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Assessing the Adequacy of Healthcare and Well-being of Inmates in Kogi Correctional Facilities, Kogi State, Nigeria

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Abstract. This study investigated the adequacy of healthcare and overall well-being services in Kogi State correctional facilities, Nigeria. Using a mixed-methods approach, data were gathered from 400 correctional officers across six facilities through surveys and interviews. The analysis, informed by rehabilitation theory, revealed widespread deficiencies in healthcare infrastructure, including poor access to mental health and dental care. Most respondents reported irregular medical visits and rated the quality of care as poor. Challenges such as overcrowding, inadequate staffing, and limited medical supplies were identified as major barriers to effective healthcare delivery. The findings show that the type, availability, and quality of healthcare services significantly affect inmates' physical health, satisfaction with care, and overall well-being. Respondents emphasized the urgent need for reform, including more medical personnel, improved resources, and mental health support. The study highlights the critical role of healthcare in rehabilitation and calls for policies that align correctional healthcare in Kogi with international human rights standards.

Index Terms- Assessment, Adequacy, Healthcare, Well-being, Inmates, Kogi Correctional Facilities,

I. Introduction

Correctional systems are a core component of Nigeria's criminal justice framework, tasked with ensuring public safety while also safeguarding the rights and well-being of incarcerated individuals. The state of healthcare within these institutions serves as a vital measure of their compliance with human rights standards and their potential for supporting inmate rehabilitation. However, Nigeria's correctional facilities have long been plagued by challenges such as overcrowding, inadequate medical services, poor sanitation, and limited access to mental health support. These conditions not only endanger the health of inmates but also compromise efforts to reform and reintegrate them into society (Ibrahim, 2019). While these systemic issues are prevalent nationwide, Kogi State presents a particularly urgent and underexplored case. Located in Nigeria's North-Central region, Kogi hosts several correctional facilities that have been repeatedly cited for poor infrastructure, high levels of inmate congestion, and lapses in medical and mental health care delivery. Its strategic location as a transit hub and its mix of urban and rural correctional settings create a unique context where both federal and state-level policy deficiencies manifest starkly (Udutchay, 2010). Recent reports of resource shortages, prolonged pretrial detention, and recurring health crises among inmates in Kogi make it a critical focus for research.

Yet, despite these concerns, there is a dearth of empirical studies addressing healthcare and well-being in the state's custodial institutions.

II. Statement of the Problem

Correctional system in Nigeria, particularly in Kogi State, is grappling with serious problems when it comes to providing proper healthcare and ensuring the well-being of inmates. Unfortunately, it often falls short of both national and international standards. According to the United Nations Standard Minimum Rules for the Treatment of Prisoners, also known as the Nelson Mandela Rules, inmates should receive healthcare that is on par with what's available in the community, along with humane living conditions. However, various studies have pointed out ongoing issues within Nigeria's correctional facilities, including limited access to medical staff, a lack of medical supplies, poor nutrition, inadequate sanitation, and almost nonexistent mental health support (Amnesty International, 2020; Onyemelukwe, 2023). These dire conditions not only infringe on the basic rights of inmates but also heighten health risks, obstruct rehabilitation efforts, and make it harder for them to reintegrate into society.

In Kogi State, which is situated in Nigeria's North Central region, correctional facilities are reported to reflect these national challenges, worsened by local issues like overcrowding, insufficient funding, and a shortage of staff (Eze, 2022). Recent statistics reveal that Nigerian prisons, including those in Kogi, are operating at over 150% capacity, which puts immense pressure on resources and hampers healthcare delivery. (Nigerian Correctional Service, 2024). Additionally, mental health services are nearly absent, even as cases of psychological distress among inmates are on the rise due to long periods of detention and poor living conditions (Adebayo & Okorie, 2023). While these reports highlight systemic shortcomings, there's a significant gap in empirical research that specifically evaluates the adequacy of healthcare and overall well-being in Kogi State's correctional facilities.

Ndukwe and Iroko (2014), cited in Aboki (2007), pointed out that in the triangular relationship of the criminal justice system, the third leg carries the Correctional Institution. According to the author, the prison is responsible for the custody of the final product in the criminal justice process through maintenance of custody by carrying out measures to prevent escape, including erecting high walls or chain links, fences, placing guards, constant checks on cell perimeter walls, surveillance from time to time.

However, it is neither supposed to be a bed of thorns and thistles meant to stuff life out of the occupants. The absence of comprehensive data obscures the true extent of these problems and impedes evidence-based policymaking, While the Nigerian Correctional Service Act (2019) mandates healthcare standards, implementation monitoring remains weak and existing studies focus predominantly on federal prisons (e.g., Ikoh & Umukoro, 2021), leaving a knowledge void regarding State-level facilities like those in Kogi, integrated analysis of medical, nutritional and psychological well-being. It was on this premise that this study aims to address these implementation gaps in policy framework and critical research gaps by providing a detailed examination of healthcare and well-being in Kogi's correctional facilities, highlighting deficiencies and informing targeted interventions to improve inmate welfare.

Research Questions

- What is the current state of healthcare services in Kogi State correctional facilities?
- How available and accessible are healthcare services for inmates in Kogi correctional facilities?
- What are the contemporary challenges facing correctional facilities in Kogi State?

Aim and Objectives

The general aim of this study is to assess the adequacy of healthcare and well-being of inmates in Kogi Correctional Facilities, Kogi State, Nigeria. The specific objectives are as follows:

- To assess the current state of well-being of inmates and healthcare services in Kogi State correctional facilities.
- To ascertain the availability and accessibility of healthcare services for inmates in Kogi Correctional Centres.
- To identify the contemporary challenges facing correctional facilities in Kogi State.

Research Hypothesis

The following hypothesis was formulated and tested at a 0.05 level of significance for the study:

H_0: Access to quality of healthcare services have no significant effect on inmates' health and well-being.

Significance of the Study

This study is incredibly important for a variety of stakeholders. This includes policymakers, correctional administrators, healthcare providers, human rights advocates, and the academic community. Its importance stems from its focus on filling crucial gaps in our understanding and enhancement of inmate welfare within Nigeria's correctional system, particularly in Kogi State. Ultimately, this study's significance extends beyond Kogi State, offering insights that can inform national and regional efforts to improve correctional systems across Nigeria and similar contexts. By prioritizing inmate healthcare and well-being, the research contributes to a more equitable and effective criminal justice system.

III. Literature Review

The review of relevant and related literature were done in tandem with the aim and objectives of the study under the following subheadings:

Conceptual Review

Key concepts in this study are reviewed as follows:

IV. Correctional Institutions

The evolution of correctional institutions has been widely discussed in classical and contemporary literature. Scholars such as Foucault (1977) argue that the

transition from public punishment to institutional confinement marked a significant shift in the philosophy of punishment—moving from retribution to discipline. Similarly, Johnston (2000) explored how architectural designs and surveillance mechanisms shaped prison management, influencing not only order but also the delivery of services like healthcare.

While this historical context provides foundational insight, it often lacks relevance to the day-to-day realities of correctional facilities in contemporary African societies, especially in regions such as Nigeria. In post-colonial Africa, prisons were largely adopted as instruments of state control rather than reform (Bernault, 2003). The legacy of colonial administration continues to shape correctional ideology and practice, with rehabilitation often receiving rhetorical rather than practical emphasis. In Nigeria, for instance, the punitive orientation remains dominant, limiting the implementation of rehabilitative frameworks in custodial institutions.

Critically, these conceptual frameworks have rarely been interrogated within the Nigerian context to assess how such ideological underpinnings affect healthcare delivery. While the literature outlines the theoretical importance of humane treatment and reform, there is a gap in translating these ideas into measurable indicators of inmate welfare. This study attempts to bridge that gap by focusing on Kogi State—a region where such theoretical principles have yet to materialise in policy or practice. In doing so, it moves beyond historical narration to interrogate how conceptual understandings of correctional institutions influence operational realities in Nigerian prisons.

V. Availability and accessibility of healthcare in correctional facilities

One of the most persistent themes in the correctional health literature is the systemic neglect of inmate healthcare services. Fair and Walmsley (2021) observed that for decades, global health bodies such as the WHO paid minimal attention to prison health, effectively excluding incarcerated individuals from mainstream public health agendas. This oversight contributed to widespread underfunding, minimal research, and policy inertia. In many African contexts, including Nigeria, healthcare in correctional facilities is characterised by chronic under-resourcing, fragmented delivery systems, and weak institutional accountability. Posholi (2019) identified that medical personnel in African prisons often lack the training or competence to address severe medical conditions. In Nigeria, many prison medical units are manned by general health assistants without specialised training in correctional or psychiatric healthcare. Petracek (2012) adds that inmates suffering from mental illness are often mismanaged due to institutional ignorance and unsympathetic legal structures, leading to extended incarceration and deteriorating mental health.

Despite these important contributions, much of the existing literature is descriptive and lacks analytical depth. There is little synthesis of the causal relationships between structural deficits (like staffing shortages) and health outcomes. Moreover, empirical evidence is often lacking, with most studies relying on policy reviews, anecdotal reports, or media coverage. This study addresses this methodological limitation by employing a convergent parallel mixed-methods design to assess not just whether healthcare is available, but how often, to what quality, and with what outcomes—particularly in Kogi correctional centres. The findings will enrich the literature by

highlighting not only the presence of services but also their accessibility, reliability, and effectiveness from the perspective of frontline officers.

The Nelson Mandela Rules (United Nations, 2015) provide a universally recognised standard for the treatment of inmates, including detailed provisions on healthcare, nutrition, and psychological support. These rules stipulate that prisoners should enjoy the same standard of health care available in the community and should have access to necessary medical, dental, and psychiatric care. This aligns with a broader human rights discourse that sees healthcare as a fundamental right, regardless of custodial status. In Nigeria, the Nigerian Correctional Service Act (2019) adopts several of these principles. However, the gap between legislation and implementation remains significant. Onyemelukwe (2023) pointed out that while the law mandates healthcare provision, there is no effective monitoring mechanism to ensure compliance. Amnesty International (2020) reported widespread violations, including delayed medical attention, lack of drugs, and denial of care for terminal illnesses in several Nigerian prisons. Yet, much of this literature falls short of assessing the degree to which these international norms have been localised and institutionalised in everyday prison operations, especially at the subnational level.

This study seeks to fill that void by evaluating the extent to which international and national health mandates are reflected in practice within Kogi State's correctional facilities. It also critically examines whether correctional officers are aware of these standards and how institutional constraints affect their ability to comply. By comparing theoretical commitments to practical implementation, the study offers insight into the policy-practice gap and identifies specific barriers that hinder the realisation of humane correctional healthcare in Nigeria.

VI. Contemporary Challenges facing Correctional Facilities

Contemporary literature outlines numerous challenges plaguing prison health systems, particularly in low- and middle-income countries. In Nigeria, these include severe overcrowding, underfunded medical units, lack of essential drugs, and poor sanitation (Eze, 2022; Nigerian Correctional Service, 2024). According to Adebayo and Okorie (2023), the neglect of mental healthcare has emerged as a critical concern, especially given the growing rates of psychological distress among inmates due to prolonged detention, poor nutrition, and environmental stressors. Despite the breadth of documentation, these studies often operate in silos, addressing overcrowding separately from medical staffing or failing to account for the interaction between poor infrastructure and mental health. Few studies integrate these variables into a comprehensive explanatory framework. Even fewer explore how these systemic problems are perceived and managed by correctional officers, who play a central role in daily inmate care. In addition, there is minimal comparison of methodologies across studies—most employ secondary analysis or legal review, leaving a gap in field-based research that captures the lived realities of prison health service delivery.

This study offers a critical departure from previous research by using primary data from all correctional facilities in Kogi State. Through its combination of surveys and key informant interviews, it examines how correctional staff experience and interpret healthcare challenges, thereby uncovering institutional blind spots and informal practices that escape policy scrutiny. By addressing these gaps, the study provides a

richer, more grounded understanding of the operational and ethical dilemmas surrounding inmate health and well-being in Nigeria.

VII. Theoretical Framework

This study was anchored on Rehabilitation Theory as discussed below:

Rehabilitation theory, rooted in the reformist criminological school, prioritises the transformation of offenders into socially integrated and law-abiding citizens. It posits that criminal behaviour often stems from underlying social, psychological, economic, or health-related deficiencies, and therefore correctional institutions should not merely serve as punitive spaces but as environments that address these root causes through structured interventions (Cullen & Gendreau, 2000).

In the context of this study, healthcare and well-being are not merely supportive services; they are core components of the rehabilitative process. Physical health enables inmates to participate meaningfully in rehabilitation programs such as vocational training, education, and counselling. Mental health, meanwhile, is essential for emotional stability, impulse control, and behavioural change. Malnourished, chronically ill, or psychologically distressed inmates are less likely to engage with or benefit from reform initiatives. Thus, poor healthcare services undermine the fundamental premise of the rehabilitation model.

Within Kogi State correctional facilities, the conditions observed—overcrowding, limited access to medical personnel, absence of mental health services, and lack of chronic disease management, directly contravene the goals of rehabilitation theory. Rather than supporting reform, these conditions exacerbate trauma, reinforce feelings of neglect, and reproduce cycles of recidivism. For example, an inmate suffering from untreated anxiety or depression is not only less likely to cooperate with rehabilitation efforts but may also develop deeper antisocial tendencies that worsen post-release outcomes.

Rehabilitation theory also foregrounds the role of correctional staff as agents of transformation, not merely custodians of confinement. In this study, the voices of correctional officers are central to understanding systemic limitations and institutional attitudes toward inmate health. Their testimonies reveal the disconnect between the rehabilitative ideals espoused by national and international frameworks (such as the Nelson Mandela Rules) and the lived reality within Kogi's facilities. Officers often express frustration over inadequate staffing, lack of supplies, and bureaucratic bottlenecks that prevent timely referrals or effective treatment—barriers that make it difficult for them to contribute meaningfully to inmate rehabilitation.

Moreover, rehabilitation theory aligns with international human rights perspectives by asserting that incarceration should not diminish a person's right to health. If correctional institutions are to function as reformative spaces, they must uphold the principle of equivalence of care. This is echoed in the Nelson Mandela Rules, which call for healthcare standards in prisons that match those available in the wider community. In applying rehabilitation theory, this study critiques not only the operational failures within Kogi's custodial institutions but also the broader structural disregard for prisoner welfare in Nigerian criminal justice policy.

In summary, this study uses rehabilitation theory to underscore that inmate health is not peripheral but foundational to correctional success. It demonstrates that the absence of adequate medical and psychological care is a structural failure that sabotages the

rehabilitative mission of correctional institutions. By examining the healthcare deficits in Kogi State's prisons through this theoretical lens, the study seeks to reposition inmate health and well-being as a non-negotiable pillar of meaningful correctional reform.

Research Methods

This study employed a convergent parallel mixed-methods design to assess healthcare and well-being of inmates in Kogi State correctional facilities. Data were collected from all the 502 Correctional officers in all the 6 Correctional facilities in Kogi State, comprising of Koton-Karfe, Ankpa, Idah, Kabba, Dekina and Okene minimum correctional homes.

Sampling Technique and Procedure

This study adopted a convergent parallel mixed-methods design, combining quantitative and qualitative approaches to obtain comprehensive insights into the adequacy of healthcare and well-being services in correctional facilities across Kogi State. To align with the study's objectives, ensure representative and context-rich data, distinct but complementary sampling techniques were employed for each component of the research.

Quantitative Sampling Procedure

The quantitative component of the study targeted all correctional officers across the six operational correctional facilities in Kogi State: Koton-Karfe, Ankpa, Idah, Kabba, Dekina, and Okene. A total enumeration sampling technique (also known as census sampling) was adopted for this phase. This technique was considered most appropriate due to the manageable population size of 502 correctional officers, allowing the study to capture data from the entire accessible population without exclusion. This approach ensured maximum coverage and enhanced the reliability of the descriptive and inferential statistical analyses, particularly for identifying institutional patterns across facility types, ranks, and geographic locations.

Qualitative Sampling Procedure

For the qualitative component, a purposive sampling technique was employed to select participants for the Key Informant Interviews (KII). The purposive approach was deemed suitable for identifying officers with direct and in-depth experience in inmate healthcare delivery, facility management, or welfare monitoring. Key informants were selected based on the following criteria:

Position and role within the facility (e.g., medical unit supervisors, welfare officers, custodial heads).

Years of experience, ensuring inclusion of officers with substantial institutional knowledge.

Availability and willingness to participate in in-depth interviews during the data collection period.

A total of six key informants, one from each correctional facility, were interviewed. This number was guided by the principle of data saturation, where no new information was emerging during the later interviews. Each interview lasted approximately 30–45 minutes and was conducted in a private setting within the facility premises to ensure confidentiality and openness.

This dual-pronged sampling strategy allowed the study to integrate broad-based statistical trends with rich, narrative insights, thus providing a well-rounded understanding of healthcare adequacy and inmate well-being in Kogi State correctional facilities.

Instrument of Data Collection

Data collection instruments include structured questionnaire and Key Informant Interview. The data collected were presented in tables of distribution majorly for descriptive purposes.

Ethical Consideration

The study adhered to all required ethical principles for research, including research permits, confidentiality, informed consent, informed participation, objectivity, honesty, and integrity in reporting. All participants in both the quantitative and qualitative components were provided with informed consent forms outlining the purpose of the study, confidentiality assurances, and their right to withdraw at any stage. Permission to conduct the study was obtained from the Nigerian Correctional Service headquarters and each facility's command structure.

Results

Of the 502 officers surveyed, 400 completed the structured questionnaire, yielding a response rate of approximately 79.7%. Hence, analysis was based on the response rate as follows:

Socio-Demographic Characteristics of Respondents

Table 1: Socio-demographic characteristics of respondents

Variables	Category	Frequency (N=400)	Percentage (%)
Sex	Male	220	55.0
	Female	180	45.0
Age in Years	21-30yrs	80	20.0
	31-40yrs	140	35.0
	41-50yrs	160	40.0
	51-60yrs	20	5.0
Religious Affiliation	Christianity	199	49.8
	Islam	185	46.3
	traditional belief	16	4.0
Marital status	Single	60	15.0
	Married	305	76.3
	Widowed	11	2.8
	Divorced	24	6.0
Level of income	N 71,000 - N 170,000	338	84.5
	N 171,000 - N 270,000	40	10.0
	N 271,000 - N 370,000	22	5.5
Educational Level	Primary	20	5.0
	Secondary/ Technical	180	45.0

	Tertiary	200	50.0
Years in service	less than 5years	80	20.0
	5-9yeras	120	30.0
	10-14years	140	35.0
	15-19years	40	10.0
	20years and above	20	5.0
Rank of officers	Superintendent of Corrections (SC)	10	2.5
	Deputy Superintendent of Corrections (DSC)	14	3.5
	Asst. Superintendent of Corrections 1(ASC 1)	29	7.2
	Asst. Superintendent of Corrections 11 (ASC 11)	40	10.0
	Senior Inspector of Corrections (SIC)	51	12.8
	Inspector of Corrections (IC)	66	16.5
	Asst. Inspector of Corrections (AIC)	56	14.0
	Corrections Assistant 1 (CA1)	54	13.5
	Corrections Assistant II (CA1I)	60	15.0
	Corrections Assistant III (CA1II)	20	5.0

VIII. Source: Field Survey (2025)

From the gender distribution, 220 (55.0%) were male, while 180 (45.0%) were female. This near parity reflects a fairly balanced gender representation within the correctional workforce. Such balance is significant when analysing how gender perspectives influence sensitivity to inmate healthcare needs, especially in areas like reproductive health, hygiene support for female inmates, and emotional care. Female officers may be more attuned to the often-overlooked needs of female inmates, and their representation in the sample helps to broaden the scope of institutional assessments in this regard.

In terms of age, 80 respondents (20.0%) were aged 21–30, 140 (35.0%) were aged 31–40, 160 (40.0%) were aged 41–50, and 20 (5.0%) were aged 51–60. The concentration of officers within the 31–50 age range, which makes up 75% of the sample, indicates a workforce that is active, mature, and likely in leadership or supervisory roles. This age range is commonly associated with high productivity and operational awareness. These individuals are more likely to have long-term exposure to the systemic issues surrounding inmate healthcare and can therefore provide informed and experience-based assessments. Officers in this age group also likely handle both administrative and hands-on responsibilities, including crisis management and medical referrals, making their responses crucial for evaluating institutional performance.

With regard to religious affiliation, the data reveals that 199 respondents (49.8%) were Christians, 185 (46.3%) were Muslims, and 16 (4.0%) adhered to traditional beliefs. This distribution mirrors the broader religious makeup of Kogi State and indicates that the perspectives shared cut across major belief systems. In correctional contexts,

religion often intersects with issues of diet, mental health, end-of-life care, and inmate morale. Officers' religious affiliations can influence how they interpret the adequacy of spiritual and psychological care, particularly for inmates whose well-being is closely tied to their faith practices.

Marital status data shows that the majority of officers, 305 (76.3%), were married, while 60 (15.0%) were single, 24 (6.0%) divorced, and 11 (2.8%) widowed. The predominance of married respondents suggests a high level of social responsibility and perhaps a heightened sensitivity to welfare issues. Officers with families may empathise more with the needs of vulnerable inmates and be more critical of deficiencies in healthcare, as they may naturally compare inmate conditions to those they would deem acceptable for their own loved ones.

Income levels were also revealing: 338 respondents (84.5%) earned between ₦71,000 and ₦170,000 monthly, 40 (10.0%) earned ₦171,000–₦270,000, and only 22 (5.5%) earned between ₦271,000 and ₦370,000. These figures reflect a workforce operating under modest economic conditions. Officers earning in the lowest bracket may experience reduced motivation or limited job satisfaction, which could affect their perceptions of institutional capacity and responsiveness. More importantly, economic stress may influence how much attention officers can afford to give to inmate welfare, particularly in resource-constrained environments where both staff and inmates compete for basic necessities.

The educational qualifications of the respondents indicate that 200 officers (50.0%) held tertiary qualifications, 180 (45.0%) had secondary or technical education, and 20 (5.0%) had only primary education. This high level of education among staff is noteworthy. Educated officers are likely to be familiar with human rights standards, policy frameworks, and the ethical obligations of correctional facilities. As such, their evaluations of healthcare adequacy may be better informed and less likely to be coloured by institutional loyalty or misinformation. The presence of tertiary-educated staff also suggests that poor healthcare outcomes in the facilities are not due to a lack of awareness among staff, but rather deeper structural deficiencies.

Regarding years in service, 80 officers (20.0%) had less than 5 years of experience, 120 (30.0%) had between 5–9 years, 140 (35.0%) had served for 10–14 years, 40 (10.0%) for 15–19 years, and 20 (5.0%) for over 20 years. This data reveals a workforce with a strong base of experienced personnel. Over 65% had served for at least 5 years, suggesting that most respondents had been exposed to the institutional realities of healthcare delivery for a significant period. These officers are likely to be familiar with longstanding patterns of neglect or reform efforts that have failed to materialise, making their insights especially valuable in understanding the persistence of healthcare inadequacies.

In terms of rank, the majority of respondents held operational or mid-level positions. Specifically, 66 (16.5%) were Inspectors of Corrections, 51 (12.8%) were Senior Inspectors, 56 (14.0%) Assistant Inspectors, and 60 (15.0%) Correctional Assistants III. The higher supervisory ranks were less represented: 10 (2.5%) were Superintendents, and 14 (3.5%) Deputy Superintendents. The predominance of lower and middle-tier officers means the data captures insights from those who are directly involved in day-to-day inmate supervision, emergency healthcare referrals, and the implementation of facility-level health policies. These frontline workers are often the first responders during health crises and are well-positioned to comment on the responsiveness and adequacy of inmate healthcare services.

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Finally, the length of deployment in current facilities shows that 80 officers (20.0%) had been in their facility for less than 6 months, 120 (30.0%) for 6 months to 2 years, and 100 each (25.0%) had served for 2–5 years and more than 5 years. This spread ensures that perspectives include both recently deployed officers with fresh eyes and long-serving personnel who understand the institutional trajectory of health and well-being services. The inclusion of officers with different exposure lengths helps validate the findings as both grounded in history and alert to recent developments or emerging trends.

However, the socio-demographic profile of respondents strengthens the reliability and depth of the study's findings. The diversity in gender, age, religion, income, education, and professional experience ensures that a wide array of perspectives were considered. The presence of both junior and mid-level officers ensures that the data reflect the lived realities of those who interact most frequently with inmates and who are directly involved in delivering or facilitating healthcare. Their observations about gaps in medical supplies, absence of mental health services, or delayed referrals are therefore credible and grounded in firsthand experience.

Moreover, the high educational attainment and considerable years of service among respondents suggest that the critiques they offer about healthcare adequacy are likely informed by institutional familiarity, ethical understanding, and policy awareness. This makes the study's findings more than anecdotal complaints, they are evidence-based insights from a knowledgeable and experienced workforce. Their shared concerns about systemic inadequacies thus point to deep-rooted structural problems that demand urgent policy intervention and administrative reform.

Research Question 1: What is the current state of healthcare services in Kogi State correctional facilities?

Table 2: The Current State of Healthcare Services in Kogi State Correctional facilities? (N = 400)

Response	Frequency	Percentage (%)
Yes	280	70
No	120	30

Types of medical services are available

Response	Frequency	Percentage (%)
General consultations	260	92.9
Emergency care	180	64.3
Mental health services	60	21.4
Dental care	40	14.3
Chronic disease management	100	35.7
HIV/TB treatment	120	42.9
Other (e.g., eye care)	20	7.1

How often do medical personnel visit the facility?

Response	Frequency	Percentage (%)
Daily	40	10
Weekly	100	25
Monthly	120	30
Rarely	100	25
Never	40	10

Inmates referred to external hospitals when necessary

Response	Frequency	Percentage (%)
Yes	160	40
No	80	20
Sometimes	160	40

How long do inmates typically wait before receiving medical attention?

Response	Frequency	Percentage (%)
Immediately	60	15
Within 24 hours	100	25
2–3 days	140	35
A week or more	100	25

How would you rate the quality of healthcare provided?

Response	Frequency	Percentage (%)
Excellent	20	5
Good	60	15
Fair	120	30
Poor	140	35
Very Poor	60	15

There are enough medications and medical supplies in the facility

Response	Frequency	Percentage (%)
Always	40	10
Sometimes	160	40
Rarely	140	35
Never	60	15

Are there mental health services available for inmates?

Response	Frequency	Percentage (%)
Yes	80	20

No	320	80

Inmates with chronic illnesses receive consistent care

Response	Frequency	Percentage (%)
Yes	100	25
No	140	35
Occasionally	160	40

on Table 2, one of the foremost challenges identified is the uneven availability of designated healthcare facilities within correctional centres. While 280 officers (70.0%) reported the presence of some form of healthcare facility, a significant 120 respondents (30.0%) stated that no designated healthcare infrastructure existed in their centres. This absence highlights the fragmented nature of health access across facilities and suggests that a sizable proportion of inmates are detained in environments with no structured provision for even basic medical care. The implications are stark: without a defined healthcare space, medical consultations, emergencies, and chronic condition management must rely on makeshift arrangements that are both inefficient and unethical.

The types of medical services available in centres that do have facilities reveal further deficiencies. Among the 280 officers who reported facility availability, 92.9% (260) cited general consultations, 64.3% (180) mentioned emergency care, and 42.9% (120) indicated HIV/TB treatment. However, specialised services were alarmingly scarce: only 21.4% (60) reported availability of mental health care, and 14.3% (40) confirmed access to dental services. These figures reflect a serious lack of comprehensive care. The near absence of mental health and dental services is particularly concerning given the high rates of psychological distress and oral infections reported globally among incarcerated populations. Inmates who suffer from trauma, depression, or psychotic episodes are likely to be untreated, which can exacerbate behavioural issues, increase the risk of suicide, and further compromise institutional safety.

Access to healthcare professionals is another critical challenge. Only 40 officers (10.0%) indicated that medical personnel visit their facilities daily, while 100 (25.0%) reported weekly visits, and 120 (30.0%) stated that medical staff visit only once a month. Another 100 (25.0%) noted that visits were rare, and 40 (10.0%) claimed that medical personnel never visit at all. This erratic access to healthcare professionals severely limits timely intervention in health crises, undermines the early detection of illness, and hinders continuity of care especially for inmates with chronic or infectious diseases.

Referral systems to external hospitals were also found to be inconsistent. While 160 respondents (40.0%) confirmed that inmates are referred to hospitals when necessary, an equal number (40.0%) stated that referrals occurred only sometimes, and 80 (20.0%) reported that referrals are never made. These inconsistencies suggest bureaucratic bottlenecks, inadequate transport arrangements, or financial constraints—factors that delay life-saving interventions. In a prison context, where freedom of movement is restricted, the absence of a reliable referral system can turn otherwise treatable conditions into fatal ones.

Waiting time before inmates receive medical attention further illustrates the institutional inefficiency. Only 60 officers (15.0%) reported that inmates receive care immediately upon need, while 100 (25.0%) indicated that care is delivered within 24 hours. However, the largest group—140 officers (35.0%) reported that inmates wait two to three days for attention, and 100 officers (25.0%) stated that it takes a week or more. These delays expose inmates to unnecessary suffering, risk of deterioration, and potentially irreversible health outcomes, especially for acute infections or injuries.

The quality of healthcare delivery is equally compromised. Only 20 respondents (5.0%) rated healthcare services in their facilities as excellent, and 60 (15.0%) considered them good. In contrast, 120 (30.0%) judged them as fair, 140 (35.0%) as poor, and 60 (15.0%) as very poor. With half of the respondents giving negative evaluations (poor or very poor), the data clearly points to systemic failures in service delivery. Quality issues likely stem from inadequate diagnostic tools, inconsistent treatment protocols, and reliance on underqualified staff.

Availability of medications and medical supplies was also critically low. Only 40 respondents (10.0%) claimed that supplies were always available, while 160 (40.0%) said they were sometimes available. 140 officers (35.0%) indicated that supplies were rarely available, and 60 (15.0%) reported that they were never available. This scarcity undermines all other aspects of healthcare delivery. Even when personnel are present and willing to provide care, the lack of medication renders them ineffective and contributes to a sense of helplessness among both staff and inmates.

Perhaps most alarming is the data on mental health services. A staggering 320 respondents (80.0%) reported that no mental health services were available in their facilities. Of the 80 respondents (20.0%) who acknowledged the existence of such services, 40 (50.0%) said the services were not effective, 30 (37.5%) described them as only somewhat effective, and just 10 (12.5%) rated them as very effective. This points to a profound neglect of psychological well-being in an environment already predisposed to anxiety, depression, and trauma. The implications are dire: untreated mental illness can lead to behavioural problems, increased risk of suicide, and

difficulty reintegrating into society upon release, which ultimately undermines the rehabilitative goals of correctional systems.

Chronic disease management is similarly inadequate. Only 100 respondents (25.0%) stated that inmates with chronic illnesses receive consistent care. 160 (40.0%) said they receive care occasionally, while 140 (35.0%) reported that such inmates do not receive care at all. This situation is particularly dangerous in a setting where diseases such as hypertension, diabetes, asthma, and HIV are prevalent and require constant monitoring and medication.

The implications of these findings are far-reaching. For instance, poor prison health contributes to overall public health risks, especially as most inmates eventually return to their communities. Moreover, the neglect of inmate health undermines Nigeria's constitutional and international obligations to ensure humane treatment for all individuals, including those in custody.

Research Question 2: How available and accessible are healthcare services for inmates in Kogi correctional facilities?

Table 3: Availability and accessibility of Healthcare Services for Inmates in Kogi Correctional Facilities

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Statements	Category	Frequency (N=400)	Percentage (%)
What type of healthcare services are available to inmates in your correctional centre?	General medical care (routine check-ups, physical exams, etc.)	260	65.0
	Emergency medical care	60	15.0
	Dental care	20	5.0
	Mental health services (psychological counselling, therapy)	20	5.0
	Substance abuse treatment	20	5.0
	Preventive care (vaccinations, screenings, etc.)	20	5.0
How frequently are healthcare services available to inmates?	Daily	280	70.0
	Several times a week	120	30.0
How would you rate the overall Quality of healthcare provided in the correctional centre?	Good	20	5.0
	Fair	300	75.0
	Poor	80	20.0
What are the facilities for inmates with special health needs (e.g., disabilities, chronic illness, and ageing)?	No specialised facilities or accommodations	380	95.0
	Not sure	20	5.0
Do inmates have access to any fitness or recreational activities to promote physical wellbeing?	Yes, Unlimited access to fitness or recreational facilities	60	15.0
	Yes, there is limited access to fitness or recreational facilities	280	70.0
	Not sure	60	15.0
How are inmates' health-related concerns addressed if they are not satisfied with the care they receive?	Inmates can speak with a supervisor or healthcare administrator	340	85.0
	There is no formal process, and concerns are typically ignored	60	15.0
Do you feel that the correctional facility adequately addresses the overall health and wellbeing of inmates?	Yes, fully	20	5.0
	Yes, to some extent	260	65.0
	No, there are significant gaps in care	120	30.0

IX. SOURCE: FIELD SURVEY (2025)

The findings presented in Table 3 provide an empirical basis for assessing the extent to which inmates in Kogi correctional centres have access to adequate and functional healthcare services. The responses from 400 correctional officers shed light on the systemic patterns of healthcare provision and expose the structural limitations affecting the well-being and rehabilitation of incarcerated individuals. Data shows that 260 respondents (65.0%) reported the availability of general medical care, such as routine check-ups and physical exams. This reflects some level of commitment to primary healthcare, suggesting that baseline medical screening is in place in many facilities. However, the remaining 35% of facilities where such care is unavailable raises concern, as routine assessments are crucial for early disease detection and chronic illness monitoring. The absence of even basic care in over a third of correctional centres is indicative of significant health neglect and contributes to avoidable morbidity within the prison population.

Specialised healthcare services are markedly lacking. Only 60 officers (15.0%) acknowledged the presence of emergency medical care, and a mere 20 (5.0%) each confirmed access to dental care, mental health services, substance abuse treatment, and preventive care (such as vaccinations or screenings). These low percentages reveal a systemic failure to address the broader health needs of inmates. For example, the near-total absence of mental health and substance abuse treatment is particularly troubling, given the psychological toll of incarceration and the high prevalence of addiction or trauma among inmate populations. Without these services, inmates experiencing psychological distress or drug dependency are left untreated, which can lead to behavioural issues, increased disciplinary problems, and reduced prospects for rehabilitation.

In terms of service frequency, 280 respondents (70.0%) stated that healthcare services were available daily, while 120 (30.0%) indicated availability several times a week. At face value, this might suggest adequate service coverage; however, when considered alongside the limited availability of specialised services, it appears that this "daily availability" likely refers only to minimal or basic medical engagement—perhaps attendance by a general nurse or the distribution of painkillers. This discrepancy highlights the difference between availability in form and adequacy in substance.

When asked to rate the overall quality of healthcare, the majority—300 respondents (75.0%)—described it as fair, with 80 (20.0%) rating it poor, and only 20 (5.0%) rating it good. The overwhelming majority of responses fall within the mid-to-low quality range, pointing to broad dissatisfaction with the current state of healthcare in these facilities. This dissatisfaction likely stems from the lack of trained personnel, insufficient drugs, outdated equipment, and poor referral systems. "Fair" in this context may mean care is available in name but compromised in quality, scope, and responsiveness.

Concerning facilities for inmates with special health needs, 380 officers (95.0%) confirmed that there were no specialised accommodations for inmates with chronic illnesses, disabilities, or age-related conditions. This figure is alarming and demonstrates a violation of the principles of equity in prison healthcare. The lack of tailored services for vulnerable groups renders the system discriminatory and increases the risk of preventable deaths, particularly among older inmates or those with terminal diseases like cancer, diabetes, or hypertension.

On access to fitness or recreational activities that support physical well-being, only 60 respondents (15.0%) confirmed unlimited access, while 280 (70.0%) noted limited access, and 60 (15.0%) were unsure. Physical activity is essential for both physical and mental health in closed environments. Limited access to exercise facilities contributes to sedentary lifestyles, depression, and increased risk of non-

communicable diseases. The lack of emphasis on rehabilitation-focused activities underscores the punitive, rather than reformative, character of these institutions.

Regarding the mechanism for addressing health-related complaints, 340 officers (85.0%) noted that inmates can speak with a supervisor or healthcare administrator, while 60 (15.0%) reported no formal grievance process, meaning concerns are often ignored. While it is encouraging that most facilities allow inmates to express dissatisfaction, the lack of an independent and transparent complaint resolution mechanism limits the effectiveness of this process. Without external accountability, internal systems may default to tokenism, where inmate complaints are heard but rarely acted upon.

When asked whether the correctional facility adequately addresses overall health and well-being, only 20 respondents (5.0%) affirmed this fully. 260 (65.0%) said this was done to some extent, while 120 (30.0%) reported that there were significant gaps in care. This distribution reflects widespread recognition among staff that current healthcare systems are falling short. The 30% who view the system as significantly inadequate reinforce the call for urgent and comprehensive reform.

However, the analysis of healthcare availability and accessibility in Kogi correctional facilities reveals a system that is functionally present but operationally weak. The relative presence of general medical services contrasts sharply with the near-total absence of specialised care, pointing to an unbalanced health system that fails to meet the complex health needs of the incarcerated population.To buttress the above findings, verbatim quotes of the relevant data from the Key Informant Interview (KII) revealed the information below:

The above was corroborated by a key Informant who stated this:

> "They receive the care as inmates too, but the care is not adequate to address the health needs of the inmates. There is a lack of adequate medical supplies, medications, and healthcare professionals within correctional facilities. Many of our correctional institutions are struggling with understaffed medical units, leading to delayed or inadequate care for inmates".

(Correctional Officer in Idah Custodial Centre, January 8th, 2025)

Another correctional Officer also highlighted that

> "Logistics, essential supplies for the inmates, and mosquito nets are inadequate and need to be given attention if we are to cater for the wellbeing of the inmates

(Correctional Officer in Okene Custodial Centre, January 12th, 2025)

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A Correctional Officer in Koto-Karfe further supported the comments made by other colleagues that:

"Feeding needs improvement. Also, in terms of infrastructure, where the inmates stay should be renovated. Some areas have been left unattended for a long time".

(Correctional Officer in Koto-care Custodial Centre, January 13th, 2025)

The implications of these findings are multi-layered. Firstly, without adequate preventive and curative services, prisons become hotspots for disease transmission and deterioration of inmates' health, which in turn undermines rehabilitation goals. Secondly, the lack of facilities for inmates with chronic or special needs exposes the system to legal and ethical violations, particularly in light of the Nelson Mandela Rules which demand the same standard of care in prisons as in the broader community. Thirdly, insufficient mental health services risk escalating behavioural issues within prisons, threatening institutional safety and contributing to recidivism upon release. Furthermore, although some officers reported daily availability of healthcare services, the overall poor quality ratings, limited specialisation, and lack of infrastructure paint a picture of systemic inefficiency. Officers' responses signal an awareness of these gaps but also hint at institutional inertia, where problems are well known but remain unresolved due to structural and policy limitations.

Research Question 3: What are the contemporary challenges affecting healthcare delivery to inmates in Kogi correctional facilities ?

Table 4: Contemporary Challenges Affecting Healthcare Delivery to Inmates in Kogi Correctional Facilities

Response	Frequency	Percentage (%)
Lack of medical personnel	320	80
Insufficient drugs/equipment	340	85
Overcrowding	300	75
Poor sanitation	280	70
Delayed referrals to hospitals	260	65
Other (e.g., corruption)	40	10

Source: Field Survey (2025)

When asked about the major challenges affecting healthcare delivery, officers overwhelmingly identified structural and resource-related constraints: 340 respondents (85.0%) cited insufficient drugs and equipment, 320 (80.0%) highlighted

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a lack of medical personnel, 300 (75.0%) mentioned overcrowding, 280 (70.0%) pointed to poor sanitation, and 260 (65.0%) referenced delayed referrals to hospitals. These challenges not only compromise the health of inmates but also increase the burden on correctional officers, who often assume non-clinical roles due to medical staff shortages.

X. TESTING OF HYPOTHESIS

Hypothesis: Access to quality of healthcare services have no significant effect on inmates' health and well-being.

Table 5: One-way Multivariate Analysis (One-Way MANOVA) Showing the Combined Main Effects of the type of healthcare service, frequency of healthcare availability, and Quality of healthcare provided on Special health needs, Physical wellbeing, Satisfaction with the level of healthcare, and overall health and wellbeing.

Multivariate Test

	Effect	Value	F	Hypothesis df	Erro
Intercept	Pillai's Trace	.989	11652.885[b]	3.000	389.0
	Wilks' Lambda	.011	11652.885[b]	3.000	389.0
	Hotelling's Trace	89.868	11652.885[b]	3.000	389.0
	Roy's Largest Root	89.868	11652.885[b]	3.000	389.0
Type of healthcare service	Pillai's Trace	.720	30.858	12.000	1173.
	Wilks' Lambda	.406	34.817	12.000	1029.
	Hotelling's Trace	1.160	37.468	12.000	1163.
	Roy's Largest Root	.802	78.442[c]	4.000	391.0
Frequency of healthcare Availability	Pillai's Trace	.537	150.413[b]	3.000	389.0
	Wilks' Lambda	.463	150.413[b]	3.000	389.0
	Hotelling's Trace	1.160	150.413[b]	3.000	389.0
	Roy's Largest Root	1.160	150.413[b]	3.000	389.0
Quality of healthcare provided	Pillai's Trace	.464	39.222	6.000	780.0
	Wilks' Lambda	.573	41.560[b]	6.000	778.0
	Hotelling's Trace	.679	43.919	6.000	776.0
	Roy's Largest Root	.565	73.427[c]	3.000	390.0
Type of healthcare service * Frequency of healthcare Availability	Pillai's Trace	.610	204.472[b]	3.000	393.0
	Wilks' Lambda	.390	204.472[b]	3.000	393.0
	Hotelling's Trace	1.561	204.472[b]	3.000	393.0
	Roy's Largest Root	1.561	204.472[b]	3.000	393.0

Test of Between Subjects Effects

Independent Variable	Dependent Variable	Type III Sum of Square	df	Mean Square	F
Type of healthcare service	Special health needs	.000	4	.000	.
	Physical wellbeing	10.889	4	2.722	34.21
	Satisfaction with the level of healthcare	.889	4	.222	2.793
	Overall health and wellbeing	42.000	4	10.500	76.97
Frequency of healthcare Availability	Special health needs	.000	1	.000	.
	Physical wellbeing	22.222	1	22.222	279.2
	Satisfaction with the level of healthcare	.889	1	.889	11.17
	Overall health and wellbeing	32.000	1	32.000	234.6
Quality of healthcare provided	Special health needs	.000	2	.000	.
	Physical wellbeing	15.556	2	7.778	97.75
	Satisfaction with the level of healthcare	2.222	2	1.111	13.96
	Overall health and wellbeing	5.000	2	2.500	18.32
Error	Special health needs	.000	391	.000	
	Physical wellbeing	31.111	391	.080	
	Satisfaction with the level of healthcare	31.111	391	.080	
	Overall health and wellbeing	53.333	391	.136	

- Design: Intercept + Type of healthcare service + Frequency of healthcare Availability + Quality of healthcare provided + Type of healthcare service * Frequency of healthcare Availability + Type of healthcare service * Quality of healthcare provided + Frequency of healthcare Availability * Quality of healthcare provided + Type of healthcare service * Frequency of healthcare Availability * Quality of healthcare provided.
- Exact statistic; c. The statistic is an upper bound on F that yields a lower bound on the significance level; d. Computed using alpha = .05

Source: Field survey, 2025

The multivariate test results rejected the null hypothesis, revealing significant effects of healthcare access on all dependent variables. The type of healthcare service had a 25.9% effect size (Wilks' $\Lambda = .406$, $F(12, 1029.489) = 34.817$, $p < .001$, partial $\eta^2 = .259$), significantly influencing physical well-being ($F(4, 391) = 34.212$, $p < .001$, $\eta^2 = .259$), satisfaction with healthcare ($F(4, 391) = 2.793$, $p < .001$, $\eta^2 = .028$), and overall health ($F(4, 391) = 76.978$, $p < .001$, $\eta^2 = .441$). Frequency of healthcare availability showed the strongest impact, with a 53.7% effect size (Wilks' $\Lambda = .463$, $F(3, 389) = 150.413$, $p < .001$, $\eta^2 = .537$), significantly affecting physical well-being ($F(4, 391) = 279.286$, $p < .001$, $\eta^2 = .417$), satisfaction ($F(4, 391) = 11.171$, $p < .001$, $\eta^2 = .028$), and overall health ($F(4, 391) = 234.600$, $p < .001$, $\eta^2 = .375$). Quality of healthcare had a 24.3% effect size (Wilks' $\Lambda = .573$, $F(6, 778) = 41.560$, $p < .001$, $\eta^2 = .243$), impacting physical well-being ($F(4, 391) = 97.750$, $p < .001$, $\eta^2 = .333$), satisfaction ($F(4, 391) = 13.965$, $p < .001$, $\eta^2 = .067$), and overall health ($F(4, 391) = 18.328$, $p < .001$, $\eta^2 = .086$). The interaction between type and frequency of healthcare services had the largest effect size at 61.0% (Wilks' $\Lambda = .390$, $F(3, 393) = 204.472$, $p < .001$, $\eta^2 = .610$), indicating a strong combined influence on well-being outcomes. Tests of between-subject effects confirmed that each healthcare factor significantly affected physical well-being, satisfaction, and overall health, with frequency having the most substantial impact.

These findings indicate that the availability, frequency, and quality of healthcare services significantly shape inmates' health outcomes, contradicting the null hypothesis. The results underscore the need for improved healthcare access in Kogi correctional facilities to enhance inmate well-being and support rehabilitation, aligning with international standards like the Nelson Mandela Rules.

XI. DISCUSSION OF FINDINGS

This study examined the adequacy of healthcare services and well-being of inmates in Kogi State correctional facilities. The findings offer new insight into the institutional and structural realities that shape prison healthcare in Nigeria and which either reinforce or challenge prior scholarly observations as discussed below:

The study found that while 65% of the officers reported that general healthcare services such as physical check-ups are available, only 15% confirmed the presence of emergency services, and a mere 5% acknowledged the availability of dental, mental health, substance abuse treatment, or preventive care. This uneven distribution mirrors the assertions by Posholi (2019) and Amnesty International (2020), who noted that African prison systems often fail to provide comprehensive healthcare, particularly in mental health and specialised treatment areas. Petracek (2012) emphasised that mental

health needs are largely neglected in African correctional systems, a finding strongly supported by this study, where 80% of respondents stated that there are no mental health services in their facilities.

However, the finding that 70% of the officers reported daily access to some form of medical care slightly contrasts with Eze (2022), who reported that many Nigerian prisons receive medical visits only sporadically. This discrepancy may reflect regional variations or recent improvements in staffing routines in some parts of Kogi State. Nevertheless, when considered alongside the poor quality and limited scope of care, even daily presence does not equate to adequate or effective service delivery, a nuance that aligns with Onyemelukwe's (2023) critique of the difference between policy presence and operational impact.

The study further revealed that 95% of the officers reported the absence of specialised facilities for inmates with chronic illnesses, disabilities, or age-related needs. This finding supports Adebayo and Okorie (2023), who observed that correctional health systems in Nigeria are not equipped to cater to vulnerable populations. It also aligns with the global perspective presented by Fair and Walmsley (2021), who argue that the neglect of prison health undermines broader public health and constitutes a violation of basic human rights.

Additionally, the data revealed that 75% of respondents rated the overall quality of healthcare as fair, with only 5% considering it good. These assessments reflect a general dissatisfaction consistent with Onyemelukwe's (2023) evaluation of weak implementation of the Nigerian Correctional Service Act (2019), which mandates equitable and quality care. The finding that 70% of respondents reported only limited access to fitness or recreational facilities reinforces the claim by Bernault (2003) that African prisons are structured more for containment than rehabilitation—an orientation that ultimately undermines inmate well-being.

Interestingly, despite the structural deficiencies, 85% of respondents noted that inmates can at least voice healthcare complaints to a supervisor. This contrasts with some studies (e.g., Eze, 2022) that report complete lack of grievance mechanisms. While this is a relatively positive finding, the lack of formal, independent, and enforceable complaint procedures still means inmate concerns are unlikely to lead to substantive improvements.

The study identified insufficient medical supplies (85%), lack of trained personnel (80%), overcrowding (75%), and poor sanitation (70%) as the most pressing challenges affecting healthcare delivery. These findings reaffirm the conclusions of Amnesty International (2020) and Onyemelukwe (2023), who both point to resource constraints, poor planning, and administrative neglect as barriers to humane and effective inmate care. Overcrowding in particular, as observed in this study, complicates disease control, increases staff workload, and strains already limited resources, a situation that Petracek (2012) described as "institutionalised health risk."

The respondents' recommendations—ranging from recruitment of medical staff to improved facilities and the inclusion of mental healthcare—mirror the policy suggestions of Fair and Walmsley (2021) and the United Nations (2015), reinforcing the need to align correctional healthcare in Nigeria with international human rights standards, particularly the Nelson Mandela Rules.

The findings support the Rehabilitation Theory underpinning the study, which argues that correctional facilities should provide opportunities for reform, including healthcare as a fundamental component. The evidence from Kogi shows that the lack of adequate

healthcare services significantly impairs inmates' physical and mental well-being, thereby weakening the institutions' capacity to rehabilitate. Inmates denied proper care are less likely to participate meaningfully in reform programmes, more likely to suffer recurring health crises, and ultimately more vulnerable to recidivism, a pattern consistent with Cullen and Gendreau's (2000) reformist assumptions about the link between wellness and reintegration.

XII. CONCLUSION

The findings of this study both support and extend existing literature on prison healthcare in Nigeria at large and Kogi State in particular. While some facilities in Kogi provide minimal daily healthcare contact, the system is still overwhelmed by resource shortages, lack of specialisation, inconsistent policy implementation, and widespread neglect of inmate well-being. The gaps between national policies and on-ground realities are wide, and unless urgently addressed, the correctional system in Kogi State will continue to operate in contradiction of its rehabilitative goals.

Recommendations

To tackle the ongoing issues in healthcare and overall well-being within Kogi State's correctional facilities, as highlighted in the study, the recommendations were made:

Boost Funding for Healthcare Infrastructure: It's crucial to allocate budgets that will allow all facilities to have well-equipped medical clinics, addressing the current lack of necessary drugs and equipment. Collaborating with health ministries to secure funding for medications, especially for chronic diseases, will help minimize delays in care and ensure that everyone has fair access to healthcare.

Hire and Train Medical Staff: There is the need to bring on board doctors, nurses, mental health professionals, and dentists to fill the reported staff shortages. Additionally, training correctional staff on health awareness and providing incentives can help attract professionals to the rural areas of Kogi. This approach will lead to more frequent medical visits and enhance specialized care, particularly in mental health.

Create Mental Health Programs: It's essential to introduce counseling, therapy, and psychiatric services to address the alarming statistic of inmate's report having no access to mental health services. Partnering with NGOs to deploy psychologists and conduct regular screenings can significantly alleviate psychological distress, aiding in rehabilitation and reintegration efforts. Furthermore, the Courts need to speed up judicial processes to cut down on pre-trial detention, especially since a staggering 75% of people point to overcrowding as a major issue (with prisons operating at 150% capacity). It's also crucial to expand facilities and enhance sanitation

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