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LEVEL OF COMPLIANCE TO THE UNITED NATIONS MINIMUM STANDARDS (NELSON MANDELA RULES, 2015) ON HEALTHCARE NEEDS AND TREATMENT OF OFFENDERS IN KANO CENTRAL AND GORON-DUTSE PRISONS OF KANO STATE, NORTHWESTERN NIGERI

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Abstract
Prison health is an integral part of public health concern. In this regard, addressing healthcare in prisons is central to any public health framework geared towards promoting health care. In view of the great variety of legal, social, economic and geographical conditions of the world, the United Nations developed the Minimum Standard Rules for the Treatment of Offenders in 1955 which is now revised in the year 2015 and named after Nelson Mandela. They represent, as a whole, the minimum conditions which are accepted as suitable by the United Nations. This study examined the state of compliance to the Health provisionsof the Minimum Standards in Kano Central and GoronDutse Prisons. It utilized both quantitative and qualitative methods in collecting data from convicted prisoners and awaiting trial inmates and healthcare officials in the prisons. A total of 350 inmates were proportionately selected across convicts and awaiting trial inmates using Stratified Sampling technique as suggested by Wiseman's 1999 table of sample size. Two
(2) other respondents (healthcare officials) were purposively selected for interviews. The study revealed some shortfalls especially in the area of assessing prisoner's health condition and associated risks before admission into the prison.

Key words: Prison, Rules, Health, Inmates, Compliance

Introduction

The health condition of prisoners is a complex issue of utmost relevance especially considering the poor condition of prisons in Nigeria and elsewhere. A review of epidemiological assessments demonstrates that many diseases, illnesses and long-term conditions are over-represented in the prison population showing that this group faces a myriad of health challenges. Thus, the prison setting is one of the most challenging for health care, health protection and the problem related to theprevention of spread of diseases, particularly HIV/AIDS, sexually transmitted infections (STIs) and other diseases such as Tuberculosis (TB) and Malaria.

The need to enjoy the highest and attainable standard of physical, social and mental health is a fundamental right of every human being which the World Health Organization has echoed since its inception. In line with this call, the United Nations in its global bid to ensure and promote humane and positive treatment of all human beings especially those in detention (prisoners), created and adopted several International Standards of practice to guarantee and protect human rights. The UN Minimum Standard Rules for the Treatment of Offenders (Nelson Mandela Rules, 2015) is an integral part of these standards.

The Nelson Mandela Rules for the Treatment of Offenders (2015) has clearly stated that; at every institution there shall be available the services of at least one qualified medical officerwho should have some knowledge of psychiatry. The medical services should be organized in closerelationship to the general health administration of the community or nation. They shall include apsychiatric service for the diagnosis and, in proper cases, the treatment of states of mentalabnormality. More so, in relation to healthcare in prisons, section 48 of the Nigerian Prisons Standing Order (2011) also stated that; each prisoner shall be seen by the medical officer in-charge upon arrival in prison, the aim of which is to conduct a thorough assessment to ascertain the state of the prisoner's health for immediate and subsequent action when the need arise. Prisoners around the world constitute one of the most marginalized and vulnerable populations (Penal Reform International, 2017). People who spend time in prison will usually return to the wider community and their health care needs both inside and outside of prison is an important issue worthy of consideration, as is the provision of adequate healthcare to meet these needs.

In line with the positions above, compliance to International Standards such as the Nelson Mandela Rules in prisons, points to the extent to which healthcare is adequately provided to those behind the bars. This position therefore, informed the direction of this study to assess the level of compliance to the provisions of the Minimum Standard Rules for the treatment of offenders (prisoners) especially as it concerns healthcare in Kano Central and GoronDutse prisons.

Statement of the Problem

Since the UN Rules for the Treatment of Offenders was adopted in 1955, approved by the resolution of the UN Economic and Social Council in 1957 and 1977 as well as its subsequent review and acceptance in 2015, there has been greater understanding of the pathways of offenders, the impact of their imprisonment, and the need for specific approaches to accommodate their needs especially those around healthcare. Yet the prison population continues to rise in all continents. Globally, estimates shows that there were over 20 million prisoners living in prisons around the world, either in pre-trial detention or having been convicted and sentenced.

People in prison frequently have complex health needs. There are high rates of premature mortality and mental health illness, as well as disease resulting from unhygienic prison conditions. The rates for HIV, tuberculosis and other infectious diseases among prisoners remain much higher. The Joint United Nations Programme on HIV/AIDS estimates that people in prison are on average five times more likely to be living with HIV compared with adults outside prisons (UNAIDS, 2017), although a higher estimate of 15 per cent is given by the World Health Organization (WHO, 2017).

A shortage of qualified healthcare staff continues to act as a barrier to health provision in prisons around the world, especially in Africa. In Uganda for instance, only 56 of 448 prison units across the country have provision for health clinics. Similarly, in Bangladesh, there are 63 jails without doctors. In Scotland, a government report found that prisoners were not receiving the healthcare they needed because there was not enough prison staff to transfer them to health centres (WHO, 2017).

The United Nations Minimum Standard Rules for the Treatment of Offenders has identified prisoners as a key population with higher needs for responses to epidemics, treatment provision and prevention measures in prisons which studies have reported to be non-existent in some prisons, and remain wholly inadequate in many others (Obioha, 2011; Ibikunle, 2014). In line with these, this study attempts to provide answers to the following questions;

1) Whether respondents (prison inmates) were medically assessed upon arrival in prison?
2) What is the respondents' medically history upon arrival in prison?
3) What medical conditions were the respondents tested for?

Objectives of the Study

The broad objective of this study is to examine the level of compliance to the Minimum Standard Rules for the Treatment of Offenders in Kano Central and GoronDutse prisons. However, the specific objectives are;

1) To determine whether respondents were medically assessed upon arrival in prison.
2) To ascertain the respondents' medical history upon arrival in prison.

3) To identify medical conditions for which the respondents were tested.

Study Hypothesis

The understated hypothesis was formulated to guide the study;

Ho: The medical history of an inmate does not affect medical condition of the inmate in prison

Review of Related Literature

Clarification of the Concept of Health Various conceptions of health have been advanced after Hippocrates. Popular among these definitions is that put forth by the WHO (1948) that "health is a complete state of physical, mental and social wellbeing, not merely the absence of disease or infirmity". This definition according to Jimoh and Razum (2014) is wholistic and covers the major components of health. These for them include;

- The ***physical*** component which is used to refer to the soundness of the body which is the most important determinant of health. Thus, health entails in the orderliness of the individual's biological components which is largely determined by laboratory and clinical examinations.
- The ***social*** component represents the behavioural aspect of human health. In this regard, health entails in establishing a network of social interaction and the ability to meet up with the demands of social roles and expectations. Impliedly, inactivity in the social network represents a form of pathology.
- The ***mental*** component takes account of the psychological and emotional status of an individual, the maladjustment of which constitutes an infraction in health or the manifestation of illness. This implies that an individual's inability to comprehend, manage and make meaning of any situation indicates a poor health status.

The prison population is increasing and the health problems of prisoners are considerable. Prison is designed for punishment, correction and rehabilitation to the community in mind and these goals may conflict with the aims of health care. Thus, the need for an all-round concern on the physical, social and mental wellbeing of the prisoners is one that cannot be relegated. This informed the review of the Minimum Standard Rules to provide for pressing challenges in prisons, one of which is healthcare among other pressing challenges.

The Prison and Its Purpose

There is no society without a prison system and prisons have existed in different civilizations in ancient times. It included short-term detention facilities for the confinement of persons awaiting trial, sentencing, execution, deportation (transportation to other countries as punishment) whipping or some other form of corporal punishment (Reid, 2012). In other words, prison has several purposes among which are separation from society and confinement for the safety of society, punishment for crime, correction and rehabilitation for reintegration into the community.

World over, prisons exist to enforce societal stipulated rules and regulations, maintain the safety of the general population, provide punishment to offenders in consonance with their offences as provided by the law, and most importantly rehabilitate prisoners. While the aim of prison systems around the world is relatively similar, the structures and organization of prisons systems around the world differ in many ways (Mukiza, 2014).

The Nelson Mandela Rules

The Standard Minimum Rules for the Treatment of Prisoners have without a doubt constituted the universally acknowledged minimum standards for the administration and management of prison life and the treatment of prisoners, and have been of tremendous value and influence in the development of prison laws, policies and practices in Member States all over the world (United Nations, 2015). Following an extensive inter-governmental review process initiated to reflect advances in international law and correctional science, the General Assembly adopted, in 2015,a revised set of the rules as the United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules). An updated standard for prison management in the modern times, the rules were reviewed and named as the Nelson Mandela Rules in order to honour the progressive legacy of the late President of South Africa, Nelson Mandela, who spent 27 years in prison as a result of his struggle for human rights, democracy and the promotion of a culture of peace.

According to the United Nations Office on Drugs and Crime (2017), the provision of health care in prisons is a crucial element of prison management for various reasons. First of all, the right to the highest attainable standard of physical and mental health, as embodied in the Covenant on Economic, Social and Cultural Rights, applies to everybody. Secondly, the general health profile of prisoners tends to be comparatively lower than in the community, and there is a higher prevalence of mental illness, substance misuse and infectious diseases, such as HIV, tuberculosis and hepatitis among prisoners. Thirdly, a neglect to address health issues in prisons may result in the transfer of prison health problems into the wider community, just as community health problems can enter prisons. In that context it has been acknowledged that the lack of adequate health-care services in prisons not only significantly hinders the social reintegration of prisoners, but also risks leading to the spread of transmissible and life-threatening diseases in prisons and the community. This informs the provision of Rule 24(1) in the Minimum Standard which stated that;

> The provision of health care for prisoners is a State responsibility. Prisoners should enjoy the same standards of health care that are available in the community, and should have access to necessary health-care services free of charge without discrimination on the grounds of their legal status.(Rule 24:1).

Implicit in the provision above is that, states have a responsibility to provide and ensure that healthcare professionals positively impact the quality of life in prisons, protect or improve prisoners' physical and mental health by paying particular attention to prisoners with special health-care needs as a way of contributing and promoting their prospects for a successful reformation, rehabilitation and social reintegration. Thus, in providing medical care, the state through the prison administration is expected to provide those services that are commensurate with what the general public is entitled to. In line with this, Bloom (2008) observed that the tenets of health rights services to be granted to inmates is defined by the extent to which the government and prison authorities are able to provide within prisons those health services normally provided to the general populace.

Level of Compliance to International Standards on Prison Healthcare Delivery

Much analysis has been done to understand the extent to which the above conditions are being met by the prison administrations in most countries around the world. In his study on human rights and prison management Coyle (2012) observed that most prisons are incapable to deliver essential health services to inmates. He further argued that in a number of cases funding to prisons service is often inadequate and of course quite stands low in the many priorities amongst government development projects. The study concluded that no serious healthcare provision to inmates has ever been achieved in prisons whether in developed or developing nations.

Coyle's position above was corroborated by Nigel (2007), who identified various prisons in America, Haiti, Russia and Africa, and in Nigeria, where there have been poor responses to inmates health needs. However, in a similar study conducted in the Netherlands by Karo(2007), it was reported that prison reforms through increased public funding, partnerships and use of community service have contributed significantly towards the delivery of health services to inmates. These is evident in clean accommodation wards, low level of disease incidence amongst inmates and, fewer cases of health complaints and low incidences of prisoners' mortality.

In countries where prison healthcare have fully been implemented such as Japan, the Netherlands and in Canada, health infrastructures available in prison quite correspond to those being provided to the general public, (Bloom, 2008). This trend is slowly being witnessed in Africa as admitted by Makubetse (2008) who observed that some African countries such as South Africa, Malawi and Kenya have comprehensive HIV/AIDS control units and extensive collaboration with NGOs in the delivery of health services. Whether the efforts have culminated into improved health of inmates remains a matter of extensive academic studies.

Some studies have confirmed the vulnerability of prisoners with mental health problems becoming problematic to correctional staff and other prisoners than prisoners without mental health problems (Hilton and Simmons, 2007). Such empirical studies are still

lacking in the Nigerian context. Studies on mental health issues in Nigerian prisons have become crucial in providing empirical evidence on which prisons reform could be achieved. An appraisal of the mental health policy in Nigeria by Odebiyi (2009) revealed a general poor social attitude from the government and other stakeholders towards the mentally ill. As mentioned earlier, those in prisons are worse off as they are left out of the policy. The policy has not addressed the challenges of caring for the mentally ill in the populace and that of prisoners who are worse off.

Theoretical Framework

This study is anchored on Talcott Parsons model of functional prerequisites otherwise referred to as the AGIL scheme. Talcott Parsons, an influential American sociologist lived between 1902 and 1979. Parsons was said to be largely influenced by Bronislaw Malinowski, Emile Durkheim, Max Weber among others. His functionalist orientation especially in his second intellectual phase (1937-1950), when he published one of his classics; *Social System*, was an attempt to resolve the theoretical anomalies he had posed earlier (Appelrouth & Edles, 2007). Like many other systems, Parsons argued that, social systems are characterized too by needs or what he regarded as 'functional prerequisites'. This refers tothe extent to which people's relations to others are embedded in and constrained by social subsystems. Social systems can only exist, in fact, if four functional prerequisites are met. These are; Adaptation (that is, to the external or natural environment), Goal Attainment (or the mobilization o fresources to meet relevant ends), Integration (or the achievement of regulation and coordination for coherence and stability) and Latency or Pattern Maintenance (or the provision of means to sustain the motivational energy of actors) (Baert, 1998). Parsons refers to this as the *AGIL*-scheme.

The AGIL scheme as introduced by Parsons, is a central element in his own theoretical agenda. He maintained that there are four basic problems that a society, group or individual must confront in order to survive as a system (Parsons, 1971:4). For Parsons, these four functional prerequisites or imperatives are evident at every level of every system. The prison as a system and a focal point of concern in this study forms an integral part of this concern.

Specifically, adaptation (A) refers to responses to the physical environment. At the level of the social system, the economy provides for the fulfillment of adaptation need or requirement. In other words, the economy is the subsystem that adapts to the environment for social purposes (provision of goods and services). Relating this to the prison, the prison management or authority through the state, has the responsibility of providing for all that is needed for a purposeful life for those incarcerated within the prison walls. Central to this provision is the important issue of the highest attainable and all-encompassing system of healthcare delivery to all inmates in the prison.

Secondly, Goal attainment (G), refers to the problem of resolving the discrepancies between "the inertial tendencies of the system and its needs resulting from interchange with the situation" (Parsons, 1961) in (Appelrouth & Edles, 2007). At the level of the social system of which a prison is a typical example, the problem of goal attainment is typically met by the polity, as it is the agency in which goals and resources are prioritized and discrepancies are resolved. Central to this concern is the government which establishes status and reward system so that social goals can be achieved. In this regard therefore, as a social system, the prison is established for the sole aim of providing an enabling environment for the reformation and rehabilitation of those who were found to have transgressed upon the societal laws. The success of this is dependent upon several factors; one of which is the provision of healthcare delivery system to accommodate the health needs of the inmates.

Integration (I) on the other hand refers to the coordination of a system's or subsystem's constituent parts, since "all social systems are differentiated and segmented into relatively independent units" (Parsons, 1961). Integration involves solidarity, which is the feeling of inclusiveness in a social group as distinct roles are carried out. This largely depends on interaction and the norms that guide interaction. Thus, in this direction therefore, integration or inclusiveness in relation to healthcare delivery in prisons entails in a close-knit relationship between the prison administration, external agencies and the inmates especially as it concerns the healthcare needs of the inmates.

The final lap in Parsons's functional imperative is latency/pattern maintenance (L). This refers to "the imperative of maintaining stability of the patterns of institutional culture" (Parsons, 1961). Essentially, in the maintenance of pattern for survival, a system must furnish, and renew both the motivation of individuals and the cultural patterns that create and sustain that motivation. In this regard therefore, maintaining a pattern of healthcare delivery in prisons requires that all stakeholders in prison healthcare delivery stick to the provisions contained in standards for healthcare delivery such as those in the (Nelson Mandela Rules 2015).

Materials and Methods

Data was obtained from primary and secondary sources. The primary sources of data are the key respondents from a selection of inmates who are the direct beneficiaries of health services in the prisons and healthcare officials in the prisons. Secondary sources of information for this study were obtained from stored information at various resource outlets (published and unpublished dissertations, online journal articles and textbooks) in the form of documents. A total of 355 respondents were sampled for this study. Thus, the following are the breakdown of the size of the respondents;

Category of Respondents	**Size**
Inmates	350
Prison Health Workers	2
Total	**352**

The sample size above was derived using a revised Wiseman (1999) table of sample size which suggested that in a population of 3000-3499, the sample size should be 341. More so, the study employed stratified sampling technique in drawing respondents among the inmates, where the researcher identified the strata of interest (convicted and awaiting trial inmates). Given the size of the inmates from the two prisons as at the time of data collection which was 3,172 inmates put together, the respondents were proportionately selected from the two prisons as follows;

P = Population of the study, P1 = Population of first prison, P2 = Population of second prison. Thus, P = P1 + P2 (1732 + 1440 = 3,172). Therefore, the required percentage of respondents from Kano Central prison were computed as follows; 1732 × 100/3172 = 55% and the required percentage of respondents from GoronDutse prison were computed as follows; 1440 × 100/3172 = 45%. Therefore, selecting the respondents on proportionate grounding as a result of disparity in the number of inmates in the two prisons under study, 55% (194) of the respondents were drawn from Kano Central prison while 45% (156) other respondents were drawn from GoronDutse. More so, the selection of the elements was done with the help of some prison staff.

Research Findings/Results

Table1: The Age Distribution of the Respondents

Age	**Frequency**	**Percentage**
17 - 26 years	100	28.6
27 - 36 years	138	39.4
37 - 46 years	92	26.3
57 and above	20	5.7
Total	**350**	**100.0**

Table 1 above shows the distribution of respondents by age. The age category with the highest respondents is 27-36 (39.4 percent), and over 28 percent are within the age of 17-26. Also, over 26 percent are within the age of 37-46; up to 5.7 percent of were found to be 57 years old and above. This shows that youth constitute a significant majority of those incarcerated.

Tabled 2: The Sex Distribution of the Respondents

Sex	Frequency	Percentage
Male	301	86
Female	49	16
Total	**350**	**100.0**

Table 2 above shows the distribution of respondents by sex. It reveals that an overwhelming majority (86%) were males, while only 16 percent were females. Impliedly, male prisoners formed an integral part of the prison population. This disparity was a function of the fluctuating nature of the prison population, especially among female inmates.

Table 3: The Distribution of the Respondents by Ethnic Affiliation

Ethnic Affiliation	Frequency	Percentage
Hausa/Fulani	212	60.6
Igbo	20	5.7
Yoruba	79	22.6
Others	39	11.1
Total	**350**	**100.0**

Table 3 above shows the distribution of the respondents by ethnic affiliation. Majority (60.6 percent) were of Hausa/Fulani extraction, 22.6 percent are of Yoruba origin, 5.7 percent Igbos and 11.1 percent from other minority tribes.

Table 4: The Distribution of the Respondents by Religious Affiliation

Religious Affiliation	Frequency	Percentage
Islam	278	79.4
Christianity	72	20.6
Total	**350**	**100**

Table 4 above indicates that 79.4 percent of the respondents are Muslims and 20.6 percent Christians. This disparity is informed by the fact that the location of the two prisons under study is predominantly inhabited by the Muslim faithful though with a few Christians

Table 5: The Respondents Highest Level of Education

Educational Attainment	Frequency	Percentage
Qur'anic	20	5.7
Primary Complete	50	14.3
Secondary Incomplete	89	25.4
Secondary Complete	112	32.0
Tertiary	79	22.6
Total	**350**	**100.0**

Table 5 above shows the distribution of the respondents by the highest level of education attained. It shows that 32% had a complete secondary school education. Over 25 had incomplete secondary education, 22.6 percent reported having up to tertiary level of education, while 14.3 percent reported having a complete primary education. However, 5.7 percent of the respondents had only Qur'anic Education. In other words, they lacked formal western education. Implicit in the responses above is that a significant number of them were literate.

Table 6: The Respondents' Occupation Prior to Imprisonment

Occupation prior to incarceration	Frequency	Percentage (%)
Farming	90	25.7
Civil servant	39	11.1
Artisanship	58	16.6
Trading	143	40.9
Schooling	20	5.7
Total	**350**	**100.0**

Table 6 above shows the distribution of the respondents by their various occupations prior to incarceration. It indicates that majority (40.9 percent) were involved in various trading activities. Over 25 percent were involved in farming, 16.6 percent were artisans prior to imprisonment and 11.1 percent civil servants, while a few (5.7 percent) were students in different institutions of learning prior to their imprisonment. Implicit in the findings above is that, even though nobody reported being unemployed prior to imprisonment, it is obvious that majority had no formal jobs prior to their incarceration but were involved in various economically productive activities to earn a living.

Table 7: The Distribution of the Respondents by Prison Status

Imprisonment Status	Frequency	Percentage
Awaiting Trial Inmate	239	68.3
Convicted	111	31.7
Total	**350**	**100.0**

Table 7 presents the imprisonment status of the respondents. It shows that a significant majority (68.3 percent) were awaiting trial while 31.7 percent were convicts. Impliedly, majority are awaiting trial inmates.

Table 8: The Time Spent in Prison by the Respondents

Time spent in prison	Frequency	Percentage
> 1month	29	8.3
< 3months	88	25.1
< 6months	51	14.6
1 year and above	151	43.1
No response	31	8.9
Total	**350**	**100.0**

Table 8 above presents the time spent in prison by the inmates. It shows that 43.1 percent have spent one year and above in the prison, 25.1 percent less than 3 months in the prison and 14.6 percent reported being in the prison for less than 6 months. However, 8.9 percent could not account for the time they have spent while 8.3 percent reported to have spent less than a month. Impliedly, majority could be seen to have spent one year and above, hence their knowledge of healthcare situation in the prisons.

Table 9: Distribution of Prisons by the Number of Sampled Respondents

Prisons	Frequency	Percentage
Kano Central Prison	194	55
GoronDutse	156	45
Total	**350**	**100.0**

Table 9 above indicates the distribution of the study population as proportionately sampled from the two prisons. The disparity in the sample is informed by the differences in the number of inmates in each of the two prisons. It shows that the majority of the study population 55.4 percent were sampled from Kano central prison while 44.6 percent other respondents were drawn from Goron-Dutse prison. Impliedly, Kano central prison has higher concentration of inmates compared to Goron-Dutse prison as at the time of data collection.

Table 10: Distribution of Respondents by Prison Status

Imprisonment Status	Frequency	Percentage
Awaiting Trial Inmate	239	68.3
Convicted	111	31.7
Total	**350**	**100.0**

Table 10 above presents the imprisonment status of the respondents. It shows that a significant majority of the respondents 68.3 percent were awaiting trial inmates while 31.7 percent of the inmates were convicts. Impliedly, majority of the inmates in the prisons under study are awaiting trial inmates.

Table 11: Whether Respondents Were Medically Assessed on Arrival in Prison

Response	Frequency	Percentage
Yes	350	100.0
No	0	0
Total	**350**	**100.0**

Table 11 above presents the responses elicited on whether the respondents were medically assessed upon arrival in prison. It shows that all the respondents answered in affirmation that they were subjected to medical screening upon their arrival in prison. Impliedly, the health condition of inmates is given attention as part of their admission process.

In the in-depth interview conducted with a respondent in Kano Central prison, he stated that;

> Most people come to prison with healthcare concerns especially drugs and sex related offenders. It is however part of the many requirements for admission into prison to have them undergo series of medical test to ascertain their real health status or condition especially as it concerns infectious and contagious diseases that can easily be transmitted in a crowded place like the prison. (IDI: Prison Health Official).

Another respondent in GoronDutse prison stated that;

> It is a requirement that prisoners must undergo medical screening before being formally admitted into the prison. The essence of this is to ascertain their health condition in order to place them under appropriate treatment. This is usually conducted on all prisoners. (IDI: Prison Health Official).

Table 12: Respondents Medical History on Arrival in Prison

Medical history on arrival in prison	Frequency	Percentage
Medically fit	281	80.3
Medically unfit	69	19.7
Total	**350**	**100.0**

Table 12 above shows the distribution of responses elicited on the medical history of the respondents upon arrival in prison. It shows that a significant majority of the respondents, over 80 percent reported being medically fit upon their arrival in prison while 19.7 percent other respondents reported being medically unfit upon their arrival in prison. The reasons why some were medically unfit are presented in table 13.

Table 13: The Nature of Respondents Medical Condition on Arrival in Prison

Medical Condition	Frequency	Percentage
Cough	19	27.5
Malaria Fever	21	30.4
Scabies	9	13.0
Typhoid fever	20	29.1
Total	**69**	**100**

Table 13 above, shows the distribution of the responses of those who reported being medically unfit upon their arrival in prison. It shows that 30.4 percent of the respondents reported having malaria fever upon arrival in prison, 29.1 percent of the respondents reported having typhoid fever, and 27.5 percent of the respondents reported having cough

while 13.0 percent other respondents reported suffering from scabies upon their arrival in prison.

Table 14: Medical Conditions for Which Respondents Were Tested

Healthcare Services		Frequency	Percentage
Mental Health Assessment	Yes	90	25.7
	No	260	74.3
	Total	**350**	**100.0**
Dental Health Assessment	Yes	192	54.9
	No	158	45.1
	Total	**350**	**100.0**
Self-harm Assessment	Yes	20	5.7
	No	330	94.3
	Total	**350**	**100.0**
Blood Test	Yes	209	59.7
	No	141	40.3
	Total	**350**	**100.0**
Eye Test	Yes	216	61.7
	No	134	38.3
	Total	**350**	**100.0**
Hearing Test	Yes	127	36.3
	No	223	63.7
	Total	**350**	**100.0**
Stool/Sputum Test	Yes	141	40.3
	No	209	59.7
	Total	**350**	**100.0**
Suicide Risk	No	350	100.0
	Total	**350**	**100.0**
Infectious Diseases Test	Yes	141	40.3
	No	209	59.7
	Total	**350**	**100.0**
Drug Dependence Test	Yes	39	11.1
	No	311	88.9
	Total	**350**	**100.0**

Table 14 above shows the distribution of the various medical conditions for which the inmates were tested upon their arrival in prison as part of the operational guidelines for healthcare delivery in prisons. It shows that about 25.7 percent of the respondents reported to have been mentally assessed while 74.3 percent of the respondents were not assessed as such, over 54 percent of the respondents were rendered dental health assessment while 45.1 percent other respondents were not examined for dental health. Few respondents, about 5.7 percent reported being assessed for self-harm tendencies while majority of the respondents, 94.3 percent reported not receiving any form of assessment related to self-harm tendencies and 59.7 percent of the respondents reported that their blood sample was tested while 40.3 percent of the respondents were not tested as such.

Further to above, over 61 percent of the respondents reported being examined for eye defects while 38.3 percent of the respondents reported that they were not examined for eye defects. More so, 36.3 percent of the respondents reported been assessed for hearing defects while 63.7 percent of the respondents were not assessed as such, and 40.3 percent of the respondents had their stool/sputum tested while 59.7 percent of the respondents reported not having any medical test associated with stool/sputum. Meanwhile, none of the respondents reported been assessed for suicide risk. However, where 40.3 percent of the respondents reported being tested for infectious, 59.7 percent other respondents were not tested as such and majority of the respondents 88.9 percent reported not being tested for drug dependence while few other respondents, 11.1 percent reported being tested for drug dependence upon arrival in prison.

Implicit in the responses above is that, there seems to be some level of adherence to operational standards of healthcare delivery. However, critical issues associated with healthcare in prison are no doubt accorded little or no attention especially as it finds expression in lack of thorough assessment of inmates concerning drug dependence, self-harm tendencies and suicide risk all of which no doubt should have form an important component of healthcare delivery in prison.

From the inference above, it can be seen that there were critical healthcare issues that seems to be accorded little consideration, signifying a shortfall in compliance to prison healthcare standard and has a serious implication for an average prisoner and the prison community in general. For instance, it was found that mental health assessment was not given serious attention on admission of inmates into the prisons. Therefore, the lack of credible mental health assessment and care can amplify the condition of prisoners with mental health issues. Most obvious implication of this is that, such a trend may interfere with the transition from prison to home and equally impede an ex-prisoner's chances for successful re-integration into a social network and employment setting as the case may be.

On the issue of drug dependence test, like mental health assessment, this study revealed a serious deficit in its conduct which also portends a serious implication for the wellbeing of the inmates in the prison. This can have significant impact in amplifying the health-related and criminal impacts of dependent drug use, and can also negatively affect prison management as more prisoners are likely to be involved in continued drug use and dealing especially among inmates with history of drug abuse and dependence. Reducing the number of suicides in prisons is an international priority and many countries have policy provisions and guidelines for suicide prevention in custodial settings. This study however revealed that drug dependence test was not accorded serious priority in the prisons.

Nevertheless above, stool and sputum test which is key in revealing the presence of certain healthcare problems such as tuberculosis and other possible infections was not accorded a priority. This is evident in the responses flow as contained in the table above.

The respondents interviewed in Kano Central and Goron Dutse prisons shared similar responses on the kind(s) of medical screening conducted on inmates. They stated that;

> It is a requirement that upon arrival in prison, inmates should be thoroughly examined for medical defects. This cut across mental health, eye, hearing, infectious disease, drug dependence among others. However, emphasis is more on eye test, infectious diseases. More so, specific attention is given to HIV/AIDS, tuberculosis and hypertension. This is due to the persistent need for care and close watch on those suffering from these life threatening conditions (IDI: Prison Healthcare Officials).

Test of Hypothesis

The following hypothesis was formulated for the study and tested at level of $p<0.05$ significance;

Ho: There is no significant relationship between inmate's medical history and current medical condition of an inmate.

Table 15: Medical History * Illness in Prison

Medical History * Illness in Prison Cross Tabulation										
			Illness at prison							**Total**
			Malaria	Diarrhea	TB	Headache	High Blood Pressure	HIV/AIDS	Diabetes	
Medical History	Medically Fit	Count	75 (26.7%)	116 (41.3%)	35 (12.5%)	15 (5.3%)	14 (5.0%)	12 (4.3%)	14 (5.0%)	281 (100.0%)
	Medically Unfit	Count	6 (8.7%)	11 (15.9%)	6 (8.7%)	17 (24.6%)	11 (15.9%)	9 (13.0%)	9 (13.0%)	69 (100.0%)
Total		Count	81 (23.1%)	127 (36.3%)	41 (11.7%)	32 (9.1%)	25 (7.1%)	21 (6.0%)	23 (6.6%)	350 (100.0%)

Table of 15 above shows the cross tabulation of the medical history of the prisoners before going into prison and illness they had in the prison. From the table, 75(26.7%) were medically fit before imprisonment but end up having malaria in prison. Also, 116(41.3%)were medically fit before imprisonment but end up having diarrhea in prison, while, 35(12.5%)were medically fit before imprisonment but end up having tuberculosis in prison. In addition, 15(5.3%) were medically fit before imprisonment but end up having persistent headache in prison. Also, 14(5.0%)were medically fit before

imprisonment but end up having High Blood Pressure in prison while, 12(4.3%)were medically fit before imprisonment but end up having HIV/AIDS in prison as 14(5.0%)were medically fit before imprisonment but end up having Diabetes in prison.

Moreover, from the table, 6(8.7%) were not medically fit before imprisonment but end up having malaria in prison. Also, 11(15.9%) were not medically fit before imprisonment but end up having diarrhea in prison, while, 6(8.7%) were not medically fit before imprisonment but end up having tuberculosis in prison. In addition, 17(24.6%) were not medically fit before imprisonment but end up having persistent headache in prison. Also, 11(15.9%)were not medically fit before imprisonment but end up having High Blood Pressure in prison while, 9(13.0%)were not medically fit before imprisonment but end up having HIV/AIDS in prison as 9(13.0%)were not medically fit before imprisonment but end up having Diabetes in prison.

Table 16: Chi-Square Tests

	Value	Df	Asymp. Sig. (2-sided)
Pearson Chi-Square	62.691[a]	6	.000
Likelihood Ratio	57.736	6	.000
Linear-by-Linear Association	44.322	1	.000
N of Valid Cases	350		

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The table 16 above shows the chi-square test for the hypothesis stating that there is no significant relationship between inmate's medical history and current medical condition of an inmate. From the table above the Probability value of the chi-square test statistic is P=0.000, which is less than 0.05. Hence since the P-value is less than 0.05, hence the Null Hypothesis is hereby rejected and we conclude that there is a significant relationship between inmate's medical history and current medical condition of an inmate.

Discussion of Findings

Although the prison authorities in charge of healthcare reported doing everything possible to provide for the healthcare needs of inmates in the prisons, the findings however points to an ineffective healthcare delivery in the prisons. Impliedly, there are shortcomings in the way and manner healthcare is provided in Kano Central and Goron Dutse prison. This equates the findings of Lawal (2012) that specifically, in Kano Penal Institutions; there is unavailability of effective healthcare services. This also confirmed the position of Ekwurukwe (2005) who found that prison healthcare situations are characterized by lack of standard clinics and hospitals, lack of drugs and in most cases lack of unqualified medical personnel to provide for the healthcare needs of inmates.

Although, there is a little compliance to the provisions of the instruments guiding healthcare delivery in prisons, there is however a reflection of non-compliance especially as it concerns the absence of screening for critical healthcare issues such as hepatitis,

mental health, dental health, drug dependence and self-harm tendencies. In this regard, Obioha (2011) noted that healthcare delivery in Nigerian prisons fall short of UN standards for the treatment of prisoners, the worst conditions of which constitute ill-treatment. Hilton & Simmons (2010) also noted that given the non-compliance to best practices of healthcare delivery in Nigerian prisons especially as it concerns mental healthcare and other critical health issues, there is the plausibility of prisoners with mental health problems becoming problematic to correctional staff and other prisoners. However, this kind of state of being becomes even more essential when one finds him/herself in prison which is by its nature a closed community, thus making it a particularly risky environment as its very nature can aggravate the onset of such mental illness and health distress. Nevertheless, specifically on mental health, a balanced state of mental health is important in the life of every human being and is a good determinant of one's quality of life. Lack of mental health may result in chaos and disruption in the daily life course of not just the individual, but also for the running and sustenance of an entire community.

Thus, given the theoretical orientation adopted in this study; Talcott Parsons' (1902-1979) four (4) functional imperatives or the AGIL schema, namely; Adaptation, Goal-Attainment, Integration and Latency (Pattern Maintenance), it is imperative to state that, the structure of healthcare delivery in prison largely affects the experience of inmates and the attainment of the purpose of imprisonment. Thus, the survival of the inmate is largely an outgrowth of the functionality of prison health systems.

Conclusion

The main aim of imprisonment is to reform and rehabilitate offenders that are confined to the four walls of the prison. However, the provision of a comprehensive healthcare to the inmates in prison is beyond any reasonable doubt central to an effective reformation. This was clearly recommended in the UN Minimum Standard for the Treatment of Offenders as revised (2015). Accordingly, it is the conclusion of this study that; healthcare delivery in the prisons (Kano Central and Goron Dutse) is below the minimum standard, and do not augur well with the complex reformation needs of the inmates. In this regard, it is apparent that poor healthcare delivery in prisons can destroy the very essence for which an individual is sent to prison.

Recommendations Consequent upon findings and above conclusions, the following recommendations are offered;

1) The state should provide and ensure the utilization of requisite resources for promoting effective healthcare delivery as stated in the Nelson Mandela Rules 2015.
2) Further to above, prison administrators should institute a structure for periodic review of healthcare delivery processes in order to ensure compliance to the provisions of the Nelson Mandela Rules 2015.

3) The general welfare of prisoners should be seen as a national priority. In this regard therefore, the need for partnership withwell-meaning individuals, philanthropists, NGOs, corporate bodies and organizations in order to see to the promotion of health of inmates in prisons cannot be relegated.
4) Given the hypothesis tested and the result, there is the need to ensure routine check on inmates in the prisons in order to provide prompt medical assistance where and when required.

References

Appelrouth, S. Edles, L.D (2007). Classical and Contemporary Sociological Theory: Text and Readings, Sage Publications. North Miami Beach. Florida. USA

Baert, P. (1998). Social Theory in the Twentieth Century. New York University Press. Washington Square. New York

Bloom B.E. (2008). Addressing Mental Health of Needs of Women Offenders, American Psychological Association, New York

Coyle, A. (2012).A Human Right Approach to Prison Management, International Centre for Prison Studies, London.

Hilton N, Simmons J.L (2007). The Influence of Actuarial Risk Assessment in Clinical Judgments and Tribunal Decisions about Mentally Disordered Offenders in Maximum Security.*Journal of Law and Human Behaviour*.25:393-408.

Ibikunle, S. (2014). Challenges of Imprisonment in the Nigerian Penal System: The Way Forward. *American Journal of Humanities and Social sciences,* Vol.2:2, 94-104

Jimoh, A. Razum O. (2014). *Medical Sociology in Africa*. Springer Publisher

Karo O.J. (2007).*Criminology and Penal Corrections in Norway*. Oslo. Norway.

Nigel, R. (2007).*The Treatment of Prisoners under International Law*.Queenswich, London.

Obioha, E. E., (2011). Challenges and Reforms in the Nigerian Prisons System, *Department of Safety and Security Management*, Tshwane University of Technology, Pretoria, South Africa.

Odebiyi A (2009). Appraisal of the Mental Health Care Policy in Nigeria.Center for Policy Development.Ibadan.

Parsons, T. (1961).“An Outline of the Social System” in Theories of Society.Edited by Parsons et al. Free Press. New York

Parsons, T. (1971).Definition of Health and Illness in the Light of American Values and Social Structure, Free Press, New York.

Penal Reform International (2017).*Global Prison Trend*.United Nation Commission on Crime Prevention & Criminal Justice.www.penalreform.org/global-prison-trends-2017

United Nations Office on Drugs and Crime (2017).*Introductory Handbook on the Prevention of Recidivism and the Social Reintegration of Offenders*. Available at:http://www.unodc.org/documents/justice-and-prisonreform

United Nations. (2015).*Human Rights and Prisons*: A Compilation of International Human Rights Instruments Concerning the Administration of Justice. New York: UN Publication.

United Nations (2017).Assessing Compliance with the Nelson Mandela Rules (2015). Available at: http://www.unodc.org/documents

UNAIDS. (2017). *Update on HIV in Prisons and other Closed Settings*. UNAIDS/PCB (41)/17.

World Health Organization (1948).Preamble to the Constitution of the WHO. Geneva.