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CHALLENGES OF HEALTH CARE PROVISIONING FOR INMATES IN NIGERIAN CORRECTIONAL SERVICES: EVIDENCE FROM DOCUMENTARY SOURCES.

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Abstract

Health care is an essential service required by inmates of penal-correctional custodial facilities, especially given the precarious conditions of imprisonment. This paper analyses the level of health care provisioning in correctional (custodial) centres in Nigeria and identifies challenges and prospects for enhancing health care service delivery for inmates. Data were obtained from secondary sources, especially official publications of the Nigerian Correctional Service and other international organisations that provide yearly reports on prison conditions. Findings indicated that health care services are below the standard prescribed by international instruments. Lack of priority and resources accounted for most of the inadequacies. Effective health care in correctional custodial centres requires adequate and qualified personnel with appropriate work ethics and adequate infrastructure as well as effective collaboration and referral framework between health care services within the custodial centres and the federal or state ministries of health.

Keywords: Health care, Correctional centre, & Inmates,

Introduction

Prisons and correctional centers pursue diverse goals, notably, retribution, penitence, resocialization, rehabilitation and reintegration of persons convicted of crime and sentenced to custodial and non-custodial supervision (Nigerian Correctional Service Act 2019). However, prisoners have general health needs similar to those found in the general population different from health care needs related to offending behaviour such as substance misuse and mental health problems. Prisoners also have health care needs which are a consequence of imprisonment which restricts access to family networks, informal cares and over the counter medication; the prison environment can be overcrowded and may be violent. More importantly, prisoners suffer emotional deprivation and may become drug abusers and develop mental health problems (Fazel et al 2016) whilst incarcerated. Other health care needs may be made more complicated by

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imprisonment such as the management of chronic diseases like diabetes or epilepsy and infectious diseases (Borschmann et al., 2020). Also, certain health care needs are requirements of the prison system itself, for example health screening on arrival at prison and assessments carried out to determine a prisoner's fitness to appear in court (Marshal, Simpson, and Steven, 2000). Imprisonment is a severe punishment in any democratic society that strips inmates of their independence in decision-making and erodes many fundamental rights, especially freedom of movement, association, assembly and privacy (Osefo, 1990). As a total institution, prisons control or influence the minutest decisions of inmates and ensure their total dependence on the personnel, rules and regulations of the custodial centres.

There are international guidelines for health care in correctional and penal services. Most prominent among them is the United Nations Standard Minimum Rule for the Treatment of Prisoners, generally referred to as the Minimum Rule or Mandela Rule (2015), which required with regards to health care, that custodial centres or prisons should provide covered sleeping environment, lightning and ventilation, sanitation and hygiene, water supply, 'food of nutritional value', access to medical personnel and medications, pre-natal and ante-natal care, and nursery care (United Nations 2016). Extant literature indicated that the Nigerian Prisons Service had serious challenges in providing adequate health care services to inmates.

Despite the signing of the 2019 Act which saw the penal institution changed from the Nigerian prisons to the Nigerian Correctional Service by the then President Mohammadu Buhari, critical components of the Act are yet to be implemented while prison conditions remained unchanged. In particular, conditions of the healthcare facilities in most of the correctional facilities have remained grossly inadequate in meeting the needs of inmates. Healthcare facilities are in dilapidated condition characterised by lack of proper medical equipment and supplies, severely impacting inmates' physical and mental health (Aluko et al., 2022). This raises critical questions as follows:

How well has the change from a prison system to a correctional system affected the general conditions of the prisons in Nigeria? What is the condition, scope and quality of health care in Nigerian correctional centres? How has the health conditions in the prisons affected the mental health of the inmates in Nigeria?

This paper analyses the conditions of health care services in Nigeria's correctional (custodial) centres. It also examines the major challenges facing the implementation of the UN Minimum Standard Rules for the treatment of inmates with particular reference to healthcare provisioning and service delivery in Nigeria's custodial centers. More importantly, the paper seeks to propose measures for improved health care service for custodial inmates in the country.

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The significance of the study lies in its contribution to both scholarship and policy. It advances understanding of prison health as a public health issue embedded within broader institutional and governance structures. Empirically, it provides evidence-based insights into staffing adequacy, service capacity, and systemic constraints affecting inmate healthcare in Nigeria. From a policy perspective, it offers critical guidance for correctional administrators and policymakers seeking to align practice with national legal mandates and international standards such as the Mandela Rules.

Evolution of Prison System in Nigeria

The functions of the criminal justice agencies are interconnected in a manner reflecting a production chain in which the police are the gate-keepers or front-end stage while the prison and correctional agencies are at the rear of the criminal justice administration process, and often operates beyond public view, behind custodial walls.

Nigeria inherited a colonial prison system which was fundamentally operated as a warehouse for remand of suspects and punishment of convicts. The first prison was established by colonial government in 1872 on Broad Street in Lagos (Awe, 1968; Alemika, 1983). Numerous inadequacies of the country's prison system since colonial origin to present time have been observed. Among such inadequacies are punitive orientation and lack of resources for resocialization, overcrowding, poor sanitation and health care (Awe, 1968, Alemika & Kayode, 1981, Alemika & Alemika, 1994; Alemika, 1983, 1993; Civil Liberties Organization, 1991; Public Service Review Commission, 1974; Nigerian Law reform Commission, 1983; Federal Government of Nigeria, 2006).

Over the past four decades, there has been persistent advocacy for the correction and reform of offenders rather than mere incapacitation and punishment of inmates (Alemika & Kayode, 1981; Alemika, 1983, Nigeria Law Reform Commission, 1983). Two of the major protracted problems associated with imprisonment in the country are overcrowding and inadequate health care for inmates. There has been persistent public demand for the reform of the prison system and attempts by government to respond to the problem of overcrowding and other inadequacies (Nigeria Law reform Commission, 1983; National Working Group on Prisons Decongestion, 2005 and Presidential Committee on Prisons Reform, 2006). In 2019, the Nigerian Correctional Services Act was enacted. In this paper, we analyses the framework and challenges of healthcare service in Nigerian custodial centers

The Nigerian Correctional Service Act, 2019

The demand for the transformation of the Nigerian Prison Service led to the enactment of Nigeria Correctional Service Act in 2019. The objectives of the Act are to:

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(a) ensure compliance with international human rights standard and good correctional practices;

(b) provide enabling platform for implementation of non-custodial measures;

(c) enhance the focus on corrections and promotion of reformation, rehabilitation, and reintegration of offenders; and

(d) establish institutional, systemic, and sustainable mechanisms to address the high number of persons awaiting trial.

The Act has two faculties; the Custodial Service and Non-Custodial Service. The Custodial Service, among other roles, will take custody and control of persons legally interned in safe, secure, and humane conditions. It will also convey remand persons to and from courts in motorised formations. It seeks to identify the existence and causes of anti-social behaviours of inmates and conduct risk and needs assessment aimed at developing appropriate correctional treatment methods for reformation, rehabilitation and reintegration. The custodial service will ensure the implementation of reformation and rehabilitation programs to enhance, among others, the reintegration of inmates back into the society **(**Gulleng, Gurumyen & Akintunde, 2025). This represents significant expansion of the roles of the country's penal and correction agency. Thus, in addition to concern with safe custody of inmates, the correctional system is required to also correct, reform, rehabilitate and reintegrate offenders, thereby extending the organizational roles beyond the walls of confinement.

Literature review and Theoretical framework

There remains a significant scarcity of empirical data and scholarly publications addressing the health conditions within correctional facilities. The limited research and allocation of resources toward incarcerated populations result in a fragmented and inadequate understanding of the state of healthcare delivery in custodial settings. Many correctional facilities across Africa, largely inherited from colonial administrative systems, continue to experience chronic overcrowding, poor nutrition, and systematic neglect of fundamental human rights (Sarkin, 2019). These conditions create an enabling environment for the transmission of infectious diseases, posing serious risks not only to inmates but also to correctional staff and the wider communities to which inmates eventually return.

Across Africa, existing studies have consistently highlighted unhygienic overcrowding, poor sanitation, and substandard living conditions, with many penal institutions falling below internationally accepted minimum standards (Van Hout & Mhlanga-Gunda, 2019; Engdaw, Masresha, & Tesfaye, 2023). Evidence further indicates that in at least 17 African countries, juveniles are detained alongside adults, thereby increasing their

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exposure to physical violence and sexual abuse (Van Hout & Mhlanga-Gunda, 2019). Similarly, research conducted in Zambian correctional centres revealed heightened vulnerability among younger inmates, largely attributable to financial deprivation, which renders them susceptible to exploitation and sexual abuse by older and more powerful inmates (Topp, Moonga, Luo, et al., 2016). Additional concerns documented in the literature include inadequate food quantity and quality, limited access to healthcare services, and shortages of basic necessities essential for human dignity.

In the Nigerian context, available studies equally reveal persistent deficiencies in healthcare provision within correctional facilities. Multiple investigations have documented inadequate resource allocation, poor living conditions, and insufficient medical infrastructure, all of which adversely affect inmates' physical and psychological wellbeing (Aluko et al., 2021). Other scholars report that healthcare services remain grossly inadequate, with inmates' basic health needs barely met due to chronic shortages of medical personnel, essential drugs, and functional equipment (Adefisoye, Adejumo, & Olufemi, 2024). Notably, there is an acute lack of specialized health professionals, including psychologists, despite the high prevalence of mental health disorders among incarcerated populations (Jeremiah et al., 2021). High numbers of awaiting-trial inmates and inefficiencies within the judicial system further contribute to overcrowding and the deteriorating state of custodial facilities.

Further evidence suggests that mental health challenges within Nigerian custodial centres are widespread and difficult for affected inmates to manage (Omoruyi & Igbinoba-Ojo, 2022). The absence of psychiatric professionals within the Nigeria Correctional Service means that inmates with mental health conditions are often referred to external hospitals for care. Researches on inmates' mental health in Nigeria suggests that mental health challenges in Nigeria Correctional Services are increasing astronomically due to years of neglect of inmates (Armiya'ul, Obembe, Audu, & Afolaranmi, 2013). Poor living conditions and degrading custodial environments have been shown to produce profound physical and emotional distress among inmates, thereby increasing their vulnerability to mental illness (Agboola & Udofia, 2017). Mental health disorders now constitute one of the leading contributors to morbidity within Nigerian correctional facilities. Effective mental healthcare within correctional systems is therefore critical, particularly through comprehensive psychiatric assessments that help establish links between mental disorders and criminal behaviour (Westbrook, 2011). The growing burden of mental illness in correctional facilities across developing countries has intensified global advocacy for increased government investment in correctional mental health services.

Healthcare delivery within the Nigeria Correctional Service is guided by the United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules), which affirm inmates' right to healthcare equivalent to that available in the general population. This is premised on several grounds. First, inmates have rights to life,

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which can be compromised in a custodial centre due to closure. Second, diseases in custodial centres can rapidly spread due to enclosure and loss of agency by inmates. Third, inmates who serve their term are released to society and those with untreated communicable diseases can, on release, spread them in society. Despite these provisions, the realities within most Nigerian correctional facilities contrast sharply with international standards, as institutions remain constrained by inadequate funding, overcrowding, and weak healthcare systems. Cultural differences, such as stigma around mental and sexual health, reduce the effectiveness of interventions like counselling or disease screening. Unlike regions where health ministries manage prison healthcare, many African nations rely on justice departments, leading to inefficiencies. Additionally, weak health data systems, unique challenges of stigma, reintegration challenges, and prolonged judicial delays exacerbate overcrowding and health crises, highlighting the urgent need for context-specific and locally grounded policy responses (Okunlola, Babatunde, Akoki, Ilori, et al,2024).

Theoretical Review

This study is anchored in the Human Rights–Based Approach (HRBA), which conceptualises access to healthcare as a fundamental human right rather than a discretionary service. The HRBA is grounded in international human rights law and emphasises the obligation of the state to respect, protect, and fulfil the rights of all individuals, including incarcerated persons. Within this framework, prisoners are regarded as rights-holders, while the state and its institutions function as duty-bearers responsible for ensuring the realisation of these rights.

In the context of incarceration, the HRBA is particularly relevant because imprisonment lawfully restricts liberty but does not extinguish other fundamental rights, including the right to health. International instruments such as the United Nations Standard Minimum Rules for the Treatment of Prisoners (the Mandela Rules) affirm that inmates are entitled to healthcare equivalent to that available in the wider society. The HRBA therefore provides a normative lens for assessing whether healthcare provisioning in Nigerian correctional centres meets minimum standards of availability, accessibility, acceptability, and quality.

Applied to this study, the HRBA enables a systematic interrogation of healthcare delivery in Nigerian custodial centres by focusing on structural conditions, institutional practices, and resource allocation as matters of rights compliance rather than administrative inadequacy alone. Issues such as overcrowding, shortage of healthcare personnel, weak referral systems, and poor health information management are interpreted as indicators of the state's failure to fulfil its human rights obligations toward incarcerated populations.

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Furthermore, the HRBA situates prison health within a broader public health and social justice framework, recognising that neglect of inmates' health has implications beyond custodial facilities, particularly upon reintegration into society. By adopting this framework, the study moves beyond descriptive accounts of prison conditions to a rights-informed analysis that links healthcare provisioning to accountability, equity, and correctional reform.

Methodology

This study adopted a documentary research design relying on secondary data. First, state of the art literature were consulted using google scholar search engine on specific concepts of prison, prison healthcare conditions, mental health care and general prison conditions. Similarly, official publications of the Nigerian Correctional Service (NCS) and other international organisations reports like the World health Organisation, United Nations, etc were consulted. NCS documents were selected because the service is the statutory authority responsible for custodial correctional centers and maintains nationwide administrative records on inmate population and healthcare services. Data sources included NCS annual report (2018-2023), relevant policy and legal instruments, and international person health guidelines. Documents were selected based on institutional authenticity, relevance to inmate healthcare, and temporal coverage of post-2019 correctional reform period. Quantitative data were extracted directly from the reported figures. Qualitative data were derived from narrative sections of the reports and policy documents. Analysis combined content analysis (systematic examination of narrative sections of annual reports) and descriptive statistical techniques to summarize trends.

Findings

Health care provisioning in Prisons

Health, according to the World health Organization, "is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity' (World Health Organisation, 1948: 100)[1]. From this definition, dimensions of health comprise physical, mental and social well-being. Health care services refers to "any set of activities whose primary intent is to achieve a state of complete physical, mental and social well-being" (da Costa et al, 2022: 566). The United Nation Minimum Rule for the Treatment of Offenders, which is also known as Mandela Rule, is the basic international instrument guiding the treatment of offenders in custody. The Mandela Rule specified two overarching principles for the provision of health care to prisoners. Rule 24(1) provided

[1] World Health Organization (1948). Summary Reports on Proceedings Minutes and Final Acts of the International Health Conference held in New York from 19 June to 22 July 1946. World Health Organization, available from: https://apps.who.int/iris/handle/10665/85573.

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that "The provision of health care for prisoners is a state responsibility. Prisoners should enjoy the same standards of health care that are available in the community, and should have access to necessary health-care services free of charge without discrimination on the grounds of their legal status". The Mandela Rule also provided that "Every prison shall have in place a health-care service tasked with evaluating, promoting, protecting and improving the physical and mental health of prisoners, paying particular attention to prisoners with special health-care needs or with health issues that hamper their rehabilitation" (Rule 25(1)).

Specific provisions in the Rule required classification and separation of inmates for accommodation and resocialization (Rule 11); adequate accommodation that meets 'all requirements of health', with 'due regards being paid to climatic conditions, … cubic content of air, minimum floor space, lighting, heating and ventilation (Rule 13); adequate sanitary installation (Rule 15); adequate and appropriate facilities for bathing (Rule 16); cleanliness of all parts of the prison used by prisoner (Rule 17); adequate water and toilets for prisoners to maintain personal hygiene (Rule 18).

The Minimum (Mandella) Rule also prescribed clean and suitable clothing (Rule 19-21); regular and adequately nutritious meal required for health and strength (Rule 22), alignment of health care of prisoners with public health administration (Rule 24); prompt access to medical attention in urgent cases (Rule 27); adequate staffing of prison health care facilities (Rule 27); ethical professional conduct by personnel responsible for health care of prisoners, including maintain duty of care, autonomy and privacy of prisoners; consent and confidentiality in relationship with inmates and avoidance of any act that may constitute torture, cruelty, inhuman and degrading treatment of inmates.

Notwithstanding these provisions of the Mandela Rule, health care for prisoners do not match those available in the community, neither is the government's responsibility for prisoners' health wellbeing taken seriously. Lack of priority and adequate investment in appropriate resources negatively impact access to health by prisoners. (Simpson, Guthrie, Jones, & Butler 2021).

The significance of data and research on prison health care has been underscored by scholars. It has been observed that "it is critical to sustain efforts to improve surveillance, to create prison health datasets at national or subnational level, to provide research that can inform decision-making, to conduct systematic evaluations and to document best practices". Health care in society and prisons can be assessed using several indicators that measure or describe "inputs and processes, outputs and impacts" (da Costa 2022: 565). These measures what resources are injected, how allocation of resources is determined

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and utilized, what services are delivered and how they impact on health welfare of recipients and their community.

In Nigeria, data for reliably assessing these factors are significantly lacking. Even in the Nigerian custodial centers, with captive population, where this problem ought not to exist, it manifests, in spite of the existence of a health information management system within the Health and Welfare Directorate of the Nigerian Correctional Service. The problem of lack of data and unreliability of available information on health care service delivery within the custodial correctional centers in the country stems from a lack of culture of documentation and data collection. The Annual Report of the Service reported that data on health care service are not provided by majority of the state commands in the country. Often, reports on the morbidity and mortality of inmates "from most commands were not received or received late" (NCoS Annual Report – 2018: 26; 2020: 61; 2021: 135).

Health care services for inmates in Nigerian Correctional Service

Data for this study were primarily sourced from the Nigerian Correctional Service 2018, 2020, 2021, 2022, 2023.*Annual Report* Abuja: published by the Planning, Research and statistics Unit, Nigerian Correctional Service.

The Service is structured into Headquarters, Zonal and state commands and formations of different categories of custodial centres. Thus, the Services consists of the Headquarters, located in Abuja, 8 directorates, 8 Zonal Commands, 37 State Commands and 298 formations, including 140 Custodial Centres, 85 Satellite Custodial Centres, 3 All female custodial centres, 19 Farm Centres, 10 Agricultural projects, 7 Borstal Institutions (Kaduna, Abeokuta, Ilorin, Enugu, Gwako, Kano, Suleja), 1 Staff College (Kakuri Kaduna), 1 Corrections Academy (Ijebu-Igbo, Ogun State), 5 Staff Training Schools (Kaduna, Enugu, Lagos, Owerri, Kebbi) (NCoS Annual Report 2023)

The Directorates of the Nigerian Correctional Service are Finance and Account; Health and Welfare, Human Resources, Inmates Training and Productivity, Non-Custodial services, Operation, Training and Staff Development and Works and Logistics. Health care for the prisoners is the responsibility of the Health and Social Welfare Directorate. The Directorate has the following key departments and units: Health Information Management System, Henry Akingba Medical Research Centre, Dental unit, Eye Unit, Medical Record Unit, Nursing and Midwifery Unit, K9 Unit, Medical laboratory, Deradicalization, Medical, Welfare, NIPRIPHARM Drug Research Centre, Nursing (Hospital Services Development), Pharmacy, Preventive Health Service, Psychological and mental health care, Catering services, Sport (NCoS Annual Report, 2023: p. xvii).

Available information from the Annual Report of the Nigerian Correctional Service (2021: 75) indicated that the average daily inmate population in the correctional centers in 2021 was 68,901 of which 19,667(29%) were convicted and 49,234 (71%) were

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awaiting trial; 2,991 (4.3% of the total inmate population and 15.2% of convicts) were sentenced to death and on death row.

The Service has limited health care resources and infrastructure. There were only 882 health care personnel attending to an average of daily population of 68,901 inmates (NCoS Annual Report, 2021). The distribution of the health personnel is presented in table 1. In spite of transition from prison to correctional service, the strength of staff remained unchanged.

Staff of Health and Social Welfare Directorate

Health Professionals	2018	2020	2021
Medical doctors	44	47	35
Dental surgeons	5	5	3
Pharmacists	29	29	29
Nurses	452	452	452
Laboratory scientists/technicians/assistants	45	45	45
Psychologists	45	-	-
Pharmacy technicians	20	20	20
Environmental health officers	66	66	66
Community health officers/community health extension officers	232	232	232

Morbidity and mortality

Data on morbidity and mortality in the custodial centres are not reliable due to the failure of several commands to submit reports to the national headquarters. Inmate morbidity and mortality were not reported by majority of states. Only 13 states rendered comprehensive report in 2018. Most common disease in 2018 from partial or incomplete reports[2] from 13 commands were malaria, dermatological allergy, respiratory impairment, muscular and skeletal problems, gastrointestinal conditions. During the year 2018, 662 inmates in custodial centres of 27 state commands were of unsound mind, 259 inmates were reported to be of unsound mind in only five of the custodial centres (NCoS 2018: 26). In 2018, 100 inmates were reported dead in 29 state commands (NCoS 2018:.26).

[2] Reports are supposed to be filed on monthly basis. Majority of the Commands did not submit reports to the Headquarters, and those who submitted did only for some months.

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Major causes of death were severe anaemia, cardiac arrest, diabetes, sepsis, AIDS, respiratory tract infection, hypoglycaemia, intestinal obstruction, asthma, hypertension, bullet injury, chronic liver disease, renal failure, tuberculosis, lung cancer/abscess, malnutrition, diarrhoea, lobar pneumonia, cerebrovascular accident, gastroenteritis, anorexia nervosa, snake bite, subarachnoid haemorrhage (NCoS 2018:31). During the year, the pharmacy received 1,640 prescriptions, fully dispensed 1343, prescriptions, partly dispensed 246, and 51 not dispensed (2018, p.35).

Prison overcrowding and health care

Information on health care services in the Service, became even more scanty since 2020, after its transition from prison to correctional service. Average daily prison population in 2020 was 64,016 comprising awaiting trial – 46,700 (73%), convicted – 17,316 (27%). In 2022, there was an average daily inmate population of 73,614 (awaiting trial – 51,021 and convicted – 22,593). Comparative statistics for 2020 and 2022 shows an increase of nearly 10,000 inmates over two years. This underscores the problem of overcrowding in the country's custodial centres. Against the background of strength of personnel in table 1, access to health care is grossly limited.

Challenges of health care in the correctional centres

Health care delivery in correctional centres remains one of the most vital yet neglected aspects of custodial administration. Despite the transition from the Nigerian prison service to the Nigerian correctional service, significant structural, institutional and systemic challenges continue to undermine the provision of effective health care of inmates. These challenges are multifaceted ranging from inadequate manpower and poor infrastructure to overcrowding, weak health information systems and limited access to specialized medical services.

Inadequate Health Care Personnel

One of the most pronounced challenges confronting health care delivery in correctional centres is the severe shortage of qualified health personnel. Available data indicate that 882 health care personnel were responsible for attending to an average daily inmate population of 68, 901 in 2021, resulting in a high health worker: inmate ratio (1:78). This shortage cuts across critical cadres such as medical doctors, dental surgeons, pharmacist, laboratory scientist and mental health professionals. For instance, the number of medical doctors declined from 47 in 2020 to 35 in 2021, while psychologists were entirely absent from workforce by 2021.

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The implication of this shortage is that most custodial centres operate without resident doctors, relying heavily on nurses, community health officers, or referrals to external hospitals. This situation comprises timely diagnoses, continuity of care, and effective management of chronic and emergency health conditions.

Overcrowding and Excessive Inmate Population

Overcrowding remains a persistent structural problem that significantly exacerbates health challenges with correctional centres. In 2022, the average daily inmate population rose to 73,614, representing an increase of nearly 10,000 inmates over a two-year period. A substantial proportion of this population consist of awaiting trial inmates, who accounted for over 70 percent of inmates across several years. Overcrowded living conditions facilitate the rapid spread of communicable diseases such as respiratory infections, skin diseases and gastrointestinal diseases. The pressure created by excessive inmates' population further limits health workers' ability to deliver individualised and comprehensive care thereby restricting inmates' access to timely and adequate medical care.

Weak Health Information and Reporting Systems

Absence of a reliable health information management system is another major challenge to health care delivery in custodial centres. Morbidity and mortality data from custodial centres are grossly incomplete, as many states commands fail to submit health reports to the national headquarters. For example, in 2018, only 13 states provided morbidity data, making it difficult to assess disease burden, plan interventions, or allocate resources effectively. The lack of adequate data also undermines evidence-based policymaking and limits accountability within the correctional system.

Limited Access to Essential Drugs and Medical Supplies

Pharmaceutical services in custodial centres are constrained by irregular drug supply and limited dispensing capacity. In 2018, out of 1,640 prescriptions received, only 1,343 were fully dispensed, while other were either partially dispensed or not dispensed at all. This shortage directly affects treatment outcomes and may contribute to diseases complications and avoidable deaths.

Inadequate Mental Health Services

Mental health care represents one of the most neglected aspects of correctional health services. The documented presence of inmates with mental illness contrasts sharply with the limited availability of trained mental health professional and specialized facilities. As a result, psychological disorders are often underdiagnosed, poorly managed, or untreated, increasing vulnerability to self-harm, violence and deterioration of overall health.

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High burden of Diseases and Preventable Mortality

Inmates in correctional centres experience a high burden of both communicable and non-communicable diseases, including malaria, respiratory infections, tuberculosis, HIV/AIDS -related illnesses and gastrointestinal conditions. Reported causes of death indicate that many fatalities result from conditions that are preventable or manageable with timely and adequate medical care. This reflects systemic weakness in early detection, drug availability, referral mechanisms, and continuity of treatment. The population of inmates, the strength of personnel (table 1) and available health infrastructure reflect gross inadequacy of health care in the country's correctional centres.

The Health and Welfare Directorate in its annual report from 2018 to 2023 identified major factors inhibiting health care in Service as funding, inadequate staff, poor record management, inadequate in-service training as well as inadequate facilities and offices. To overcome the inadequacy of health care in the custodial centres, inmates with serious ailments are often referred to public health institutions. Even here, resources for effectively utilising referral system are grossly limited.

Conclusions

From the findings and available documentary reports, indications are that inmates in penal-correction often suffer from various illnesses before and during incarceration that are unlikely to be effectively treated due to inadequate health-care access, quality and resources within the prisons service. Literature also revealed that access to health care by inmates is determined by several factors, including the availability and quality of health care services in society, penal philosophy enshrined in the legal system pertaining to the rights and treatment of incarcerated persons, and the relevant resources (human, financial, infrastructure, etc.) available to the prisons service. Similarly, there are intersections of imprisonment with low socio-economic status. This explains why the needs of persons imprisoned in custodial centres are rarely given appropriate and adequate priority. Living conditions of inmates are precarious with inadequate accommodation, nutrition, training and recreational facilities and health care. Prisons staff also suffer neglect compared to their counterparts in other criminal justice institutions.

To overcome these challenges, there is need to generally improve conditions for inmates because most of them will be released to society. If they are not given adequate reformation and rehabilitation including better healthcare, alongside better facilities to enable them maintain human dignity and treated for ailments, a very significant proportion of which are communicable diseases, the goals and objectives of imprisonment will be jeopardised. It is therefore imperative that government works towards improving the general condition of correctional facilities as has been renamed for better healthcare and wholistic rehabilitation of inmates.

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References

ACLED. (2022). Armed Conflict Location & Event Data Project. Nigeria. Retrieved from https://acleddata.com/

Baca, K. (2019). The Triggers and Catalysts of Farmer-Herder Conflict in West Africa. A publication by the Modern War Institute at West Point.

Bello, A. U. (2022). Digital Technologies and Conflict Management: A Study of Farmer-Herder Conflicts in Nigeria. Journal of Information Technology & Politics, 19(2), 145-160.

Cinjel, N.D, Musa, L & Umaru, S. (2018). Empirical Assessment of Herders and Adefisoye, I. D., Adejumo, O. J., & Olufemi, B. D. (2024). Assessment of quality of life of inmates in Nigerian correctional centres: A systematic review. *African Journal of Sociology, Psychology and Rural Studies, 4*(2), 75–97.

Agboola, A., Babalola, E., & Udofia, O. (2017). Psychopathology among offenders in a Nigerian prison. *International Journal of Clinical Psychiatry, 5*(1), 10–15.

Alemika, E. E. (1983). The smoke screen, rhetorics and reality of penal incarceration in Nigeria. *International Journal of Comparative and Applied Criminal Justice, 7*(1), 137–149.

Alemika, E. E. (1988). Socio-economic and criminological attributes of convicts in two Nigerian prisons. *Journal of Criminal Justice, 16*(3), 197–207.

Alemika, E. (1993). Trends and conditions of imprisonment in Nigeria. *International Journal of Offender Therapy and Comparative Criminology, 37*(2), 147–162.

Alemika, E., & Alemika, E. (1994). Penal crisis and prison management in Nigeria. *Lawyers Bi-Annual,* 1(2), 62–80.

Alemika, E. E., & Kayode, O. (1981). Some predictors of recidivism: A study of inmates of Nigerian prison. *International Journal of Comparative and Applied Criminal Justice, 5*(2), 187-195.

Aluko, O. O., Esan, O. T., Agboola, U., Ajibade, A. A., John, O. O., et al. (2022). How secured and safe is the sanitation and hygiene services in a maximum-security correctional facility in Southwest Nigeria. *International Journal of Environmental Health Research, 32*(10), 2200–2217. https://doi.org/10.1080/09603123.2021.1949438

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Armiya'ul, A., Obembe, A., Audu, M., & Afolaranmi, T. (2013). Prevalence of psychiatric morbidity among inmates in Jos maximum security prison. Open Journal of Psychiatry, 3(1), 12–17.

Awe, B. (1968). History of the prison system in Nigeria. In T. O. Elias (Ed.), *The prison system in Nigeria*. Lagos, Nigeria: Faculty of Law, University of Lagos.

Borschmann, R., Janca, E., Willoughby, M., Fazel, S., Hughes, N., Patton, G. C., et al. (2020). The health of adolescents in detention: A global scoping review. *The Lancet Public Health, 5*(2), e114–e126.

Civil Liberties Organisation. (1991). *Behind the wall: A report on prison conditions in Nigeria and the Nigerian prison system*. Lagos, Nigeria: Author.

Colson, C. (1980). Towards an understanding of imprisonment and rehabilitation. In J. Stott & N. Miller (Eds.), *Crime and responsible community*. London, England: Hodder and Stoughton.

Da Costa, F., Veschuure, M., Andersen, Y., Struup-Toft, S., Daniel, L., et al. (2022). The WHO prison health framework: A framework for assessment of prison health system performance. *European Journal of Public Health, 32*(4), 565–570.

Ellis, R. (2021). Prisons as porous institutions. *Theory and Society, 50*, 175–199.

Engdaw, G. T., Mesresha, A. G., & Tesfaye, A. H. (2023). Self-reported personal hygiene practice and associated factors among prison inmates in Gondar City, Northwest Ethiopia. *American Journal of Tropical Medicine and Hygiene, 109*(1), 174–181.

Fazel, S., Hayes, A., Bartellas, K., Clerici, M., & Trestman, R. (2016). Mental health of prisoners: Prevalence, adverse outcomes and interventions. *The Lancet Psychiatry, 3*(9), 817–828.

Federal Government of Nigeria. (1967). *Working party report on police and prisons*. Lagos, Nigeria: Federal Government Printers.

Federal Government of Nigeria. (2005). *National working group on prison decongestion.* Abuja, Nigeria: Author.

Federal Government of Nigeria. (2006). *Report of the presidential committee on prison reform*. Abuja, Nigeria: Author.

Geis, G. (1979). Epilogue: On imprisonment. In M. E. Wolfgang (Ed.), *Prisons: Past, present and possible*. Toronto, Canada: Heath.

Goffman, E. (1961). Asylums: *Essays on the social situation of mental patients and other inmates*. New York, NY: Doubleday.

Goffman, E. (1968). *Asylums*. Harmondsworth, England: Penguin.

Gulleng, D. Y., Gurumyen, B. P., & Akintude, C. (2025). "They are all sadists": Inmates' perception of correctional staff and its effects on rehabilitation in Jos Correctional Centre, Plateau State, Nigeria. *Nigerian Journal of Criminology and Security Studies, 1*(1), 107–121.

Jeremiah, T. A., Jacob, R. B., Jeremiah, Z. A., Enweani-Nwokelo, I. B., & Anyamene, C. (2021). Haematological indices as a measure of quality of life amongst inmates of Port Harcourt correctional institutions. *Science Publishing Group, 7*(3), 74.

Marshall, R. W., Simpson, S., & Stevens, A. (2000). *Health care in prisons: A health needs assessment.* Birmingham, England: University of Birmingham.

National Correctional Service (NCoS). (2018). *Annual Report 2018.* Abuja: Nigerian Correctional Service.

National Correctional Service (NCoS). (2020). *Annual Report 2020.* Abuja: Nigerian Correctional Service.

National Correctional Service (NCoS). (2021). *Annual Report 2021.* Abuja: Nigerian Correctional Service.

National Correctional Service (NCoS). (2022). *Annual Report 2022.* Abuja: Nigerian Correctional Service.

National Correctional Service (NCoS). (2023). *Annual Report 2023.* Abuja: Nigerian Correctional Service.

Nigeria Law Reform Commission. (1983). *Report and draft bills for the reform of prisons in Nigeria*. Lagos, Nigeria: Author.

Nigerian Correctional Service Act, Cap. NCS. (2019).

Okunlola, P. O., Babatunde, A. O., Akoki, D. M., Ilori, O. T., et al. (2024). Towards equitable health care: Bridging the gap in the health of incarcerated individuals in Africa. *Public Health Challenges, 3*(4), 70020.

Omoruyi, O. L., & Igbinoba-Ojo, O. I. (2022). Nigerian Correctional Service and the challenges of inmates' rehabilitation. *Port Harcourt Journal of History and Diplomatic Studies, 9*(2), 29–43.

E-ISSN: 1595-4765 | Volume 3, Issue 1 | January 2026

Osefo, N. F. (1990). The need for counsellors in correctional institutions in Nigeria. *The Counsellor, 10*(1), 28–37.

Public Service Review Commission. (1974). Report. Lagos, Nigeria: Federal Government Printer.

Sarkin, J. (2019). Prisons in Africa. *In Oxford Research Encyclopedia of Politics.* New York, NY: Oxford University Press.

Simpson, P. L., Guthrie, J., Jones, J., & Butler, T. (2021). Identifying research priorities to improve the health of incarcerated populations. *The Lancet Public Health, 6,* 771–779.

Sociology, 6, 143–185.

Topp, S. M., Moonga, C. N., Luo, N., et al. (2016). Exploring the drivers of health and healthcare access in Zambian prisons: A health systems approach. *Health Policy and Planning, 31*(9), 1250–1261.

United Nations. (2016). *United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules).* New York, NY: United Nations.

Van Hout, M. C., & Mhlanga-Gunda, R. (2019). Prison health situation and health rights of young people incarcerated in Sub-Saharan Africa. *BMC International Health and Human Rights, 19*(1), 17.

Vandergrift, A. L., & Christopher, P. P. (2021). Do prisoners trust the health care system? *Health Justice, 9*(1), 15.

Westbrook, A. H. (2011). Mental health legislation and involuntary commitment in Nigeria: A call for reform. *Washington University Global Studies Law Review, 10*, 397–418.

World Health Organization. (1948). *Summary reports on proceedings, minutes and final acts of the International Health Conference* held in New York from 19 June to 22 July 1946. World Health Organization, available from: https://apps.who.int/iris/handle/10665/85573.