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# Should social enterprises complement or supplement public health provision?

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**Abstract**

*Purpose*

This paper explores how stable employment, company culture, and tailored health, digital, and core skills training provided by a social enterprise (SE) in the Philippines affect survivors of exploitation. Research shows survivors experience adverse social conditions and physical and mental health outcomes caused by their exploitative experience. Stable, decent employment has been identified as critical to their recovery and reintegration. This paper discusses the SE's impact on the employees' physical, mental, and social health and behaviour. Based on our findings, we discuss the contribution of SE in improving health outcomes and providing health services, and conclude that SEs should not replace but complement public health government programmes.

*Design/methodology/approach*

This paper uses mixed methods, presenting data from a longitudinal survey (household income, mental health, and social wellbeing, among others), and a follow-

up qualitative study, which uses in-depth interviews and participatory videos to explore survey findings.

*Findings*

The quantitative analysis demonstrates positive, but gradual, changes in sexual and reproductive health behaviour; personal empowerment; and trauma, anxiety, and depressive symptoms. The qualitative findings show how improvements in executive functioning, self-regulation, and self-esteem occur incrementally over time. As their self-efficacy improves, employees need to avoid being overly dependent on the SE, to support their autonomy, therefore access to complementary public health services is fundamental.

*Originality/value*

This paper focuses, to our knowledge, on a unique SE, which hires survivors of exploitation, without losing their competitiveness in the market.

*Keywords*

psychosocial wellbeing, employment, survivors of exploitation, sexual exploitation, mental health, sexual and reproductive health

*Paper type*

Research paper

# Introduction

Social enterprises (SE) aim to maximise both financial and social value (Cornforth, 2014). Notwithstanding the potential tensions and challenges in achieving this dual mission, many social enterprises are unable to remain profitable in the long term (Kay et al., 2016; Khieng and Dahles, 2015; Smith et al., 2013). Emerging research explores whether the provision of health services within SEs is also possible (Roy et al., 2017, 2014, 2013). Debates focus on whether SEs can be an alternative provider of healthcare (Hazenberg and Hall, 2016; Roy et al., 2013), to understanding how SEs affect health outcomes (Farmer et al., 2016; Gordon et al., 2017). Much of the former research stream arises from countries where the public health infrastructure is well developed, such as the United Kingdom (UK) (Macaulay et al., 2018, 2017). The latter stream of research examines the pathways by which SEs can address health and

wellbeing (Roy et al., 2013), and the social determinants of health (Macaulay et al., 2017; Whitehead and Popay, 2010). The potential health effects are varied, with the specific impact seemingly dependent on the type of SE (Macaulay et al., 2017).

This paper aims to contribute to the growing literature exploring how a SE can impact an individual's physical and psychological wellbeing. To do so, this paper focuses on empirical research conducted in the Philippines, in partnership with a SE that provides supported employment to survivors of exploitation whilst operating in a competitive marketplace. It begins with a review of current research on SE and its intersection with health and labour exploitation. Second, we frame our understanding of labour exploitation to illuminate the challenges in hiring, training, and supporting survivors. This is followed by a discussion of SE and health in the Philippines' context and a description of our case study, including the methodology used for our research. Fourth, our findings are presented and followed by a discussion. We discuss the potential role of SEs in improving health outcomes in survivor populations, and their potential contribution towards enhancing access to health services. We conclude that, while their contribution is valuable in addressing many of the psychosocial determinants of health, it should not replace, but instead complement, the provision of public health services.

## The intersection of social enterprises, health, and labour exploitation

Three different fields of research intersect in our case study, making it's contribution unique. The following sections review the literature pertaining to these intersections to frame our research and identify our contributions.

### Social enterprise and public health provision

With the growing prominence of SEs, there is an increasing recognition of their usefulness in public service provision (Teasdale, 2012). For instance, research supports that, while SEs cannot substitute publicly owned services, when operating in a collaborative environment they can have a positive impact on health outcomes and their social determinants, in comparison with traditional care and social care systems (Calò et al., 2018; Roy et al., 2014). More recent research by Calò et al. (2019) shows that, when funded sufficiently over time, SEs can be as effective as public sector organizations in delivering positive outcomes. This is due to their flexibility in

responding to the needs of their service users and their role as "boundary spanners" in creating strong ties and connectedness between different stakeholders (Caló et al., 2019). While SEs have increasingly been delivering public health services, not all programs have demonstrated improved outcomes. This paper aims to contribute to this growing debate, expanding its reach to SEs in the Global South.

## Labour exploitation and health

The terms human trafficking and forced labour are often used interchangeably. Forced labour has been defined by the International Labour Organization (ILO) in Convention 29 as *"work or service which is exacted from any person under the menace of any penalty and for which the person has not offered himself voluntarily"* (ILO, 1930, p. np). Our definition of labour exploitation is based on Skřivánková's continuum of exploitation which plots all work environments, ranging from 'decent work' (as defined by ILO) at one end, to 'forced labour' at the other (Skřivánková, 2010). Between the two extremes are situations that do not comply with ILO's definition, ranging from discrimination and payment under minimum wage, on one extreme, to debt bondage, and physical or sexual violence, on the other extreme.

For the purpose of this paper, we use the phrase *labour exploitation* to refer to exploitation for purposes of sex or other work, and *survivors of exploitation* to represent individuals who were exploited, and who comprise the main cohort of the employees of our SE and research partner. While severe exploitation and human trafficking usually evoke the complex events occurring from recruitment, transportation, transfer, coercion and deception, our work focuses solely on the post-trafficking phase, also known as the recovery and reintegration phase. Zimmerman et al. (2011, p. 330) define reintegration, (adapted from European Council on Refugees and Exiles, (ECRE, 2002), as *"long-term and multi-dimensional stages of […] reintegrating into a home country setting, which are not achieved until the individual becomes an active member of the economic, cultural, civil and political life of a country and perceives that he or she has oriented and is accepted"*. Although survivors may be "reintegrating" into a home country setting—as the participants in our research were—it is not necessary that they return to the previous roles, social identities, and communities they had before their exploitative experience. In fact, this is often not desirable if the vulnerabilities they experienced in those roles contributed toward their exploitation.

Research demonstrates the multiple layers of vulnerability experienced by survivors. In the case of sexual exploitation survivors, they often come from *"impoverished backgrounds where, as well as the effects of poverty, they have experienced physical or sexual abuse, significant family dysfunction, and lack of a support system"* (Gill, 2017, p. 2). Upon reintegration, survivors not only experience social stigma, family rejection, housing and economic instability, and constrained access to services, but ongoing physical and mental health problems caused by the exploitative experience (Lisborg, 2009; Surtees and NEXUS Institute, 2017; Zimmerman et al., 2011). Physical symptoms depend on the type of exploitation experienced. For sexual exploitation survivors, this can include memory problems, fatigue, headaches, dizziness, and sexually transmitted infections (Kiss et al., 2015a; Zimmerman et al., 2006). Emerging research demonstrates that survivors also present high rates of anxiety, depression, and post-traumatic stress disorder (PTSD) (Hossain et al., 2010; Katona et al., 2015), which may endure beyond the time they return (Ostrovschi et al., 2011). PTSD negatively impacts learning, memory, attention, and executive functioning or control of complex goal-directed behaviour (Aupperle et al., 2012). Studies have also linked PTSD to an emotional bias towards threat and negative emotional stimuli (Aupperle et al., 2012). According to Zimmerman, *et al.* (2011), *"Mental health is perhaps the most dominant health dimension in trafficking cases because of the profound psychological damage caused by (often chronic) traumatic events and the common somatic complaints that frequently translate into physical pain or dysfunction"* (p. 331). Findings from these studies have suggested that service providers should be cognizant of this and provide mental health support to survivors, addressing cognitive dysfunctions, mental disorders, and physical symptoms.

## Social Enterprises and labour exploitation

Sustained employment is a key to the successful reintegration of survivors of exploitation, being the 'critical bridge between the past and its debilitating emotions, and a future of self-sufficiency … enabling survivors to successfully participate in mainstream society' (Zimmerman et al., 2003). Research with survivors has found that safe, fairly paid employment is one of their highest priorities and a strong predictor of long term psychosocial wellbeing (Brunovskis and Surtees, 2012; Lisborg, Anders and Issara Institute, 2017). Despite the importance of sustained employment to survivors, we identified only research involving SEs serving people with physical and mental

health disabilities (Boardman, 2003; Krupa et al., 2003; Rinaldi et al., 2004), incarcerated individuals (Cosgrove and O'Neill, 2011), homeless individuals (Ferguson and Xie, 2008), and youth from disadvantaged backgrounds (Ferguson, 2012), making our case study a particular example within our revised literature.

For initiatives focusing on the recovery and reintegration of survivors, Surtees and de Kerchove (2014) have identified significant deficiencies in their approach. Whilst shelter facilities and other aftercare organizations commonly provide vocational training programs, many of these offer a narrow set of gendered training options (such as cooking, knitting, or sewing) and/or provide vocational training that is not relevant to local job markets in survivors' home communities. Furthermore, many training programs do not help survivors access real employment opportunities because of lack of linkages to actual businesses (Surtees, 2012; Surtees and de Kerchove, 2014). When inadequate support is provided to individuals after their exit from labour exploitation, survivors may experience worse financial difficulties than before they were exploited (Tran et al., 2017). This in turn may lead to exacerbating physical and mental health problems.

## Improving health, promoting recovery

### Understanding health and its social determinants

The concept of health is complex, multidimensional, and not easily defined. It can be understood under many different paradigms including medical, sociological, health promotion, cultural, or lay approaches (Keleher and Murphy, 2004, p. 4). Lay or 'ordinary' concepts of health can differ significantly from the medical or 'expert' (Blaxter, 1990, p. 14) and thus a survivor's understanding of and 'measures' for their own health may differ substantially from those of clinicians and researchers. However, for the purpose of this article, the definition of health as per the Alma Ata Declaration (International Conference on Primary Health Care, 1978) is adopted. In this definition, health is considered holistically as "*not merely the absence of disease or infirmity*" but a "*state of complete physical, mental, and social well-being*" (p.1). Furthermore, not only is health considered a basic human right, but the complex determinants of health are recognized together with the need for engagement across "*many other social and economic sectors in addition to the health sector*" (International Conference on

Primary Health Care, 1978, p. 1) to improve health outcomes and reduce health inequalities.

Biological factors or health behaviour can be considered health determinants as can the conditions in which people are born, live, work, as well as age, sex and constitutional factors, such as socioeconomic status and education level (See Figure 1; Dahlgren and Whitehead, 1991; Marmot et al., 2008; Reidpath, 2004). Within the social determinants framework, work or employment is placed as a more distal determinant of health, influencing factors such as financial security and income, social status, exposure to potential hazards, and stress (Marmot et al., 2008). Depending on the working conditions and context, work can have either a positive or negative effect on health outcomes (Marmot et al., 2012). One positive outcome is an improvement in self-efficacy through skills gained via vocational training (Gist and Mitchell, 1992; Margolis and Mccabe, 2006).

Overarching these social conditions are structural determinants such as social and economic policies and politics, which can result in the unequal distribution of power, money, and resources reflected in variables such as living conditions and access to health care (Marmot et al., 2008). These systematic and avoidable differences in health between social groups are termed 'health inequities', with poorer health outcomes at lower socioeconomic positions both within and between countries (Marmot et al., 2012, 2008). These inequities are mediated through factors such as early life experiences, food, social support, inclusion, and stress (Wilkinson and Marmot, 2003).

## The importance of executive functioning for recovery

As described above, survivors of exploitation experience adverse effects caused both by their exploitation experience and more distal determinants or conditions (Gill, 2017). As individuals acquire cognitive resources during childhood, household neglect or deprivation can lead to impaired cognitive development (Jensen, 2009; Messer, 2014). However, research has shown cognitive development continues in adolescence and adulthood; therefore, people can recover from the negative impacts of a less favourable upbringing (Center on the Developing Child at Harvard University, 2016; Jensen, 2009).

To improve cognitive skills, research supports focusing on self-regulation (planning, focus, self-control, awareness and flexibility), which depends on individuals' executive function (inhibitory control, working memory, and mental flexibility) (Center on the Developing Child at Harvard University, 2016). Tracking how individuals embrace or retreat from their own responsibility shows the individual's self-regulation capacities, as accepting responsibility for one's own actions demonstrates the ability to monitor and evaluate one's own performance in relation to established goals (Bandura, 1991; Ylvisaker and Feeney, 2002). Similarly, how individuals process and manage their emotions show both their self-regulation (self-control) (Diamond and Aspinwall, 2003; Gross, 2014, 2002) and executive functioning (inhibitory control) (Hoeksma et al., 2004; von Hippel and Gonsalkorale, 2005).

To treat PTSD, various therapies (e.g. cognitive processing therapy, narrative exposure therapy) work on the assumption that patients should *"decrease avoidant behaviours, habituate to triggering stimuli, learn that they can cope with strong emotions, and alter their cognitions and perceptions of the trauma, themselves, and the world in general"* (Aupperle et al., 2012, p. 692). Studies also show how improving self-esteem and self-confidence relate to increased resilience, enhanced cognitive skills (e.g. problem solving), and can lead to better health and social behaviour (Dumont and Provost, 1999; Mann et al., 2004). Accordingly, increasing self-esteem and self-confidence leads to an improvement in overall wellbeing. The following figure summarises our theoretical framework, signalling its main components.

**Figure 1:** The individual and the causes or determinants of health and illness (Source: the Authors, based on Dahlgren and Whitehead, 1991; Marmot et al., 2008; Reidpath, 2004)
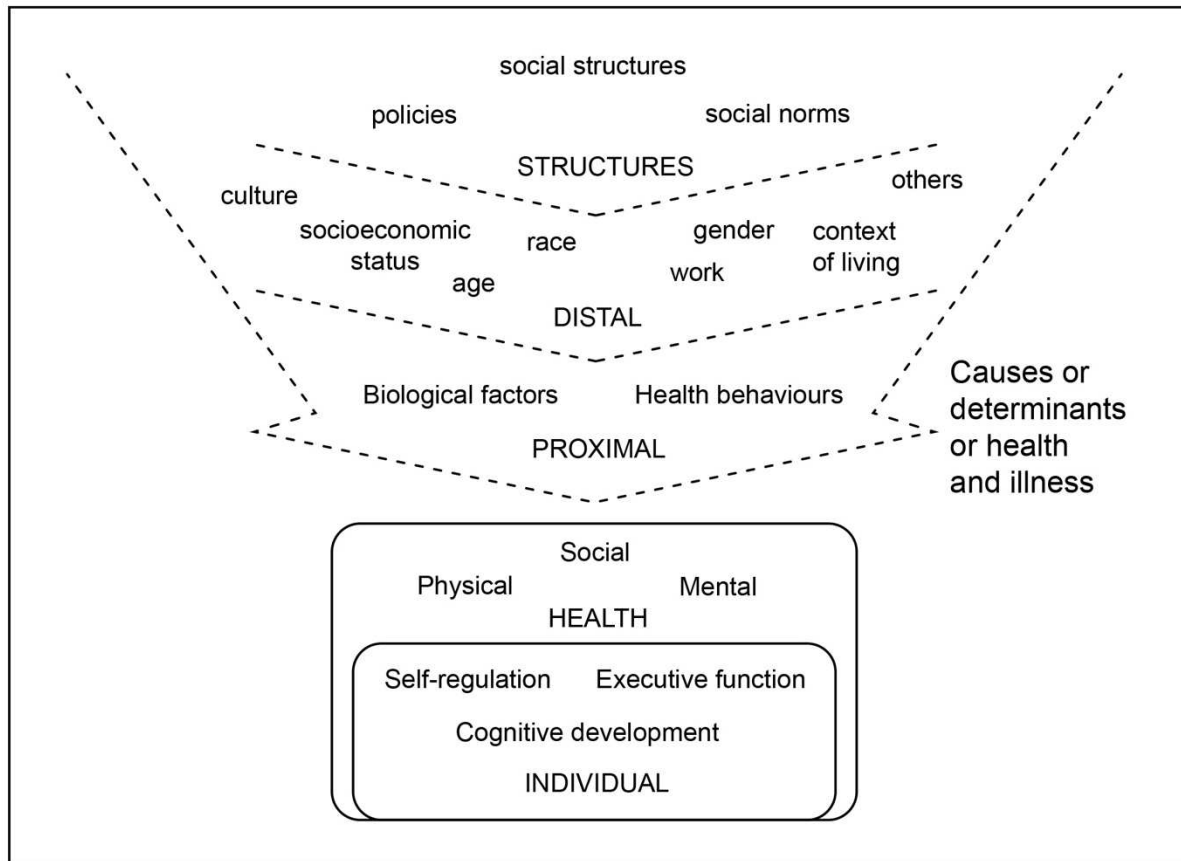
## The specific context of the Philippines and case study

### Social enterprises in the Philippines

Unlike other countries, SEs have not been formally institutionalized and legally defined in the Philippines (CSO-SEED Project, 2017). A common definition is proposed by Dacanay (2007 as cited in Dacanay, 2012a) which defines SEs from the Philippine contexts as "(a)*social-mission driven wealth creating organizations that serve the poor or* marginalized *as primary stakeholders and have distributive enterprise philosophy"* (p.1)*.* Notwithstanding the absence of a SE-specific legislation, the sector is supported by a number of related laws and government interventions (ODI, 2015) albeit stronger institutional support and enabling policy environment are often highlighted as the weak links in creating a sustainable SE ecosystem in the Philippines (Magno-Ballesteros and Llanto, 2017).

SEs have existed in the Philippines since the 1980s (CSO-SEED Project, 2017). Their rise can be characterized as a response to poverty and inequality coupled with the failure of state and market institutions to serve the poor and marginalized (Dacanay,

2012b). These SEs have taken different legal forms and organizational models including cooperatives, non-government organizations (NGOs) - initiated earned income enterprises, small and medium enterprises, microfinance institutions, fair trade organizations among others (Dacanay, 2012a). These organizations have grown steadily, with an estimate of 30,000 in 2007 (Dacanay, 2013), increasing to 164,473 in 2017 (CSO-SEED Project, 2017). It is estimated that 19% work in the agriculture sector, followed by education (9%), business development (9%), financial services (8%), and employment creation (8%) (CSO-SEED Project, 2017).

Extant literature on Philippine SEs reflects a heavy focus on the agricultural space (CSO-SEED Project, 2017; Habaradas and Aure, 2015; ODI, 2015) with limited coverage on other sectors including the information technology-business process outsourcing space (IT-BPO). The focus on case studies and a lack of comprehensive data has been noted as a weakness (Magno-Ballesteros and Llanto, 2017). Our case study aims to add diversity to the understanding of SEs in the Philippines and provide unique insights by featuring a SE working in the IT-BPO space - an underexplored research frontier in the Philippines, due to its involvement with survivors of exploitation.

## Public health in the Philippines

Countries with stronger social protection and higher social spending have both lower wealth and health inequality (Marmot et al., 2008; Raphael, 2006). This is particularly relevant in the Philippines, where 26% of the population live below the Philippine poverty threshold (Philippine Statistics Authority (PSA) and ICF International, 2014) with growing income inequality (United Nations et al., 2017), together with highly inequitable access to healthcare and significant out-of-pocket health expenditure (Dayrit MM et al., 2018). Research demonstrates significant socioeconomic differences in outcomes such as health care utilization, maternal and child mortality, nutrition, and immunization rates, especially among the urban poor (FNRI-DOST, 2014; Haw, Nel Jason et al., 2017; Hodge et al., 2016).

The Philippines has a dual public and private sector health delivery system. The public sector consists of Level 1-3 hospitals, municipal health centres, and community health stations, which are principally financed through a tax-based budgeting system (Dayrit MM et al., 2018). Whilst the national Department of Health (DOH) provides overall policy and strategic direction and supervises some of the hospitals and community-

level services, service provision is largely devolved to each of the Philippine's 1490 municipalities. This results in disparities in health financing and spending, service quality and access, and health outcomes which particularly affect poorer and more remote municipalities and constituents (Romualdez (Jr.) et al., 2011). Health care costs are partly covered by a social health insurance system administered by the Philippine Health Insurance Corporation (PhilHealth). Although 92% of the population are reportedly enrolled in this program, membership covers an average of only 30% of inpatient costs and provides minimal coverage for outpatient care, resulting in more than 50% of the total health spending being out-of-pocket, often spent within the burgeoning private sector (Dayrit MM et al., 2018).

## Our Case Study

The SE provides IT-BPO services using an ethical sourcing model. It was founded in 2014 by a sole proprietor with a technology and operations background. After encountering the issue of human trafficking, the founder quickly realized the deficiencies in employment-based aftercare and hypothesized that an approach similar to that used by large corporations to build highly functioning individuals and teams could be transformative in the lives of survivors. The venture was privately funded by the founder and operates as a for-profit entity, currently employing 150 individuals, within the Philippines but with plans for expansion. The SE focusses on market-driven and financially sustainable IT-BPO services including back-office support, customer service, accounting services, and digital photo and video editing. The SE partners with NGOs and aftercare agencies for recruitment, and from academic institutions for research and development of specialised core skills programs (e.g. health and financial literacy).  The SE aims not only to provide both a living wage through enhanced technical skills and long-term employment in a supportive environment, but also an environment where survivors of exploitation can progress toward achieving full and sustained recovery and reintegration.

Abuse history is not elicited from trainees but the SE accepts the background information and classifications of the referring agency[1]. The SEs criteria for 'vulnerability' is evolving and currently includes relatives of trauma survivors and

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[1] The SEs primary referring partner uses the United Nations Protocol to Prevent, Suppress and Punish Trafficking in Persons (UNHCHR, 2000) to assess whether clients had been trafficked.

individuals living in impoverished communities where abuse and exploitation is more common due to a lack of opportunities for higher education or skilled employment.

To enter the training program, candidates must be high school graduates and pass a written and verbal assessment in English or their preferred language. Technical and core skills training occurs in tandem, with trainees graduating to probationary employment after three months and tenured employment at six months. An overview of the SEs approach to core skills development has been detailed elsewhere (Gill and Tsai, 2018). The SEs approach addresses physical, mental, and social health outcomes through a range of strategies. Beyond basic nursing care, the SE does not provide health services, but instead builds the employees' health literacy, namely their capabilities to understand and access public health services, which are most appropriate for their individual needs. A workplace counsellor is also available, as access to trained mental health professionals is very limited in the Philippines. To our knowledge, this SE and its approach is unique worldwide, both for being competitive in the market, and for hiring survivors of exploitation.

## Research Design

This research study can be broadly construed as a case study. We use Robson's definition of case study methodology as a "strategy for doing research which involves an empirical investigation of a particular contemporary phenomenon in its real life context using multiple sources of evidence" (Robson, 2002, p. 178). According to Yin (2009) a "case study is an empirical inquiry that investigates a contemporary phenomenon in depth and within its real-life context, especially when the boundaries between phenomenon and context are not clearly evident" (p.18).To present the research design, the quantitative (longitudinal survey) is first introduced, followed by the qualitative (interviews and participatory video approach) data used for this research. By using multiple types and streams of information, this approach can reveal different aspects of a single phenomenon (Denzin, 1970), and improve trustworthiness (internal validity), transferability (external validity) and reliability of findings (Rossman and Wilson, 1985).

### Longitudinal Quantitative Data

Quantitative data is collected via a prospective cohort study where successive batches of 10 - 15 employees starting training are invited to participate in the research. The quantitative research has been approved by the Central Visayas Research Ethics Committee (Code: 001/2017-03- GILL).

The survey covers a range of indicators including household income and poverty, financial literacy, physical and mental health, and relationship and social wellbeing. Where possible, questions already validated for the Philippine population are used. If not available, tools widely used in similar populations have been selected. Symptoms of PTSD are assessed using the Harvard Trauma Questionnaire with a mean score of above 2.0 considered indicative of probable PTSD, which is the cut-off recommended and commonly used in relevant literature (Hossain et al., 2010; Kiss et al., 2015a; Mollica, 2004). Anxiety disorders are measured using the Hopkins Symptoms Checklist using the recommended cut off point of 1.75 for probable (Hossain et al., 2010; Kiss et al., 2015b; Mollica, 2004). Depression is measured using the Patient Health Questionnaire (8) with a threshold of 10.0 for depression (Kroenke and Spitzer, 2002; Que et al., 2013). Use of family planning and personal empowerment (financial and household decision-making) are assessed using questions from the Philippines National Demographic and Health Survey (Philippine Statistics Authority (PSA) and ICF International, 2014).

The research is guided by the applicable standards (United Nations Inter-Agency Project on Human Trafficking, 2008; World Health Organization, 2016). Written consent is obtained prior to collection of data, highlighting the study's purpose and content, the right to refuse or interrupt participation without impacting employment, and confidentiality. Each respondent is allocated a private ID number which is used on all surveys (respondents' names or birth dates are not collected during the survey). IDs are matched with respondents' names on a separate password-protected workbook available only to the lead and assistant researcher. Data is collected in groups of 10 – 15 people using desktop computers and an online survey tool (Kobo Collect).

*Data analysis*

The quantitative research aimed to test the hypothesis that employment within the SE significantly contributes to the process of recovery and reintegration as defined earlier

and to understand some of the key determinants to successful reintegration. Statistical analysis was undertaken using standard statistical software (SPSS). Respondents who dropped out at any stage of employment were not included in the analysis, however the majority of dropouts occurred within the first six months. Although the SE commenced operations five years ago, the survey was introduced for the second cohort for whom there is two-year follow up data. As the SE has grown rapidly over the past 10 months, there is significantly more enrolment and six-month data than 12 and 24-month longitudinal data. However, enrolment data for earlier and later cohorts was compared for each of the variables reported in this research and no statistically significant differences were found. Because of these big variations in sample size, hypothesis testing was not undertaken on the dichotomous variables due to potential issues with the logistic model. Mixed categorical (employment period) and interval data were analysed using the Kruskal-Wallis H Test, with a level of statistical significance set at <0.05.

## Qualitative Data

Participatory video (PV) is defined as "a collaborative approach to working with a group or community in shaping and creating their own film, in order to open spaces for learning and communication and to enable positive change and transformation" (PV-NET, 2008, p. np). This method "utilizes video as a social and community-based tool for individual and group development … to develop their confidence and self-esteem, to encourage them to express themselves creatively, to develop a critical awareness and to provide a means for them to communicate with others" (Shaw and Robertson, 1997, p. 11). We used this method to facilitate a process by which current employees could tell their stories in their own voice, setting their own priorities and objectives, acknowledging from the start their agency and the importance of their own voice. PV was used to encourage employees to reflect on their personal journeys since they joined the SE, providing insights to the researchers to identify how the process of hiring, each of the trainings (health, soft and digital skills) and continuous support, have impacted their work and private lives. This research was designed to provide mutual benefits to employees, researchers and SE managerial staff. Employees benefit by learning how to plan, produce and edit videos, skills that may be useful in their daily jobs and in their personal time. By participating, they would also be encouraged to self-reflect and acknowledge all they have accomplished post-

exploitation, as a way to further strengthen their self-esteem and self-confidence. Researchers benefit by gathering a variety of rich qualitative data sources produced by the participants during the participatory video process and interviews. Finally, the SE benefits by having some of their employees trained in video editing; by supporting their employees to participate in a process that will further increase their self-esteem and self-confidence; and by receiving further feedback about benefits and shortcomings of their work with survivors.

Before undertaking this research, ethics approval was sought and obtained from the UNU-CS HSRP board (reference 201803-01). To allow us to identify changes in perceptions, and see patterns of longer term impact from trainings, our selection criteria was, first, to work with participants of one specific exploitation category, namely, sexual exploitation and online sexual exploitation of children (OSEC) survivors. Participants were contacted and selected by the SE to protect their privacy. The second criteria was to have participants from a broad cross-section of time at SE. Employees ranged in time at SE from 0-6 months (referred to within the SE as "newbies"- 6), up to 24 months (mid-term - 4) and 4+ years (part of the original cohort, - 3 or "batch one", long-term). Employees who participated in this study were asked to complete three activities: initial survey, workshop, and an in-depth interview.

The survey, taken prior to the workshop, was designed to understand more about the participants' educational experience, as well as their use of computing equipment and software packages at home and at work. This information was used by researchers to understand the current level of technology expertise of participants. The workshop was organised around a series of activities. During each PV session, video footage was produced and screened to provoke discussions about filming and editing and to critically discuss the issues being filmed. Three final films were produced by the participants who were organised into teams. The PV workshop lasted a total of 13 hours during a two-week period. The in-depth semi-structured interviews were designed to solicit feedback on their experience at the SE, the application of the training they have received, and where they would like to see themselves in ten years. Interviews lasted between 11 minutes and 72 minutes. These explicitly avoided asking questions about the employees' experiences of exploitation. If the participants brought them up, the research team would allow them to continue, but not press them for any

further details. In addition to employees' interviews, open-ended interviews with 7 individuals holding senior management roles within the SE were also conducted.

*Data analysis*

The workshop discussions, videos created by participants and interviews were recorded, transcribed, and anonymised to ensure participants' privacy (each participant is here presented by their code, e.g. C013). Data was coded in NVivo, using open codes resulting from the transcription process, and codes based on variables defined in the longitudinal survey. Data was analysed using the theoretical framework, and discussed with the participants and SE staff for validation. Because we designed our qualitative study based on the longitudinal study, after the PV data was analysed in itself, it was compared to the quantitative data to triangulate findings.

## Quantitative findings from the longitudinal survey

### Demographic information and trauma background

Our sample included 77 individuals currently in training or employed within the SE. With the exclusion of dropouts, this represented 63% of those who commenced training. Most participants were female (83%) with a high school certificate (74%) and an average age of 23 years (17 – 53) at the start of training.  The type of exploitation is included in Table 1. The largest demographic difference was whether individuals spent time in residential care facilities.

**Table 1:** Employee demographic information per trauma background

| | **Labour exploitation** | **Sex exploitation** | **Sexual abuse** | **Vulnerable** | **Other** | **P value** |
|---|---|---|---|---|---|---|
| **No. (%)** | 9 (11.7%) | 18 (23.4%) | 14 (18.2%) | 30 (39.0%) | 6 (7.8%) | |
| **Age (mean)** | 24.7 (SD 4.3) | 20.4 (SD 1.9) | 23.6 (SD 5.0) | 22.4 (SD 5.2) | 31 (SD 12.3) | |
| **Sex** | | | | | | |
| Female | 7 (77.8%) | 16 (88.9%) | 14 (100%) | 21 (70.0%) | 6 (100%) | |

| **Educational level** | | | | | | |
|---|---|---|---|---|---|---|
| Secondary | 6 (66.7%) | 14 (77.8%) | 9 (64.3%) | 24 (80.0%) | 4 (66.7%) | |
| Vocational or college | 3 (33.3%) | 4 (22.2%) | 5 (35.7%) | 5 (16.7%) | 2 (33.3%) | |
| **Civil status** | | | | | | |
| Single | 5 (55.6%) | 12 (66.7%) | 10 (71.4%) | 17 (56.7%) | 1 (16.7%) | |
| Married or living as a couple | 3 (33.3%) | 5 (27.8%) | 3 (21.4%) | 9 (30.0%) | 3 (50.0%) | |
| **Aftercare** | | | | | | |
| Lived in residential care facility | 0 (0%) | 14 (77.8%) | 13 (92.9%) | 6 (24.0%) | 2 (33.3%) | |
| **Mental health scores on enrolment** | | | | | | |
| PTSD | 1.79 (SD 0.53) | 1.78 (SD 0.49) | 1.91 (SD 0.51) | 1.72 (SD 0.48) | 1.57 (SD 0.59) | 0.736 |
| Anxiety | 1.43 (SD 0.42) | 1.74 (SD 0.63) | 1.61 (SD 0.45) | 1.47 (SD 0.48) | 1.30 (SD 0.35) | 0.403 |
| Depression | 3.33 (SD 2.1) | 5.78 (SD 2.8) | 4.71 (SD 2.3) | 6.80 (SD 5.2) | 4.48 (SD 4.7) | 0.100 |

## Health outcomes

Upon recruitment, many individuals already had children (42%), with half of these children reported as being unplanned.  Although most sexually active women (83%) report 'doing something' to avoid or delay pregnancy, most were using 'natural methods' such as withdrawal (62%) or calendar method/periodic abstinence (21%). The minority of sexually active women (28%) were using modern contraception.

 As seen in Table 2, there is an increase in use of modern contraception throughout employment with a reduction in use of withdrawal, although these changes are most marked in the data collected after 12 months of employment, with 75% using a modern

method at two years. In tandem with these changes is a significant increase in confidence in negotiating condom use with current or future partners.

At the commencement of training, the mean score for PTSD was 1.76 (SD 0.47) with 27% of employees reporting symptoms. The mean score for anxiety was 1.54 (SD 0.5) with the prevalence of anxiety being 32% at commencement of training. For depression the mean score was 5.62 (SD 4.05) with 9% reporting symptoms (of depression) (Table 2). When these scores were disaggregated per population, there was no significant difference (Table 1). Throughout employment, there was a significant reduction in PTSD symptoms; a non-significant reduction in mean anxiety scores; and no significant change in depression scores, although the prevalence of these disorders appears to fall.

Measures of personal empowerment increased throughout employment. This includes participation in four key household decisions (health care, major and minor household purchases, and social visits) and control over personal finances. However, despite the improvements in physical, mental, and social health, employees reported ongoing issues accessing health care. The primary issue, which persisted throughout employment, was insufficient financial resources, despite significant increases in household income and provision of government health insurance by the SE.

**Table 2:** Physical, mental, and social health outcomes throughout employment

| | Enrolment | 6 months | 1 year | 2 years | P value |
|---|---|---|---|---|---|
| **Physical health outcomes: sexual and reproductive health** | | | | | |
| **Respondents** | **29** | **20** | **11** | **8** | |
| Using any family planning method | 83% | 90% | 91% | 87% | |
| Using withdrawal method | 62% | 75% | 45% | 50% | |
| Using any modern contraception | 28% | 30% | 46% | 75% | |
| Total Respondents | 77 | 42 | 17 | 9 | |
| Confidence negotiating use of condoms with a partner | 6.79 | 8.52 | 8.71 | 9.44 | 0.00 |

| **Mental health outcomes: prevalence of PTSD, depression, and anxiety** | | | | | |
|---|---|---|---|---|---|
| **Respondents** | **77** | **42** | **17** | **9** | |
| PTSD score (mean) | 1.76 (SD 0.47) | 1.63 (SD 0.44) | 1.47 (SD 0.3) | 1.41 (SD 0.27) | 0.025 |
| PTSD prevalence | 27.3% | 23.8% | 5.9% | 0.0% | |
| Depression score (mean) | 5.62 (SD 4.05) | 5.45 (SD 3.74) | 5.41 (SD 3.2) | 6.11 (SD 2.52) | 0.778 |
| Depression prevalence | 9.1% | 14.3% | 5.9% | 0.0% | |
| **Respondents** | **66** | **37** | **17** | **9** | |
| Anxiety score (mean) | 1.54  (SD 0.5) | 1.45 (SD 0.44) | 1.33 (SD 0.22) | 1.33 (SD 0.35) | 0.481 |
| Anxiety prevalence | 31.8% | 27.0% | 5.9% | 11.1% | |
| **Social health outcomes: household participation** | | | | | |
| **Respondents** | **76** | **42** | **17** | **9** | |
| Mean participation in four household decisions | 2.57 (SD 1.41) | 2.83 (SD 1.41) | 2.92 (SD 1.20) | 3.33 (SD 0.71) | 0.454 |
| Proportion of employees participating in 3 or 4 household decisions | 55.30% | 66.70% | 70.60% | 88.90% | |
| Mainly respondent controls personal finances | 44.20% | 64.30% | 82.40% | 88.90% | |
| **Access to health services: proportion of employees reporting issue is a 'big problem' throughout employment with average household income** | | | | | |
| **Respondents** | **77** | **42** | **17** | **9** | |
| Permission to go to the doctor a big problem | 10.4% | 14.3% | 11.8% | 11.1% | |
| Distance to the health facility a big problem | 14.3% | 21.4% | 0.0% | 0.0% | |

| | | | | | |
|---|---|---|---|---|---|
| Not wanting to go alone a big problem | 18.2% | 16.7% | 23.5% | 22.2% | |
| Money needed for advice or treatment a big problem | 68.8% | 57.1% | 58.8% | 77.8% | |
| **Respondents** | **56** | **29** | **14** | **7** | |
| Average household income $USD per person/day | 1.60 (SD 1.78) | 2.56 (SD 1.88) | 2.16 (SD 1.18) | 3.27 (SD 1.74) | 0.00 |

## Qualitative findings from the PV approach

Our qualitative study explored in-depth issues identified by the quantitative study. Our findings, resulting from the triangulation of these data, are presented below, to complement and expand our quantitative findings.

### Physical health outcomes: Sexual and reproductive health

The SE offers education concerning sexual and reproductive health during probation (2-4 months). Although employees' sexual and reproductive health knowledge increases post program, changes in their behaviour are only visible much later. During our PV workshop and interviews, mid and long-term participants were more confident in commenting about changes in their sexual and reproductive health, mentioning the frequency of unplanned pregnancies resulting, in part, from knowledge gaps.

The first change identified was changed perceptions of sexual and reproductive health, and modern contraception. Some participants described how the training had helped correct cultural myths (for example, being afraid of showering during menstruation), or how poorly educated they used to be.

> *I realize that I have to be more [careful]... because I have 3 children already. [...] I didn't know anything. I didn't educate about that, even a little I don't know [...] I am so pity in myself because I always get pregnant, pregnant again. (C005, 12-24 months)*

During the interview C005 described how she had not known that menstruation should be regular, and had been advised that using contraception would give her headaches,

therefore was 'afraid' of trying. The information acquired in the course helped her be better informed and less afraid of talking publicly about contraception, which led her to adjust her health behaviours by deciding to go to a health centre. This allowed her to stop feeling bad about herself for having many children or fearing becoming pregnant again. By taking positive action, she also increased her self-regulation and personal empowerment. While she still required support from the SE in terms of information and emotional support, she had to overcome her fear and seek medical advice and medication herself. In this case, it was important for her to realise the support she received from the SE was complementing rather than supplementing public health services. While information was available at the SE, prescriptions were only available at the health centre.

Another important change was the participant's inclination to talk about contraception with their partners:

> *There is a sensitive and personal question about me and, like, with my relationship with my husband… about birth control.. [...] it's really helping me because I can open up with Miss C020 and Miss C019. Because they know about that [...] anytime we can ask them, even if our training is done then we can always ask them about our health (C012, 12-24 months)*

When further discussed, it was clear that talking about contraception with their partners was challenging and uncomfortable, partly due to the many misconceptions and sociocultural barriers. Because private medical services are expensive, employees reported not wanting to use them. Hence, they require significant motivation to navigate the public health services. Having social support from the SE, together with the core skills training helped them acquire the information and confidence to overcome their fears and experience a genuine change in behaviour.

When other aspects of their health management were analysed, it was evident that employees implement changes that directly affect themselves first, such as getting enough sleep and improving their eating habits. As time progresses, this extends to others - for instance, ensuring their children were receiving adequate nutrition, and making decisions with their partners about family planning. In this case, any health support available at the SE was for the employee and during working hours, complementing public health services. If other members of the family require medical

services, they need to access public health services. For this reason the SE needs to reinforce employees' autonomy, so they can seek medical advice and services beyond the work environment.

## Mental health outcomes: confidence and self-esteem

During our training and interviews, participants were asked to reflect on how they felt before entering the SE. Participants from every group described their initial lack of confidence, often in their technical skills and spoken English. For instance, C004 (0-6 months) talked about feeling "nervous" and "confused" and standing outside the door on her first day, asking herself "can I do this or not?" and "[wanting] to give up." Yet most participants made similar comments saying that their confidence had grown:

> *Before, when I started training, I get so overwhelmed [...] I'm just so scared [...] now I have confidence in myself, even though I'm not good in English...I can be proud. (C005, 12-24 months)*

Participants expressed that they felt an initial nervousness, followed by an increase in confidence. This improvement in confidence was attributed to the 'Learning to Learn' training, where employees are encouraged to see learning as a process, and failing as part of it. Within the SE, employees are expected to improve their skills, but within a friendly and supportive environment, which acknowledges the difficulties they might encounter. Employees have access to additional support from the HR Director and the workplace counsellor. This support was added as mental health services are scarce and very expensive. As such, employees benefit from having time to improve core skills and a reduction in their trauma symptoms, while being employed and earning an income, crucial for their financial stability. In this regard, being employed was also a source for their increased confidence, as it influenced how other people perceived them:

> *The place now where I live with my partner... all of them know who I am before. So, when they saw me every morning going here at work, they would just smile at me. Before they would not smile at me. "ahhh that girl has..." but now... I was so happy, because I also have a thinking that "I am now able to stand on my own, to raise with my family, and don't have any problem like that". (C005, 12-24 months)*

For C005 her neighbours' treatment of her had a strong impact on her self-esteem. Their changed perceptions solidified her own shifting self-perception. The sense of self-efficacy conferred by her job and her role as a professional employee has also provided C005 a sense of security and increased self-esteem and life satisfaction. More than one participant in our study experienced this change in people's perceptions. For instance, C001 (12-24 months) recounted how she now could go 'outside' with pride whereas she previously isolated herself.

Long-term participants demonstrated much deeper reflections and improvements in their confidence and self-esteem than earlier groups. They reflected in a more nuanced and holistic way on their journeys, their satisfaction about their post-exploitation lives, and the changes they have witnessed in themselves and their colleagues since they joined the SE.

> *The thing is, I'm also thankful because of my past. But it's not about, you know, sticking to the past but also moving forward. Because if not for my past I will not be here. At work, I don't know why I always feel empowered, something like that, or I feel recovered from my past. Maybe I can also, maybe because I was in a group, I can say that we are recovered from the past, we've been together for how many years. And then it's like, seeing C013, or seeing my colleagues change, it makes me feel different (C011, +4 years)*

Long-term employees described how, not only their increased confidence helped them in personal relationships, but also how personal relationships, vulnerability, and connection can themselves build self-esteem. They also described personal coping mechanisms, including a mobile app (C003, 4+ years) and a mantra (C013, 4+ years), that have helped them maintain self-esteem through stress and difficulties.

Changes in their confidence and self-esteem were also present in two (of three) final videos created by the participants in the PV course. For instance, one group's video focused on one individual's self-transformation. It starts with a woman feeling "pain… hopeless… defeated, judged", followed by being offered an opportunity, symbolised by the word HOPE written in hands reaching out (Figure 2).

**Figure 2:** Second group final film images

Know that it's not the end
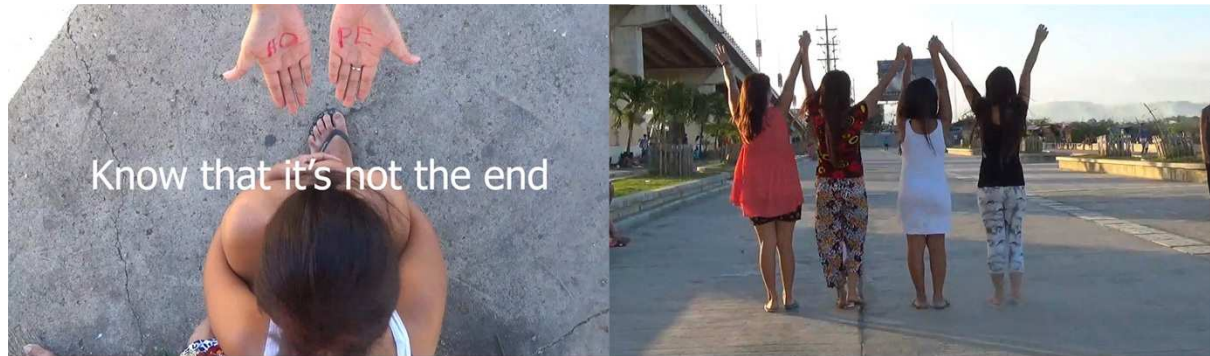
After the "defeated" woman takes hold of the "hope" hands, which represent the SE employment opportunity, the video cuts to a scene with four women laughing and enjoying themselves, as a representation of their recovery. The film closes with the statement "[SE] provides 99.9% accuracy and efficiency. Behind those numbers are those people who were transformed from no-one to someone". Their increased self-esteem and confidence is therefore represented as a result of the different training attended at the SE and being accurate and efficient in the work they do (efficacy-based self-esteem). Time, in tandem with the workplace environment and support, led to a gradual improvement in their mental health. This finding reinforces the need for public health services to offer more widely mental health services, as the workplace counsellor benefits only employees and during working hours.

## Social health outcomes: improvement in social capital and increased responsibility

Another area where SE has helped influence their employees is through establishing healthy relationship habits and taking responsibility for their own lives. Through the core skills training and other activities, the SE has encouraged its employees to improve their relationships, which sometimes entails ending or limiting damaging relationships.

Changes in their own attitudes and behaviours, like being more patient or being able to control their temper, aided by an improvement in their communication skills, helped them improve their relationships. One participant explained:

> *We are family oriented but there is a point in our lives that we have to let them realise that not all the time we have to be connected. [...] if they're not a good influence, we wouldn't let them be in the circle of our lives. (C013, 4+years)*

This participant acknowledges how family is important in Filipino culture, which means being assertive with family members is very difficult and counter-cultural. Yet, employees who have been in SE more than 4 years show increased assertiveness and use this to manage their negative relationships. Some recounted being assertive with family or friends, saying 'no' when appropriate (2 participants), ending/distancing from negative relationships with partners or parents (2), and learning who you can trust (1). Employees described the SE as 'family' and how the 'culture' of the organization has helped them and accepted them (C008).

> *SE is my... the sunshine of my life because... [...] the whole SE, the management, the people, my colleagues, they are the missing piece of my life. Like, they are the one who made me complete, they made me whole, because it's not just the training, it's also about... our relationship with everyone. (C012, 12-24 months)*

This different attitude towards their relationships has helped them cope in their professional and personal lives, and has shown how valuable social capital is for their recovery and reintegration. This kind of support is not expected nor should be provided by public health services, yet it plays an important role in helping survivors deal with their trauma and actively search health advice when required.

## Discussion

Five years ago, the SE in the Philippines commenced operations with the aim of helping survivors of exploitation achieve successful and sustained recovery and reintegration through supported, technology-centric employment. As there is an absence of research concerning how SEs address health both in the Philippines and in the broader survivor aftercare literature, the SE has developed its own approach. This involves addressing health in both a distal (decent, meaningful work with a living wage) and more proximal manner, the latter through holistic, tailored core skills, development strategies, and programs aimed at improving physical, mental, and social wellbeing. Quantitative data collected through an employee survey and qualitative

data collected via a Participatory Video and in-depth interviews demonstrate improvements in each of these domains.

Because it is neither ethically nor logistically possible to have a matched control group, it is not possible to prove causation or isolate which specific workplace-based strategies or programs are most impactful. However, triangulating the quantitative data with qualitative research strengthens the argument that the improvements are indeed caused by the workplace and present the survivors' perspective on what elements are more meaningful for them. Similarly, there are clear limitations to the findings of the quantitative longitudinal data given the small number of respondents included after 12 months. Despite this, the research shows promising trends, which the authors believe can make a significant contribution to, on one hand, how SEs engage their employees, and the type and degree of health-related improvements, which can be achieved. On the other hand, it illuminates how SEs may offer survivors of exploitation supported employment, whilst operating a self-sustaining enterprise by providing competitive BPO services.

The findings demonstrate improving mental health outcomes, particularly trauma symptoms, which the qualitative data suggests is due to improving executive functioning and self-regulation, self-esteem and self-confidence, and a sense of belonging arising from the workplace. These changes occur incrementally over time, starting with overcoming their fear of failure and progressing to the strengthening of self-image and self-efficacy through the self-mastery experiences provided in the workplace. These findings are supported by emerging research which suggests important elements in trauma symptom recovery among survivors of trafficking and similar populations, such as: improved coping mechanisms (Katona et al., 2015; Okech et al., 2018); the presence of social support (Abas et al., 2013; Okech et al., 2018); finding 'belonging' and becoming aspirational (Katona et al., 2015); and a reduction in feelings of guilt and shame (Salami et al., 2018). However, there is no research to date demonstrating the superiority of any one type of trauma intervention over another (Altun et al., 2017; Salami et al., 2018). Katona et al (2015) suggest, approaches which are integrated and address multiple determinants, are likely to be more effective in improving mental health outcomes among survivor populations as occurs within our case study.

The prevalence of mental health issues on enrolment is similar to that documented in pooled PTSD prevalence studies, which are typically undertaken in the early phase of post-exploitation care (Ottisova et al., 2016). In comparison, the SE population have typically exited years before entering employment. This supports the argument that the reduction in scores is not merely due to the passage of time. Time, in tandem with specific support, is required. Although the qualitative research pertains to survivors of sexual exploitation only, our quantitative data demonstrates similar demographic profiles and no significant difference in PTSD scores between the different workplace populations. Hence, we would argue that the qualitative findings are transferable to these populations. It is possible that differences in mental health profiles and vulnerabilities, including experiences of childhood trauma and neglect, will emerge with a larger employee sample, and we look forward to continuing our research in this direction.

The second major finding in our research was an increase in the proportion of employees proactively managing their sexual and reproductive health through use of modern contraception which, after two years of employment, was much higher than use in women with a similar demographic profile in the Philippines (approximately 40%) (Philippine Statistics Authority (PSA) and ICF International, 2014, p. 17). This change occurred more slowly than mental health improvement, which, together with the findings of the qualitative research, suggests that the improvement in executive functioning is required for the more complex nature of this behaviour. Similarly, both datasets suggest that increasing self-confidence enables the employees to engage in the difficult negotiations required with their sexual partners. Research from the Philippines demonstrates that increasing personal empowerment, as reflected in higher participation in household decision-making, is positively associated with greater use of modern contraception (Philippine Statistics Authority (PSA) and ICF International, 2014). This change, together with improvements in sleep and eating habits, shows employees increased health literacy.

The research demonstrates ongoing barriers to accessing health services care due to financial constraints. This is despite increasing household income, the provision of government health insurance by the SE, the availability of cash advances for urgent health care needs, and access to a financial capability and savings program. As mentioned above, this SE differentiates from others by being competitive in the IT-

BPO market, and it is through this manner that the SE is able to finance the multiple trainings and support offered to its employees. Therefore, the SE avoids becoming the primary health service provider to its employees because it is financially untenable if it is to remain competitive and profitable. Furthermore, this would undermine the core skills training which aims to strengthen the employees' own personal empowerment to care for their own selves in a proactive and responsible manner. Consequently, the employees are encouraged to become active citizens, fulfilling their duties but also understanding their rights as citizens, such as access to quality and affordable public health services. The findings presented above show how the model used by the SE is currently serving its purpose. On the one hand, it is helping those hired to become good employees, resulting in a competitive IT-BPO. On the other hand, the employees gradually improve their personal empowerment, which not only helps them within their job, but also addresses their physical and mental health issues.

The targeted and limited interventions and wellness programs of the SE can only complement rather than supplement the role of the state in ensuring 'health for all' as enshrined in the Alma Ata declaration (International Conference on Primary Health Care, 1978). Our case study demonstrates that SEs can be involved and play a role in addressing some social determinants of health. However, structural determinants including economic, health care and social policies remain under the general remit of the public sector. This is a challenge faced not just by those hired by the SE, but by all vulnerable citizens, due to unequal social structures, such as social and economic policies and politics, resulting in the high inequalities experienced in relation to health services and outcomes in the Philippines (Dayrit MM et al., 2018; Marmot et al., 2008). Public health service provision, as a contested space, therefore involves input from multiple stakeholders, including new and emerging ones such as social enterprises, with the state's role remaining paramount.

## Conclusions

This research provides empirical evidence, to our knowledge a unique SE, which hires survivors of exploitation, without losing their competitiveness in the market. It shows how SEs can play a positive role in addressing the psychosocial and physical wellbeing of employees from vulnerable backgrounds. This is mainly achieved through the provision of health education and core skills programs together with an enabling

environment conducive to recovery from trauma experiences. In this regard, our findings contribute to ongoing academic conversations on the role of SEs in improving health outcomes and the mechanisms that enable SEs to fulfil this role.

The research has also illustrated how a focus on developing employees' health literacy has had a positive impact on health and wellbeing. In using this approach, the SE aims to provide a supportive scaffolding for employees, whilst avoiding creating dependency. Such findings have practical implications in designing health interventions targeting survivors of exploitation beyond the context of SEs.

In the context of the case study presented, the role of the SE, is limited to a complementary rather than supplementary role for health service provision, especially when broader social determinants of health are considered. It is unattainable for one SE to overcome the multiple constraining social structures, which affect access to quality, affordable health services. Neither is it possible for SEs to replace the many stakeholders responsible for the delivery of public health services. Furthermore, it is not advisable given the established correlation between higher social protection and government spending and better health outcomes within a country. Finally, if health is truly upheld as a 'fundamental human right', it remains incumbent upon the government to create effective, equitable social, economic, and health sectors which enable all of its constituents to achieve a 'state of complete physical, mental, and social well-being' (International Conference on Primary Health Care, 1978).

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