Headfort Foundation For Justice

DRPC
Development Research and Projects Centre
30 Years of Delivering Inclusive Development

POLICY DOCUMENT ON INMATES' HEALTHCARE IN NIGERIA CORRECTIONAL CENTERS

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TABLE OF CONTENT

Executive Summary IV
Purpose and Scope of Policy..... IV - V
Key Findings ..... VI - VIII
Recommendation and Implementation ..... VIII - X
Acknowledgement..... XI

Section ONE: Introduction and Methodology

1.1 Background and context: health in places of detention in Nigeria 1-2
1.2 Policy development process..... 3-4
1.3 Data sources (primary/secondary)..... 4-6
1.4 Ethical considerations and data protection..... 6-7

Section TWO: Problem Statement

2.1 Overview of health outcomes in correctional settings..... 8-11
2.2 Service delivery gaps (access, quality, continuity)..... 12-13
2.3 Systemic constraints (governance, financing, workforce, supplies, infrastructure)..... 13-15
2.4 Consequences for inmates, staff, and public health..... 16-17

Section THREE: Causes of the Problem

3.1 Structural and legal factors..... 18-20
3.2 Operational and managerial bottlenecks..... 20-21
3.3 Socioeconomic determinants of inmate health..... 21-22
3.4 Overcrowding and Staffing Shortage..... 23-24
3.5 Corruption and Inadequate Funding..... 25
3.6 Data, monitoring, and accountability gaps..... 26

Section FOUR: Current Legal and Policy Framework

4.1 1999 Constitution of the Federal Republic of Nigeria (As Amended) (overview)..... 28
4.2 Nigerian Correctional Service Act (overview)..... 29-30
4.3 International and regional standards (e.g., Mandela Rules, Bangkok Rules, Abuja Declarations)..... 30-31
4.4 Gap analysis: law vs. practice..... 31-32

Section FIVE: Physical Health Services in Correctional Centres

5.1 Primary care package (triage, screening, routine care)..... 34
5.2 Maternal, newborn, and child health (ANC, PNC, infant care)..... 34-35
5.3 Infectious diseases (TB, HIV, hepatitis, skin infections, outbreaks).....35

5.4 Non-communicable diseases (hypertension, diabetes, asthma, epilepsy, cancer screening)..... 35-36
5.5 Emergency care and referral pathways..... 36
5.6 Pharmacy, essential medicines, diagnostics, and supply chains..... 37

Section SIX: Mental Health and Psychosocial Support (MHPSS)

6.1 Prevalence and risk factors in custodial settings..... 38
6.2 Screening, assessment, and treatment pathways..... 38
6.3 Crisis management, suicide and self-harm prevention..... 38-39
6.4 Substance use disorders and integrated care..... 39
6.5 Psychosocial support, counselling, and peer-led programs..... 39
6.6 Continuity of mental healthcare on transfer and post-release..... 39-40

Section SEVEN: Vulnerable and Key Demographic Groups

7.1 Women and girls (including menstrual health and reproductive health)..... 42-43
7.2 Pregnant and postpartum women (ANC/PNC, safe delivery, nutrition)..... 44-45
7.3 Men and young men..... 45-46
7.4 Elderly persons (geriatric care, mobility, chronic disease management)..... 47-48
7.5 Infants and children living with incarcerated mothers..... 49-51
7.6 Persons with disabilities..... 51- 53
7.7 Pre-trial detainees and short-stay inmates..... 53-55

Section EIGHT: Service Delivery Model and Care Pathways

8.1 Entry health screening and medical records..... 56-57
8.2 Routine and periodic health checks..... 57-58
8.3 Referral networks, telemedicine, and specialist outreach..... 58
8.4 Emergency evacuation protocols.....58-59
8.5 Infection prevention and control (IPC) and WASH standards..... 59-60

Section NINE: Headfort Foundation for Justice: Wellness Behind Bars Initiative

9.1 Program overview and theory of change..... 61
9.2 Geographic coverage and beneficiary profile..... 61-62
9.3 Service components (medical outreaches, diagnosis, mental health, health education)..... 62
9.4 Partnerships with NCoS, CSOs, pro bono clinicians..... 63-64
9.5 Results to date (outputs, outcomes, case studies)..... 64-65
9.6 Lessons learned and scalability opportunities..... 66-67
9.7 Integration with this policy (roles in implementation, M&E, advocacy) Policy Recommendations..... 68-69

Section TEN: Policy Recomendation

10.1 Legal and policy reforms..... 70
10.2 Service delivery and clinical standards..... 70
10.3 Workforce strengthening and training..... 71

10.4 Financing and procurement improvements..... 71
10.5 Data systems, M&E, and research priorities..... 71
10.6 Partnerships and coordination (inter-ministerial and CSO)..... 72
10.7 Phased implementation plan (quick wins, medium-term, long-term)..... 72-73

Implementation Plan

11.1 Objectives, activities, timelines, and responsible actors..... 74-75
11.2 Risk analysis and mitigation matrix..... 76
11.3 Change management and capacity-building plan..... 76 -78
11.4 Communication and advocacy plan..... 78
11.5 Objectives..... 78 - 79

Conclusion

12.1 Commitments required and next steps..... 80
12.2 Call to action..... 81
12.3 References..... 83 - 85

Executive Summary

This Executive Summary provides a concise overview of the policy document on inmates' healthcare in Nigerian Correctional Centres.The Nigerian Correctional Service (NCoS) is primarily perceived as a custodial institution for inmates. However, a critical aspect that often receives little attention is the overall well-being of those in custody, particularly their access to healthcare services.

Recent observations and data from correctional centres across the country reveal that the health and welfare of inmates are not consistently prioritized. One of the key contributing factors is chronic overcrowding, which puts immense strain on already limited medical infrastructure, personnel, and supplies. This has led to an increase in preventable illnesses, delayed treatments, and deteriorating mental health conditions. While the Nigerian Correctional Service Act (2019) mandates access to adequate and free healthcare, implementation gaps continue to undermine this right. This policy brief examines the root challenges affecting inmate healthcare, explores feasible policy alternatives, and recommends actionable solutions that can be adopted by the Ministry of Interior and relevant stakeholders to improve correctional health systems across Nigeria.

Purpose of the Policy.

The purpose of this policy document is to provide a comprehensive framework for addressing healthcare delivery within Nigerian Correctional Centres. It seeks to identify and analyze the systemic gaps in the provision of physical and mental healthcare services for inmates, while also highlighting the urgent need for reforms that align with both national legal obligations and international human rights standards. This document is intended to guide policymakers, correctional administrators, civil society organizations, and other stakeholders towards evidence-based, practical, and sustainable solutions that protect and promote the health and dignity of persons in custody.

The policy has been developed in response to the growing concerns over the deplorable state of healthcare in Nigerian correctional facilities, where inmates often face overcrowded conditions, inadequate medical personnel, insufficient medical supplies, delayed or non-existent treatment, and poor mental health support. It also responds to the neglect of specific demographic groups such as women, pregnant women, infants living with their incarcerated mothers, the elderly, and persons with disabilities—who require tailored medical interventions but are often overlooked. This policy aims to address these pressing issues by:

- Defining clear standards and protocols for both preventive and curative healthcare in correctional facilities.
- Outlining the legal and policy obligations of the Nigerian state under national laws such as the Nigerian Correctional Service Act, the Nigerian Constitution, and international treaties like the United Nations Standard Minimum Rules for the Treatment of Prisoners (the Mandela Rules).
- Highlighting the intersection between public health and correctional health, recognizing that the health of inmates has direct implications for public health due to eventual reintegration into society.
- Proposing structured interventions for mental health care, including screening, counselling, therapy, and rehabilitation programs, to reduce recidivism and promote reintegration.
- Providing specific recommendations for the unique needs of vulnerable groups such as pregnant women, nursing mothers, children, elderly persons, and those with chronic or terminal illnesses.

It is applicable to both convicted persons and those awaiting trial, recognizing that a large proportion of the prison population in Nigeria consists of pre-trial detainees who are entitled to the same standard of care as convicted inmates. It addresses both short-term interventions—such as immediate improvements to medical supplies, personnel, and facilities—and long-term systemic reforms including budgetary provisions, capacity building, policy enforcement, and monitoring mechanisms.

This policy further incorporates the experience and interventions of the Headfort Foundation for Justice through its Wellness Behind Bars initiative, which has provided a practical, tested model for delivering healthcare in correctional facilities. Lessons learned from this initiative, along with other best practices, are integrated into the recommendations to ensure that the policy is realistic, implementable, and adaptable across diverse correctional environments in Nigeria.

In essence, this document serves as both an advocacy and operational tool—bridging the gap between the existing legal framework and the lived realities of inmates, while providing a roadmap for achieving an equitable, functional, and humane correctional healthcare system in Nigeria.

Figure 1: Title: Overview of Health in Nigerian Correctional Centres

Key Findings

The assessment of healthcare delivery within Nigerian Correctional Centres reveals several systemic and operational deficiencies that significantly undermine the right of inmates to adequate medical care, as guaranteed under national laws and international human rights standards.

A critical gap identified is the absence of comprehensive health screening upon admission into correctional facilities. In many centres, individuals are not routinely tested for essential health indicators such as pregnancy status, HIV status, hepatitis, tuberculosis, or other communicable and non-communicable diseases. This lack of early diagnosis not only delays access to appropriate care but also heightens the risk of disease transmission within overcrowded facilities. For instance, several women who had missed their regular menstrual cycles for over a month while in custody were unaware of their pregnancy status, exposing them and their unborn children to avoidable health risks.

The shortage of qualified medical personnel is another significant concern. Many facilities operate with an extremely limited number of healthcare workers, often without specialists such as gynaecologists, psychiatrists, or paediatricians who are crucial for addressing the diverse health needs of the inmate population. The understaffing is compounded by poor staff-to-inmate ratios, which makes it impossible to provide timely, quality healthcare services.

Equally alarming is the inadequacy of medical infrastructure and equipment. Many prison clinics are poorly equipped, with obsolete diagnostic tools, insufficient beds, and limited access to essential medicines. In some cases, life-saving medications are unavailable or must be procured by inmates' families, creating disparities in care based on external support networks rather than medical urgency.

Mental health care is almost entirely neglected in most Nigerian correctional centres. There is no structured mental health support system, and inmates with psychosocial disabilities or mental health challenges are often left undiagnosed and untreated. The lack of counselling services, psychiatric assessment, and therapeutic interventions exacerbates the psychological toll of incarceration, contributing to high levels of depression, anxiety, and in severe cases, suicide attempts.

The situation is further worsened by the absence of tailored healthcare for specific demographics. Pregnant women, nursing mothers, infants, the elderly, and persons with disabilities often face unique vulnerabilities that are not adequately addressed.

Pregnant women frequently lack access to antenatal care, skilled birth attendants, and nutrition support, while elderly inmates suffer from untreated chronic illnesses such as hypertension and diabetes. Infants and young children residing with their incarcerated mothers do not always receive proper paediatric care, vaccinations, or nutritional support.

In addition, health education and preventive healthcare measures are largely absent. Inmates are rarely provided with information on hygiene, reproductive health, nutrition, or mental well-being. This not only hampers their capacity to maintain personal health during incarceration but also poses long-term public health risks upon their release.

Recommendations and Implementation Roadmap

Based on the key findings and gaps identified, it is evident that urgent and coordinated action is required to reform healthcare service delivery within Nigerian correctional centres. The recommendations outlined below are designed to address systemic deficiencies, strengthen institutional capacity, and ensure the provision of comprehensive, accessible, and rights-based healthcare for all inmates, in alignment with national health policies, the Nigerian Correctional Service Act, and international human rights standards.

1. Establish Mandatory Comprehensive Health Screening Protocols

It is recommended that the Nigerian Correctional Service (NCoS) institute a compulsory health screening policy for all inmates within 24 hours of admission. This screening should include tests for pregnancy, HIV, hepatitis, tuberculosis, malaria, and other communicable and non-communicable diseases. Special attention should be given to identifying mental health conditions and pre-existing chronic illnesses.

Implementation Roadmap:

- Develop and issue a national standard operating procedure (SOP) for inmate health screening.
- Provide correctional facilities with rapid diagnostic kits, laboratory support, and trained personnel.
- Create a centralised health data reporting system linking correctional centres to state and federal health monitoring platforms.

2. Strengthen Medical Staffing Levels and Training

Correctional health units across Nigeria are grossly understaffed. A national staffing ratio should be introduced to ensure that each facility has adequate numbers of medical doctors, nurses, midwives, mental health professionals, pharmacists, and laboratory scientists.

Implementation Roadmap:

- Conduct a nationwide healthcare staffing audit for correctional centres.
- Recruit additional healthcare workers under a special national correctional health scheme.
- Establish a continuous professional development program with a focus on prison health, mental health, and human rights-based healthcare delivery.

3. Upgrade Medical Facilities, Equipment, and Medicine Supply Chains within Correctional Facilities

To ensure adequate diagnosis and treatment, correctional medical units should be equipped with basic diagnostic tools, essential drugs, maternity care facilities, and emergency response equipment.

Implementation Roadmap:

- Allocate federal and state budget lines specifically for prison healthcare infrastructure.
- Establish a national procurement and distribution framework for essential medical supplies to correctional centres.
- Partner with teaching hospitals and primary health centres for referral and specialist services.
- Partner with private pharmaceutical companies for supplies of essential drugs

4. Integrate Mental Health Support into Correctional Healthcare

Mental health services remain almost entirely absent in most correctional facilities. It is essential to provide psychiatric evaluations, counselling services, and rehabilitation programs for inmates with mental disorders, trauma, and substance use challenges.

Implementation Roadmap:

- Deploy trained psychologists, counsellors, and social workers to facilities on either full-time or rotational bases.
- Create confidential mental health reporting channels to encourage inmates to seek help.
- Partner with mental health NGOs and professional associations for ongoing therapy and capacity support.

5. Specialised Care for Vulnerable Populations

Women, pregnant inmates, elderly prisoners, infants living with their mothers, and persons with disabilities require specialised care. This includes antenatal and postnatal services, paediatric care, geriatric health management, and disability-inclusive healthcare.

Implementation Roadmap:

- Develop gender-responsive and child-friendly healthcare policies in correctional centres.
- Provide separate and adequately equipped maternity units within female correctional facilities.
- Ensure regular health monitoring for elderly inmates and those with chronic illnesses.

6. Establish a National Inmate Health Information System

The absence of reliable health data hinders policy planning and resource allocation. A centralized inmate health database would improve service delivery and monitoring.

Implementation Roadmap:

- Create a digital health information management system linked to the Federal Ministry of Health and the NCoS headquarters.
- Train healthcare and administrative staff in proper health data entry and analysis.
- Publish annual national prison health reports to enhance transparency and accountability.

7. Strengthen Partnerships and Multi-Sectoral Collaboration

Healthcare delivery in correctional centres cannot be the sole responsibility of the NCoS; it requires collaboration with federal, state, and local governments, private organisations, CSOs, and development partners.

Implementation Roadmap:

- Establish a National Prison Health Committee comprising the NCoS, Federal Ministry of Health, civil society, and professional bodies.
- Create memoranda of understanding (MoUs) with public hospitals and NGOs for service delivery support.
- Integrate prison health into the National Health Insurance Authority (NHIA) coverage to ensure sustainable funding.

Acknowledgement

This policy document was developed through the commitment and collaborative efforts of Headfort Foundation for Justice, whose dedication to advancing access to justice and promoting the welfare of individuals in custody remains unwavering. We extend our heartfelt gratitude to our dedicated team, whose tireless work, research, and advocacy have been instrumental in bringing this policy to life.

We are deeply thankful to the Development Research and Projects Center (DRPC) for providing the funding support that made this work possible. Their investment in evidence-based policy development has been invaluable in driving meaningful reforms. This work was undertaken in close collaboration with the Nigerian Correctional Service, whose openness, cooperation, and provision of access and information were essential to understanding the realities within correctional centers. We also appreciate the contributions of Arogi Trauma Care Foundation and SRIHIN, whose expertise in trauma-informed care and health interventions enriched the quality and depth of this policy document.

Together, these partnerships have not only shaped the recommendations contained herein but have also strengthened the foundation for a coordinated, holistic approach to improving healthcare services for persons in custody across Nigeria.

SECTION 1:

INTRODUCTION AND METHODOLOGY

1.1 Background and context: health in places of detention in Nigeria

The right to health is a fundamental human right enshrined in international, regional, and national legal frameworks, including the International Covenant on Economic, Social and Cultural Rights, the African Charter on Human and Peoples' Rights, and the Constitution of the Federal Republic of Nigeria. This right extends to all persons, without discrimination, including those in detention.

> Individuals in custody are entitled to a standard of healthcare equivalent to that available in the community, a principle often referred to as the ***"principle of equivalence of care."***

However, in Nigeria, the health situation in places of detention is marked by systemic challenges that threaten the wellbeing, dignity, and in some cases, the lives of persons deprived of liberty. Overcrowding, poor sanitation, inadequate nutrition, limited access to clean water, and insufficient medical personnel create an environment where illness can spread rapidly and where chronic and acute health needs often go unmet. In addition, limited access to mental health care and specialized services for vulnerable groups—including women, older persons, and persons with disabilities—further compounds the health crisis within correctional facilities.

Nigeria's correctional system, while guided by the Nigerian Correctional Service Act, 2019, and other relevant regulations, continues to face structural and operational barriers in providing adequate healthcare. Section 24 of the Nigerian Correctional Service Act (2019) guarantees inmates access to free and adequate healthcare, including mental health services, this right remains largely unrealized in practice.

> The Act clearly states, **"Every inmate shall be entitled to free medical treatment, including psychiatric care,"** yet recent data as of July 2025 shows that only **43.4%** of inmates have accessed medical consultation within the last three months.

Many facilities lack ully equipped clinics, essential drugs, diagnostic tools, and trained medical staff.

Referral pathways to external hospitals are often delayed or obstructed by logistical, financial, or bureaucratic hurdles, leading to avoidable morbidity and mortality.

Health in detention cannot be separated from public health. The majority of individuals in custody eventually return to their communities, meaning that untreated infectious diseases such as tuberculosis, HIV, hepatitis, and COVID-19 within correctional facilities have direct implications for community health. Similarly, the neglect of mental health needs can result in reintegration challenges, recidivism, and further strain on families and society at large. The healthcare situation in detention settings is also shaped by socio-economic inequalities, stigma, and the marginalization of justice-impacted persons. Without targeted interventions and a coordinated policy framework, these issues remain entrenched, perpetuating cycles of ill health and injustice. It is against this backdrop that this policy document has been developed—to provide a comprehensive framework for improving healthcare delivery in Nigeria's correctional facilities. It draws on evidence from field research, consultations with key stakeholders, and international best practices to propose actionable recommendations for reform. By situating healthcare in detention within a broader human rights and public health context, this policy seeks to ensure that persons in custody receive dignified, timely, and effective medical care, thereby safeguarding both individual wellbeing and the health of the wider community.

1.2 Policy development process

The development of this policy document was undertaken through a collaborative, inclusive, and evidence-driven process to ensure that it reflects the realities of health in places of detention across Nigeria, addresses existing gaps, and aligns with both national priorities and international human rights standards. The process was designed to engage a broad spectrum of stakeholders whose perspectives and expertise are critical to the effective implementation of health policies in correctional settings.

The starting point was a comprehensive desk review of existing national and international instruments, including the Nigerian Correctional Service Act, the Nigerian Constitution, the National Health Policy, and relevant United Nations Standard Minimum Rules for the Treatment of Prisoners (the Mandela Rules). This review provided a foundational understanding of current legal obligations, operational frameworks, and global best practices for delivering healthcare in detention facilities.

Following the desk review, primary data collection was conducted to capture the lived realities of persons deprived of liberty and the operational challenges faced by correctional staff. This involved facility visits to four correctional centres across three states in Nigeria(Kirikiri Female Correctional Facility, Ikoyi Correctional Facility, Ado Ekiti Correctional Facility, and Enugu Correctional Facility), direct observations, and informal interviews with inmates, healthcare providers, custodial officers, and facility administrators. These visits revealed critical gaps in medical screening, availability of essential medicines, mental health support, and reproductive health services for women in custody.

The process also incorporated a series of multi-stakeholder consultations at the facility. Participants included officials from the Nigerian Correctional Service (NCoS), civil society organizations such as Headfort Foundation for Justice, Arogi Trauma Care Foundation, and SRIHIN, as well as development partners. These sessions were instrumental in ensuring that the policy framework was not only technically sound but also operationally feasible within the Nigerian context.

Special attention was given to the inclusion of vulnerable groups in the consultations. Women, juveniles, and inmates with disabilities were engaged via interviews to ensure their unique health needs were documented and incorporated into the policy recommendations.

These engagements also helped to highlight the intersection between health rights and broader justice sector reforms, underscoring the role of healthcare in safeguarding the dignity and rehabilitation prospects of inmates. The policy drafting process was iterative and consultative. Initial drafts were circulated among stakeholders for review and validation, ensuring that the final document reflects a shared vision for reform.

Inputs were meticulously integrated to align with Nigeria's national health priorities, correctional service realities, and resource constraints while maintaining compliance with international human rights obligations.

This participatory development process ensures that the policy is grounded in evidence, driven by inclusivity, and shaped by collective ownership—a crucial factor for its acceptance, adoption, and sustainable implementation at the national level.

1.3 Data Sources

The development of this policy document is grounded in evidence drawn from multiple, credible, and diverse sources. These sources were carefully selected to ensure a comprehensive understanding of the health situation in places of detention, as well as the systemic and operational gaps that need to be addressed. The data was collected using both qualitative and quantitative methods to capture the lived realities of persons deprived of liberty, as well as the institutional perspectives of those responsible for their welfare.

1. Interviews with Inmate

Direct, face-to-face interviews were conducted with inmates across two correctional facilities. These interviews provided first-hand narratives on their experiences with healthcare services, including medical screenings at admission, access to ongoing treatment, and availability of medicines and equipment.

Through these discussions, recurring themes emerged, such as the absence of initial health checks for conditions like pregnancy, HIV, tuberculosis, and other communicable or chronic illnesses, as well as inadequate follow-up medical care. Inmates' testimonies also revealed the psychological toll of incarceration without mental health support, alongside the challenges posed by overcrowding and poor sanitary conditions

2. Interviews with Correctional Service Officials

A baseline assessment was held with key personnel of the Nigerian Correctional Service, including medical staff and administrative officers. These interviews offered institutional insights into the operational limitations faced by correctional facilities, such as shortage of trained medical personnel, limited medical supplies, outdated diagnostic equipment, and lack of mental health professionals. Officials also shared constraints related to funding, infrastructure, and coordination with external health agencies.

3. Pre- and Post-Outreach Surveys Conducted by Headfort Foundation for Justice

As part of the outreach programs facilitated by Headfort Foundation for Justice, structured surveys were administered before and after medical and legal outreach sessions in correctional facilities. The pre-outreach surveys assessed the baseline health awareness, knowledge of available services, and self-reported health conditions among inmates. The post-outreach surveys captured changes in awareness, access to care, and reported satisfaction with interventions provided during the outreach. These surveys provided quantitative indicators of existing health service gaps and the immediate impact of targeted interventions

4. Review of Statutes, Policy Frameworks, and Regulatory Instruments

Relevant national and international legal and policy documents were reviewed, including the Nigerian Correctional Service Act, national health policies, human rights frameworks, and applicable international treaties such as the United Nations Standard Minimum Rules for the Treatment of Prisoners (the Mandela Rules). This legal and policy review offered an understanding of the formal obligations regarding the provision of healthcare in detention settings and the extent to which these obligations are being met.

5. Media Reports and Publicly Available Materials

Reports from reputable news outlets, human rights organizations, and public domain publications were analyzed to identify trends, documented cases, and external assessments of healthcare in correctional facilities. These sources complemented primary data collection by providing broader societal perspectives and independently verified accounts of systemic health challenges in prisons.

1.4 Ethical considerations and data protection

The development of this policy was guided by strict adherence to ethical standards and applicable data protection laws to ensure the dignity, safety, and confidentiality of all participants. Given the sensitive nature of correctional facilities and the vulnerability of individuals in custody, the research team adopted a human-rights-based and trauma-informed approach throughout the process.

First, in compliance with Nigerian Correctional Service protocols and relevant privacy regulations, photography and videography were strictly prohibited within the correctional facilities. This ensured that no inmate, official, or sensitive infrastructure was visually documented in a manner that could compromise privacy, security, or dignity.

Second, confidentiality of participants was paramount. Many correctional facility officials and inmates explicitly requested that their names, personal identifiers, and positions not be disclosed in the report or any related publication. The research team fully respected this request, ensuring that all personal references were anonymised, and any quotes were attributed only to their general role (e.g., “a female inmate in Lagos facility” or “a senior medical officer”) without revealing identifiable details.

Third, informed consent was obtained from all interview participants. Before each interview or survey, the purpose of the research was explained, along with how the information would be used, the voluntary nature of participation, and the assurance of confidentiality. Participants were also informed of their right to decline to answer any question or to withdraw from the process entirely without any consequence.

Fourth, the pre- and post-outreach surveys conducted by Headfort Foundation for Justice were designed in compliance with data protection laws, ensuring that only necessary information was collected. Data was stored securely, with access restricted to the core research team, and no raw data containing personal identifiers was shared outside the project team.

Lastly, in accordance with ethical research principles, special care was taken when engaging with inmates who had experienced trauma, mental health challenges, or health-related stigma (such as HIV status or pregnancy). Questions were framed sensitively, and the team avoided any lines of inquiry that could cause distress or re-traumatization.

This strong ethical foundation ensured that the policy development process maintained the trust of participants, complied with institutional and legal requirements, and upheld the principles of respect, dignity, and integrity in working with justice-impacted populations.

SECTION 2:

PROBLEM STATEMENT

In Nigeria's correctional facilities, the health crisis among inmates is both silent and severe, manifesting in untreated illnesses, unaddressed mental health conditions, and a system stretched far beyond its capacity.

A recent survey conducted by Headfort Foundation for Justice revealed a stark reality: 6 out of 10 inmates identified inadequate medical care as one of their most pressing concerns during incarceration. These concerns ranged from long wait times to see a health worker, lack of essential medication, absence of routine check-ups, and minimal or non-existent mental health support.

During our outreach in a correctional facility in Lagos, two women confided that they did not even know their pregnancy status—an alarming indication of the absence of basic reproductive health services. In the same facility, a 60-year-old woman told us her story: she had been arrested and detained in place of her son. The unjust incarceration has taken a severe toll on her mental health, leaving her withdrawn, anxious, and utterly hopeless. She spoke with a trembling voice, eyes fixed on the ground, embodying the emotional weight of neglect and injustice.

Other inmates in Lagos facilities echoed similar concerns, telling us bluntly:

> ***"There are no medicines for us, and there is no routine check-up and in many cases, they or their family members had to pay for medications and where they cannot afford it, they continue to live in pain and untreated illness."***

The situation is not unique to Lagos. In the Ado-Ekiti Correctional Facility, officials themselves lamented the deteriorating health conditions of inmates—conditions they attributed to inadequate medical supplies and an overstretched healthcare system.

These testimonies are not isolated accounts; they reflect systemic challenges corroborated by independent investigations. A publication by Sahara Reporters published on the 13th of August 2025 highlighted the Nigerian Correctional Service's own acknowledgment of the crisis. In the report, Dr. Glory Essien, Assistant Controller General of Corrections in charge of medical services disclosed that there are 8,246 inmates living with mental health conditions,

conditions in custodial centers across the country, yet the number of doctors available to care for them is grossly insufficient.

> ***"We have 8,246 inmates with mental health conditions in our custodial centers,"*** she said, lamenting the acute shortage of medical personnel.

The same report quoted Mohammed Bashir, Assistant Controller General responsible for pharmaceutical services, who raised concerns over the lack of drug availability and the near absence of structured mental health care for inmates. This shortage of medication and professional care means that even treatable conditions are left to worsen, sometimes with irreversible consequences.

What emerges from these accounts is a deeply troubling picture: Nigerian correctional facilities are not equipped to safeguard the most basic health rights of those in their custody. The combination of inadequate infrastructure, chronic understaffing, insufficient medical supplies, and the neglect of mental health has created a public health emergency behind prison walls. This crisis undermines rehabilitation efforts, worsens human suffering, and raises urgent questions about the country's commitment to the humane treatment of those deprived of their liberty.

2.1 Overview of health outcomes in correctional settings

Correctional facilities are often viewed solely through the lens of security, order, and discipline, yet they are also public health environments with a unique and highly vulnerable population. Globally, evidence shows that individuals in custodial settings tend to experience poorer health outcomes compared to the general population, and this disparity is particularly stark in developing countries like Nigeria. The health of incarcerated persons is shaped by a combination of pre-existing vulnerabilities, the prison environment, and the adequacy—or inadequacy—of available health services.

Many inmates arrive in correctional facilities with existing health conditions—chronic diseases such as hypertension, diabetes, tuberculosis, and HIV, as well as untreated mental health disorders. The often-overcrowded, poorly ventilated, and unhygienic conditions within many Nigerian custodial centres serve as catalysts for the deterioration of these conditions and the rapid spread of communicable diseases. Preventive healthcare is virtually non-existent in most facilities, meaning inmates are rarely screened regularly for emerging health issues. Instead, healthcare tends to be reactive and crisis-driven, leading to late diagnoses and poor treatment outcomes.

Physical health outcomes are compounded by the absence of routine medical check-ups, insufficient medicines, and a critical shortage of healthcare personnel. According to recent disclosures from the Nigerian Correctional Service, over 8,200 inmates are living with mental health conditions, yet there is an acute shortage of psychiatrists, psychologists, and trained mental health professionals to manage these cases. In many instances, inmates suffering from depression, anxiety, psychosis, or post-traumatic stress disorder remain untreated or are managed rather than therapeutic interventions.

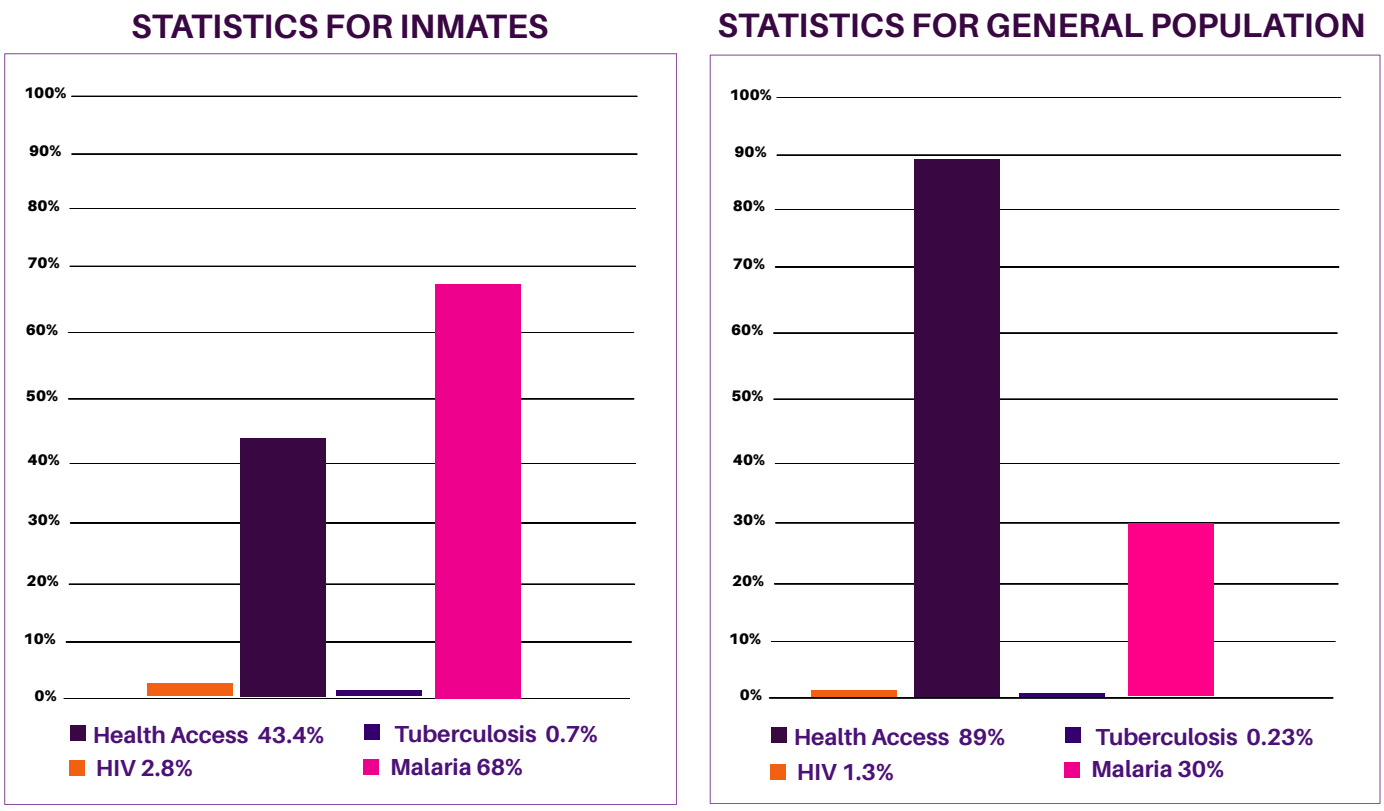
The consequences of inadequate healthcare are far-reaching. Untreated illnesses can result in long-term disability, irreversible complications, or preventable deaths. Poor health outcomes not only affect the individual inmate but also have a ripple effect on prison management, increasing tension, aggression, and unrest within facilities. Mental health issues, when left untreated, can manifest as self-harm, suicide attempts, or behavioural challenges that correctional officers are ill-equipped to manage.

The problem extends beyond the prison walls. Inmates eventually return to their communities, often with worsened health conditions, thereby increasing the public health burden. For example, the transmission of infectious diseases such as tuberculosis or hepatitis can be amplified by the lack of treatment continuity post-release. Furthermore, when incarcerated women do not receive adequate antenatal care—or are not even aware of their pregnancy status—both maternal and child health outcomes are severely compromised.

Internationally, the Mandela Rules (United Nations Standard Minimum Rules for the Treatment of Prisoners) affirm that incarcerated individuals are entitled to the same standard of healthcare available in the wider community, without discrimination. In reality, however, Nigerian custodial centres fall far short of these standards. The lack of funding, poor coordination between correctional health services and the national health system, and the absence of robust health monitoring mechanisms contribute to the systemic neglect of prisoners' health needs.

The health outcomes in Nigerian correctional facilities are therefore not simply the result of individual illness or personal misfortune—they are structural and systemic failures. Addressing them requires a deliberate policy shift towards integrating correctional healthcare into the national public health strategy, ensuring that incarceration does not equate to a death sentence by neglect.

Figure 2: Title: Health Access & Disease Burden (Inmates vs General Population)



Note: Tuberculosis Statistics for 700 per 100,000 inmates (0.7%)
Tuberculosis Statistics for 219 per 100,000 General Population (0.23%)

2.2 Service delivery gaps (access, quality, continuity)

Health service delivery in Nigerian correctional facilities faces critical challenges in three core dimensions—access, quality, and continuity. These gaps not only undermine the constitutional right to health of inmates but also exacerbate existing inequalities and worsen health outcomes, particularly for vulnerable groups such as pretrial detainees, women, juveniles, and persons with disabilities.

Access to Healthcare Services

Many correctional facilities in Nigeria operate with severely limited health infrastructure. Inmates report significant delays in receiving medical attention, with some stating that requests for medical attention could take days or even weeks to be attended to. This delay is often due to understaffing, lack of dedicated medical personnel on site, and bureaucratic procedures for approving hospital referrals. In several facilities, especially in rural areas, access is further constrained by poor transportation arrangements for inmates requiring specialist care outside the facility.

In Enugu Correctional Facility, inmates have no access to clean water, and the situation worsens during the dry season. This not only increases the incidence of waterborne diseases such as cholera, typhoid, and dysentery but also compounds hygiene-related health issues like skin infections and gastrointestinal disorders. Limited access to safe drinking water is a direct violation of both national health regulations and international human rights standards governing the treatment of persons deprived of liberty.

Additionally, financial barriers further limit access to care. Inmates disclosed that in many cases, they and their families were required to pay for prescribed drugs. Where they could not afford these medications, they continued to live with untreated ailments, enduring prolonged pain and worsening conditions.

Quality of Healthcare Services

The quality of care in most correctional facilities is severely compromised by inadequate medical supplies, outdated diagnostic equipment, and the absence of standard treatment

protocols. Health facilities within prisons are often poorly ventilated, lack essential drugs, and have no functioning laboratories. Several inmates reported receiving only basic painkillers, regardless of the nature or severity of their illness, which often leads to mismanagement of conditions such as hypertension, diabetes, respiratory infections, and tuberculosis.

Poor sanitation, overcrowded cells, and insufficient nutrition further undermine quality care. These environmental conditions contribute to the spread of communicable diseases and hinder recovery, creating a vicious cycle of illness and reinfection.

Continuity of Care

Continuity of care is almost nonexistent in many correctional facilities. Inmates with chronicconditions such as HIV, tuberculosis, or mental health disorders often experience interruptions in treatment due to medication shortages, delayed refills, or lack of follow-up appointments. Transfers between facilities frequently occur without proper transfer of medical records, leading to lapses in care.

Furthermore, post-release continuity of care is rarely supported, leaving released inmates at risk of relapse, untreated conditions, and further marginalization in society. Without structured referral systems linking correctional health services to community healthcare providers, the transition from incarceration to freedom often marks a dangerous gap in health management.

2.3 Systemic constraints (governance, financing, workforce, supplies, infrastructure)

The health system in Nigerian correctional facilities operates within a context of profound systemic challenges that undermine its ability to provide adequate, equitable, and sustainable care to inmates. These constraints are multi-dimensional, spanning governance weaknesses, chronic underfunding, human resource shortages, inadequate supply chains, and dilapidated infrastructure. Collectively, they perpetuate poor health outcomes, widen disparities between correctional and community health services, and erode trust in the system.

Governance structures for health in correctional facilities remain fragmented and insufficiently integrated with the national health system. While the Nigerian Correctional Service (NCoS) is responsible for inmate health, its health department often operates in isolation from state ministries of health, leading to policy incoherence and poor coordination. There is no clear accountability framework for ensuring that inmates receive care that meets the constitutional standard of the right to health. Oversight mechanisms are weak, and decision-making is often reactive rather than evidence-based.

Furthermore, inter-agency collaboration—between NCoS, the Ministry of Interior, the Ministry of Health, and non-governmental actors—tends to be ad hoc. This lack of structured coordination results in duplication of efforts in some areas and neglect in others, such as mental health services and infectious disease control.

Health financing in correctional facilities is chronically inadequate. Funding for inmate health is drawn from general correctional budgets, where security-related expenditures are often prioritised over healthcare. This results in insufficient allocation for medicines, diagnostic equipment, and health workforce salaries. Inmates and facility officials reported that in many cases, the cost of essential medicines and treatments is passed on to inmates and their families. Where individuals cannot afford to pay, they are left to endure untreated illnesses, chronic pain, and worsening health conditions. This cost-shifting practice undermines the principle of equitable healthcare and exacerbates the vulnerability of indigent inmates.

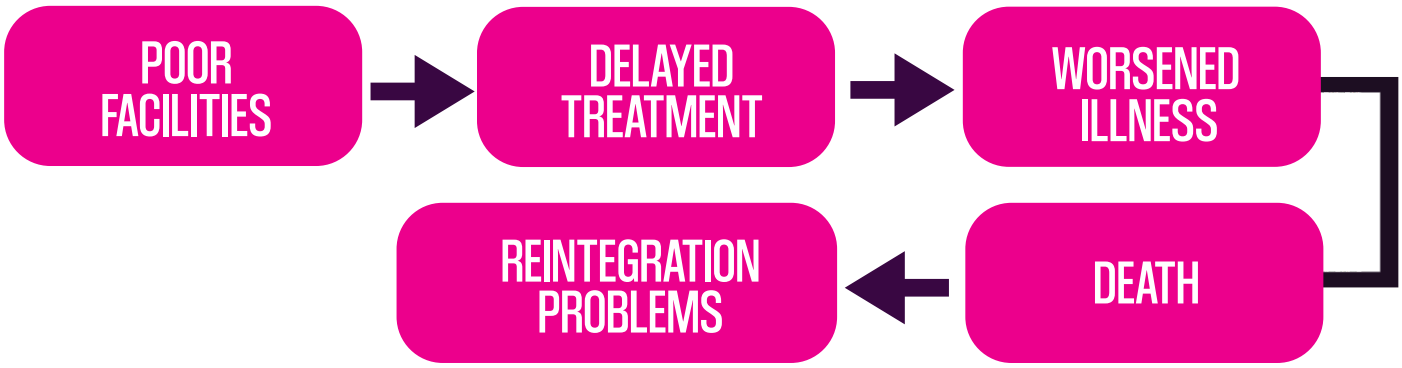
The health workforce in correctional settings is severely understaffed and often under-skilled for the range of complex health issues encountered. Many facilities operate with only a small number of medical personnel—sometimes just one or two nurses—serving hundreds of inmates. Access to physicians is irregular, with specialist services such as dentistry, psychiatry, and physiotherapy being extremely rare. High turnover rates and

limited opportunities for professional development further weaken the workforce. In some facilities, security staff are called upon to perform basic health tasks due to staff shortages, raising concerns about quality and confidentiality of care.

The medical supply chain to correctional facilities is unreliable and inconsistent. Essential medicines, diagnostic tools, and basic consumables like gloves, disinfectants, and bandages are frequently in short supply or completely unavailable. Interruptions in the supply of chronic disease medications—such as those for hypertension, diabetes, or HIV—lead to dangerous treatment lapses.In some facilities, even basic health supplies are dependent on donations from NGOs, religious organisations, or family members of inmates. This reliance on charity-based provision creates uncertainty and leaves gaps in care when external support is unavailable.

The physical infrastructure of many correctional health units is outdated, poorly maintained, and inadequate for the delivery of quality healthcare. Many clinics lack functional consultation rooms, diagnostic spaces, or isolation facilities for infectious diseases. Equipment, where available, is often obsolete or non-functional due to lack of maintenance. Overcrowding further compounds these infrastructure deficits, making it difficult to control the spread of communicable diseases. In Enugu Correctional Facility, for example, inmates reported having no access to clean water—an issue that worsens during the dry season—leading to heightened risk of waterborne diseases and skin infections. Sanitation facilities are generally inadequate, with poor waste disposal systems contributing to unhealthy living conditions.

Figure 3: **Title: Cycle of Poor Health in Correctional Centres**



2.4 Consequences For Inmates, Staff, And Public Health

The Cumulative Impact Of Service Delivery Gaps And Systemic Constraints Within Nigeria's Correctional Health System Is Profound, Manifesting At Three Interconnected Levels: The Individual Inmate, Correctional Staff, And The Broader Society.

For Inmates

- Increased Morbidity And Mortality: Inmates Experience Worsening Of Pre-existing Conditions, Delayed Diagnoses, And Preventable Deaths. Infectious Diseases Such As Tuberculosis, Hiv/aids, And Hepatitis Spread Unchecked, While Chronic Illnesses Remain Poorly Managed.
- Psychological Deterioration: Untreated Depression, Anxiety, And Trauma Create Cycles Of Hopelessness, Self-harm, And Suicide. For Vulnerable Groups Such As Women, Juveniles, And Elderly Detainees, Neglect Has Lifelong Consequences.
- Erosion Of Human Dignity And Rights: Denial Of Basic Healthcare Undermines Constitutional Guarantees And International Obligations Under The Mandela Rules, Effectively Reducing Incarceration To A Form Of State-sanctioned Neglect.
- Stalled Rehabilitation: Poor Health Impairs Inmates' Ability To Participate In Educational, Vocational, Or Reintegration Programs, Defeating The Corrective Purpose Of Incarceration.

For Correctional Staff

- Occupational Health Risks: Overcrowded And Poorly Ventilated Environments Expose Staff To The Same Infectious Diseases As Inmates. Staff Working In Facilities With No Protective Equipment Or Vaccination Programs Face Heightened Risk Of Infection.
- Increased Workload And Stress: In The Absence Of Adequate Medical Staff, Correctional Officers Are Forced To Assume Informal Caregiving Roles, Often Without Training. This Dual Burden Contributes To Burnout, Frustration, And Strained Staff-inmate Relations.
- Security And Safety Challenges: Untreated Mental Health Issues And Deteriorating Physical Conditions Among Inmates Contribute To Aggression, Violence, And Unrest, Putting Staff Safety At Greater Risk.

For Public Health and Society

- Disease transmission to communities: Inmates are not permanently cut off from society; they eventually return to their families and communities. When individuals are released with untreated tuberculosis, hepatitis, or other communicable diseases, correctional facilities become amplifiers of epidemics.
- Strain on the public health system: The failure to manage inmates' health while incarcerated results in higher costs for the public health system post-release, as conditions that could have been managed early require more intensive, expensive interventions.
- Undermining of justice and rehabilitation goals: A correctional system that fails to provide healthcare fosters cycles of ill-health, recidivism, and social exclusion. Instead of being rehabilitated, inmates are released as more vulnerable, stigmatized, and medically compromised individuals.
- Erosion of public trust: Persistent reports of neglect and abuse undermine citizens' confidence in state institutions, fueling perceptions of injustice and further weakening social cohesion.

Conclusion

The consequences of neglecting inmates' health extend far beyond prison walls. Correctional facilities that fail to provide basic healthcare not only violate human rights but also compromise staff welfare, destabilize prison environments, and endanger public health. Ultimately, this crisis represents a failure of governance that perpetuates cycles of suffering and inequality.

SECTION 3:

CAUSES OF THE PROBLEM

The challenges facing inmate health and wellbeing in Nigeria's correctional facilities do not arise in isolation; they are the product of deep-rooted structural, institutional, and social factors that interact in complex ways. Understanding these causes is essential because any attempt to improve conditions within correctional centres will fail unless the root drivers are addressed. For decades, Nigerian prisons have been described as overcrowded, underfunded, and poorly managed, but such descriptions often mask the systemic issues that produce and sustain these conditions.

At the structural and legal level, the framework governing correctional services remains outdated and weakly enforced, creating an environment where the rights of inmates exist largely on paper rather than in practice. On the operational front, inefficiencies in management, coordination failures between justice sector actors, and weak capacity among prison staff contribute to prolonged detentions and inadequate healthcare delivery.

Beyond institutional shortcomings, socioeconomic realities play a central role. Many inmates come from marginalized backgrounds, entering the system with pre-existing health vulnerabilities, untreated mental illnesses, and little or no access to social support. These vulnerabilities are then compounded by overcrowding, inadequate staffing, and chronic underfunding, which transform prisons into high-risk environments for disease transmission, violence and psychological trauma.

Furthermore, corruption and accountability failures worsen these challenges. Limited resources are often diverted, while monitoring systems remain weak, leaving abuses unreported and systemic neglect unchecked. Without reliable data on inmate health conditions, planning and reform efforts are left to guesswork rather than evidence.

Taken together, these factors create a cycle of neglect in which correctional facilities fail not only to meet international standards but also to function as places of rehabilitation. Instead, they become spaces that deepen inequality, perpetuate suffering, and pose risks to both inmates and the wider society. This section therefore examines the major causes of the problem under six broad headings.

3.1 Structural and Legal Factors

The foundation of inmate wellbeing in any correctional system lies in the strength and enforcement of its legal and structural frameworks. In Nigeria, the correctional system operates under the Nigerian Correctional Service Act, 2019, which replaced the long standing Prisons Act of 1972.

> The 2019 Act represents an important legislative reform, particularly by changing the terminology from ***"prisons" to "correctional centres"*** and embedding principles of rehabilitation, restorative justice, and human rights protection.

However, while the law is progressive on paper, implementation remains weak, leaving a persistent gap between legal guarantees and lived realities within correctional facilities. From a structural perspective, the correctional system is burdened by overlapping mandates and fragmented coordination across the justice sector. Delays in prosecution, reliance on custodial sentencing, and weak enforcement of alternatives to imprisonment —such as community service or parole—exacerbate overcrowding. These legal and structural shortcomings place undue pressure on correctional institutions, making it nearly impossible to provide adequate healthcare, nutrition, and psychosocial support to inmates.

At the international level, Nigeria is a signatory to various conventions and standards, including the International Covenant on Economic, Social and Cultural Rights (ICESCR), which recognizes the right to health, and the United Nations Standard Minimum Rules for the Treatment of Prisoners (Mandela Rules), which outline minimum standards for humane treatment. Similarly, the African Charter on Human and Peoples' Rights enshrines the right to dignity and health, with provisions that apply equally to incarcerated persons. Despite these commitments, Nigeria's correctional centres fall short of these global standards due to weak enforcement mechanisms, insufficient political will, and a lack of accountability structures.

Moreover, structural inadequacies such as the absence of independent monitoring bodies and ineffective complaint mechanisms further entrench systemic neglect. Inmates often lack avenues to report violations of their rights, while civil society oversight is limited by bureaucratic restrictions. The result is a structural environment that perpetuates poor well-being outcomes, where the health and dignity of inmates remain secondary to punitive and custodial priorities.

In summary, while Nigeria has made strides in reforming its legal framework through the Correctional Service Act of 2019, the absence of robust implementation, combined with structural weaknesses in justice administration, continues to undermine inmate well-being. Addressing these challenges requires not only strengthening laws but also ensuring their consistent application, in line with both national aspirations and international obligations.

3.2 Operational and Managerial Bottlenecks

The well-being of inmates is often undermined not only by structural or legal shortcomings but also by the operational realities of running correctional facilities. Even where policies exist on paper, their translation into daily practice is frequently obstructed by inefficiencies, poor planning, and limited managerial capacity. These bottlenecks manifest in ways that directly affect the health, safety, and dignity of inmates.

One key issue is the absence of effective coordination between correctional centres and relevant state institutions, particularly health and social services. In many cases, prison authorities lack clear operational frameworks for engaging external healthcare providers or ensuring continuity of care for inmates with chronic conditions. As a result, inmates are left vulnerable to untreated illnesses, delayed interventions, and preventable complications.

Furthermore, weak internal management practices often lead to poor allocation of resources. Food, medicine, and basic supplies are not only insufficient but also poorly distributed, leaving some inmates with little or no access to essentials. Decision-making is often centralised, slow, and constrained by bureaucracy, making it difficult to respond to urgent health crises or emergencies within prison walls.

Staffing also reflects operational weaknesses. Correctional officers, who are central to

maintaining order and ensuring inmate welfare, are often overburdened with responsibilities that exceed their training or mandate. The absence of continuous professional development, coupled with inadequate welfare incentives, leads to low morale and, in some cases, abusive behaviour towards inmates. Without effective supervision and accountability mechanisms, misconduct is either overlooked or normalised, creating an environment where inmates' well-being is routinely compromised.

These managerial inefficiencies are further reinforced by poor data systems. Prisons frequently operate without accurate, up-to-date records on inmate populations, health status, or available resources. The lack of reliable data not only obstructs effective planning but also prevents transparency in decision-making, leaving prison administrations vulnerable to inefficiency and malpractice.

In essence, operational and managerial bottlenecks reflect a gap between principle and practice. While frameworks for inmate care may exist; their poor implementation results in a prison environment where rights are routinely violated and well-being is treated as an afterthought. Addressing these challenges requires strengthening institutional capacity, enhancing accountability structures, and fostering a culture of proactive, rights-based prison management.

3.3 Socioeconomic Determinants of Inmate Health

The health and wellbeing of inmates cannot be understood in isolation from the wider socioeconomic conditions that shape their lives both before and during incarceration. Many individuals who enter the criminal justice system already come from marginalized backgrounds where poverty, limited access to healthcare, poor education, and unemployment are dominant realities. These pre-existing vulnerabilities follow them into custody, often worsening within the prison environment.

Poverty, in particular, plays a central role. Inmates from low-income backgrounds are less likely to afford proper legal representation, which often results in prolonged pre-trial detention and overcrowding in facilities. Once incarcerated, their financial limitations mean they are unable to supplement inadequate prison provisions with food, medicine, or other necessities—advantages often available to wealthier inmates who can rely on family support or informal prison economies.

Educational disparities also contribute to health inequalities behind bars. A significant proportion of inmates have limited formal education, making it more difficult for them to understand health information, follow medical advice, or advocate for their rights within the correctional system. Illiteracy or low literacy rates further impede inmates' ability to engage with rehabilitation programs that could improve their wellbeing.

Additionally, unemployment and systemic inequality before incarceration often translate into poor coping mechanisms within prison. Many inmates enter correctional centres already struggling with mental health challenges, substance abuse disorders, and poor nutritional habits linked to economic hardship. The prison system, rather than addressing these vulnerabilities, tends to exacerbate them through neglect, stigma, and lack of structured psychosocial support.

Social stratification within prison itself also influences wellbeing. In some facilities, informal hierarchies emerge, where wealthier or more influential inmates gain privileged access to resources, such as better sleeping spaces, healthcare services, or protection, while poorer inmates remain at the margins. This perpetuates cycles of deprivation and deepens inequalities, creating conditions where the most vulnerable inmates face the harshest health outcomes.

In summary, socioeconomic determinants of health are critical to understanding why inmate wellbeing is persistently poor. Poverty, inequality, limited education, and pre-existing health vulnerabilities not only increase the likelihood of imprisonment but also dictate the quality of life behind bars. Addressing inmate wellbeing therefore requires a dual approach: tackling systemic inequalities in wider society while ensuring that prison management systems actively mitigate, rather than reproduce, these disparities.

Figure 4: Title: Root Causes of Poor Inmate Healthcare

3.4 Overcrowding and Staffing Shortage

One of the most pressing challenges to inmate wellbeing is the persistent problem of overcrowding within correctional facilities, compounded by chronic shortages in trained staff. Overcrowding occurs when the number of inmates far exceeds the official capacity of a prison, stretching available resources beyond manageable limits. In many cases, this is the direct result of systemic issues such as high rates of pre-trial detention, slow judicial processes, and limited use of non-custodial sentencing options. The consequence is a prison population that outpaces the infrastructure, leading to conditions that are not only inhumane but also detrimental to physical and mental health.

In overcrowded facilities like Ikoyi Correctional facility in Lagos State, where the capacity is 800 but the facility houses over 3000 inmates per time, basic necessities such as sleeping space, food, clean water, and sanitation facilities become scarce. Cells designed for two or three people often house double or triple that number, forcing inmates to share beds or sleep on bare floors. Such conditions foster the rapid spread of communicable diseases like tuberculosis, scabies, and cholera, while also heightening tensions that frequently result in violence. The psychological toll is equally severe, as cramped and unsanitary living environments fuel anxiety, depression, and aggression among inmates.

Closely linked to overcrowding is the issue of staffing shortages. The ratio of prison staff—particularly healthcare workers, counsellors, and trained correctional officers—to inmates is often grossly inadequate. This shortfall undermines the ability of prisons to provide even basic medical attention, psychosocial support, or effective rehabilitation services. In some facilities, a single nurse or doctor is tasked with attending to hundreds of inmates, making timely and quality healthcare nearly impossible. Similarly, a lack of sufficient custodial staff weakens security oversight, heightens risks of inmate violence, and fosters environments where corruption and informal hierarchies thrive unchecked. The combined effect of overcrowding and staffing shortages is a vicious cycle.

Overpopulated prisons strain existing personnel, increasing burnout and reducing staff morale. Understaffed facilities, in turn, struggle to maintain order, address medical

emergencies, or implement welfare programs, worsening the already fragile conditions created by overcrowding. In such settings, the goal of rehabilitation is overshadowed by the daily struggle for survival—both for inmates and the staff responsible for their care.

Addressing this dual challenge requires systemic reforms, including reducing reliance on custodial sentences, expanding alternatives such as community service or parole, investing in prison infrastructure, and recruiting and training more correctional and healthcare staff. Without tackling overcrowding and staffing shortages simultaneously, efforts to improve inmate wellbeing will remain severely constrained.

Figure 5: Title: Overcrowding and Staffing (Illustrating the Capacity of the correctional Facility as against the actual estimated numbers of inmates.

3.5 Corruption and Inadequate Funding

One of the persistent challenges affecting inmate well-being in Nigeria's correctional facilities is the dual issue of inadequate funding and weak financial management structures. Available records show that while the government makes annual provisions for healthcare within correctional centres, the amounts are often modest when compared with the scale of need. For instance, in the 2025 budget proposal, the federal government allocated approximately 1.06 billion for medical supplies across correctional facilities nationwide. In contrast, more substantial sums were earmarked for feeding (38 billion) and infrastructure upgrades (7.2 billion). This allocation, though a positive recognition of health needs, highlights the broader concern that healthcare often receives a comparatively smaller share of the total corrections budget.

Beyond the quantum of funding, the challenge of effective utilisation has also been identified in several studies. Limited transparency in procurement processes, weak monitoring frameworks, and gaps in accountability have sometimes resulted in resources not reaching the intended beneficiaries in adequate measure. These systemic issues contribute to shortages of essential drugs, delayed medical interventions, and reliance on external support from families or non-governmental organisations to fill healthcare gaps.

In addition, the constrained financial environment makes it difficult for facilities to provide equitable access to health services for all inmates. Those without external support may be disproportionately affected, leading to visible disparities in well-being among the prison population. Taken together, inadequate funding levels and inefficiencies in resource management create a situation where the right to health, though formally recognised, is difficult to guarantee in practice.

3.6 Data, Monitoring, and Accountability Gaps

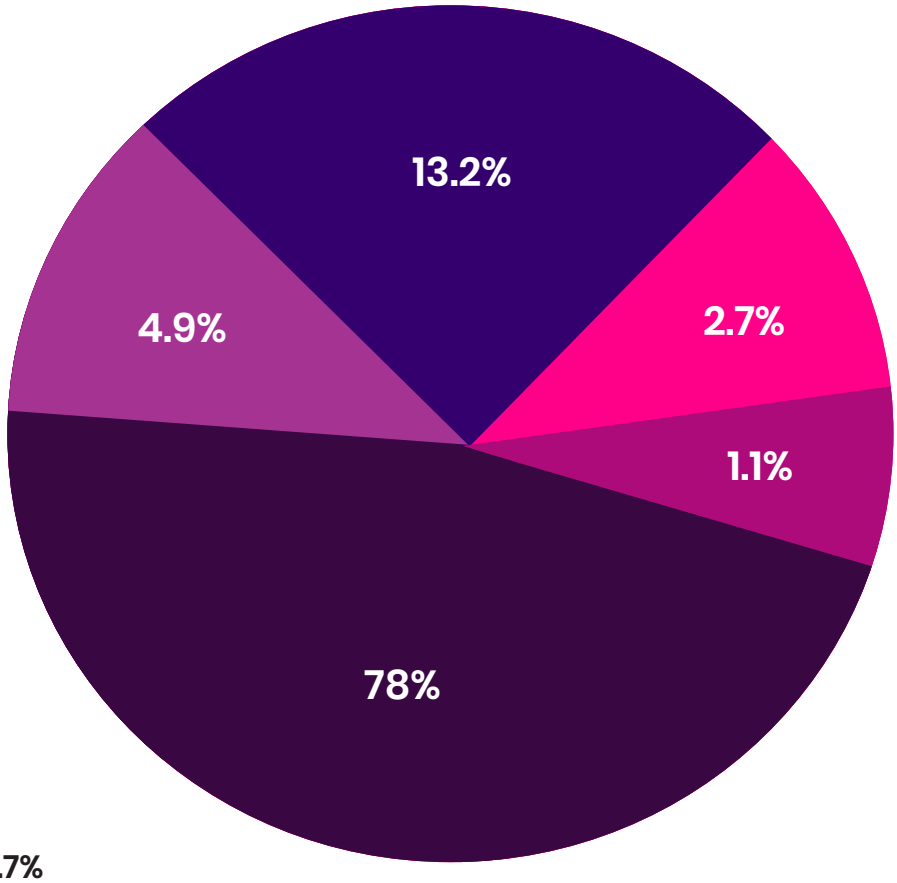
The Nigerian Correctional Service Act, 2019 establishes a legal basis for health monitoring in custodial facilities. Section 23 requires daily health inspections by qualified practitioners, Section 24 provides for mental health support, and Section 25 ensures referral to hospitals where treatment cannot be adequately provided within the facility. These provisions are intended to guarantee consistent monitoring, systematic documentation, and accountability for the health and wellbeing of persons in custody.

However, the practical implementation of these statutory provisions reveals significant gaps. While health practitioners are present in custodial centres, the ratio of medical staff to inmates is disproportionately low, limiting effective monitoring and reducing the frequency and depth of follow-up care. In practice, this means that health challenges may be recorded but not systematically tracked or acted upon. For example, shortages of medical staff and delays in external hospital referrals weaken the enforcement of the Act's monitoring obligations.

Evidence from Headfort Foundation for Justice's outreach on 23rd July at the Kirikiri Female Custodial Centre illustrates the extent of these gaps. Out of 182 inmates reached through vitals checks, malaria testing, medical consultations, a mental health session, and the distribution of drugs and sanitary pads, findings showed that 13.2% had malaria symptoms, 2.7% were pregnant, 1.1% were uncertain of pregnancy status, and 4.9% were living with a child. These figures underscore the importance of admission screenings, structured monitoring of health status, and consistent follow-up, which are often missing in practice.

Accountability mechanisms also remain weak. Although the Act envisages structured oversight, there is limited transparency on how collected data is analyzed or used to inform health planning and resource allocation. The absence of periodic independent reviews or publicly available reports makes it difficult to assess compliance with statutory health obligations, creating a gap between policy and practice.

***Figure 6:** Health-related findings among 182 inmates reached during Headfort Foundation's outreach at Kirikiri Female Custodial Centre (July 2025).*



In summary, while the legal framework provides clear mandates for data collection, health monitoring, and accountability, the operational reality shows gaps in implementation. These weaknesses undermine the full realization of inmates' right to health as guaranteed under the Correctional Service Act, 2019.

SECTION 4:

CURRENT LEGAL AND POLICY FRAMEWORK

4.1 1999 Constitution of the Federal Republic of Nigeria (As Amended)

The 1999 Constitution of Nigeria provides the supreme framework for human rights protection and applies to every person within the country, including those in correctional facilities. It explicitly safeguards the right to life (Section 33), the right to dignity of the human person (Section 34), the right to personal liberty (Section 35), and the right to fair hearing (Section 36). These provisions collectively affirm that incarceration does not strip individuals of their humanity or their entitlement to fundamental rights.

While the Constitution does not expressly mention inmates' health rights, the rights to life and dignity logically require access to essential healthcare, clean water, food, and sanitary living conditions. Denying medical treatment or exposing inmates to conditions that compromise health undermines both the right to life and protection against inhuman or degrading treatment. In this sense, the Constitution provides not only a legal basis but also a moral obligation for the State to ensure that persons in custody receive adequate healthcare.

Importantly, the Constitution positions the State as the primary duty-bearer. Section 17 (3)(d) (under the Fundamental Objectives and Directive Principles of State Policy) further emphasizes that,

> ***"The State shall direct its policy towards ensuring that... there are adequate medical and health facilities for all persons."***

Although not justiciable on its own, this provision reinforces the spirit of Chapter IV and strengthens the argument that inmates' healthcare is a constitutional duty, not a privilege.

However, enforcement remains weak. Many inmates experience a disconnect between constitutional guarantees and the realities of correctional life. The gap between law and practice highlights systemic issues such as underfunding, inadequate staffing, and poor accountability mechanisms.

Thus, while the Constitution lays down a strong legal foundation for inmates' healthcare rights, the practical implementation continues to fall short, leaving incarcerated individuals reliant on external support systems, non-state actors, or sheer chance to secure their health and dignity.

4.2 Nigerian Correctional Service Act, 2019

The Nigerian Correctional Service (NCoS) Act represents the most comprehensive domestic legislation guiding prison administration and inmate welfare. Section 24(1) mandates the Service to provide inmates with adequate healthcare, while Section 24(2) provides for medical examination upon admission, continuous treatment, and transfer to hospitals where necessary. The Act also recognizes vulnerable categories of inmates, including pregnant women, nursing mothers, and persons with mental health conditions, and directs special care for them.

Beyond these health-specific provisions, the NCoS Act is notable for embedding broader human rights principles into correctional administration. It affirms rehabilitation and reintegration as central objectives of imprisonment, thereby situating healthcare as not only a welfare obligation but also a critical component of successful re-entry into society. By explicitly requiring the establishment of health facilities within custodial centres and ensuring the presence of qualified medical personnel, the Act attempts to institutionalize standards that mirror international instruments such as the UN Standard Minimum Rules for the Treatment of Prisoners (the Mandela Rules).

In principle, the Act marks a progressive step towards safeguarding inmates' right to health and dignity, moving beyond the punitive philosophy of earlier laws to a rights-based approach. However, its practical realization remains deeply uneven across correctional centres in Nigeria. While some facilities in urban areas may demonstrate partial compliance by maintaining clinics and medical staff, the majority operate with severe shortages of drugs, equipment, and trained professionals. Many correctional centres are unable to meet even basic medical obligations, resulting in reliance on external hospitals or families of inmates to bridge the gap.

The disparity between law and practice also reflects broader systemic issues such as underfunding, bureaucratic inefficiencies, and weak oversight. As a result, the transformative vision of the NCoS Act is yet to be fully translated into lived realities for inmates. Instead, what persists is a healthcare system within correctional centres that is largely symbolic on paper but practically inadequate, leaving the constitutional and legislative promises of humane treatment and adequate healthcare unfulfilled.

4.3 International and Regional Standards

Nigeria is a signatory to several international and regional instruments that outline the minimum standards for the treatment of inmates, particularly regarding their health and dignity. These instruments not only provide guiding principles but also impose obligations that Nigeria is expected to uphold to protect the rights of individuals in detention. The United Nations Standard Minimum Rules for the Treatment of Prisoners, also known as the Mandela Rules, emphasize that prisoners are entitled to the same standards of healthcare that are available in the wider community. These rules stress that such care must be provided free of discrimination, ensuring that imprisonment does not strip individuals of their fundamental right to health. Importantly, the Mandela Rules place a duty on the State to provide adequate healthcare for all inmates, underscoring that the deprivation of liberty does not equate to the deprivation of dignity or basic human rights.

The United Nations Rules for the Treatment of Women Prisoners and Non-Custodial Measures for Women Offenders, commonly referred to as the Bangkok Rules, establish gender-sensitive standards in recognition of the unique healthcare needs of women. These include access to prenatal and postnatal care, provision of sanitary materials, and ensuring the protection and wellbeing of children who may be living with their incarcerated mothers. The Bangkok Rules go further by calling for alternatives to imprisonment for women wherever possible, particularly when the offense is minor or when imprisonment would disproportionately impact dependent children.

The African Charter on Human and Peoples' Rights, ratified by Nigeria, enshrines two critical rights relevant to prison conditions: the right to health under Article 16, and the right to dignity under Article 5. By ratifying the Charter, Nigeria has committed to ensuring that the treatment of individuals, including those deprived of liberty, respects these fundamental rights. This places a legal and moral responsibility on the Nigerian government to prevent conditions that undermine health and to prohibit practices that degrade human dignity.

In addition, the Kampala and Abuja Declarations highlight the intersection between prison health and public health, stressing that the health of prisoners cannot be isolated from that of the general population. These declarations call for African states to strengthen prison healthcare systems, recognizing that neglecting prison health not only endangers inmates but also poses risks to communities at large when diseases spread beyond prison walls.

Taken together, these international and regional standards represent both binding and non-binding obligations on Nigeria. They establish that humane conditions of detention are not optional but fundamental, with healthcare as a core component. Compliance with these standards is not only a matter of international accountability but also a reflection of Nigeria's commitment to justice, human dignity, and public health.

4.4 Gap Analysis: Law vs. Practice

First, resource constraints remain a fundamental barrier. Many correctional centres lack functional clinics, qualified health personnel, essential drugs, and even basic equipment such as beds, diagnostic tools, and emergency care facilities. This undermines Section 24 of the NCoS Act and the Mandela Rules' requirement of equivalence of care. In practice, many correctional facilities lack reliable drug supplies, leaving inmates to depend on external support from relatives for essential medicines. However, weak oversight in drug distribution systems often creates opportunities for exploitation, as medications intended for inmates are not accessed in a timely or equitable manner. This further erodes confidence in the prison healthcare system and exacerbates inequalities, since only those with supportive families or financial means can secure treatment, contrary to the principle of healthcare as a right.

Second, overcrowding severely compromises healthcare delivery. With facilities operating at more than double their official capacity, medical staff are overwhelmed, and routine care becomes impossible. This violates both domestic and international standards, particularly the Mandela Rules' prohibition of inhumane treatment. Overcrowding also fuels the spread of infectious diseases, making preventive and curative care ineffective.

Third, neglect of vulnerable groups persists. Pregnant women, nursing mothers, persons with disabilities, and inmates with mental health conditions are frequently denied specialized care despite explicit provisions in the NCoS Act and the Bangkok Rules. Reports have documented cases of women giving birth without medical supervision, lack of access to sanitary products, and untreated mental health crises leading to self-harm or violence.

Fourth, weak oversight and accountability mechanisms limit the enforcement of constitutional rights and NCoS Act provisions. Independent monitoring of correctional centres is rare, and complaints mechanisms for inmates are either absent or ineffective. This allows systemic abuses, neglect, and corruption, including diversion of medical supplies, to persist unchecked.

Fifth, public health risks remain dangerously high. Correctional centres are hotspots for tuberculosis, HIV/AIDS, and most recently COVID-19, yet preventive measures such as regular testing, vaccination, health education, and adequate sanitation are poorly implemented. These conditions not only endanger inmates but also pose a threat to public health as staff, visitors, and released inmates reintegrate into society.

Finally, the gap between policy and practice reflects broader issues of governance and political will. Nigeria's legal framework is relatively robust, but implementation falters due to chronic underfunding, poor inter-agency coordination, and limited prioritization of prison reform. Without systemic investment in infrastructure, human resources, and accountability, the rights guaranteed under the Constitution, the NCoS Act, and international treaties remain largely theoretical for inmates.

Figure 7: ***Comparison Table***
Title: What the Law Promises vs What Happens
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WHAT THE LAW PROMISES	WHAT HAPPENS
1). NCOS ACT (2019): FREE HEALTHCARE	ONLY 43.4% RECEIVED MEDICAL CONSULTATION.
2). CONSTITUTION: RIGHT TO HEALTH	NOT ENFORCED.
3). MANDELA RULES: EQUAL HEALTHCARE	NOT APPLIED.
4). AFRICAN CHARTER: GUARANTEES HEALTH	LARGELY IGNORED.

SECTION 5:

PHYSICAL HEALTH SERVICES IN CORRECTIONAL CENTRES

5.1 Primary Care Package

Primary healthcare is often the first line of defence for inmates entering correctional centres. On paper, every inmate should undergo medical screening upon admission, a crucial step that can identify illnesses early and prevent complications. This step is often reduced to a few hurried questions or a brief visual inspection, especially in overcrowded centres where hundreds may arrive in a single day.

This gap has devastating consequences. An inmate with undiagnosed hypertension may suffer a stroke month into his sentence, or someone with untreated tuberculosis may unknowingly spread the disease to cellmates in cramped, poorly ventilated quarters. Mental health conditions such as depression or schizophrenia are rarely identified during intake, meaning that individuals silently endure their conditions until they erupt into crises. Routine care, such as check-ups for minor ailments, is frequently absent. Small cuts and infections are left untreated, sometimes escalating into severe sepsis. Without structured health records or electronic monitoring, continuity of care becomes nearly impossible. When inmates are transferred, often without notice, their medical histories are lost, forcing new health staff to start from scratch. For those living behind bars, the absence of these basic services translates into a constant fear that minor illnesses could turn deadly.

5.2 Maternal, Newborn, and Child Health

For women of reproductive age, imprisonment compounds existing vulnerabilities. A pregnant woman entering custody should, in principle, have access to antenatal check-ups, nutritional support, and safe delivery under skilled supervision. Yet, in many correctional centres, she may be cared for by untrained staff or forced to deliver her baby without professional medical assistance.

Stories from Nigerian correctional centres reveal women giving birth on the floor of their cells, attended only by fellow inmates. Inadequate nutrition worsens the risk of complications, while the lack of access to sanitary products undermines both dignity and health. After childbirth, postnatal care is often non-existent, exposing both mother and child to preventable infections.

Infants who remain in custody with their mothers face a bleak reality. Many grow up in environments devoid of child-friendly spaces, toys, or fresh air. Immunizations, crucial for child survival, are irregular or entirely absent. Mothers often struggle to breastfeed adequately due to poor nutrition, leaving infants malnourished and vulnerable. The Bangkok Rules call for gender-sensitive healthcare, yet for many women, motherhood in custody means raising a child in conditions far from the standards guaranteed by law.

5.3 Infectious Diseases

When it comes to infectious diseases, the correctional environment itself often contributes to the problem. Overcrowded cells, poor ventilation, and inadequate sanitation create conditions for rapid disease transmission. During monitoring visits, a recurring concern raised by inmates was the prevalence of skin infections, including persistent rashes and itching in sensitive areas. Such conditions are likely exacerbated by limited access to clean water, soap, and functioning toilet facilities, which not only compromise personal hygiene but also heighten vulnerability to infections.

In addition to skin-related illnesses, respiratory infections such as tuberculosis remain a serious risk in poorly ventilated facilities, especially where inmates spend most of the day locked in congested cells. Gastrointestinal infections, often linked to contaminated food or water, further complicate the health landscape. The lack of systematic infection control measures such as regular disinfection of living spaces, provision of personal hygiene items, or timely isolation of sick inmates allows diseases to spread unchecked.

Moreover, the scarcity of trained healthcare staff and essential medications means that many infections go untreated until they progress into severe or chronic conditions. This not only undermines the health of affected inmates but also poses broader public health risks, since prisons are not isolated from the wider community - staff, visitors, and released inmates can all contribute to the circulation of infections.

5.4 Non-Communicable Diseases (NCDs)

Non-communicable diseases represent a silent emergency in correctional centres. Inmates living with hypertension, diabetes, asthma, or epilepsy face daily struggles to access consistent medication. A man with diabetes may ration his insulin because supplies are erratic, risking long-term complications like blindness or kidney failure.

An inmate with epilepsy may go months without anti-seizure drugs, experiencing repeated convulsions in overcrowded cells where stigma and misunderstanding lead to neglect or abuse.

Cancer care is almost absent. Women in custody rarely undergo cervical cancer screening, and men with prostate issues often go undiagnosed until it is too late. Without preventive programs or regular check-ups, correctional centres miss opportunities to detect these diseases early. For inmates, the lack of NCD services sends a stark message: survival depends less on medical rights and more on luck or family resources.

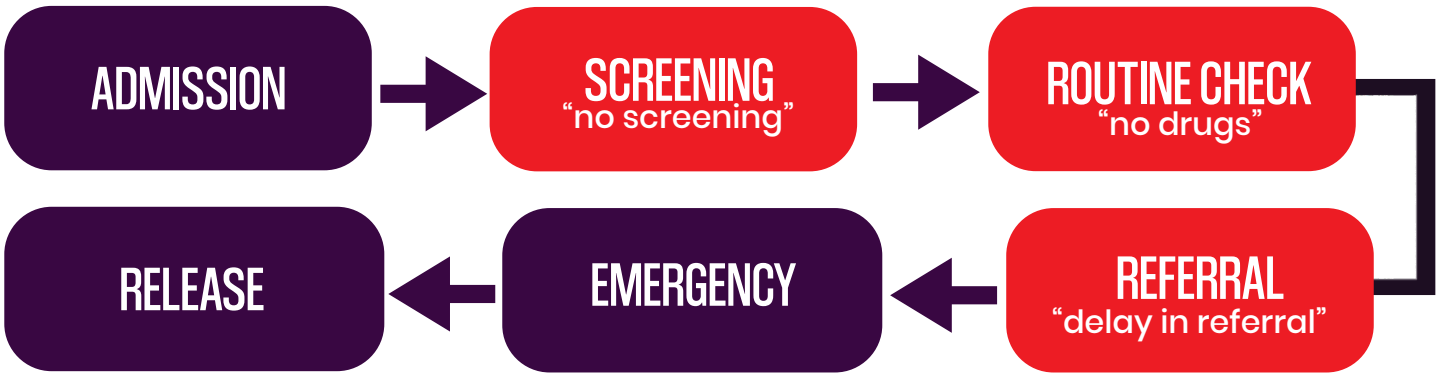
During monitoring visits, some inmates informally mentioned their struggles with basic management of chronic illnesses, including requests for simple but lifesaving medications such as inhalers for asthma. These conversations underscore the systemic failure of correctional health systems to provide continuous care for NCDs, leaving inmates dependent on irregular supplies or external goodwill.

5.5 Emergency Care and Referral Pathways

Emergencies in correctional centres often turn tragic due to systemic delays. A heart attack, an asthma crisis, or an obstetric emergency can strike at any time. In a well-functioning system, immediate resuscitation and swift transfer to a tertiary hospital could save lives. In Nigerian prisons, however, such emergencies are often met with bureaucratic hurdles. Permission must be sought, escorts arranged, and vehicles secured, all of which consume valuable time.

Functional ambulances are rare, and many prisons rely on staff vehicles or improvised transport, sometimes long after the emergency has turned fatal. Even when referral is approved, security concerns often outweigh medical urgency, leading to avoidable deaths. For inmates, the fear is not just of illness itself but of knowing that, should an emergency arise, the odds of timely help are slim.

Figure 8: ***Inmate Health Journey and Gaps***



Note: Red box highlight major system breakdowns in the Inmates health journey.

5.6 Pharmacy, Essential Medicines, Diagnostics, and Supply Chains

Medicines are the lifeline of any healthcare system, but in correctional centres, they are in chronic shortage. Basic antibiotics, pain relief, and anti-hypertensives frequently run out. Inmates often depend on relatives to purchase medicines externally, yet even this system is plagued by inefficiencies and at times exploitation, where drugs meant for inmates fail to reach them directly.

Diagnostic services are another critical gap. Without laboratories, even basic tests for malaria, blood sugar, or pregnancy are unavailable in many facilities. X-rays, ultrasounds, and advanced diagnostics are almost always referred to outside hospitals, a process delayed by bureaucracy and funding shortages.

The weak supply chain reflects deeper governance issues such as lack of dedicated budgets, poor coordination between the Nigerian Correctional Service and health ministries, and reliance on ad-hoc donations. For inmates, this translates into uncertainty: not knowing if the medicine they need will be available tomorrow or whether their illness will be diagnosed in time.

SECTION 6:

MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT (MHPSS)

6.1 Prevalence and Risk Factors in Custodial Settings

Mental health disorders are disproportionately prevalent in correctional facilities compared to the general population. Inmates in Nigeria face high rates of depression, anxiety disorders, post-traumatic stress disorder (PTSD), substance-induced psychosis, and schizophrenia. Overcrowding, poor living conditions, prolonged pre-trial detention, limited access to justice, violence, and social isolation serve as major risk factors.

Several Nigerian studies confirm this burden: Osasona and Koleoso (2015) found high prevalence of depression and anxiety among inmates in Benin City; Abdulmalik et al. (2014) documented psychiatric morbidity among awaiting trial prisoners in Ibadan; and Armiya'u et al. (2013) reported high levels of psychiatric disorders among inmates in Jos maximum security prison. Collectively, these findings suggest that more than 40% of inmates in Nigeria present with one or more mental health conditions, yet few receive appropriate treatment due to systemic neglect and stigma.

6.2 Screening, Assessment, and Treatment Pathways

Effective mental health care in custodial settings begins with comprehensive screening at the point of admission. Unfortunately, routine screening and structured assessment for mental health cases are rare in Nigerian correctional centres. Medical records are poorly kept, and staff often lack training to identify mental health needs. Treatment pathways are limited, with very few centres having psychiatric professionals on site. Referrals to tertiary hospitals are constrained by security challenges and lack of resources.

Best practices globally recommend the integration of mental health screening into initial health assessments and the adoption of simplified diagnostic tools under the WHO's mhGAP Intervention Guide. Strengthening referral systems and ensuring timely treatment would greatly improve outcomes for inmates.

6.3 Crisis Management, Suicide and Self-harm Prevention

Suicide and self-harm represent critical risks within correctional facilities. The combination of hopelessness, overcrowding, stigma, and lack of adequate psychosocial support creates an environment where suicidal ideation thrives. Crisis management protocols are largely absent in most Nigerian prisons, and staff are ill-equipped to recognize early warning signs.

Suicide attempts are often met with punitive rather than therapeutic responses. Establishing crisis intervention teams, confidential reporting systems, and peer-support monitoring are essential. Training custodial staff in suicide risk assessment and developing referral mechanisms to psychiatric professionals would contribute significantly to prevention.

6.4 Substance Use Disorders and Integrated Care

Substance abuse and dependence remain significant problems among incarcerated persons. Many inmates enter correctional facilities with pre-existing drug and alcohol use disorders, while others develop dependency within the system due to illicit drug circulation. The current approach within Nigerian correctional centres is largely punitive, focusing on discipline rather than rehabilitation. This worsens the cycle of dependency and recidivism.

Integrated care models that combine detoxification, cognitive behavioural therapy, vocational training, and peer support are recommended. Addressing substance use as a health issue rather than solely a criminal concern will reduce relapse rates and facilitate reintegration.

6.5 Psychosocial Support, Counselling, and Peer-led Programs

Psychosocial interventions are essential components of mental health care in custodial settings. Access to counselling, therapy sessions, peer-led support groups, and chaplaincy services contribute to inmates' resilience and rehabilitation. In Nigeria, such interventions are sporadic and largely dependent on the presence of NGOs, faith-based organizations, or volunteer mental health professionals.

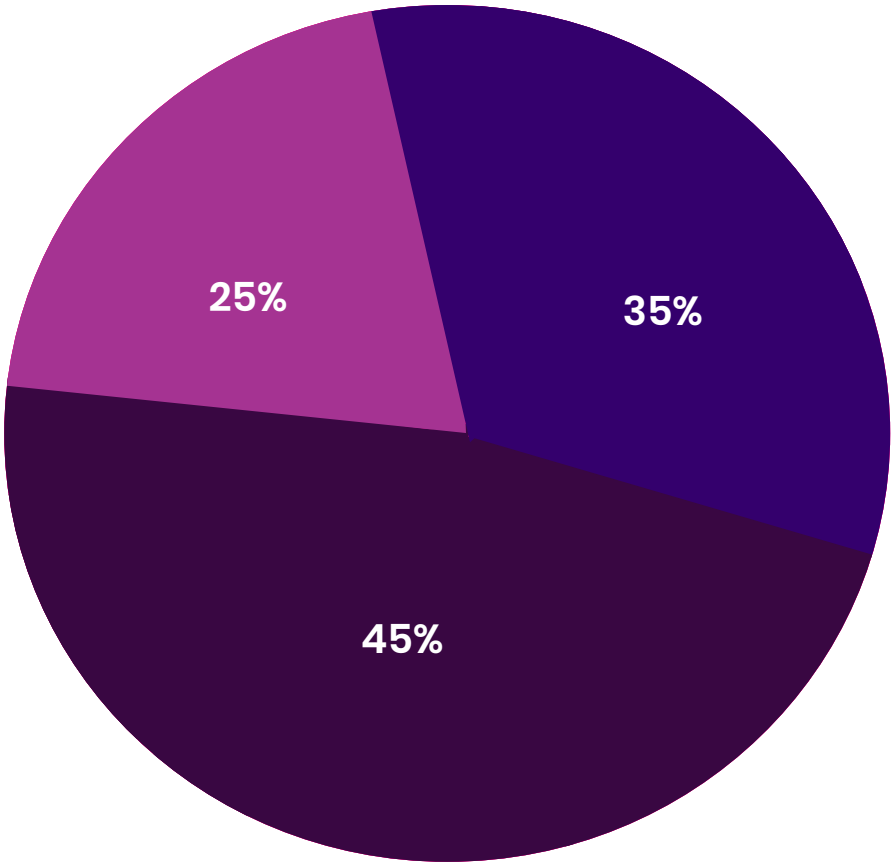
Peer-led initiatives, where inmates are trained to support one another, have been shown to improve mental wellbeing, reduce conflict, and enhance coping strategies. Structured psychosocial programs should be institutionalized within correctional centres to promote rehabilitation and reduce recidivism.

6.6 Continuity of Mental Healthcare on Transfer and Post-release

A major gap in inmate mental health care is the lack of continuity during transfer between facilities and upon release. Many inmates who receive treatment lose access to medications or counselling when they are relocated or discharged. There is little coordination between correctional centres and community-based mental health services, leading to relapse and reinstitutionalization.

Effective transition planning, medical record transfers, and referral linkages with community clinics are vital. Partnerships with state primary healthcare centres, NGOs, and halfway homes would ensure sustained care and improve reintegration outcomes.

Figure 9: ***A Pie Chart illustrating the Availability of Mental Health Services***



- 25% of centres have psychologists
- 30% have counsellors
- 45% have no mental health service

SECTION 7:

VULNERABLE AND KEY DEMOGRAPHIC GROUPS

Correctional health systems are not monolithic; rather, they must respond to the diverse and sometimes complex health needs of different categories of inmates. Within custodial settings, certain groups face heightened vulnerabilities due to gender, age, physical condition, social status, or stage in the criminal justice process. These vulnerabilities often compound the already harsh realities of incarceration, increasing health risks and limiting access to adequate care.

The Nigerian Correctional Service Act, 2019, alongside international instruments such as the United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules), the United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders (the Bangkok Rules), and regional human rights frameworks, recognize that correctional health must address these differentiated needs. The Act provides for healthcare services, referrals, and the welfare of inmates, but implementation challenges persist, particularly for groups whose health requirements demand targeted interventions. In Nigerian custodial facilities, demographic categories such as women and girls, pregnant and postpartum women, young men, the elderly, children living with incarcerated mothers, persons with disabilities, and pre-trial detainees experience health disparities in unique ways. These disparities manifest through inadequate reproductive and maternal care, poor provision for chronic diseases, weak mental health support, limited accessibility for persons with disabilities, and inconsistent screening or monitoring mechanisms for short-stay detainees.

Understanding the specific health challenges of these groups is essential for an accurate picture of custodial health. By examining their conditions within correctional centres, this section highlights how systemic constraints intersect with gender, age, and vulnerability, shaping the lived realities of healthcare access and outcomes in custody.

7.1 Women and Girls (including Menstrual Health and Reproductive Health)

The presence of women and girls in custodial facilities presents unique health considerations that differ significantly from those of the male majority population. Although women constitute a smaller proportion of the custodial population in Nigeria, their health needs are broader and often more complex, requiring tailored responses. International instruments such as the Bangkok Rules emphasize that women's healthcare in custody must be equivalent to, and continuous with, that provided in the community, with attention to reproductive and gender-specific health.

Menstrual Health: Access to menstrual hygiene products remains an ongoing concern within correctional facilities. While the Nigerian Correctional Service Act, 2019 provides for the welfare of inmates, the provision of sanitary materials is inconsistent and often inadequate. Many women rely on external donations or family support to meet their monthly needs, and shortages contribute to poor hygiene, discomfort, and increased risk of infection. Limited privacy in custodial settings further compounds menstrual health challenges, as facilities

may lack gender-sensitive infrastructure, such as private washing spaces and proper disposal systems

Reproductive and Sexual Health: Reproductive healthcare services for incarcerated women are limited in scope. Routine gynecological care, screening for reproductive health conditions (such as cervical cancer or sexually transmitted infections), and access to contraceptives are often unavailable or provided only upon referral. Pregnant inmates, as discussed in detail under Section 7.2, require antenatal and postnatal care, but broader reproductive health concerns — including family planning counseling and management of reproductive tract infections — remain under-addressed.

Mental Health and Gender-Specific Stressors: Women and girls in custody also face mental health vulnerabilities linked to stigma, family separation, histories of trauma, and gender-based violence prior to incarceration. These factors intersect with reproductive and menstrual health challenges, often intensifying health disparities In summarry, women and girls in Nigerian custodial centres face systemic gaps in the provision of menstrual hygiene products, reproductive healthcare services, and gender-sensitive health support. While legal and human rights frameworks recognize their needs, the operational reality remains one of inadequate supply, irregular access, and infrastructural shortcomings.

7.2 Pregnant and Postpartum Women (ANC/PNC, Safe Delivery, Nutrition)

Pregnant and postpartum women represent one of the most vulnerable populations within custodial facilities, requiring specialized healthcare services that address both maternal and neonatal wellbeing. The Nigerian Correctional Service Act, 2019 (Section 34) explicitly mandates the provision of necessary healthcare for female inmates during pregnancy and confinement, including safe delivery arrangements and care for the child. However, practical implementation remains uneven across facilities.

Antenatal and Postnatal Care (ANC/PNC): While some custodial centres facilitate access to antenatal clinics through referrals to government hospitals or visiting medical officers, the frequency and quality of such care are inconsistent. Routine ANC services — such as blood pressure monitoring, ultrasound scans, tetanus immunization, and counseling — are not systematically available on-site. Postnatal care, including monitoring for complications (e.g., hemorrhage, infection, postpartum depression), is often neglected after delivery, leaving mothers vulnerable during the critical recovery period.

Safe Delivery: Section 34 of the Corrections Act provides that pregnant women shall not be detained in the same cell as other inmates and that arrangements must be made for their safe delivery in appropriate medical facilities. In practice, custodial centres often rely on external hospitals for childbirth. While this can ensure access to skilled birth attendants, delays in referrals, inadequate emergency transport, and bureaucratic hurdles may compromise timely care during obstetric emergencies such as obstructed labour or preeclampsia.

Nutrition: Proper nutrition during pregnancy and postpartum is critical for both mother and child, yet food provision in custodial centres is standardized and not tailored to the specific dietary needs of pregnant or lactating women. Reports suggest that additional nutritional support, such as protein-rich foods or micronutrient supplements, is either irregular or dependent on family support and donations. This gap heightens the risk of maternal malnutrition, low birth weight infants, and poor maternal recovery after childbirth.

Psychosocial Considerations: Beyond physical healthcare, pregnant and postpartum women in custody face significant emotional stress due to incarceration, separation from family, and uncertainty regarding their child's welfare. Mental health support and counseling are seldom prioritized, despite their critical role in maternal and infant health outcomes.

Although the Corrections Act, 2019 provides a legal framework to safeguard the health of pregnant and postpartum women, operational challenges persist. Gaps remain in routine ANC and PNC, safe delivery logistics, and adequate nutrition, leaving many women reliant on external interventions, family support, or ad-hoc measures for maternal and child wellbeing.

7.3 Men and Young Men

Men constitute the overwhelming majority of Nigeria's incarcerated population, with young men (particularly those between the ages of 18–35) forming the largest demographic group. This age bracket is significant, as it reflects both the national youth bulge and broader socio-economic vulnerabilities that contribute to conflict with the law. Although men are often assumed to be less vulnerable than women or children, their health and wellbeing in custodial facilities are deeply impacted by both systemic inadequacies and age-specific risk factors.

Health Needs of Incarcerated Men: Incarcerated men face heightened risks of communicable diseases such as tuberculosis (TB), HIV, hepatitis, and skin infections due to overcrowding, poor ventilation, and limited access to timely medical care. Mental health challenges are also prevalent, with depression, anxiety, substance withdrawal symptoms, and suicidal ideation being common but often underdiagnosed or untreated. Younger inmates are particularly susceptible to peer pressure, violent encounters, and risky behaviors such as tattooing, drug use, and unprotected sexual activity, all of which increase vulnerability to infections.

Young Men and Violence Exposure: Custodial environments expose young men to violence, exploitation, and trauma. The high rate of pre-trial detention among this demographic contributes to frustration, unrest, and sometimes violent clashes within facilities. Young men are also more likely to be placed in shared, overcrowded cells, which exacerbates health risks and fosters cycles of aggression and vulnerability.

Rehabilitation and Reintegration Challenges: For young men, incarceration interrupts education, skill acquisition, and family relationships, creating long-term consequences for reintegration after release. Although the Corrections Act, 2019 emphasizes rehabilitation and vocational training, implementation remains uneven. Many young men leave custody without tangible skills or psychosocial support, increasing their likelihood of recidivism. Nutrition and Physical Health: The standard custodial diet, which is already inadequate for the general population, fails to account for the higher caloric and nutritional needs of young men in their most active years of physical development. Malnutrition, coupled with lack of exercise facilities, contributes to both undernutrition and poor overall health outcomes.

Although men and young men make up the largest population in custody, their health and rehabilitation needs require targeted attention. Overcrowding, infectious disease exposure, poor nutrition, violence, and lack of structured rehabilitation programs all combine to make this demographic particularly vulnerable. Their experiences in custody not only affect their immediate wellbeing but also have broader implications for community safety and reintegration upon release.

7.4 Elderly Persons (Geriatric Care, Mobility, Chronic Disease Management)

Although the elderly make up a relatively small proportion of Nigeria's incarcerated population, they represent a uniquely vulnerable group whose needs are often overlooked within custodial settings. The challenges of ageing are compounded by the harsh conditions of incarceration, creating layered vulnerabilities that demand specific attention.

Health and Chronic Disease Management: Older persons in custody are disproportionately affected by non-communicable diseases such as hypertension, diabetes, cardiovascular diseases, and arthritis. The custodial health system, however, is primarily designed to respond to acute and infectious diseases, leaving chronic disease management under-prioritized. Limited access to routine medical check-ups, diagnostic equipment, and essential medications means that elderly inmates often endure preventable complications, disability, or premature mortality.

Mobility and Accessibility: Custodial facilities in Nigeria were largely built without consideration for persons with reduced mobility. Elderly inmates with limited physical strength, arthritis, or visual impairment struggle with climbing stairs, using shared sanitary facilities, or accessing medical clinics. The lack of mobility aids—such as walking sticks, wheelchairs, or adapted bedding—exacerbates their daily hardship. In some facilities, elderly persons rely on the goodwill of younger inmates for physical support, a dependency that exposes them to exploitation.

Nutritional Needs: Standard prison diets, already inadequate in meeting the caloric and micronutrient requirements of the general population, are particularly unsuitable for elderly persons. Diets high in starch and low in protein, fiber, and vitamins contribute to poor health outcomes and worsen conditions such as diabetes, hypertension, and gastrointestinal complications.

Mental and Emotional Health: The experience of imprisonment is particularly traumatic for older individuals, many of whom struggle with separation from family and social support systems. Feelings of abandonment, isolation, and loss of dignity are common, and custodial environments rarely provide targeted psychosocial support or age-appropriate mental health care.

Custodial Environment: The harsh physical environment—overcrowding, poor ventilation, and inadequate bedding—takes a greater toll on elderly bodies. Exposure to extreme temperatures, mosquito infestations, and unhygienic facilities aggravates chronic illnesses and compromises immunity. With the prison system still largely overcrowded, elderly inmates are not typically housed in specialized units that could cater to their health and dignity.

Elderly persons in Nigerian custodial facilities face compounded vulnerabilities due to the mismatch between their health, mobility, and nutritional needs and the custodial system's capacity to provide adequate geriatric care. Their experience underscores the urgent need for age-sensitive approaches to healthcare, accommodation, and rehabilitation in the correctional system.

7.5 Infants and Children Living with Incarcerated Mothers

The presence of infants and young children within custodial facilities highlights one of the most complex humanitarian and rights-based challenges in correctional practice. Nigerian law, through the Correctional Service Act (2019), permits incarcerated mothers to keep their infants with them for up to 18 months, in recognition of the essential bond between mother and child, especially during breastfeeding. However, the custodial environment is inherently ill-suited to child development, exposing this demographic to risks that extend beyond health to long-term well-being.

Headfort Foundation's work in correctional centres has repeatedly illustrated these challenges. During legal and medical outreaches, our teams have encountered women nursing infants in conditions marked by overcrowding, inadequate ventilation, and poor sanitation. For example, during the July 2025 medical outreach at the Kirikiri Female Custodial Centre, several mothers reported not receiving adequate nutrition to sustain both themselves and their breastfeeding infants. In one case, an incarcerated mother expressed concern that her child had never seen a doctor since admission, underscoring the systemic absence of structured child health monitoring within correctional facilities.

The challenges faced by infants in custody are multidimensional. Nutritional needs are often unmet, with breastfeeding mothers lacking supplementary support such as formula, vitamins, or age-appropriate weaning foods. The absence of child-friendly spaces means infants grow up in cramped cells, exposed to stress, noise, and potential communicable diseases. Furthermore, during the needs assessment carried out by Headfort Foundation for Justice before carrying out the July 2025 Medical Outreach, it was highlighted that the female custodial facility needed Vitamin Syrup, amongst others, designated for infants and newborns.

From a rights-based perspective, these conditions contravene both the United Nations Rules for the Treatment of Women Prisoners and Non-Custodial Measures for Women Offenders (Bangkok Rules) and the Convention on the Rights of the Child, both of which emphasise that children should not be disadvantaged due to their mother's incarceration. In practice, however, the Nigerian custodial system often treats infants as “extensions” of their mothers rather than as rights-holders in their own regard.

This dual vulnerability, where both mother and child suffer the compounded effects of incarceration, points to the urgent need for policies and programs that go beyond mere permission for co-residence. While the law acknowledges the importance of maternal bonds, it does not provide clear guidelines or resources for ensuring that children in custody receive adequate healthcare, nutrition, and psychosocial stimulation. Without targeted interventions, infants and young children risk developmental delays and poor health outcomes that may persist long after release.

Maternal and Child Health: Infants and young children depend entirely on their mothers and custodial health systems for survival and growth. Yet, healthcare in most facilities remains geared toward the adult prison population, with minimal provisions for child-focused medical services. Immunization, growth monitoring, and access to pediatric care are often absent or inconsistent. Consequently, infants are vulnerable to preventable illnesses such as respiratory infections, diarrheal diseases, and malnutrition.

Living Conditions and Safety: Custodial environments, typically overcrowded and unsanitary, are unsafe for children. Exposure to infections, extreme temperatures, mosquitoes, and poor bedding materials undermines their health. Moreover, correctional facilities lack safe spaces for children to play, explore, and develop motor and social skills, impeding early childhood development.

Psychosocial and Developmental Needs: The formative years of life are critical for emotional, cognitive, and social growth. Infants and children raised in custodial settings are deprived of stimulation, interaction with peers, and access to early learning opportunities. They also witness the distress, frustration, and sometimes violence associated with prison life, experiences that may have long-lasting psychological impacts.

Legal and Rights-Based Concerns: The continued presence of children in correctional facilities raises questions about the best interests of the child, a principle enshrined in both Nigerian law and international human rights instruments. While keeping children with their mothers ensures maternal bonding and breastfeeding, it also places them in harmful environments not designed for child development. The absence of structured alternatives—such as safe community-based care or child-friendly custodial units—leaves correctional authorities with limited options.

Infants and children living with incarcerated mothers experience multiple layers of vulnerability in Nigeria's custodial facilities. Their health, nutrition, safety, and developmental needs are inadequately addressed within environments primarily designed for adult incarceration. This demographic highlights the urgent need for child-sensitive policies and practices that balance maternal rights with the best interests of the child.

7.6 Persons with Disabilities

Persons with disabilities (PWDs) represent one of the most marginalized and underserved groups within correctional facilities. Their vulnerabilities are compounded by systemic

barriers to healthcare, lack of accessibility, and widespread stigma. Disability in custodial settings is not only physical but also encompasses sensory, intellectual, and psychosocial impairments, each requiring tailored responses that correctional health systems rarely provide.

Accessibility and Infrastructure: Most Nigerian custodial facilities are not designed with accessibility in mind. Inmates with mobility impairments face difficulties navigating stairs, narrow doorways, uneven floors, and unsanitary latrines. The absence of ramps, handrails, or wheelchair-accessible spaces leaves many confined to bed spaces, increasing risks of pressure sores, muscle atrophy, and social isolation.

Healthcare and Rehabilitation: Access to specialized healthcare for PWDs is severely limited. Essential services such as physiotherapy, occupational therapy, assistive device provision (wheelchairs, crutches, prosthetics, hearing aids), and routine medical check-ups are either unavailable or irregular. Chronic conditions such as spinal injuries, blindness, epilepsy, and mental health disorders often go unmanaged, resulting in deterioration of health while in custody.

Daily Living and Dependence: The prison environment assumes a baseline level of independence among inmates, which PWDs may not possess. Those with severe disabilities often rely heavily on fellow inmates or overstretched custodial staff for basic needs such as bathing, toileting, and meal access. This dependence creates risks of neglect, abuse, or exploitation.

Psychosocial Wellbeing: Stigma, discrimination, and exclusion are pervasive challenges for PWDs. Many experience marginalization within the prison community, further isolating them from social and rehabilitative activities. For those with psychosocial or intellectual disabilities, a lack of understanding among staff and inmates may lead to mistreatment, mislabeling, or disciplinary action rather than care.

Legal and Human Rights Dimensions: International standards, including the UN Convention on the Rights of Persons with Disabilities (CRPD), emphasize the right of PWDs to equal treatment and accessibility. In Nigeria's custodial facilities, however, compliance remains weak. The lack of disability-sensitive policies, reasonable accommodation, and inclusive healthcare practices undermines these rights and perpetuates structural inequities. Persons with disabilities in Nigerian correctional facilities face profound barriers to health, dignity, and inclusion. The absence of accessible infrastructure, specialized healthcare, and protective policies exacerbates their vulnerability, leaving them at heightened risk of neglect and ill-treatment. This demographic underscores the need for custodial systems that are disability-inclusive and responsive to the rights and needs of all inmates.

7.7 Pre-trial Detainees and Short-Stay Inmates

Pre-trial detainees and short-stay inmates constitute a significant proportion of Nigeria's custodial population. According to official statistics, more than 70% of inmates in correctional facilities are awaiting trial, with many held for months or years due to delays in the justice system. This demographic presents unique healthcare needs and challenges, shaped by the short and often unpredictable duration of custody, as well as the psychosocial stress of unresolved legal status.

Transience and Continuity of Care: The uncertain length of stay complicates health service delivery. Many detainees are remanded without adequate medical screening, resulting in missed opportunities to detect communicable diseases such as tuberculosis, HIV, hepatitis, or mental health concerns. When released or transferred suddenly, continuity of care is often disrupted, withno referral mechanisms to community health providers. This poses risks both to the individual and to public health, particularly in the spread of infectious diseases.

Psychological Stress and Vulnerability: Pre-trial detainees experience heightened anxiety, depression, and trauma due to the uncertainty of their legal status. Unlike convicted inmates, they may not have access to structured rehabilitation or psychosocial support programs, leaving their mental health needs largely unmet. The stigma of incarceration without conviction further compounds this vulnerability, especially among young detainees and first-time offenders.

Overcrowding and Health Risks: Since pre-trial detainees make up the majority of inmates, they are the most affected by overcrowding, poor ventilation, and inadequate sanitation in custodial centres. The constant inflow and outflow of detainees amplifies the risk of introducing and spreading communicable diseases, creating a cycle of ill health that affects both inmates and surrounding communities.

Short-Stay Inmates: Inmates serving very short sentences or held briefly for minor offences often miss out on basic health assessments or interventions altogether. The brevity of their stay is often used as justification for not enrolling them in structured health programs, even though they may carry untreated conditions or urgent needs. In some cases, their custodial stay can exacerbate pre-existing health problems due to poor nutrition, stress, and exposure to unhygienic environments. Findings from Headfort Foundation for Justice's July 2025 medical outreach at the Kirikiri Female Custodial Centre reinforce this concern in the Nigerian context. During the outreach, it was observed that inmates who had been in custody for two months or less had not undergone any form of medical assessment. Some women could not even confirm their pregnancy status, an alarming indication of the absence of systematic admission screening and reproductive health checks for short-stay detainees.

This oversight underscores the inconsistency with which the statutory requirement under the Nigerian Correctional Service Act (2019), which mandates health screening for all inmates upon admission, is implemented. The consequence is that short-term detainees

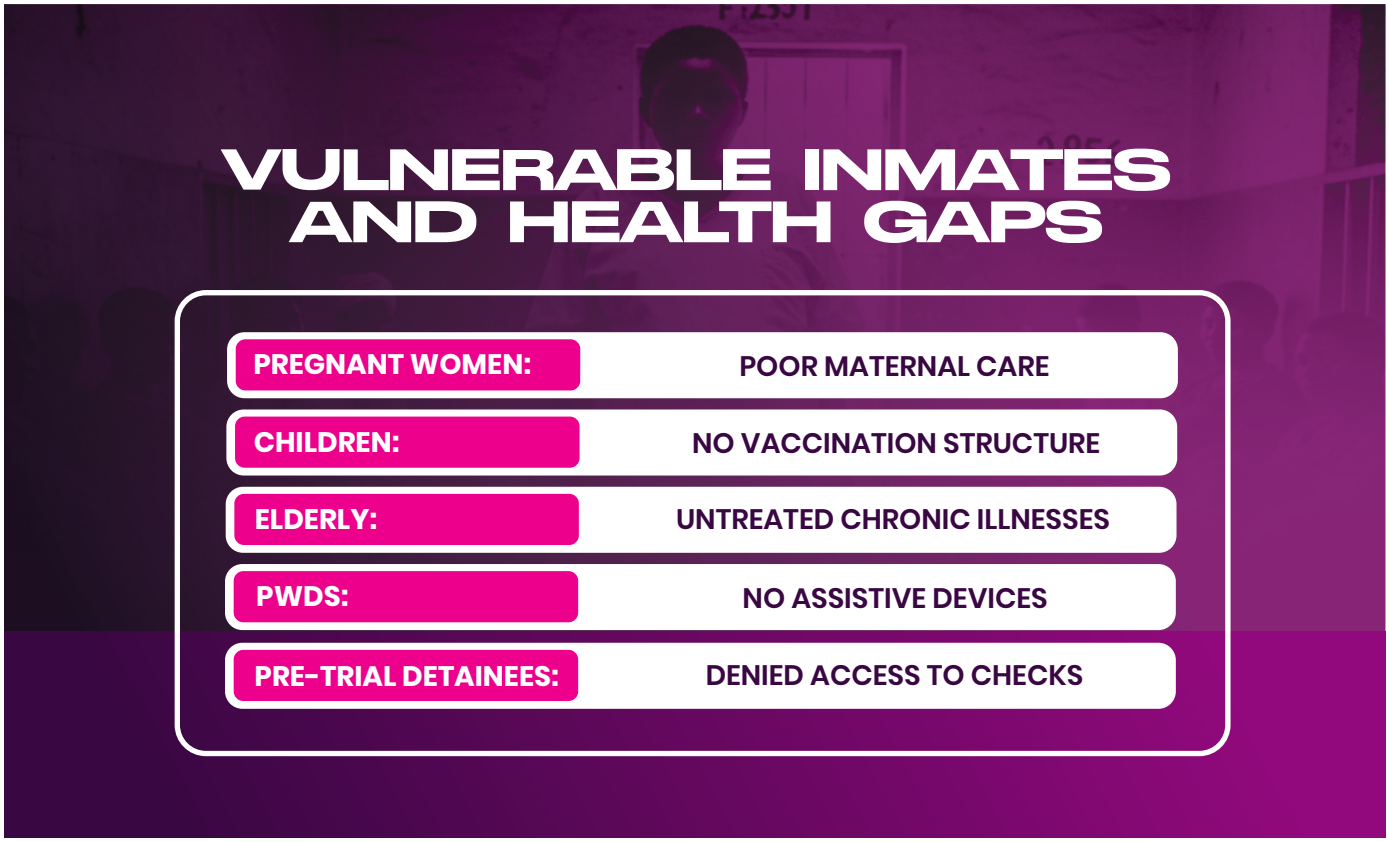
may leave correctional facilities with untreated illnesses or undetected conditions, posing risks both to their personal well-being and to public health upon re-entry into their communities.

Legal and Ethical Dimensions: The principle of presumption of innocence underscores the rights of pre-trial detainees, including access to the same standard of healthcare as the general population.

Yet, in practice, pre-trial and short-stay inmates face systemic neglect. The absence of systematic screening, weak referral mechanisms, and limited psychosocial support undermines both their health rights and Nigeria's obligations under international human rights standards.

Pre-trial detainees and short-stay inmates occupy a particularly vulnerable position within custodial healthcare. Their transience, exposure to overcrowded facilities, and lack of structured health and psychosocial support place them at heightened risk. Addressing their needs requires recognizing the dual imperatives of safeguarding individual health and protecting public health through continuity of care.

Figure 10: ***Vulnerable Inmates and Health Gaps***



SECTION 8:

SERVICE DELIVERY MODEL AND CARE PATHWAYS

A functional and efficient healthcare service delivery model is the backbone of a humane correctional system. Inmates in Nigerian correctional centers enter custody from diverse backgrounds, many already living with undiagnosed medical conditions, untreated mental health needs, or infectious diseases acquired in resource-poor communities. For a significant proportion, prison becomes the first place where they encounter any form of structured healthcare. Yet, systemic gaps, chronic underfunding, and weak coordination mean that these services are often fragmented, reactive, and inadequate. This section outlines the key components of an integrated care pathway that should guide correctional healthcare delivery, from entry screening to emergency response, ensuring that all inmates, regardless of their status, have access to quality, continuous, and dignified medical care.

8.1 Entry Health Screening and Medical Records

Upon admission into correctional centres, every inmate should undergo a comprehensive entry health screening, a critical step to identify communicable diseases, chronic illnesses, and mental health concerns early. Ideally, this screening should include physical examinations, laboratory testing, mental health assessments, and medical history documentation. However, monitoring visits across multiple facilities reveal that intake assessments are frequently rushed or entirely bypassed due to overcrowding, staff shortages, and lack of resources.

The consequences of this gap are severe. Inmates with uncontrolled hypertension or diabetes often go undiagnosed until complications arise; those with untreated tuberculosis or hepatitis may inadvertently infect cellmates in congested, poorly ventilated cells. Mental health conditions, including depression, schizophrenia, and substance dependence, are rarely flagged during admission, leaving vulnerable inmates to silently deteriorate until they reach crisis points.

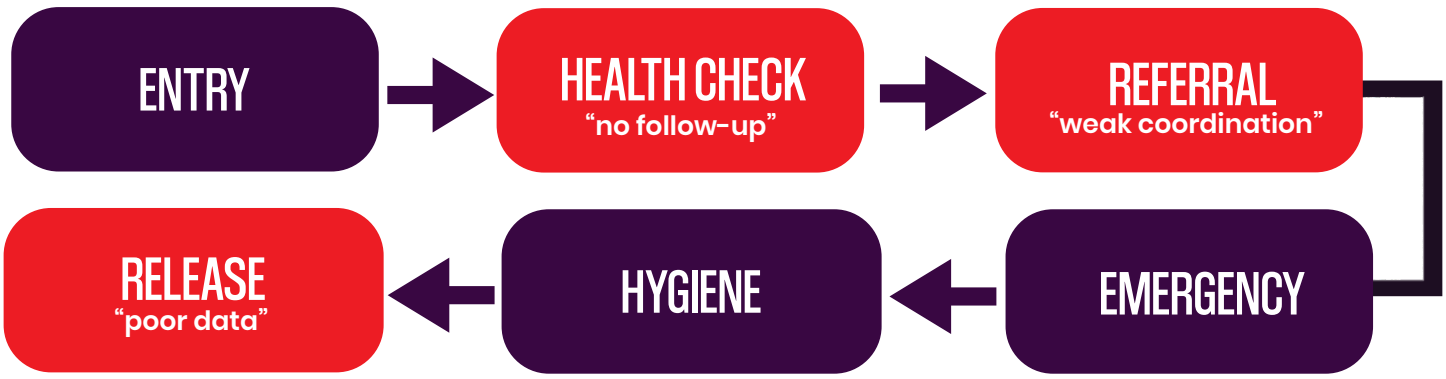
Even when screenings occur, the absence of a centralized electronic medical records (EMR) system undermines continuity of care. Paper-based files are frequently misplaced during inmate transfers, forcing new health staff to restart diagnosis and treatment from scratch. This disrupts effective care and violates inmates' right to health, as enshrined in both the Nigerian Correctional Service Act (2019) and international human rights standards.

8.2 Routine and Periodic Health Checks

Correctional healthcare should not stop at entry screening; it must include routine and periodic health assessments to monitor, prevent, and manage emerging illnesses. In well-functioning systems, inmates would receive scheduled check-ups for both communicable and non-communicable diseases, dental care, reproductive health, and mental wellness support

In reality, these checks are inconsistent or absent in most facilities. A minor wound may progress into sepsis due to neglect; an untreated dental infection may become life-threatening. Without regular monitoring, chronic conditions like asthma, epilepsy, and hypertension worsen unnecessarily, while cancers, particularly cervical and prostate cancer, go undetected until advanced stages.

Figure 11: ***Flow Diagram***
Title: How Correctional Health Services Should Work



Note: Red box highlight major system breakdowns in the correctional health service chain, where coordination, continuity, and record-keeping are weakest.

The lack of structured schedules for health assessments reflects deeper systemic issues: inadequate staffing, unreliable funding, and fragmented coordination between the Nigerian Correctional Service (NCoS) and the Federal Ministry of Health (FMoH). Establishing routine health checks, supported by standardized care protocols and reliable data systems, is therefore essential to safeguarding inmate wellbeing.

8.3 Referral Networks, Telemedicine, and Specialist Outreach

Complex medical cases cannot be managed within correctional centres alone. An effective healthcare delivery model requires strong referral networks linking prisons to tertiary hospitals, specialist clinics, and external laboratories. For example, inmates with advanced cancers, complicated pregnancies, or surgical emergencies must be referred promptly to appropriate facilities where life-saving interventions are available.

However, referrals are frequently delayed by bureaucratic bottlenecks, requiring multiple approvals, escorts, and transportation logistics, leading to preventable complications or deaths. Strengthening referral systems requires clear Standard Operating Procedures (SOPs), dedicated referral officers, and efficient case tracking mechanisms to ensure timeliness.

Emerging innovations such as telemedicine offer promising solutions to bridge gaps in access to specialist care. Through virtual consultations, inmates can benefit from psychiatric evaluations, infectious disease consultations, and even remote diagnostic reviews without leaving the facility. Similarly, specialist outreach programmes, where external healthcare teams conduct on-site clinics, can significantly reduce backlogs in areas like dental care, mental health assessments, and maternal services.

8.4 Emergency Evacuation Protocols

Medical emergencies are an inevitable reality in correctional centres, but current systems are poorly equipped to respond swiftly and effectively. Heart attacks, obstetric crises, asthma attacks, or traumatic injuries require immediate intervention; delays can mean the difference between life and death.

In theory, every facility should have an emergency evacuation protocol, including functional ambulances, 24-hour medical staff availability, and pre-arranged partnerships with nearby hospitals. In practice, ambulances are scarce, security concerns often override medical urgency, and approval processes can take hours or even days. The lack of structured emergency response procedures compounds preventable mortality. Establishing Rapid Medical Response Units (RMRUs) within correctional facilities, supported by clear SOPs and well-trained personnel, is essential. Inmates, correctional staff, and nearby tertiary

8.5 Infection Prevention and Control (IPC) and Water, Sanitation, and Hygiene (WASH) Standards

Infection Prevention and Control (IPC) measures and Water, Sanitation, and Hygiene (WASH) standards form the foundation of a healthy custodial environment. Yet, overcrowding, poor ventilation, and inadequate sanitation in Nigerian correctional centres fuel the rapid spread of communicable diseases.

Regular monitoring visits have documented alarming levels of skin infections, gastrointestinal outbreaks, tuberculosis, and respiratory illnesses, all of which are worsened by limited access to clean water, soap, functional toilets, and proper waste disposal systems, especially in older facilities.

To strengthen IPC within correctional centres, it is essential to establish isolation units where contagious cases can be managed discreetly and safely. Clean water and hygiene supplies must be consistently provided to inmates and staff alike, while both groups should also receive regular training on basic hygiene practices and infection control procedures. Furthermore, routine cleaning and disinfection of living spaces should become a standard requirement rather than an occasional intervention.

Adherence to WHO Prison Health Guidelines and the UN Bangkok Rules is critical for protecting inmates, staff, and surrounding communities. Correctional centres are not isolated environments; outbreaks within facilities can easily extend beyond prison walls, underscoring the urgent need for robust, well-coordinated IPC and WASH frameworks.

SECTION 9:

HEADFORT FOUNDATION FOR JUSTICE: WELLNESS BEHIND BARS INITIATIVE

9.1 Program Overview and Theory of Change

The Wellness Behind Bars Initiative is a flagship program of Headfort Foundation for Justice designed to address one of the most neglected aspects of prison reform in Nigeria, the health and wellbeing of incarcerated individuals. Nigerian correctional facilities are characterized by overcrowding, poor sanitation, inadequate medical attention, and almost non-existent psychosocial support. Also, a recent disclosure from Sahara Reporters on the 13th of August 2025 highlights a staggering challenge within Nigeria's correctional system: 8,246 inmates nationwide are currently suffering from mental illness and there is a critical shortage of doctors, nurses, psychiatric clinicians, and consistent drug supplies to address their needs. These gaps not only undermine the dignity of inmates but also increase their vulnerability to preventable diseases, mental health crises, and premature deaths. The Wellness Behind Bars project addresses critical health and psychosocial gaps in Nigerian correctional facilities through targeted medical consultations, mental health and psychosocial support (MHPSS), health education, and essential health resources (e.g., emergency water provision).

Theory of change

Our organisation proposed a theory of change when we decided to embark on the Wellness Behind Bars Initiative to guide our activities and outcome/impact. Our theory of change is that;

- If inmates receive regular medical check-ups, gender-responsive MHPSS, and health education, and facilities receive essential health resources when crises arise;
- Then immediate health risks fall, mental wellbeing improves, and coping capacity rises;
- Which strengthens rehabilitation prospects, reduces preventable morbidity, and provides credible evidence to advocate policy and budget reforms in correctional health.

9.2 Geographic coverage and beneficiary profile

- Ekiti (Dec. 2024): 100 inmates benefitted from wellness outreach.
- Enugu (Feb. 2025): 3,602 inmates benefitted from provision of water tankers during acute water scarcity.
- Akwa Ibom (May 2024): 100 inmates (men and women) participated in mental health sessions.

- Calabar (June 2025): 150 inmates participated in mental health sessions.
- Kirikiri, Lagos (July 2025): 200 female inmates (including pregnant women, elderly, and nursing mothers) benefitted from a full medical and wellness outreach, including check-ups, consultations, drug dispensation, and hygiene kits.

Beneficiary profile. Indigent inmates (men and women), including vulnerable sub-groups: women, older persons, and inmates with untreated physical and mental health conditions.

9.3 Service Components

- Medical Outreaches: Screening (blood pressure, sugar, malaria tests), one-on-one consultations, and drug dispensation.
- Mental Health Sessions: Trauma care and resilience training facilitated by Arogi Trauma Care Foundation.
- Welfare & Hygiene Support: Distribution of sanitary pads, detergents, toothbrushes, tissue paper, toothpaste, food items (e.g., garri), and clothing.
- Water & Sanitation Support: Provision of water tanker to Enugu prison to reduce risk of health hazards.
- Health Education: Practical coping strategies, preventive health knowledge, and awareness of symptoms requiring care.

9.4 Partnerships with NCoS, CSOs, and Pro Bono Clinicians

The Nigeria Correctional Service (NCoS) has been central to the success of the Wellness Behind Bars Initiative. Beyond granting approvals, the Service consistently provided the operational support needed to implement the outreaches across Ekiti, Enugu, Akwa Ibom, Calabar, and Lagos. Their role included facilitating access into the correctional centers, mobilizing inmates and ensuring security during activities. In Enugu, NCoS highlighted the urgent water scarcity that left inmates vulnerable to health hazards, enabling a rapid intervention that reached over 3,600 inmates. In Akwa Ibom and Calabar, they ensured that mental health sessions were well attended and effectively coordinated. During the women-focused outreach in Lagos, their engagement was particularly notable, NCoS deployed officers to support crowd control and inmate mobilization, linked the team with the facility's clinic matron, and engaged in dialogue on sustaining and scaling the initiative across other facilities. These actions underscore the Service's commitment to integrating health and wellness programs into correctional systems.

Civil Society partners also played a significant role in expanding the program's reach and impact. Across different states, CSOs provided logistical support, mobilized volunteers, and reinforced advocacy around inmate welfare. In Lagos, the Arogi Trauma Care Foundation facilitated the mental health and resilience sessions, equipping female inmates with practical coping tools. Other CSOs, alongside media outlets, supported advocacy and visibility efforts that highlighted the systemic gaps in correctional healthcare and amplified calls for reform.

Equally critical has been the contribution of pro bono clinicians and volunteers. Across states, medical professionals delivered consultations, health screenings, counseling, and treatment free of charge. In Lagos, this support was particularly robust, with 14 clinicians delivering a wide range of services, complemented by monitoring and evaluation volunteers who administered pre- and post-surveys, and logistics staff who managed the structured distribution of medicines and welfare items. This collective effort ensured that the outreaches addressed both immediate and long-term wellness needs of inmates.

Together, the collaboration between NCoS, civil society, and pro bono clinicians has transformed the Wellness Behind Bars Initiative into a holistic intervention that not only delivers health and psychosocial services but also builds momentum for systemic change. This partnership model, anchored on state institutions, civil society expertise, and professional volunteerism, presents a replicable framework for national policy adoption, showing how correctional health can be sustainably integrated into Nigeria's broader public health and justice systems.

9.5 Results to Date (Outputs, Outcomes, Case Studies)

Outputs: Since inception, the Wellness Behind Bars Initiative has delivered direct health, psychosocial, and welfare interventions across multiple states, reaching 4152 inmates:

- Ekiti (Dec 2024): 100 inmates benefitted from medical consultations, mental health sensitization, and basic welfare support.
- Enugu (Feb 2025): 3,602 inmates were reached through the provision of a water tanker, a critical intervention that addressed acute water scarcity and reduced the immediate risk of health hazards linked to poor sanitation and dehydration.
- Akwa Ibom (May 2024): 100 inmates, including men and women, received structured group mental health sessions aimed at trauma healing and resilience building.
- Calabar (Jun 2025): 150 inmates benefitted from group counseling sessions focused on stress management, coping strategies, and emotional healing.
- Lagos – Kirikiri Female Correctional Center (Jul 2025): 200 women inmates, including pregnant women, elderly inmates, and nursing mothers, participated in a comprehensive medical and wellness outreach. Specific medical interventions included:
  - 182 blood pressure checks (with cases of untreated hypertension identified and managed).
  - 120 blood sugar tests (identifying inmates with diabetes and initiating treatment).
  - 100 malaria tests with immediate treatment provided.
  - 158 one-on-one doctor consultations covering conditions such as ulcers, respiratory issues, and skin infections.

○ Distribution of welfare and hygiene items including sanitary pads, toothbrushes, toothpaste, detergents, tissue paper, garri, and clothing, restoring dignity and improving inmates' living conditions.

Outcomes: The results of these interventions go beyond the numbers, showing tangible improvements in inmates' lives and institutional practices:

- For many inmates, these outreaches provided their first access to medical care in several months, and in some cases, years. Chronic conditions such as hypertension, diabetes, and ulcers were detected, treated, and flagged for follow-up by facility clinic staff.
- Female inmates benefitted significantly from psychosocial support, gaining coping strategies to manage trauma, stress, and anxiety associated with incarceration. This has translated into improved mental wellbeing, resilience, and a renewed sense of hope.
- The distribution of hygiene and welfare items directly improved the dignity and quality of life of inmates, particularly vulnerable groups such as pregnant women and mothers with children in custody.
- Partnerships with NCoS clinic staff were strengthened, ensuring that identified cases could be monitored and continuity of care sustained beyond the outreach.
- The program also enhanced public visibility and advocacy impact, with media coverage raising awareness on the systemic gaps in correctional healthcare and mobilizing broader stakeholder interest in reform.

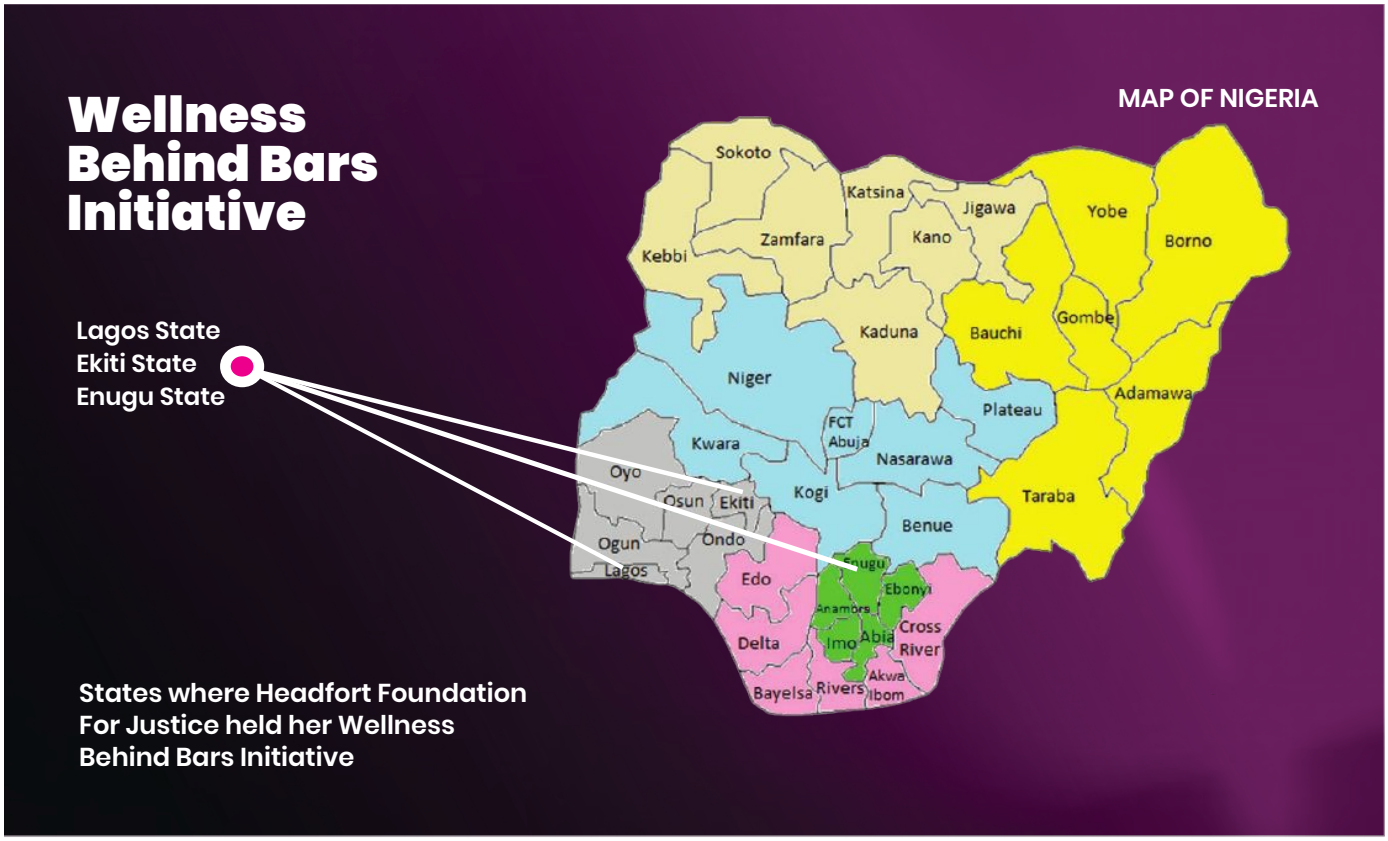
Case Study – Lagos (Kirikiri Female Correctional Center):

During the July 2025 outreach in Lagos, a 60-year-old female inmate shared her experience. She had been arrested in place of her son and had remained in custody for several months. The prolonged detention had taken a severe toll on her mental health, leaving her anxious, withdrawn, and devoid of hope.

As part of the program, she participated in a mental health session facilitated by Headfort Foundation's partners, where she was introduced to trauma-informed coping strategies for managing stress and anxiety. The facilitators emphasized that her current situation did not define her future and equipped her with tools to rebuild her emotional strength.

Following the session, she disclosed that it was the first time she had ever spoken openly about her pain. She described the experience as "a release" and expressed that the session gave her renewed hope and the emotional resilience to carry on despite her circumstances. Her story demonstrates the profound psychosocial impact of the Wellness Behind Bars Initiative, underscoring the importance of targeted mental health interventions in restoring dignity, resilience, and a sense of identity among incarcerated women.

Figure 12: Wellness behind bars.



9.6 Lessons Learned and Scalability Opportunities

Lessons Learned: The Wellness Behind Bars Initiative has yielded valuable insights that can inform both program strengthening and policy reform:

- Gender-Specific Health Needs: Female inmates face distinct challenges, particularly in relation to maternal health, menstrual hygiene management, and mental health. The July 2025 Lagos outreach highlighted how pregnant women and mothers with children in custody have unique vulnerabilities that require gender-sensitive programming. Addressing these needs not only improves health outcomes but also restores dignity for women in custody.

- Welfare Interventions Are as Critical as Clinical Care: In Enugu, the provision of a water tanker reached over 3,600 inmates and proved that welfare-focused interventions (such as water supply, hygiene kits, or nutrition) are often lifesaving. These basic needs are inseparable from clinical care and must be integrated into any holistic correctional health program.
- Collaboration with Correctional Staff Is Pivotal: Smooth implementation of outreaches in all states was possible because of the support of NCoS staff, particularly clinic matrons and correctional officers. Their assistance in mobilizing inmates, managing security, and ensuring continuity of care has demonstrated that strong institutional collaboration is the backbone of effective programming.

Data Collection Challenges in Correctional Settings: Pre- and post-surveys have provided invaluable evidence on knowledge gained, emotional wellbeing, and health improvements. However, restrictions on electronic devices in correctional centers necessitate manual data collection, which can be time-consuming and resource-intensive. Creative solutions, such as paper-based surveys and verbal feedback methods, are needed to sustain evidence gathering.

Scalability Opportunities:

The initiative has revealed multiple opportunities for expansion and systemic integration:

- Institutionalize Mental Health Support: Partnering with trauma care organizations, routine mental health sessions can be embedded into correctional health systems, ensuring inmates have sustained psychosocial support.
- Replicate Water and Sanitation Interventions: The Enugu water supply model should be replicated in other overcrowded facilities facing sanitation crises, demonstrating how practical welfare interventions mitigate immediate health risks.
- Strengthen Policy Advocacy: Data and evidence from the outreaches provide a compelling case to integrate correctional health into Nigeria's broader public health agenda, positioning inmate health as a matter of public health equity and justice.

9.7 Integration with Policy (Roles in Implementation, M&E, Advocacy)

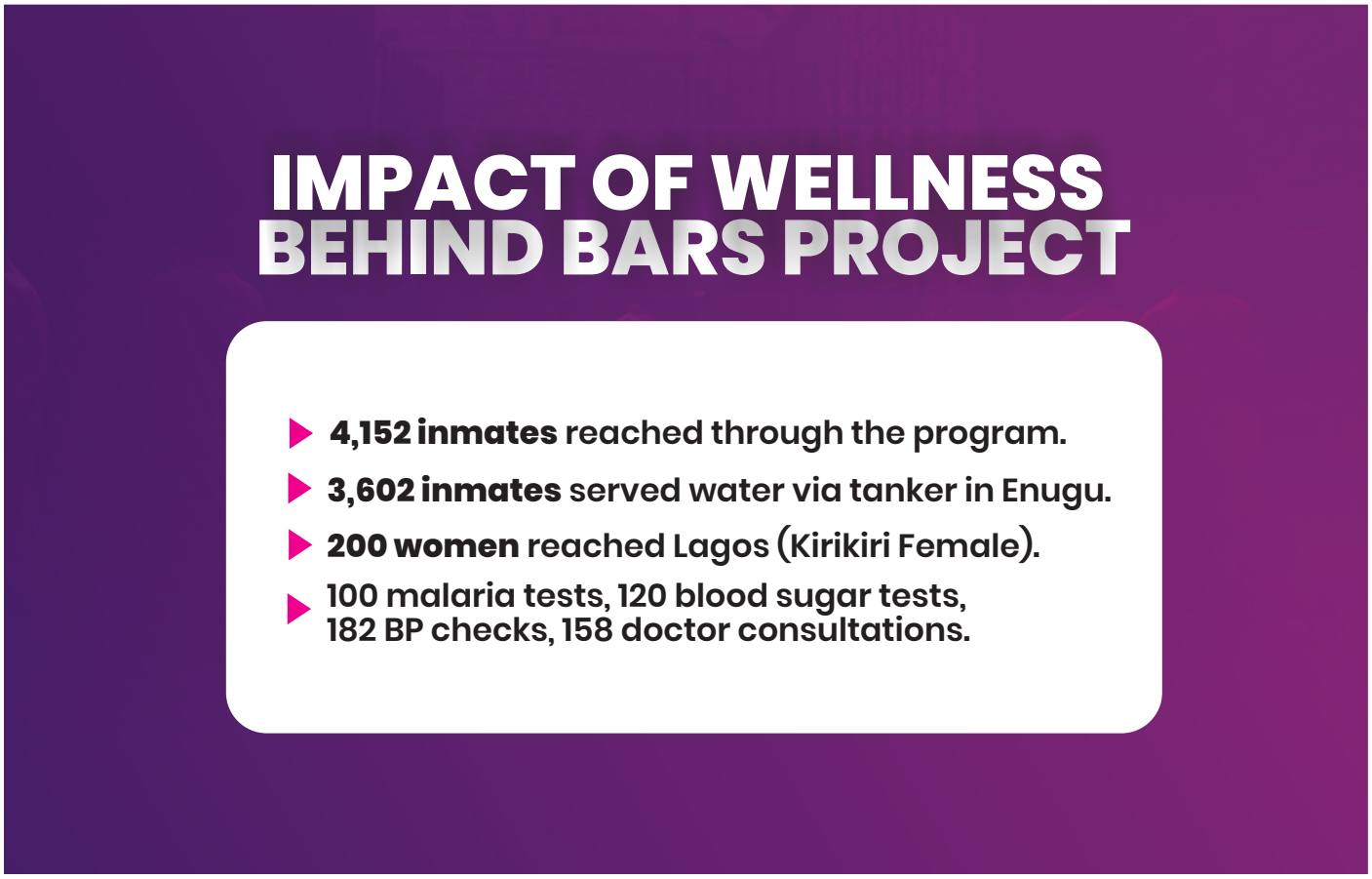
Implementation: Headfort Foundation for Justice leads program coordination, designing and executing wellness outreaches with the approval and operational support of the Nigeria Correctional Service (NCoS). The foundation works closely with pro bono clinicians and volunteers—including doctors, nurses, psychologists, and trauma care specialists—to deliver medical, mental health, and welfare interventions. Civil society partners contribute to psychosocial support, advocacy, and visibility.

Monitoring and Evaluation (M&E): M&E is integrated into every outreach to capture both quantitative and qualitative impact. Pre- and post-surveys measure inmates' knowledge of health practices, shifts in emotional wellbeing, and improvements in medical conditions. Manual survey tools and verbal feedback mechanisms ensure data collection despite electronic restrictions. The evidence is collated into structured reports that feed into program learning, donor accountability, and policy engagement.

Advocacy: The program leverages evidence from the field to influence national correctional health policy. For example, data from the Lagos outreach revealed that 103 out of 200 women had not received medical care in the last three months. Such findings are used to advocate for systemic reforms, including the institutionalization of routine medical care, regular mental health sessions, and improved sanitation services in correctional facilities. Media visibility and CSO partnerships further amplify advocacy messages, creating public awareness and pressuring policymakers to integrate prison health into national public health strategies.

Figure 13: Title: Partners and Roles

Figure 14: Impact of Wellness Behind Bars Project



SECTION 10:

POLICY RECOMMENDATIONS

Transforming healthcare in Nigeria's correctional facilities requires bold, multi-layered reforms that address governance, financing, service delivery, human resources, and accountability. The following recommendations provide a roadmap for achieving sustainable improvements in inmate health outcomes, grounded in legal and policy reforms, strengthened service delivery, and coordinated multi-sectoral action.

10.1 Legal and Policy Reforms

- Integrate correctional healthcare into the national health system by enacting legislation that mandates state Ministries of Health to oversee health services in correctional facilities, ensuring equivalence of care with the general population, in line with the Mandela Rules.
- Review and amend the Nigerian Correctional Service Act, 2019, to explicitly define healthcare as a statutory right of inmates and to create enforceable standards for medical service delivery.
- Establish oversight and accountability mechanisms, including an independent body or ombudsman to monitor health rights compliance in correctional centres.
- Strengthen mental health legislation to mandate regular screening, diagnosis, and treatment of inmates with psychological conditions, while prohibiting inhumane practices such as prolonged solitary confinement for mentally ill inmates.

10.2. Service Delivery and Clinical Standards

- Introduce mandatory entry health assessments for all new inmates, including pregnancy testing for women, HIV and tuberculosis screening, and mental health evaluation.
- Develop and enforce national clinical standards for correctional healthcare, covering maternal health, infectious diseases, non-communicable diseases, and mental health services.
- Ensure availability of essential medicines and supplies, aligned with the National Essential Medicines List, in every correctional health unit.
- Establish routine health check-ups for inmates at least quarterly, with referral systems for specialist care in public hospitals when required.
- Strengthen water, sanitation, and hygiene (WASH) facilities, ensuring access to clean water, particularly in facilities like Enugu where scarcity is acute.

10.3. Workforce Strengthening and Training

- Recruit and retain qualified healthcare workers (doctors, nurses, pharmacists, psychiatrists, and psychologists) in all correctional centres, supported by competitive remuneration and career progression pathways.
- Introduce mandatory training for correctional health staff on human rights-based approaches, trauma-informed care, and prison-specific health challenges.
- Create joint training programmes between the Nigerian Correctional Service and the Federal/State Ministries of Health to harmonise standards and build a shared pool of skilled personnel.
- Deploy community health workers and trained volunteers through partnerships with NGOs and professional associations to complement overstretched facility staff.

10.4. Financing and Procurement Improvements

- Ring-fence budgetary allocations for inmate healthcare within the national and correctional service budgets, ensuring funds are dedicated and not diverted only to security operations.
- Introduce pooled procurement mechanisms for essential medicines and supplies to reduce costs and prevent frequent stockouts.
- Explore public-private partnerships (PPPs) with pharmaceutical companies, NGOs, and donor agencies for sustained supply of drugs, diagnostic equipment, and laboratory services.
- Pilot health insurance schemes or government-subsidised coverage for inmates to guarantee financial sustainability of services.

10.5. Data Systems, Monitoring & Evaluation (M&E), and Research Priorities

- Establish a centralized inmate health information system integrated with the national health database, capturing data on communicable and non-communicable diseases, maternal health, and mental health outcomes.
- Conduct routine M&E assessments of correctional health services, with public reporting on indicators such as availability of medicines, staff-to-inmate ratio, and morbidity/mortality rates.
- Invest in operational research to identify context-specific innovations in correctional healthcare, including telemedicine, mobile clinics, and peer-support models.
- Promote collaboration with universities and research institutions to generate evidence for policy and programme refinement.

10.6. Partnerships and Coordination

- Formalise inter-agency collaboration between the Nigerian Correctional Service, Ministry of Interior, Federal and State Ministries of Health, and Civil Society Organisations (CSOs) to harmonise service delivery.
- Leverage partnerships with NGOs and international development partners (e.g., WHO, UNODC, DRPC, Arogi Trauma Care Foundation, and SRIHIN) to mobilise technical and financial resources.
- Establish multi-stakeholder coordination platforms at national and state levels to align correctional health priorities with broader public health agendas.
- Strengthen community linkages to ensure continuity of care for inmates upon release, including referral systems to primary healthcare centres.

10.7. Phased Implementation Plan

Short-Term (1–2 years)

- Conduct baseline assessments of all correctional health facilities.
- Roll out mandatory entry health screening and quarterly medical check-ups.
- Provide emergency recruitment of medical staff in high-volume facilities.
- Begin essential medicines procurement reform with pooled purchasing.

Medium-Term (3–5 years)

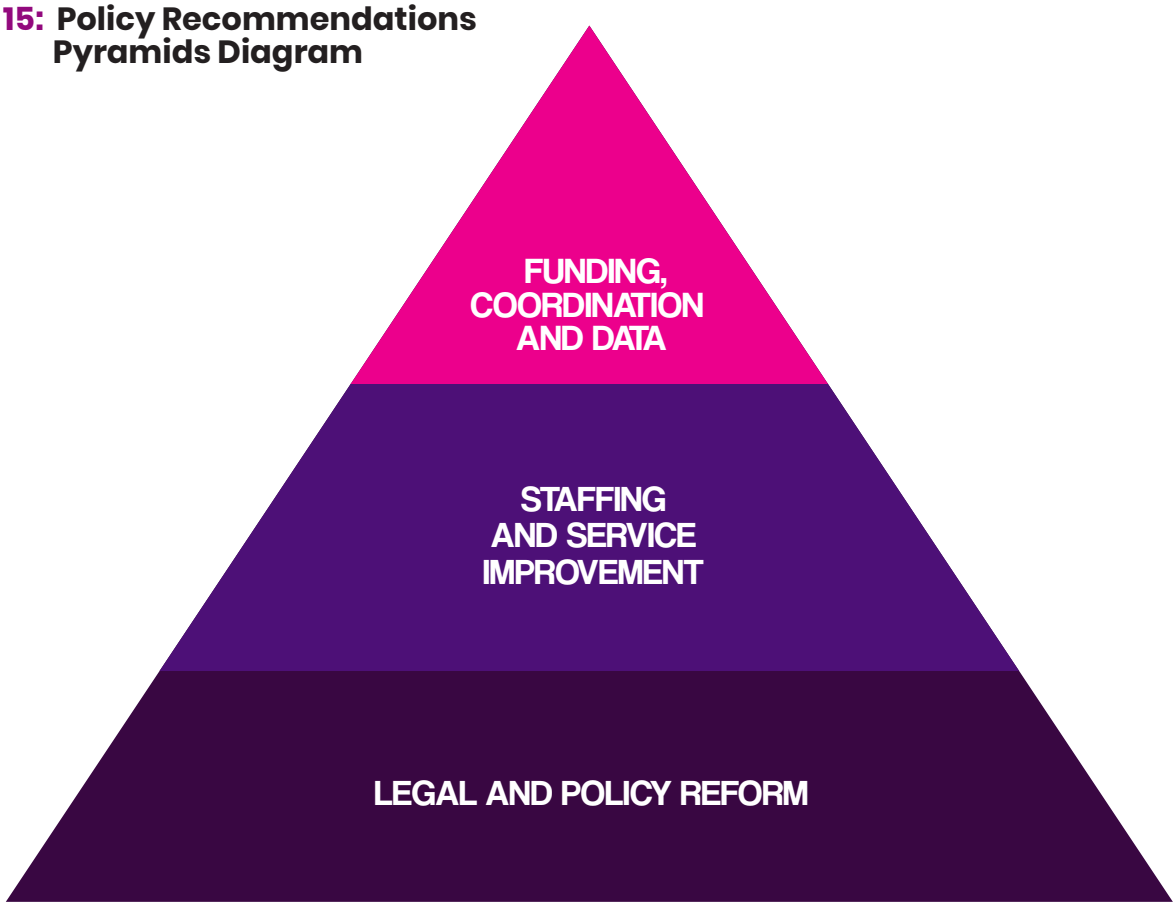
- Integrate correctional healthcare into state health systems.
- Establish functional mental health units in at least one correctional centre per geopolitical zone.
- Digitise health data collection and reporting across facilities.
- Build capacity of the correctional health workforce through continuous professional development.

Long-Term (5–10 years)

- Achieve full equivalence of care between correctional facilities and the general public health system.
- Institutionalise health insurance coverage for inmates.
- Sustain coordinated multi-stakeholder platforms for correctional health governance.
- Position correctional health services as a central component of Nigeria's public health system, with strong legal backing and adequate financing.

The health of inmates is both a human rights obligation and a public health imperative. By addressing systemic barriers through legal reform, improved service delivery, strengthened workforce capacity, sustainable financing, robust data systems, and effective partnerships, Nigeria can transform correctional facilities from centres of neglect into institutions that uphold dignity, health, and rehabilitation. A phased, strategic implementation of these recommendations will ensure that the right to health for incarcerated persons becomes a reality rather than an aspiration.

Figure 15: **Policy Recommendations Pyramids Diagram**



SECTION 11:

IMPLEMENTATION PLAN

11.1 Objectives, Activities, Timelines, and Responsible Actors

The success of any prison health and welfare reform depends not only on well-articulated policy recommendations but also on a deliberate plan of action that translates commitments into measurable change. Implementation requires clarity on what must be achieved (objectives), how it will be achieved (activities), when it should be done (timelines), and who bears responsibility (actors). Without this clarity, even the strongest legal and policy frameworks risk remaining aspirational.

The first core objective is to ensure the immediate stabilization of health and welfare services within custodial centres. This includes addressing urgent deficits such as inadequate medical supplies, overcrowding, and poor sanitation, which pose direct threats to inmate survival and dignity. Activities under this objective should prioritize rapid needs assessments, emergency procurement of essential drugs and equipment, and the deployment of mobile health teams to facilities most at risk. Timelines here must be short-term, focusing on quick wins within one to two years of policy roll-out. Responsible actors would include the Nigerian Correctional Service health units, supported by the Federal Ministry of Health and state-level health boards, with oversight from the Ministry of Interior.

The second objective is the institutionalization of sustainable service delivery systems that go beyond adhoc responses. This entails developing standardized clinical protocols, integrating correctional health into the broader national health system, and establishing routine referral mechanisms between custodial centres and external hospitals. Activities will include the design of service guidelines, capacity-building for medical staff, and the creation of health information management systems that allow for continuity of care. These activities fall within the medium-term horizon of three to five years, requiring inter-ministerial coordination and technical input from professional health associations, while the Nigerian Correctional Service assumes the role of primary implementer.

A third objective is workforce strengthening and improved accountability. Correctional facilities cannot provide adequate care without trained, motivated personnel who are monitored and supported in their roles. Activities here will include the recruitment of additional health professionals, continuous professional development for both medical and custodial staff, and the introduction of clear accountability structures to address neglect or abuse. These efforts will be phased, beginning with immediate

refresher training within the first two years, followed by structured workforce expansion and welfare reforms over a three-to-five-year period. The Federal Ministry of Interior, in collaboration with the Civil Service Commission and Ministry of Health, would bear central responsibility, supported by donor agencies and academic institutions for technical training.

A fourth objective concerns data, monitoring, and evidence generation. Effective policy implementation must be informed by reliable, real-time information. Activities here would focus on building standardized health information systems across facilities, conducting periodic monitoring visits, and commissioning research into inmate health trends and intervention outcomes. This would be staged over the medium to long term three to five years), beginning with pilot systems in high-capacity custodial centres before national scale-up. Responsibility would fall jointly on the Nigerian Correctional Service, the National Bureau of Statistics, and independent oversight bodies, with CSOs playing a critical supporting role in data verification.

Finally, the implementation plan must prioritize multi-sectoral partnerships and coordination. No single institution can meet the health and welfare needs of inmates in isolation. Activities under this objective would include the creation of an inter-ministerial task force on correctional health, formalizing collaboration frameworks with civil society organizations, and developing community reintegration programs for released inmates. These actions should commence immediately and continue over the long term, ensuring that partnerships shift from informal, project-based collaborations to sustained institutional linkages. The Ministries of Interior, Health, Justice, and Women Affairs, together with the Nigerian Correctional Service and leading CSOs, would serve as joint responsible actors, ensuring that inmate health becomes a national, rather than peripheral, public health concern.

In essence, the implementation plan demands a phased approach: short-term stabilization to address immediate risks, medium-term system-building to entrench sustainable practices, and long-term institutional reforms to guarantee continuity and resilience. Clarity in objectives, deliberate sequencing of activities, realistic timelines, and clearly designated responsibilities are what will transform recommendations into tangible improvements in the lives of incarcerated populations.

11.2 Risk Analysis and Mitigation

The plan acknowledges the risks that could hinder its success. A lack of political will may delay reforms; this can be mitigated through sustained advocacy by civil society and the media. Insufficient funding remains a major risk, which requires diversification of financing sources, including donor support and innovative schemes such as inmate health insurance Resistance from correctional staff to new policies may occur but can be addressed through change management strategies, incentives, and continuous engagement. Delays in supply chains may disrupt access to medicines, and this risk can be mitigated by developing pooled procurement systems and partnerships with the private sector. Finally, stigma and public apathy towards inmate healthcare can undermine reforms, which highlights the importance of a strong communication and advocacy campaign.

11.3 Change management and capacity-building plan

Transforming healthcare delivery in Nigerian correctional centers requires a structured change management and capacity-building approach. Reform efforts must address both systemic resistance and skill gaps among correctional staff and health workers. Policy Priorities:

Policy Priorities:

- **Leadership Buy-In:** Engage senior officials of the Nigerian Correctional Service, Federal Ministry of Interior, and Ministry of Health to champion healthcare reforms and model accountability.
- **Capacity Building of Health Personnel:** Develop and implement continuous professional development programs for prison healthcare workers in line with national clinical guidelines, with a focus on infectious diseases, mental health, and gender-sensitive care.
- **Training of Non-Health Correctional Staff:** Provide training for prison officers on basic health literacy, hygiene promotion, and referral protocols to ensure cross-functional support for healthcare delivery.
- **Change Management Framework:** Apply structured change models (e.g., Kotter's 8-Step Framework) to introduce reforms gradually, communicate vision, and institutionalize new practices.
- **Institutional Partnerships:** Leverage collaborations with teaching hospitals, NGOs, and donor agencies to provide technical assistance, mentorship, and specialized training modules.
- **Sustainability:** Institutionalize training curricula within the Nigerian Correctional Service Academy and align career progression with healthcare-related competencies to embed reforms into long-term structures.

International Best Practices to Guide Reform:

- **South Africa:** The Department of Correctional Services integrates prison healthcare into the national health system, ensuring access to district hospitals and specialist referrals for inmates. This model shows how Nigeria can strengthen linkages between prison clinics and state health facilities.
- **United Kingdom:** The UK's National Health Service (NHS) is fully responsible for prison healthcare, which ensures parity of care between inmates and the general population. Adapting elements of this model could help Nigeria close health inequity gaps.
- **World Health Organization (WHO) Guidelines:** WHO advocates that prison health services be integrated into national health systems, emphasizing continuity of care, strong monitoring, and investment in mental health. These guidelines provide a framework Nigeria can adopt to align reforms with global standards.
- **Uganda:** Piloted peer-led health education programs in correctional facilities, where trained inmates support awareness and compliance with health protocols. This low-cost

model can complement staff training in Nigeria and strengthen inmate engagement.

- By combining structured change management with lessons from international best practices, Nigeria can create a correctional healthcare system that is resilient, rights-based, and sustainable ultimately ensuring that incarcerated individuals receive care comparable to the general population.

11.4 Communication and Advocacy Plan

Effective communication and advocacy are essential to ensure that the policy on inmates' healthcare in Nigerian correctional centers is understood, accepted, and implemented by all relevant stakeholders. This plan outlines the strategies and mechanisms for creating awareness, driving stakeholder engagement, and influencing policy adoption while fostering accountability and sustainability.

11.5.1 Objectives

The objectives of the communication and advocacy plan are to:

1. Raise awareness among stakeholders on the importance of quality healthcare for inmates.
2. Promote buy-in from policymakers, correctional authorities, healthcare providers, and the public.
3. Mobilize partnerships and resources to support policy implementation.
4. Enhance transparency and accountability through continuous updates and stakeholder feedback.
5. Influence institutional reforms and advocate for sustainable financing of inmate healthcare.

11.5.2 Target Audiences

Primary stakeholders: Nigerian Correctional Service (NCoS), Federal Ministry of Interior (FMoI), Federal Ministry of Health (FMoH), National Human Rights Commission (NHRC), and the National Assembly.

Secondary stakeholders: Civil society organizations, development partners (e.g., WHO, UNODC, UNICEF), media, community leaders, and families of inmates.

11.5.3 Strategies

The plan adopts a multi-channel approach:

Policy Advocacy: Organize stakeholder dialogues, legislative briefings, and roundtable discussions. Share evidence-based policy briefs and data-driven reports.

Public Engagement: Launch awareness campaigns through traditional and digital media. Use storytelling, infographics, and testimonials to humanize inmate healthcare needs Partnerships and Collaboration: Engage civil society, NGOs, and donor agencies to amplify visibility and secure funding.Work with international bodies like WHO and UNODC for technical support.

11.5.4 Monitoring and Timeline

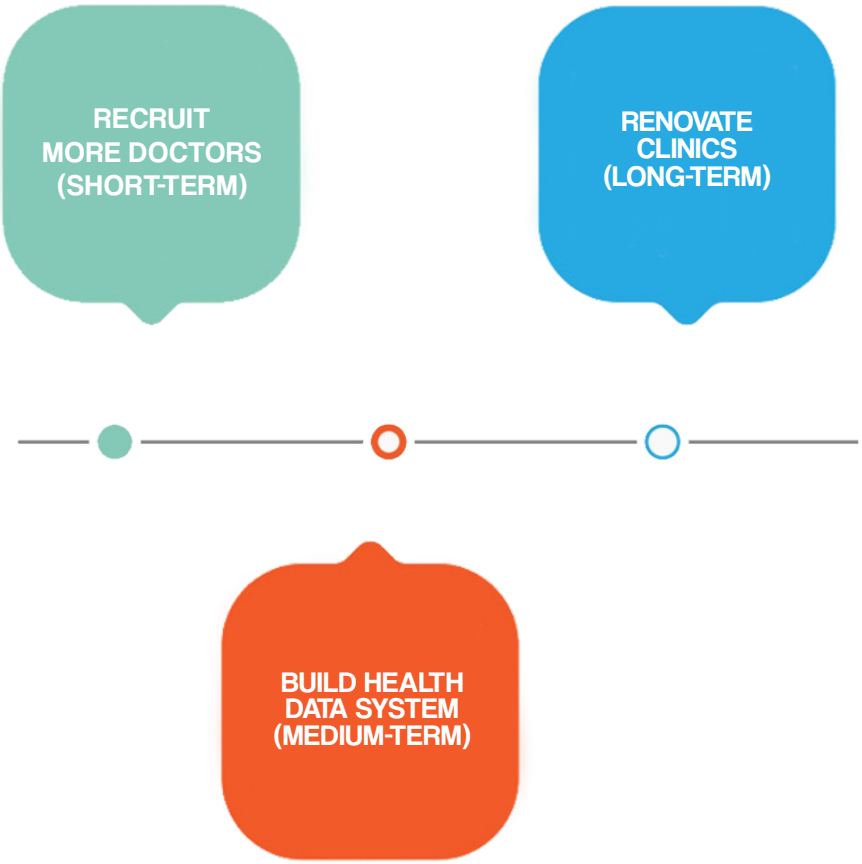
Monitoring: Track engagement levels, policy mentions in the media, stakeholder participation, and funding commitments.

Timeline:

Short-term (1–2 years): Policy launch campaigns and stakeholder sensitization.
Medium-term (3–5 years): Community dialogues, digital advocacy, and donor engagement.

Long-term (5–10 years): Policy sustainability campaigns and periodic progress reviews.

Figure 16: Implementation Roadmap



SECTION 12:

CONCLUSION

12.1 Commitment Required and Next Steps

Improving healthcare in Nigeria's correctional centres requires sustained political will, inter-agency collaboration, and resource allocation. While the gaps identified in this document are significant, they are not insurmountable if government institutions, civil society, and development partners commit to coordinated action.

First, the Federal Ministry of Interior in partnership with the Nigerian Correctional Service (NCoS) must prioritize healthcare financing within correctional centres, ensuring that annual budgets allocate specific, trackable resources for medical facilities, personnel, and essential drugs.

Secondly, there is need for inter-ministerial collaboration, particularly with the Federal Ministry of Health, the National Agency for Food and Drug Administration and Control (NAFDAC), the National Primary Health Care Development Agency (NPHCDA), and state-level health authorities to align correctional healthcare with national health policies and public health standards.

Furthermore, correctional health reforms should be embedded into ongoing judicial and criminal justice reforms to reduce congestion, thereby lowering the strain on existing health services within facilities. Partnerships with civil society and faith-based organizations can also strengthen community-based healthcare referrals and psychosocial support for inmates.

The next steps must therefore include:

- Development of an implementation roadmap with clear timelines and responsibilities for government MDAs.
- Establishing data-driven monitoring systems to track inmates' health outcomes and service delivery.
- Training and capacity-building for correctional healthcare staff.
- Strengthening referral systems to public hospitals for specialized care.
- Instituting independent oversight mechanisms to ensure accountability.

Only through deliberate commitment at all levels can the right to health of inmates, as guaranteed under the Nigerian Constitution and international human rights frameworks, be realized.

12.2 Call to Action

The state of healthcare in Nigeria's correctional centres is both a human rights imperative and a public health priority. Neglecting inmates' health undermines not only their dignity but also the health and safety of the wider society, as correctional facilities are not isolated from communities.

We therefore call upon:

- The Federal and State Governments to urgently allocate adequate funding and integrate correctional healthcare into the national health system.
- The Nigerian Correctional Service to enforce internal reforms that prioritize healthcare delivery and accountability.
- The Federal Ministry of Health and allied agencies to extend essential services, disease surveillance, and preventive care to correctional facilities.
- The National Assembly and State Houses of Assembly to provide legislative backing that guarantees sustainable health financing and oversight within correctional centres.
- Civil society, media, and development partners to maintain advocacy pressure and provide technical support for implementation.

Healthcare behind bars must no longer be treated as an afterthought. Every inmate is entitled to the right to life, dignity, and health. The time to act is now. Commitment without delay will determine whether Nigeria's correctional centres become spaces of true rehabilitation or continue to perpetuate cycles of neglect and ill health.

Figure 17: An Infographics on WHO MUST ACT

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