HEALTH WORKERS SERVICE DELIVERY AND WELLBEING OF INMATES IN ENUGU MAXIMUM CORRECTIONAL CENTER, ENUGU STATE, NIGERIA

BY

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DECLARATION

I, **AYUK, CLARA OBEN** with Registration Number SOC/Ph.D/17/026, hereby declare that this thesis on "**Health Workers Service Delivery and Wellbeing of inmates in Enugu Maximum Correctional Center, Enugu State, Nigeria**" is original and has been written by me. It is a record of my research work and has not b

DECLARATION

I, **AYUK, CLARA OBEN** with Registration Number SOC/Ph.D/17/026, hereby declare that this thesis on **"Health Workers Service Delivery and Wellbeing of inmates in Enugu Maximum Correctional Center, Enugu State, Nigeria"** is original and has been written by me. It is a record of my research work and has not been presented before in any previous publication.

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ABSTRACT

The study was carried out to examine Health Workers Service Delivery and Wellbeing of inmates in Enugu Maximum Correctional Center, Enugu State, Nigeria. Specifically, the study examine the extent to which health workers preventive services role, curative services, reformative and educational awareness role of health workers enhances the wellbeing of inmate in Enugu Maximum Correctional Center, Enugu State, Nigeria.. Literature was extensively reviewed on the four variables with the inequality theory of health care services utilization was employed to guide the study. The design employed was Ex post facto and survey design with the use of a questionnaire to elicit data from inmate respondents. A sample of 400 was drawn from a total of 2011 inmates, after field work, 382 instruments were retrieved and used for analysis. To test the study hypotheses, the Chi-square, Multiple linear regression and One Way Analysis of Variance statistical tools were employed to test the hypotheses at 0.05 level of significance. From the analysis, findings revealed that, though there is a significant relationship between health workers preventive, reformative, curative services, educational awareness role and wellbeing of inmate in Enugu Maximum Correctional Center, Enugu State, Nigeria due to corruption which has left facilities obsolete and low manpower in the correctional centre. From the study findings, it was recommended among others that, there is urgent need for medical social workers in correctional institution as complementary to health care workers roles in other to provide both rehabilitative, palliative and advocacy services to inmates in the prisons. From the study, it was concluded that in Enugu Maximum Correctional Center, Enugu State, Nigeria there are more of non-professional health workers than clinically proven care given health care professionals. The dearth of

infrastructure and poor health of inmates is a result of poor health care services delivery and poor health condition of inmate, hence the high rate of recidivism or reoffending among inmates

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TABLE OF CONTENTS

CHAPTER TWO: LITERATURE REVIEW AND THEORETICAL FRAMEWORK

CHAPTER THREE: RESEARCH METHODOLOGY

LIST OF TABLES

LIST OF FIGURES

CHAPTER ONE

INTRODUCTION

1.1 Background to the study

The health care of prisoners is an integral and essential part of every prison's work. Primary care is the foundation of prison health services. Inmate health care is the most effective and efficient element of wellbeing of people in correctional institutions (World Health Organization, 2012) and as such, should be available to every prisoner. In most respects, the purpose of health care in prison is the same as outside prison (Council of Europe, 2001).The care of patients is its core function, and its main activities are clinical. Inmate health care service includes elements of disease prevention and health promotion (Office of the United Nations High Commissioner for Human Rights, 2012). As with primary care in the community, there are secondary duties. Prison health professionals may occasionally carry out other duties and services. They may provide reports to the court and for consideration of early release of prisoners, on general or specific health grounds. In most countries, these processes occur under the protection of laws and regulations. Unless there are exceptional circumstances, such as the potential for damage to a patient or to the interests of someone else mentioned in the report (a third-party interest), patients should be entitled to see and hold copies of reports and correspondence (Odebiyi, 2012). Despite the many similarities of health care between prison and the community, there are also differences. Prison brings loss of freedom, and this has many consequences for health care (Dolan, 2005).

Odebiyi (2012) outlined the following as some of the consequences of inmate health in the correctional centers in most correctional centres in developing countries. They are as follows:

1. The prisoners automatically lose the social component of health, including the loss of control of a patient's circumstances, the loss of family and familiar social support and a lack of information and familiarity with their surroundings.
2. The environment of prison often poses a threat to mental well-being, especially a threat to a sense of personal security.
3. In most circumstances, prisoners are unable to choose their professional healthcare team.
4. Similarly, primary care teams in prison cannot select their patients.
5. Neither the patient nor the health care team chooses the beginning and end of courses of treatment or of the clinician-patient relationship in general – this is largely decided by the courts.
6. Generally, patients who are prisoners need a high level of health care

In society generally, the major continuing challenge in public health is to get services to the people who need them the most, especially those who are hardest to reach. Yet it is a sad reality of life that, at any one time, a high proportion of those with multiple health problems are incarcerated in the prisons of each country. They are certainly reachable, for a certain period at least. For more than a decade, WHO has had a network of countries of the European region (with more than 30 countries now involved) supported by senior representatives approved at the ministerial level that gather to exchange experiences and evidence on how best to make prisons healthier places for staff

as well as prisoners (Fox, 2000). The detection of serious communicable diseases such as HIV infection and tuberculosis, accompanied by adequate treatment and the introduction of harm reduction measures as necessary, contributes significantly to the health status of the communities from which the prisoners come and to which they return. In addition, it is now known that substance dependence can satisfactorily be treated in prisons (Smith, 2008). The many imprisoned people who have mental health problems can also be helped. More recent developments include the real possibility that the time in custody can be used to promote healthier lifestyles, with better control over smoking and alcohol and perhaps over the use of violence in interpersonal relationships. An information database has been developed to obtain a measure of progress throughout the European region (Fox, 2000)

According to European Health Committee (1998), experience in several countries of Europe has drawn attention to the problems that often arise if prison health services are provided separately from the country's public health services. These include difficulty in recruiting professional staff and inadequate continuing education and training. It is now strongly recommended that prison health services work closely with national health services and health ministries, so that the prisons can provide the same standard of care as local hospitals and communities. Indeed, as the WHO Moscow Declaration on Prison Health as a Part of Public Health (WHO Regional Office for Europe, 2003) acknowledged, the government ministry responsible for prison health should, where possible, be the ministry responsible for public health services. Because prison services throughout Europe face similar public health issues and can learn a lot from each other, most of the Member States have come together and participate in the WHO Health in

Prisons Project. In countries that are not currently members of the Project, it is suggested that the health ministry raise with WHO the question of either membership or association, so that these countries could also benefit from the Project and hear of developments and experiences that may be relevant to them (European Health Committee, 1998)

Emphatic comprehension of the patient in an atmosphere favourable for expressing ones feeling is undoubtedly an element of communication with the person being taken off. As a result, health care delivery in the prisons has taken a different approach to encourage inmates to make positive progress with their health needs. According to Smith (2008), self-care and informal care are not thought of as health service but availability of informal care (over the counter treatment) has an effect on the health needs of the prison inmates. The growing demand for health by day in the incarcerated homes is pathetic as many inmates are left with no option but to manage their personal health needs.

The World Health Organization (WHO, 2014) observes that the health needs of inmates can be improved upon by imbibing a positive approach to care. The attitude of health workers to exhibit empathy approach to the health needs of inmates has an effect on the formal care since it is hardly available in most of the clinic centers. According to Amnesty International (2014), several factors have accounted to limited self-care in prison it is most likely, that prisoners are unnecessarily isolated from their families who would have been of good support to the health need of inmates. Healthcare workers have seen the need to employ a holistic attitude to tackle the health needs of inmates; such as mental health, drug and alcohol withdrawal, AIDS/HIV Routine medical care and so on.

The place of health workers in the rehabilitative process of inmates cannot be undermined. According to Moritz (2012), health workers are the largest service providing group in any institution. This is because institutions like the prison service need more of professionalized care in order to help prison inmates get their feet's back into the society. Both in developed and developing societies, the prison institution requires that nursing and healthcare services be provided to inmates in an atmosphere that fosters dignity and reinforces the worth of both the individual and health care professional. However, there is little information available concerning the health care profession's knowledge, attitude or practices in the health care setting (Moritz, 2012; Werlin & Brien, 2004).

In its essence, the need to promote the health of the inmates, show empathy, uphold punitiveness and support the rehabilitation of inmates to find their feet after their period of incarceration sums the role of health workers in prisons. According to United Nation Resolution (2001), health is a fundamental human right indispensable from the exercise of other human rights. In spite of various health related policies and reforms in Nigeria geared towards restructuring health sector, the health needs of the people continues to be limited; not equitable and does not meet the needs of the majority of the Nigerian people especially among the vulnerable group (Nigeria National Health Conference, 2009). One of the excluded groups that have suffered serious neglect in terms of their health needs is the prisoners (Rutherford, Samele, & Duggan, 2008). The United Nations Basic Principles for the Treatment of Prisoners (1990) indicates that "Prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation. In other words, the fact that people are in prison does not mean that they have any reduced right to appropriate health care.

Prisoners disproportionately come from poor, undereducated and minority communities (Glaser & Greifinger, 2013). They have less access to primary care and preventive service and are exposed to more environmental and social health risk factors (Health African Prisons, 2009). It is a fact that Nigerian prisons inmates over the years have been in deplorable conditions with disease burden on the rise (Agunbiade, 2010). Human Rights Watch report (1993) reported that most prisons centers in Nigeria were overcrowded, poor sanitary conditions, inadequate lighting and ventilation, inadequate diet and hygienic living conditions are the cause of high rates of disease and dead in prison centers. Inmates are not just faced with health complications such as substance abuse, mental health conditions, communicable and non-communicable diseases and unhygienic environment but they are greatly exposed to social discrimination and stigmatization especially from prison staff of which health workers are not exempted (Watson *et al.*, 2004).

The health workers play basic and significant roles in the implementation of primary health care at all levels (Adulraheem, Oladipo & Amodu, 2011). The health policy may be excellent and result-oriented, but if the work force (staff) exhibits a counterproductive attitude in the course of implementation, the desired result may not be achieved. This may be even worse when attending to vulnerable groups such as prisoners. According to Kehinder (2017), the negative attitude of healthcare workers have resulted to the loss of over 900 inmates across Nigeria with one state accounting for 32 deaths. The attitude health workers exhibited while delivering health services tend to have significant impact in the level of utilization of health services and health status on the community (Inyang & Doubrapade, 2016). In ethic of health profession, it is required of

health workers to provide the health needs of inmates in an atmosphere that fosters dignity and reinforces the worth of both individuals and health care profession (World Health Organization, 2014). Taking care of inmates require that health workers have good knowledge of their unique health issues. Cultural differences in health workers, combined with professional ethics and personal beliefs, could also result in conflicting attitudes, which may lead to difficulties related to caring for prison inmates (Strike, Guta, de Prinse, Switzer and Chan, 2014; Makhado & Davhana-Maselesele, 2016). According to Sule, Ijadunola, Fatusi and Connell (2008) other attitudinal deficiencies reported among primary health care staff include discrimination of patients/clients based on their status and influence, lack of respect and compassion towards patients, careless and frivolous comments on patients by staff, unfriendliness and insensitivity to patients problems, laxity in dealing with patients waiting for attention, abandonment of place of work for personal gains, mismanagement of fund, drugs and other health care materials, drug leakage and illegal drug selling. These myriad of attitudinal deficiency tend to be very rampant among the prison staff.

Many studies on the attitude of health workers have focused generally on the public and exclusively on HIV/AIDS patients, pregnant women and mental health patients. However, there is little or no known study yet on health workers attitude towards the prison inmates Nigeria. This is the gap in knowledge which this study is set fill in. Thus, this study is designed to investigate health workers attitude towards the health needs of prison inmates in South-East Nigeria with particular focus on Enugu state maximum security prison.

1.2 Statement of the problem

Enugu Maximum correctional center like, any other Nigerian correctional centers appears to be structurally dysfunctional due the poor health condition of inmates after period of incarceration. In this centre, rather than rehabilitating and reconciling the offender with the social order and its laws, the centre has inadvertently become a place for the dissemination and exchange of criminal influence. These have the tendency of making offenders incapable of properly being restored to the society (Sala, 2004)

Other correctional centres in the world strive to reform offers and provide good health care services delivery to inmates, but in Enugu Correctional centres and others in Nigeria, the contrary is observed. The role of health workers in these correctional centers may have been still in doubt considering the poor state of the correctional institutional environment. The poor structural organization of the correctional centres is responsible for the spread of infectious disease probably due to lack of sufficient number of health workers. Considering the un-habitual nature of the prison wards, the area is often plagued with infectious diseases that require the attention of health care workers. But often, the curative, preventive, reformative and health awareness role of health workers are not sufficiently utilized. In Enugu Maximum Correctional centre, health workers role in providing good and efficient health care services delivery would have been beneficial to prison inmate, but due to government neglect on the importance of health service delivery, no significant result has been seen in relation to improve health of inmates in the correctional centre.

The effect of this may have contributed to the increases in inmate mortality in recent times in Enugu Maximum correctional centre. There is often lack of health

education for good preventive measures to be adopted by inmates. Furthermore, the complementary follow-up after-care services of the prison for discharged prisoners which ensure smooth re-entry into the society appears to be totally lacking. There is as well lack of sincere effort by policy makers and correctional administrators in pursuing the legislative provisions (if any) for discharged prisoners in the area of community rehabilitation and reintegration programmes, which should address the legal stipulation that denies them employment and public appointments, as well as culture based, age-long traditional apathy towards them. Howbeit, the period of transition from custody to community is usually difficult for recidivist and often contributes to the stress that is associated with being supervised in the community."

In Enugu Maximum Prisons, inmates are exposed to a lot of communicable and non-communicable diseases due to the condition of the prison services. The supposed intervention of health care services providers appears to be inadequate or lacking. This prison condition has worsened in most cases as prisoners are seen suffering from infection and viral disease such as scabies, HIV/AIDS and other STDS. This phenomenon affects inmates at a continuum as they have virtually no control over their environment and usually have no choice over the density and composition of their surroundings. The combination of factors of disease transmission and non-available preventive chemicals for environmental fumigation against malaria and other communicable disease make the correctional centre environment unfavorable or inhabitable (bacteria, viruses, protozoa, helminths and fungi) and increase the chance of infection among inmates. The vast majority of the prison population consists of people from poor and marginalized communities with little access to health services. Because of

behaviour, life circumstances and material conditions, infectious agents are more prevalent among these people.

Through this harsh health condition, a typical prisoner is more likely to be a disempowered individual with a history of disease exposure, drug use and alcohol consumption. Neglected chronic diseases, anatomical defects, coexisting infectious and noninfectious diseases, a history of inconsistent antibiotic use, high dosage and prolonged duration of exposure and poor nutritional status negatively influence the frequency of occurrence and severity of disease in prisons. In the crowded and often insalubrious prison environment, infectious agents can spread in a variety of different ways: directly – through touching, sexual intercourse, direct droplet projection from a coughing individual or contact with soil – or through several indirect transmission mechanisms: carrier-borne transmission can occur through food, water, clothing, tattooing equipment or contaminated syringes; airborne transmission can occur through the aerosols created in the large, poorly ventilated and scarcely heated rooms; and vectors can be transmitted through flies, mosquitoes and ticks. It was against this backdrop the study investigated the extent to which health workers service delivery in areas such as preventive care, promotive, curative, reformative and health care awareness have an impact on the wellbeing of inmates in Enugu Maximum Correctional Centre, Enugu State, Nigeria

1.3 Research questions

The study was posed to answer the following questions

1. Does health workers preventive role in Enugu maximum prison significantly promote the wellbeing of inmates in correction centre in Enugu State?

2. Does health workers curative services in Enugu maximum prison have any significant relationship with the wellbeing of inmates in Enugu Maximum Correctional Centre in Enugu State?
3. Is there a significant relationship between health workers reformative services and the wellbeing of Enugu Maximum Correctional Centre in Enugu State?
4. Does health workers' health educational awareness services significantly promote the wellbeing of inmates in Enugu Maximum Correctional Centre in Enugu State?

1.4 Objectives of the study

The general objective of the study was to examine the Health Workers Service Delivery and Wellbeing of inmates in Enugu Maximum Correctional Center, Enugu State, Nigeria. Specifically, the study sought to:

1. Examine the significant relationship between health workers' preventive roles and the wellbeing of inmates in Enugu Maximum Correctional Centre, Enugu State, Nigeria
2. Investigate the significant relationship between health workers curative services and the wellbeing of Inmate in Enugu Maximum Correctional Centre, Enugu State, Nigeria
3. Examine the significant relationship between reformative services and the wellbeing of inmate in Enugu Maximum Correctional Centre, Enugu State, Nigeria
4. Access the significant relationship between health workers awareness and the wellbeing of inmates in Enugu Maximum Correctional Centre, Enugu State, Nigeria.

1.5 Hypotheses of the study

The following hypotheses were tested in the study

1. There is no significant relationship between health workers preventive services and the wellbeing of inmates in Enugu Maximum Correctional Centre in Enugu State.
2. There is no significant relationship between curative services and the wellbeing of inmates in Enugu Maximum Correctional Centre, Enugu State, Nigeria
3. There is no significant relationship between health workers reformative services and the wellbeing of inmate in Enugu Maximum Correctional Centre, Enugu State, Nigeria
4. There is no significant relationship between health workers educational awareness and the wellbeing of inmates in Enugu Maximum Correctional Centre, Enugu State, Nigeria.

1.6 Significance of the study

The findings of this study are of immense benefit to prison administrators and bodies like nongovernmental organizations (NGOs),Amnesty International, Human Rights Activists etc. Specifically, the study will help the government of Nigeria to plan given that the problems faced by inmates or the harsh health condition inmates are exposed to have negative effect on their health and defy measures of reformatory processes to avoid recidivism. Thus, the findings and recommendations of this study will be significant to the Nigerian Prisons Service (NPS), the Nigerian healthcare delivery

system, Criminologists, Sociologists, Medical Sociologists, policy makers and the academia.

The study has both theoretical and practical significance. Theoretically, the findings in this study will generate knowledge that will provide insights to the factors responsible for attitudinal behaviour of care workers towards the needs of inmates in Enugu Maximum Correctional Centre, Enugu State,South Eastern Nigeria. Again, the findings are expected to add theoretical values to care workers' attitude towards the health needs of inmates in the prison. Moreover, the studies will support the ecological model which was developed in the 1950s and is still widely used today to explain health behaviours. It includes factors such as knowledge, attitudes, beliefs and personality as they interact with the physical environment. Practically, it is hoped that the findings of this research will be useful to policy makers and Nongovernmental organizations (NGOs) to develop policies that could be used in the interventions of attitudinal behaviours of health care givers toward the wellbeing of inmates.

1.7 **Scope of the study**

The primary objective of this study is to investigate the relationship between health workers activities and the wellbeing of inmates in Enugu Maximum Correctional Centre, Enugu State, Nigeria. Thus, the scope of the study covered the history of the Nigerian prisons service, health workers services delivery and wellbeing of inmates, the preventive role of health workers and wellbeing of inmates, reformative role of health workers and wellbeing of inmates, the curative role of health workers as well as the health educational role of health care workers and wellbeing of inmate. The theoretical scope of the study centered on the rehabilitation theory and the antisocial personality

disorder theory. The empirical scope of this study focused within Enugu Maximum Correctional Centre, Enugu State, Nigeria. The prison had a total of two thousand and eleven (2,011) inmates, consisting of 1,743 males and 268 females. Four hundred inmates voluntarily participated in the study, out of which were 360 males and 40 females.

1.8 Limitations of the study

The limitation of this study was that of the researcher's inability to select the respondents to participate in the study. This was due to the nature of the study, requiring inmates to respond to questions bothering on their relationship with health workers in the prison. In a trial test study carried out in Afokan Prison, Calabar South Local Government Area, of Cross River State, majority of the inmates refused to participate for lack of interest; hence, the choice of the voluntary sampling technique. Another limitation of the study was the researcher's inability to conduct interview sessions with the respondents. This was deliberately omitted due to the nature of the study, which ensured that the inmates were not intimidated with recording devices in the course of the study. Thus, administering structured questionnaire to the volunteered respondents was considered the most efficient method of gathering data for the study.

1.9 Definition of terms

For the purpose of this study, the following concepts were used operationally:

i. Prison inmate: A prison inmate is a person who is deprived of liberty against his or her will due to criminal behavior. It is a legal term for a person who is imprisoned.

ii. Health worker; these are professional care givers saddled with the responsibility of counselling inmate in order to reform them and get the reintegrated into the society

iii. Preventive role. These refers to the roles of both the health worker or social worker in the correctional institution in order to prevent them from disease of any communicable disease

iv. Curative services: these refer to treatment services for inmate who may have fallen sick in the correctional institution

v. Reformative service. This refers to the act of counselling inmate for proper rehabilitation and reintegrating into the society to be better people

vi. Educational awareness role. This refers to the art of teaching inmate how to leave, eat, take good care of themselves as well as help the to acquire relevant skills to self-reliance

vii. Wellbeing. This refers to the good social, physical and psychological functioning of prison inmates serving their jail terms in prison or correctional centre

CHAPTER TWO

LITERATURE REVIEW OF THEORETICAL FRAMEWORK

2.1 Literature review

2.1.1 Health workers provision of preventive services and wellbeing of inmate

According to United Nation (2012), in correctional institutions or prisons services, health personnel, particularly physicians, charged with the medical care of prisoners and detainees have a duty to provide them with protection of their physical and mental health and treatment of disease of the same quality and standard as is afforded to those who are not imprisoned or detained. The International Council of Prison Medical Services confirmed this principle when it agreed on the Oath of Athens (Prison Health Care Practitioners, 1979):

> *We, the health professionals who are working in prison settings, meeting in Athens on September 10, 1979, hereby pledge, in keeping with the spirit of the Oath of Hippocrates, that we shall endeavour to provide the best possible health care for those who are incarcerated in prisons for whatever reasons, without prejudice and within our respective professional ethics (pg 201).*

WHO Regional Office for Europe (2003) noted that this principle is particularly important for physicians. In some countries, fulltime physicians can spend their whole career working in the prison environment. It is virtually inevitable in such situations that these physicians will form a close relationship with prison management and indeed may be members of the senior management team of the prison. One consequence of this may be that the director of the prison will occasionally expect the physician to assist in managing prisoners who are causing difficulty. For example, the security staff may ask the physician to sedate prisoners who are violent to themselves, to other prisoners or to

staff. In some jurisdictions, prison administrations may demand that physicians provide them with confidential information about a person's HIV status (Coyle & Stern, 2004). Physicians should never lose sight of the fact that their relationship with every prisoner should be first and foremost that between physician and patient. A physician should never do anything to patients or cause anything to be done to them that is not in their best clinical interests. Similarly, as with all other patients, physicians should always seek consent from the patient before taking any clinical action, unless the patient is not competent on clinical grounds to give this consent. An Internet diploma course entitled Doctors working in prison: human rights and ethical dilemmas provided free of charge on the Internet by the Norwegian Medical Association (2004) on behalf of the World Medical Association focuses on many of these issues (Dolan, Wodak & Hall, 1999).

This primary duty to deal with prisoners as patients applies equally to other healthcare staff. In many countries nurses carry out many basic health care functions. These may include carrying out preliminary health assessments of newly admitted prisoners, issuing medicines or applying treatments prescribed by a physician or being the first point of contact for prisoners concerned about their health. The nurses who carry out these duties should be properly qualified for what they do and should treat people primarily as patients rather than as prisoners when carrying out their duties. The International Council of Nurses (1998) published a statement saying, among other things, that national nursing associations should provide access to confidential advice, counselling and support for prison nurses (Dolan *et al.*, 1999).

Furthermore, WHO strongly recommends that prison and public health care be closely linked. The Moscow Declaration on Prison Health as a Part of Public Health

(WHO Regional Office for Europe, 2003) elaborated on some of the reasons why close working relationships with public health authorities are so important.

- Penitentiary populations contain an overrepresentation of members of the most marginalized groups in society, people with poor health and chronic untreated conditions, drug users, vulnerable people and those who engage in risky activities such as injecting drugs and commercial sex work.
- The movement of people already infected with or at high risk of disease to penitentiary institutions and back into civil society without effective treatment and follow-up gives rise to the risk of the spread of communicable diseases both within and beyond the penitentiary system. Prevention and treatment responses must be based on scientific evidence and on sound public health principles, with the involvement of the private sector, nongovernmental organizations and the affected population.
- The living conditions in most prisons of the world are unhealthy. Overcrowding, violence, lack of light, fresh air and clean water, poor food and infection-spreading activities such as tattooing are common. Rates of infection with tuberculosis, HIV and hepatitis are much higher than in the general population.

Committee of Ministers of the Council of Europe (1973) Declaration makes a series of recommendations that would form the basis for improving the health care of all detained people, protecting the health of penitentiary personnel and contributing to the public health goals of every Member State in the European Region of WHO.

- Member States are recommended to develop close working links between the health ministry and the ministry responsible for the penitentiary system toensure

high standards of treatment for detainees, protection for personnel, joint training of professionals in modern standards of disease control, high levels of professionalism among penitentiary health care personnel, continuity of treatment between the penitentiary and outside society and unification of statistics.

- Member States are recommended to ensure that all necessary health care is provided to people deprived of their liberty free of charge.
- Public and penitentiary health systems are recommended to work together to ensure that harm reduction becomes the guiding principle of policy on preventing the transmission of HIV and hepatitis in penitentiary systems.
- Public and penitentiary health systems are recommended to work together to ensure that tuberculosis is detected early and is promptly and adequately treated and that transmission is prevented in penitentiary systems. State authorities, civil and penitentiary medical services, international organizations and the mass media are recommended to consolidate their efforts to develop and implement a complex approach to tackling the dual infection of tuberculosis and HIV.
- Governmental organizations, civil and penitentiary medical services and international organizations are recommended to promote their activities and consolidate their efforts to improve the quality of the psychological and psychiatric treatment provided to people who are imprisoned.
- Member States are recommended to work to improve prison conditions so that the minimum health requirements for light, air, space and nutrition are met.
- The WHO Regional Office for Europe is recommended to ensure that all its specialist departments and country officers take account in their work of the

healthcare needs and problems of penitentiary systems and develop and coordinate activities to improve the health of detainees (Committee of Ministers of the Council of Europe (2013).

Developing a whole-prison or settings approach to promoting health is important for improving the chances of intervention succeeding (Dolan, 2005).The vision for a health-promoting prison is based on a balanced approach recognizing that prisons should be:

- Safe
- Secure
- reforming and health promoting
- grounded in the concept of decency and respect for human rights.

Human rights and decency are important foundations for promoting health because they underpin all aspects of prison life. Attaining the following measures creates a basis on which to promote health:

- treatment for prisoners that respects the law
- maintaining facilities that are clean and properly equipped
- providing prompt attention to prisoners' proper concerns
- protecting prisoners from harm
- providing prisoners with a regime that makes imprisonment bearable
- fair and consistent treatment by staff.

Moritz (2012) observed that the health care of prisoners is an integral and essential part of every prison's work. Primary care is the foundation of prison health services. Primary care is the most effective and efficient element of health cares in any public health system (WHO, 1978) and as such, should be available to every prisoner. As

described in more detail in this work, prisoners have the same right to health care as everyone else in society. According to Akintola and Ajzen (2017) observed that poor general condition of inmates that requires prevention include hygiene nutrition, mobility, personality disorder, physical and mental trauma and stress, Curtis (2011) noted that, disease prevention in prisons can be organized at three levels.

i. At the individual level, the health staff members usually provide clinical interventions – such as administering antibiotics to prevent infection of wounds or treating scabies to prevent bacterial complications. However, substantial health services in prisons are delivered in lay settings as self-care or as care for the peers. Care should be taken to avoid blaming individuals for their behaviour leading to disease, since individuals often do not fully control the circumstances.

ii. At the institutional level, safe methods of searching and screening can prevent exposure to bloodborne diseases, or administrative arrangements for ventilating the indoor spaces can decrease the transmission of tuberculosis.

iii. At the population level, health-promoting interventions are organized from a public health perspective and can include regulating the quantity and quality of food, adopting standards for quality of water or indoor air and implementing policies for exchange of syringes.

El-Gilany, El-Wehady and Amr (2010) noted that to prevent the spread of communicable diseases, the weakest links of the chain agent–transmission–host have to be targeted. For example, chlorinating water destroys some agents; promoting the use of condoms removes the contact needed for transmission; using repellents, disinfectants and

protective clothing targets the vectors; and vaccination immunizes the host. In choosing the most appropriate strategy, policy-makers need to consider the risks associated with the disease, the feasibility of interventions, the costs and benefits of the interventions and equity considerations. Because of the particular circumstances of prisons, some approaches may be more difficult to apply (United Nations human rights commission, 1990). Prisons in general and prison health in particular are not always high on the agenda of politicians, but the threat of transmission of infectious diseases in prisons and ultimately from prisons to general society demonstrates the importance of ensuring better access to health care and health promotion in prisons.

Graffam, Shinkfield and Hardcastle (2008) observed that prisons represent both a challenge and an opportunity in controlling the spread of infectious diseases: a challenge because the conditions in prison often increase the risk of transmission, but also an opportunity, because many individuals have much better access to health services in prison than they normally do outside the prison. In addition, the prison population is compact and not excessively mobile, which makes efforts to screen for infectious diseases relatively easier. Finally, achieving adherence to treatment can be easier in prison than outside. Bloodborne diseases Bloodborne agents are those that are present in human blood and that can cause disease in other humans who are exposed to blood or blood products. The most relevant (but not the only) bloodborne agents include hepatitis B virus, hepatitis C virus and human immunodeficiency virus (HIV). In prisons, both health care workers and the security staff can be exposed to blood and other body fluids through sharps injuries (needle sticks and other), mucous membrane exposure and skin exposure

Otu (2009) noted that preventing the transmission of bloodborne diseases through tattooing requires efforts at three levels.

i. At the individual level, tattooists should wash their hands and use gloves. They should have the means to sterilize the equipment between uses on different prisoners – ideally, sterile tattoo needles should be used only once and then disposed of in safe containers. The remaining tattoo ink must always be thrown. The site of a tattoo needs to be cared for similarly to a superficial burn: the area must be kept clean and moisturized until the tattoo is completely healed.

ii. At the level of the institution, safe tattoo rooms can be set up, and conditions for sterilizing equipment can be offered to reduce the transmission of bloodborne diseases. However, facilities for safe tattooing are rarely available in prisons. In the absence of such facilities, inmates should reserve clean areas with good illumination for tattooing (or piercing).

iii. At the population level, clean tattooing equipment should be available to prisoners, and they should be able to set up safe tattoo rooms, but the degree to which this is possible depends on how receptive prison administrations and ministries responsible for prisons are to public health arguments. Intravenous transmission Blood transfusions are associated with the highest risks of transmission of bloodborne infections.

Clear, Rose and Ryder (2001) noted that, blood safety measures – selecting donors and screening donated blood – have drastically reduced the probability of acquiring blood borne infections through transfusions. Sharing syringes for injecting drug

use is also a very efficient way of transmitting blood borne diseases. At the population level, adopting pragmatic policies to reduce risk creates the most favourable conditions for preventing transmission. If such policies are in place, the institutions can promote safe injecting practices by interventions ranging from health education to needle and syringe programmes. The individual drug user should avoid sharing injecting equipment and, when needle and syringe programmes are available, take part (Kulkarni, Baldwin, Lightstone, Gelberg & Diamant, 2010). If clean needles and syringes are not available, bleach should be used to reduce the risk of transmission, but this will not eliminate the risk. The high concentration of hepatitis B virus and hepatitis C virus in the bloodstream and their ability to survive outside the body make them much easier to contract than HIV. Kulkarni *et al.,* (2010) avers that Providing adequate primary care in prisons ideally leads to a narrowing of the health gap and to promoting equity in health by providing prisoners with access to care for known conditions that may not otherwise be available to them in the community (such as mental health care, dental care and management of long-term conditions); and by offering an opportunity to assess, detect and treat serious illnesses, especially mental health, infections and dependence problems.

Health workers role and prevention against intravenous transmissions

Kulkarni *et al.,* (2010) noted that, health workers role in correctional institutions are often targeted at preventing inmate against intravenous transmission which are associated with Blood transfusions due to it associated risks of transmission of bloodbome infections. However, blood safety measures – selecting donors and screening donated blood – have drastically reduced the probability of acquiring bloodbome infections through transfusions. Sharing syringes for injecting drug use is also a very

efficient way of transmitting bloodborne diseases. Despite efforts to keep drugs from entering prisons, injecting drug use is common in many prisons and creates a great risk factor for transmission of bloodborne infections. Because smuggling injecting equipment into prisons is much more difficult than smuggling drugs, often only a few syringes circulate in prison, which increases the likelihood that many people will inject using the same syringe. When a syringe enters the vein, the plunger is pulled back to ensure that the needle is in the vein. Some of the blood that enters into the syringe may remain in it and be injected by the next user. Transmission is caused by the exchange of blood. The injecting drug user who never shares syringes will not get HIV or other bloodborne infections from syringes (Norwegian Medical Association, 2004).

Prevention is based on blocking transmission caused by using contaminated syringes. At the population level, adopting pragmatic policies to reduce risk creates the most favourable conditions for preventing transmission. If such policies are in place, the institutions can promote safe injecting practices by interventions ranging from health education to needle and syringe programmes. The individual drug user should avoid sharing injecting equipment and, when needle and syringe programmes are available, take part. If clean needles and syringes are not available, bleach should be used to reduce the risk of transmission, but this will not eliminate the risk. The high concentration of hepatitis B virus and hepatitis C virus in the blood stream and their ability to survive outside the body make them much easier to contract than HIV. To prevent infection with hepatitis B virus and hepatitis C virus, injecting drug users should avoid sharing any part of their injecting materials, including syringe, cotton, water and cooker.

In a formal correctional institution, health workers helps inmate against the following communicable disease due to the nature of the prison environment (Norwegian Medical Association, 2004). They observed that following as health risk factors that must be prevented.

Tuberculosis

Being a disease caused by Mycobacterium tuberculosis, these bacteria are spread through the air and attack primarily the lungs. The source is the person with active pulmonary tuberculosis who spreads the Mycobacterium tuberculosis by airborne particles, when coughing, sneezing, speaking or singing. Prisons are often overcrowded and poorly heated. To prevent the loss of heat, inmates often seal the windows, which create the perfect environment for Mycobacterium tuberculosis to persist in the air. Persons who share the room with people with active tuberculosis are at the greatest risk of infection.

Most individuals who inhale tuberculosis bacteria and become infected have no symptoms and do not feel sick. Mycobacterium tuberculosis stays alive in their bodies but stops growing. This situation is called latent infection. Most people who have latent tuberculosis infection never develop active tuberculosis. But when the immune system cannot stop the bacteria from growing, the Mycobacterium tuberculosis starts multiplying, causing active tuberculosis. People infected with HIV have very weak immune systems, which increases their vulnerability. The prevalence of HIV in prisons is higher than in the general population, which creates an additional burden for tuberculosis control programmes. Substance abuse and low body weight, both prevalent in prison, can also weaken a person's immune system.

The individual behaviour of people with tuberculosis can significantly reduce the spread of tuberculosis:

- most importantly, tuberculosis drugs must be taken regularly;
- covering the mouth with a tissue when coughing, sneezing or laughing is also important;
- people with active tuberculosis should not go to places where contact with healthy people is possible; and
- windows should be opened frequently so that rooms can be ventilated adequately.

Remember that tuberculosis is spread through the air. Despite widespread misconceptions, people cannot get infected through handshakes, sitting on toilet seats or sharing dishes and utensils with someone who has tuberculosis. Pulmonary tuberculosis can cause such symptoms as:

- coughing for more than two weeks
- coughing up sputum or blood
- chest pain
- weakness and fatigue
- weight loss
- fever
- night sweating.

Institutional measures to prevent the spread of tuberculosis include schedules for ventilating living areas, measures to ensure good heating (while avoiding sealing windows) and allowing prisoners to spend enough time outside. Support for case finding – such as by referring prisoners with symptoms to health care workers – can lead to

earlier treatment, reducing the amount of time people who are infectious spend with other prisoners, and can therefore be an efficient measure for controlling tuberculosis.

Prison Health Care Practitioners (1979) observed that the fact that tuberculosis can be cured with correct treatment led to the most potent interventions – the ones that take into account the population perspective. Mathematical modelling has shown that identifying at least 75% of the infectious cases and curing at least 85% of them will sharply reduce the rate of transmission in the population – to the extent that this effectively controls disease. These are the classical objectives of tuberculosis control under the strategy recommended by WHO (2004).

Ideally, tuberculosis control in prisons should be integrated into a country's national tuberculosis control programme, but where this is not possible, the prison tuberculosis services can be strengthened alone. High-quality treatment with a full spectrum of tuberculosis drugs will positively affect both individuals and the prison population as a whole without significant risk of resistance, even in the extreme case when some people cannot complete their course because they are released before treatment ends. The diagnosis is based on staining and direct microscopy of sputum. Mass X-ray screening is justified in the prison population, but it needs to be complemented with screening for symptoms and with passive case-finding.

Sexually transmitted infections

Prison Health Care Practitioners (1979) noted that a prison population affected by sexually transmitted infections may expect an increase in the number of cases of HIV infection: the sexually transmitted infections that disrupt the integrity of the skin or mucous membranes can bleed easily, thereby increasing a person's infectiousness and

susceptibility to HIV. Further, sexually transmitted infections are an important predictor of HIV infection because they indicate the presence of behaviour associated with the transmission of HIV.

The best way to prevent sexually transmitted infections is to avoid sexual contact altogether, but this is not realistic for many prisoners, most of whom are in their sexually active years and some of whom may be subjected to various forms of sexual abuse. However, prisoners can be encouraged to learn how to prevent sexually transmitted infections and the common symptoms of sexually transmitted infections and seek health care as soon as they notice any symptoms.

HIV

HIV is found in blood but also in semen, vaginal fluid, breast milk, saliva and tears. It is unable to survive or reproduce outside its living host but can effectively spread through sexual contact with an infected person. Highly active antiretroviral therapy became available in the late 1990s and changed the status of HIV from a fatal disease to a manageable chronic condition. However, cure is still not possible and highly active antiretroviral therapy remains expensive. Prevention remains vital. The proper (correct) and consistent (every time) use of condoms for sexual intercourse – vaginal, anal or oral – can greatly reduce a person's risk of acquiring or transmitting sexually transmitted infections, including HIV infection.

To be comprehensive, HIV programmes in prisons should include the following components:

- preventing new infections through, in particular: (1) reducing sexual transmission by improving life-skills (especially among younger prisoners), providing easy,

anonymous access to condoms and lubricants, controlling sexually transmitted infections, notifying partners and implementing measures aimed at reducing sexual abuse and rape; (2) ensuring blood safety by testing transfused blood for HIV, reducing the number of nonvital blood transfusions and enrolling donors at lower risk; and (3) reducing transmission through sharing contaminated injecting equipment by implementing needle and syringe programmes, substitution therapy and peer-based education;

- mitigating HIV-related diseases by providing appropriate care, treatment(including highly active antiretroviral therapy) and support for HIV and related diseases;
- mitigating social impact by undertaking measures to counter HIV-related stigma and discrimination;
- conducting surveillance of HIV and AIDS; and
- providing easy access to voluntary HIV counselling and testing.

The United Nations Office on Drugs and Crime, UNAIDS and WHO (2006) recently released *HIV/AIDS prevention, care, treatment and support in prison settings: a framework for an effective national response.*

During the past decade, the treatment of people living with HIV has changed dramatically, with a resulting reduction of morbidity and mortality: a previously fatal disease has become a manageable chronic condition. Although most of the people living with HIV in need worldwide still do not have access to this life-saving treatment, an initiative by WHO and UNAIDS to bring treatment to three million people in low-income countries by 2005 (the "3 by 5" Initiative), coupled with the unprecedented availability of

funds from the Global Fund to Fight AIDS, Tuberculosis and Malaria, has resulted in rapid scale-up of antiretroviral therapy. This largely became possible because the treatment schemes were standardized and adapted to the context of resource-constrained settings.

Singleton *et al.*, (2003) observed that using fixed-drug combinations solves several problems: daily tablet doses are significantly reduced, adherence improves and the risk of emergence of resistance is reduced, costs are lowered, logistics is easier and supervised treatment strategies are facilitated. More recently, at the 2006 High Level Meeting on AIDS, the world committed to pursue all necessary efforts towards the goal of universal access to comprehensive prevention programmes, treatment, care and support by 2010. Providing access to antiretroviral therapy for those in need in the context of prisons, particularly in resource-constrained settings, is a challenge, but it is necessary and feasible. Studies have documented that, when prisoners are provided care and access to antiretroviral therapy, they respond well. Adherence rates in prisons can be as high or higher than among people in the community, but the gains in health status made during the term of incarceration may be lost unless careful discharge planning and links to community care are undertaken.

As antiretroviral therapy is increasingly becoming available in low-income countries and countries in transition, ensuring that it also becomes available in the countries' prison systems will be critical. Ensuring continuity of care from the community to the prison and back to the community as well as continuity of care within the prison system is a fundamental component of successful efforts to scale up treatment.

Sustainable HIV treatment programmes in prisons, integrated into countries' general HIV treatment programmes or at least linked to them, are needed (Small, 2005).

One serious problem of antiretroviral therapy is that any interruption of treatment can lead to resistance to at least some of the drugs used. Health staff should try to ensure compliance. In addition, other measures are needed to ensure that interruption of treatment does not occur. At the country level, (1) prison departments must have a place within the national HIV and AIDS coordinating committees, and prison issues need to be part of the agreed action framework for HIV and AIDS and country-level monitoring and evaluation system; (2) prison departments need to be involved in all aspects of scaling up treatment, from applications for funding (to ensure that funds are specifically earmarked for prisons), to developing, implementing and monitoring and evaluating plans for rolling out treatment; (3) the ministry responsible for health and the ministry responsible for the prison system should collaborate closely, recognizing that prison health is public health; alternatively, governments should assign responsibility for health care in prisons to the same ministries, departments and agencies that provide health care to people in the community; (4) guidelines should be developed specifying that people living with HIV are allowed to keep their medication upon them, or are to be provided with medication, upon arrest and incarceration and at any time they are transferred within the system or to court hearings. Police and correctional officers need to be educated about the importance of continuity of treatment. At the regional and local level, prisons should form partnerships with health clinics, hospitals and universities and nongovernmental organizations (including organizations of people living with HIV) to provide health care

and other services for prisoners and to develop integrated rather than parallel care and treatment programmes.

Small, *et al.*, (2005) observe that people receiving antiretroviral therapy are regaining immune constitution, which may result in an inflammatory response for the first one to two months. Clinically this can manifest as fever, lymph node swelling, pulmonary and central nervous system involvement. People with latent tuberculosis infection can develop active tuberculosis. If active tuberculosis develops, antiretroviral therapy should not be stopped. Some special considerations apply to people with tuberculosis.

- Rifampicin interacts with nevirapine and protease inhibitors.
- The pill burden increases and adherence becomes more difficult to maintain.
- The first-line recommendation is: zidovudine or stavudine + lamivudine + efavirenz (600 or 800 mg/day), with zidovudine + lamivudine + abacavir being an alternative.
- The use of nevirapine is questioned due to likelihood of increased liver toxicity and poor efficacy.

Certain adverse effects are associated with use of antiretroviral drugs:

- mitochondrial toxicity with nucleotide reverse-transcriptase inhibitors;
- lactic acidosis, mitochondrial toxicity and lipodystrophy with nucleoside reverse-transcriptase inhibitors;
- skin rash and hepatitis with non-nucleoside reverse-transcriptase inhibitors; and
- lipodystrophy, hyperlipidaemia and hyperglycaemia with protease inhibitors.

Antiretroviral therapy requires clinical and laboratory assessments at baseline and regularly during therapy. Stage of HIV disease, concomitant conditions (tuberculosis and pregnancy), concomitant medication use (including traditional therapy), body weight and the patient's readiness for therapy are evaluated at baseline. While on therapy, signs and symptoms of potential drug toxicity, body weight, response to therapy and adherence are assessed and, when clinically indicated, depending on the antiretroviral drug regimen used, laboratory evaluation is performed.

Syphilis

Stöver (2002) observed that without treatment, the agent of syphilis, *Treponemapallidum*, persists in the body for life, leading to mutilation, nervous system disorders and death. Syphilis evolves in several phases, with symptoms varying with each phase.

- Primary syphilis: three weeks to three months after infection, painless wet ulcers (chancres) appear at the site of inoculation – genitals, anus, lips or mouth. The chancre lasts three to six weeks. The lymph nodes of the area may swell during the primary phase.
- Secondary syphilis: three to six weeks after the chancre, body rashes appear, often on the palms of the hands and the soles of the feet. Other symptoms include subfebrility, fatigue, sore throat, loss of hair in a patchy pattern (allopetia), weight loss, swollen lymph nodes, headache and muscle pains. The phase of secondary syphilis lasts for up to two years.
- Latent syphilis: this phase is characterized by the absence of any symptoms.

- Late syphilis: in untreated patients with syphilis, serious damage to the nervous system, heart, brain, and other viscera may occur and cause death.

Syphilis is spread through unprotected vaginal, anal and oral intercourse, through kissing, or from the mother to the fetus during pregnancy. It is most contagious in the early phases – the liquid that transudes from the chancre is highly infectious. Diagnosis: blood samples are screened with serological tests. Dark-field microscopic examination of fluid from the chancre can confirm the diagnosis. Treatment: antibiotics are highly successful. *Treponemapallidum*is remarkably susceptible, and the disease is completely curable. However, the damage it can cause in the later phases is irreparable. Prevention: consistent use of condoms (for vaginal, anal and oral intercourse) reduces the risk of transmission.

Gonorrhoea

Stöver (2002) avers that the agent of gonorrhoea is *Neisseria gonorrhoeae*, a bacterium that infects the urethra in men and women and the cervix, uterus and fallopian tubes in women. *Neisseria gonorrhoeae*can affect the mouth, throat, eyes and anus. Many men with gonorrhoea have no symptoms, but most develop symptoms two to five days after infection.

Symptoms: a burning sensation during urination and a white or greenish discharge from the penis. Occasionally men complain of painful or swollen testicles. Most women who are infected have no symptoms. When present, these symptoms are not highly specific for gonorrhoea: painful or burning urination, vaginal discharge or bleeding can indicate banal urinary tract infections. Rectal infection with Neisseria gonorrhoeae may cause no

symptoms but can manifest itself through discharge, anal itching, soreness, bleeding or painful defecation.

Transmission: gonorrhoea is spread through contact with the penis, vagina, mouth or anus. Untreated gonorrhoea can cause serious complications. In women it can lead to infertility or extrauterine pregnancies through damage to the fallopian tubes. In men infertility occurs through epididymitis, an inflammatory condition of the testicles. Gonorrhoea can cause arthritis or sepsis, which is life-threatening.

Diagnosis: gonorrhoea can be diagnosed by Gram staining of a urethral sample and microscopy. Because gonorrhoea indicates high-risk sexual behaviour, tests for other sexually transmitted infections should be offered to all prisoners who are diagnosed with it.

Treatment: antibiotics can cure gonorrhoea, but drug-resistant strains of gonorrhea are an increasing problem. It is important to ensure that the people with gonorrhoea are adherent and take a full course of medication. Even when infection is cured, the damage caused by the disease can be irreparable.

Prevention: using condoms reduces the risk of transmission of gonorrhoea. Inmates can be encouraged to stop having sex and to see a doctor whenever they have genital symptoms (such as discharge or burning at urination).

Trichomoniasis

Trichomoniasis is caused by monocellular protozoa. Symptoms: women may notice foamy discharge with blood spots and itching in the vagina, painful, burning, frequent urinations, abdominal discomfort and painful intercourse. The symptoms

develop 4 to 28 days after the contact. Men rarely have symptoms, and sometimes women do not have symptoms either.

Transmission: trichomoniasis is transmitted through vaginal intercourse. The diagnosis is made by microscopic examination of vaginal discharge or urethral specimens. Treatment: trichomoniasis is treatable with imidazoles. Treating all partners simultaneously is important to prevent possible reinfection.

Prevention: proper use of condoms reduces the risk of infection. Limiting the number of sexual partners reduces the risk of encountering someone who has trichomoniasis.

Urinary tract infections

Urinary tract infections are caused by the ascension to the urethra and bladder of the rectal bacteria dislocated to the vagina or penis. This often occurs during sexual intercourse or sex play, but poor hygiene leading to contact of vagina or urethra with faeces can also result in urinary tract infections. Urinary tract infections include cystitis; ureteritis (affecting the ureters) and urethritis (when the urethra is affected). Urinary tract infections that are left untreated may lead to kidney infection (pyelonephritis). Urinary tract infections are common among sexually active men and women. In general, women are more likely to be affected given the anatomy of a woman's urethra (shorter and closer to the anus). But in prisons, unprotected anal sex can expose male prisoners to an increased risk of urinary tract infections.

Symptoms of urinary tract infections include imperative, painful and sometimes involuntary urination, especially at night, lower abdominal pain or back pain, fever and blood and pus in the urine. Diagnosis is usually based on clinical signs. Antibiotics and symptomatic drugs are used for treatment.

To prevent urinary tract infections, inmates should use condoms during vaginal or anal intercourse, use lubricants, maintain the pubic area clean and dry, drink adequate liquids, urinate when they feel the urge and urinate immediately after intercourse.

Skin conditions

Scabies

Stöver and Lines (2005) noted that the agent of scabies is an arachnoid that is most often sexually transmitted, but in crowded prison environments inmates can also pass it to one another through casual contact, bedding and clothing. Itching is the most prominent symptom. It is particularly intense at night. Dirty-looking, curved lines are surrounded by small bumps and area of rashes. The favourite location is the thin skin of the penis, thighs, buttocks, around the navel and between the fingers. Usually, scabies does not present difficulties for clinical diagnosis. It is often self-diagnosed. Scabies causes physical suffering and can be associated with serious bacterial infection.

For treatment, sulfur-containing prescriptions are applied neck-to-toe to all those who are affected or may have been exposed. All bedding, towels, and clothing that may have been exposed are autoclaved, boiled or dry-cleaned. Pediculosis (head lice); The agent of pediculosis is *Pediculushumanuscapitis*, an insect parasiting the heads of people. Away from the host, the louse dies within two days. Pediculosis is a common condition in prisons, but reliable data on prevalence are rarely available. The lice are found in three forms: the nit, the nymph and the adult. Nits are the oval eggs of *Pediculushumanuscapitis* that are attached to the hair. The nit hatches into a nymph. It takes about seven days for a nymph to mature, and in this interval nymphs feed on blood. The adult lice lay nits for about 30 days and feed on blood. The symptoms of pediculosis

include the feeling that something is moving in the hair, itching, irascibility and occasionally infected sores resulting from scratching.

The head lice are transmitted by contact with an infested person, wearing infested clothing and using infested combs, brushes, towels and bed linen. The diagnosis can be established by inspecting the hair for nits, nymphs or adults. In general, pediculosis only causes discomfort and inconvenience. Occasionally it can be complicated by secondary bacterial infections resulting from scratching. The treatment is with insecticides. Some kill lice, but not the unhatched nits, which requires a second treatment in 7–10 days. Most insecticides are safe if used correctly but can be dangerous if misused or overused. To prevent reinfestation and the further spread of pediculosis, all clothing and bed linens are washed with hot water or dry cleaned if they were in contact with the infested person in the last two days before the treatment. Alternatively, clothing can be stored in plastic bags and sealed for two weeks. Combs and brushes have to be washed with soap and hot water.

Infectious diseases of the digestive tract

Gastroenteritis

Furthermore, Stöver and Lines (2005) avers that Gastroenteritis is an irritation and inflammation of the digestive tract. It is very prevalent both in the general population and in prisons. In most countries it is second only to the common cold in frequency of occurrence. The agents of gastroenteritis are very diverse: viruses, bacteria or parasites. Food poisoning, stress, alcohol or tobacco abuse, food allergies, inadequate diet, aspirin or corticoids can all cause gastroenteritis too, but viral and bacterial gastroenteritis can be easily transmitted. Symptoms include loss of appetite, nausea, vomiting, diarrhoea,

abdominal cramps, fever or chills, weakness and headache. Viral gastroenteritis usually lasts from several hours to several days. Bacterial or parasitic infections can la than one week and may require antibiotics for treatment. For a healthy person, the condition is as trivial as a common cold, but vomiting and diarrhoea can lead to dehydration and important metabolic disturbances. Elderly prisoners are at significant risk of shock from dehydration. Inflammatory damage to the intestinal mucosa can lead to diarrhoea that continues even after the initial infection is over. Diabetes mellitus and chronic liver or kidney problems put a person with gastroenteritis at additional risk for complications.

For treatment, prisoners should reduce their physical activity for the period of vomiting and diarrhoea; drink only clear liquids on day 1, until diarrhoea and vomiting stop; avoid solid foods and eat rice, crackers, soup and bread on day 2, and refrain from spicy fried food, dairy products, raw vegetables and fruits; drink 1.5–2.5 litres of liquid daily to balance the dehydration through diarrhoea and vomiting; and refrain from taking aspirin or ibuprofen. In severe cases a prison health worker can prescribe antiemetic and/or antispasmodic medication. This should be stopped as soon as the normal intestinal motility is restored. Prolonged diarrhoea can require testing and specific antibacterial treatment. Severe dehydration may occasionally require parenteral rehydration, and prisoners should seek health care if mucus or blood is found in stools, symptoms persist for more than 48 hours or if there is severe abdominal or rectal pain. Not every case of abdominal discomfort should be treated automatically as gastroenteritis. Surgical abdominal catastrophes can start with similar symptoms and have to be ruled out first.

Routine hygiene measures can effectively prevent infections that can cause gastroenteritis. Among these are: regularly cleaning and disinfecting toilets, washing

hands after using the toilet, before eating or before preparing food; keeping raw meat and fish separate from cooked foods; and using individual towels.

Food poisoning

Stöver and Nelles (2004) observes that food poisoning is an acute illness caused by ingesting food contaminated by bacteria, bacterial toxins, viruses, natural poisons (such as mushrooms) or chemicals. The most common causes are bacteria such as Staphylococcus aureus, Salmonella and pathogenic Escherichia coli. These bacteria are commonly found in the environment, but producing illness requires a large number of bacteria. Bacteria multiply best between 5°C and 65°C. Proper cooking and refrigeration greatly reduce the risk of food poisoning. Sometimes large groups of prisoners who ate the same food in prison or who shared homemade food brought by relatives can be infected at the same time. The symptoms of food poisoning can last for days and usually include abdominal cramps, diarrhoea, vomiting, nausea and fever. The onset is usually abrupt, and improvement occurs without any specific treatment. Severe cases can result in life-threatening nervous system, liver and kidney problems, occasionally leading to death. The measures that should be used to prevent food poisoning include: washing hands and utensils before and after handling raw foods to prevent cross-contamination, serving hot foods immediately or keeping them heated above 70°C to prevent bacteria from multiplying and heating canned foods for 5 to 10 minutes before tasting to destroy the toxins of botulism.

Developments in several countries have shown that the justice system can play an important role in educating groups or individuals who are potentially at risk of becoming infected with HIV or other bloodborne or sexually transmitted infections. Individuals

arrested, detained or incarcerated in police stations, pretrial detention centres or penal institutions can be informed, trained and provided with the means to protect themselves. They are often in contact with help facilities for the first time in their life, even though they have been drug users for a fairly long period of time. The authorities in most countries have provided facilities at nearly every level of the criminal justice system to facilitate drug users' access to treatment. Since the late 1980s and early 1990s, authorities have been aware of the problems drug users have and cause in all stages of the criminal justice system. Since then, the number of options for counselling and treatment has increased. At every step of the judicial process, the judicial system should ask whether treatment could be a viable and feasible option either as an alternative to detention or punishment or during the prison sentence. Some of these options could be characterized as coercing drug users into treatment by early intervention or while in prison.

Most prisons regard information about the effects of drugs, harm reduction measures and preventing the transmission of bloodborne viruses as a prerequisite for behavioural change or at least a change in attitudes. Some prisons have consolidated social and health care support for drug-addicted offenders, using the first contact during admission with enforcement authorities as a door to treatment or counselling facilities. The admission situation in prison is often perceived as a suitable setting to discuss future plans and drug-free orientation. In countries applying the principle of therapy instead of punishment, the chances of an early transfer into therapeutic communities in the community can be discussed. This is also the first opportunity to hand out brochures, leaflets or other material designed to avoid health damage and to start information and education campaigns. In Austria since 1998, each prisoner has been given a care pack at

the beginning of imprisonment containing an information folder, condoms and a leaflet indicating specific risks.

Detoxification

Nearly all prisons in European Union countries offer detoxification facilities, although they vary in length and form. Detoxification policies vary between countries and often between regions, especially in countries with a federal structure. Many prisons increasingly treat withdrawal symptoms using medication. Immediately reducing the dosage to zero has been replaced with a more pragmatic approach: people dependent on drugs are treated with medication, which permits in-depth analysis of the psychosocial causes and circumstances of dependence. In several clinics the dosage is gradually reduced, depending on people's needs, abilities and resources to overcome or at least cope with their drug problem. Sometimes the detoxification treatments also include psychosocial support, self-help groups, peer support or even ear acupuncture.

Turnbull and McSweeney (2000) observe that the procedures in detoxification programmes vary considerably. In Ireland, for instance, two forms of detoxification are offered: a 14-day programme or an intensive programme that lasts 13 weeks. This involves a support group and counselling. After this programme, prisoners are either transferred to the training unit (drug free semi-open institution) or granted temporary release. In other parts of Europe, post-detoxification centres have been established, such as in HMP Holloway in England, United Kingdom. This is a community in which residents and staff work together to create a supportive and confidential environment in which inmates can explore drug- and alcohol-related problems during incarceration. It aims to help inmates to become drug-free and cope with staying drug-free, both in prison

and on release. The inmates may stay at the centre for up to three weeks. Topics of group work include:

- drug and alcohol awareness
- harm minimization
- sexual health
- dance movement
- art therapy
- acupuncture
- peer support groups
- CARAT assessment
- sleep and relaxation
- stress management
- social skills
- goal setting
- communication and relationship skills.

Prison Service Order 3550 (HM Prison Service for England and Wales, 2000) elaborates clear guidelines to provide effective evidence-based detoxification management for all inmates who misuse opiates. One of the central components is that each prison will have a detoxification service for opiate users developed in conjunction with local National Health Service consultants using evidence-based guidelines in line with the ones developed outside.

Best practice

The Mandatory Task List of Prison Service Order 3550 (HM Prison Service for England and Wales, 2000) includes:

- assessment of needs, which includes the signs and symptoms of drug misuse, and evidence of opiate withdrawal, and also indications that a mental health assessment may be required;
- corroboration of information from the general practitioner, local substance is use service or dispensing pharmacist;
- urine testing;
- result of urine test to be placed in the inmate medical record;
- the importance of prisoners understanding the need to provide correct information and the potentially life-threatening risk of concurrent illicit drug useduring detoxification;
- detoxification guidelines for one or all of the following: methadone, lofexidineor dihydrocodeine; and
- observation by trained and experienced staff, especially in the first 72 hours of treatment, recorded on documentation kept with the prescription chart or inmate medical record to permit the recording of regular observations.

If detoxification cannot be undertaken exclusively in health care centres, a protocol for sharing information, having obtained prisoners informed consent, with wing staff must be in place:

- staff training;
- availability and guidelines for use of naloxone in the event of the opiate overdose;
- requirements for transfer to hospital in the event of overdose;

- guidelines for the management of those not manifesting withdrawal symptoms; and
- referral to CARATs.

Training programmes, in which the staff of prison health care units participates at regular intervals, should provide the necessary knowledge of the latest standards in withdrawal treatments for opiate dependence or multiple dependence and detoxification treatments for alcohol, benzodiazepine and barbiturate dependence. It is advisable to seek the advice of outside doctors who specialize in medication-based withdrawal treatments.

Counselling and support services for inmates participating in withdrawal treatment in prison cannot be effective without the aid of outside drug service providers. The staff in many health care units of prisons has no clear idea about the course of the treatment and do not document the data properly. This applies to examinations of infectious diseases as well as to examinations of other typical side effects of opiate consumption, such as tuberculosis.

Drug-free units

Drug-free units or wings or contract treatment units aim to allow the prisoner to keep distance from the prison drug scene and market and to provide a space to work on dependence-related problems. The focus in these units is on drug-free living. Prisoners stay in these units voluntarily. They commit themselves (sometimes with a contract) to abstinence from drugs and to not bringing in any drugs and agree to regular medical check-ups often associated with drug testing. Prisoners staying in these units sometimes enjoy a regime with more favours, such as additional leave, education or work outside, excursions and more frequent contact with the family.

Drug-free units (often called drug-free zones, such as in Austria in Justizanstalt Hirtenberg) do not necessarily include a treatment element. They aim to offer a drug-free environment for everyone who wants to keep distance from drug-using inmates. Drug-free units have developed since the early 1990s and in some countries since the late 1990s. In several countries the number of places in drug-free units is increasing rapidly.

2.1.2 Health worker provision of curative services and wellbeing of inmate

WHO (2004) not that, amongst all correctional institutions in the world like Enugu Maximum prisons, to avoid improper treatment in people who have previously been treated (and hence, to reduce the possibility of selecting resistance), to ensure efficient use of resources and to reduce the number of side effects by avoiding excessive doses, WHO recommends that the standard treatment regimens be matched to the diagnostic category of each case of tuberculosis. The case definitions are determined by the site of tuberculosis, the result of sputum smear microscopy, the severity of tuberculosis and the history of previous treatment for tuberculosis.

Usually, after taking drugs for a few weeks, people with tuberculosis feel good and may stop being infectious. This has important consequences – when people with tuberculosis are not infectious and do not feel sick, they can function the same way as before they had active tuberculosis. Unfortunately, the diagnosis of tuberculosis often sticks to individuals long after they stop being infectious, causing unjustified stigma, distracting the attention from the unknown active cases of tuberculosis or from the people with tuberculosis being treated who are still infectious.

The tuberculosis drugs can occasionally cause side effects. Some of the more serious are: loss of appetite, nausea and vomiting; yellowish skin or eyes; fever for three

or more days; abdominal pain; skin rash; bleeding easily; changed vision; ringing in the ears; and hearing loss.

Although the clinical situation improves rapidly, tuberculosis bacteria die slowly in the body of the person with tuberculosis. At least six months is required to complete the treatment.

Treatment outcomes

Incomplete treatment may lead to relapses and to the development of resistance to tuberculosis drugs. This means that the medicine can no longer kill the bacteria. Sometimes the bacteria become resistant to two most potent tuberculosis.

Ogudipe and Adebayo (2016) observed that instead of ensuring curative services, most health workers in prisons seriously violate the rules of medical ethics if they:

- in any way assist in (even by merely being present) sessions of torture or advise the torturers;
- provide facilities, instruments or substances to that effect; • certify that a prisoner is able to withstand a torture session; or
- weaken the resistance of the victim to torture.

Podrasky and Sexton (2008) however observed that, the health service in a prison can potentially play a very important role in the fight against ill treatment within the establishment and elsewhere (specifically police stations). In the context of medical consultations, people sometimes show physical signs or even mental symptoms compatible with having been subjected to torture or other forms of cruel, inhuman or degrading treatment. In light of these facts, the physical and mental examination performed on admission of a newcomer is particularly important. During a physical

examination (and most specifically the one performed upon arrival), any trace of violence compatible with torture must be duly noted and registered, both in the personal file of the detainee as well as any general register listing traumatic lesions. Equally, any psychological or psychiatric disturbances that may also indicate that the person has been subjected to any form of ill-treatment must be recorded. Such information must be automatically transmitted with no delay to the prison or judiciary surveillance authorities.

Reid (2015) observes that detainees can obtain a copy of their medical report at any time. However, the simple fact of being identified by the health care services as bearing traces of traumatic lesions or mental symptoms compatible with torture can trigger measures of reprisal against the victim. In order to best protect patients from this risk of retaliation, doctors must formally inform patients that they are going to report to the competent authority the evidence they have gathered during the consultation. If the patients fear that they will be subjected to reprisal, they may decide not to divulge how the lesions were inflicted and even lie about them. In their report, doctors must clearly distinguish between the allegations (circumstances of the physical or mental trauma as described by the patient) and the complaints (subjective sensations experienced by the patient) from the clinical and para-clinical objective findings (mental state; size, location, aspect of the lesions, X-rays, laboratory results, etc.). If the doctors' training and/or experience allow it, they must indicate whether the patients' allegations are compatible with their own clinical finding.

Ogundipe (2012) observed that health works need to provide curative and rehabilitation services in areas like drug inmate dependence, infections, dental disease and chronic disorders (lung disease, heart disease, diabetes, epilepsy, diseases of the

reproductive system, cancer). They also need provide psychological related curative services such as low mood or self-confidence (self-esteem and dependence: drugs or alcohol), anxiety, depression , severe mental disorders Co-occurring problems which may include "vulnerable" people (learning disability, brain injury, learning difficulty, for instance resulting from autistic spectrum disorder or Asperger's syndrome or dyslexia; and the nature of the sentence (harm against women, offences against children, bullying or recollection of being a victim of abuse

Ogundipe (2012) noted that the physician as a complementary role, must visit patients regularly and, if the patient agrees, conduct regular follow-up examinations. These consultations should be held in a positive, personalized climate, and the physician should inform patients of the progressive decline of health. In this way, strikers can freely change their mind at any time and abandon the strike, having been duly informed of the worsening nature of the risks to which they are exposing themselves. Occasionally strikers may ask to receive a certain type of diet, such as a hypercaloric concentrate in liquid form, rich in protein, vitamins and trace nutrients. It is usually best to grant the request. This prescription may protect the striker's health from irreversible damage. By lengthening the time of the fast, it can allow both the striking detainee and the authorities to propose a mutually acceptable solution for both parties in order to avoid lethal deadlock.

Contract treatment units and drug-free units

WHO (2000) observe that, the purpose of staying in a contract treatment unit is that the inmate will remain drug free or at least become motivated for continued treatment after imprisonment. Attempts will be made to motivate the inmate to strengthen

his or her health and personality, to participate in work routines and to maintain and strengthen his or her social network. Before being placed in the unit, inmates have to declare, by signing a contract, that they are willing to remain drug-free during their stay, to submit to regular urine sampling to check for the absence of drugs and to participate actively and positively in the life of the unit.

The unit offers support in the form of close staff contact and possibly relaxed prison conditions for treatment reasons as long as the inmate refrains from taking drugs during the prison term. The contract treatment units work with group therapy and behavioural consciousness. The treatment principles for the contract treatment units reflect a fundamental concept that the inmates can be supported in their decision to stop drug use by offering close personal contact and talks with abuse experts. Thus, a person is attached to each inmate in a contact person scheme in the units. The contact person is responsible for the inmate's treatment plan and for handling general casework concerning the inmate.

Moreover, WHO Regional Office for Europe (2003) noted that treatment includes sessions with supervisors: external people with a theoretical and practical background as therapists. The contact person, the supervisor and the inmate hold regular sessions tripartite talks to investigate the inmate's development and consider the course of the future treatment. Another part of the treatment is the group dynamics. This consists of motivating the inmates to support each other in the everyday life in the unit. Group dynamics are developed by creating good physical surroundings and an open environment in the units and by both staff and inmates participating in a series of activities inside and outside the unit. Finally, the units work with the concept of the

consequential teaching procedure, which means that an inmate caught using drugs or counteracting the principles of the unit is expelled from the unit. The treatment plans take into account the treatment needs of the individual. They set out targets for the inmates' stay in the unit, and decisions are made on any further treatment outside.

Abstinence-oriented treatment and therapeutic communities in prison

WHO Regional Office for Europe (2003a) observed that abstinence-oriented treatment for prisoners is provided predominantly in special facilities (therapeutic communities). Most of the Council of Europe countries have abstinence-based programmes. Therapeutic communities are intensive treatment programmes for prisoners with histories of severe drug dependence and related offending who have a minimum of 12–15 months of their sentence left to serve. Therapeutic communities are drug-free environments that implement an intensive treatment approach that requires 24-hour residential care and comprehensive rehabilitation services. Residents are expected to take between 3 and 12 months to complete the programme. In general, therapeutic community treatment models are designed as total-milieu therapy, which promotes the development of pro-social values, attitudes and behaviour through positive peer pressure.

Although each therapeutic community differs in terms of servi-programmes are based on a combination of behavioural models with traditional group-based, confrontational techniques. As a high-intensity, often multistage programme, therapeutic communities are provided in a separate unit of the prison.

Many in-prison therapeutic communities ensure a continuum of care by providing community-based aftercare, which is closely connected to the specific therapeutic community and part of the correctional system. Hardly any research has been done on the

effectiveness of therapeutic communities. Any programmes evaluated have mainly been at the local or prison level and are not representative for the respective country.

Substitution treatment

WHO Regional Office for Europe (2003a) observed that substitution has become a widely acknowledged and adopted treatment option for drug users in the last 20 years. An estimated 550 000 people currently participate in these programmes in Europe. Substitution treatment has a long and varied history. In Western Europe, the first methadone programmes were introduced from the late 1960s in Denmark, the Netherlands, Sweden and the United Kingdom; the 1970s in Finland, Italy, Luxembourg and Portugal; the 1980s in Austria and Spain; and the 1990s in Belgium, France, Germany, Greece and Ireland. Different types of substitution programmes exist, from low-threshold programmes in some countries to high threshold ones in others.CES provided, most Already in 1993, the *Guidelines on HIV infection and AIDS in prisons* (WHO, 1993) stated: "Prisoners on methadone maintenance prior to imprisonment should be able to continue this treatment while in prison. In countries where methadone maintenance is available to opiate-dependent individuals in the community, this treatment should also be available in prisons."

The aims of methadone (or other substitution) treatment in detention are to help:

- to reduce the demand (craving) for opiates in detention;
- to reduce the risks of transmission of infectious diseases (HIV and hepatitis Band C);
- to facilitate contact with health care and enable the treatment of other diseases;
- to reduce recidivism;

- to stabilize drug users physically and socially to increase their motivation for participation in further support programmes; and
- to provide a basis for participation in working, education, and training.

More and more countries provide substitution treatment in prisons (Stöver *et al.*, 2004). Scientific studies (Dolan *et al.*, 2005) have proven that this reduces the frequency of injecting among inmates and significantly reduces the incidence of hepatitis C. In addition, the provision of substitution treatment in prison has also been shown to contribute to a significant reduction in serious drug charges and in behaviour related to activities in the drug subculture. Offenders participating in substitution treatment generally tended to have lower and slower readmission rates than people not on substitution treatment. Finally, evidence (Stallwitz & Stöver, in press) indicates that continued substitution treatment in prison benefits in transferring prisoners into drug treatment after release.

However, for prison-based methadone programmes to be effective, a sufficiently high dose of methadone (more than 60 mg) must be provided for the entire period of imprisonment. Both research into the subjective experiences of inmates participating in substitution programmes and research into the organizational aspects of substitution programmes reveals the heterogeneity of prescription practices and policies in prisons. Short courses of methadone detoxification are frequently experienced as insufficient and inadequate, and prisoners have expressed their dissatisfaction with such a procedure. Scientific evidence (Stöver *et al.*, 2004) strongly suggests continuing substitution treatment begun in the community; adapting the dosage due to the strongly supervised intake situation in the prison setting can be considered.

Very striking is also the inconsistency in methadone prescription in prison compared with the community. The disruption of treatment when entering penal institutions can lead to physical and mental problems and to an increase in injecting drug use and sharing of injecting equipment in prison as well as to an increased risk of fatal overdose after release. Singleton *et al.*, (2003) reported that, in the week following release, prisoners are about 40 times more likely to die than the general population. They recommend providing methadone maintenance in prisons for all individuals with long-standing opioid dependence. In order to meet the requirement that people in prison have access to the same treatments offered outside prison, inmates falling into the following groups should be permitted to participate in methadone treatment in detention:

- those who had already started methadone treatment before imprisonment; and
- those who apply for participation in methadone treatment after incarceration, while in prison, and who meet the requirements for this treatment.

Counselling and peer support

Peer education and peer support can be defined as the process by which trained people carry out informal and organized educational activities with individuals or small groups in their peer group (people belonging to the same societal group, such as of the same age or prisoners). Peer education has the overall aim of facilitating improvement in health and reduction in the risk of transmitting HIV or other bloodborne diseases, targeting individuals and groups that cannot effectively be reached by existing services.

Based on the data available and extrapolating from the literature on community based programmes, education programmes in prisons – as in community settings – are

more likely to be effective if peers develop and deliver them. As Grinstead *et al.,* (1999) have stated:

> *When the target audience is culturally, geographically, or linguistically distinct, peer education may be an effective intervention approach. Inmate peer educators are more likely to have specific knowledge about risk behavior occurring both inside and outside the prison. Peer educators who are living with HIV may also be ideal to increase the perception of personal risk and to reinforce community norms for safer sexual and injection practices. Peer education has the additional advantage of being cost-effective and, consequently, sustainable Inmate peer educators are always available to provide services as they live alongside the other inmates who are their educational target.*

2.1.3 Health workers reformative role and wellbeing of inmates

Podrasky and Sexton (2008) avers that, for the wellbeing of inmate in the prisons, the physician- health worker and the medical social workers in the prisons must visit patients regularly and, if the patient agrees, conduct regular follow-up examinations. These consultations should be held in a positive, personalized climate, and the physician should inform patients of the progressive decline of health. In this way, strikers can freely change their mind at any time and abandon the strike, having been duly informed of the worsening nature of the risks to which they are exposing themselves.

World Medical Association (2006).Medical personnel seriously violate the rules of medical ethics if they:

- in any way assist in (even by merely being present) sessions of torture or advise the torturers;
- provide facilities, instruments or substances to that effect;
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However, the health service in a prison can potentially play a very important role in the fight against ill treatment within the establishment and elsewhere (specifically police stations). In the context of medical consultations, people sometimes show physical signs or even mental symptoms compatible with having been subjected to torture or other forms of cruel, inhuman or degrading treatment. In light of these facts, the physical and mental examination performed on admission of a newcomer is particularly important.

WHO Regional Office for Europe (1999) noted that during a physical examination (and most specifically the one performed upon arrival), any trace of violence compatible with torture must be duly noted and registered, both in the personal file of the detainee as well as any general register listing traumatic lesions. Equally, any psychological or psychiatric disturbances that may also indicate that the person has been subjected to any form of ill-treatment must be recorded. Such information must be automatically transmitted with no delay to the prison or judiciary surveillance authorities. Detainees can obtain a copy of their medical report at any time.

However, the simple fact of being identified by the health care services as bearing traces of traumatic lesions or mental symptoms compatible with torture can trigger measures of reprisal against the victim. In order to best protect patients from this risk of retaliation, doctors must formally inform patients that they are going to report to the competent authority the evidence they have gathered during the consultation. If the patients fear that they will be subjected to reprisal, they may decide not to divulge how the lesions were inflicted and even lie about them.

In their report, doctors must clearly distinguish between the allegations (circumstances of the physical or mental trauma as described by the patient) and the

complaints (subjective sensations experienced by the patient) from the clinical and para-clinical objective findings (mental state; size, location, aspect of the lesions, X-rays, laboratory results, etc.). If the doctors' training and/or experience allow it, they must indicate whether the patients' allegations are compatible with their own clinical findings. Health professionals should never be complicit in any way (even by their presence)to capital punishment, should not be involved in examining the detainee immediately before the execution, nor in confirming death and should not issue the death certificate.

United Nations (1966) observed that one of the central pillars of health promotion is the concept of empowerment and reformation of inmates: the individual inmate has to be able to make healthy choices and has to be allowed to do so with the help of a health care professionals. In health promotion in prisons, this approach is not possible. It is therefore important that as much empowerment and reformation as possible be built into the prison regime. One area that has been found to be important is providing health information to prisoners. United Nations (1966) observed that Fact sheets should be made available for prisoners suffering from chronic ailments such as diabetes, explaining what the prison health service can provide and providing advice as to how the prisoner can best cope with such an illness while in prison. If written fact sheets will not be effective, because of language barriers or poor literacy, alternative ways of sharing information should be used, such as the use of videos and other visual aids or health discussion groups with a trained health worker. Selected fact and advisory sheets can be produced based on this guide and adapted for use where necessary. WHO Regional Office for Europe (2003) noted that, regular contact with local community services and the involvement of voluntary agencies can assist greatly in promoting health and well-being

in prisons. Where possible, prisoners should be connected to key community services before leaving prison, such as probation or parole and social services.

The European Health Committee (established in 1954 by the Committee of Ministers of the Council of Europe) stated in 1995: One of the inevitable consequences of imprisonment is the temporary weakening of social contacts. It is true that family ties are not broken off completely, in the sense that in most cases a visit of at least one hour per week is permitted; nevertheless the prisoners' relationships suffer enormously from the confinement. A large number of wives, husbands and children of detainees feel punished themselves to a similar extent as their convicted spouses and fathers. Besides, and worse still, in many cases the marriage is bound to fail or be ruined.

Social contacts in general also suffer as a consequence of the imprisonment. In some countries such as Denmark and Switzerland, prisoners are given the opportunity to see their partners without supervision. Supervision is fairly relaxed in Sweden. Working with families of prisoners is a central part of rehabilitation and social reintegration in many countries. In some (such as Scotland, United Kingdom), special family contact development officers are employed to help families to keep or initiate contact with prisoners' relatives, to help to work on relatives' drug problems, to inform families about drug problems in prison and outside and to enhance family visits.

The drug strategy of HM Prison Service for England and Wales (United Kingdom Parliament, 1999) defines throughcare as follows: "By throughcare we mean the quality of care delivered to the offender from initial reception through to preparation for release establishing a smooth transition to community care after release". The aims are as follows:

- to understand the pressures and fears affecting people's judgement on entry to prison;
- to ease the transition process between the community and prison for drug users;
- to provide continuity, as far as possible, for those receiving treatment and support in the community on arrival in prison, on transferring between prisons and on returning to the community;
- to recognize the opportunity that imprisonment offers to drug users to begin to deal with their drug misuse problem, particularly for those with no experience of community helping agencies;
- to ensure that drug users have the opportunity of leaving prison in a better physical state, with a less chaotic lifestyle, than when they entered; and
- to minimize the dangers of reduced tolerance levels on release from prison.

The Scottish Prison Service has general considerations required for through care:

- good working relationships and clear lines of communication between prisons and external service agencies;
- drug workers using a partnership approach in prison with their clients;
- encouraging contacts between external agency and inmate; and
- maintaining continuity of care where possible, particularly for short-term prisoners.

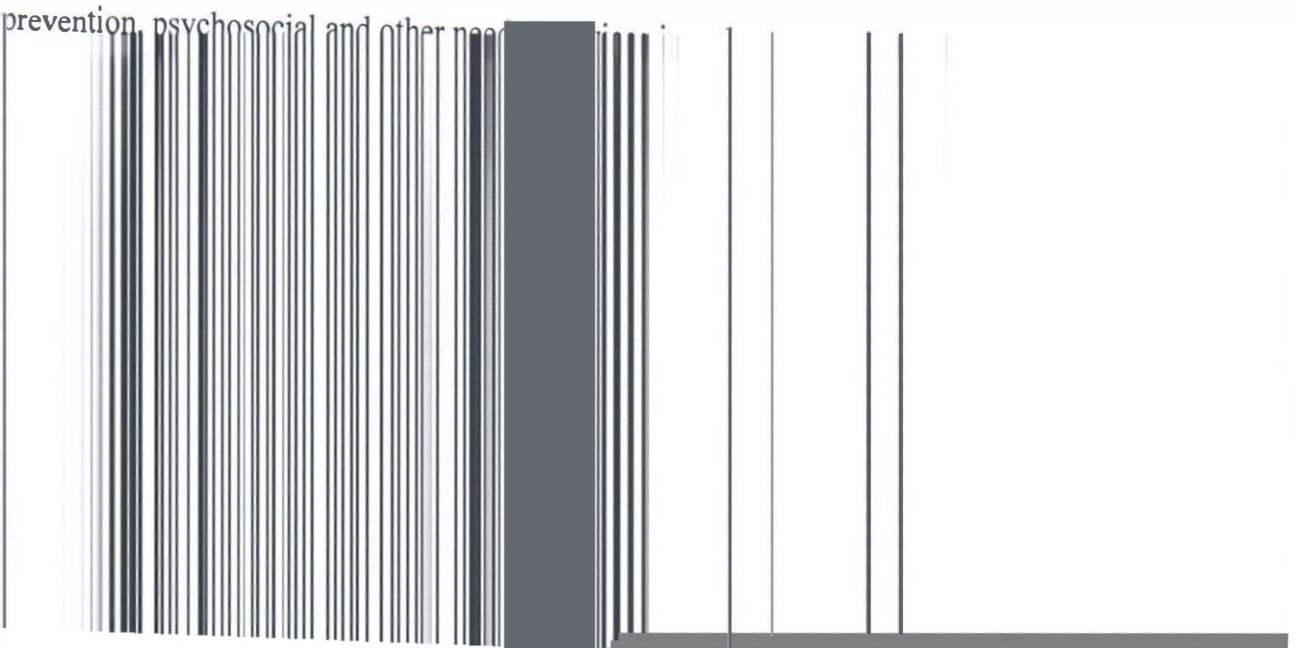
Throughcare must involve multi-agency cooperation, which means intensive integration of external agencies that, at the time of release, will continue these efforts. The point of release is vital: how will the treatment work started in prison be continued on the outside, and have the treatment in prison and that available outside been

coordinated? The phase of preparation for release should involve community based professional drug workers. After release, probation officers are involved in further treatment.

Several countries have legal provisions for suspending the sentence of drug users. In Sweden, Section 34 of the Prison Treatment Act states that a prisoner may be permitted – while still serving the prison sentence – to be placed in a treatment facility outside prison. This is not by definition a suspended sentence – it is an alternative to staying in prison until release. Another possibility is that the court sentences a person to probation with contract treatment. This is possible when there is a clear connection between drug abuse and crime. The person has to accept and give consent to treatment instead of prison. If the person interrupts or neglects the treatment, the contract treatment will be interrupted and converted into a prison sentence.

In Germany, Section 35 of the Opium Law allows prisoners to undergo treatment instead of punishment when the sentence is no more than two years. In Greece, after a period of 7–10 months in custody, a drug user may apply to the public prosecutor to continue treatment outside prison, using a law specifically designed to allow drug users to receive therapeutic treatment rather than to stay in prison.

WHO Regional Office for Europe (1999) observed that counselling is a direct, personalized and client-centred intervention designed to help initiate behaviour change – keeping off drugs, avoiding infection or, if already infected, preventing transmission to other inmates or partners – and to obtain referral to additional health care, disease prevention, psychosocial and other need[illegible]



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WHO Regional Office for Europe (1999) observed that counselling is a direct, personalized and client-centred intervention designed to help initiate behaviour change – keeping off drugs, avoiding infection or, if already infected, preventing transmission to other inmates or partners – and to obtain referral to additional health care, disease prevention, psychosocial and other needed services in order to remain healthy.

Health care employees require different information than guards or surveillance staff; inmates have their own specific background, subculture and language. Disease prevention material from the outside cannot simply be transferred to the prison setting the relevant target groups require prison-adapted versions. This requires input from different groups based on interviews and focus-group discussions. Initial drafts and design need to be tested and approved. Both prison staff and prisoners greatly influence any prison environment. Both groups should therefore participate actively in developing and applying effective preventive measures and in disseminating relevant information.

Involvement and support from municipal health structures should have priority; nongovernmental HIV and AIDS organizations have especially valuable expertise and networks that can contribute to enhancing the quality of material development and sustaining this as an ongoing activity.

According to Wool and Pont (2006), many Länder in Germany include external drug service providers in taking care of inmate drug users. Some prisons even have their own advisory bureau on drug issues, and the social workers in some prisons take care of these problems. In contrast to internal workers, prisoners more widely accept and trust external workers because the outsiders have a duty to maintain confidentiality and have the right to refuse to give evidence. Moreover, the external workers are more experienced and know about the content of and requirements for the various support services offered. Counsellors on drug issues in prison should primarily provide information about the various support services and programmes available inside and outside prisons. In a second step, their efforts should focus on motivating prisoners to overcome their drug

use. A major advantage of external drug counselling is that it links life inside and outside the prison and thus is very helpful for continuing treatment that was started in prison.

World Medical Association (2006) observed that both doctors and prison staff confront multiple drug use in their everyday routine work. Use of benzodiazepines and opioids is widespread, and withdrawal and craving are relatively frequent. Nevertheless, physicians and prison personnel know too little about issues and problems related to drug use. It is vital, therefore, that staff receive adequate training to tackle the problems connected with drug use in prisons and to move towards a more treatment-focused approach. Prison staff need training and regular updating on all aspects concerning HIV, hepatitis and drug abuse, especially on medical, psychological and social aspects, in order to feel secure themselves and be able in addition to give prisoners appropriate guidance and support.

2.1.4 Health workers educational awareness role

Coyle and Stern (2004) and Tomascevski, (1992) observed that, In addition to providing health care, prisons should also provide health education, patient education, prevention and other health promotion interventions to meet the assessed needs of the prison population. Good health and well-being are keyto successful rehabilitation and resettlement, and in turn this requires an environment in each prison that is supportive of health. This chapter offers guidance to help those working with prisoners:

- to build the physical, mental and social health of prisoners (and where appropriate staff) as part of a whole-prison approach;

- to help prevent the deterioration of prisoners' health during or because of custody; and
- to help prisoners adopt healthy behaviour that can be taken back into the community.

However, imprisonment is also a unique opportunity for all aspects of health promotion, health education and disease prevention.

- Prison offers access to disadvantaged groups who would normally be hard to reach. It is therefore a prime opportunity to address inequality in health by means of specific health interventions as well as measures that influence the wider determinants of health.
- Each prison has the potential to be a healthy setting: a single institution can address spiritual, physical, social and mental health and well-being.
- For the many prisoners who have led chaotic lifestyles prior to imprisonment, this is sometimes their only opportunity for an ordered approach to assessing and addressing health needs.

Assessment of health needs lies at the heart of successful interventions and useful outcomes. Health needs can be assessed by examining the epidemiological evidence and talking to stakeholders (including physicians and other health care staff but, importantly, all other staff who influence prisoners, such as education staff, and also prisoners themselves). The following section lists topics that are likely to be relevant in prisons across Europe, although it is far from exhaustive. Priorities must be created through a local process of assessing health needs. All prisoners are likely to need:

- advice on preventing communicable diseases, including advice on avoiding sexually transmitted diseases, HIV infection and hepatitis, and advice on hepatitis B immunization;
- advice on high-risk lifestyles, including advice on avoiding drug overdose on leaving prison (needed by everyone because staff cannot identify everyone at risk); and protection against harm caused by smoking (including passive smoking);
- support in adopting healthy behaviour, including appropriate levels of physical activity and a balanced diet; and measures to promote mental health, including adequate time for association; a meaningful occupation (work, education, artistic activity and physical education);and contact with the outside world and help in maintaining family ties.

It requires that all prisoners should be considered to have these needs, although not all prisoners are necessarily at high risk. This is because staff has difficulty in identifying everyone at high risk and because all prisoners need information to reduce fear and stigma. These sorts of measures involve policy and practice not necessarily intended to affect health but with the potential to affect an individual's health and well-being. Many prisoners are likely to need:

- training in psychological skills, including training in cognitive behavioural skills, activities to improve self-esteem, training for enhancing thinking skills and training in how to manage anger;

- health education and health-related education, including practical skills training in job search skills, parenting education, training in social and life skills, dietary advice and advice on physical activity and smoking; and
- specific health promotion interventions including access to a listener, buddy or
- the equivalent and support to give up drugs, alcohol or smoking.

In many instances, a significant number of prisoners likely to need:

- education related to illnesses such as tuberculosis, including treatment options;
- immunization against tuberculosis, Pneumococcus infection or influenza;
- advice on specific conditions, such as minor illness, diabetes, epilepsy, asthma, menopause and sickle-cell disease; and
- access to cancer prevention and advice and services for early detection.

Governors, working in partnership with the National Health Service, must ensure that ... they have included health promotion considerations adequately and explicitly within their local planning mechanisms.... The Health Promotion Section in the local plan must specifically address, as a minimum, needs in the five major areas:

1. mental health promotion and well-being
2. smoking
3. healthy eating and nutrition
4. healthy lifestyles, including sex and relationships and active living
5. drugs and other substance misuse

These areas of health and well-being should reflect a process of health needs assessment and not just healthcare needs assessment, and should involve a whole prison approach. Consultation should represent a wide variety of professional stakeholders, and

prisoners must also be involved in this process. Prison Service Order 3200 has helped raise the profile of health promotion and the important contribution prisons can make to public health in England and Wales.

The United Nations (1990) observed that Basic Principles for the Treatment of Prisoners indicate how the entitlement of prisoners to the highest attainable standard of health care should be delivered: "it is noted that, Prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation" (Principle 9). In other words, the fact that people are in prison does not mean that they have any reduced right to appropriate health care. Rather, the opposite is the case. Health workers role is tied to educating inmate on help safety measures in and outside the correctional institution. However, when a state deprives people of their liberty, it takes on a responsibility to look after their health in terms both of the conditions under which it detains them and of the individual treatment that may be necessary.

All health care staff members who work in prisons must always remember that their first duty to any prisoner who is their patient is clinical education. This is underlined in the first of the United Nations (1982) Principles of Medical Ethics relevant to the Role of Health Personnel, particularly Physicians, in the Protection of Prisoners and Detainees against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, which states: Health personnel, particularly physicians, charged with the medical care of prisoners and detainees have a duty to provide them with protection of their physical and mental health and treatment of disease of the same quality and standard as is afforded to those who are not imprisoned or detained.

Peer educators can play a vital role in educating other prisoners, since most of the behaviour that puts prisoners at risk of HIV in prisons involves illegal (injecting drug use) or forbidden (same-sex activity and tattooing) and stigmatized (same-sex activity) practices. Peers may therefore be the only people who can speak candidly to other prisoners about ways to reduce the risk of contracting infections. As well, peer educators' input is not likely to be viewed with the same suspicion as the information provided by the prison hierarchy. Peer educators are more likely to be able to realistically discuss the alternatives to risk behaviour that are available to prisoners and can better judge which educational strategies will work within their prison and the informal power structure among prisoners. Finally, peer-led education has been shown to be beneficial for the peer educators themselves: individuals who participate as peer educators report significant improvements in their self-esteem (Van Meter, 1996).

However, as with other education programmes, preventive education among peers is difficult when prisoners have no means to adopt the changes that would lead to healthier choices. Peer support groups need to be adequately funded and supported by staff and prison authorities, and need to have the trust of their peers, which can be difficult when the prison system appoints prisoners as peer educators because it trusts them, rather than because the prisoners trust them (Wykes, 1997).

Best practice

In addition to peer education by and for inmates, external organizations operating outreach activities (among injecting drug users) can conduct health promotion. Mainline, a health promotion and disease prevention organization in the Netherlands, maintains

contact with detained drug users by low-threshold counseling in prison settings. In individual meetings with inmates, health issues, risk behaviour and the risks of drug use are discussed. An important feature is that as an external organization, Mainline is independent of the prison system and enjoys the trust of the prisoners. Evaluation of their activities has shown: a high level of acceptance among inmates, prison staff and administration; the activity enhances ongoing contact after release; their work is perceived as a valuable addition in the social support structure for drug users; and it is cost-effective.

Harm reduction programmes

A *Status paper on prisons, drugs and harm reduction* (WHO Regional Office for Europe, 2005) defined harm reduction measures in prisons: "In public health relating to prisons, harm reduction describes a concept aiming to prevent or reduce negative health effects associated with certain types of behaviour (such as drug injecting) and with imprisonment and overcrowding as well as adverse effects on mental health."

Harm reduction acknowledges that many drug users cannot totally abstain from using drugs in the short term and aims to help them reduce the potential harm from drug use, including by assisting them in stopping or reducing the sharing of injecting equipment in order to prevent HIV transmission that, in many ways, is an even greater harm than drug use. In addition, the definition WHO adopted acknowledges the negative health effects imprisonment can have. These include the impact on mental health, the risk of suicide and self-harm, the need to reduce the risk of drug overdose on release and the harm resulting from inappropriate imprisonment of people requiring facilities unavailable in prison or in overcrowded prisons.

As shown above, many prisoners continue to use drugs in prison, and some people start using drugs in prison. Despite often massive efforts to reduce the supply of drugs, the reality are that drugs can and do enter prisons. In prisons, as in the community, harm reduction measures have been successfully implemented in the past 15 years throughout Europe as a supplementary strategy to existing drug-free programmes. Harm reduction does not replace the need for other interventions but adds to them and should be seen as a complementary component of wider health promotion strategies.

The following hierarchy of goals should guide drug policy, in prisons as outside:

- securing survival
- securing survival without contracting irreversible damage
- stabilizing the addict's physical and social condition
- supporting people dependent on drugs in their attempt to lead a drug-free life.

The following text describes some of the most important measures.

Providing disinfectants

Providing bleach or other disinfectants to prisoners is an important option to reduce the risk of HIV transmission through the sharing of injection equipment, particularly where sterile injection equipment is not available. Many prison systems have adopted programmes that provide disinfectants to prisoners who inject drugs as well as instructions on how to disinfect injecting equipment before reusing it. Evaluations of such programmes (Correctional Service of Canada, 1999; Dolan et al., 1994, 1999; WHO, 2004) have shown that distributing bleach is feasible in prisons and does not compromise security.

However, studies in the community have raised doubts about the effectiveness of bleach in decontaminating injecting equipment. Today, disinfection as a means of HIV prevention is regarded only as a second-line strategy to syringe exchange programmes (United States Centers for Diseases Control and Prevention, 1993). Cleaning guidelines recommend that injecting equipment be soaked in fresh full strength bleach (5% sodium hypochlorite) for a minimum of 30 seconds. More time is needed for decontamination if diluted concentrations of bleach are used.

Further, a review of the effectiveness of bleach in the prevention of hepatitis C infection (Kapadia *et al.*, 2002) concluded that, "although partial effectiveness cannot be excluded, the published data clearly indicates that bleach disinfection has limited benefit in preventing [hepatitis C virus] transmission among injection drug users". In prisons, the effectiveness of bleach as a decontaminant may be reduced even further. There are at least three reasons for this (Small *et al.*, 2005; Taylor & Goldberg, 1996). The type of injecting equipment available in prisons, often consisting of whatever can be fashioned into something that pierces the skin, may be more difficult to effectively disinfect with bleach than the syringes used outside prison (on which the studies were undertaken).

- Even when bleach is made available in some locations in prison, prisoners may have problems accessing it.
- Cleaning is a time-consuming procedure, and prisoners are unlikely to engage in any activity that increases the risk that prison staff will be alerted to their drug use.

Bleach programmes should therefore be introduced in prisons but only as a temporary measure where there is implacable opposition to needle and syringe

programmes or in addition to such programmes (WHO, 2004). Where bleach programmes are implemented, full-strength household bleach should be made easily and discreetly accessible to prisoners in various locations in the prison, together with information and education about how to clean injecting equipment and information about the limited efficacy of bleach as a disinfectant for inactivating HIV and particularly hepatitis C virus.

Needle and syringe exchange programmes

In the community, needle and syringe exchange programmes are widely available in many countries and have been proven to be the most effective measure available to reduce the spread of HIV through the sharing of contaminated injecting equipment. Nevertheless, in prisons, needle and syringe programmes remain rare. However, such programmes have been successfully introduced in a growing number of prisons in a steadily growing number of countries including Belarus, Germany, Kyrgyzstan, Luxembourg, the Republic of Moldova, Scotland (United Kingdom), Spain and Switzerland.

Evaluations of existing programmes (Lines *et al.*, 2006; Stöver & Nelles, 2004; WHO, 2004) have shown that such programmes:

- do not endanger staff or prisoner safety, and in fact, make prisons safer places to live and work;
- do not increase drug consumption or injecting;
- reduce risk behaviour and disease transmission, including HIV and hepatitis C virus;

- have other positive outcomes for the health of prisoners, including a drastic reduction in overdoses reported in some prisons and increased referral to drug treatment programmes;
- have been effective in a wide range of prisons;
- have successfully employed different methods of needle distribution to meet the needs of staff and prisoners in a range of prisons; an
- have successfully cohabited in prisons with other programmes for preventing and treating drug dependence.

When prison authorities have any evidence that injecting is occurring, they should therefore introduce needle and syringe programmes, regardless of the current prevalence of HIV infection. As early as 1993, the *Guidelines on HIV infection and AIDS in prisons* (WHO, 1993) recommended that "in countries where clean syringes and needles are made available to injecting drug users in the community, consideration should be given to providing clean injection equipment during detention and on release". UNAIDS and many other national and international bodies have made the same recommendation.

The International guidelines on HIV/AIDS and human rights (Office of the United Nations High Commissioner for Human Rights and UNAIDS, 2006) also specifically state that prison authorities should provide prisoners with means of preventing HIV transmission, including "clean injection equipment".

Best practice

Two prisons in Spain introduced needle and syringe programmes in 1998–1999 as a pilot study. Following positive results, nine other prisons joined voluntarily. Evaluation showed the following.

- Implementation in a prison setting is feasible and can be adapted to the conditions of a prison.
- Needle and syringe programmes in prison produce changes in the behaviour of prisoners that lead to less risky injection practices.
- Needle and syringe programmes in prisons help to persuade prisoners to take up drug treatment.
- Implementation of needle and syringe programmes does not generally lead to an increase in heroin or cocaine use.

In 2001, prison authorities issued a directive requiring all prisons to implement needle and syringe programmes as part of the prison regime. As of 2005, these programmes were operating in 33 prisons in Spain. In Kyrgyzstan, one prison started a needle and syringe pilot project in October 2002. The prison decided to provide injecting equipment in a location where prisoners could not be seen by guards; they therefore took place in the medical wards. The pilot also provided secondary exchange using prisoners as peer volunteers. The project coordinators found that both options for providing injecting equipment were needed. In early 2003, an order was issued approving the provision of sterile needles and syringes in all prisons in Kyrgyzstan, and by April 2004 they were available in 11 prisons. In all institutions, needles and syringes are provided using prisoners trained as peer outreach workers who work with the health care unit. In April 2004, approximately 1000 drug users were accessing the needle and syringe programme.

Drug users are provided with one syringe and three extra needle tips. This allows prisoners who inject drugs to inject more – up to three times a day without having to

reuse a syringe. This also reduces the cost of the programme, since tips cost less than complete needles.

Transferring harm reduction strategies into the prison setting

Despite the evidence that prisons can successfully introduce harm reduction measures, with positive results for prisoners, staff and ultimately for the community, many are still afraid that introducing harm reduction measures would send the "wrong message" and make illicit drugs more socially acceptable. Many prisoners are in prison because of drug offences or because of drug-related offences. Preventing their drug use is an important part of their rehabilitation. Some have said that acknowledging that drug use is a reality in prisons would be acknowledging that prison staff and prison authorities have failed. Others say that making needles and syringes available to prisoners would mean condoning behaviour that is illegal in prisons. However, since HIV seriously threatens prisons and communities, harm reduction measures must be introduced to protect public health. Making available to prisoners the means necessary to protect them from HIV and hepatitis C virus transmission does not mean condoning drug use in prisons.

Introducing needles and syringes is not incompatible with a goal of reducing drug use in prisons. Making needles and syringes available to drug users has not increased drug use but has reduced the number of injecting drug users contracting HIV and other infections. Refusing to make needles and syringes available to prisoners, knowing that activities likely to transmit HIV and hepatitis C virus are prevalent in prisons, could be seen as condoning the spread of HIV and hepatitis C virus among prisoners and to the community at large.

As early as in 1993, WHO (1993) recommended a range of effective activities for preventing HIV infection and AIDS in prisons:

- measures to reduce the number of injecting drug users in prisons;
- measures to prevent drug use;
- information about the risks of injecting forms of drug application;
- information about the risks of needle-sharing;
- demonstrating means of disinfection and providing those means and means for
- hygienic drug use (alcohol swabs etc.); and
- providing sterile syringes.

Involvement of community services

In the past decade, approaches have developed and grown substantially to divert individuals away from prison and into treatment alternatives as well as a range of services within prisons. Specific legislation in several countries has attempted to enhance links between the criminal justice system and health services to reduce the number of drug users entering prison. Despite this development, the number of prisoners with drug dependence has continued to grow. As drug users often serve short sentences, they return into their communities and many return to their old drug-using habits. Support services need to be continued in order to sustain successes that may be achieved while in custody. This indicates that criminal justice agencies need to link better with drug services.

Prerelease units

Prisoners should begin to be prepared for release on the day the sentence starts as part of the sentence planning process. All staff should be involved in preparing prisoners

for release. Good release planning is particularly important for drug-using prisoners. The risks of relapse and overdose are extremely high. Measures taken in prison to prepare drug-using prisoners for release include:

- implementing measures to achieve and maintain drug-free status after release;
- granting home leave and conditional release, integrated into treatment processes; cooperating with external drug services or doctors in planning a prisoner's release;
- involving self-help groups in the release phase; and
- taking effective measures in prison to prevent prisoners from dying of a drug overdose shortly after release.

The challenge for prison services in facilitating a successful return to the community is not only to treat a drug problem but also to address other issues, including employability, educational deficits and maintaining family ties. Harm reduction information needs to be provided to reduce the risk of a relapse to heroin or multiple drug use after leaving the prison. Few prisons speak frankly and proactively about relapse. The prison in Antwerp makes available a brochure for those who leave the prison. It specifically focuses on practical information, health and risk problems (such as overdose) at the time of release.

Many prisons undertake efforts to reduce relapse and to provide social reintegration. Protocols are therefore sometimes set up with drug treatment centres from the national and community health networks. In Portugal, for instance, some projects focus on preparing for freedom and that getting a life means getting a job. Moreover, peer groups are developed to support treated drug addicts to prevent relapse.

Aftercare

Several studies (Zurhold *et al.*, 2005) show that effective aftercare for drug using prisoners is essential to maintain gains made in prison-based treatment. Nevertheless, prisoners often have difficulty in accessing assessments and payment for treatment on release under community care arrangements. The following conclusions are drawn from a multi-country survey on aftercare programmes for drug-using prisoners in several European countries (Fox, 2000).

- Aftercare for drug-using prisoners significantly decreases recidivism and relapse rates and saves lives.
- Interagency cooperation is essential for effective aftercare. Prisons, probation services, drug treatment agencies and health, employment and social welfare services must join to put the varied needs of drug-using offenders first
- Drug treatment workers must have access to prisoners during their sentence to encourage participation in treatment and to plan release.
- Short-sentence prisoners are most poorly placed to receive aftercare and most likely to re-offend. These prisoners need to be fast-tracked into release planning and encouraged into treatment.
- Ex-offenders need choice in aftercare. One size does not fit all in drug treatment.
- Aftercare that is built into the last portion of a sentence appears to increase motivation and uptake
- In aftercare, housing and employment should be partnered with treatment programmes. Unemployed and homeless ex-offenders are most likely to relapse and re-offend.

2.2 Theoretical framework

2.2.1 Rehabilitation Theory

The theory of rehabilitation was propounded by `Cialdini (2007) to justify essence of rehabilitation, by emphasizing treatment of discharged offenders. Treatment in this context means any and all efforts aimed at the remission of criminal behavior and the social reintegration of the offender within the community. This theory argues that people are self-determinate beings whose ability to freely choose is frequently obstructed by various social conditions which might lead to crime. Therefore, the theory emphasizes treatment programmes that have the goals of making offenders' law-abiding self-dependent and contributing members of the society.

Reaction to the early schools of penology and the idea that something more was needed, slowly gained acceptance throughout the nineteenth century. Jean Hampton, the major adherent of this theory sees punishment from different points of view that the aim of the penal system should be treatment and correction. The assumption of rehabilitation is that people are not natively criminal and that it is possible to restore a criminal to a useful life, to life in which they contribute positively to the development of themselves and the society. According to Packer as cited in Dambazau (2007), the rehabilitation theory teaches us that "we must treat each offender as an individual whose special needs and problems must be known in order to enable us deal effectively with him". Analyzing rehabilitation as a justification for punishment, packer further noted that the rehabilitative idea may be used to prevent crime by changing the personality of that offender that punishment in the theory is forward looking; that the inquiry is not into how dangerous the offender is but rather into how amenable to treatment he is. However,

packer also noted that the gravity of the offence committed may not give us clue as to the intensity and duration of the measures needed to rehabilitate.

In addition, Siegel (2005) affirmed that: rehabilitation embraces the notion that given the proper care and treatment, criminals can be changed into productive, law abiding citizens. Influenced by the positivist criminology, the rehabilitation school suggests that people commit crimes through no fault of their own. Instead criminals themselves are the victims of social injustice, poverty and racism, their acts are a response to a society that has betrayed them and because of their disturbed and impoverished upbringing (Siegel, 2005).

Similarly, Ugwuoke (2000) observed that, rehabilitation requires that the offender be treated humanely with dignity and respect, be shown love, kindness and compassion not cruelty, contempt and hate. The theoretical framework for this study is hinged on the rehabilitative perspective by Siegel (2005). This theory indeed captures the thrust of this study as it tries to establish the justification or rationale of health workers service delivery for the benefit of improving the health of inmates specifically through their preventive, curative, reformative and educational awareness services. The ultimate aim being to reform the attitude and behavior of the inmates so that they are able to legitimate sources of livelihood (Dinitz & Dine, 1979). This theory though relevant in the rehabilitation process of recidivist to find their footing and be integrated back to the society, does not recommend the necessary rehabilitation strategies that will empower and create self-reliance to the inmate when released from prison. The theory implies that rehabilitation cuts across health care services or the provision of good health care

services to inmates because no rehabilitation will take place if inmates are not in good health.

2.2.2 Antisocial personality disorder theory

The Antisocial Personality Disorder (ASPD) theory was developed by the American Psychiatric Association (APA, 2013) in the *Diagnostic and Statistical Manual of Mental Disorder* (DSMMD), as an explanation to the personality disorder that predisposes individuals to aggression, violence and disregard of the rights of others. The basic of the ASDP holds that persons affected by this disorder have a tendency to exhibit antisocial behaviours, including impulsion for aggression. According to Mayo Clinic (2016), antisocial personality disorder is defined by a pervasive and persistent disregard for morals, social norms, and the rights and feelings of others. Antisocial personal disorder is seen to be caused by genetic and environmental factors (Mayo Clinic, 2016).

ASPD, which is a variant of psychopathy, is a disorder that diminishes the victim's capacity for remorse and empathy towards others. In this case, the health worker with ASPD is predisposed to violating the rights of inmates seeking rehabilitation. Since victims of ASPD who are inmates at this point have a diminished capacity for remorse and empathy towards others, it explains why health workers services are essential in the prison. Not only to catre for the health needs of inmates but also to help modify their behaviour because of the different character traits in the correctional institution or center. The health worker need to provide curative services to inmates with any psychiatric of mental health disorder as well as infectious disease. To this end, health care awareness subsists to help inmates take care of their health and other social needs to help them function optimally. The theory supports reformatory services by health care providers or

workers in the correctional institution. Through this health intervention role, inmates with attitude problems or personality disorders can be reformed and find their feet back to the society

In spite of its capacity to explain health workers services delivery and the wellbeing of inmates, the antisocial personality disorder theory has been criticized for overemphasis on criminal behaviour. It is argued that all humans have levels of personality disorder at some point. While some have consistent traits of disorder, others have spatial or intermittent display of this disorder. Thus, not all cases of disorder necessarily result into lack of empathy, lack of respect, violence, aggression and disregard for the needs of others.

2.2.3 Social Inequality theory of healthcare utilization

The major progenitor of the social inequality theory was Max Weber, a German sociologist (1864-1920) and was later popularized by other sociologists such as Karl Marx and Emile Durhkeim. Although Weber identified aspects of the social structure as class parties, status groups and bureaucracies, all of these groups were made up of individuals carrying out social actions (Harablambos & Holborn, 2004).

Social inequality theory is of the premise that socio-economic status of an individual determines the quality of their medical services in the society. This occurs when resources in a given society are distributed unevenly, typically through norms of allocation that engender specific patterns along lines of socially defined categories of persons. Social inequality is found in almost every society of the world. In view of this, Max Weber in his theory of social inequalities in health defines health inequalities as differences in health status or in the distribution of health determinants between different

population groups. Lack of health equity is also evident greatly in the developing countries like Nigeria, where the importance of equitable access to healthcare has been cited as crucial to achieving many of the Millennium Development Goals (MDG's). Health inequalities can vary greatly depending on the country one is looking at. Inequalities in health are often associated with socio-economic status and access to health care which involve differences in income, educational attainment, occupation, poverty level, etc. Health inequalities can occur when the distribution of public health services is unequal, for example, Nigeria from 2000 only 12% of government spending for health was for services consumed by the poorest 20% households, while the wealthiest 2% consumed 29% of the government subsidy in the health sector (Harablambos & Holborn, 2004). Access to health care is heavily influenced by socio-economic differences or status of the people which include education, income, occupation as well as poverty level in the utilization of healthcare services. In light of this, the wealthier population groups have a higher probability of obtaining high level health services or health care when they need it than low income earners in the society. A study by Makinen (2000), found that in the majority of developing countries, wealthier groups are more likely to utilize and receive Medicare than the poorest or low socio-economic background.

When viewed critically from this theoretical orientation, unlike circular resources distribution, this inequality occurs when health care services are giving or utilized based on one's social or income status in the society. The theory as applied to this work reiterated the uneven distribution of utilization of health care services to inmates based on one's social standing in society. The theory assumes the principle of partiality in health care service provisioning to favor the political or ruling class in society, giving this

backdrop, the poor or low income earners and inmates only get their service in an uncertified patent or outdate poor services.

The relevance of the theory as applied to this study in the sense that, irrespective of an individual social class (bond or free), there should be good health care services provision. That is, every individual be it an inmate or a free person should have access to preventive health care services, curative, reformative and health educational awareness services to help improve the health of inmates or individual. In any correctional center, the theory states that, inmates should have access to preventive, curative, reformative and health care education. This will help address health issues or infectious disease inmates may have contracted in the prison so as not to contaminate the general public after serving their jail term

This criticism is on the fact that, it does not address or highlight ways in which inequality in healthcare utilization can be eradicated among the vulnerable group like prison inmates. Individuals below average income were seen as poor. To achieve effective healthcare utilization there must be an abolition of inequality in income. This is because if some people have higher than average incomes, which in-turn affects their help seeking behavior and effective utilization of healthcare services in a given society resulting to more complication and longer terms of chronicity.

2.2.4 Ecological Theory

Ecological Theory was founded by Santrock (1947) which supports the idea that: changes in social environment have a notable influence on individuals. It is important to construct environments that support individuals post incarceration, so that we as a society can prevent multiple offenses and reduce recidivism rates and crime (Santrock, 1947). By

inference, assumption can be made that availability of resources; treatment, and support services, societal attitudinal change etc, post-incarceration may indeed have a significant impact in declining the current rates of recidivism. The theory assumes that health is a vital resource. Providing discharged prisoners with curative and preventive services are seen as resources that will make them less vulnerable to re-offend. This is so because the health resource is a composite that include social, educational and psycho-social services. Thus, the theory assumes that, it is very beneficial to supply inmates with health resources and education to empower them to create healthier family lives.

Ecological Theory supports the idea that health and educational resource availability would create a positive environmental support structure for post-incarcerated individuals and would be very effective in reducing recidivism rates. The major criticism of this theory is that, environmental factors alone do not constitute the push factor to an individual committing crime. The theory lacks the theoretical template to consider other socioeconomic factors and political factors that bring about relative or absolute deprivation to individuals in the society.

The relevance of the theory to the present study is that, health workers have a role to play even in the correctional center environment to provide preventive, curative, reformative and health awareness services. This implies that, the role of the health worker in correctional centers is indispensible and should be targeted at addressing all health issues that may be faced by inmates. That is, the environment of the correctional center should also be treated.

2.2.4 Theoretical synthesis

From the three theoretical frameworks used for this research-Rehabilitation Ecological Theory, Antisocial personality disorder theory and health inequality theory of health services utilization as theories that best explain the phenomenon under study. From the four theories used or employed, each theoretical relevance was limited in scope-ecological theory and the Antisocial personality disorder theory. However, the later-rehabilitation theory and health inequality theory was seen to be more relevance to the study since it embodies both holistic restoration of the inmates and fair or health equity amongst prison inmates

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Research Design

The Expost Facto' and survey research design was used to guide the focus of this study. The purpose for this design is to afford the researcher the opportunity to get an existing data of health workers preventive and curative services among inmate of Enugu Maximum Prison. An ex post facto research design is a method in which groups with qualities that already exist are compared on some dependent variable. Also known as "after the fact" research, an ex post facto design is considered quasi-experimental because the subjects are not randomly assigned - they are grouped based on a particular characteristic or trait (Sarantakos, 1988). Like inmate, health workers and social workers, the study population is gropued based on their traits and variables functions which are the dependent variables of the present study. The main characteristic of this design is that, data were collected from the respondents (inmates) with limited interference from prison officers or the researcher.

3.2 Area of study

The study area of this study was the Enugu State Maximum Prison. The prison was established in 1915 with a maximum capacity for 600 inmates, but, currently housing over 2,011 inmates (NPS, 2018). The prison in recent times is housing more than its capacity and the inmates are sleeping in turns in the cells that were meant for two but accommodating eight persons per cell. A total of 2,011 inmates are currently being housed at Enugu Maximum Prison, while 160 are condemned prisoners who have been on Death Roll for years awaiting the hangman's noose (NPS, 2018).

3.3 Population of study

The population of the study was both inmates and staff of Enugu Maximum Correctional Centre, Enugu State, Nigeria. According to the Annual Prison Statistics (2020) Enugu Maximum Correctional Centre, Enugu State, Nigeria has a total of two thousand and eleven (2,011) inmates. This population comprised of 1,743 males and 268 females (NPC, 2018).

3.4 Sample Size

The sample size for this study was 400 respondents selected from among inmates in Enugu Maximum Correctional Centre, Enugu State, Nigeria. The selection of the 400 respondents was done using Taro Yamenes (1967) sample sized determinant formula.

3.5 Sampling technique

To obtain the required sample size, the purposive and convenience sampling techniques were adopted for this study. Odu (2013) observed that the purposive sampling technique is characterized by the use of judgment and deliberate effort to obtain representative sample by including typical areas of the study. The convenience sampling technique is most appropriate when every member of the population cannot be assessed at the time of the research rather through respondents convenient time in a study (Odu, 2013), either due to the nature of the study (sensitive information required from respondent) or the apparent risk involved. This was justified due to the nature of the study; thus, not all inmates in detention were willing to participate in the study. Not all the inmates or detainees in the prison were convicts. Hence, only volunteers who showed interest in the study were selected for the study. Therefore, using this technique, all

inmates were selected voluntarily to participate in the study. A letter of introduction was written by the Head of Department, Department of Sociology University of Calabar to the management of Enugu Maximum correctional center. Approval of the letter by the controller of the prison gave the researcher consent to conduct the study. The consent of the inmates who participated in the study was also obtained. They were also informed that, at any point in the study that, they were no longer comfortable, they were free to withdraw. The participants were voluntary respondents.

A total of 360 respondents were males while 40 respondents were females. In identifying the respondents, the researcher announced to the inmates, with the assistance of the prison authority the purpose of the exercise. This was based on the directive of the prison authority to ensure compliance and orderliness.

3.6 Instrument of data collection

The instruments used for this study were questionnaire and Key Informant Interview (KII). The instrument format and ways of use for the present study is as explained below;

3.6.1 Questionnaire

The questionnaire was used to get quantitative data. The format of the questionnaire was closed item questions. It also probes information through three forms: First, it asked about opinion that is what the participants feel about something. Second, it asks about behaviour, that is what the respondents about their corporation with health care workers in the discharge of their duties. Finally, it asks about attributes, which is about personal characteristics like age, gender, marital status, education, occupation,

religion and others (Saunders *et al.*, 2003). The reason for the use of only close a questions was due to the nature of respondents being studies (prison inmates) so that the format enables the comparison of the present study with other studies compared in other countries. The questionnaire was designed in the two (2) point Likert Agree (A), Disagree (SD) and No Response. It also employed the Yes and No format of measurement. This format of measurement helped the researcher to elicit data from inmate without further interference of the stress of interviewing them.

3.6.2 Key Informant Interview

The second instrument was a Key Informant Interview scheduled with Staff, health workers and medical social workers in the prisons. The choice of the Key Informant Interview is predicated by the nature of the study, to elicit relevant about the state of inmates by the correctional staff. However, four Key informant interviews were conducted- 2 with health workers, 1 with a social workers while 1 was conducted with health of inmates at Enugu Maximum prisons to ascertain the extent to which health workers service delivery promote the wellbeing of inmate in the prisons. Key informant interviews were conducted or carried out (see appendix for interview guide).

3.7 Validity of instrument

The research instrument for this study was subjected to the supervisor's assessment to ensure that the content matches he cognitive level of the respondents and to ensure adequate coverage in terms of the study objectives. This was to ensure that the research instrument met content and face validity. The observations and comments of the supervisor were incorporated into the instrument. The final approval administer the

instrument was given by the two supervisors having been satisfied that the instrument measured what is meant for. Thus, structuring of the questionnaire was deemed appropriate in measuring the variables under investigation. Thus, data generated from the field using the instrument were valid for the study.

3.8 Reliability of instrument

To determine the reliability of the study's instrument, a trial-test was carried out by the researcher before the actual study. This trial test was carried out in Afokang prison, Calabar South Local Government Area of Cross River State. The facility and respondents were selected based on the assumption that they share similarities with Enugu Maximum Prison and the inmates.

In the Afokang prison, the researcher systematically selected 40 inmates as respondents and administered the instrument personally. The respondents adequately informed that the exercise was for academic purpose; hence, information given thereof were not used for any other purpose. The instructions were clearly read out to the inmates. After one week interval, copies of the same instrument administered to the respondents were retrieved. The retrieved questionnaire were coded and scored. The test trial showed that most of the inmates selected to participate in the study did not comply be responding to the questions in the questionnaire. This caused the researcher adopt the convenience sampling technique in the main study to prevent apathy. The result of the reliability test was 0.87 coefficients. This showed that the instrument were internally consistent as a measuring instrument for the study.

3.9 Methods of data analysis

Data analysis was carried out or presented in sequence-in tables, chart and numbers using percentages. Hypotheses were tested one after the other, using the appropriate statistical instrument each at 0.05 levels of significance as shown below;

Hypothesis one

Health workers preventive services have no significant influence on the wellbeing of inmates in Enugu Maximum Correctional Centre, Enugu State, Nigeria

Dependent variable:	Wellbeing of inmates in Enugu Maximum Correctional Centre, Enugu State, Nigeria.
Independent variable:	Health workers preventive services
Statistical analysis:	ANOVA

Hypothesis two

Health workers provision of curative services has no significant influence on the wellbeing of inmates in Enugu Maximum Correctional Centre, Enugu State, Nigeria

Dependent variable:	*Dependent variable:* Wellbeing of inmates in Enugu Maximum Correctional Centre, Enugu State, Nigeria.
Independent variable:	Health workers curative services
Statistical analysis:	ANOVA

Hypothesis three

There is no significant influence of health workers reformative services on the wellbeing of inmate in Enugu Maximum Correctional Centre, Enugu State, Nigeria

Dependent variable:	Wellbeing of inmates Enugu Maximum Correctional Centre, Enugu State, Nigeria.
Independent variable:	Health workers reformative services
Statistical analysis:	Chi Square

Hypothesis four

Health workers health educational awareness services do not significant influence on the wellbeing of inmates in Enugu Maximum Correctional Centre, Enugu State, Nigeria

Dependent variable:	Wellbeing of inmates in Enugu Maximum Correctional Centre, Enugu State, Nigeria.
Independent variable:	health workers educational awareness services
Statistical analysis:	One Way Analysis of Variance

CHAPTER FOUR

DATA PRESENTATION, ANALYSIS AND DISCUSSION OF FINDINGS

4.1 Data presentation

This section presents the demographic data of respondents. Data presented were obtained from survey method, using questionnaire. The questionnaire was administered on a 400-sampled size respondents selected among inmates in Enugu Maximum Correctional Centre, Enugu State, Nigeria. Data generated from fieldwork were presented in tables and percentages.

The demographic data of respondents (inmates), as indicated in table 4.1 showed that 342 (85.5%) respondents and 40 (10.10%) respondents were males and females, respectively. 18 respondents (4.5%) did not indicated their sex. This indicates that majority of the inmates in Enugu Maximum Correctional Centre, Enugu State, Nigeria were males. To identify the ages of the inmates who participated in the study, table 4.1 showed that respondents between the ages of 18 to 23 were 114 (28.5%); those between the ages of 24 to 29 were 149 (37.25%) while those between the ages of 30 to 35 were 91 (22.75%). Respondents between the ages of 36 to 41 were 12 (3%) while those from 42 years and above were 24 (6%). This observation showed that respondents between the ages of 18 to 23 years old were the highest and also an indication that the prison is occupied by majority of youth. Only 24 respondents, representing 6 percent did not indicate their age.

Item on the distribution of respondents by educational qualification revealed that majority of 48.5 (185) respondents had no formal education, 26.7 (102) respondents had FSLC, 19.3 (74) respondents had secondary school education while 5.4 (21) respondents

TABLE 4.1
Demographic data of inmates

S/N	Variables	Indicators	No's of Resp.	%
	Age	18 – 23	114	28.5
		24 – 29	149	37.25
		30 – 35	91	22.75
		36 – 41	12	3
		42 – Above	10	2.5
		No response	6	6
		Total	382	100
	Sex	Males	324	85.5
		Females	40	10
		No response	18	4.5
		Total	382	100
	Educational attainment	No formal education	185	48.5
		Primary education	102	26.7
		Secondary education	74	19.3
		Tertiary education	21	5.4
		Total	382	100
	Marital Status	Single	296	77.4
		Married	67	17.5
		Separated	7	1.8
		Divorced	4	1.0
		Widow	5	1.3
		Widower	3	0.8
		Total	382	100
	Religious affiliation	Christianity	352	92.1
		Islam	10	2.6
		Traditional religion	14	3.7
		Others	6	1.6
		Total	382	100
	Time in prison	0 – 12 months	139	34.75
		13 – 24 months	100	29.5
		25 – above	139	34.75
		No response	4	1
		Total	382	100

Source: Fieldwork, 2019

had finished their tertiary education. On the distribution of respondents by marital status, findings revealed that, majority of 77.4 (296) inmates were single, 17.5 (67) respondents were married, 1.8 (7) inmates were in separated marriage, 1.0 (4) inmates were divorced in their marriages, 1.3 (5) inmates were widows while 0.8(3) inmates were widowers.

Item on the distribution of respondents by religious affiliation revealed that, majority of 92.1 (352) inmates were Christians, 2.6(10) inmates were in Islam, 1.6 (6) inmates were from anonymous religious congregation. In order to identify the duration of the inmates in the prison, the table also showed that 139 (34.75%) respondents have been in the prison between 0 month and 12 months; 118 respondents (29.5%) have been in prison between 13 to 24 months while 139 respondents (34.75) indicated that they have been in the prison between 25 months and above. Only 4 respondents, representing 1 percent did not report the duration of their stay in Enugu Maximum Correctional Centre, Enugu State, Nigeria.

Table 4.2 shows the distribution of responses measuring the relationship between health worker's preventive role and wellbeing of inmates in Enugu Maximum Prison, Enugu State, Nigeria. To identify whether Health workers frequently provide measures of good health, 342 respondents (85.5%) reported that Health workers frequently provide measures of good health h while 57 respondents (14.25%) say health workers were do not always provide measures of good health. Only 1 respondent, representing 0.25 percent did not respond to the question. To investigate whether Health workers provide health tips for good health, 54 respondents (13.5%) agreed while 345 respondents (85.75%) disagreed that Health workers provide health tips for good health. Only 3 respondents

TABLE 4.2

Distribution of responses measuring health workers' preventive role and wellbeing of inmates in Enugu Maximum Prison

S/N	Questions	Agree (%)	Disagree (%)	No response (%)
1	Health workers frequently provide measures of good health	342 (85.5)	57 (14.25)	1 (0.25)
2	Health workers provide health tips for good health	54 (13.5)	343 (85.75)	3 (0.75)
3	Health workers often show concern when inmates are ill	73 (18.25)	325 (81.25)	2 (0.5)
4	Health workers always willing to assist inmates during emergency	282 (70.5)	117 (29.25)	1 (0.25)
5	Health workers provide mosquito net against malaria	291 (72.75)	106 (26.5)	3 (0.75)
6	Health workers usually carry out their duties with compassion	101 (25.25)	297 (74.25)	2 (0.5)

Source: Field Survey, 2019/SPSS (Version 21.0 for Windows Output)

representing 0.75 percent did not respond to this question. To identify whether health workers often show concern when inmates are ill, 73 respondents (18.25%) agreed while 325 respondents (81.25%) disagreed, showing that health workers do not often show concern when inmates are ill. Only 2 respondents, representing 0.75 percent did not respond to the question.

To measure whether health workers were willing to assist inmates during emergencies, 282 respondents (70.5%) agreed to indicate that health workers often do not assist inmates during emergencies while 117 respondents (29.25%) disagreed. Only 1 respondent, representing 0.25 percent did not respond to this question. Similarly, to probe whether Health workers provide mosquito net against malaria, 291 respondents (72.75%) say health workers do not provide mosquito net against malaria while 106 respondents (26.5%) disagreed, reporting that health workers were dedicated to their duties by providing healthcare services to inmates. Only 20 respondents, representing 5.05 percent did not respond to the question. On whether health workers usually carry out their duties with compassion, 101 respondents (25.25%) say the health workers often carry out their duties with compassion while 297 respondents (74.25%) disagreed, implying that the workers usually do not show compassion when treating inmates.

The table above (4.3) shows the distribution of responses measuring health workers curative role and wellbeing of inmates in Enugu Maximum Correctional Centre, Enugu State, Nigeria. To identify whether Health workers are provide malaria drugs to sick inmate, 311 respondents (77.75%) reported that health workers were provide malaria drugs to sick inmate while 86 respondents (21.5%) disagreed. Only 3 respondents, representing 0.75 percent did not respond to the question. To investigate whether Health

TABLE 4.3

Distribution of responses measuring health workers curative services and wellbeing of inmates in Enugu Maximum Correctional Centre, Enugu State, Nigeria

S/N	Questions	Agree (%)	Disagree (%)	No response (%)
7	Health workers provide malaria drugs to sick inmate	311 (77.75)	86 (21.5)	3 (0.75)
8	Health workers provide ART for HIV patients	292 (73)	106 (26.5)	2 (0.5)
9	Health workers administer injection to inmate necessary	297 (74.25)	102 (25.5)	1 (0.25)
10	Health workers provide deworming drugs against philarisasis	320 (80)	79 (19.75)	1 (0.25)
11	Health workers are never gentle with inmates during treatment	359 (89.75)	40 (10)	1 (0.25)
12	Health workers often use force to ensure compliance to treatment	343 (85.75)	55 (13.75)	2 (0.5)

Source: Field Survey, 2019/SPSS (Version 21.0 for Windows Output)

workers provide ART for HIV patients, 292 respondents (73.0%) reported Health workers provide ART for HIV patients while 106 respondents (26.5%) disagreed that they do not provide ART for HIV patients. Only 2 respondents, representing 0.50 percent did not respond to the question. Similarly, in identifying whether Health workers administer injection to inmate where necessary, 297 respondents (74.25%) reported that health workers administer injection to inmate where necessary while 102 respondents (25.5%) disagreed. Only 1 respondent, representing 0.25 percent did not respond to the question.

To investigate whether Health workers provide deworming drugs against philarisasis, 320 respondents (80.0%) reported that health workers provide deworming drugs against philarisasis, while 79 respondents (19.75%) did not agree. Only 1 respondent, representing 0.25 percent did not respond to the question. To find out whether Health workers are never gentle with inmates during treatment, 359 respondents (89.75%) agreed that health workers were never gentle with inmates during treatment, while 40 respondents (10.0%) disagreed. Only 1 respondent, representing 0.25 percent did not respond to the question. On whether health workers often deploy force on inmates, 343 respondents (85.75%) also reported that health workers often deploy force in order to ensure compliance from inmates; 55 respondents (13.75%) did not agree with this question while only 2 respondents, representing 0.50 percent did not respond to the question.

Table 4.4 shows the distribution of responses measuring health workers reformative role and the wellbeing of inmates in Enugu Maximum Correctional Centre, Enugu State, Nigeria. To identify whether Health workers see as people that need

TABLE 4.4

Distribution of responses measuring health workers reformative role and wellbeing of inmates in Enugu Maximum Correctional Centre, Enugu State, Nigeria

S/N	Questions	Agree (%)	Disagree (%)	No response (%)
13	Health workers help inmates to get back to society after prison terms	299 (74.75)	96 (24)	5 (1.25)
14	Health workers provide rehabilitation services to reform inmates	285 (71.25)	112 (28)	3 (0.75)
15	Health workers have respect for privacy of inmates	297 (74.25)	101 (25.25)	2 (0.5)
16	Health workers teaches inmate how to be good and leave a good life at post-incarceration	234 (58.5)	164 (41)	2 (0.5)
17	Health workers do consider the opinions of inmates	330 (82.5)	65 (16.25)	5 (1.25)
18	Health workers do not disclose the health condition of inmates to others	324 (81)	73 (18.25)	3 (0.75)

Source: Field Survey, 2019/SPSS (Version 21.0 for Windows Output)

help, 299 respondents (74.75%) reported that Health workers see inmate as people that need help, while 96 respondents (24.0%) disagree. Only 5 respondents, representing 1.25 percent did not respond to the question. To investigate whether Health workers provide rehabilitation services to reform inmate, 285 respondents (71.25%) reported that health workers provide rehabilitation services to reform inmate while 112 respondents (28.0%) disagreed that health workers often pay attention to the demands of inmates in EMP. Only 3 respondents representing 0.75 percent did not respond to the question. In identifying whether Health workers have respect for privacy of inmates, 297 respondents (74.25%) agreed that health workers have respect for privacy of inmates while 101 respondents (25.25%) disagree. Only 2 respondents, representing 0.50 percent did not respond to the question.

In identify whether Health workers teaches inmate how to be good and leave a good life at post-incarceration, 234 respondents (58.5%) reported that health workers teaches inmate how to be good and leave a good life at post-incarceration, while 164 respondents (41.0%) disagree. Only 2 respondents, representing 0.50 percent did not respond to this question. On whether health workers do consider the opinions of inmates, 330 respondents (82.5%) reported that health workers do consider the opinions of inmates while 65 respondents (16.25%) disagreed, showing that health workers often pay attention to the opinions of inmates. Only 5 respondents, representing 1.25 percent did not respond to the question. To investigate whether Health workers do not disclose the health condition of inmates to others, 324 respondents (81.0%) reported that Health workers do not disclose the health condition of inmates to others. However, 73

respondents (18.25%) disagree. Only 3 respondents, representing 0.75 percent did not respond to the question.

Table 4.5 measured the relationship between health workers educational role and wellbeing of inmates in Enugu Maximum Correctional Centre, Enugu State, Nigeria. From question 19, which sought to identify whether Health workers and social worker teaches inmate good skills, 294 respondents (73.5%) reported that most of the health workers and social worker teaches the health workers and social worker teaches inmate good skills, and vice versa. However, 104 respondents (26.0%) disagreed. Only 2 respondents, representing 0.50 percent did not respond to this question. To investigate whether Health workers and staff enroll inmate in many vocational skill, 295 respondents (73.75%) confirmed that Health workers and staff enroll inmate in many vocational skill. 103 respondents (25.75%) disagreed, that health workers and staff enroll inmate in many vocational skill

To investigate whether Health worker educated inmate how to take good care of their health, 279 respondents (69.75%) reported that Health worker educated inmate how to take good care of their health. However, 118 respondents (29.5%) disagree, saying that Health workers do not educated inmate how to take good care of their health Only 3 respondents, representing 0.75 percent did not respond to this question. To observe whether Health workers treat everyone equally irrespective of gender, 72 respondents (18.0%) agreed that Health workers treat everyone equally irrespective of gender while 325 respondents (81.25%) disagreed, Health workers do not treat everyone equally irrespective of gender. Only 3 respondents, representing 0.75 percent did not respond to

TABLE 4.5

Distribution of responses measuring health workers educational role and wellbeing of inmates in Enugu Maximum Correctional Centre, Enugu State, Nigeria

S/N	Questions	Agree (%)	Disagree (%)	No response (%)
19	Health workers and social workers teaches inmate good skills	294 (73.5)	104 (26)	2 (0.5)
20	Health workers and staff enroll inmates in many vocational skill training	295 (73.75)	103 (25.75)	2 (0.5)
21	Health workers educated inmate how to take good care of their health	279 (69.75)	118 (29.05)	3 (0.75)
22	Health workers treat everyone equally irrespective of gender	72 (18)	325 (81.25)	3 (0.75)
23	Health workers are friendly to all inmates	60 (15)	337 (84.25)	3 (0.75)
24	Health workers discriminate inmates based on nature of illness	322 (80.5)	76 (19)	2 (0.5)

Source: Field Survey, 2019/SPSS (Version 21.0 for Windows Output)

the question. To determine whether health workers were friendly to all the inmates, 337 respondents (84.25%) say health workers were not friendly to inmates while 60 respondents (15.0%) say the health workers were friendly to inmates in Enugu Maximum Correctional Centre, Enugu State, Nigeria. To investigate whether health workers discriminate inmates based on the nature of their health conditions, 322 respondents (80.5%) reported discrimination of inmates by health workers based on their health conditions; however, 76 respondents (19.0%) disagreed. Only 2 respondents, representing (0.50%) did not respond to this question.

4.2 Data analysis

Hypothesis one

Health workers preventive services have no significant influence on the wellbeing of inmates in Enugu Maximum Correctional Centre, Enugu State, Nigeria as shown in Table 4.6. Data for testing hypothesis four were derived from response to item 1-5 multiple option questions of the instrument and analyzed using the One Way Analysis of Variance (ANOVA) as presented in table 4.6. From the result as presented in the table 4.6 the independent variable is Health workers preventive services while the dependent variable is wellbeing of inmates in Enugu Maximum Correctional Centre, Enugu State, Nigeria. To test the hypothesis, One Way Analysis of Variance was used to determine Health workers preventive services influence on the wellbeing of inmates in Enugu Maximum Correctional Centre, Enugu State, Nigeria. The dependent variable- Health workers preventive services was disaggregated into three level of measurement (personal

TABLE 4.6

ANOVA analysis for health worker preventive services and wellbeing of inmates

Descriptives

wellbeing of inmates

	N	Mean	Std. Deviation
personal hygiene	74	1.0000	.00000
good nutrition	97	1.0000	.00000
Morbidity	116	1.8362	.37169
reduces stress or stress management	74	2.0000	.00000
prevention against STDs	21	1.0476	.21822
Total	382	1.4503	.49817

ANOVA

wellbeing of inmates

	Sum of Squares	Df	Mean Square	F	Sig.
Between Groups	77.715	4	19.429	434.945	.000
Within Groups	16.840	377	.045		
Total	94.555	381			

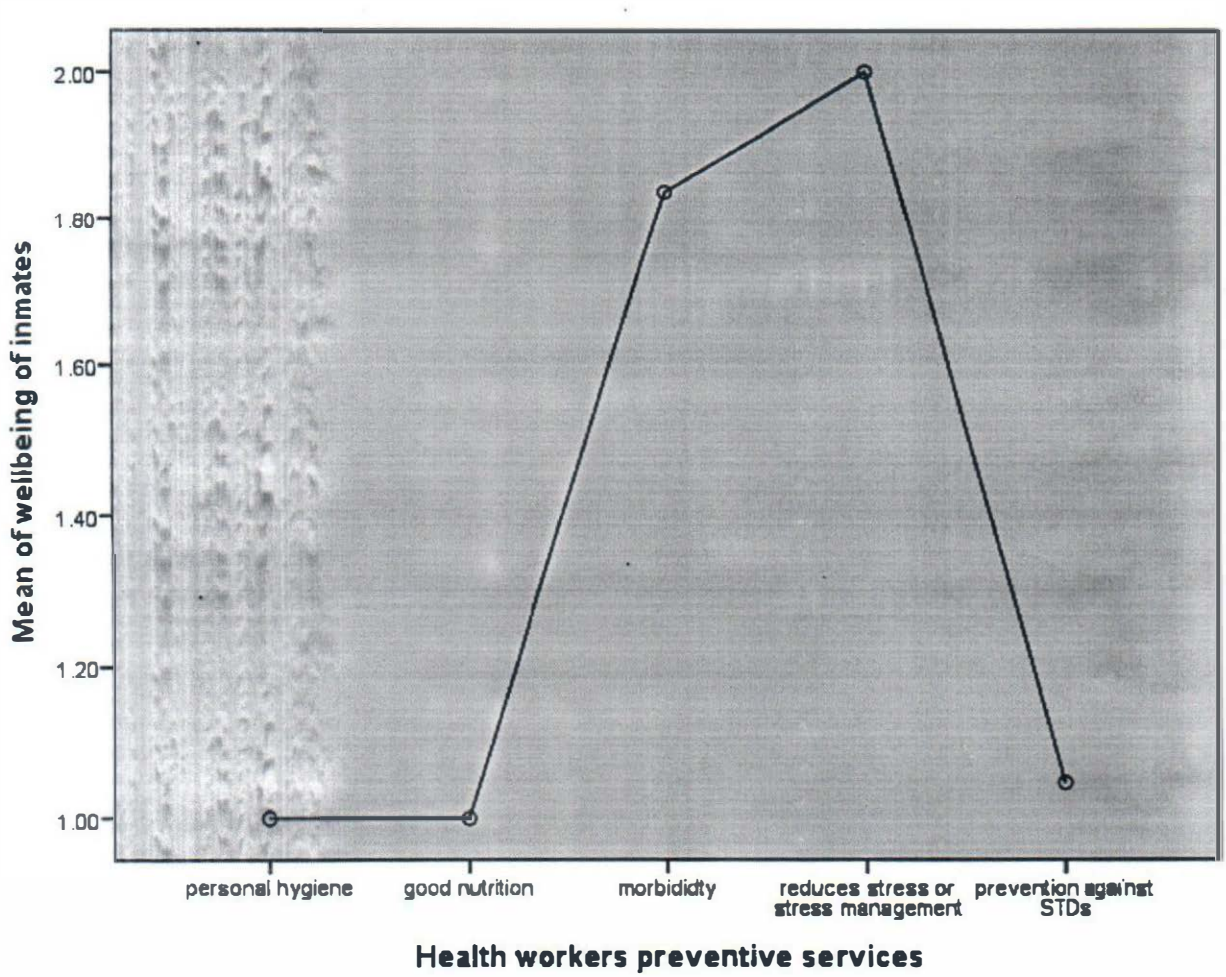

FIG 1 ANOVA analysis bar chart for health worker preventive services influence on wellbeing of inmates

Source: Field Survey, 2019/SPSS (Version 21.0 for Windows Output)

hygiene, good nutrition, morbidity, reduces stress or stress management and prevention against STDs).

The result in the table 4.6 revealed that, there are six levels of measuring educational awareness (personal hygiene, good nutrition, morbidity, reduces stress or stress management and prevention against STDs), the calculated F ratio of 434.945 is statistically significant when compared with the critical F-ratio of 3.040 at 5, 243 degree of freedom. This means that the null hypothesis which states Health workers preventive services do significantly influence wellbeing of inmates in Enugu Maximum Correctional Centre, Enugu State, Nigeria was rejected following decision rule which states that accept the null hypothesis if the calculated F-value if greater than the tabulated F-value. Finally, since the calculated F-value of 434.945 was found greater that the tabulated or critical table value of 3.040, the null hypothesis was however rejected while the alternate was accepted. This implies that Health workers preventive services have a significant influence on the wellbeing of inmates in Enugu Maximum Correctional Centre, Enugu State, Nigeria. This finding was also represented in the bar chart.

Hypothesis two

Health workers provision of curative services has no significant influence on the wellbeing of inmates in Enugu Maximum Correctional Centre, Enugu State, Nigeria as shown in Table 4.7. Data for testing hypothesis three were derived from response to item 7-12 multiple option questions of the instrument and analyzed using the One Way Analysis of Variance (ANOVA) as presented in table 4.7. From the result as presented in the table 4.7, the independent variable is Health workers provision of curative services

while the dependent variable is wellbeing of inmates in Enugu Maximum Correctional Centre, Enugu State, Nigeria. To test the hypothesis, One Way Analysis of Variance was used to determine Health workers provision of curative services influence on the wellbeing of inmates in Enugu Maximum Correctional Centre, Enugu State, Nigeria. The dependent variable- Health workers provision of curative services was disaggregated into four level of measurement (provision of drugs, rehabilitative services, palliative services and advocacy services)

The result in the table 4.7 revealed that, there are three levels of measuring educational awareness (provision of drugs, rehabilitative services, palliative services and advocacy services), the calculated F ratio of 204.942 is statistically significant when compared with the critical F-ratio of 3.040 at 3 degree of freedom. This means that the null hypothesis which states that, Health workers provision of curative services do significantly influence wellbeing of inmates in Enugu Maximum Correctional Centre, Enugu State, Nigeria was rejected following decision rule which states that accept the null hypothesis if the calculated F-value if greater than the tabulated F-value. Finally, since the calculated F-value of 204.942 was found greater that the tabulated or critical table value of 3.040, the null hypothesis was however rejected while the alternate was accepted. This implies that Health workers provision of curative services have a significant influence on the wellbeing of inmates in Enugu Maximum Correctional Centre, Enugu State, Nigeria. This finding was also represented in the bar chart.

TABLE 4.7

ANOVA analysis for health workers curative services influence wellbeing of inmates

Descriptives

wellbeing of inmates

	N	Mean	Std. Deviation
provision drugs	120	1.0000	.00000
rehabilitative services	150	1.4000	.49154
palliative services	64	2.0000	.00000
advocacy services	48	2.0000	.00000
Total	382	1.4503	.49817

ANOVA

wellbeing of inmates

	Sum of Squares	Df	Mean Square	F	Sig.
Between Groups	58.555	3	19.518	204.942	.000
Within Groups	36.000	378	.095		
Total	94.555	381			

Source: Field Survey, 2019/SPSS (Version 21.0 for Windows Output)

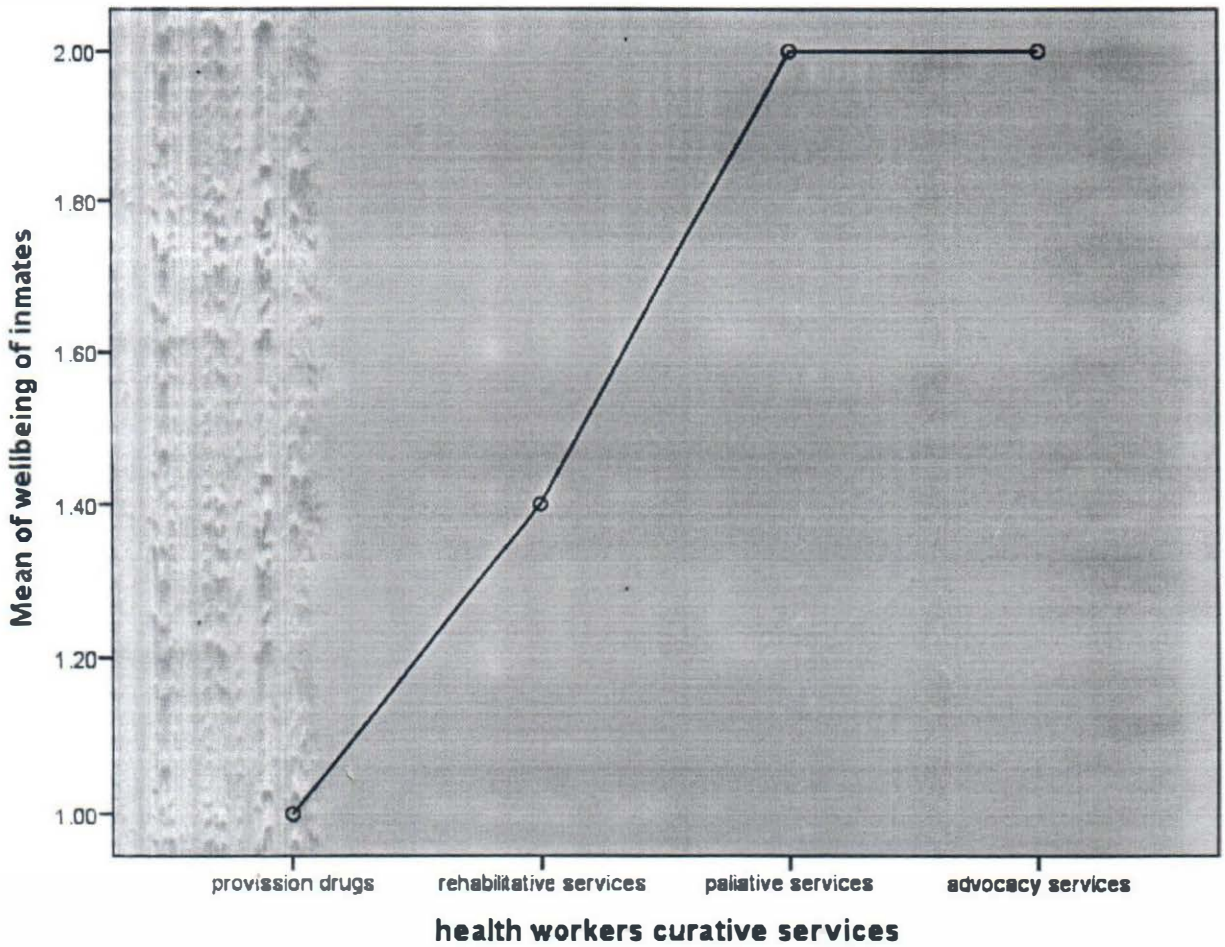

FIG. 2 ANOVA bar chart for health workers curative services and wellbeing of inmates

Source: Field Survey, 2019/SPSS (Version 21.0 for Windows Output)

Hypothesis three

There is no significant influence of health workers reformative services on the wellbeing of inmate in Enugu Maximum Correctional Centre, Enugu State, Nigeria as shown in Table 4.8. Data for testing hypothesis four were derived from response to item 13-18 multiple option questions of the instrument and analyzed using the One Way Analysis of Variance (ANOVA) as presented in table 4.8. From the result as presented in the table 4.8, the independent variable is health workers reformative services while the dependent variable is wellbeing of inmates in Enugu Maximum Correctional Centre, Enugu State, Nigeria. To test the hypothesis, One Way Analysis of Variance was used to determine health workers reformative services influence on the wellbeing of inmates in Enugu Maximum Correctional Centre, Enugu State, Nigeria. The dependent variable-health workers reformative services was disaggregated into five level of measurement (skill acquisition, referrals to life opportunities, recreational facilities, teaching morals and general behavioural modification)

The result in the table 4.8 revealed that, there are five levels of measuring reformative services (skill acquisition, referrals to life opportunities, recreational facilities, teaching morals and general behavioural modification), the calculated F ratio of 10.991 is statistically significant when compared with the critical F-ratio of 3.040 at 4 243 degree of freedom. This means that the null hypothesis which states health workers reformative services do significantly influence wellbeing of inmates in Enugu Maximum Correctional Centre, Enugu State, Nigeria was rejected following decision rule which states that accept the null hypothesis if the calculated F-value if greater than the tabulated F-value. Finally, since the calculated F-value of 10.991 was found greater that the

TABLE 4.8

ANOVA analysis for health workers reformative services influence on the wellbeing of inmate

Descriptives

wellbeing of inmates

	N	Mean	Std. Deviation
skills acquisition	95	1.0000	.00000
referrals to life opportunities	187	1.5615	.49754
recreational facilities	60	2.0000	.00000
teaching morals	20	1.0000	.00000
general behavioural modification	20	1.3500	.48936
Total	382	1.4503	.49817

ANOVA

wellbeing of inmates

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	43.962	4	10.991	81.898	.000
Within Groups	50.593	377	.134		
Total	94.555	381			

Means Plots

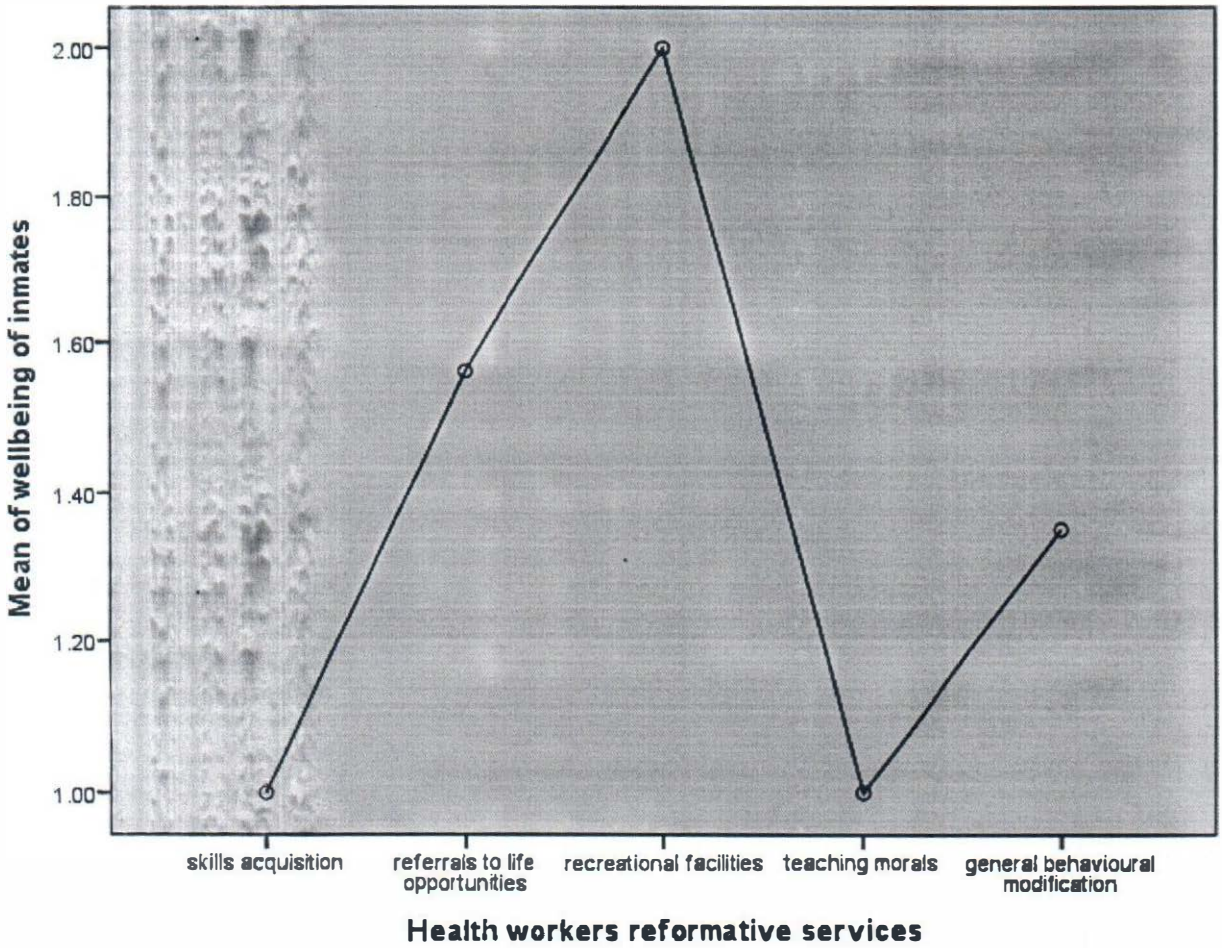

FIG..3 ANOVA chart for health workers reformative services influence on the wellbeing of inmate

Source: Field Survey, 2019/SPSS (Version 21.0 for Windows Output)

tabulated or critical table value of 3.040, the null hypothesis was however rejected while the alternate was accepted. This implies that health workers reformative services have a significant influence on the wellbeing of inmates in Enugu Maximum Correctional Centre, Enugu State, Nigeria. This finding was also represented in the bar chart

Hypothesis four

Health workers health educational awareness role do significantly promote wellbeing of inmates in Enugu Maximum Correctional Centre, Enugu State, Nigeria as shown in Table 4.9. Data for testing hypothesis four were derived from response to item 19-24 multiple option questions of the instrument and analyzed using the One Way Analysis of Variance (ANOVA) as presented in table 4.9. From the result as presented in the table 4.7, the independent variable is Health workers health educational awareness role while the dependent variable is wellbeing of inmates in Enugu Maximum Correctional Centre, Enugu State, Nigeria. To test the hypothesis, One Way Analysis of Variance was used to determine Health workers health educational awareness role influence on the wellbeing of inmates in Enugu Maximum Correctional Centre, Enugu State, Nigeria. The dependent variable- Health workers health educational awareness role was disaggregated into three level of measurement (Higher awareness role, Moderate awareness role and Lower awareness role)

The result in the table 4.9 revealed that, there are three levels of measuring educational awareness (Higher awareness role, Moderate awareness role and Lower awareness role), the calculated F ratio of 55.975 is statistically significant when compared with the critical F-ratio of 3.040 at 5, 243 degree of freedom. This means that

TABLE 4.9

One Way Analysis of Variance analysis for the influence of Health workers health educational awareness role and wellbeing of inmates in Enugu Maximum Correctional Centre, Enugu State, Nigeria (N=382).

wellbeing of inmates

	N	Mean	Std. Deviation	Std. Error
Higher educational awareness role	83	1.0000	.00000	.00000
Moderate educational awareness role	118	1.5932	.49333	.04541
Lower educational awareness role	181	1.5635	.49732	.03697
Total	382	1.4503	.49817	.02549

ANOVA

wellbeing of inmates

	Sum of Squares	Df	Mean Square	F	Sig.
Between Groups	21.561	2	10.781	55.975	.000
Within Groups	72.994	379	.193		
Total	94.555	381			

Means Plots

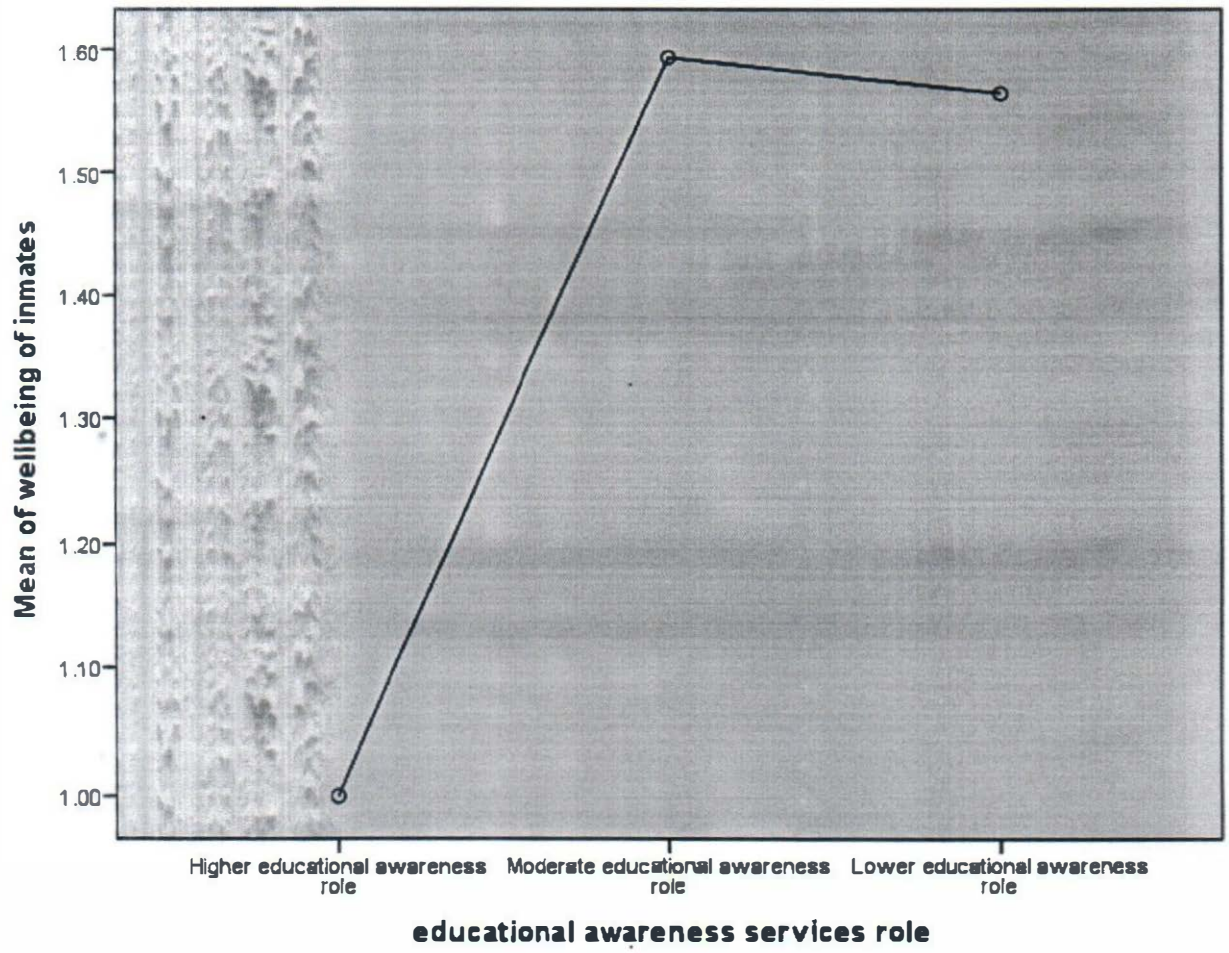

FIG. 4.3 ANOVA mean plot description for the influence of health workers educational awareness and inmate wellbeing

the null hypothesis which states that, Health workers health educational awareness role do significantly promote wellbeing of inmates in Enugu Maximum Correctional Centre, Enugu State, Nigeria was rejected following decision rule which states that accept the null hypothesis if the calculated F-value if greater than the tabulated F-value. Finally, since the calculated F-value of 55.975 was found greater that the tabulated or critical table value of 3.040, the null hypothesis was however rejected while the alternate was accepted. This implies that Health workers health educational awareness role have a significant influence on the wellbeing of inmates in Enugu Maximum Correctional Centre, Enugu State, Nigeria. This finding was also represented in the bar chart.

4.3 Discussion of findings

4.3.1 Health workers preventive services and wellbeing of inmates

The findings of the first hypothesis reveal that there is a significant relationship and association between preventive role of health care workers in prisons and wellbeing on inmates in Enugu Maximum Correctional Centre, Enugu State, Nigeria. From the analysis, finding agrees with Moritz (2012) who observed that the health care of prisoners is an integral and essential part of every prison's work. Primary care is the foundation of prison health services. Primary care is the most effective and efficient element of health cares in any public health system (WHO, 1978) and as such, should be available to every prisoner. As described in more detail in this work, prisoners have the same right to health care as everyone else in society. According to Akintola and Ajzen (2017) observed that poor general condition of inmates that requires prevention include hygiene nutrition, mobility, personality disorder, physical and mental trauma and stress

The findings agree with Curtis (2011) also who noted that, disease prevention in prisons can be organized at three levels.

i. At the individual level, the health staff members usually provide clinical interventions – such as administering antibiotics to prevent infection of wounds or treating scabies to prevent bacterial complications. However, substantial health services in prisons are delivered in lay settings as self-care or as care for the peers. Care should be taken to avoid blaming individuals for their behaviour leading to disease, since individuals often do not fully control the circumstances.

ii. At the institutional level, safe methods of searching and screening can prevent exposure to bloodborne diseases, or administrative arrangements for ventilating the indoor spaces can decrease the transmission of tuberculosis.

iii. At the population level, health-promoting interventions are organized from a public health perspective and can include regulating the quantity and quality of food, adopting standards for quality of water or indoor air and implementing policies for exchange of syringes.

El-Gilany, El-Wehady and Amr (2010) noted that to prevent the spread of communicable diseases, the weakest links of the chain agent–transmission–host have to be targeted. For example, chlorinating water destroys some agents; promoting the use of condoms removes the contact needed for transmission; using repellents, disinfectants and protective clothing targets the vectors; and vaccination immunizes the host. In choosing the most appropriate strategy, policy-makers need to consider the risks associated with the disease, the feasibility of interventions, the costs and benefits of the interventions and

equity considerations. Because of the particular circumstances of prisons, some approaches may be more difficult to apply (United Nations human rights commission, 1990). Prisons in general and prison health in particular are not always high on the agenda of politicians, but the threat of transmission of infectious diseases in prisons and ultimately from prisons to general society demonstrates the importance of ensuring better access to health care and health promotion in prisons.

In line with the quantitative analysis, the interview with health care workers and prison staff revealed that, though the activities of health care professional are very essential to the wellbeing of inmates, there is still shortage of such services in most correctional centers. The aver that, preventive role of health workers has been very helpful in inmate wellbeing because these services helps them to take care of themselves, avoid any lifestyle that will be detrimental to their health.

4.3.2 Health workers' curative services and wellbeing of inmates

The findings of the second hypothesis reveal that there is a significant relationship and association between curative services of health care workers in prisons and wellbeing on inmates in Enugu Maximum Correctional Centre, Enugu State, Nigeria. From the analysis, finding agrees with Ogudipe and Adebayo (2016) who avers that instead of ensuring curative services, most health workers in prisons seriously violate the rules of medical ethics if they:

- in any way assist in (even by merely being present) sessions of torture or advise the torturers;
- provide facilities, instruments or substances to that effect; • certify that a prisoner is able to withstand a torture session; or

physical or mental trauma as described by the patient) and the complaints (subjective sensations experienced by the patient) from the clinical and Para-clinical objective findings (mental state; size, location, aspect of the lesions, X-rays, laboratory results, etc.). If the doctors' training and/or experience allow it, they must indicate whether the patients' allegations are compatible with their own clinical finding.

Furthermore, Ogundipe (2012) submission supports the finding, but arguing that health works need to provide curative and retaliation services in areas like drug inmate dependence, infections, dental disease and chronic disorders (lung disease, heart disease, diabetes, epilepsy, diseases of the reproductive system, cancer). They also need provide psychological related curative services such as low mood or self-confidence (self-esteem and dependence: drugs or alcohol), anxiety, depression , severe mental disorders Co-occurring problems which may include "vulnerable" people (learning disability, brain injury, learning difficulty, for instance resulting from autistic spectrum disorder or Asperger's syndrome or dyslexia; and the nature of the sentence (harm against women, offences against children, bullying or recollection of being a victim of abuse

Ogundipe (2012 noted that the physician as a complementary role, must visit patients regularly and, if the patient agrees, conduct regular follow-up examinations. These consultations should be held in a positive, personalized climate, and the physician should inform patients of the progressive decline of health. In this way, strikers can freely change their mind at any time and abandon the strike, having been duly informed of the worsening nature of the risks to which they are exposing themselves.

The finding of the interview also corroborated with the quantitative data, adding the, the best services for inmate is the curative services. This service according to them

ranges from the provision of drugs and care by correctional services nurses and social workers. This often happens when inmates are sick or are in need of curative services or disease outbreak to prevent transmission and thus treat the infected inmates

4.3.3 Health workers reformative role and wellbeing of inmates

The third hypothesis revealed that, there is a significant relationship and effect of health workers reformative role and wellbeing of inmates in Enugu Maximum Correctional Centre, Enugu State, Nigeria. The findings is in line with United Nations (1966) observed that one of the central pillars of health promotion is the concept of empowerment and reformation of inmates: the individual inmate has to be able to make healthy choices and has to be allowed to do so with the help of a health care professionals. In health promotion in prisons, this approach is not possible. It is therefore important that as much empowerment and reformation as possible be built into the prison regime. One area that has been found to be important is providing health information to prisoners. United Nations (1966) observed that Fact sheets should be made available for prisoners suffering from chronic ailments such as diabetes, explaining what the prison health service can provide and providing advice as to how the prisoner can best cope with such an illness while in prison. If written fact sheets will not be effective, because of language barriers or poor literacy, alternative ways of sharing information should be used, such as the use of videos and other visual aids or health discussion groups with a trained health worker. Selected fact and advisory sheets can be produced based on this guide and adapted for use where necessary.

Findings form the interview revealed that, the cardinal role of the correctional centre is the offer reformatory services to inmates to avert recidivism. It is the role of the

health worker and the medical social workers to help reform the inmate together with other correctional centre staff. According to participants during the interview, health workers helps in restoring prison inmates to normal or to be integrated back into the society. This according to thee participant the health workers and the medical social worker do to avoid any form of societal discrimination at post-incarceration.

4.2.4 Health workers health educational awareness role and wellbeing of inmates

The forth hypothesis examine Health workers health educational awareness role and wellbeing of inmates in Enugu Maximum Correctional Centre, Enugu State, Nigeria. It was tested with One Way Analysis of Variance analytical tool and findings revealed a significant relationship. The findings aggress with United Nations (1990) who observed that Basic Principles for the Treatment of Prisoners indicate how the entitlement of prisoners to the highest attainable standard of health care should be delivered: "it is noted that, Prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation" (Principle 9). In other words, the fact that people are in prison does not mean that they have any reduced right to appropriate health care. Rather, the opposite is the case. Health workers role is tied to educating inmate on help safety measures in and outside the correctional institution. However, when a state deprives people of their liberty, it takes on a responsibility to look after their health in terms both of the conditions under which it detains them and of the individual treatment that may be necessary

The findings on the last variable on the influence of health workers awareness services delivery on wellbeing of inmates from the interview conducted revealed that, health workers provide health seminar and campaigns to educate the inmates on the need

to take good care of their health while still in the correctional centre. During the interview, participants aver that, in most cases health workers educate inmates about healthy living and how this can have an impact on the wellbeing of inmates. They however said that, it is only health workers and medical social workers that can help inmates be well acquainted with health promotion and good health among inmates in Enugu Maximum correctional center.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1 Summary

The main thrust of the study was on health workers delivery and wellbeing of inmates in Enugu Maximum Correctional Centre, Enugu State, Nigeria. The objectives of the study include:

1. Examine the relationship between health workers preventive role and wellbeing of inmates in Enugu Maximum Correctional Centre, Enugu State, Nigeria
2. Access the impact of health workers curative services and health of Inmate in Enugu Maximum Correctional Centre, Enugu State, Nigeria
3. Examine the effect of health workers reformative services on the wellbeing of inmate in in Enugu Maximum Correctional Centre, Enugu State, Nigeria
4. Evaluate the ways health workers health educational awareness role promotes the wellbeing of inmates in Enugu Maximum Correctional Centre, Enugu State, Nigeria

A 24-item structured closed-ended questionnaire was designed and administered on a sample size of 400 respondents comprising 360 males and 40 females. Data generated were presented and analyzed in tabular format. Four hypotheses formulated to guide the focus of the study were tested using Chi Squared statistical tool at .05 level of significance and 2, 3, 4 and 3 degrees of freedom for hypothesis one, two, three and four, respectively. The hypotheses were stated in null forms. Two theories were used in explaining the attitudes of health workers and the wellbeing of inmates in Enugu Maximum Correctional Centre, Enugu State, Nigeria. These theories include the

rehabilitation theory by Cialdini (2007) and antisocial personality disorder theory by Robert K. Merton (1957).

The central premise of the rehabilitation theory holds that individuals are not naturally criminal (as opposed to Lombroso's classical biological theory of crime and deviance) and that it is possible to restore a criminal to a useful life; a life in which they could contribute positively to the development of themselves and the society. Thus, it could be explained that the primary role of the correctional officer (including health workers) is the rehabilitation of the detainee. In most cases, the detainees are persons awaiting trial, who have not been convicted. Therefore, it was unethical, from the assumption of the rehabilitation theory for a detainee to be given attitudes that could hamper effective rehabilitation.

On the other hand was the Antisocial Personality Disorder Theory, developed by the American Psychiatric Association (APA, 2013) in the Diagnostic and Statistical Manual of Mental Disorder (DSM-MD).The basic assumption of the antisocial personality disorder theory holds that individuals with this disorder are characterized by long term disregard and violation of the rights of others as well as a history of aggressive behaviours. In analyzing the attitudes of health workers and how it affects the wellbeing of inmates, the theory showed that most health workers with this disorder have a greater tendency to abuse, infringe, disregard and violate the rights of inmates in his or her care; thus. hampering their effective rehabilitation.

The study area was Enugu Maximum Prison, located in Enugu State, Nigeria. The total population of inmates, according to the Nigeria Prisons Service (NPS, 2018) records was 2,011. A sampled size of 400 respondents was selected voluntarily from participants

who showed interested in the study. The study adopted the survey research design, which guided the researcher to generate the desired data.Data generated for the study were presented in tables and explained in percentages. The four hypotheses generated for the study were tested and analyzed using Chi Squared, Multiple linear regression and Pearson Product Moment Correlation Coefficient analytical tools. However, finding revealed as follows:

1. Health workers preventive services have a significant impact on the wellbeing of inmates in Enugu Maximum Correctional Centre, Enugu State, Nigeria
2. Health workers provision of curative services have a significant impact on the wellbeing of inmates in Enugu Maximum Correctional Centre, Enugu State, Nigeria
3. There is a significant impact of health workers reformative services on the well being of inmate in Enugu Maximum Correctional Centre, Enugu State, Nigeria
4. Health workers health educational awareness services do significant influence on the wellbeing of inmates in Enugu Maximum Correctional Centre, Enugu State, Nigeria

5.2 Conclusion

The studies examine the role of health care worker in prisons and the wellbeing of inmate in Enugu Maximum Correctional Centre, Enugu State, Nigeria. The specific focus of the study emphasized the preventive as well as the curative services of health care professionals. These services are fundamental to the wellbeing of inmate in any correctional services system of prisons globally. From the study findings, it was believed

with empirical evidence that in spite of the important role health workers have in correctional institution to promote the wellbeing of inmate, these services are far reached in Enugu Maximum Correctional Centre, Enugu State, Nigeria. This from the study is tied to corruption, obsolete infrastructure and lack of manpower train for such services. It suffices to say that in Enugu Maximum Correctional Centre, Enugu State, Nigeria, there are more of non-professional social workers than clinically proven care given health care professionals. The dearth of infrastructure in the prison often result to poor health care services delivery and poor health condition of inmate, hence the high rate of recidivism on reoffending among inmates.

5.3 Recommendations

Based on the findings of the study, the following recommendations are made

1. All health personnel providing care to inmate need to focus of preventive health care service in order to avert the rate and rise of infectious disease in the correctional institution
2. Government should address all the issues addressed in this work including the particularities of working in different prisons to provide curative care for the teaming population of inmates in all correctional institutions, Enugu Maximum Correctional Centres inclusive
3. There is urgent need for medical social workers in correctional institution as complementary to health care workers roles in other to provide reformative services through skill acquisition and health talks that will improve their health condition

4. Health education is essential to all, hence there is urgent need for health care workers to provide health education seminars workshop and campaigns to help educate inmates on the dangers of poor health education.

5.4 Suggestion for further studies

The following areas were suggested for further research:

1. Healthcare services and healthy living among Nigerian correctional services
2. Healthcare facility access and communicable diseases in Nigerian correctional services
3. Overcrowding and hygiene practices among inmates of Nigerian correctional services.

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APPENDIX 1

LETTER TO RESPONDENTS

Department of Sociology,
Faculty of Social Sciences,
University of Calabar,
Calabar
August 2018

Dear Respondents,

I am a post graduate student pursuing a Doctor of Philosophy degree in Medical Sociology, in the department of Sociology, University of Calabar, Calabar. I am carrying out a research on the topic: **Health workers service delivery and Wellbeing of Inmates in Enugu Correctional Centre of Enugu State, Nigeria.**

Please, you are requested to complete this questionnaire by providing adequate responses to questions below as demanded. The responses you give here are purely for academic purpose and do not have any economic, political or cultural intention.

Data generated from this research shall be tested against the study's hypotheses and the findings presented for academic and public policy purposes, only.

Your cooperation is highly solicited.

Thank you.

Yours Sincerely,

AYUK, CLARA O.
SOC/M.Sc/Ph.D/16/006

PART A

DEMOGRAPHIC DATA OF RESPONDENTS

Please tick [√] against each item as it applies to you.

1. Age: 18 years – 23 years [], 24 years – 29 years [ ], 30 years – 35 years [ ], 36 years-40 years [ ], 41 years and above [ ]
2. Gender: Male [ ], Female [ ]
3. Educational attainment; No formal education [ ] Primary education [ ] Secondary education [ ] Tertiary education [ ]
4. Marital Status; Single [ ] Married [ ] Separated [ ] Divorced [ ] Widow [ ] Widower [ ]
5. Religious.affiliation; Christianity [ ] Islam [ ] Traditional religion [ ] Others [ ]
6. Times in prison: 0-12 months [ ] 13-24 months [ ] 25-above [ ] None [ ]

PART B

Please tick [√] on one level of each statement as applicable to you.

S/N	STATEMENTS	Strongly agree	Agree	Disagree	Strongly disagree
HEALTH WORKERS PREVENTIVE ROLE EMPATHY AND WELLBEING OF INMATES					
1	Health workers frequently provide measures of good health				
2	Health workers provide health tips for good health				
3	Health workers often show concern when inmates are ill				
4	Health workers always willing to assist				

	inmates during emergency				
5	Health workers provide mosquito net against malaria				
6	Health workers usually carry out their duties with compassion				
HEALTH WORKERS CURATIVE ROLE AND WELLBEING OF INMATES					
7	Health workers provide malaria drugs to sick inmate				
8	Health workers provide ART for HIV patients				
9	Health workers administer injection to inmate where necessary				
10	Health workers provide deworming drugs against philarisasis				
11	Health workers are never gentle with inmates during treatment				
12	Health workers often use force to ensure compliance to treatment				
HEALTH WORKERS REFOMATIVE ROLE AND WELLBEING OF INMATES					
13	Health workers are seen as helper to inmates				
14	Health workers provide rehabilitation services to reform inmates				
15	Health workers have respect for privacy of inmates				
16	Health workers teaches inmate how to be good and leave a good life at post-incarceration				
17	Health workers do consider the opinions of inmates				

18	Health workers do not disclose the health condition of inmates to others				

HEALTH WORKERS EDUCATIONAL ROLE AND WELLBEING OF INMATES

19	Health workers and social worker teaches inmate good skills				
20	Health workers and staff enroll inmate in many vocational skill				
21	Health worker educated inmate how to take good care of their health				
22	Health workers treat everyone equally irrespective of gender				
23	Health workers are friendly to all inmates				
24	Health workers discriminate inmates based on nature of illness				