



BODILY AUTONOMY IN CUSTODY: CAN ARTIFICIAL INTELLIGENCE ADVANCE INMATES' HEALTH RIGHTS IN NIGERIA?

Dorcas Adesola Thanni¹, Rosetta Okiemute Isiavwe², Mary Ann O. Ajayi³

1. Lecturer at Bowen University, Iwo, Nigeria.
2. Distinguished Legal Scholar and Lecturer at Bowen University, Iwo, Nigeria.
3. Head of the Law Programme at Bowen University, Iwo, Nigeria.

Article Information:

Article Type:
Research Article

Manuscript Received:
30 July 2025

Final Revision Received:
11 January 2026

Published Online:
15 April 2026

Keywords:
Bodily autonomy,
Informed consent, health
rights, Artificial
Intelligence, correctional
facilities, digital health,
medical law

Abstract:

Bodily autonomy and informed consent are fundamental principles in medical law and ethics, enshrined in both domestic and international human rights instruments. However, in regimented environments such as correctional facilities, these rights are frequently undermined by institutional constraints, power imbalances, and inadequate legal oversight. In Nigeria, where the correctional health system is fraught with systemic neglect, overcrowding, and poor medical governance, the right of inmates to refuse treatment or make autonomous healthcare decisions remains largely unexamined in both law and practice. This study investigates the extent to which inmates in Nigerian correctional facilities can exercise their rights to bodily autonomy and informed consent, particularly the right to accept or refuse medical treatment. It further explores the potential of artificial intelligence (AI) to support the ethical administration of healthcare in custodial settings by improving documentation, enhancing transparency, and monitoring compliance with consent protocols. While AI offers promising applications in safeguarding inmates' health rights, it also raises ethical concerns around surveillance, bias, and the erosion of human-centred care. Through a doctrinal methodology this article examines existing legal framework protecting inmate's right to health and emerging AI technologies. This study aims to uncover the gaps between legal guarantees and custodial realities, and to propose actionable recommendations for rights-based inmates' health governance in Nigeria. The findings contribute to the broader discourse on correctional reform, digital justice, and the ethical deployment of AI in public health systems, particularly for marginalized and vulnerable populations.

Cite this article: Dorcas A. Thanni, Rosetta O. Isiavwe, and Mary Ann O. Ajayi (2026). Bodily Autonomy in Custody: Can Artificial Intelligence Advance Inmates' Health Rights in Nigeria?. The Journal of Sustainable Development, Law and Policy. Vol. 17:4. 382-416. DOI: 10.4314/jsdlp.v17i4.13.



© The Author(s)

Publisher: Institute for Oil, Energy, Environment and Sustainable Development (OGEES Institute), Afe Babalola University, Ado Ekiti, Nigeria.

1. INTRODUCTION

Bodily autonomy and informed consent represent two of the most fundamental principles in the fields of medical law, human rights, and ethical healthcare practice. Anyone capable of making decisions has a right to accept or refuse medical treatment, regardless of the wisdom or consequences of the decision.¹ Informed consent is a core medical law and bioethics principle which is founded in acknowledging respect for patients as being capable of making decisions affecting their own body.² Before treating a patient, it is required that the medical practitioner gets the patient's consent or agreement to go ahead, except in certain exceptional circumstances where another person is authorized to give consent on his behalf, or in cases of necessity where the medical practitioner will act in the patient's best interest.³

Obtaining the consent of the patient is not just a single act or stage, but the entire process leading to the patient approving or authorizing a medical intervention after receiving adequate information, understanding that information, and making a voluntary decision free from coercion or undue influence.⁴ Thus, embedded in the principle of informed consent are three core elements which are disclosure, comprehension, and voluntariness.⁵ Disclosure requires the medical practitioner to furnish the patient with material information relating to the nature, purpose, benefits, risks, and alternatives to the proposed treatment.⁶ Comprehension demands that the patient actually understands this information, taking into account factors such as literacy, language, cognitive capacity, and socio-cultural context.

¹ Heart of England NHS Trust v. JB [2014] EWHC 342 (COP)

² Tom L Beauchamp and James F Childress, *Principles of Biomedical Ethics* (7th edn, Oxford University Press 2013) 99–101.

³ Jonathan Herring, *Medical Law and Ethics* (6th edn, Oxford University Press 2018).

⁴ Lokesh P Nijhawan, Manthan Janodia, Muddu Krishna, Prashant B Musmade and others, 'Informed Consent: Issues and Challenges' (2013) 4(3) *Journal of Advanced Pharmaceutical Technology & Research* 134–140.

⁵ Muhammed Olanrewaju Afolabi, Joseph Okebe, Nuala McGrath, Heidi J Larson, Kalifa Bojang and Daniel Chandramohan, 'Informed Consent Comprehension in African Research Settings' (2014) 19(6) *Tropical Medicine & International Health* 625 <https://doi.org/10.1111/tmi.12288> accessed 20 December 2025.

⁶ Paulina Tindana, Nancy Kass, and Patricia Akweongo 'The Informed Consent Process in a Rural African Setting' (2006) 28(3) *IRB: Ethics & Human Research* 1, 3.

Voluntariness, finally, ensures that the patient's decision is made without manipulation, pressure, or structural compulsion, whether from medical professionals, family members, or institutional constraints.⁷

Although closely related, bodily autonomy and informed consent are conceptually and legally distinct. Bodily autonomy refers to the broader normative principle that individuals possess sovereign authority over their own bodies, grounded in dignity, liberty, and personhood.⁸ It is a constitutional and human rights value that affirms the right to self-determination and freedom from non-consensual interference.⁹ Informed consent, by contrast, is the procedural mechanism through which bodily autonomy is operationalised within medical decision-making. While bodily autonomy establishes the right to decide, informed consent regulates the conditions under which that decision is recognised as valid in law and ethics.¹⁰ This distinction is particularly significant in jurisdictions such as Nigeria where paternalistic¹¹ medical practices persist. A patient may possess theoretical bodily autonomy yet be denied meaningful informed consent where information is withheld, risks are minimised, or consent is elicited through deference to medical authority.¹² According to Olutayo and Thanni, such is the experience of inmates of

⁷ Chijioke Arinze-Umobi and Chukwuemeka Okeke, 'A Review of Socio-Cultural Factors Affecting Patients' Right to Informed Consent and Autonomy in Medical Practice in Nigeria' (2020) 4(1) *African Journal of Law and Human Rights*.

⁸ Muhammed Olanrewaju Afolabi et al (n5)

⁹ Beauchamp and Childress (n2) 103–105

¹⁰ Emmanuel OC Obidimma and Reginald Anosike Uzoechi, 'The Limits of Patient Autonomy as a Ground to Refuse Medical Treatment' (2021) *African Journal of Comparative and Applied Law*.

¹¹ This refers to an approach in which healthcare professionals make decisions on behalf of patients based on what they perceive to be the patient's best interests, often with minimal disclosure of information or limited patient participation in decision-making. This model is historically rooted in the Hippocratic tradition and is characterised by professional dominance, informational asymmetry, and the assumption that medical expertise justifies overriding or curtailing patient autonomy. While paternalism may be defensible in limited circumstances as earlier explained, it has been widely criticised in contemporary medical law for undermining informed consent, bodily autonomy, and the patient's status as a rights-bearing individual. See further Jonathan Herring ch 5 (n3); Tom L Beauchamp and James F Childress, 208–214 (n2); Obidimma and Uzoechi (n10)

¹² Obidimma and Uzoechi (n13)

Nigerian Correctional facilities.¹³ Conversely, formal consent obtained without genuine understanding or voluntariness fails to respect bodily autonomy in substance.¹⁴ Recognising this distinction is required for policymakers to move beyond tokenistic consent practices and to evaluate whether medical interactions genuinely respect the patient's status as a rights-bearing individual.

Globally, these rights are embedded in legal frameworks such as the Universal Declaration of Human Rights¹⁵, the International Covenant on Civil and Political Rights¹⁶ and regionally, in the African Charter on Human and Peoples' Rights.¹⁷ They are further reinforced by professional medical codes of ethics and judicial precedents. However, the effective implementation and observance of these rights remain complex in custodial settings, particularly within the Nigerian correctional facilities where several factors militate against the observance of the rights of inmates.

Inmates, despite incarceration, legally retain their fundamental human rights except those that are lawfully restricted by virtue of their conviction and sentence. Incarceration justifies only those restrictions that are **inevitable and proportionate consequences of imprisonment**, foremost being the loss of liberty of movement. Ancillary rights such as privacy, freedom of association, communication, and certain political rights may be **regulated but not extinguished**, and only to the extent strictly necessary for security, order, and rehabilitation. All other rights, particularly **human dignity, freedom from torture or inhuman treatment, access to healthcare, equality before the law, and access to courts**, remain fully protected. The right to health is not extinguished by imprisonment. The United Nations Standard Minimum Rules for the Treatment of Prisoners explicitly state that prisoners must enjoy the same

¹³ D Olutayo and A Thanni, 'Health Rights of Inmates of Correctional Institutions in Nigeria During Endemic Periods: Challenges and Policy Responses' (2025) *African Journal of Law and Human Rights* <https://journals.ezenwaohaetorc.org/index.php/AJLHR/article/view/3209>

¹⁴ Tindana and others (n6)

¹⁵ See Article 25

¹⁶ See Article 7

¹⁷ See Article 16

standards of health care available in the community and should have access to necessary healthcare services free of discrimination.¹⁸ The right to refuse treatment and provide informed consent is a question of human dignity, which should ordinarily not be derogated from. The dignity of inmates is to be observed in all instances, including in the observance of their health rights. In the custodial setting, this right becomes even more crucial due to the heightened vulnerability of inmates, the power imbalance between inmates and authorities, and the increased risk of coercion or neglect. It could also be because of inadequate facilities, poor funding and lack of medical personnel. Prison authorities tend to prioritise the security of the facility over any other consideration.¹⁹

Despite international safeguards, the Nigerian correctional system presents numerous structural and legal obstacles to the realisation of inmates' medical rights. The Nigerian Constitution²⁰ does not explicitly guarantee the right to health, although it is implied in Chapter II under the Directive Principles of State Policy. Furthermore, the Correctional Service Act²¹, while a step forward in prison reform, falls short in providing clear frameworks for medical autonomy or ethical standards for correctional healthcare delivery. The lack of specific guidelines on informed consent, mental health treatment, refusal of medication, or the involvement of inmates in their healthcare decisions creates a legal vacuum in which rights violations can occur unchecked.²²

Health care in Nigerian correctional facilities is deeply underfunded and under-prioritized. Reports by the Nigerian Correctional Service and independent watchdogs such as Prisoners' Rehabilitation and Welfare Action (PRAWA) indicate widespread neglect, insufficient medical

¹⁸ Rule 24(1) United Nations Standard Minimum Rules for the Treatment of Prisoners. UNODC. December, 2025.

¹⁹ Jenna Widyawati, 'Security and Safety Management at Correctional Facilities' <https://www.unafei.or.jp/publications/pdf/RS_No118/No118_08_PART_ONE_Participants_Papers_01.pdf> accessed 21 July 2025.

²⁰ Constitution of the Federal Republic of Nigeria 1999

²¹ Nigerian Correctional Service Act 2019

²² TA Ajayi and K Olatunji, 'Legal and Ethical Challenges in the Delivery of Health Services in Nigerian Prisons' (2022) 8(1) Nigerian Journal of Health Law and Policy 31.

personnel, lack of medical equipment, and poor sanitation across custodial facilities.²³ The implications are dire, especially for inmates with chronic illnesses, mental health conditions, or terminal diseases who often receive treatment without adequate diagnosis or the required active participation in the decision-making process.²⁴ The structural environment itself; marked by overcrowding, poor nutrition, and unhygienic conditions exacerbates the health risks faced by inmates and limit their capacity to make voluntary, well-informed choices regarding their medical care.²⁵

Legal awareness and health literacy among inmates remain low, and there is often no institutional effort to inform inmates of their medical rights. It may be important to query the extent of health literacy among the general population of Nigerians who are not inmates and infer that this may be one of the reasons why inmates are unaware of the rights and protection they have.²⁶ Security and safety of the physical structure of the correctional facility tend to be more important to the managers of correctional facilities because of its severe implications for staff where security is compromised or breached.²⁷ Inmates' correctional health system is therefore dominated by a disciplinary culture rather than a rehabilitative one, often treating inmates as subjects of control rather than as patients with rights. Where consent is obtained, it is frequently under duress or without full disclosure, thus invalidating its legal and ethical basis. These dynamics contribute to systemic violations of inmates' rights to bodily autonomy and informed medical decision-making.

In the fragile context of correctional healthcare, artificial intelligence (AI) presents new opportunities for reform, offering tools like automated diagnostics, consent tracking, and anomaly detection to enhance accountability and service delivery. However, these benefits come with

²³ Prisoners' Rehabilitation and Welfare Action (PRAWA, *Assessment of Health Services in Nigerian Correctional Facilities* (PRAWA 2020)).

²⁴ Ibid

²⁵ Ibid

²⁶ M Ode, M Adejo and M Adadu, 'Health Literacy as a Precursor to Functional Health in Nigeria: Challenges and Way Forward' (2012) 16(3) *Jewel Journal of Librarianship*.

²⁷ See s28, 29 Nigerian Correctional Service Act, 2019 which provides for the security of custodial facility and criminalises involvement of correctional officers in the escape or desertion of inmates from lawful custody.

significant risks, including surveillance misuse, data bias, and digital exclusion.

This study considered the doctrinal method; otherwise known as the black-letter law method as best suited. The method is concerned with systematically identifying, interpreting, analysing, and synthesising legal rules and principles from primary sources such as constitutions, statutes, case law, treaties, and regulations, and secondary materials including legal commentaries and academic literature. According to Hutchinson and Duncan, doctrinal research is ‘research into the law and legal concepts’ involving locating, analysing, and synthesising primary legal materials such as statutes and judicial decisions to establish coherent legal propositions.²⁸ Ekhaton and Obani,²⁹ in their study stated that doctrinal legal research is primarily concerned with identifying and analysing the legal rules and principles relevant to a given legal issue, providing the foundation upon which normative legal arguments can be developed. In this study, the doctrinal research method is applied to identifying the legal issues surrounding inmates’ legal right to refuse medical treatment in Nigeria and explores how AI can be ethically integrated into correctional health systems without compromising autonomy, consent, or privacy. It highlights the gap between law, policy, and practice, and considers whether technology will strengthen or weaken inmates’ health rights.

2.0 THE RIGHT TO HEALTH, BODILY AUTONOMY AND INFORMED CONSENT

The right to health is a human right issue. Article 25 of the UDHR affirms that everyone has the right to ‘a standard of living adequate for the health and well-being of himself and of his family, including medical care.’ Similarly, Article 12 of the ICESCR recognises ‘the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. Regionally, Article 16 of the African Charter on Human and

²⁸ Terry Hutchinson and Nigel Duncan, ‘Defining and Describing What We Do: Doctrinal Legal Research’ (2012) 17 *Deakin Law Review* 83. Pg 83-5

²⁹ E Ekhaton and P Obani , ‘Women and Environmental Justice Issues in Nigeria: An Evaluation’ in *Intersectionality and Women’s Access to Justice in Africa* (Lexington Books 2022) <https://doi.org/10.5040/9781666995213.ch-12> accessed 22 December 2025

Peoples' Rights similarly guarantees the right to enjoy the best attainable state of physical and mental health.

The right to bodily autonomy, that is the right of individuals to govern what happens to their own bodies; is central to medical ethics and law.³⁰ Informed consent is not merely a procedural formality; it reflects respect for human dignity, integrity, and self-determination. It ensures that patients are not treated as passive recipients of care but as active participants in their health management.³¹ In legal contexts, the failure to obtain valid informed consent can amount to a breach of professional duty and even result in claims of medical assault.³²

The implications of these principles are far-reaching: they condition how medical care is delivered, how patients engage with healthcare providers, and how healthcare institutions are held accountable. When enforced, they promote trust, transparency, and ethical responsibility in health systems. When violated, they give rise to paternalism, abuse, and systemic disenfranchisement.

3.0 AUTONOMOUS INMATES IN NIGERIAN CORRECTIONAL FACILITIES?

The paper is founded on a blend of the Human Rights and Rule of Law Theories. Human Rights Theory provides the normative foundation for assessing inmates' rights, based on the principle that all individuals, including inmates, possess inherent and inalienable rights which are protected under instruments such as the Universal Declaration of Human Rights (UDHR) and International Covenant on Civil and Political Rights (ICCPR). These rights include humane treatment, dignity, fair procedures,

³⁰ A A Ojo, 'The Rights to Patient's Informed Consent in Nigeria and South Africa: A Comparative Discourse' (2021) 9(11) *Quest Journal of Research in Humanities and Social Sciences* 43.

³¹ MN Umenweke and IB Okoye, 'A Review of the Extant Law and Practice of Informed Consent in Medical Procedures in Nigeria' (2025) 1 *Journal of Law and Clinical Legal Education*.

³² KSI Ng, 'Informed Consent in Clinical Practice: Old Problems, New Challenges' (2024) 54(2) *Journal of the Royal College of Physicians of Edinburgh*.

and protection from degrading conditions.³³ The Rule of Law Theory complements this by emphasising that rights are only meaningful when supported by legal systems that ensure accountability, equality before the law, and enforceability through fair processes and independent institutions.³⁴ Together, both theories provide a rights-based legal framework through which the use of artificial intelligence in Nigerian Correctional facilities can be evaluated: AI tools must operate within a system bound by legal standards that protect inmates' rights and must not rely on discretionary administrative practices. This combined framework therefore requires that AI deployment in correctional settings supports dignity, due process, and legal accountability, rather than undermining them.

While the right to health, bodily autonomy, and informed consent is theoretically universal, its enforcement is context-dependent and particularly fragile in custodial settings. Inmates, though deprived of liberty, do not lose their inherent human rights, including the right to health. However, in Nigeria, the practical realisation of these rights within correctional facilities is severely constrained. The Correctional Service Act fails to provide comprehensive protections for the medical rights of inmates. There are no robust protocols on informed consent, and there is minimal documentation or institutional accountability in cases where inmates refuse treatment or report maltreatment.³⁵ Moreover, the possibility of exercising medical autonomy within Nigerian custodial environments, which are generally characterised by overcrowding, lack of medical infrastructure, inadequate staffing, and poor health literacy among inmates are further eroded.³⁶

³³ Amartya Sen, 'Elements of a Theory of Human Rights' (2004) 32(4) *Philosophy & Public Affairs* (Blackwell Publishing, Inc).

³⁴ Anthony Valcke, *The Rule of Law: Its Origins and Meanings (A Short Guide for Practitioners)* (1 March 2012) 2 https://www.researchgate.net/publication/255726723_The_Rule_of_Law_Its_Origins_and_Meanings_A_Short_Guide_for_Practitioners accessed 22 December 2025.

³⁵ ID Adefisoye, JO Adejumo and DB Olufemi, 'Assessment of Quality of Life of Inmates in Nigerian Correctional Centres: A Systematic Review' (2024) 4(2) *African Journal of Sociology, Psychology and Rural Studies*.

³⁶ Ibid

Inmates represent a uniquely vulnerable population within Nigeria's health sector. Many are from marginalised backgrounds and suffer from pre-existing health conditions, including infectious diseases, mental illnesses, and chronic non-communicable conditions. There are systemic lapses in medical record-keeping, denial of basic treatment, and instances of treatment without disclosure or consent.³⁷ In such contexts, the assumption that consent has been validly obtained is often unfounded. Informed consent in correctional settings is severely limited by coercion, power imbalances, lack of medical personnel, and systemic corruption.³⁸ Inmates often lack the freedom to refuse treatment, undermining ethical and legal standards. To uphold bodily autonomy, there is a need for rights-based protocols tailored to custodial realities, supported by legal and institutional reforms. Without these, systemic neglect continues, and the integrity of Nigeria's healthcare and justice systems is compromised.

4.0 HEALTH LITERACY AND ITS IMPLICATIONS FOR INMATES' RIGHT TO HEALTH IN NIGERIA

Nigerian citizens have a right to health, but the extent to which this right is enjoyed is a direct correlate of how knowledgeable they are about the existence and extent of that right. In other words, poor health literacy is a significant barrier to the effective enjoyment of the right to health in Nigeria. The World Health Organisation (WHO) states that universal health literacy guarantees equal access to health services.³⁹ As of 2021, Nigeria's literacy rate stands at 63%, with a gender disparity of 74% literacy among men compared to 53% among women. This statistics place Nigeria in the category of countries where extremely low literacy rates are prevalent, particularly in Sub-Saharan Africa, South Asia, and West Asia.⁴⁰ Generally, low literacy levels contribute to low health literacy levels.⁴¹ It

³⁷ Prisoners' Rehabilitation and Welfare Action (PRAWA), *Assessment of Health Services in Nigerian Correctional Facilities* (PRAWA 2020) Lagos.

³⁸ LE Solbakken and R Wynn, 'Barriers and Opportunities to Accessing Social Support in the Transition from Community to Prison: A Qualitative Interview Study with Incarcerated Individuals in Northern Norway' (2022) 10 BMC Psychology 185.

³⁹ KT Olabanji, 'Interventions to Improve Health Literacy in Nigeria: Systematic Review of Effectiveness and Policy Recommendations' (2023) 23(3) *The Nigerian Health Journal* 707.

⁴⁰ *Ibid*

⁴¹ O Chiweta-Oduah and S Buchanan, 'Exploring health literacy in developing economies: Perspectives and practices of health communication professionals in rural Nigeria' (2025)

accounts for limited understanding of medical instructions, poor engagement with healthcare providers, and increased vulnerability to disease. In Nigeria, the implications of this reality are far-reaching. Low general literacy translates into low health literacy, undermining the population's ability to make informed decisions about health and access necessary care.⁴² This has hindered progress toward national and global health development goals, including the Millennium Development Goals (MDGs) and, more recently, the Sustainable Development Goals (SDGs).⁴³

Apart from low literacy levels, limited understanding of medical legal rights also accounts for low health literacy. According to WHO, health literacy refers to the individual's ability to acquire and apply health-related knowledge and skills developed through everyday experiences, social connections, and cultural transmission over time. These abilities are shaped and influenced by the systems and resources in place such as institutions and community services that support people in finding, understanding, evaluating, and using health information and services to improve and sustain their own health and that of others.⁴⁴ It is uncertain that the Nigerian system, particularly as it relates to medicine and health care are designed in such a way as to support people in 'finding, understanding, evaluating, and using health information and services to improve and sustain their own health and that of others.'⁴⁵ The Nigerian population is generally affected by low health literacy and inmates are among the groups most affected. Often drawn from socioeconomically disadvantaged backgrounds and rural areas with limited educational access, inmates constitute a vulnerable group within the Nigerian healthcare landscape.⁴⁶ Low health literacy in Nigeria contributes significantly to harmful traditional practices, the misuse of medications,

3(1) Health Literacy and Communication Open
<https://doi.org/10.1080/28355245.2025.2482197>

⁴² Ibid

⁴³ United Nations Economic and Social Council, 'Health Literacy and the Millennium Development Goals: United Nations Economic and Social Council (ECOSOC) Regional Meeting Background Paper (Abstracted)' (2010) 15(S2) *Journal of Health Communication* 211 <https://doi.org/10.1080/10810730.2010.499996>

⁴⁴ World Health Organization, *Health Promotion Glossary of Terms 2021* (WHO 2021).

⁴⁵ M Ode et al n26

⁴⁶ Ibid

misinterpretation of health advice, and the reliance on unqualified practitioners.⁴⁷ In custodial settings, limited access to health information and low health literacy leave inmates highly vulnerable, often unable to understand their rights or make informed medical decisions. Tackling this issue is essential to achieving meaningful informed consent in Nigeria's correctional facilities.

5.0 STRUCTURAL AND SYSTEMIC BARRIERS TO CORRECTIONAL HEALTH CARE

Vulnerable groups such as the poor, uneducated, persons with disabilities, and those with mental illness or substance use disorders already face significant healthcare disparities. When overrepresented in correctional facilities, it becomes crucial to assess both their access to healthcare and their satisfaction with the care provided. In a cross-sectional survey conducted across select Nigerian prison facilities, Ochonma and Chijioke⁴⁸ found that **across all correctional facilities assessed, patients expressed dissatisfaction with all the evaluated healthcare services.** Notably, the highest levels of dissatisfaction were recorded in relation to the **physical condition of the facilities and the quality of medical equipment** (mean = 2.40 ± 1.33), as well as the **timely availability of laboratory results** (mean = 2.46 ± 1.36). A comparative analysis across the different facilities showed that **satisfaction levels varied significantly**, with statistical evidence of this difference ($p < .001$).⁴⁹

Many prison systems, particularly those in low- and middle-income nations, suffer from inadequate medical facilities, a lack of diagnostic tools, and a shortage of pharmaceuticals. In the absence of sufficient resources, inmates might be offered few or no treatment alternatives, which would undermine the legitimacy and voluntariness of their assent. Multiple alternatives, sufficient information and voluntary choice are necessary for

⁴⁷ Ibid

⁴⁸ OG Ochonma and OU Chijioke, 'Healthcare Services Satisfaction in the Prison: A Cross-Sectional Survey and Comparative Analysis of Patient Inmates' Perspective Analysis in African Country' (2019) 5(2) International Journal of Health and Pharmaceutical Research. <https://iijournals.org/get/IJHPR/VOL.%205%20NO.%202%202019/HEALTHCARE%20SERVICES%20SATISFACTION.pdf>> accessed 21 July 2025

⁴⁹ Ibid

informed consent. When prisons are underfunded, circumstances frequently force inmates to take whatever care is offered, even if it is subpar, since there is no other option.⁵⁰

Medical access may be further hampered by practical problems including transportation to other facilities, lack of privacy for consultations, or security threats, even in cases where personnel and resources are available. By restricting access to various treatments and information disclosure, these restrictions have an impact on the inmate's liberty. Clouds *et al* found that logistical problems create numerous levels of oppression that restrict inmates from engaging in autonomous health seeking behaviours.⁵¹ Furthermore, discussions frequently take place while correctional personnel watch, which violates secrecy and privacy, two essential requirements for willing informed consent.⁵² Access to care is frequently delayed or denied by strict procedural hierarchy and administrative red tape. The inmate's condition may worsen as treatment requests are handled slowly or need several layers of approval. The permission process may be further undermined by these delays, which may further compromise patient-provider confidentiality and trust.

Inmates' medical complaints are often subjected to prolonged bureaucratic scrutiny, according to a report by Penal Reform International (2022), and inmates generally lack the authority to oversee their own medical care.⁵³ Informed consent is a cornerstone of ethical healthcare, but in correctional settings, its key elements—voluntariness, understanding, and decision-making—are undermined by delayed care, limited options, rushed consultations, and security constraints. These systemic failures strip inmates of meaningful medical autonomy.⁵⁴ In many prison systems, chronic under-staffing of both security and healthcare personnel severely

⁵⁰Tom L Beauchamp and James F Childress (n2)

⁵¹David H Cloud and others, 'Self-Injury and the Embodiment of Solitary Confinement among Adult Men in Louisiana' (2023) 22 *SSM Population* 101354.

⁵² Ibid

⁵³ In 2022, attempts were made to focus rehabilitation, lower incarceration rates, and improve prison conditions as part of penal reform and Penal Reform International (PRI) and similar organizations.

⁵⁴ World Health Organization Regional Office for Europe, *WHO/Europe 2023 Report* (2023).

limits inmates' access to timely medical care, often nullifying their autonomy and reducing healthcare to a reactive model.⁵⁵ As Mulgrew notes, these systemic failures strip inmates of essential medical interventions, making informed consent meaningless when treatment itself is inaccessible.⁵⁶

6.0 MEDICAL ETHICS IN THE UNITED STATES OF AMERICA

The United States (US) has more prisoners than practically any other nation in the world.⁵⁷ Although right to health care is not guaranteed under its Constitution, the Supreme Court has ruled since 1976 that wilful disregard for the grave medical needs of those who are incarcerated, the poor, ill, and members of a marginalised racial and ethnic groups violates the Eighth Amendment's ban on cruel and unusual punishment.⁵⁸ Thus, fundamental values such as autonomy, beneficence, non-maleficence, and justice should be upheld in medical ethics in all custodial settings. The main legal foundation for prisoners' healthcare rights in the United States is the Eighth Amendment to the Constitution which forbids 'cruel and unusual punishment,' and the U.S. Supreme Court held in the seminal decision of *Estelle v. Gamble*,⁵⁹ that 'deliberate indifference to serious medical needs of prisoners' is an Eighth Amendment violation. This decision made it clear that prisoners have a right to quality medical care and that it is not just unethical but also against the constitution to deny them that care.

⁵⁵ Ibid

⁵⁶ Roisin Mulgrew, 'Prisoners' Lives Cut Short: The Need to Address Structural, Societal, and Environmental Factors to Reduce Preventable Prison Deaths' (2023) 23(2) *Human Rights Law Review* ngad006.

⁵⁷ Helen Fair and Roy Walmsley, *World Prison Population List* (14th edn, Institute for Crime & Justice Policy Research 2024) https://www.prisonstudies.org/sites/default/files/resources/downloads/world_prison_population_list_14th_edition.pdf accessed 7 July 2025.

⁵⁸ J M Hyatt, S N Andersen and B Van Tiem, 'Perceptions of Incarcerated People: Prison Conditions, Public Health, and Justice in the United States' (2024) 45 *Journal of Public Health Policy* 446.

⁵⁹ *Estelle v Gamble*, 429 US 97 (1976).

Medical personnel employed in correctional facilities in the United States are required to adhere to the ethical standards set out by their respective professional societies, such as the American Medical Association's (AMA) Code of Medical Ethics, which requires personnel to prioritise patients' welfare above any other allegiance. There is also the Standards of the National Commission on Correctional Health Care (NCCHC) which include recommendations for confidentiality, informed consent, care access, and post-release continuity of care. Dual loyalty, where medical staff must navigate conflicting duties to inmates and prison authorities presents serious ethical challenges. Practices such as force-feeding, hunger strikers or withholding information have been condemned by Physicians for Human Rights (PHR), for violating international medical ethics standards particularly in cases where inmates are held at the Guantanamo Bay Detention Camp's (GBDC) medical facility situated in Southeastern Cuba. The GBDC is US Naval hospital having a specialised smaller unit within the detention area for detainees (terrorism suspects) under the purview of military health services.⁶⁰

6.1 Comparative Analysis of the Practice in the US as Guide for Nigerian Correctional Facilities

It should be acknowledged from inception that while comparing the US and Nigeria legal frameworks, both countries operate on different legal systems and state obligations differ. The differences identified below only serve as persuasive authority to demonstrate how other countries have navigated process of upholding prisoners' rights to healthcare.

In the US, the Constitution via the the Eight Amendment's "Cruel and Unusual punishment" language provides constitutional protections for prisoner healthcare in the country. On the other hand, it can be argued that the Nigerian Constitution does not explicitly specifically guarantee anyone's right to health care, including prisoners, however the constitution protects citizens from torture and cruel or humiliating

⁶⁰ Physicians for Human Rights, *Dual Loyalty and Human Rights in Health Professional Practice: Proposed Guidelines and Institutional Mechanisms* (2003) <https://phr.org/our-work/resources/dual-loyalty-and-human-rights-in-health-professional-practice/> accessed 7 July 2025.

treatment.⁶¹ Section 17 (30 (d) of the Nigeria is non-justiciable but lists health as a state purpose. The US precedent shows how courts might read constitutional rights to include the right to health care. Nigerian courts can apply a similar interpretation of Section 34, contending that wilful disregard for critical medical needs amounts to "inhuman and degrading treatment." A tried-and-true legal foundation for this argument is provided by the *Estelle v. Gamble* precedent. Hence, US caselaw shows how courts might read constitutional rights to include the right to healthcare.

Considering the professional ethics requirements, the US correctional medical personnel must adhere strictly to specialised correctional standards (NCCHS Standards) and Professional Association codes (AMA Code of Medical Ethics. In the Nigerian setting, the Medical and Dental Council of Nigeria (MDCN) Code of Medical Ethics and the Nursing and Midwifery Council of Nigeria Standards bind Nigerian healthcare workers. The issue is that, unlike NCCHC, Nigeria probably does not have such specific requirements for correctional healthcare. Nigeria must create context-specific ethical principles or guidance that address the following issues, as demonstrated by the US example: confidentiality in custodial settings; informed consent processes for detained populations; access to care protocols; and post-release continuity planning.

On the issue of dual loyalty dilemma that exist in correctional centres in the US where medical staff serve both patient welfare and institutional security interests, Nigerian prison medical staff face similar pressures considering that they lack clear ethical frameworks like the PHR provides in the US context. Problems like coerced medical examinations, recordkeeping for disciplinary purposes, or pressure to restrict care for security reasons will persist. Nigeria is bound by international agreements it has ratified, such as the UN Standard Minimum Rules for the Treatment of Prisoners (Nelson Mandela Rules), the International Covenant on Economic, Social, and Cultural Rights, and the African Charter on Human and Peoples' Rights (Article 16: right to health). This makes the reference to PHR and international medical ethics standards essential.

⁶¹ Section 34 Constitution of the Federal Republic of Nigeria, 1999.

Nigerian reform can be modelled after the US pattern, which shows how international standards can be integrated into domestic law and ethical practice.

6.2 Challenges to Autonomy in Correctional Health Care in Nigeria

Incarceration entails both the imposition of institutional authority and the denial of liberty. The fundamental tenets of autonomy, self-determination and free will are fundamentally at odds with this setting. In the coercive environment in which correctional health care is provided, security considerations frequently take precedence over personal preferences, immediately impeding the ability to make autonomous decisions.⁶²

In *Schloendorff v. Society of New York Hospital* case from the New York Court of Appeals in 1914,⁶³ Justice Benjamin Cardozo said, ‘every human being of adult years and sound mind has a right to determine what shall be done with his own body.’ This idea forms the basis of informed consent under medical law. Dworkin describes the principle governing informed consent as a ‘creature of law’⁶⁴ created in a number of legal fields where one party authorises another to carry out ‘some course of action to which the consented to party would have had no moral right.’⁶⁵ Requirements for informed consent are common in healthcare and are considered to be essential to moral medical practice.⁶⁶ When applied to custodial cases, the situation is slightly different considering the fact that prison life is typically marked by limited autonomy and options available to inmates.

Scholars including Douglas have debated and questioned whether consent is required to impose a medical intervention since the state can imprison a

⁶² Jörg Pont, ‘Medical Ethics in Prisons: Rules, Standards and Challenges’ (2006) 4(2) *International Journal of Prison Health* 259.

⁶³ *Schloendorff v Society of New York Hospital* 105 NE 92, 93 (NY 1914) citing *Pratt v Davis* 79 NE 562 (Ill 1906).

⁶⁴ Gerald Dworkin, *The Theory and Practice of Autonomy* (Cambridge University Press 1988).

⁶⁵ John Kleinig, *The Nature of Consent* (Oxford University Press 2012).

⁶⁶ Jonathan Pugh, *Autonomy, Rationality and Contemporary Bioethics* (Oxford Academic 2020) <https://academic.oup.com/book/33778> accessed 30 June 2025.

criminal without the offender's consent.⁶⁷ Other have argued that it would be unethical to treat criminals medically without first getting their informed consent. Several scholars are of the opinion that it would be immoral to provide medical interventions to criminals without obtaining their informed consent.⁶⁸ In order to counter these claims, it has been suggested that the purposes of medical intervention and incarceration are different⁶⁹. Only the freedom of movement is restricted by incarceration. According to self-determination theory (SDT), autonomy is a fundamental psychological need that enhances well-being, marked by a sense of volition and self-direction. In correctional healthcare settings, however, inmates often face severe restrictions on autonomy due to the system's emphasis on control, power imbalances, and security concerns. This limits their ability to make informed healthcare decisions, creating internal conflict and pressure.⁷⁰ Incarcerated patients are especially vulnerable, with little to no choice over their healthcare providers or the care they receive.⁷¹

Some of the challenges to autonomy in correctional health care are:

- i. **Information and Choice Limitations:** There may be limited access to thorough, objective information regarding diagnosis, treatment options, dangers, and advantages. The ability to make meaningful, independent decisions is undermined by formulary limits, limited access to specialists or specific therapies and limited availability of second opinions.⁷²
- ii. **Lack of Inmates Understanding of Medical Terms:** Inmates often give consent without fully understanding the risks or alternatives

⁶⁷ Thomas Douglas, 'Criminal Rehabilitation through Medical Intervention: Moral Liability and the Right to Bodily Integrity' (2014) 18 *The Journal of Ethics* 101.

⁶⁸ John McMillan, 'The Kindest Cut? Surgical Castration, Sex Offenders and Coercive Offers' (2013) *Journal of Medical Ethics* <https://doi.org/10.1136/medethics-2012-101030>.

⁶⁹ Alan Wertheimer and Franklin Miller, 'There Are (STILL) No Coercive Offers' (2013) *Journal of Medical Ethics* <https://doi.org/10.1136/medethics-2013-101510>

⁷⁰ Dana Lehrer, 'Compassion in Corrections: The Struggle Between Security and Health Care' (2021) 27(2) *Journal of Correctional Health Care* 81.

⁷¹ Ibid

⁷² Party Shah, Imani Thornton, Nancy L Kopitnik and John E Hipskind, 'Informed Consent' (National Library of Medicine, 30 May 2025) <https://www.ncbi.nlm.nih.gov/books/NBK/430827/> accessed 30 May 2025.

due to complex medical language and low health literacy. When information is not tailored to their cognitive needs, it undermines both their autonomy and trust in the healthcare system.

iii. Erosion of Self-Worth: Prevailing harsh conditions such as overcrowding, unsanitary environments, abuse, and lack of privacy gradually wipe off human dignity and self-worth, indirectly undermining inmates' autonomy. As inmates internalize dehumanizing treatment, they may give up on engaging in medical decision making, feel undeserving of care or believe their health needs would not be acknowledged, and thus give up insisting on their rights.

iv. Privacy and Confidentiality: Strict patient confidentiality is necessary for ethical medical practice. However, privacy is frequently violated when treating inmates. During consultations, security personnel might be present, and others other than doctors occasionally have access to medical records. This undermines confidence in the patient-provider relationship and deters inmates from being honest. According to Cloud et al, the breakdown of privacy in prison health systems is a type of structural violence that erodes the ethical standard of care and reinforces inequality rather than being just a practical problem.⁷³

v. Gender-Specific Ethics and Respect for Reproductive Rights: There are additional ethical issues for women who are in custody. Human rights concerns are raised by issues like shackling during childbirth, inadequate pre-natal and post-natal care, and limited access to post exposure prophylaxis. In a study conducted in Abakaliki custodial centre in Nigeria, Macpherson et al⁷⁴ found that women in male facilities are generally faced with various forms of discriminative practices; an obvious apparent disparity in prison rules and management, with women being significantly disadvantaged. They

⁷³ David H Cloud, Brie Williams, Gegine Haardoerfe, Justin T Hosbey and Hannah LF Cooper, 'Self-Injury and the Embodiment of Solitary Confinement among Adult Men in Louisiana' (2023) 22 *SSM Population Health* 101354.

⁷⁴ Macpherson Uchenna Nnam and others, "Nowhere is Safe for Us": An Analysis of Gender Discrimination against Female Inmates in a Male Correctional Institution' (2025) 81 *International Journal of Law, Crime and Justice* 100745 <https://doi.org/10.1016/j.ijlcj.2025.100745> accessed 21 July 2025.

further found that ‘the prison reproduces a sexist ideology and shapes the realities of these women within the system.’⁷⁵

7.0 THE POTENTIAL OF ARTIFICIAL INTELLIGENCE (AI) IN CORRECTIONAL HEALTHCARE SYSTEMS

The intersection of Artificial Intelligence (AI) and correctional healthcare represents one of the most complex and ethically fraught domains of modern digital justice. As prisons worldwide grapple with chronic healthcare challenges from overcrowding and resource shortages to insufficient medical governance, AI technologies present both a possible answer and a source of new ethical dilemmas. The role of AI in prison healthcare systems is multifaceted, and an attempt will be made at considering how it might enhance or undermine the health rights of incarcerated individuals.

7.1 Predictive Healthcare and Risk Assessment

According to research, AI machine learning algorithms are capable of accurately identifying prisoners who may be at danger of suicide, self-harm,⁷⁶ or other medical crises using such factors like socio demographics, physical health, psychological assessments, criminology characteristics, crime history, social support, and in-prison behaviours.⁷⁷ For predicting self-harm within a year, a machine learning model - CatBoost created for female inmates in a United Kingdom prison has a mean area under the curve (AUC) of 0.92, high sensitivity (0.83), and specificity (0.94). This indicates that the model might outperform earlier methods in both general and prison populations by accurately identifying most at-risk persons while decreasing false positives.⁷⁸ Also, with an excellent predictive capacity for self-harm risk, an enhanced screening tool for male inmates

⁷⁵ Op cit.

⁷⁶ Khayyam Akhtar and others, ‘Predicting Inmate Suicidal Behavior with an Interpretable Ensemble Machine Learning Approach in Smart Prisons’ (2024) 10 PeerJ Computer Science <https://doi.org/10.7717/peerj-cs.2051> accessed 21 July 2025.

⁷⁷ D Mu, Zhang, S., Zhu, T., Zhou, Y., & Zhang, W, ‘Prediction of Recidivism and Detection of Risk Factors under Different Time Windows Using Machine Learning Techniques’ (2024) 42 Social Science Computer Review 1379 <https://doi.org/10.1177/08944393241226607>.

⁷⁸ Tiffin, P., Leelamanthep, S., Paton, L., & Perry, A., ‘Predicting Self-Harm at One Year in Female Prisoners: A Retrospective Cohort Study Using Machine Learning’ (2023) medRxiv preprint <https://doi.org/10.1101/2023.09.20.23295770>.

had an AUC of 0.84. Current suicide thoughts and prior self-harm while incarcerated were important risk factors.⁷⁹ Inmates suicidal and self-harming inclinations were more accurately predicted by AI algorithms that examined medical and mental health records than by relying just on the structured data present in conventional databases, according to a 2023 research from California's Orange County Jail.⁸⁰ With early intervention, this skill might possibly save lives and marks a substantial improvement in preventive healthcare.

7.2 Enhancing Documentation and Consent Processes

The recording and oversight of medical consent procedures in prisons might be greatly enhanced by AI technology especially via digital document processing and smart prisons. Conventional paper-based systems are vulnerable to manipulation, uneven documentation, and human mistake. AI-powered solutions could automatically identify missing documents, produce unchangeable recordings of consent procedures, and guarantee that all necessary components of informed consent are appropriately covered.⁸¹ In India, digital inmate records, automated parole and AI legal bots are used,⁸² Russia has automated information processing software (ACUS) for digital processing of inmates records and assignments,⁸³ Finland has AI and virtual reality rehabilitation

⁷⁹ H Ryland and others, 'Predicting Self-Harm in Prisoners: Risk Factors and a Prognostic Model in a Cohort of 542 Prison Entrants' (2020) 63 *European Psychiatry* <https://doi.org/10.1192/j.eurpsy.2020.40>

⁸⁰ H Lu and others, 'Predicting Suicidal and Self-Injurious Events in a Correctional Setting Using AI Algorithms on Unstructured Medical Notes and Structured Data' (2023) 160 *Journal of Psychiatric Research* 19 <https://doi.org/10.1016/j.jpsychires.2023.01.032>.

⁸¹ O Czenczer and T Hinkel, 'The Hungarian Prison System in the Light of AI and Smart Tools' (2024) *Journal of Criminology and Criminal Law* <https://doi.org/10.47152/rkkp.62.3.5>.

⁸² M K and M Reddy, 'Tech-Driven Solutions for Undertrial Prisoners' (2025) *International Journal of Scientific Research in Engineering and Management* <https://doi.org/10.55041/ijsem43810>

⁸³ A Babkin and others, 'Digital Technologies and Automated Information Processing Systems in the Penitentiary System' (2025) *International Scientific and Practical Conference "Smart Cities and Sustainable Development of Regions"* (SMARTGREENS 2024) <https://doi.org/10.63550/iceip.2025.1.1.039>

tools for inmates,⁸⁴ Germany has an AI-based smart mirror (Prison AI 2.0) which supports rehabilitation, cognitive and social health of inmates.⁸⁵ China and Hong Kong have intelligent CCTV, AI-driven surveillance and wearable wristbands for real-time behaviour monitoring and health data collection.⁸⁶

To detect situations when an inmates' autonomy has been violated, machine learning algorithms can be trained to identify patterns in consent documents that point to coercion or a lack of comprehension. This skill is especially important in correctional settings, where power disparities between prisoners and medical professionals can erode sincere consent.

7.3 Streamlining Healthcare Operations

Beyond improving patient care on an individual basis, AI in correctional healthcare may also enhance the system. To ensure that resources are spent effectively and that inmate's requirements are addressed on time, AI algorithms can optimize meal distribution, medical visits, and leisure activities.⁸⁷ This optimization can guarantee that urgent medical requirements are given the proper priority, enhance medication compliance, and shorten wait times for medical services.⁸⁸ Additionally, AI systems can support telemedicine initiatives, allowing professionals to consult remotely and eliminating the need for expensive and logistically challenging medical transports. For prison systems that serve wide geographic areas or are in distant locales, this feature is very beneficial.

⁸⁴F Fedorczyk, 'Navigating the Dichotomy of Smart Prisons: Between Surveillance and Rehabilitation' (2024) 16 *Law, Innovation and Technology* 243 <https://doi.org/10.1080/17579961.2024.2313793>

⁸⁵ T Ertl and others, 'The Social Mile – How (Psychosocial) ICT Can Help to Promote Resocialization and to Overcome Prison' (2019) 3 *Proceedings of the ACM on Human-Computer Interaction* 1 <https://doi.org/10.1145/3370270>

⁸⁶ T Ertl and others, 'The Social Mile – How (Psychosocial) ICT Can Help to Promote Resocialization and to Overcome Prison' (2019) 3 *Proceedings of the ACM on Human-Computer Interaction* 1 <https://doi.org/10.1145/3370270>

⁸⁷Y Li and others, 'Innovation and Challenges of Artificial Intelligence Technology in Personalized Healthcare' (2024) 14 *Scientific Reports* <https://doi.org/10.1038/s41598-024-70073-7>

⁸⁸A Amjad, P Kordel and G Fernandes, 'A Review on Innovation in Healthcare Sector (Telehealth) Through Artificial Intelligence' (2023) *Sustainability* <https://doi.org/10.3390/su15086655>

It is pertinent to state that although AI has a lot of promise for use in correctional settings by maximizing resource allocation, anticipating medical crises, and guaranteeing uniform recording of medical consent procedures, the use of AI in these settings also raises serious concerns over algorithmic bias, monitoring, and the possible degradation of human-centred care, which are especially pressing given the vulnerable status of jailed people.⁸⁹

8.0 ARTIFICIAL INTELLIGENCE IN NIGERIAN CORRECTIONAL FACILITIES: CURRENT STATE AND FUTURE POTENTIAL

Artificial intelligence is still hardly used in Nigerian correctional facilities, despite its potential benefits in correctional healthcare. There are no known instances of AI being used for medical purposes in Nigerian Correctional facilities, according to a thorough analysis of the literature, institutional reports and policy papers that are currently available. This absence reflects the challenges with Nigeria's penal system, including a lack of comprehensive digital health plans, obsolete infrastructure, insufficient budget and limited technological capability.

Since the 2019 Act, the Nigerian Correctional Service has implemented various modernization initiatives, such as computerized record-keeping in some facilities and biometric inmate registration. But rather than AI-enabled systems, many initiatives continue to focus on fundamental digitalization. No indication of AI-assisted consent documents, predictive analytics for medical emergencies, or machine learning algorithms for health monitoring has been found in any Nigerian Correctional facilities.

This lack of technology exacerbates already-existing healthcare issues. Nigerian prisons serve as an example of the considerable health disparities that African correctional populations face, as Okunlola *et al* highlight in their examination of health equity for incarcerated individuals in Africa.⁹⁰

⁸⁹ J Pfeiffer and others, 'Algorithmic Fairness in AI' (2023) 65 Business & Information Systems Engineering 209 <https://doi.org/10.1007/s12599-023-00787-x>

⁹⁰ P Okunlola, et al 'Toward Equitable Health Care: Bridging the Gap in the Health of Incarcerated Individuals in Africa' (2024) 3 Public Health Challenges <https://doi.org/10.1002/puh2.70020>.

Sophisticated AI applications seem like far-off goals rather than imminent possibilities in the absence of fundamental healthcare facilities, medical staff or necessary drugs.

8.1 Barriers to AI Implementation in Nigerian Correctional Healthcare

Firstly, reliable energy, internet access and the fundamental technological infrastructure required for AI systems are lacking in many Nigerian prisons. Where predominantly poor broadband, unreliable power and underdeveloped digital infrastructure continue to exist in Nigerian correctional prisons, AI systems premised on digital prison records would remain unrealistically deployable.⁹¹ Secondly, allocating resources to AI technologies seems unlikely soon due to the severe underfunding of correctional healthcare in Nigeria. Several literature analysing enforcement of the right to emergency medical care in Nigeria, indicates that the country's health system struggles to provide basic emergency services and advanced technological interventions remain low priority.⁹² Thirdly, correctional services frequently lack the technological know-how needed to implement and maintain AI systems. Since healthcare workers in Nigerian prisons deal with heavy caseloads and inadequate support, using sophisticated technology without proper training could make the situation worse rather than better.

Fourthly, Nigeria lacks comprehensive legal frameworks for AI in healthcare in general and hence correctional healthcare is no exception in this regard. Significant gaps exist in the legal frameworks governing AI deployment, data protection, and algorithmic accountability resulting in regulatory uncertainty and reliance on fragmented regulations in health,

⁹¹ C. Nwosu, et al 'Artificial intelligence in public service and governance in Nigeria' (2024) *Journal of Governance and Accountability Studies* <https://doi.org/10.35912/jgas.v4i2.2425>.

⁹² A Ahmad & M Koya, 'Corruption and Healthcare Delivery: Towards a Progressive Intervention in Nigerian Correctional Centres' (2020) 18, 2 103-116 *The Nigerian Journal of Sociology and Anthropology* [https://doi.org/10.36108/njsa/0202/81\(0260\)](https://doi.org/10.36108/njsa/0202/81(0260)) and A Olabamiji, 'Prison Overcrowding in the Nigerian Correctional System: Implications for Offender Rehabilitation at The Ado-Ekiti Correctional Center' (2025) 13 2 14 – 34 *Global Journal of Arts, Humanities and Social Science* <https://doi.org/10.37745/gjahss.2013/vol13n21434>.

data laws, information and communication technology.⁹³ Lastly, inmates and civil society organizations may legitimately view AI systems with distrust, viewing them as surveillance tools rather than health initiatives, given the pervasive corruption and abuse that have been reported in Nigerian correctional facilities. Addressing basic accountability and human rights issues is the first step in developing the trust required for the ethical application of AI.⁹⁴

8.2 Lessons from International Experience

Notwithstanding these prevalent barriers, international experiences offer valuable insights for prospective future AI implementation in Nigerian correctional healthcare. Ogunwale et al while reviewing AI and forensic mental health in Africa, contended that although African contexts pose difficulties, they also present opportunities for creative, contextually relevant AI applications that steer clear of the pitfalls of systems built for high-resource settings. Instead of building all-encompassing AI systems, it is imperative that Nigeria starts with focused applications that deal with certain, significant issues. For example, basic demographic and health data already gathered might be used to create simple predictive algorithms for identifying prisoners at risk of infectious disease epidemics.

Inmates, medical professionals, and monitoring organizations must be able to understand any AI system. Recommendations from "black-box" algorithms that do not explain them erode responsibility and confidence. Transparency and explainability are highlighted as fundamental prerequisites in Nasir, Khan, and Bai's ethical framework for utilizing AI power in healthcare.⁹⁵ AI should strengthen rather than weaken the

⁹³ D Akinpelu, & S Akintola, 'Navigating the Legal and Ethical Terrain of Artificial Intelligence in Enhancing Patient Safety in Nigeria' (2023) *Journal of Intellectual Property and Information Technology Law (JIIPIT)* <https://doi.org/10.52907/jipit.v3i1.261> and C Onah, et al 'Digital Transformation in Healthcare Business: Telemedicine, AI and Fintech in Nigeria vs High-Income Economies' (2025) *Journal of Economics, Business and Commerce* <https://doi.org/10.69739/jebc.v2i1.597>.

⁹⁴ A. Ogunwale, et al 'Artificial intelligence and forensic mental health in Africa: a narrative review' (2024) 37 3 – 13 *International Review of Psychiatry* <https://doi.org/10.1080/09540261.2024.2405174>.

⁹⁵ S Nasir, et al 'Ethical Framework for Harnessing the Power of AI in Healthcare and Beyond' (2023) 12, 31014-31035 *IEEE Access* <https://doi.org/10.1109/access.2024.3369912>.

autonomy of prisoners and should complement human judgment rather than replace it. For ensuring or integrating responsible AI implementation in healthcare environments, the SHIFT Framework (Sustainability, Human-centeredness, Inclusiveness, Fairness, and Transparency) offers helpful guidelines.⁹⁶ Nigeria must have thorough legal frameworks controlling AI in healthcare, including clauses unique to correctional settings, before implementing AI.⁹⁷ When developing and managing any AI systems, prisoners, medical professionals, legal advocates and civil society organizations must all play a significant role. In addition to ensuring accountability and fostering trust, this participative method assists in identifying and mitigating potential risks.⁹⁸

With several pilot programs and research projects examining a range of applications, the US has been in the forefront of implementing AI in correctional settings. AI systems can be used to spot possible disputes before they get out of hand, enabling early interventions that can stop violence. Automated monitoring systems, predictive analytics for healthcare requirements, and AI-powered risk assessment tools have all been tested in American prisons. The American experience does, however, also draw attention to the possible drawbacks of implementing AI. It has been said that the employment of algorithmic risk assessment systems in criminal justice undermines due process rights and reinforces racial bias. Similar biases may lead to unfair medical treatment in healthcare apps, raising further problems. The European Union (EU) has adopted a more rights-based and cautious stance when it comes to the use of AI in penal settings. The General Data Protection Regulation (GDPR) and the Artificial Intelligence Act (AIA) of the EU offer robust foundations for

⁹⁶ H Siala & Y Wang ‘SHIFTing artificial intelligence to be responsible in healthcare: A systematic review’ (2022) 296, 114782 *Social Science & Medicine*. <https://doi.org/10.1016/j.socscimed.2022.114782> .

⁹⁷ P Goktas & A Grzybowski, ‘Shaping the Future of Healthcare: Ethical Clinical Challenges and Pathways to Trustworthy AI’ (2025) 14 *Journal of Clinical Medicine* <https://doi.org/10.3390/jcm14051605> .

⁹⁸ P Ukam, et al ‘Artificial Intelligence (AI) and the Vagaries of Law and Practice in Nigeria: Matters Arising’ (2024) *Interciencia* <https://doi.org/10.59671/bqwphc8> and R Ejjami, (2024). AI-driven Justice: Evaluating the Impact of Artificial Intelligence on Legal Systems. *International Journal for Multidisciplinary Research* <https://doi.org/10.36948/ijfmr.2024.v06i03.23969>.

safeguarding individual rights and guaranteeing the ethical application of AI. When implementing AI, European jail systems have often placed a strong emphasis on accountability, openness, and human monitoring.

This legislative strategy has led to a more restricted, but maybe more moral use of AI in European prisons. This lowers the possibility of prejudice, discrimination, and human rights abuses, even while it could restrict some of the efficiency advantages that AI can provide.

8.3 Potential Applications for Nigeria

Nigeria made a big step toward integrating AI in August 2024 when the Federal Minister of Communication, Innovation, and Digital Economy released the National Artificial Intelligence Strategy (NAIS). The three main goals of the NAIS are to advance technological leadership, foster social development and inclusiveness and use AI to boost economic growth and competitiveness. Two of the NAIS's five pillars - Pillar 4 (Ensuring Responsible and Ethical AI Development) and Pillar 5 (Building a Robust AI Governance Framework) are especially pertinent to correctional healthcare.

A closer look at the NAIS, however, reveals that it does not specifically list correctional healthcare as a priority area for AI deployment. The document ignores the difficulties of providing medical treatment to inmates in favour of concentrating mostly on mainstream healthcare delivery. This absence is particularly concerning given that correctional facilities represent some of Nigeria's most vulnerable healthcare environments, where inmates face compounded health risks due to overcrowding, inadequate infrastructure, and limited access to medical personnel. The omission to expressly include correctional healthcare in the national AI roadmap means that inmates cannot now rely on government-driven AI initiatives to better their conditions.

Despite present constraints, if applied ethically and with appropriate precautions, several AI technologies could potentially address certain issues in Nigerian correctional healthcare. Based on age, pre-existing conditions, and environmental factors (seasonal disease patterns, overcrowding), basic machine learning models could identify prisoners

who are more likely to have medical emergencies. Healthcare could become proactive instead of just reactive as a result. Digital consent systems with AI-assisted completeness checks could guarantee that informed consent forms have all necessary components and identify possible problems (such as missing information, signs of coercion, or literacy challenges). This fills in the existing documentation gap that PRAWA and other monitoring groups have pointed up.

AI-powered telemedicine platforms have the potential to link prisoners with specialized doctors, especially for mental health services, managing chronic illnesses, and complex diagnoses that call for knowledge not found in prisons. AI-driven Chabot's or interactive systems could solve the previously mentioned health literacy deficiencies by giving prisoners easily available health information in a variety of languages and reading levels. AI systems might monitor the distribution of medications, spot problems with adherence, and notify medical professionals of any drug interactions or side effects there are significant gaps in pharmaceutical management that have been found in Nigerian prisons.

Notwithstanding the above, it is pertinent to state that technology enthusiasm must not take precedence over fundamental rights protections, as Ehirim found in his analysis of the legal and ethical aspects of patients' rights to safety in AI-assisted healthcare delivery in Nigeria. The question is not if AI can be used, but whether it should be, and if so, under what circumstances and with what protections.⁹⁹

9.0 THE PERILS: HOW ARTIFICIAL INTELLIGENCE CAN UNDERMINE HEALTH RIGHTS

While AI has the potential to completely transform the way healthcare is provided in correctional facilities, there are serious hazards associated with its use that jeopardize the very health rights it seeks to defend.

⁹⁹ U. G. Ehirim, 'Artificial Intelligence and Healthcare Delivery in Nigeria: Legal and Ethical Dimensions of Patients' Rights to Safety' (2025) 1(1) Indonesian Journal of Sharia and Socio-Legal Studies 47-71 <https://doi.org/10.24260/ijssls.1.1.10> .

i. Algorithmic Bias and Discrimination

The use of AI in jail healthcare systems is fraught with dangers, especially when it comes to algorithmic prejudice, despite its potential. Racial, gendered, and socioeconomic prejudices are just a few of the ways that bias might appear in AI and machine learning (ML) systems. Discriminatory treatment decisions resulting from these biases, may also maintain or worsen already-existing healthcare inequities among jail populations.¹⁰⁰ The criminal justice and healthcare systems past biases are frequently reflected in the training data used to create AI systems. These biased datasets can reinforce discriminatory behaviours when they are used to train algorithms, leading to AI systems that consistently underserve demographic groups. Given the overrepresentation of racial and socioeconomic minorities in correctional settings, this is especially problematic.¹⁰¹

ii. Surveillance and Privacy concerns

Concerns around privacy rights and monitoring are bound to arise when AI is used in prison treatment. AI programs created to track the conduct of prisoners for medical reasons may be readily adapted for more extensive surveillance tasks, which may discourage prisoners from seeking medical attention or talking about delicate health matters. As AI capabilities grow, the distinction between intrusive surveillance and helpful health monitoring becomes blurry.¹⁰² Additionally, sensitive medical data is frequently included in the data that AI systems gather in correctional settings. Inmates' privacy is seriously at danger, and there may be long-term repercussions for their health and well-being if this data is misused either by third parties, correctional authorities, or data breaches.¹⁰³

¹⁰⁰ V Subasri, N Baghbanzadeh, L Celi and L Seyyed-Kalantari, 'Potential for Near-Term AI Risks to Evolve into Existential Threats in Healthcare' (2025) 32 *BMJ Health & Care Informatics* <https://doi.org/10.1136/bmjhci-2024-101130>

¹⁰¹ C Macrae, 'Managing Risk and Resilience in Autonomous and Intelligent Systems: Exploring Safety in the Development, Deployment, and Use of Artificial Intelligence in Healthcare' (2024) 45 *Risk Analysis* 910 <https://doi.org/10.1111/risa.14273>

¹⁰² E Canli, 'Smartification of Punishment: AI, Criminal Justice and the Future of Carceral Communication' (2022) *Interactions: Studies in Communication & Culture* https://doi.org/10.1386/isc_00063_1

¹⁰³ J Iverson, 'Surveilling Potential Uses and Abuses of Artificial Intelligence in Correctional Spaces' (2022) *SSRN Electronic Journal* <https://doi.org/10.2139/ssrn.4197486>

iii. Erosion of Human Centred Care

The possible degradation of human-centred treatment is one of the biggest worries regarding the use of AI in jail healthcare. AI technologies are guaranteed to assist patients and not harm them through error, prejudice, or abuse according to the principles of beneficence and non-maleficence. However, the focus on cost-cutting and efficiency that frequently propels the use of AI in correctional settings may come at the price of personalized, empathetic treatment.¹⁰⁴ AI systems run the risk of replacing human empathy and judgment rather than serving as instruments to improve them. This is especially troublesome in prison environments, where prisoners frequently have complicated medical and psychological requirements that call for sophisticated knowledge and individualized treatment plans.¹⁰⁵

10.0 ETHICAL FRAMEWORKS FOR ARTIFICIAL INTELLIGENCE IN CORRECTIONAL HEALTHCARE

The deployment of AI in correctional facilities cannot be approached as a purely technical exercise, it demands careful ethical deliberation grounded in frameworks that prioritize human dignity, justice and accountability. Several established ethical principles offer crucial guidance for ensuring that AI systems serve inmates' interests rather than merely advancing institutional efficiency or control.

At the foundation of ethical AI deployment lies the principle of transparency and explainability. AI systems utilized in correctional medical treatment must have open and transparent decision-making procedures. It should be possible for inmates and their advocates to comprehend how AI systems arrive at their judgments and, when

¹⁰⁴H Chan and N Lo, 'A Study on Human Rights Impact with the Advancement of Artificial Intelligence' (2025) *Journal of Posthumanism* <https://doi.org/10.63332/joph.v5i2.490>

¹⁰⁵Y Chen, E Clayton, L Novak, S Anders and B Malin, 'Human-Centered Design to Address Biases in Artificial Intelligence' (2023) 25 *Journal of Medical Internet Research* <https://doi.org/10.2196/43251>

necessary, contest those results.¹⁰⁶ For instance, the conscientious AI framework which emphasizes openness, justice, accountability, and a human-centred approach that may be modified to fit intricate healthcare settings like correctional facilities.¹⁰⁷

Non-discrimination and fairness are essential when developing AI systems. They must be routinely examined to make sure they do not reinforce or worsen preexisting prejudices. This necessitates close consideration of algorithm design, training data, and continuous result monitoring across various demographic groups.¹⁰⁸ The regulatory genome approach suggests global cooperation, quantifiable trustworthiness, and adaptive supervision for reliable AI.¹⁰⁹

Strict privacy and data protection regulations must govern how AI systems gather and use health data. Regarding their health information, inmates must have rights, such as the ability to see, update, and, in some situations, remove their data.¹¹⁰

When making healthcare choices, AI should support human judgment rather than take its place. AI-driven choices need to be subject to transparent accountability chains with significant human monitoring at every stage. Notable examples are the frameworks which prioritise sustainability, human-centeredness, inclusiveness, fairness, and transparency for responsible AI in healthcare (SHIFT Framework)¹¹¹ and

¹⁰⁶S Nasir, R Khan and S Bai, 'Ethical Framework for Harnessing the Power of AI in Healthcare and Beyond' (2023) 12 IEEE Access 31014 <https://doi.org/10.1109/ACCESS.2024.3369912>

¹⁰⁷ Ibid.

¹⁰⁸P Goktas and A Grzybowski, 'Shaping the Future of Healthcare: Ethical Clinical Challenges and Pathways to Trustworthy AI' (2025) 14 Journal of Clinical Medicine <https://doi.org/10.3390/jcm14051605>

¹⁰⁹ Ibid.

¹¹⁰ M Goirand, E Austin and R Clay-Williams, 'Implementing Ethics in Healthcare AI-Based Applications: A Scoping Review' (2021) 27 Science and Engineering Ethics <https://doi.org/10.1007/s11948-021-00336-3>

¹¹¹ H Siala and Y Wang, 'SHIFTing Artificial Intelligence to Be Responsible in Healthcare: A Systematic Review' (2022) 296 Social Science & Medicine 114782 <https://doi.org/10.1016/j.socscimed.2022.114782>

deliberative balancing approach which promotes considering principles like responsibility, public benefit, and professional ethics while using AI.¹¹²

11.0 RECOMMENDATIONS

The difficulty facing correctional administrators is striking a balance between the fundamental rights of those who are confined and the efficiency improvements that AI may bring about. This balance necessitates thorough analysis of every AI application, strong supervision procedures, and continuous result review.

The objective should be to implement AI in methods that really enhance healthcare results while upholding the rights of inmates, not to maximize its adoption such as the SHIFT Framework. This might entail putting in place extra protections that lessen efficiency advantages while preserving basic rights or agreeing to some restrictions on the use of AI.

It is crucial to create thorough regulatory frameworks for AI in correctional healthcare using the SHIFT Framework approach. These frameworks ought to cover human rights protection, bias avoidance, algorithmic transparency, and data protection. The power to audit AI systems, investigate complaints, and punish infractions should belong to regulatory agencies. The development of these frameworks through international collaboration may help guarantee uniform standards and avert an economic race to the bottom in AI legislation. Global guidelines for AI in correctional healthcare might be developed by institutions such as the World Health Organization and the United Nations.

Inmates, their supporters, medical professionals, and civil society groups must all be meaningfully involved in the development and use of AI in correctional healthcare. All phases of AI development, from basic design to continuous assessment and improvement, should see this involvement. To preserve public confidence and guarantee accountability, transparency in AI operations is essential. Regular reports on AI use, including result

¹¹² T Lysaght, H Lim, V Xafis and K Ngiam, 'AI-Assisted Decision-Making in Healthcare' (2019) 11 *Asian Bioethics Review* 299 <https://doi.org/10.1007/s41649-019-00096-0>

statistics, bias evaluations, and details regarding system upgrades or adjustments, should be released by correctional systems.

Continuous monitoring and assessment are necessary when implementing AI in correctional healthcare to make sure the systems are functioning as planned and not inadvertently harming inmates. Regular bias audits, result evaluations, and analyses of the systems effects on the rights and health of inmates should all be part of this monitoring. To spot issues early and make the required corrections, systems for receiving input from inmates and medical professionals should be put in place. When making changes to the system, this input should be taken seriously and shielded from reprisals.

12.0 CONCLUSION

The absence of AI in Nigerian correctional healthcare reflects deeper structural inequalities in the country's health system. Existing research shows that while some urban hospitals are beginning to adopt AI tools, correctional facilities which serve some of the most socioeconomically marginalized populations remain severely under-resourced and excluded. Okunlola et al.¹¹³ highlight that inmates already experience disproportionate burdens of infectious, mental, and chronic illnesses, yet receive inadequate care. Even if AI technologies were introduced, low health literacy, limited digital competence, and linguistic barriers which are conditions more pronounced in correctional facilities than in the wider population would undermine meaningful use. Without addressing these foundational gaps, AI risks becoming a superficial technological fix that fails to improve health outcomes or equity for inmates.

Nonetheless, with under-resourced facilities, chronic understaffing, and minimal oversight, the potential for AI and digital health technologies to transform this landscape is both urgent and profound. From improving record-keeping and tracking refusals of treatment to identifying patterns of neglect and enabling real-time monitoring by oversight bodies, AI can

¹¹³ P O Okunlola, A O Babatunde, D Akoki and S Tundealao, 'Toward Equitable Health Care: Bridging the Gap in the Health of Incarcerated Individuals in Africa' (2024) 3(4) Public Health Challenges <https://doi.org/10.1002/puh2.70020>

help address long-standing gaps in transparency, accountability, and service delivery. However, this potential can only be realized if the deployment of such technologies is anchored in a rights-based approach. International experiences show that AI can enhance correctional healthcare by improving data integration, identifying hidden health disparities, and supporting mental-health monitoring, but they also reveal serious risks.¹¹⁴ While some jurisdictions such as Australia, New Zealand, Finland, and parts of Europe demonstrate the benefits of AI-assisted diagnosis, suicide detection, and integrated digital health services under strong human-rights frameworks like the General Data Protection Regulation (GDPR)¹¹⁵ and Artificial Intelligence Act (AIA),¹¹⁶ U.S. examples highlight how AI can reinforce bias, expand surveillance, and undermine inmate privacy.¹¹⁷ These contrasting outcomes underscore that Nigeria must adopt clear legal and ethical safeguards before introducing AI into correctional health settings. AI should support, not replace, healthcare professionals, and its development must be shaped by meaningful engagement with inmates, clinicians, and civil-society stakeholders to prevent misuse and ensure accountability.

¹¹⁴ C L Ezeji, 'Smarter Corrections and Intelligence-Driven Innovations in Correctional Services in Contemporary Society' (2026) 7(6) *International Journal of Business Ecosystem and Strategy* 244 <https://doi.org/10.36096/ijbes.v7i6.1036>.

¹¹⁵ The EU's comprehensive data protection and privacy law, governing how personal data including sensitive health and biometric data is collected, used, stored, and shared. Widely regarded as one of the world's strongest privacy frameworks, it applies even to organisations outside the EU that handle EU residents' data. Its requirements for transparency, data minimisation, and human oversight are especially relevant to AI in correctional settings, where power imbalances heighten risks of surveillance, discrimination, and rights violations.

¹¹⁶ The EU's proposed framework for regulating AI, focusing on safety, transparency, accountability, and protection of fundamental rights. It categorises AI systems by risk, with stricter obligations for high-risk applications such as healthcare or correctional services. In custodial settings, the AIA's emphasis on human oversight, bias mitigation, and accountability is crucial to ensure that AI tools support, rather than undermine, inmate welfare and rights.

¹¹⁷ M J Mousa, A M Barhoom, M I Alhabbash and S S Abu-Naser, 'AI and Ethics in Surveillance: Balancing Security and Privacy in a Digital World' (2024) 8(10) *International Journal of Academic Research* 8.

Government action must be deliberate, rights-centred, and multi-pronged for AI to meaningfully benefit Nigerian correctional healthcare. This requires revising the NAIS to prioritize correctional healthcare, establishing robust regulatory frameworks to ensure transparency, data protection, and non-discrimination, and investing in the necessary digital infrastructure. Capacity-building initiatives such as improving health literacy, staff training, and inmate engagement must accompany AI deployment to enable informed participation. Further, there is need for independent oversight and participatory governance, involving civil society and inmate representatives to safeguard rights, maintain accountability, and ensure that technological adoption enhances, rather than undermines inmate's welfare.

Until these measures are taken, AI in Nigerian correctional facilities will remain a theoretical tool, and inmates will continue to face the compounded vulnerabilities of incarceration without technological safeguards for their health and autonomy. The future of correctional healthcare in Nigeria will depend not on how advanced our technological tools are, but on how intentionally they are used to restore dignity and ensure justice. If properly harnessed, AI could become a critical instrument in reshaping Nigeria's correctional health system not merely to modernize it, but to humanize it.