

Accessibility and Availability of Healthcare Services in Jail Facilities among Persons Deprived of Liberty (PDL) in Dumaguete City, Philippines

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ABSTRACT

Background. Access to prison healthcare and healthcare equity remains poorly understood in the Philippines. With Philippine jail health systems subjected to budgetary restrictions, optimization of efficient mechanisms in healthcare delivery is warranted. This makes understanding how PDLs' utilization to healthcare services more relevant and of high importance.

Objectives. This study sought to determine healthcare accessibility and explored what influences healthcare access by Persons Deprived of Liberty (PDLs). Additionally, the study looked into whether healthcare was equally accessible to different PDL subgroups.

Methods. A descriptive-correlational design was employed in recruiting 261 PDLs utilizing stratified random sampling in two jail facilities in Dumaguete City from May to June 2023. Data on healthcare accessibility and availability from self-report survey questionnaires were analyzed using SPSS version 25.

Results. Hierarchical linear regression analysis shows that, collectively, predisposing factors (age, sex) $F=200.82$, enabling resources (availability of health services) $F=52.52$, and perceived needs (physical activities, sleep, diet, and mental health) $F=30.24$ significantly predict healthcare accessibility, having the availability of healthcare services as the strongest predictor with an R^2 change of 43.7% followed by perceived needs (3.9%) and predisposing factor (1.4%), respectively. Furthermore, ordinal logistic regression analysis shows that healthcare by age groups 18-34 ($OR=0.379$) and 35-54 ($OR=0.449$) are less likely to be available and accessed than those aged 55 and above. Additionally, availability and accessibility of healthcare are less likely for males ($OR=0.24$) than females while PDLs with average physical activities ($OR=0.87$), good ($OR=50.7$) to average sleep ($OR=27.4$), and average mental health ($OR=0.35$) have higher odds of availing and accessing healthcare than their poor counterparts.

Conclusion. These findings indicate that PDLs tend to access healthcare services based predominantly on availability rather than their desired needs warranting strategies that allow catering to a wide range of health needs in PDL subgroups which ultimately lead to better prison health outcomes.

Keywords: *persons deprived of liberty, healthcare services, accessibility, availability*

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INTRODUCTION

Prison healthcare and health equity remain important areas of study for public health researchers. Several areas of health research show how variations in the level of accessibility and availability of healthcare services affect the health of Persons Deprived of Liberty (PDLs). Global prison health trends show underresourced and undermanned prison health facilities, especially observed during the rollouts of vaccines in prison facilities in over 120 countries.¹ A study by Penal Reform International and Harm Reduction International revealed that of the 131 countries surveyed, only 56 or 43% have included prisoners in their vaccination plans.² Their report also shows a significant lack of human resources, with 200 prison healthcare staff positions in Spain and over 100 of 193 jail medical officers in Pakistan vacant. The recent COVID-19 pandemic has taken its toll on prison healthcare in several countries where non-COVID-19 conditions have been given less attention, with all substantial resources directed towards pandemic response.³ This resulted in diminished emergency services offered to prisoners as well as diminished access to treatment for chronic health conditions for extended periods in countries like Bulgaria, Iran, Sri Lanka, Turkey, and even in the UK and South Africa.⁴ In the WHO European Region, a report from 2020 collected data from 36 countries revealed that mental health disorders were prevalent among incarcerated individuals, with suboptimal access to treatment and care.⁵ The report also highlighted challenges such as overcrowding, inadequate access to hepatitis C treatment, and the need for improved continuity of care and access to community health services.⁶ Moreover, the World Prison Brief indicates a significant increase in the global prison population, exceeding 11 million, leading to severe overcrowding and deprivation in prison conditions worldwide.⁷ Improving healthcare outcomes for PDLs offers significant opportunities, primarily by addressing systemic issues such as overcrowding, limited healthcare access, and stigma. Implementing routine health assessments at admission and providing clear guidance on available health services can prevent health decline.⁸ Additionally, offering educational and vocational opportunities can support the social reintegration of PDL, reducing recidivism and improving mental health.⁹ These opportunities can be achieved through comprehensive health interventions, enhanced educational and vocational programs, and fostering a more humane and equitable healthcare environment inside correctional facilities. The following sections outline key strategies to improve healthcare outcomes for PDL.

In the Philippines, the congestion rate is at its all-time high getting over 500%, hailing it to be one of the highest jail occupancies in the world. Overcrowding is evident as global data shows over 200,000 people held in facilities meant to house 41,000.¹⁰ The issue of prison congestion coupled with poor ventilation in jail facilities makes PDLs in the Philippines even more vulnerable to infectious

diseases increasing the prevalence rates of diseases like TB to double compared to that of the general population. PDLs' demographic differences as well as pre-existing medical conditions (e.g., hypertension, heart and respiratory diseases, and diabetes) provide vulnerabilities that affect their overall well-being and can contribute to how they access available healthcare services.¹¹

Several studies have explored personal characteristics and context-specific factors that affect healthcare access by PDLs. Demographic factors such as higher age groups, female gender, and ethnicity as well as context-specific factors such as mental health treatment and substance abuse are seen to be associated with PDLs' healthcare utilization.¹²⁻¹⁵ Although this has been elucidated in research conducted abroad, almost none have explored how these factors affect healthcare access by PDLs in the Philippines. With Philippine jail health systems subjected to budgetary restrictions, optimization of efficient mechanisms in healthcare delivery is warranted. This makes understanding how PDLs' utilization to healthcare services more relevant and of high importance. This can assist in better planning and organization of resources to ensure that the needs of all individuals are met in an equitable manner. Thus, this study aims to determine the accessibility and availability of healthcare services in jail facilities among PDLs in Dumaguete city. Specifically, it intends to determine the PDLs' demographic profile as well as what factors significantly predict their access to healthcare services. Additionally, this study would also like to determine whether or not there is a significant difference in terms of accessibility and availability of healthcare services in different PDL subgroups.

Theoretical Underpinning

This study uses Andersen's behavioral model of healthcare utilization. This well-validated theory provides a good framework for measuring healthcare access as it systematically considers both social and individual determinants.¹⁶ Andersen has seen the danger of operationalizing healthcare access as some of its contemporaries tend to oversimplify the multidimensional nature of healthcare access and goes to define potential access (to healthcare) as the presence of enabling resources.¹⁷ Enabling resources are factors that either augment or depreciate the use of healthcare services. Examples of these are family support, access to health insurance, and one's community to mention a few. It is crucial to understand that within the context of PDLs, their freedom is restricted, leading to isolation and limitations in accessing communal support. However, their right to health permits the government to provide essential healthcare resources for them, making healthcare services an integral part of enabling resources.¹⁸ Enabling resources is seen to be a component that predicts healthcare utilization along with predisposing factors and need variances. Predisposing factors can be demographic characteristics such as age, sex, race, or educational status while need variables are either self-perceived or actual needs

for health services. For instance, if a PDL knows (based on educational status) or believes (based on need) that a specific treatment is effective in treating a symptom, he or she would likely seek care. The dynamics of these three components determine healthcare access. Furthermore, healthcare utilization is realized care whereas equitable access is when demographic and need variables account for most of the variance in healthcare utilization. Further modification of the initial model by Andersen was that of Aday et al. wherein part of the behavioral pattern that governs healthcare utilization is that of the healthcare system.¹⁹ It acknowledges the external environment including physical, political and economic components as an integral part in understanding use of health services. The addition of the healthcare system recognizes that the availability of resources is an important determinant of the population's use of services. With the assumptions presented in the preceding statements, the researcher would like to hypothesize that predisposing, enabling, and need variables are predictors of healthcare accessibility and healthcare availability would be the strongest predictor in the context of PDLs in jail facilities of the current study.

METHODS

Design

This research used a descriptive correlational design. This study aims to determine PDLs profile as well as the factors that significantly affect healthcare accessibility and test whether access to healthcare is equal to different PDL subgroups.

Respondents

This study involves selecting PDLs who met the inclusion criteria. They shall be (1) incarcerated in either of the two jails in Dumaguete City or in the municipality of San Jose with no less than a month, (2) aged 18 and above. For proper and unbiased selection of representatives, stratified random sampling was used to identify respondents, specifically through sex stratification, to ensure equal numbers from each institution. Respondents were selected by assigning codes in the questionnaires and with the help of the jail nurse, who released respondents by cell to prevent duplication. The PDLs who received a questionnaire represent the corresponding code, thus maintaining anonymity. Jail (A) has 402 male PDLs and 10 females, while Jail (B) has 326 males and 40 females. After calculations, a total of 261 respondents were obtained. The sample size was determined through power analysis with a 95% confidence level and a 5% margin of error (Figure 1).

Environment

This study was conducted in the jails in Dumaguete City that have access to public and private hospitals. Jail A is situated in Brgy. Bajumpandan, Dumaguete City and under the management of the Bureau of Jail Management

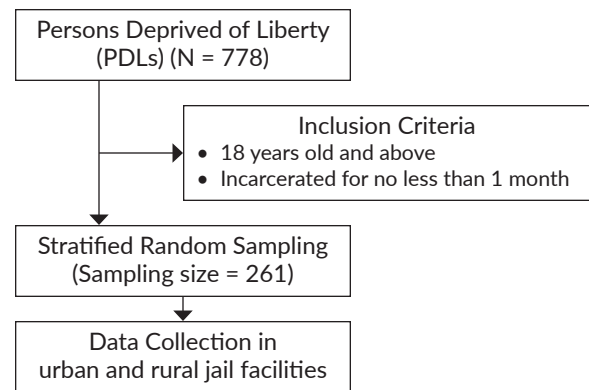


Figure 1. Methodology flow diagram.

and Penology and Jail B is located at San Jose St., Dumaguete, 6200 Negros Oriental, under the management of the Governor in the Province of Negros Oriental and Provincial Administrator. San Jose's rural coastal location creates significant accessibility barriers. Although it is only 14 kilometers from Dumaguete City, residents must travel to access specialized healthcare services. The municipality lacks private healthcare facilities and has no tertiary schools, which limits local healthcare expertise. In contrast, Bajumpandan benefits from its position within Dumaguete City, which has three hospitals offering advanced medical treatments, including cardiology, endocrinology, gastroenterology, and other specialties.

Instrument

The researcher used a self-made survey questionnaire with three parts. The first part gathered the profiles of the PDLs, including age, sex, and time spent in jail. The second part focused on physical and psychosocial variables which include: 20 items for physical activities and diet using the Health Promotion Model Exercise Benefit Scale adapted from the study of Otu M and Karagozoglu S having Cronbach's alpha value of 0.73, 20 items for mental health using the World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) adapted from the study of Saxena et al. having a Cronbach's alpha value 0.86, and 10 items using the Sleep Quality scale adapted from the study of Asowata et al. having a Cronbach's alpha value of 0.90.²⁰⁻²² It is measured in a 5-point likert scale which collectively represents the needs variables, where 1 indicates 'never', 2 'rarely', 3 'sometimes', 4 'often', and 5 'always'. The third part evaluated healthcare utilization, specifically focusing on accessibility and availability using the National Hospital Care Survey adapted from the study of Alford, et al. with a Chronbach's alpha value of 0.89 also measured in likert scale with the corresponding weights described the same as with the needs variables.²³ Before collecting data, the research instrument was subjected to content validation by three content experts, specifically by two BJMP nurse officers and a municipal health officer. Content experts were

asked to rate the questionnaire in terms of: (1) clarity, (2) presentation and organization of questions, (3) adequateness of the content, (4) attainment of purpose, and (5) scale and evaluation rating having to rate a 5-point likert scale ranging from '5' as excellent to '1' as poor. The questionnaire had a very good content validity, having an average rating of 4.66. The questionnaire was then translated into the Visayan dialect. Respondents were involved in a pilot study at BJMP Tanjay / Tanjay District Jail in Tanjay City.

Statistical Treatment

Descriptive statistics were employed to determine the demographic-related variables and the extent of healthcare utilization in terms of accessibility and availability of the PDL respondents. Accessibility and availability were measured using a 50-point inventory scale. For classification purposes, a cutoff score was established based on the total index scores. Scores were summed up from their corresponding items to create an index: 0-10 (*Very Poor*), 11-20 (*Poor*), 21-30 (*Average*), 31-40 (*Good*), 41-50 (*Very Good*). In testing what factors significantly predict healthcare accessibility, a hierarchical linear regression analysis was employed where the research enters the variables in theoretical order to minimize biases in the model.²⁴ In also testing whether different PDL subgroups do not significantly differ in terms of accessibility and availability of healthcare services, ordinal logistic regression was performed. Bootstrapped confidence intervals (BCa CIs) in beta values were reported to reduce the introduction of bias in the regression models. Three responses were observed to be missing from the data set which were treated as missing values in the statistical software. To avoid statistical bias from missing values, all statistical analysis procedures were conducted using SPSS version 25.

Ethical Consideration

The research proposal was submitted to the Silliman University Ethics Committee for clearance. Informed consent was provided to the dormitory wardens of Dumaguete City Jail and the administrator of Negros Oriental Detention and Rehabilitation Center. The study's purpose and the respondents' role were clearly explained, and their right to fair treatment was guaranteed. Respondents were free to participate and could withdraw at any time. They provided active, clear, and signed consent before participating. To safeguard against disclosure, the flash drive containing the data will be stored in a portable steel combination locker box. The survey questionnaires will be burned after use to prevent information disclosure.

RESULTS

Descriptive Statistics

Table 1 describes the independent variables for healthcare access: predisposing factors, availability, and need variables. The majority (47.5%) in the sample belongs to the

Table 1. Summary Statistics of Independent Variables

	N (%)
Predisposing factors (n=261)	
Age (years)	
18 to 34	124 (47.5%)
35 to 54	107 (41.0%)
55 and above	30 (11.5%)
Sex	
Male	216 (82.8%)
Female	45 (17.2%)
Time spent in jail	
0-5 months	25 (9.6%)
6 months to 1 year	59 (22.6%)
Above 1 year	177 (67.8%)
Enabling resources	
Availability of health services	
Very Poor	8 (3.1%)
Poor	29 (11.1%)
Average	75 (28.7%)
Good	75 (28.7%)
Very Good	74 (28.8%)
Needs	
Physical activities	
Poor	-
Average	120 (46.0%)
Good	141 (54.0%)
Sleep	
Poor	2 (0.8%)
Average	185 (70.9%)
Good	73 (28.0%)
Diet	
Poor	3 (1.2%)
Average	185 (70.9%)
Good	73 (28.0%)
Mental health	
Poor	27 (10.3%)
Average	227 (87.0%)
Good	7 (2.7%)

18 to 34-year-old age group being almost equal in terms of number in the 35 to 54-year-old age group (41%). Also, the majority of the PDLs are male (82.8%) having served more than a year in prison (67.8%). The majority of the PDLs reported average to very good availability of healthcare services, although 14.2% rated availability as poor. Regarding the needs variables, most respondents reported having good access to physical activities. For sleep, diet and mental health needs, contrary to other variables, the majority rated average, constituting 70.9%, 70.9%, and 87%, respectively. Although a small proportion of PDLs (10.3%) rated their mental health status as poor.

Regression Models

In testing the predictors of healthcare accessibility, a series of regression analyses were employed to model how

several independent variables interact with healthcare access by PDLs. A hierarchical method was used in the regression models where the researcher selects the variables in theoretically sound order correcting the inherent problems of the stepwise method such as (1) inappropriate use of the degrees of freedom, (2) poor identification of predictors, and (3) replicability.²⁵ All variables were count variables except sex which was categorical while age and time spent in jail were measured as ordinal variables. Since categorical variables cannot be used in regression analysis, the sex variable was dummy-coded as 0 for males and 1 for females, allowing it to be entered into the regression models.²⁶

Table 2 shows the resultant models in the regression analysis. Model 1 shows the first block of the regression entering predisposing variables as predictors of the dependent variable (i.e., accessibility of healthcare). It shows that among the entered predictors time spent in jail is positively associated with accessibility with its bootstrap confidence interval (BCa CIs) not crossing zero. Taking it all together, predisposing characteristics significantly predict healthcare access ($F=200.82$; $p=0.01$) accounting for 7 percent of the data's variance. Model 2 shows the inclusion of the availability of healthcare as theoretically representing enabling resources of the PDL's access to healthcare services while controlling for the predisposing variables. Results show that availability is positively associated with accessibility with its bootstrap confidence interval (BCa CIs) also not crossing to zero. It is important to note that the results demonstrate strong support for the researcher's previously stated hypothesis. Availability appears to be a significant predictor of healthcare access, as indicated by an R^2 change of 0.437, explaining 44.2 percent of the data's variance. Lastly, Model 3 comprises of needs variables as predictors while controlling for predisposing and enabling factors. Among the needs variables entered in the model, only physical activities are seen to have a positive

association with healthcare access, although when taken together, predisposing characteristics, enabling resources, and needs variables are seen to be significant predictors ($F=30.24$; $p=0.01$) accounting for almost 50% of the data's variance.

An ordinal logistic regression analysis was conducted to examine the likelihood of healthcare accessibility for PDLs from various demographic groups within the sample. Table 3 shows the resultant models. This analysis aimed to determine whether healthcare services were accessed and available to different groups of PDLs. Comparing healthcare availability and accessibility logistic regression models side by side, for predisposing characteristics, age is associated with the probability of healthcare accessibility and availability. Older age groups are more likely to access healthcare services compared to younger age groups ($OR=0.44$; $p<0.05$), and the probability of available health services is higher for older individuals ($OR=0.45$; $p<0.05$). Sex is seen also to be associated with the probability of healthcare accessibility ($OR=0.24$; $p<0.01$) and availability with females being more likely to access healthcare ($OR=0.45$; $p<0.05$). For time spent in jail, the probability of availability and accessibility of health care is not significantly associated. No association is seen in healthcare access for PDLs engaging in physical activities though healthcare tends to be less available 0.46 times to average physical activities than their good counterparts. PDLs with good to average sleep are more likely to access health services than those with poor sleep ($OR=50.79$; $p<0.01$). Additionally, healthcare services are also more likely to be available to those with good sleep ($OR=30.92$; $p<0.01$). Finally, PDLs with good mental health tend to access healthcare more likely than their poor counterparts ($OR=3.73$; $p<0.34$) and availability also coincides with healthcare access as it is more available to those with good mental health over their poor counterparts ($OR=0.35$; $p<0.05$).

Table 2. Hierarchical Regression Models of Healthcare Accessibility

Variables	Model 1	Model 2	Model 3	Df
Standardized β (95% BCa CIs LL - UL)				
Predisposing factors				(1,259)
Age	0.06 (-0.038; 0.166)			
Sex	-0.11 (-0.210; 0.166)			
Time spent in jail	0.104* (0.14; 0.218)			
Enabling resources				(3,256)
Availability		0.66** (0.494; 0.654)		
Needs				(4,252)
Physical activities			0.159* (0.09; 0.42)	
Diet			0.04 (-0.07; 0.16)	
Sleep			-0.04 (-0.16; 0.074)	
Mental health			0.08 (-0.02; 0.23)	
F-statistic	200.82**	52.52**	30.24**	
R²	0.07	0.442	0.490	
R² change	0.014	0.437	0.039	

Note: * $p < 0.05$, ** $p < 0.01$

Table 3. Ordinal Logistic Regression Models of Healthcare Accessibility and Availability

Predictors	Availability of HCS – β (95% BCa CIs LL – UL)	Odds Ratio	Accessibility of HCS – β (95% BCa CIs LL – UL)	Odds Ratio
Age (years)				
18 – 34	-0.970 (-1.76; -0.25)	0.379*	-1.137 (-1.927, -0.365)	0.321*
35 – 54	-0.801 (-1.60; -0.02)	0.449*	-0.790 (0.086, 6.751)	0.454*
55 and above	-	-	-	-
Sex				
Male	-1.428 (-2.13; -0.80)	0.240**	-0.790 (-1.281, -0.305)	0.454**
Female	-	-	-	-
Time spent in jail				
0 – 5 months	-0.012 (-0.84; 0.83)	0.988	-0.477 (-1.346, 0.391)	0.621
6 months – 1 year	-0.015 (-0.58, 0.55)	0.985	-0.132 (-0.695, 0.432)	0.876
Above 1 year	-	-	-	-
Physical Activities				
Good	-	-	-	-
Average	-0.130 (-0.62; 0.36)	0.878	-0.776 (-1.278, -0.281)	0.460**
Sleep				
Good	3.928 (1.17; 7.24)	50.791**	3.432 (0.587, 6.784)	30.925*
Average	3.31 (0.60; 6.60)	27.472*	3.007 (0.197, 6.333)	20.224*
Poor	-	-	-	-
Mental Health				
Good	1.318 (-0.42; 3.41)	3.734	0.069 (-1.583, 1.746)	1.072
Average	-0.807 (-1.63; 0)	0.446	-1.038	0.354*
Poor	-	-	-	-

Note: * $p < 0.05$, ** $p < 0.01$

DISCUSSION

Demographic-wise, the study shows the majority of the PDLs are male and belong to young to middle adult age groups which provides us insight into the probable sources of morbidity and understand the health needs of PDLs in the sample. A study by Vasquez and Roxas-Roque explored disease and access to treatment of more than 70,000 inmates in Peru.²⁷ Their results showed that over 60 percent of their sample came from the 20-39 age groups, with tuberculosis being the most prevalent infectious disease (4.3%) and was more common in men than women followed by HIV/AIDS. Additionally, depression and anxiety were predominant and were more common among women than men. In the current study, from concurrent interviews, respondents reported that common coughs and colds, arthritis, and hypertension were claimed prevalent with some experiencing mental health problems such as depression and sleep deprivation although proper empirical investigation is warranted. Favril et al. also supported in their study of extant literature the prevalence of major depression (11.4%), post-traumatic stress disorder (9.8%), and other psychotic illnesses (3.7%) from over 29 meta-analyses reports.²⁸ Respondents from the current study show that although predominantly consisting of young and middle-aged PDLs, ordinal logistic regression models reveal a higher likelihood of healthcare access from women and 50-above age groups. This finding confirms the previously stated study by Vasquez and Roxas-Roque that generally

women tend to access medical treatment than men. Dawkin et al. stated that gender was the most common demographic barrier to healthcare access among low- and middle-income countries.²⁹ They further explained that often than not, socio-cultural perceptions about gender roles and minimal female empowerment are reasons for delayed decision to seek care. Thus, for women PDLs, this means that delaying access to care may result in devastating outcomes, as the delay could exacerbate their treatable illnesses thus warranting more clinic visits in the long run. The frequent access to healthcare services might also imply women's specific needs are unmet. Van den Bergh et al. discussed that the current provision of health services to imprisoned women failed to meet their needs showing a lack of gender sensitivity in policies and practices in prisons.³⁰ Women in prisons' specific needs of regular showers, provision of hygiene products, and sanitary napkins are not part of prison health services as well as maternal education and nutrition for pregnant women among others.

Hierarchical regression models show that the strongest predictor of healthcare access among PDLs in the study is availability explaining almost half of healthcare accessibility variance alone. This would imply that PDLs might only access basic available services and may not cater to a myriad of health needs inherent to such a vulnerable group of individuals. Unavailability of services only delays necessary healthcare and can lead to worsened health conditions due to a lack of sufficient professionals to address specific

health needs. While basic services may exist, demands from overpopulated jail facilities may render appropriate services unavailable to everyone. Thus, there is a need for prison facilities to organize prison health governance in such a way that addresses all the health needs of an overpopulated jail facility. McLeod et al. emphasized a “critical lack of evidence” in global prison health governance and stated that little is known about how healthcare services in prisons are structured and funded and that there is a need to study the sociopolitical dynamics of our national government.³¹ They further urged the need to evaluate our current prison health governance models in addressing health inequalities on a global scale. It is important to note that equitable access to healthcare, according to Andersen’s model of healthcare utilization, is demonstrated when predisposing and needs variables account mostly for the variance of healthcare access.³² The fact that when combined predisposing and needs variables only account for 10.9% of the variance strongly suggests the inequitable nature of healthcare access among PDLs in the study. Combined with healthcare availability being the stringent predictor accounting for 44.2 % of the variance of healthcare accessibility when controlling for the predisposing variables, it shows strong evidence that PDLs tend to access healthcare based not on their needs but on what healthcare services are available. Despite the consensus of lack of healthcare availability in prisons from different low- middle-income countries, there is a shortage of research on PDLs healthcare access and availability in the Philippines.³³⁻³⁵ Among the few was that of Acevedo et al. who explored the health and well-being of PDLs in Metro Manila.³⁶ Their results show that barriers to healthcare access include stigma, attitudes toward marginalized genders, and discrimination among PDLs with special needs from healthcare workers. Additionally, difficulties in receiving healthcare resulted from a lack of specialized clinics, a shortage of medical equipment, and budgetary limitations. Some of their participants expressed that even in the presence of available health aid 24 hours a day, some did not have enough medicine for their daily maintenance. Amidst these constraints, medical services are ensured to be delivered by the BJMP including health promotion and disease prevention campaigns, treatment and rehabilitative interventions, and medicines, if available.

Mental health among PDLs in the study is seen to be interesting since the regression models show it is not significantly associated with healthcare accessibility. It is suggested that PDLs reflect a high level of psychosocial well-being, which may imply that they have already adjusted and learned how to cope with the stressors inside the facility. This may also suggest that the services offered by the institution are effective in providing a strong support system, such as PDLs’ family and friends, to cope with the challenges of incarceration and to maintain a positive outlook. A study by Maruschak found that PDLs who received and availed of mental health-related programs in jail were less likely to experience symptoms of depression and anxiety.³⁷ Although

some PDLs in the study have expressed experiencing depression and anxiety as 10.3% rated their mental health as poor, this might be attributed to sleep deprivation and poor social interaction which might increase feelings of loneliness and isolation. The results indicate that among PDLs in Dumaguete City, healthcare accessibility is strongly linked to certain aspects of physical health needs as well as the availability of health services. Statistically significant correlations highlight the importance of studying the complex relationship between healthcare utilization, and psychosocial and physical well-being in correctional settings, which requires further investigation.

However, this study has several limitations. First, the respondents were taken from only two jail facilities in Dumaguete city. Thus, making generalizations to a larger population of PDLs is challenging and may be unreliable. Future research on PDL in the country could benefit from engaging a broader population of PDLs at the subnational level and, if resources permit, at the national level. Second, the results of the study are based on the perspectives of PDLs regarding the accessibility and availability of healthcare. It is important to consider that these perceptions may not necessarily align with the true utilization and availability of healthcare services. This is because individuals may evaluate healthcare services based on their existing knowledge and experiences, potentially overlooking healthcare options that are unfamiliar to them. This could lead to an incomplete assessment of the actual healthcare services being offered. Future research on PDL could focus on conducting a comprehensive analysis of the variables more objectively. This can be achieved by evaluating the actual health services delivered and consumed. Additionally, qualitative research methods could be employed to provide further validation and enhance the credibility of the findings from this study. Lastly, the clinical profile was not included as a study variable. Including the clinical profiles of the respondents is crucial, as it provides a deeper understanding of the specific health needs and challenges faced by PDLs. Researchers might also consider capturing information on chronic illnesses, mental health status, and other medical conditions. The study can then more accurately assess how these factors influence healthcare accessibility within the jail environment. This inclusion allows for the identification of vulnerable subgroups who may experience greater barriers to care, ensuring that analyses account for health-related confounding variables.

CONCLUSION

Duration spent in jail, female PDLs, and good physical activities are predictors of healthcare accessibility in jail facilities. When combined, the needs, predisposing, and enabling factors of PDLs contribute to their likelihood of accessing healthcare. Additionally, the availability of health services as an enabling factor is the strongest predictor of healthcare accessibility. These findings support the notion that

PDLs tend to access healthcare based on availability rather than actual needs. Inequalities in healthcare accessibility are present among PDLs in jail facilities as evidenced by predisposing and need factors being less stringent than the enabling factor (i.e., Availability). Furthermore, advancing age, being female, engaging in regular physical activity, getting adequate sleep, maintaining good mental health, and having improved access to healthcare are all factors associated with the availability of health services. Such findings support the contentions of healthcare utilization theory when applied in the context of correctional facilities. To achieve better prison health outcomes, it is important to develop comprehensive strategies that can effectively address the diverse health needs within PDL subgroups. By implementing tailored interventions and programs, we can ensure that the health requirements of all individuals in correctional facilities are met, leading to improved overall health within the prison system.

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