



Implementation of the Right to Health Services in Juvenile Correctional Institutions in Benue and Lagos States of Nigeria

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Abstract

The Child's Rights Act (CRA) of Nigeria in Part II, Section 13 emphasizes that juveniles in juvenile correctional institutions (JCIs) have 'right to health and health services'. However, there is strong argument that right to health and health services is not provided to juveniles institutionalized in juvenile correctional institutions in the 24 states out of the 36 states of Nigeria that adopted and adapted the Child's Rights Act. This study, therefore, investigated the implementation of this right in JCIs in Benue and Lagos States of Nigeria. A cross-sectional design was used for the study and 1,082 persons from 18 – 65 years from the study areas provided data through the use of questionnaire for quantitative analysis, while in-depth interviews (IDIs) were used to collect qualitative data. Findings revealed that 88.7% of respondents from Benue rated provision of health services in JCIs as very poor but no respondent from Lagos rated provision of health services in JCIs as very poor. It is recommended amongst others that health services should be provided to juveniles in Benue JCIs and other States in Nigeria should emulate Lagos in the provision of health services in JCIs as enshrined in CRA.

Keywords: Health, Child, Rights, Correctional, Institutions

1. Introduction

The Child's Rights Act (CRA) of Nigeria in Part II, Section 13 emphasizes that juveniles in juvenile correctional institutions (JCIs) have '*right to health and health services*'. This position is also affirmed in Article 24 of the United Nations Convention on the Rights of the Child (CRC) which equally recognizes the right of the child to enjoyment of the highest attainable standard of health and facilities for the treatment of illness and rehabilitation of health. The CRC further states that State parties (Nigeria is a state party) shall strive to ensure that no child is deprived of his or her right of access to such health care services (UNCRC, 1989). This is in tandem with the declaration made in the Constitution of the World Health Organization (WHO) which came into effect in 1948. The WHO recognizes health as basic human right and states that 'the enjoyment of the highest attainable standard



of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition (WHO, 2014).

Thus, ‘every child is entitled to enjoy the best attainable state of physical, mental and spiritual health’ and ‘every government, parent, guardian, institution, service, agency, should provide for the child the best attainable health’ as stated in Part II, Section 13, subsections 1 and 2 of the Child’s Rights Act of Nigeria. The provision of health and health services in JCI requires the identification and prioritization of effective and efficient services for at-risk juveniles in the JCI, delivered by a coordinated team of service providers in the clinical and public health streams (Braverman & Murray, 2011). Morris, Harrison, Knox, Troman-Hauser, Marquis & Watts (1995) and Litt & Cohen (1974) found that the categories of health needs of juveniles in the JCI are not different from those of their peers in the community. They include dermatologic, respiratory, dental, gastrointestinal, genito-urinary, and metabolic problems as well as developmental and mental health issues. Furthermore, the findings of these scholars indicate that other categories are influenced, in part, by the juveniles’ engagement in high-risk behaviours such as violence, substance abuse, and sexual activity, which may be more prevalent than those of their peers in the general population. Hein, Cohen and Litt (1980) rightly observed that in some cases, juveniles have had inadequate health care because they have been runaways or living in inconsistent living conditions that do not warrant continuity of health services.

Eighteen years after the promulgation of the Child’s Rights Act at the national level and a presidential directive that the Act should be formally adopted and adapted for domestication as State laws in the 36 States of the federation and the Federal Capital Territory, the CRA has been domesticated and promulgated into law in 24 States in Nigeria. These States are: Abia, Akwa Ibom, Anambra, Bayelsa, Benue, Cross River, Delta, Ebonyi, Edo, Ekiti, Imo, Jigawa, Kwara, Kogi, Lagos, Nasarawa, Niger, Ogun, Ondo, Osun, Oyo, Plateau, Rivers, and Taraba States. The Act has also been promulgated into law in the Federal Capital Territory – FCT (News Agency of Nigeria, 2013). However, there are strong claims that even with the domestication of the CRA in these 24 States, juveniles are denied the right to health and health services in the JCI in these States (NAN, 2013; James, 2008; Sa’ad, 2006; Wabila, 2005). Despite the strong arguments that health services are not provided to juveniles in these States JCI (Wabila, 2005; Sa’ad, 2006; James, 2008; News Agency of Nigeria, 2013), there is no comprehensive study on the provision of functional health services to juveniles in the JCI, neither are there data to ascertain the level of functionality of health services in the JCI in the 24 States of Nigeria that claim to have domesticated the CRA. Data on this is very important, as it will enable Nigeria and Nigerians to know whether or not functional health services are provided in the JCI. This study, therefore, fills this gap by focusing on ascertaining whether or not functional health services are provided in the JCI in Benue and Lagos States of Nigeria. The choice of Lagos and Benue states is informed by the fact that Lagos is the first state in Nigeria to adopt and adapt the Child’s Rights Act in 2006, three years after the enactment



of the Act by the National Assembly (James, 2008). Moreover, Lagos State has the highest number of juvenile correctional institutions in Nigeria. Benue State, on the other hand, is chosen because the State claimed to have the most functional juvenile correctional facility in the Middle Belt of Nigeria and the State adopted the Child's Rights Act almost entirely in its original form.

As used in this study, 'Functional' simply means working practically and producing positive results. Therefore, 'functional health services' in this study means health services that exist practically and are actually provided to the target population, not just written about on paper or documents as policy statement. After careful consideration of the problems stated, the study tries to like at the level of provision of functional health services in the JCI in Benue and Lagos States of Nigeria; such that the higher the degree of functionality of health services as rehabilitative strategy in JCI, the more the implementation in JCI.

2. Literature Review

Theoretical Framework

The two theories adopted as the framework for this study are Implementation theory and Rehabilitation theory. Implementation theory was propounded by Pressman and Wildavsky (1973). The theory argues that implementation is clearly defined in terms of a relationship to policy as laid down in official documents. In other words, implementation lays great emphasis on practically carrying out policy decisions as laid out in official documents (Hill and Hupe, 2002; Mazmanian and Sabatier, 1983; Pressman and Wildavsky, 1973). Some of the scholars who theorized and did extensive work on the theory, after Pressman and Wildavsky, included Van-Meter and Van-Horn (1975); and Mazmanian & Sabatier (1996, 1983, 1980 & 1979). Van-Meter and Van-Horn introduced a top-down approach in policy formation in implementation theory and identified six variables as: (1) policy standards, which 'elaborate on the overall goals of the policy decision to provide concrete and more specific standards for assessing performance; (2) the resources and incentives made available; (3) the quality of inter-organizational relationships; (4) the characteristics of the implementing agencies, including issues like organizational control and inter-organizational issues, 'the agency's formal and informal linkages with the 'policy-making' body; (5) the economic, social and political environment; and (6) the 'disposition' or 'response' of the implementers, involving three elements: their recognition (comprehension, understanding) of the policy, the direction of their response to it (acceptance, neutrality, rejection) and the intensity of that response. Sabatier and Mazmanian (1986, 1980 & 1979), in contributing to policy implementation, analysed the implementation of a 'top-level' policy decision by asking: (1) to what extent were the actions of implementing officials and target groups consistent with that decision? (2) to what extent were the objectives attained over time, i.e. to what extent were the impacts consistent with the objectives? (3) what were the principal factors affecting policy outputs and impacts, both those relevant to official policy as well as other politically significant ones? (4) how was the policy reformulated over time on the basis of experience?



Implementation theory has been criticised by some scholars who observed that it focuses upon a single policy process, in a mainly descriptive way (Hill and Hupe, 2002, p. 107). However, Meier (1999) rightly debunked this. He went on to test hypotheses on large aggregates of data and found that the theory can be used in testing hypotheses on large aggregates of data, using formal models. Implementation theory is relevant to implementation of the CRA in the JCI in Nigeria. The theory provides an insight on the fact that the failure of officials concerned, to practically implement the provisions of the CRA in the JCI, as laid down in the Act, is capable of undermining CRA implementation in JCI. This practical implementation of the provisions of the CRA in the JCI include practical provision of health services in the JCI and the importance of functional health services in JCI cannot be overemphasized as it prepares juveniles for a better future and therefore, a reduction in criminal and deviant activities such as violence, alcohol, drug and substance abuse, and deliberate spread of infectious diseases.

Rehabilitation theory was formulated by August Aichhorn in 1925 (Aichhorn, 1955). Rehabilitation theory takes the stance that crime is best prevented by addressing directly the factors – economic, social, or personal, believed to be the cause of crime. The theory uses the treatment model, formulated by Aichhorn (1955) which seeks to work directly with the individual offender in order to bring about a reduction in offending (Hollin, 2020). The basis of the rehabilitation theory is that if the factors that bring about crime can be addressed, then it is possible to reduce crime. Meta-analyses found that effective correctional treatment programmes follow basic principles to be effective in reducing re-offending (Hollin, 2020). Meta-analyses is of the view that to be effective in reducing re-offending, treatment programmes must: (1) be carefully designed to target the specific characteristics and problems of offenders that can be changed in treatment (dynamic characteristics) and that are predictive of future criminal activities (criminogenic characteristics), such as antisocial attitudes and behaviour, drug use, and anger responses; (2) be implemented in a way that is appropriate for the participating offenders and that uses therapeutic techniques known to work (for example, the programme must be delivered as designed, and treatment must be provided by appropriately educated and experienced staff); (3) require offenders to spend a reasonable length of time in the programme considering the changes desired (deliver sufficient dosage); (4) give the most intensive programmes to offenders who are at the highest risk for re-offending; and (5) use cognitive and behavioural treatment methods based on theoretical models such as behaviourism, social learning, or cognitive behavioural theories of change that emphasize positive reinforcement contingencies for pro-social behaviour and are individualized as much as possible. Rehabilitation, as can be seen, is relevant, practical and achievable.

Harris and Rice (2016) criticised rehabilitation theory by pointing out that therapeutic approaches actually make psychopaths if not worse, then far more adept at manipulating others and concealing their behaviour. They argued that psychopaths are generally considered to be not only incurable but also untreatable. However, these criticisms generalize and also disregard the huge successes that can be achieved by rehabilitation



theory in non-psychopath cases. Rehabilitation theory is relevant to the implementation of the Child's Rights Act in the JCI's in Nigeria. The theory has provided a clearer understanding of what can work in JCI's. The theory strongly supports the idea that some rehabilitative programmes will work with some offenders under some circumstances and therefore the issue is not whether something works, but what works for whom. The Rehabilitation theory of Aichhorn (1955) and Implementation theory of Pressman and Wildavsky (1973) discussed above provide the analytical framework for the study. A combination of the two theories provides an ideal context in which to understand CRA implementation in the JCI's.

The implementation theory covers some aspects of the CRA implementation in JCI's not captured in the rehabilitation theory because no matter how well designed treatment programmes and strategies are, the key to their success in JCI's is dependent on practical implementation of such programmes and strategies. The theory has also provided an insight on the fact that the failure of officials concerned, to practically implement the provisions of the CRA in the JCI's, as laid down in the Act, such as the provision of functional health services, is capable of and has been undermining CRA implementation in JCI's in Nigeria.

3. Methodology

The study was conducted in Benue State, located in Middle-Belt of Nigeria and Lagos State, located in South-Western Nigeria. The choice of Lagos and Benue states is informed by the fact that Lagos is the first state in Nigeria to adopt and adapt the Child's Rights Act in 2006, three years after the enactment of the Act by the National Assembly (James, 2008). Moreover, Lagos State has the highest number of juvenile correctional institutions in Nigeria. Benue State, on the other hand, is chosen because the State claimed to have the most functional juvenile correctional facility in the Middle Belt of Nigeria and the State adopted the Child's Rights Act almost entirely in its original form. Benue State has 23 Local Government Areas. At end of June 2019, the population of Benue State was 5,741,815 (National Bureau of Statistics, 2019). Lagos State on the other hand comprises 20 Local Government Areas. At end of June 2019, the total population of Lagos State was 17,500,000 (National Bureau of Statistics, 2019).

The target population in this study are persons employed by government to put into practical effect the provision of functional health services in the JCI's in Benue and Lagos States of Nigeria. This population is made up of males and females aged 18 and 65 years old. These persons are from (1) Benue State Judiciary, (2) Benue State Ministry of Women Affairs and Social Development, (3) Lagos State Judiciary, and (4) Lagos State Ministry of Youth and Social Development. The list (sampling frame) of 1,479 and 1,688 were obtained from Benue and Lagos States, bringing the total to 3,167. This frame was divided into 22 clusters and from these clusters, purposive sampling was used to select 12 Departments. This is because it is not all the departments and staff in these four organisations in these two states that are directly involved in CRA implementation in the JCI's. Therefore, only the departments concerned with CRA implementation in the JCI's



were selected. After this selection, the number of staff in Benue came to 808 and Lagos came to 1551, bringing the total to 2, 359. Thereafter, the sample size of 1, 447 for the study was statistically determined by applying Taro Yamane's formula on finite population. Content validity of the questionnaire was determined by experts in the fields of criminology and sociology. The test re-test method was used to ascertain the reliability of the questionnaire, and Pearson Product Moment Correlation Co-efficient of 0.99 was obtained. The 1, 447 were administered the questionnaires.

For the in-depth interviews (IDIs), the Coordinator of the Benue State Remand Home/Approved School was purposively selected. Ten children between the ages of 10 and 17 who were institutionalized in Benue State's Remand Home/Approved School were also purposively selected. This is because these children are institutionalized in the JCI and their views will help to understand if the right to health and health services is implemented in the JCI or not. Furthermore, the five Principals of the Lagos State's five JCIs were each purposively selected. Twenty children (four each from the Lagos state's five JCIs) were also purposively selected. Therefore, 36 in-depth interviews were conducted in the study. The quantitative data were analysed using the Statistical Package for Social Sciences (SPSS) and the hypothesis was tested with Chi-square (X^2) statistic at 0.05 level of significance. The IDI data were analysed using thematic method. This consisted of quotes and illustrative expressions under distinct themes.

4. Results

In this study, a total of 1, 447 questionnaires were administered to selected officials employed by the Benue and Lagos States of Nigeria, to implement the right to health and health services provisions of the Child's Rights Act in the Juvenile Correctional Institutions (JCIs) in these two States. Out of the 1, 447 questionnaires, a total of 1082 or 75.0% were validly completed and returned for analysis. The study adopted the whole 1, 082 for analysis. From these 1, 082, 57.4% of them were from Lagos State while the remaining 42.6% were from Benue State. Specifically, 39.4% work in Lagos State Judiciary, while 18.0% work in Lagos State Ministry of Youth and Social Development, 27.7% work in Benue State Judiciary and 14.9% work in Benue State Ministry of Women Affairs and Social Development, respectively.

Socio-Demographic Characteristics of the Respondents

The need to understand the socio-demographic composition of the respondents in this study led to descriptive analyses of sex, marital status, highest level of education, and religious affiliation of the respondents, using data from the survey. The result of the socio-demographic composition of the respondents is presented in table 1 below.



Table 1: Distribution of Socio-demographic Characteristics of Respondents

Socio-Demographic Characteristic		Respondents state		Total
		Benue state	Lagos state	
Sex	Male	180 (39.0%)	241 (38.9%)	421 (38.9%)
	Female	281 (61.0%)	380 (61.2%)	661 (61.1%)
	Total	461 (100.0%)	621 (100.0%)	1082 (100.0%)
Age	18 to 30 years	74 (16.1%)	72 (11.6%)	146 (13.5%)
	31 to 40 years	172 (37.3%)	161 (25.9%)	333 (30.8%)
	41 to 50 years	139 (30.2%)	192 (30.9%)	331 (30.6%)
	51 to 60 years	44 (9.5%)	123 (19.8%)	167 (15.4%)
	61 to 65 years	32 (6.9%)	73 (11.8%)	105 (9.7%)
	Total	461 (100.0%)	621 (100.0%)	1082 (100.0%)
Marital status	Single	74 (16.1%)	60 (9.7%)	134 (12.4%)
	Married	347 (75.3%)	426 (68.6%)	773 (71.4%)
	Divorced	20 (4.3%)	50 (8.1%)	70 (6.5%)
	Separated	2(0.4%)	38 (6.1%)	40 (3.7%)
	Widowed	18(3.9%)	47 (7.6%)	65 (6.0%)
	Total	461 (100.0%)	621 (100.0%)	1082 (100.0%)
Highest education qualification	Primary school	1 (0.2%)	0	1 (0.1%)
	NECO/WASC/GCE	6 (1.3%)	11 (1.8%)	17 (1.6%)
	NCE/OND	59 (12.8%)	32 (5.2%)	91 (8.4%)
	Bachelor degree/HND	304 (65.9%)	321 (51.7%)	625 (57.8%)
	Postgraduate degree	90 (19.5%)	255 (41.1%)	345 (31.9%)
	Others	1 (0.2%)	2 (0.3%)	3 (0.3%)
Total	461 (100.0%)	621 (100.0%)	1082 (100.0%)	
Religious Affiliation	African tradition	3 (0.7%)	7 (1.1%)	10 (0.9%)
	Christianity	452 (98.0%)	339 (54.6%)	791 (73.1%)
	Islam	5 (1.1%)	275 (44.3%)	280 (25.9%)
	No religion	1 (0.2%)	0	1 (0.1%)
Total	461 (100.0%)	621 (100.0%)	1082 (100.0%)	

Source: Author Field Survey, 2020

A comparative analysis in Table 1 shows that females constitute 61.0% of the respondents from Benue and 61.2% from Lagos State. So, having more female respondents in the organisations surveyed in Benue and Lagos States implies having more female employees in those government agencies that deal with Child's Rights Act implementation in the Juvenile Correctional Institutions. This was somewhat expected.

In both Benue State and Lagos State, most respondents are female, between ages 31 – 50 years. On marital status, the data showed that most of the respondents used in the study from Benue and Lagos States were married.

A critical look at the respondents' level of education from the two States surveyed revealed that majority of respondents from Benue State (65.9%) and Lagos State (51.7%) had



Bachelors degree/HND as their highest educational qualification. Those with Postgraduate degree were 19.5% from Benue State and 41.1% from Lagos State respectively. This implies that the majority of the respondents from Benue and Lagos States had obtained Bachelors Degree/HND. Considering the nature of the input required from these respondents in their places of work, one could say that the high education attainments of the respondents were expected as their job requires high degree of enlightenment to succeed. On Religious Affiliation, 98.0% of the respondents from Benue State and 54.6% from Lagos State were Christians, while 1.1% from Benue State and 44.3% from Lagos State were Muslims. The findings revealed that majority (98.0%) of the respondents used for the study from Benue were Christians and this is not surprising because Benue State is predominantly Christian. Lagos State however, has a substantial number of Muslims. Therefore, the fact that 44.3% of respondents from Lagos were Muslims did not come as a surprise.

Provision of Functional Health Services in the Juvenile Correctional Institutions (JCIs) in Benue and Lagos States of Nigeria

In the questionnaire for the study, respondents were asked in question 9 *whether functional health services were provided in the JCIs?* in the two States (Benue State and Lagos State). The result showed that in Benue State, 4.8% said ‘Yes’ while majority of respondents (91.8%) said ‘No’ and 3.4% said they did not know if functional health services were provided. In contrast, when asked *whether functional health services were provided in Lagos JCIs?* Majority of the respondents in Lagos State (98.3%) said ‘Yes’, while only 0.3% said ‘No’ and 1.4% said they did not know.

To ascertain how respondents from the two States rated provision of health services in their JCIs, question 10 in the questionnaire asked respondents to rate the level of provision of functional health services in their JCIs. The result is presented in Table 2 below.

Table 2: Comparison of the respondents’ rating of provision of functional health services in JCIs in Benue and Lagos States of Nigeria

Level of Provision of Functional Health Services in the JCIs	Benue State	Lagos State	Total
Health Services			
Very poor	409(37.8%)	0	409 (37.8%)
Poor	32(3%)	5(0.4%)	34 (3.4%)
Good	12(1.1%)	12(1.1%)	24 (2.2%)
Very Good	7(0.6%)	597(55.2%)	604 (55.8%)
Excellent	1(0.1%)	7(0.6%)	8(0.7%)
Total	461(42.6%)	621(57.4%)	1082 (100%)

Source: Author Field Survey, 2020

Table 2 which is a combination of computation from Benue and Lagos States shows a comparative rating of provision of functional health services based on respondents’ views from the two States respectively. The findings showed that when asked to indicate the level of provision of functional health services in JCIs, only 0.6% out of the 55.8% of the



respondents who rated health services as very good were from Benue. On the other hand, 37.8% of respondents from Benue and none from Lagos rated provision of health services in JCIs as very poor, meaning that 88.7% of the respondents in Benue rated provision of health services in Benue JCIs as very poor. From the analysis, it could be deduced that health services in Benue JCIs are poorly implemented as compared to Lagos JCIs.

The responses from the in-depth interviews conducted in the JCIs in Benue State totally agree with the above quantitative data as revealed by the 10 children interviewed in the Remand Home/Approved School, Gboko. When asked whether health services were provided in the JCI? , here is what one of them said:

Medical care does not exist. We have no access to hospitals, doctors, nurses, or any health worker. Malaria fever is very common here due to mosquito bites as all nets both on beds and windows are torn. When we are down with malaria fever, one female staff here that we call ‘Aunty’ uses her personal money to buy anti-malaria drugs for us (IDI with a 16-year old, Senior Secondary School 2 boy, who had spent 4 months in the Remand Home/Approved School, Gboko, Benue State).

In Lagos State’s JCIs, all the 20 children interviewed confirmed of the existence of functional health services and almost all the correctional institutions had sick bay right within the premises. For juveniles, whose health issues required health services outside the JCIs, provision was made to carry them in a bus to Lagos State University Teaching Hospital (LASUTH). When asked about the existence of functional health services in the JCI? this was the response given by one of them:

There is a sick bay right over there (pointing at the sick bay), where we are treated when we are sick. As you can see, it is right within the premises. Health workers, including doctors and nurses are always there to attend to us when we get sick. In the sick bay, there are all kinds of medications. Sometimes, the workers there admit us in the sick bay as there are sufficient beds and the workers are usually very nice to us (IDI with a 14 year old male child in the Special Correctional Centre for Boys, Oregun, Lagos State).

Test of Hypothesis

H₁: The higher the degree of functionality of health services as rehabilitative strategy in JCIs, the more likely the implementation of right to health and health services in JCIs.

H₀: The higher the degree of functionality of health services as rehabilitative strategy in JCIs, the less likely the implementation of the right to health and health services in JCIs.

To test this hypothesis, level of implementation was cross tabulated with question 16(iii) which only captured the functionality of health services as rehabilitative strategy in JCIs.



Table 3: Functionality of Health Services as a Rehabilitative Strategy in JCI and Level of Compliance $\chi^2= 942.464$; $df=1$; $p<.000$

<i>Functionality of Health Services in JCI</i>	<i>Level of compliance</i>		<i>Total</i>
	<i>Less Implementation</i>	<i>More Implementation</i>	
Low functionality of Health Services	437(99.3%)	33(5.1%)	470(43.4%)
High functionality of Health Services	3(0.7%)	609(94.9%)	612(56.6%)
Total	440(100%)	642(100%)	1082(100%)

Source: Author Field Survey, 2020

The result above shows that 99.3% of respondents indicated there was low functionality of health services in JCI, which resulted in low implementation (5.1%) in Benue State. In contrast, in Lagos State, only 0.7% of respondents rated functionality of health services low as a rehabilitative strategy in JCI, and therefore, there was more implementation (94.9%) of health services.

Decision: Since the computed chi square value (942.464) is greater than the critical chi square value of 3.84 at 0.05 level of significance, it implies that there is a significant relationship between functional health services and rehabilitation in JCI. What it means is that the more functional health services becomes, the more the level of implementation of the right to health and health services in JCI. Consequently, we reject the null hypothesis (H_0) and accept the substantive hypothesis (H_1) which states that the higher the degree of functionality of health services as a rehabilitative strategy in JCI, the more likely the implementation of right to health and health services.

Discussion of Findings

This study provides insight into the strong argument that no functional health services are provided to juveniles in the Juvenile Correctional Institutions (JCI) in the 24 States of Nigeria that claim to have adopted and adapted the Child's Rights Act, including Benue and Lagos States. The study found that a higher percentage of respondents in Lagos State indicated that functional health services are provided in the JCI in Lagos and the level of implementation of the right to health and health services in the JCI in Lagos is very high. In contrast, functional health services not provided in JCI in Benue State. This is worrisome.

From the analyses of the data thus far, and consistent with findings of previous studies, such as those of Sa'ad (2006), James (2008), and Okoye (2011), functional health services and therefore, the right to health and health services has largely not been implemented in the JCI in some states of Nigeria like Benue as evident in the study. Thus, juveniles committed to the JCI in Benue State have been denied health services as enshrined in Section 13 (*Right to Health and Health Services*), Part II of the CRA. This ultimately results in many cases of unmet physical, developmental, and mental health needs.



Therefore, juveniles in Benue JCI experience a higher degree of non reformation and rehabilitation, when compared to the juveniles committed to the JCI in Lagos State. This actually calls for great concern. A critical probe of the respondents revealed that lack of funds and government's commitment contributed greatly to the lack of functional health services in the JCI in Benue State.

5. Conclusion and Recommendations

The importance of functional health services provided to at-risk juveniles in JCI cannot be overemphasized. The provision of functional health services in the JCI is one of the first things States are supposed to consider when adopting and adapting the CRA. Functional health services helps in no small measure in reforming and rehabilitating at-risk juveniles in the JCI. Health challenges of juveniles, such as drug, alcohol, and substance abuse and addiction, anger mismanagement, sex abuse, withdrawal syndrome, suicidal ideation, psychiatric and mental illness are better handled in JCI with functional health services, where pediatric and adolescent comprehensive preventive services are provided. So domesticating the CRA without provision of functional health services in the JCI as evident in Benue State is a denial of the right to health and health services to the juveniles in the JCI, which contravenes the Section 13 of the CRA.

In view of the findings of this study, it is recommended that: Benue State Government should provide functional health services to juveniles in its JCI; Benue State and other States in Nigeria that claim to have domesticated the CRA should study how Lagos State has been able to successfully provide functional health services to juveniles in its JCI and emulate same. Benue State and other States in Nigeria without functional health services in JCI should improve on funding of the JCI and also provide the facilities as well as engage required health personnel that will sustain paediatric and adolescent comprehensive preventive services. Benue and other States that claim to have domesticated the CRA should not only be more committed to ensuring the availability of all the material and human resources necessary for functional health services but should strengthen the monitoring and evaluation of the right to health and health services in their JCI; If this is done, will result to reformation, rehabilitation, and reintegration of juveniles at risks, who are in the JCI.

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APPENDIXES



Figure 1: Map of Nigeria Showing Benue State in orange colour



Figure 2: Map of Nigeria Showing Lagos State in red colour