthcare and how it could be improved.

**Do you have to take part in the study?**

Your participation in this study is completely voluntary, it is your choice completely decide whether you would like to participate or not. There are no repercussions to yourself for choosing not to participate.

**What will you be asked to do in the study?**

If you agree to take part in the study, we will conduct an interview with you - with the help of an interpreter - in order to ask some questions about the health of children in your care. The interview will be conducted in a private setting convenient to you, and take no more than an hour. We will cover topics such as health problems in the children, the healthcare they received at the facility and how their healthcare could be improved. You do not have to answer a question if you do not wish to. If at any point you feel uncomfortable during or after the consultation, you can leave this study without reason at any time, with no negative consequences. In order to do so, please contact one of us or Dr Pickering from the Integritas team.

**Who will be present during the interview?**

During the interview, Miriam and Rosie will be present alongside an interpreter. The interpreter will help to translate your answers into English, unless you wish to speak in English. The interview will be voice recorded, which will only be heard by the researchers and interviewer - in order to translate any answers in Tagalog into English following the interview. All the information you provide will be anonymous, meaning your name will not appear in any report derived from the study.

**What are the risks of being involved in the study?**

This research poses no risk to your health. It will involve us asking you questions - however if you do not wish to answer you may skip the question or stop your participation at any time. If you feel unwell at any point during or after participation, you will be able to contact someone from the Integritas medical team.

**What are the benefits of taking part in the study?**

No payment will be received in return for your participation. However, taking part will allow you to provide your opinions on and information about the health of detained children, which may be of great help to local NGOs and those children in the future.

**What will happen to the research results?**

Other carers and formerly detained looked-after adolescents will participate in this study. The information from all participants will be combined and analysed in order to summarise your views. This information will all be anonymized. The final report will collate this information and form conclusions on the health situation and healthcare provisions to detained children. Direct quotes from the interviews may be used in the final report, however these will also be anonymised and the speaker unidentifiable. The final report may be published at a conference or in a journal paper. However, your name will not appear in any part of the research, now or in the future - as all your answers will be anonymised.

**What should you do next if you want to be involved in the study?**

If you are interested in taking part in the study, please contact Miriam, Rosie or Dr Pickering. We are happy to answer any further questions you might have.

**Contact information**

If you would like to contact the researcher with any questions at all, please send an email or give them a call on the number below.

Email address: um15rhb@leeds.ac.uk or um15m2f@leeds.ac.uk or rachael.pickering@integritashealthcare.com

Phone number: +447982510337 or +447772306480

**Thank you for taking the time to read this information sheet.**

## Appendix 2: Carer Consent Form

Leeds Institute for Health Sciences

| **Consent for carer to take part in a study investigating child health.** | Add your initials next to the statement if you agree |
|---|---|
| I confirm that I have read and understand the information sheet dated _____ explaining the above research project and I have had the opportunity to ask questions about the project. | |
| I understand that my participation is voluntary and that I am free to withdraw up to 48 hours after the interview without giving any reason and without there being any negative consequences. In addition, should I not wish to answer any particular question or questions, I am free to decline. If you choose to withdraw from the study, your data will not be included in the study.<br><br>Researcher contact numbers: +447982510337 or +447772306840 | |
| I give permission for members of the research team to have access to my anonymised responses. I understand that my name will not be linked with the research materials, and I will not be identified or identifiable in the report or reports that result from the research. I understand that my responses will be kept strictly confidential. I understand that direct quotes from the interview may be used in the final report, however these will also be anonymised. | |
| I agree for data to be collected from me, which may be in the form of an audio recording. This is to be stored and used in relevant future research in an anonymised form. | |
| I understand that other researchers may use my words in publications, reports, web pages, and other research outputs, only if they agree to preserve the confidentiality of the information as requested in this form. | |
| I understand that relevant sections of the data collected during the study, may be looked at by auditors from the University of Leeds where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records. | |
| I agree to take part in the above research project and will inform the lead researcher should my contact details change during the project and, if necessary, afterwards. | |

| | |
|---|---|
| Name of participant | |
| Participant's signature | |
| Date | |
| Name of lead researcher | |
| Signature | |
| Date* | |

*To be signed and dated in the presence of the participant.

Once this has been signed by all parties the participant should receive a copy of the signed and dated participant consent form, the letter/ pre-written script/ information sheet and any other written information provided to the participants. A copy of the signed and dated consent form should be kept with the project's main documents which must be kept in a secure location.

## Appendix 3: Adolescent Information Sheet

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Faculty of Medicine and Health, School of Medicine,

Leeds Institute for Health Sciences

UNIVERSITY OF LEEDS

The health status, determinants and barriers to healthcare for detained children in the Philippines.

Participant information sheet for **adolescents**.

Researchers: Miriam Farrant and Rosie Blount

Our names are Miriam and Rosie, we are students at the University of Leeds in the United Kingdom. We are studying International Health at university. We would like to research the health and healthcare of detained children. This forms part of our university studies.

This study has been approved by the Ethics Committee of the University of Leeds, and we are inviting you to be part of our research project. It is your choice if you want to be part of our research project or not. This document is to give you some information about it and what you will have to do if you decide to be part of our research.

Please read this sheet in full and take some time to think about whether you would like to be involved. Thank you.

**Background**

There is not much information on the health or healthcare of detained children. Therefore, we would like to find out what types of health problems detained children in the Philippines experience, and what kind of healthcare they receive. This could help local organisations provide healthcare for detained children.

**Why have you been chosen?**

You have been chosen because we would like to know about your health whilst you were detained in Manila, and any healthcare you received. We would also like to speak to you about whether you think changes should be made to healthcare for detained children. Understanding your opinions on these subjects could help organisations to provide healthcare to detained children in the future.

**Do you have to take part in the study?**

You do not have to be part of this study. It is your choice whether you would like to take part. It is not a problem and there are no negative effects to you if you do not take part.

**What will you be asked to do in the study?**

If would like to take part in our research, we will ask you some questions about your health whilst you were detained and your healthcare. The interview will take place with Miriam and Rosie and an interpreter, to help us understand your answers. A carer you know will also be present. We will ask you these questions in a quiet private place in the care home, so anything you say will be private. The interview will take less than an hour. You do not have to answer a question if you do not want to. If you want to stop the interview at any time you can. You can also choose to leave the study for up to 2 days after the interview, and we will not include your answers in our report. Your answers will be anonymous, which means your name will not be included anywhere in our report and no one will know who said which answers.

**Who will be present during the interview?**

During the interview, Miriam and Rosie will be present with an interpreter. The interpreter will help to translate your answers into English. The interview will be voice recorded, which will only be heard by the researchers and interviewer - in order to translate your answers into English after the interview.

**What are the risks of being involved in the study?**

There are no risks to your health by doing this research. It will involve us asking you questions - but if you do not wish to answer you may skip the question or stop the interview at any time. If you feel unwell at any point during or after participation, you will be able to contact someone from the Integritas medical team.

**What are the benefits of taking part in the study?**

You will not be paid for being in this study. Your answers will help teach local organisations on how to help improve the health and healthcare of detained children in the future.

**What will happen to the research results?**

Other carers and teenagers from the care home will answer the same questions in this study. We will look at all of the information we collect and summarise your answers in our report. Your name will not be included with this information. The final report will form conclusions about the health of detained children, their healthcare, and how healthcare could be improved. This may be published at a conference or in a journal paper for other people to read. However, your name will not be on the final report, now or in the future. A direct quote of what you said in the interview may be used in the report, however again no names will be included in the report, so no one will know who said what.

**What should you do next if you want to be involved in the study?**

If you are interested in taking part in the study, please contact one of your carers, Miriam, Rosie or Dr Pickering. We are happy to answer any further questions you might have.

**Contact information**

If you would like to contact the researcher with any questions at all, please send an email or give them a call on the number below.

Email address: um15rhb@leeds.ac.uk or um15m2f@leeds.ac.uk or rachael.pickering@integritashealthcare.com

Phone number: +447982510337 or +447772306840

**Thank you for taking the time to read this information sheet.**

## Appendix 4: Adolescent Consent Form

Faculty of Medicine and Health, School of Medicine,

Leeds Institute for Health Sciences

UNIVERSITY OF LEEDS

| **Consent for adolescent to take part in a study investigating child health.** | Add your initials next to the statement if you agree |
|---|---|
| I understand the information sheet with the date _____ about this research project . I have had the chance to ask questions about the research project. | |
| I know that I can choose to take part or not, and I know that I can stop taking part up to 48 hours (2 days) after the interview. I do not need a reason to stop taking part, and there is no problem with this. I know that I do not have to answer every question. I know that if I stop taking part, my data will not be included in the study.<br><br>If I have any problems, I will contact the researchers with the help of my carers:<br><br>+447982510337 or +447772306840 | |
| I am happy for members of the research team to see my nameless responses. I know my name will not be included in the research report and no one will know what I said or that I have taken part. I know that some direct quotes from the interviews might be used in the final report, but no names will be next to these so readers will not know who said that answer. | |
| I agree for my interview answers to be recorded on an audio recorder/ mobile phone so the researchers can listen to the answers again and write them down. I know that this audio recording will be kept safe and private. | |
| I know that other researchers may use information from me in research publications, reports, web pages, and other research outputs, only if they keep the information private and nameless. | |
| I know that some of my answers from the interview may be looked at by the University of Leeds, but the information will be private and nameless. | |
| I agree to take part in the above research project and will tell the lead researcher if my contact details change during the project. | |

| | |
|---|---|
| Name of participant | |
| Participant's signature | |
| Date | |
| Name of lead researcher | |
| Signature | |

| | |
|---|---|
| Date* | |

*To be signed and dated in the presence of the participant.

Once this has been signed by all parties the participant should receive a copy of the signed and dated participant consent form, the letter/ pre-written script/ information sheet and any other written information provided to the participants. A copy of the signed and dated consent form should be kept with the project's main documents which must be kept in a secure location.

## Appendix 5: Question Guides

KEY:

Questions asked by Miriam

Questions asked by Rosie

PREDA Carer Interview Question Guide

- Introduce self and interpreter, confirm participant details.
- Ensure participant understands interview structure & purpose.
- Do you have any questions before we start?
- Gain consent verbally and in writing if literate.

Demographics:

- Age
- Gender
- Total time working in PREDA home

1. How would you describe the health of the children when they arrive at this home?

2. What health problems do you see most often in children arriving at this home?

If require prompting: respiratory, tummy, skin, wounds, nutritional, dental, mental, sexual, menstrual

3. How long have they had these problems/ (state specific problem mentioned) for? (Short term or long term)

5. Are there any differences in health problems between age groups?

6. Have you seen any children detained in Manila?

If so, did you notice any health issues they have?

7. What do you think causes illness in detained children?

If require prompting:Do you think the following factors affect the health of detained children and to what extent?

Hygiene/washing, drinking water, food, weather, overcrowding/ other people being ill, clean/dirty environment, insects

8. Are you aware of any healthcare being provided to the children in Manila? – explore e.g. children able to get treatment?

9. If applicable - why do you think the children have health problems when they arrive at the home? – explore e.g. do they ask for help?

10. How are children treated by staff at the facility, particularly regarding their health?

12. How much do the children know about health problems and healthcare when they arrive?

13. How do you think access to healthcare for detained children could be improved?

## Adolescent Interview Question Guide

- Introduce self and interpreter, confirm participant details.
- Ensure participant understands interview structure & purpose.
- Do you have any questions before we start?
- Gain consent verbally and in writing if literate.

Demographics:

- Age
- How long have you lived here in the PREDA home?
- How long were you detained in the rehabilitation centre in Manila before coming here?

1. Was your health checked when you were illegally detained in Manila?
- Yes – can you tell me more about this? e.g. Where were you taken? Who took you and who did you see? Did you receive treatment? What? Why not?
- No - Why not?
2. Whilst detained in Manila, did you have any health problems?

*If adolescent requires prompting utilize photos…*
*Breathing, tummy ache, skin infection, wounds, fever, worms, mental health, teeth*

3. When you were unwell, how long did you feel unwell for?
*Or* how long did (*specified*) illness last?
*4.* What do you think caused these illnesses *(if specified)*/ you to feel unwell?

*If adolescent requires prompting use photos…*
Do you think any of these factors affect your health?
*Hygiene/washing, drinking water, food, weather, overcrowding/ other people being ill, clean/dirty environment, insects*

5. Would you seek help when you were unwell?
- Yes – how? Can you tell me more about this? e.g. Who helped you? Where were you taken? Did you receive treatment? What? Why not? Was the health problem resolved? How/why not?
- No – why not?

6. How were you treated by staff at the facility/ in police custody? Particularly when you had a health problem?
7. Looking back – how do you think your healthcare could have been improved whilst you were detained?

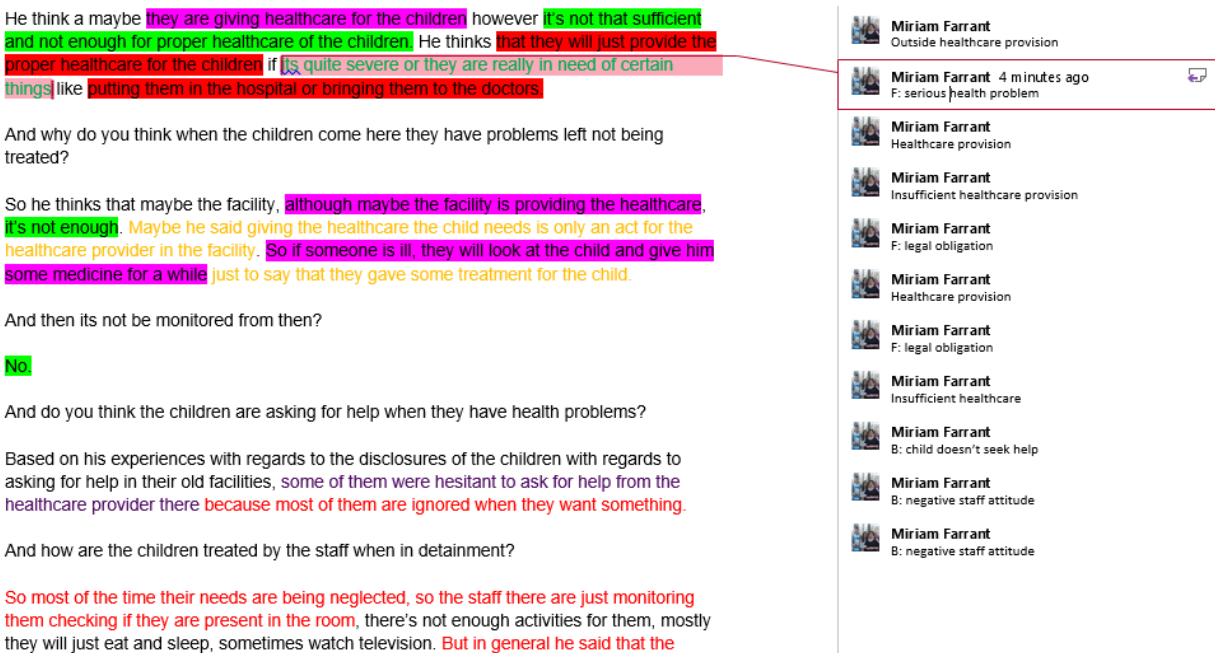
Adult prison general practitioner

- Introduce self and interpreter, confirm participant details.
- Ensure participant understands interview structure & purpose.
- Do you have any questions before we start?
- Gain consent verbally and in writing if literate.

1) Can you please describe your role within Filipino prisons? How long have you had this role?
2) Whilst working in adult prisons, have you seen any children also detained there?
   - In how many jails have you witnessed children present?
   - Approximately how many children have you witnessed each jail?
   - Are you aware if these children have been convicted themselves or if they are the children of the adult prisoners?

3) From what you have seen of detained children, how would you describe their health?
4) What health conditions have you witnessed?
5) Are these health conditions usually being treated?
   - If so – correctly?
   - Why/why not?
6) In your opinion, what are the key factors that cause illness in detained children?
7) What are the attitudes of the staff in the facility towards the children, particularly regarding their health? Are they treated differently to adult prisoners?
8) Are you aware of any health care provisions to these child prisoners?
   - How do children access this?
9) How much do children, adult prisoners and staff in prisons know about health problems and healthcare?
10) How do you think access to healthcare for these children could be improved?

## Appendix 6: Example of Coding Process



He think a maybe they are giving healthcare for the children however it's not that sufficient and not enough for proper healthcare of the children. He thinks that they will just provide the proper healthcare for the children if its quite severe or they are really in need of certain things like putting them in the hospital or bringing them to the doctors.

And why do you think when the children come here they have problems left not being treated?

So he thinks that maybe the facility, although maybe the facility is providing the healthcare, it's not enough. Maybe he said giving the healthcare the child needs is only an act for the healthcare provider in the facility. So if someone is ill, they will look at the child and give him some medicine for a while just to say that they gave some treatment for the child.

And then its not be monitored from then?

No.

And do you think the children are asking for help when they have health problems?

Based on his experiences with regards to the disclosures of the children with regards to asking for help in their old facilities, some of them were hesitant to ask for help from the healthcare provider there because most of them are ignored when they want something.

And how are the children treated by the staff when in detainment?

So most of the time their needs are being neglected, so the staff there are just monitoring them checking if they are present in the room, there's not enough activities for them, mostly they will just eat and sleep, sometimes watch television. But in general he said that the

Miriam Farrant
Outside healthcare provision

Miriam Farrant 4 minutes ago
F: serious health problem

Miriam Farrant
Healthcare provision

Miriam Farrant
Insufficient healthcare provision

Miriam Farrant
F: legal obligation

Miriam Farrant
Healthcare provision

Miriam Farrant
F: legal obligation

Miriam Farrant
Insufficient healthcare

Miriam Farrant
B: child doesn't seek help

Miriam Farrant
B: negative staff attitude

Miriam Farrant
B: negative staff attitude

Highlighted colour = healthcare provision theme

Coloured text = barrier or facilitator

## Appendix 7: Thematic Framework

| B v F | S v P | Code | Who | Quote |
|---|---|---|---|---|
| Facilitators | Systematic | Medical missions | PC1 | Once in a while they might have a medical mission, you know, or a dental, and then a group of doctors |
| | | | PC2 | Some [healthcare provided], like when someone is donating or having a free medical mission. That is |
| | | | PC3 | Yep, before um, us the medical team, we always go to different jails in manila for we call it the jail resc |
| | | | PC3 | [Referring to healthcare] I dunno but the only thing I know is that Preda is helping together with us, tha |
| | | | PC3 | But actually now there's still medical mission that are happening, but its only like the social workers. S |
| | | | PC4 | I know that there are some volunteers also who came, or who goes to those centres, but its very like, I |
| | | | PC9 | Preda is also providing that. For instance, we have the doctors, and then they went to the jail facilities |
| | | | HCW1 | So we'll often end up picking up the pieces there. |
| | | | HCW1 | (Talking about treatment in prisons) That's why we're here |
| | | | HCW1 | We'll also usually have to stump up the cash for the investigation |
| | | Law | PC1 | The law says they should be when they're apprehended by the authorities the barangay or the police |
| | | | PC1 | Well it primarily depends on the centre head, you know, and if that's a compassionate, understanding |
| | | | PC7 | Maybe he said giving the healthcare the child needs is only an act for the healthcare provider in the fa |
| | | | HCW1 | Therefore even if they were taken along in the middle of the night to a lovely emergency room and as |
| | Personal | Prison staff attitude | PC1 | Well it primarily depends on the centre head, you know, and if that's a compassionate, understanding |
| | | | PC4 | There were cases the children disclose to us that the staff would probably be listening only to those w |
| | | | PC5 | Some of them they said that their staff is good to them. Like they are treated like baby. |
| | | | PC6 | There are some house parent who really giving their time to take care of them |
| | | | A3 | He was brought to the hospital but this staff, Shelley, so that's the time they found out that he has this |
| | | | A3 | The staff also (gave him medicine) |
| | | | A3 | He said they are quite fair on monitoring them, so if there are some other boys who are bullying, they |

B = barrier

F = facilitator

S = systematic

P = personal

PC = Preda carer

A = adolescent

HCW = healthcare worker