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ASSESSMENT OF QUALITY OF LIFE OF STAFF AND INMATES OF MAXIMUM SECURITY PRISON, ABEOKUTA, OGUN STATE COMMAND

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Abstract: **This study was designed to assess the quality of life of staff and prison inmates, the quality of life and health challenges with strategic plan on how to improve the quality of life of both the staff and the inmates. Exploratory design was used to identify and describe the quality of life of the respondent. The research was carried out at the maximum prison, Abeokuta, Ogun State with the staff and inmates of the prison as the target population. Data on quality of life of staff and inmates were collected with the use of structured self – administered questionnaire which consists of sections A, B and C. section A elicit questions on their current health status. Sections B and C inquire the medical needs and socio – demographic characteristics respectively. The data collected were analyzed through descriptive statistics presented by means of frequencies and percentages using SPSS version 17. A total number of 300 subjects were assessed comprising of 271 inmates and 29 staff. The average age range is 26 – 29 years. The findings showed that most of the inmates and staff have a number of health challenges ranging from loss of sleep, lack of concentration, depression to anxiety disorders with limited resources to cope with them. However, most of the respondents were highly mobile with good appetite and sound sense of hearing. The study reveals need for better care and support for the inmates and provision of well equipped well stocked facility. A repeat of the research is advocated for other prisons in the country to ascertain whether or not the quality of life is the same.**

Keywords: **health challenges, prison inmates, medical needs, highly mobile, sound sense.**

1. BACKGROUND OF THE STUDY

The optimum state of health of a patient is a unipersonal concept. It is changeable and is measured with a varying degree of subjectivity that does not always coincide with the doctor's opinion of the severity of a patient's illness (Martı´nez-Gonza´lez 2000). Prisons offer a unique opportunity to make positive interventions not only in relation to health issues but also to address the social determinants of ill health. Even with the limited knowledge we have had in regard to the health of Western Australia's prisoners it is apparent that prisons concentrate patients with significantly greater levels of morbidity than most other environments. (Sharan2009).

Quality of life is a descriptive term for people's emotional, social and physical well-being, and their ability to function in carrying out the ordinary tasks of living. Basu(2004) traces concepts of quality of life in medicine to the early 1960s, with major work on developing systems of quality of life measurement from the 1980s onwards, including mental health-specific measures. The quality of life concept can enable systematic investigation of the social, emotional and physical effects of illnesses and treatments on people's daily lives, from objective and subjective perspectives. In theory, well-constructed, reliable, valid and responsive quality of life measures can help doctors and healthcare providers, families and patients to choose between different treatment approaches and monitor outcomes. The reality may not match the theory, particularly from the perspective of service users. (Jan Wallcraft, 2011).

It has been estimated that in a given year, about 25% of all people in the United States who have HIV disease, about 33% who have HCV infection, and more than 40% who have tuberculosis disease will pass through a correctional facility that same year. (Hammett et al, 2002). This means that prisons and jails must be among the primary settings for interventions to prevent and treat infectious disease. This study confirms the high prevalence of mental disorders among primary care attendees, specifically a one-year prevalence of 23%. Mood and anxiety disorders are the most common, with one-year prevalences of 10% and 9%, respectively. These figures are close to the average values previously reported by the WHO's transcultural study performed in the primary care populations of 14 different countries using the same diagnostic instrument: the Composite International Diagnostic Interview (CIDI). It is found that around 24% of all the patients had a mental disorder, ranging from 7% in China to 52% in Chile; overall 10% had depression, ranging from 3% in Japan to 29% in Chile, and approximately 8% had anxiety, ranging from 1% in Turkey to 23% in Brazil. (Goldberg D.P, 1995).In a study conducted in District Jail Mathura, India on oral health and quality of life; the overall prevalence of Oro-mucosal lesions was 59.8%, (63.7 %) inmates were suffering with problems regarding Temporo - mandibular joint disorder, 40.2% of the inmates had no abnormal condition followed by 31.1% with Leukoplakia, 17.9% with ulceration, 3.6% with lichen planus, 4% with candidiasis, 2.9% with acute necrotizing gingivitis, whereas 0.2% were having abscess. (Dhanker et al, 2013)

Jail inmates are more likely than the general public to have health problems—including high rates of drug and alcohol abuse and communicable diseases such as tuberculosis and syphilis which can spread and can affect the overall health of a community if their health needs are not addressed while they are in jail. Also, their chronic conditions may worsen perhaps resulting in a need for more costly care on their release which may be beared by public clinics or hospitals. Providing health care is not a jail's primary mission, but it is a critical function that jails must perform under more challenging circumstances than most health care providers face to improve their quality of life (Jill, 2005). The populations in Nigerian prisons consist of the "Convicted and the Awaiting Trial." The latter form the majority. Prison authorities feel they have full responsibility for the convicted, but not quite for the awaiting trial. They therefore have problems with feeding, accommodation and health services. The reason for this includes general paucity in infrastructures, policies, workshops and corrupt disposed system which will definitely undermine inmates' welfare and their quality of life (Ayuk *et al*. 2013).

Inadequate resources and bureaucracy among the police is often responsible for the long imprisonment of the awaiting trial therefore suffer many years of malnutrition, starvation, unhygienic conditions, deficiency diseases and may die of preventable causes, and nobody feels responsible for their fate (Chikwe 2009).Officers and men of Nigeria prisons epitomize corruption and no will to discharge their duties and responsibilities –certainly not satisfied with their conditions of service and are helpless when face with overwhelming health challenges of the inmates they are call to cater for. Interestingly, prison still remains indispensable in correcting, reforming and rehabilitating "perceived convicts" in Nigeria (Ayuk et al. 2013).Adequate measures to improve the quality of life of these incarcerated population has receive proper attention, the policies made on decongesting the prisons are inconclusive with poor provision for health facilities. Nigeria prisons are "living hell" twenty to thirty inmates arrive at the prison every day, thus overcrowding over-crowding the reformatory structure which do not even exist in the true sense often times tripling the original carrying capacity of most maximum security prisons. There are shortages of bed spaces only half of the inmates sleep on bed. Disease is widespread cells are unclean and offer little ventilation resulting in unhealthy and dangerous sanitary condition (The Nation News Paper 2010)

2. MATERIALS AND METHODS

2.1. Research Design:

Exploratory design was used to identify and describe the quality of life of the respondents.

2.2. Population and sampling:

The target populations for the study were the staff and inmates of Maximum Security Prison, Abeokuta (i.e. Condemned Convicts, Convicted Prisoners, awaiting Trials) and Correctional Officers.

A non-probability sampling design using convenient sampling was used to select the sample. The sample will consist of 271 inmates and 29 staff of the institution making a total of 300respondents. The researcher ensured that all inmates had equal right to participate in the study.

2.3. Instrument and Data Collection:

A structured self-administered questionnaire was developed for the purpose of data collection. The questionnaire consists of three sections (A, B and C). Section A comprised of questions pertaining to their current health status, Section B is about accessibility of the respondents to medical needs and Section C is about socio-demographic characteristics.

After the permission for the research was granted, a prior visit was made to the office of Deputy Controller in charge of the command to establish the actual population to be dealt with. This gave insight into the number of questionnaire to be administered. This also provided the opportunity to familiarize with the inmates and correctional officers. On a later date, the questionnaires were administered to the inmates. The questionnaire contained a note explaining the purpose of the study to the subjects. The questionnaires were collected and analyzed.

2.4. Data Analysis:

Statistical Package for Social Sciences (SPSS version 17) computer program was used to analyze the data, and descriptive statistics presented by means, frequencies and percentages was used to present the data.

3. RESULTS

3.1 Socio – demographic profile:

Table 1 show the socio-demographic distribution of respondents and it reveals that 3% of the respondents aged between 1—19 years, 39.7% between 20-29, 33% between 30-39, 13.3% between 40-49, 5% between 50-59 years respectively. 79.7% were males and 15.3% were females. 17% had primary education as their highest educational qualification, 2.7% JSSCE, 22.7% SSCE, 4% OND, 1.2% HND, and 5% BSC and 1% had none. 19.6% were artesian, 2% business men/women, 3% civil servants, 10.7% farmers, 8.3% self employed, 3% students and 2% traders.

3.2 Respondents quality of life:

Table 2 represents the distribution of respondents on their quality of life. The mean value for vision was 4.62, hearing 4.98, mobility 4.92, eating 4.80, sleeping 4.04, excretion 4.73, breathing 4.08, discomfort and symptoms 4.09, distress 4.14, appearance 4.03, school and hobbies 4.27, friends 4.54, concentration 3.77, learning and memory 4.29, speech 4.64, depression 4.13.

Table 1: Distribution of Respondents Based on Socio-demographic Variables

Variables	Frequency	Percentage %
Age		
10-19	9	3.0
20-29	119	39.7
30-39	99	33.0
40-49	40	13.3
50-59	15	5.0
No response	18	6.0
TOTAL	300	100
Sex		
Male	238	78.7
Female	46	15.3
No response	18	6.0
TOTAL	300	100
Education		
PRIMARY EDUCATION	51	17.0
JSCE	8	2.7
SSCE	68	22.7
OND	12	4.0

HND	4	1.3
BSC	15	5.0
NIL	6	2.0
NO RESPONSE	136	45.3
TOTAL	300	100
Occupation		
Artisan	59	19.6
Business	6	2.0
Civil servant	9	3.0
Driver	24	8.0
Farming	32	10.7
Self employed	16	5.3
Student	6	2.0
Trader	6	2.0
Nil	23	7.7
No response	119	39.7
TOTAL	300	100

Table 2: Distribution of Respondents Based on Quality of Life On a scale of 1-5 with 5 being the best option and 1 being the worse

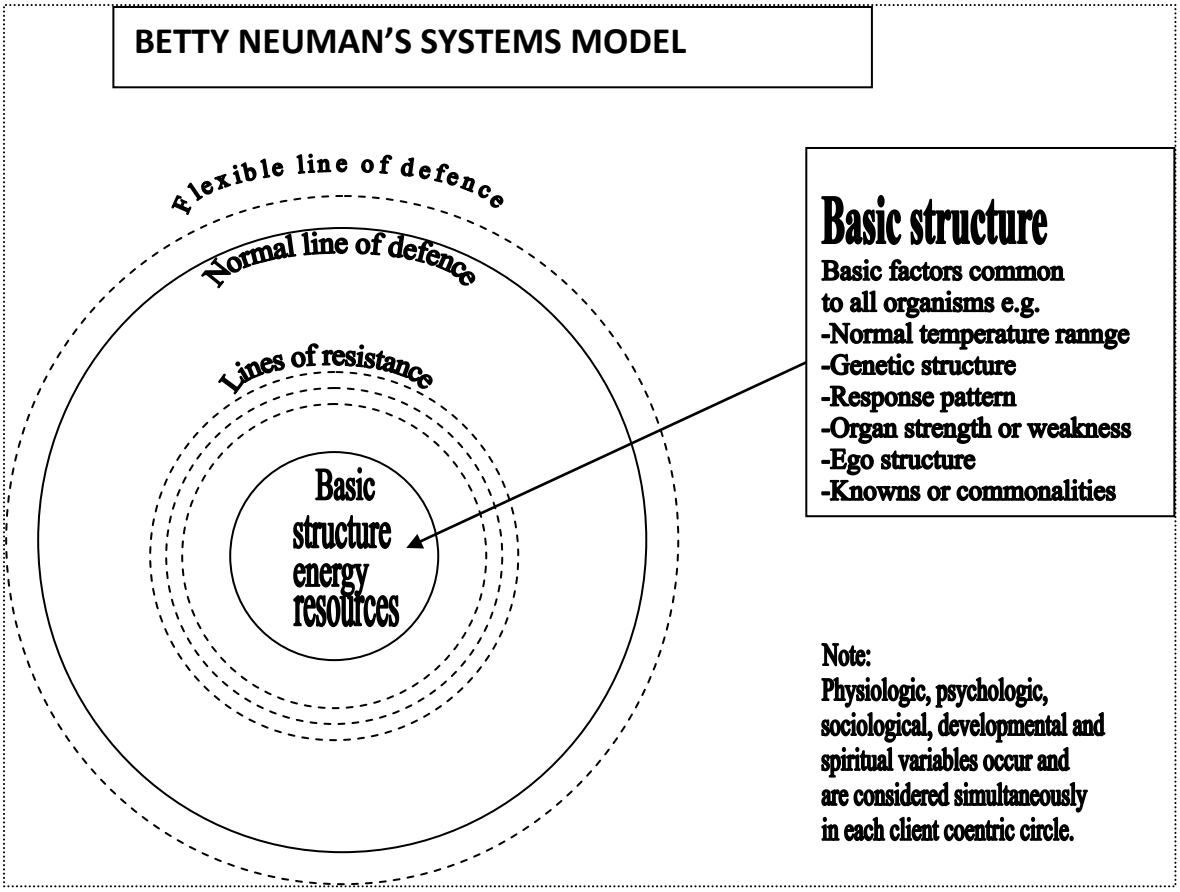
	Mean	Std. Deviation	Range	Minimum	Maximum
Vision	4.62	0.719	3	2	5
Hearing	4.98	0.140	1	4	5
Mobility	4.92	0.441	3	2	5
Eating	4.80	0.850	5	0	5
Sleeping	4.04	1.446	6	0	6
Excretion	4.73	0.848	5	0	5
Breathing	4.08	1.235	5	0	5
Discomfort and symptoms	4.09	1.240	5	0	5
Vitality	4.21	1.089	5	0	5
Distress	4.14	1.132	5	0	5
Appearance	4.03	1.286	6	0	6
School and hobbies	4.27	1.298	5	0	5
Friends	4.54	1.045	5	0	5
Concentration	3.77	1.270	5	0	5
Learning and Memory	4.29	0.961	5	0	5
Speech	4.64	0.983	5	0	5
Depression	4.13	0.896	5	0	5

3.3 Distribution of Respondents Based on Current Health Complaints:

The table 3 which shows the distribution of respondents on current health complaints reveals that 2% have diarrhea, 12% body pain, 7.3% headache, 3.3% catarrh, 0.3% cold, 5% ear ache, 2% eczema, 25 fever, 4.7% anorexia, 7.3% itching, 2% difficulty in seeing, difficulty in mobility, rashes and stomach ache respectively and 2.7% had tooth ache and depression respectively.

Consequently, the distribution of respondents on the drugs currently used showed that 0.7% was on anti-malaria, 2% on anti-diarrhea, 2.7% on anti psychotic, 3% on chloroquine, 53% on none, 4.6% paracetamol, and 3% on septrin.

Theoretical Frame Work:



(Note: From *The Neuman's Model*, 4th ed. (p. 15), by Neuman and Fawcett, 2002, Upper Saddle River, NJ: Prentice Hall. Reprinted with permission)

Fig 1: Neuman system model to environmental stressors

Betty Neuman views the client as an open system that responds to stressors in the environment. The client variables are physiological, psychological, socio – cultural, developmental, and spiritual. The client system consists of a basic or core structure that is protected by lines of resistance. The usual level of health is identified as the normal line of defense that is protected by a flexible line of defense. Stressors are intra-, inter-, and extra-personal in nature and arise from the internal, external, and created environments. When stressors break through the flexible line of defense, the system is invaded and the lines of resistance are activated and the system is described as moving into illness on a wellness-illness continuum. If adequate energy is available, the system will be reconstituted with the normal line of defense restored at, below, or above its previous level.

The basic core structure is surrounded by two concentric bounds of rings referred to as lines of resistance. The two lines of resistance represent internal factors that help the person to defend against the stressors. Outside the lines of resistance are two lines of defense. The inner one, depicted as a solid line, represents the person's normal line of defense characterized by the person's state of equilibrium or the state of adaptation developed and maintained.

Nursing interventions occur through three prevention modalities. Primary prevention occurs before the stressor invades the system; secondary prevention occurs after the system has reacted to an invading stressor; and tertiary prevention occurs after the system has reacted to an invading stressor; and tertiary prevention occurs after secondary prevention as reconstitution is being established.

4. DISCUSSION

The just concluded study examined and evaluated the quality of life of inmates in Maximum Security Prison, Abeokuta, Ogun State Command. This was carried out with a view to access the current trends, thereby giving room for policies that would facilitate maintenance, improvements and adjustments to ensure a better, quality of life for prison inmates.

Collection of data was done with the aid of validated questionnaires which were administered to concerned respondents at Abeokuta prison. This was complimented using oral interviews with respondents who shared their mind on issues relating to their health.

The result of social demographic distribution of respondents revealed that majority of respondents were males aged between twenty and thirty nine years of age and this conforms with Gilliard and Beck, 1996 which commented that women inmates represent about 10 percent of the total criminal justice population and most of them were artisans. Furthermore, many of the respondents 42.4% had between primary and secondary education with only a small percentage of 10.2% having tertiary education.The assessment of the quality of life of using seventeen (17) factors revealed that majority of the respondents had good quality of life. Respondents showed the highest quality on hearing as there was a mean value of 4.98 on the grading scale which implied that majority of them hears normal speech without hearing aids. This was closely followed by mobility with a mean score of 4.92 implying that almost all the respondents could move around or walk without any difficulty and eating/ nutrition with a mean score of 4.92 as most of the respondents were able to feed without any difficulty. It was however identified that some respondents had poor quality of life in some areas with concentration having the highest percentage. About 15.3% could only concentrate for only a short while and 11.7% had their thoughts jumping from one thing to another and could really not concentrate. Also, 29.3% had a little difficulty learning and remembering new things and 15.7% found this quite hard to achieve. Furthermore many respondents were sad or depressed with the level of sadness with some affected slightly while others were severely affected and this conforms to the review by Mendlowicz and Stein (2000), in which it was reported that anxiety disorders, including; panic disorder, social phobia, posttraumatic stress disorder, generalized anxiety disorder, cause significant impairment in quality of life and psychosocial functioning, Angermeyer also reported that quality of life was significantly better in a group of patients whose depression remitted following treatment compared to those with persisting symptoms, and greater depressive symptoms have been associated with lower quality of life. Although majority of the respondents had no pain at all, it was however assessed that 42% had little pain and 8.7% had pain ranging from a little to very much. Assessment also revealed that although most respondents had no difficulty with excretion, about 6% experienced incidences of messing or wetting their trousers or bed and often had diarrhoea. Finally, many of the respondents felt depressed with depression ranging from a little to an extreme.

Assessment of the current health complaints of respondents revealed that body pain was the predominant health complaint closely followed by headache and itching with 7.3% each. About 4.7% had anorexia and 2.5% had fever. Tooth ache was experienced by 2.7%. the lowest percentage was observed to be cold with only 0.3% , eczema and diarrhoea were experienced by only 2% of the respondents and this is in line with Ayuk, 2003 which stated that inmates especially those awaiting trial may suffer many years of malnutrition, starvation, unhygienic conditions, deficiency diseases and may die of preventable causes, and nobody feels responsible for their fate, this is however in discord with Wilper et al. 2009 which indicated that over half of inmates suffered from at least one chronic health condition.

Assessment of the current drugs used by respondents revealed that 53% of the respondents were not on any drug. Furthermore, the paracetamol had the highest percentage of use as 4.6% were on paracetamol and this was closely followed by chloroquine with 3% and septrin with 3% also. 2.7% were on anti-psychotic drugs and only 0.7% were on other forms of anti-malaria. The reason for this low number was attributed to unavailability of drugs for use which supports the report of Odigha, 2004 which iterated that inmates have problems with feeding, accommodation and health services.

Assessment of the views of respondents on the health professional they seek to be seen by revealed that majority of the respondents sort the services of a doctor and a nurse as revealed by 44% and 33.3% of the respondents respectively. However, 4% sort the service of a counselor and this implies that there is currently shortage of these personnels to attend to the health needs of the inmates. This further supports the findings of Odigha, 2004 which iterated that inmates have problems with feeding, accommodation and health services.

4.1 Implication of Study:

Findings of this study has revealed that although the quality of life of respondents were generally assessed to be good, there still lies some areas that need medical and nursing intervention such as in treating or managing depression amongst inmates as a substantial number of the respondents admitted some level of sadness or depression. There is also the need for prompt provision of drugs to treat conditions especially pain which was assessed to be the predominant health challenge amongst respondents. The study has also revealed the need for increase access of inmates to the services of nurse and doctors.

4.2 Recommendations:

Based on the findings from this study, I wish to recommend the following;

- That there should be regular surveillance of the quality of life of inmates in the various Nigerian prisons as this would help to monitor how they are faring from time to time.
- Government agencies and philanthropies should contribute meaningfully to support the procurement of drugs and other basic health amenities in the Abeokuta prison to improve on the current quality of life and prevent any form of deterioration.
- Health professionals should volunteer to serve on grounds of charity once in a while in helping to assess and treat inmate with minor health conditions as this would help to prevent these ailments from becoming chronic and also relieve to an extent, the burden on the government.
- The criminal justice system should be improved on so as to regulate the number of persons in the prison from time to time as this would help to reduce the overcrowding currently experienced and hence relieve the burden on prison facilities.

5. CONCLUSION

This study concludes that there is need for continuous monitoring of the quality of life of inmates and the provision of essential drugs and health professionals to treat minor health challenges amongst inmates.

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