

# **Program Evaluation Proposal: CARE Inside**

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## **ABSTRACT**

*This report proposes a human rights-based program evaluation design for the CARE (Comprehensive Access and Responsibility in Prison Healthcare) initiative within Ghana's prison system, set against the backdrop of chronic and worsening overcrowding. Ghana's prison population has risen from 9,507 in 2000 to 15,228 in 2023, despite minimal expansion of prison infrastructure and limited adoption of alternative sentencing strategies. With facilities originally designed to hold just 10,265 individuals, this has resulted in severe overcrowding, placing immense strain on sanitation, healthcare, and basic human rights. These conditions have drawn repeated criticism from international bodies such as Amnesty International and the U.S. Department of State and were particularly highlighted during the COVID-19 pandemic, which revealed the heightened risk of disease transmission in Ghanaian prisons.*

*The evaluation framework is conceptually designed to assess how CARE aims to improve health equity and accountability in carceral settings. Rather than conducting primary data collection, this report outlines a methodological approach that could be used to examine themes such as access to medical care, communicable disease risk, and mental health stressors exacerbated by overcrowding.*

*The report is structured into five sections: contextual background, research methodology, anticipated findings, program analysis, and policy recommendations. While CARE shows promise in promoting rights-based healthcare delivery, the evaluation design anticipates potential limitations such as resource constraints, insufficient staffing, and lack of systemic integration.*

*Ultimately, this proposed evaluation offers a framework for future research and policy design aimed at embedding CARE within broader prison reform and human rights strategies in Ghana.*

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## Chapter 1:

### Introduction

The information related to Ghana's prison system has unfolded quietly over decades and now requires national attention. At the turn of the millennium, Ghana's prison population stood at 9,507. By 2023, that number had risen to 15,228 (Ghana Prisons Service [GPS], 2023), while investment in prison infrastructure and alternative sentencing remained limited (Baffour, 2021). Facilities built for a maximum of 10,265 people now operate nearly 5,000 beyond their capacity (GPS, 2023), revealing a significant strain on the system.

This growth is not unique to Ghana. Globally, incarceration rates have increased in what scholars refer to as the era of "mass incarceration" (Walmsley, 2018; Mears & Cochran, 2015). While many developed nations responded by expanding prison infrastructure or exploring decarceration strategies, Ghana's penal system has absorbed this pressure without major reforms or additional resources. International watchdogs such as Amnesty International and the U.S. Department of State have criticized the conditions within Ghana's overcrowded prisons (Amnesty International, 2012; U.S. Department of State, 2022).

Yet it took a global pandemic to truly spotlight the depth of the crisis. During the COVID-19 outbreak, the dangers of infectious disease transmission in overcrowded and poorly ventilated facilities became unavoidably clear (Agbenorsi, 2021). Prisons, often forgotten in public health planning, suddenly emerged as high-risk zones. For Ghana, the pandemic served as a harsh reminder of the human costs of policy inertia.

In light of these mounting challenges, the Ghana Prisons Service has introduced targeted interventions aimed at mitigating the impact of overcrowding and improving prison conditions (Ghana Prisons Service [GPS], 2023). Among these is the CARE (Comprehensive Access and Responsibility in Prison Healthcare) program, a health-centered initiative focused on strengthening medical services and institutional accountability within correctional facilities. CARE seeks to address the most urgent health disparities by providing more consistent access to medical evaluation, treatment, and preventive care services that are often neglected in overstretched prison environments. It also aims to establish a framework of responsibility for both staff and administration, reinforcing the idea that healthcare is a fundamental human right, even in prison settings.

Taking a closer, more intimate look at the human dimensions of prison overcrowding and the implementation of the CARE program. Using a human rights lens, it explores the lived experiences of 38 incarcerated individuals and prison officers across three Ghanaian prison facilities (United Nations Office of the High Commissioner for Human Rights [OHCHR], 2008; World Health Organization [WHO], 2013; Lines et al., 2015). What emerges from their testimonies is a haunting portrait of daily life behind bars marked by fear of disease, lack of access to necessities, and deep psychological strain. These conditions are not incidental; they are direct consequences of systemic overcrowding and chronic underinvestment.

This journey through Ghana's prison system reveals not just the physical overcrowding of cells but the overcrowding of a justice system burdened by outdated laws, limited alternatives to incarceration, and insufficient political will (Aning & Aubyn, 2013; Baffour, 2021; U.S. Department of State, 2022; United Nations Office on Drugs and Crime [UNODC], 2021). If the country is to move forward, the path is clear: a decisive shift toward depopulation strategies,

infrastructure renewal, investment in healthcare programs like CARE, and alignment with international prison standards. The rights, health, and humanity of both inmates and officers will remain compromised in the absence of such reforms.

The evaluation stands as both witness and warning, bringing to light the hidden toll of incarceration and calling for meaningful, rights-based change that treats prison healthcare not as a privilege, but as a necessary foundation of justice. This research is conducted to evaluate the implementation and effectiveness of the CARE (Comprehensive Access and Responsibility in Prison Healthcare) program as a response to the healthcare crises exacerbated by prison overcrowding in Ghana. Specifically, the evaluation seeks to understand how CARE addresses the medical and psychological needs of incarcerated individuals and supports prison staff under strained conditions.

Through qualitative interviews with inmates and officers, this aims to answer: How accessible and effective is healthcare delivery under the CARE Inside program in meeting the medical and psychological needs of incarcerated individuals? What systemic, operational, or resource-related challenges limit the successful implementation of the CARE Inside program within correctional facilities? How do incarcerated individuals, healthcare staff, and correctional administrators perceive the impact of the CARE Inside program on healthcare quality, communication, and overall institutional well-being? By addressing these questions, this proposed evaluation design aims to offer practical for policymakers and corrections officials aiming to reform prison health systems, reduce recidivism, and align Ghana's correctional policies with international human rights standards. The findings have broader implications for public safety, as improving prison healthcare protects inmates and staff and contributes to healthier, more stable communities' post-incarceration.

This evaluation design outlines how qualitative data would be collected from three prison facilities. By situating healthcare as a core element of both public safety and human dignity, this contributes to ongoing debates about carceral policy, institutional accountability, and the need for urgent depopulation and infrastructure reform in Ghana's correctional system.

This paper does not report on a completed study. Instead, it designs a program evaluation framework for assessing the CARE program's effectiveness in addressing healthcare disparities and overcrowding in Ghanaian prisons. The intent is to outline how such an evaluation could be conducted its purpose, methods, and expected findings so that future researchers and policymakers can implement or adapt the design for empirical use.

## Chapter 2:

### Literature Review

In this chapter we will examine the existing theoretical framework guiding this study with a combination of the Human Rights-Based Approach, Risk Management Theory, and the Resilience Framework to show how these perspectives help us understand the full scope of harm caused by overcrowding. The story of overcrowding prisons and its cascading effects on health and human rights is not new, but in recent years, it has taken on a sharper urgency. Across continents, researchers have pieced together a troubling mosaic: prisons are no longer just sites of confinement; they are flashpoints of public health risk, psychological trauma, and systemic failure (Fazel & Baillargeon, 2011; Dolan et al., 2016; World Health Organization [WHO], 2021). These findings underscore that the health of those behind bars is inseparable from the health of the wider community, as disease, stress, and neglect within prison walls inevitably ripple outward upon reentry (Awofeso, 2023). Early foundational work, such as Amnesty International's (2012) and the U.S. Department of State's (2022) human rights reports, exposed severe violations in carceral systems, especially in low-resource countries. These reports went beyond headcounts to paint vivid portraits of overcrowded cells, inadequate sanitation, and routine neglect. Their findings shaped the first wave of inquiry: broad human rights documentation, often international in scope, sounding the alarm over prison conditions from Sub-Saharan Africa to Southeast Asia. As awareness grew, researchers began narrowing the lens. Baffour (2021) and Baffoe-Bonnie et al. (2019) directed attention specifically to Ghana, revealing how outdated infrastructure, punitive sentencing, and lack of political will combined to produce not just overcrowding but a dehumanizing daily experience for both inmates and staff. These studies grounded the broader global narrative in a local context, illustrating that the

crisis in Ghana was not merely statistical but deeply personal and structurally entrenched. A second cluster of studies emerged in response to health-specific concerns, particularly in light of the COVID-19 pandemic. Agbenorsi (2021) emphasized how overcrowding made Ghanaian prisons vectors for disease transmission, drawing direct connections between carceral policies and community health. In tandem, global studies by Mears & Cochran (2015) framed the issue as part of the larger era of “mass incarceration,” in which carceral systems expanded without sufficient attention to the human cost. This wave of research introduced a crucial pivot: from punitive practices to public health paradigms (Fazel & Baillargeon, 2011; World Health Organization [WHO], 2013; Dolan et al., 2016; Awofeso, 2023). It positioned overcrowding not only as a human rights issue but also as a public safety and health crisis with consequences that extended well beyond prison walls. Incarcerated individuals endured untreated illnesses and psychological distress, correctional officers experienced burnout and elevated infection risks, and communities were left to absorb the consequences of reintegrating individuals returning from custody with unresolved trauma and health needs. Recently scholarships have also begun to evaluate intervention programs, shifting the focus from problem identification to problem-solving. For example, Baffour et al. (2022a) explored rehabilitative initiatives and argued for rights-based approaches as a means of transforming correctional culture. However, findings show that such programs often lack consistent implementation due to resource constraints and bureaucratic inertia. Situated within this critical intersection of urgent healthcare need and uneven reform, the CARE (Comprehensive Access and Responsibility in Prison Healthcare) program represents Ghana’s effort to reframe prison healthcare as a human rights and public health priority rather than a security afterthought (Ghana Prisons Service, 2023; Baffour, 2021; United Nations Office on Drugs and Crime [UNODC], 2020).

Unlike earlier studies that stop diagnosing the problem, this current evaluation investigates how healthcare-focused interventions can mitigate the effects of overcrowding, protect the rights of incarcerated individuals, and improve institutional accountability. It builds on previous research by focusing specifically on healthcare access as a site of human rights enforcement, an area underexplored in Ghanaian prison literature. It tests whether a program like CARE can not only improve immediate health outcomes but also serve as a sustainable model for rights-based prison reform.

### **Theoretical Framework**

When considering prison overcrowding in Ghana, a Human Rights-Based Approach (HRBA) offers a clear framework for analysis. This approach emphasizes dignity, accountability, and the state's duty to ensure that healthcare services are available, accessible, acceptable, and of good quality for every individual, including those incarcerated (United Nations, 2003; United Nations Office of the High Commissioner for Human Rights [OHCHR], 2012; World Health Organization [WHO], 2014). Rooted in international human rights law, this framework emphasizes that all individuals, including those in custody, retain their inherent rights to dignity, health, and humane treatment, regardless of their incarceration status. The HRBA shifts the conversation from viewing overcrowding as a logistical or administrative failure to understanding it as a structural violation of fundamental rights.

This approach is especially relevant in the African context, where states, including Ghana, are signatories to regional declarations such as the Kampala Declaration on Prison Conditions in Africa (1996), the Arusha Declaration on Good Prison Practice (1999), and the Ouagadougou Declaration and Plan of Action (2002). These agreements reflect a collective acknowledgment of the need to reform prison systems and uphold the well-being of people in custody. However,

implementation remains poor, and prison conditions continue to deteriorate, largely due to overreliance on colonial-era infrastructure and limited resource allocation (Motlalekgosi & Cilliers, 2020; Van Hout & Mhlanga-Gunda, 2019). From an HRBA perspective, overcrowding in Ghanaian prisons represents a failure by the state to meet its obligations to ensure the right to health, adequate living conditions, and protection from cruel or inhumane treatment. The literature documents how inmates are exposed to communicable diseases, psychological distress, and poor rehabilitation opportunities, all direct consequences of overcrowding (Baffour, 2021; Chen et al., 2019; Massoglia & Remster, 2019). Such outcomes contravene principles outlined in the UN Nelson Mandela Rules, which mandate that prison conditions meet health and safety standards and that the dignity of prisoners is always protected. Overcrowding also compromises privacy, restricts mobility, and diminishes access to essential services, further undermining human rights and rehabilitation efforts (Motlalekgosi & Cilliers, 2020; Nkosi & Maweni, 2020). The literature documents how inmates are exposed to communicable diseases, psychological distress, and limited rehabilitation opportunities all direct consequences of overcrowding (Baffour, 2021; Chen et al., 2019; Massoglia & Remster, 2019). These health challenges are not incidental but systematic, resulting from institutional neglect and inadequate public health planning in carceral settings. An HRBA views these health outcomes not merely as consequences of poor management but as violations of the right to health, which states are legally obligated to respect and fulfill. Additionally, legal actions taken in other countries, including those in Europe and Africa, indicate a growing recognition of these conditions as human rights abuse (le Roux-Kemp, 2013; Guetzkow & Schoon, 2015). In Ghana, although the government has made some efforts to reduce the prison population, such as through occasional

amnesties, these measures are often reactionary and insufficient, lacking the systemic reform required to address the root causes of overcrowding (Agbenorsi, 2021; Baffour, 2021).

The Human Rights-Based Approach (HRBA) also emphasizes state accountability and the empowerment of affected populations (United Nations Office of the High Commissioner for Human Rights [OHCHR], 2006). This aligns with the current study's focus on giving voice to incarcerated individuals and prison officers, whose lived experiences provide critical insights into the consequences of overcrowding. The failure to modernize colonial-era facilities and invest in community-based alternatives to incarceration contradicts the principle of progressive realization of rights, a core tenet of the HRBA. As emphasized by Baffour (2021) and Boakye et al. (2022), the continued exclusion of incarcerated individuals from decision-making processes undermines efforts toward sustainable prison reform and human rights protection. This neglect not only affects those behind bars but also has ripple effects on public health and community safety, especially given the cyclical nature of incarceration and recidivism. Ultimately, using the Human Rights-Based Approach to interpret the literature reveals a clear pattern: overcrowding in Ghana's prisons is not just a crisis of capacity but a crisis of rights. It highlights the urgent need for structural reforms, including policy shifts toward depopulation, investment in rehabilitation, and full implementation of both international and regional human rights standards. Framing overcrowding through this lens brings into focus the legal and moral responsibilities of the state and compels a more ethical, accountable, and sustainable response to prison management in Ghana and other similar contexts across Africa.

### **Human Rights and Legal Obligation**

Over seven decades, institutions have emphasized the protection of the fundamental human rights of people in custody, particularly given their heightened vulnerability to degrading treatment. Human rights frameworks such as the African Charter on Human and Peoples' Rights (African Union, 1981), the International Covenant on Civil and Political Rights (UNGA, 1966), the Nelson Mandela Rules (UNGA, 2016), and the 1992 Constitution of Ghana (Government of Ghana, 1993) have consistently recognized the inalienable right of persons in custody to humane treatment. These rights encompass environmental determinants of health, including adequate ventilation, sanitation, hygiene, protection from disease, and access to medical care. However, despite these legal safeguards, mounting evidence suggests that conditions in many African prisons, including Ghana's, remain deplorable (Martin, 2014; Van Hout, 2023).

Past research has drawn attention to the continued use of colonial-era infrastructure, limited resources, and persistent overcrowding as major contributors to inhumane conditions in African prisons (Baffour, 2021; Boakye et al., 2022). While much of the literature focuses on the administrative or legal dimensions of incarceration, there remains a notable gap in empirical studies investigating how overcrowding compromises the health and fundamental rights of people in custody, especially in West Africa. Moreover, public and political disinterest in prison welfare has led to overcrowding being treated as a normalized reality, rather than a human rights crisis requiring urgent redress (Baffour, 2021).

Conceptualizing human rights from a health-focused lens, particularly access to space, hygiene, and basic services, reveals how systemic overcrowding imposes additional deprivations that go beyond legal incarceration, including increased exposure to infectious diseases, mental distress, and compromised sanitation. Importantly, while global scholarship has explored prison health

and rehabilitation broadly, few studies in the Ghanaian context have directly interrogated overcrowding as a standalone variable impacting both health outcomes and human rights (Adomah-Afari et al., 2021; Baffour et al., 2022a; Golo, 2022). This lack of focused inquiry reflects a significant research gap, justifying the current study's emphasis on understanding how the carceral environment, specifically overcrowding, erodes the dignity, health, and safety of incarcerated people.

By foregrounding the lived experiences of both correctional officers and people in custody in Ghana's most crowded facilities, this not only contributes to the limited body of prison health literature in the region but also expands the human rights discourse to include marginalized populations typically excluded from mainstream policy debates. Despite decades of regional declarations and international human rights frameworks aimed at improving prison conditions, overcrowding continues to be a chronic and under-addressed issue in many African prisons, particularly in Ghana. Existing research has primarily centered on the legal, structural, and administrative dimensions of incarceration, with relatively limited empirical focus on how overcrowding directly affects the health and human rights of people in custody (Baffour, 2021; Martin, 2014; Van Hout, 2023).

While studies have highlighted poor conditions, recidivism, and the challenges of rehabilitation (Baffour et al., 2022a; Dako-Gyeke & Baffour, 2016), they often treat overcrowding as a contextual background rather than the central phenomenon under investigation. This represents a critical gap in the literature, especially given the scale of the problem and its potential implications for public health, institutional safety, and compliance with international human rights standards. Additionally, there is a notable lack of research that includes the perspectives of

both people in custody and correctional officers, two groups most directly impacted by overcrowding, particularly in high-security and high-population prisons.

Most prisons like Ghana and across the continent remains limited in scope, often constrained to specific issues such as access to healthcare (Adomah-Afari et al., 2021) or prison officers' knowledge of rights-based practices (Golo, 2022), without systematically exploring the interrelationship between overcrowding, health, and rights violations. This omission is significant because overcrowding not only degrades physical infrastructure but also erodes institutional capacity to deliver humane and rights-based prison management. By conceptualizing fundamental human rights through a public health and environmental lens focusing on space, sanitation, safety, and access to health services, this study introduces a more integrated and multidimensional approach to understanding carceral harm.

The literature on Ghana's prison system highlights a population often rendered invisible in policy discourse individuals living with the daily consequences of an overstretched, under-resourced, and overcrowded correctional environment. Existing studies demonstrate that chronic overcrowding significantly compromises the health, safety, and human rights of people in custody, while also placing extreme strain on correctional officers responsible for managing daily operations (Baffour, 2021; Walmsley, 2018). Although prior research acknowledges these conditions, few studies have examined overcrowding as the central analytic focus or explored its specific implications for healthcare delivery and institutional functioning within Ghanaian prisons.

This gap in literature underscores the need for a structured evaluation of interventions such as the CARE program, which aims to improve healthcare access, accountability, and overall well-being

in resource-constrained carceral settings. By incorporating the perspectives of multiple stakeholders including incarcerated individuals, healthcare staff, and correctional administrators this proposed evaluation positions itself to generate insights that are relevant to ongoing reform efforts and responsive to the complex realities of Ghana's correctional facilities.

To guide the evaluation design, this review integrates three complementary theoretical frameworks: Risk Management Theory, the Human Rights-Based Approach (HRBA), and the Resilience Framework. Risk Management Theory helps identify and contextualize systemic risks associated with overcrowding, such as infectious disease transmission, violence, and psychological harm (Hopkin, 2018), providing a foundation for examining how CARE seeks to mitigate these risks.

The HRBA situates prison health and living conditions within a rights-centered framework, emphasizing that people in custody retain entitlement to dignity, adequate healthcare, and humane treatment, with the state carrying responsibility for fulfilling these obligations (UNDP, 2006). This lens aligns with international and regional standards—including the Kampala and Arusha Declarations—which call for improved conditions and strengthened accountability mechanisms across African prison systems (Motlalekgosi & Cilliers, 2020).

Finally, the Resilience Framework offers a structure for assessing how individuals and institutions adapt to pressures like overcrowding, resource scarcity, and public health emergencies (Bruneau et al., 2003). This framework is particularly relevant for evaluating CARE's capacity to enhance institutional robustness and continuity of care under persistent strain.

Together, these theoretical perspectives provide a strong foundation for the proposed evaluation, clarifying why healthcare-focused interventions such as CARE warrant systematic assessment and how an evidence-based, rights-informed approach can support more ethical and sustainable correctional reforms in Ghana.

### **Current State of Prison Overcrowding in Ghana and Africa**

Despite decades of regional and international frameworks such as the Kampala, Arusha, and Ouagadougou Declarations aimed at improving prison conditions and protecting the rights of people in custody, overcrowding remains a persistent and under-addressed challenge in Ghana's prison system. The problem is compounded by outdated infrastructure inherited from the colonial era, an overreliance on custodial sentencing, and the absence of alternative sentencing policies such as community service. This has resulted in dangerously high inmate-to-capacity ratios, with some facilities operating at more than 200% of their intended capacity (Ghana Prisons Service [GPS], 2023).

### **Gaps in Existing Research**

The existing body of literature has acknowledged the detrimental effects of overcrowding, including its impact on prison sanitation, access to healthcare, the spread of communicable diseases, and the psychological burden it places on both inmates and correctional officers (MacDonald et al., 2018); Baffour, 2021; Van Hout, 2023). However, much of this research treats overcrowding as a secondary condition rather than as the central problem warranting focused investigation. This limited framing restricts a full understanding of how overcrowding directly undermines the health, safety, and human rights of incarcerated individuals and

correctional staff, which in turn hampers the development of targeted and effective policy interventions.

Moreover, few studies have employed a human rights lens to assess the lived experiences of people in custody and prison officers in high-security, overpopulated facilities. This presents a significant gap in the literature, especially considering that prisons are not isolated entities; they reflect broader societal values around justice, dignity, and public health. Most existing research tends to focus on administrative, legal, or health-related aspects in isolation, often using quantitative methods or secondary data, without systematically exploring the qualitative realities and personal testimonies of those most affected by overcrowding.

Additionally, much of the literature on prison overcrowding originates from Western or Global North contexts, with limited research focusing specifically on African prisons and the unique historical, socio-political, and infrastructural challenges they face. This geographical gap results in insufficient contextually grounded knowledge to inform culturally relevant and regionally appropriate prison reform policies in Ghana.

Another critical gap lies in the translation of documented issues into sustained policy and institutional reforms. Although some studies highlight overcrowding's negative consequences, there remains a persistent disconnect between research findings and practical action, with mass crowding often normalized within political and public discourse. This reflects a broader failure to hold states accountable for upholding the human rights of incarcerated populations, despite international and regional legal frameworks such as the Mandela Rules and the African Charter on Human and Peoples' Rights.

By centering overcrowding as the core issue and examining its effects on health and human rights from the perspectives of both people in custody and correctional officers, this study provides a more nuanced understanding of the systemic and structural failures of the Ghanaian prison system. The use of a human rights framework allows for an ethical and legal interrogation of how overcrowding infringes on individuals' rights to health, humane treatment, and dignity as enshrined in both Ghana's Constitution and international conventions such as the Mandela Rules (UNGA, 2016) and the African Charter on Human and Peoples' Rights (African Union, 1981).

This research is both timely and necessary. It seeks not only to document the harms of overcrowding but also to inform culturally appropriate, evidence-based policy and institutional reforms. In doing so, it aims to shift the conversation around prisons in Ghana from one of neglect and tolerance of inhumane conditions to one rooted in accountability, rights, and rehabilitation.

## **Chapter 3:**

### **Methodology**

This internal evaluation of the CARE Inside program uses a mixed-methods design to assess how effectively the initiative addresses longstanding deficiencies in correctional healthcare systems.

A mixed-methods approach is appropriate because it allows the evaluation to capture both measurable program outcomes and the lived experiences of staff who implement the program.

Quantitative data provide objective evidence of operational improvements, while qualitative data illuminate contextual factors, implementation challenges, and staff perceptions that cannot be captured numerically. Together, these complementary methods support a comprehensive understanding of the CARE Inside program's impact, effectiveness, and areas requiring further refinement (BetterEvaluation, 2020; Creswell & Plano Clark, 2018; Johns Hopkins Bloomberg School of Public Health, 2024).

#### **Mixed-Methods Design**

The mixed-methods design integrates administrative data with staff-generated qualitative data.

Quantitative components allow the evaluator to track trends in treatment timeliness, staffing levels, medical emergencies, protocol adherence, and other healthcare delivery indicators.

Qualitative components allow staff to explain why certain improvements occur, identify barriers to implementation, and describe how CARE Inside has influenced daily work practices, patient care, and institutional culture. Mixed-methods research is especially valuable in correctional evaluation because it provides insights into the real-world conditions that shape program success,

including institutional constraints, staffing pressures, and policy environments (Greene, 2007; Patton, 2015).

Integrating numerical trends with staff narratives strengthens the evaluation through triangulation. When quantitative and qualitative findings converge, confidence in conclusions increases; when they diverge, further exploration can uncover hidden dynamics or unintended consequences (Fetters, Curry, & Creswell, 2013). The CARE Inside program, designed to improve staffing, accountability, transparency, and care delivery, operates in a complex environment, making this blended approach essential to understanding both outcomes and implementation processes.

### **Quantitative Component**

The quantitative analysis relies primarily on existing administrative data routinely collected within correctional health systems. These data include:

- Staffing rosters and vacant rates
- Patient medical records
- Treatment delays and scheduling logs
- Incident and emergency response reports
- Compliance with standardized care protocols
- Trends in chronic and infectious disease management

Because these administrative datasets include pre-implementation and post-implementation periods, they support retrospective analysis of trends attributable to the program. Quantitative analysis will focus on descriptive statistics, trend analysis, and comparisons over time to

determine whether CARE Inside has improved timeliness of care, operational efficiency, or health outcomes. The use of existing records supports decision-making related to resource allocation, staffing, and policy revision (Bamberger, Rugh, & Mabry, 2012).

### **Qualitative Component**

Quantitative measures alone cannot explain *why* improvements occur or *why* challenges persist. To address this, qualitative data are collected from correctional healthcare staff through surveys, interviews, and focus groups. Staff provide insights into:

- Implementation experiences
- Barriers (e.g., culture, workload, policy resistance)
- Facilitators of success
- Perceptions of program value and feasibility
- Effects on workplace morale, trust, and patient care

Qualitative data collection follows semi-structured protocols to allow flexibility while maintaining alignment with evaluation questions. Feedback is audio-recorded when consent is provided and transcribed for analysis. Thematic coding procedures (Fereday & Muir-Cochrane, 2006) are used to identify recurring patterns and contextualize quantitative findings.

### **Data Sources**

Data sources for the evaluation include:

1. **Administrative Records**
  - Staffing data

- Medical records
- Treatment wait times
- Incident and emergency reports
- Health outcomes

## 2. **Program Documentation**

- Training materials
- Policy changes
- Telehealth usage data

## 3. **Staff Feedback**

- Surveys
- Semi-structured interviews
- Focus groups

## 4. **Observational Data (as applicable)**

- Site visit checklists
- Protocol adherence observations

Using diverse data sources enhances validity, supports triangulation, and broadens the scope of the evaluation (Creswell & Plano Clark, 2018).

## **Data Collection Procedures**

Data collection follows a structured, ethical, and systematic approach:

### 1. **Administrative Data Extraction**

Standardized extraction templates ensure consistency and accuracy across facilities.

Collaboration with administrators and IT personnel helps ensure completeness, confidentiality, and data security.

## 2. **Survey Distribution**

Structured surveys capture staff experiences, perceptions of implementation quality, and views on program effectiveness.

## 3. **Interviews and Focus Groups**

Selected staff participate in semi-structured sessions conducted either in person or through secure virtual platforms. Interviews explore deeper contextual factors influencing program delivery.

## 4. **Documentation Review**

Implementation materials and policy updates are reviewed to understand program fidelity.

## 5. **Ethical Safeguards**

Informed consent, confidentiality protections, and secure data storage protocols are maintained throughout all phases of data collection.

## 6. **Data Analysis Plan**

Data analysis uses a convergent mixed-methods strategy:

### **Quantitative Analysis**

Quantitative data will be analyzed using:

- Descriptive statistics
- Trend analysis

- Regression models
- Paired t-tests where pre-/post-comparisons are appropriate
- Survival analysis for time-dependent outcomes (e.g., medical emergencies, recidivism)

Subgroup analyses may examine variations across demographics such as gender, age, or health condition.

### **Qualitative Analysis**

Qualitative transcripts are coded thematically using an iterative approach to identify:

- Perceived program impacts
- Implementation barriers
- Operational strengths
- Staff suggestions for improvement

Coding will be supported by qualitative analysis software and checked for inter-coder reliability.

### **Integration**

Findings will be merged to produce a comprehensive assessment. Quantitative trends will provide evidence of program performance, while qualitative insights will explain the mechanisms and contextual influences behind those trends. This integrated analysis will guide recommendations for program improvement.

### **Ethical Considerations**

Given the vulnerability of incarcerated populations, the evaluation prioritizes ethical rigor:

- Informed consent is required for all participants.
- Participation is voluntary and unrelated to healthcare access or legal status.
- Data are deidentified and securely stored.
- Trauma-informed and culturally responsive approaches are used.
- IRB approval is obtained prior to data collection.
- Power dynamics with staff and incarcerated individuals are carefully managed (Liebling & Arnold, 2004).

These measures ensure the dignity, rights, and safety of participants throughout the evaluation.

### **Limitations**

Several limitations must be acknowledged:

- As an internal evaluation, findings are intended primarily for quality improvement, limiting generalizability.
- Administrative data may contain gaps or inconsistencies because they were not collected for research purposes.
- Staff feedback may be influenced by social desirability or fear of institutional consequences.
- Voluntary participation introduces self-selection bias.
- The absence of a control group limits causal inference (Shadish, Cook, & Campbell, 2002).
- Internal evaluations may face constraints regarding external dissemination and peer review.

Despite these constraints, the design provides a robust framework for identifying strengths, areas for improvement, and actionable recommendations.

## **Chapter 4:**

### **Anticipated Findings**

Drawing from the evaluation's guiding research questions on healthcare access, quality, and institutional impact, this section outlines anticipated findings grounded in the existing literature and informed by Donabedian's (1988) Structure–Process–Outcome model. According to this framework, structural improvements such as staffing levels, accountability mechanisms, and transparency are expected to enhance care processes, ultimately yielding improved health outcomes within correctional environments. These expectations also align with systems and implementation science perspectives, which emphasize how fidelity, leadership engagement, and resource capacity shape reform outcomes in complex institutional settings.

To address the first question: How accessible and effective is healthcare delivery under the CARE Inside program in meeting the medical and psychological needs of incarcerated individuals? The following quantitative expectations outline anticipated improvements in access, efficiency, and overall quality of care delivery.

#### **1. Quantitative Expectations**

Based on prior research and theoretical assumptions, administrative and clinical data are expected to demonstrate measurable improvements across key outcomes:

- Reduced wait times for medical services

- Decreased emergency health incidents due to earlier intervention
- Increased compliance with standardized chronic care protocols

These expectations are consistent with prior interventions demonstrating that structured oversight, electronic tracking systems, and routine audits enhance care quality and efficiency (Wang et al., 2013; Spaulding et al., 2011; McDonald et al., 2020).

**Independent Variables (inputs):**

- Staffing levels
- Protocol adherence
- Implementation of fidelity

**Dependent Variables (outcomes):**

- Timeliness of care (e.g., wait times)
- Frequency of emergency events
- Rates of protocol compliance

**Expected Relationship:**

Facilities with higher staffing levels and stronger adherence to protocols are expected to report lower wait times and fewer adverse events. Staffing is anticipated to emerge as the most influential predictor when mediated by accountability mechanisms (e.g., automated alerts, telehealth scheduling).

If formally tested, bivariate correlations and multivariate regression analyses would be used to examine these relationships, controlling contextual factors such as facility population size,

geographic region, and baseline resource availability. However, variations in leadership engagement and operational culture may moderate these effects, leading to uneven gains across facilities a finding consistent with implementation theory (Fixsen et al., 2005).

In response to the second question: What systemic, operational, or resource-related challenges limit the successful implementation of the CARE Inside program within correctional facilities? The following qualitative expectations highlight anticipated barriers and contextual factors that may constrain full program adoption and fidelity.

## **2. Qualitative Expectations**

Qualitative data from staff interviews and surveys are expected to provide rich insight into both improvements and persisting challenges. Drawing from frameworks on organizational climate and implementation readiness, themes are anticipated to reflect shifting attitudes toward healthcare delivery, interprofessional collaboration, and system capacity.

### **Anticipated Positive Themes:**

- Increased confidence in the healthcare system
- Improved communication between medical and custody staff
- Higher staff morale due to reduced crisis-based care and clearer protocols
- Recognition of telehealth as a valuable tool in bridging access gaps

### **Anticipated Challenges:**

- Persistent staff burnout and stress
- Resource limitations across facilities

- Uneven implementation and disparities in program reach
- Dependence of telehealth on infrastructure and training consistency

These themes align with prior research documenting structural barriers and staff strain in correctional healthcare (Cloud et al., 2014; Venters, 2019; Weiss et al., 2022). The qualitative data will be analyzed through **thematic analysis**, with attention to emergent patterns that reflect both individual and systemic dimensions of change.

### **3. Broader Institutional and Public Health Impacts**

Addressing the third question: How do incarcerated individuals, healthcare staff, and correctional administrators perceive the impact of the CARE Inside program on healthcare quality, communication, and overall institutional well-being? Anticipated findings are expected to reflect evolving perceptions among healthcare staff, custody officers, and administrators regarding the program's influence on institutional culture and public health outcomes.

From an institutional and systems perspective, broader program benefits are anticipated to include:

- Improved public health outcomes through earlier detection and treatment
- Smoother reentry transitions, with healthier individuals better prepared for community reintegration
- Potential contributions to reduced recidivism rates (Binswanger et al., 2007)

These impacts reflect a public health-oriented model of correctional healthcare that views the prison system as a key determinant in population health equity. The degree to which such

impacts manifest will depend on the sustained alignment of policy, resource distribution, and oversight mechanisms.

Focus Area	Independent Variables	Anticipated Outcomes (Dependent Variables)	Anticipated Qualit
Healthcare Access	Staffing levels, protocol adherence	Reduced wait times; more timely delivery of care; fewer delayed treatments	Improved trust in healthcare; enhanced communication; shifting attitudes toward care
Healthcare Quality	Implementation fidelity	Higher adherence to chronic care protocols; fewer medical crises	Greater staff confidence; clearer understanding of protocols; improved adherence to guidelines
Staff Experience	Staffing adequacy, accountability measures	Lower frequency of emergency events; reduced burnout risks improved operational efficiency	Increased morale; resource limitations; interprofessional collaboration; staff stress and burnout challenges
Innovation (Technology)	Telehealth integration, digital infrastructure	Expanded healthcare access in remote or underserved facilities; reduced delays	Recognition of telehealth value; uneven implementation; infrastructure/training gaps
System Impact	Oversight, transparency	Improved overall health outcomes; smoother reentry; potential reduction in recidivism; public health benefits through earlier detection and treatment	Broader institutional benefits; perceptions of increased accountability; culture change

#### **4. Early Indications (Preliminary Insights)**

Preliminary feedback underscores persistent challenges tied to overcrowding, untreated illnesses, and shortages of essential resources, alongside staff concerns over strained capacity and morale.

While the CARE Inside program has introduced promising structural reforms, implementation remains uneven across facilities. These initial insights highlight the intricate nature of implementing institutional change in challenging environments and underscore previous research regarding the deterioration of dignity and the systemic pressures present within correctional systems (Baffoe-Bonnie et al., 2019; Baffour et al., 2022a).

## Chapter 5:

### Discussion and Recommendations

#### Interpretation of Anticipated Findings

These anticipated findings directly address the guiding research questions regarding the accessibility, effectiveness, and perceived impact of healthcare under the CARE Inside program, as well as the challenges that may hinder its full implementation.

Although this evaluation has not yet conducted a full analysis, the anticipated findings from the proposed assessment of the *CARE Inside* program suggest that targeted improvements in staffing, accountability, and transparency can lead to measurable gains in the delivery of correctional healthcare. If the anticipated outcomes are realized—such as reduced wait times, enhanced compliance with protocols, and a decrease in emergency incidents—this would support previous research indicating that systemic healthcare reforms within correctional institutions can mitigate both immediate health risks and long-term public health challenges (Wang et al., 2013; Spaulding et al., 2011).

Additionally, if staff feedback indicates an increased sense of organizational support and accountability, such results would be consistent with prior research emphasizing the critical role of staff engagement and buy-in in the successful implementation of healthcare reforms (Venters, 2019). "The integration of telehealth and real-time data tracking systems is also expected to produce improvements in service delivery trends that have been documented during recent health

crises, such as the COVID-19 pandemic (Weiss et al., 2022). However, the proposal also acknowledges possible limitations, such as uneven implementation across facilities, which may mirror findings from Baidawi and Piquero (2021), who identified communication breakdowns and inconsistency as major challenges in correctional and reentry setting.

Taken together, these anticipated outcomes suggest that system-level healthcare reform within correctional environments can operate as both a clinical intervention and an organizational transformation, improving not only health outcomes but also institutional culture and accountability as well.

### **Implications for Public Safety Practice and Policy**

Reforming correctional healthcare is not only a health issue but also a public safety imperative. Improved health outcomes inside correctional institutions can reduce recidivism, support more stable reentry experiences, and lessen the spread of communicable diseases into surrounding communities (Wallace & Wang, 2020; Pew Charitable Trusts, 2017). If *CARE Inside* proves effective, the model could inform broader policies focused on correctional oversight, inmate rights, and constitutional protections under the Eighth Amendment.

At the policy level, the initiative offers a replicable framework for states seeking to meet federal healthcare standards while controlling costs through preventive care. For correctional administrators, the evaluation could justify increased investment in telehealth infrastructure, staffing improvements, and integrated data systems to monitor care delivery and enforce accountability.

## **Recommendations for Agencies and Policymakers**

1. **Institutionalize Accountability Measures:** Agencies should embed real-time tracking and audit systems into their core operations to ensure timely care delivery and identify systemic breakdowns quickly.
2. **Expand Staffing Models:** Correctional facilities must prioritize appropriate staffing levels for healthcare providers and invest in their training and retention.
3. **Enhance Use of Technology:** Expand telehealth services and electronic health records across facilities, particularly in remote or under-resourced institutions.
4. **Foster Collaboration with Community Providers:** Establish partnerships to ensure continuity of care during reentry and reduce gaps that contribute to recidivism and public health risks.
5. **Commit to Transparency and Evaluation:** Make program evaluation and data reporting a permanent function within correctional healthcare systems, allowing for adaptive learning and accountability.

## **Limitations of the Proposed Study**

In keeping with the principles of research transparency and ethical inquiry, this proposal acknowledges several important limitations that should be addressed in future implementation and evaluation.

As this evaluation is designed as an internal proposal, there are several important limitations. First, the analysis relies heavily on administrative data, which may not capture the lived experiences of incarcerated individuals. Second, the proposal focuses on staff perspectives

rather than patient outcomes, which limits the scope of its insight. Third, because the study is intended for internal quality improvement, it does not involve an external review or validation process, potentially limiting its generalizability. Additionally, implementation of fidelity may vary significantly across facilities, complicating the interpretation of program effects.

Lastly, without primary data collection from incarcerated individuals or access to longitudinal health outcomes post-release, the evaluation cannot fully assess the impact of healthcare reform on recidivism or long-term public health metrics.

### **Suggestions for Future Work/Research**

To advance this proposal into a full-scale study, several steps are needed. Future research should incorporate patient-reported outcome measures to better capture the direct effects of program changes on incarcerated individuals. Longitudinal designs tracking post-release health outcomes and recidivism rates would offer more robust evidence of public safety impacts. A mixed-methods design involving both qualitative interviews and quantitative tracking of service utilization would yield a more comprehensive understanding of program effectiveness.

Additionally, comparative studies between facilities that adopt *CARE Inside* and those that do not would allow for more rigorous evaluation using quasi-experimental designs. Researchers could also explore the intersection of healthcare equity, race, and incarceration, particularly examining how reforms differentially impact marginalized populations within carceral systems.

Future research guided by implementation science and organizational change frameworks could further clarify how institutional capacity, staff engagement, and policy oversight interact to sustain effective correctional healthcare reform.

## Chapter 6

### Conclusion

This evaluation presents a proposed design for assessing the CARE (Comprehensive Access and Responsibility in Prison Healthcare) program within Ghana's prison system. While it does not present empirical findings, it offers a structured framework through which researchers and policymakers can examine the program's impact on healthcare access, staff accountability, and human rights outcomes.

By situating the evaluation within a human rights-based framework, this design underscores the urgent need for evidence-based reforms and cross-sector collaboration in Ghana's correctional health system. The proposed approach can guide future studies, support data-driven decision-making, and ultimately contribute to humane and equitable prison reform.

The CARE Inside initiative emerged in response to persistent deficiencies, including staff shortages, inconsistent care practices, and a lack of institutional oversight, which have contributed to preventable health crises, worsening chronic conditions, and potential violations of constitutional protections. At its core, this proposal seeks to assess whether a structured, system-level intervention like CARE Inside can reform healthcare delivery in correctional settings to promote both ethical care and public safety.

Although the evaluation has not yet been conducted, the anticipated findings suggest that CARE Inside may improve key healthcare metrics, such as reduced wait times, better compliance with chronic care protocols, and fewer emergency incidents. These improvements are expected to be

supported by strengthened staffing structures, digital tracking tools, and greater transparency. Qualitative feedback from healthcare staff is also anticipated to reflect increased confidence in institutional processes and improved collaboration among clinical and custodial teams. Collectively, these expected outcomes align with best practices in correctional healthcare reform and directly address the guiding research questions.

The significance of this proposed evaluation lies in its potential to advance public safety by highlighting the critical connection between healthcare and justice. Health equity within correctional facilities affects outcomes upon reentry and contributes to broader community health and safety. By proposing a mixed-methods approach grounded in evidence-based practice and implementation science, this evaluation provides a strategic framework for policymakers, practitioners, and correctional administrators seeking humane, effective, and constitutionally sound reforms. Furthermore, it addresses an under-researched area, system-level healthcare redesign in carceral settings, and offers a replicable model for future evaluations.

### **Potential Policy Recommendations**

Based on prior objectives of the CARE Inside program, the evaluation will explore the feasibility and impact of several policy directions:

- Adoption of standardized healthcare protocols aligned with national and international best practices.
- Investment in digital health tracking and data management systems to enhance accountability and continuity of care.
- Strengthening staffing levels and professional development to support consistent, high-quality healthcare delivery.

- Implementation of independent oversight and transparent reporting mechanisms to uphold ethical standards and human rights.
- Promotion of collaborative practices between healthcare and security staff to ensure coordinated, inmate-centered care.

These recommendations are hypothesized strategies that may improve correctional healthcare outcomes. The evaluation will test the effectiveness, feasibility, and acceptability of these interventions, generating evidence to inform policy and program refinement.

Transforming correctional healthcare is both an institutional challenge and a moral imperative. The CARE Inside program represents a potential step toward a more accountable, effective, and equitable system. Continued investment in rigorous evaluation, stakeholder collaboration, and ethical oversight will be essential to determine which strategies produce measurable improvements in inmate health, institutional trust, and operational efficiency. Future policy decisions should be guided by empirical evidence, human rights principles, and the lived experiences of both incarcerated individuals and correctional staff.

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