Imprisoned Women and Reproductive Health: A Site of Reproductive Rights Violation?

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Abstract

Reproductive healthcare is a fundamental aspect of women's rights. Despite this, there has been no systematic approach to the reproductive rights and healthcare of women who are in prison. Approaches to women prisoners have focused on aspects of their reproductive health as 'issues' that need to be resolved (such as prenatal care), rather than understanding women's reproductive healthcare as a fundamental aspect of their lived experiences and rights. Examples of reproductive care and rights include: women's ability to access contraception and abortion services; to determine when, how and how many children they have; how they parent those children (including suitable childcare arrangements); their reproductive health and access to related screening and healthcare services; and health and personal care for mensuration, this includes access to sanitary products and suitable medical care for related gynaecological conditions. In this chapter we critically analyse approaches to imprisoned women's reproductive rights and healthcare, advocating that reproductive rights take centre-stage when considering how to support women who are imprisoned.

Key words

- Reproductive rights
- Women in prison
- Pregnancy
- Menstruation
- Reproductive health

Introduction

As has been detailed in chapters in this Handbook (internal cross reference), women who are imprisoned are some of the most vulnerable in our society. Imprisoned women are known to be at increased risk of experiencing detrimental health conditions and to receive limited support (internal reference to chapter in handbook?), this extends to

their reproductive health. The World Health Organisation (2021) defines reproductive health as:

> a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes.

Therefore, reproductive health encompasses more than simply pregnancy or illnesses and diseases of reproductive organs, such as cervical or ovarian cancer. Instead reproductive health involves experiences of menstruation and related health conditions, access to sanitary products; treatment for sexually transmitted diseases and infections and support to prevent infection; prevention of pregnancy through adequate and suitable contraception, including abortion; the ability to become pregnant, such as through assistive technologies such as in vitro fertilisation (IVF); health and wellbeing during pregnancy, childbirth and delivery; postpartum health and wellbeing, including breastfeeding support; health and support during menopause; general health of reproductive organs, including disease prevention and treatment.

As aspects of reproduction are fundamental to women's lives (specifically, but not exclusively, the ability to become pregnant) adequate and suitable reproductive healthcare must be seen as a key aspect of women's rights. The ability to control when she becomes pregnant, how often she wishes to become pregnant (if at all) and decisions around whether or not to continue a pregnancy can and do have life-altering implications for women. If women are denied the ability to control their pregnancies, then they are prevented from becoming full members of society, which limits their other rights and opportunities (Faludi, 1992; Gordon, 1986). For many women, the health conditions that are connected to their reproductive organs, for example endometriosis or fibroids, can have debilitating implications (see, for example, Bullo, 2018; Nicholls et al., 2004; Denny, 2009). Similarly, a lack of suitable personal care items for menstruation and difficulty in accessing the facilities and resources needed for proper menstrual hygiene, make it harder for women and young girls to manage their periods safely and with dignity (Moffat and Pickering, 2019).

Women's experiences of reproductive health are often made worse by the instantaneous operations of the social divisions of 'race'[1], ethnicity, class and location. The issue of 'period poverty' for example, tends to be experienced predominately by of a socioeconomically marginalised group. This is especially the case, Vora (2020) argues, for women who are experiencing homelessness. Likewise, treatment for conditions, such as fibroids, are easier to access for certain groups of women than others. As Myles (2013) explains, this can be due to variations in medical care, access to resources and experiences of racism. The adequacy and suitability of reproductive healthcare as a key aspect of women's rights therefore needs to be understood and framed according to this intersectional understanding.

The issues surrounding women's reproductive health and reproductive rights are intensified when a woman is imprisoned. In England and Wales, following an agreement based on a formal contract between HM Prison Service (HMPS) and the National Health Service (NHS) in 2000, there is a statutory recognition that prisons are required to provide the 'same level of care and access to services' as those in the wider community (North, N.D.). In addition, the United Nations General Assembly (2010) *Rules for the Treatment of Women Prisoners and Non-Custodial Measures for Women Offenders*, also referred to as Bangkok Rules, state that women in prison should be given and have access to gender-specific care. This means that maternity services and reproductive health services in prison are provided by the NHS. It also means that, at least in theory, all aspects of women's reproductive healthcare should be of equal standards to those provided in the community. However, as numerous scholars and charities have outlined, current conditions in prison and inadequacies in policy create barriers to delivering such adequate care for women (for instance see Corston, 2007; North, N.D.).

In this chapter we will outline the framework of reproductive justice, a prism through which we can assess the implications of prison on women's reproductive rights. Then we review current policies and guidance in place in England and Wales to support women's reproductive rights. Following this, we will examine the current state of

[1] 'Race' has been placed in quotation marks due to it being a relational, plural, dynamic and socially constructed concept, rather than biological category.

knowledge of women's ability to access reproductive healthcare, and thus their reproductive rights while in prison, concluding that far too often prison is a site of reproductive rights violation. While the policy, law and experiences of women presented here are focused on women's imprisonment in England and Wales, the conceptual arguments we make will be of relevance to other jurisdictions.

Imprisoned Women and Reproductive Rights

It is widely recognised that reproductive rights are a fundamental aspect of women's rights. While often seen as synonymous with women's ability to access abortion, and so decide whether to continue a pregnancy, reproductive rights encompass far more. Employing a 'reproductive justice' framework, initially developed by the American organisation SisterSong, allows a conceptualisation of women's reproductive rights that is holistic in nature. Reproductive justice developed as a social justice movement that emphasised the intersection of social identities with community-developed solutions to structural inequalities (Luna and Luker, 2013). The movement specifically developed due to women of colour in the United States emphasising that their ability to access their reproductive rights is dependent upon the social, cultural, economic and political factors that surround their identities. Women's 'race' and class has specific implications for their ability to exert control over their bodies. SisterSong (N.D.) defines reproductive justice as,

> the human right to maintain personal bodily autonomy, have children, not have children, and parent the children we have in safe and sustainable communities.

A key principle for SisterSong is that there is little point having the legal right to have an abortion if poverty, lack of healthcare and lack of suitable housing, education and childcare means that a woman feels she cannot support a child due to her socio-economic, political and cultural situation.

While the movement of reproductive justice has a specific origin and context in the United States (Nelson, 2003; West, 2009), which is distinct from the reproductive rights movement in the UK, mostly as the debate in the United Kingdom is less political in nature (Amery, 2020), there is relevance to the understanding of women's

reproductive rights and experiences of reproductive healthcare, as we argue here. Specifically, that women are supported by the State and wider society to have the freedom to access the healthcare they need for gynaecological concerns and difficulties, to support their lived experiences of menstruation, to have children, to not have children, to raise their children without fear of poverty or deprivation.

An understanding of women's reproductive healthcare and rights within this context is essential for our analysis of the experiences of women who are in prison. As has been noted in other chapters in this handbook (internal cross references), women who are imprisoned have distinct vulnerabilities and lead difficult lives. Such life challenges have specific implications for women's access to their rights in general, as well as their reproductive rights. In this chapter we will consider two questions: first, to what extent are women who are imprisoned not supported to obtain and access their reproductive rights; and second, does the experience of imprisonment actively damage and limit such rights for women?

Policy and Guidance framework in England and Wales

Prison Service Orders (PSO) outline policy and guidance for prison staff in England and Wales. In 2008, PSO 4800 introduced policy and guidance 'to provide regimes and conditions for women prisoners that meet their needs' (HM Prison Service, 2008, p. 1). This was the first policy document that specifically focused on the needs of imprisoned women. As discussed below, this PSO has recently been replaced. While providing little in the way of specific guidance relating to women's reproductive health, PSO 4800 did advise the following:

- Women must have easy access to a choice of sanitary provision.
- Ante-natal and post-natal services include specific provision for pregnant drug users should be available.
- With reference to pregnant women, it is specified that suitable nutrition and rest are required but that staff should be mindful that perceived 'special treatment' may leave a woman open to becoming a target for bullies.
- Pregnant women should not be transported in cellular vehicles 'unless exceptionally the risk has been assessed as acceptable by the prison's healthcare manager'.

- Women in active labour are not handcuffed either en route to, or while in, hospital.
- On the first night in prison at least one 5 minute free phone call should be offered on reception to enable women to resolve urgent family and childcare issues.
- Women prisoners should be held as close to their home and family as possible.
- Children should not be penalised from visiting or contacting their mother because of the mother's behaviour.
- Women should be allowed to hug family and hold young children on their laps.
- Women should be given support and information to assist them in understanding the effects of their imprisonment on their separated children, how to tell their children of their imprisonment and how to support them.
- Specific section on Mother and Baby Units (MBU).

The PSO provides a clear indication that specific aspects of women's experiences connected to their reproductive rights and health have been a focus of consideration. However, the approach in this PSO was to see specific aspects of women's lives that are connected to their reproductive health –pregnancy and childcare – as 'issues' that needed to be addressed, rather than as part of a wider context of the lives of women, and thus their reproductive rights. Furthermore, gaps between policy and implementation of that policy have been noted. For example, The Fawcett Society (2009) argued that despite PSO 4800 providing direction on the treatment of pregnant women, there is a need for further guidance, consistency across the prison estate and the sharing of good practice.

In December 2018, PSO 4800 was cancelled and replaced by the Women's Policy Framework (Ministry of Justice and HM Prison and Probation Service, 2018), a far less detailed document. For example, outside of information that is specific to MBUs, the guidance only states the following in relation to 'outcomes' that cross-cut court, community and custody:

- The needs of pregnant women and women who have given birth are assessed and addressed.

- Women who are separated or who are separating from their children (including through fostering and adoption) are given appropriate support, including those experiencing loss or bereavement (paras 3.2 and 3.3).

One of the difficulties here is how needs are assessed and 'addressed' and what is defined as 'appropriate support'. Neither of these concepts are defined, leaving scope for individual interpretation at the point of implementation.

The approach in both PSO 4800 and the Women's Policy Framework is to view women's reproductive health as 'issues' to be addressed and 'managed', rather than as essential elements of women's experiences that originate from their bodies. As Abbott (2018, p. 164) argues, the language is 'cloaked in benign paternalism'.

Reproductive rights on the inside: what is currently known

A review of policies and guidance related to imprisoned women's reproductive rights as well as academic literature suggests that there is a substantial gap in what we know about women's experiences of accessing reproductive healthcare, and thus their rights. Knowledge in this area mostly falls around pregnancy and experiences of being pregnant while in prison, as well as accessing MBUs. There is also some limited information about access of abortions in prison, which suggests that, regularly, prison is a site of reproductive rights violation.

Pregnancy and childcare in prison

Much of the academic research in the broad area of women's reproductive healthcare while in prison has focused on pregnancy and the ante- and postnatal care women have received. Therefore, this is the area of women's experiences of reproductive healthcare that we have the greatest level of information about.

While a small number of studies have considered women's views on or experiences of pregnancy while in prison (Abbott, 2018; Plugge et al., 2006; Sikand, 2017; Sleed et al., 2013), most studies have utilised scoping exercises and/or drawn on the views of prison staff and healthcare professions to reach their conclusions (see for instance, Corston, 2007; Gardiner et al., 2016; North N.D). The consequence of this is that women's experiences are often marginalised at the expense of reports of health outcomes for the women who experience pregnancy in prison and/or their foetus/baby;

see Elton (1988), for example, who argues that the risk of stillbirth and low birth rates reduce with imprisonment.

One of the challenges of understanding women's experiences of pregnancy in prison is that records are not collected to show how many women who enter prison are pregnant upon reception. It is estimated that 6 to 7 percent of the female prison population are pregnant at any one time, with around 100 babies born in prison each year (Abbott, 2018; Birth Companions, 2016; Prison Reform Trust, 2017). However, not every woman will choose to have a pregnancy test on arrival, and some women may pass through prison without their pregnancies being recorded (Ginn, 2013).

In terms of women's experiences of pregnancy, the unfit conditions and regimes of prison have been reported to have a negative impact on pregnant women's health and wellbeing, specifically in relation to nutrition, issues with bathing and showering and fresh air and lack of comfort (Abbott, 2015; Abbott et al., 2020; Corston, 2007; Gulberg, 2013; North, N.D.). Abbott et al. (2020) reports that women are not provided with healthy snacks, breast pads or suitable bedding. Bodily suffering during pregnancy is thus often exacerbated in prison. Existing academic literature (Abbott, 2015, 2018; Abbott et al., 2020; Gardiner et al., 2016) has also revealed evidence conveying the stress, fear and anxiety caused by such experiences. In order to navigate feelings of a loss of control, disempowerment, shame and humiliation, Abbott et al. (2020) note that women employ various coping mechanisms. Fearing for the safety of their unborn child, women often wear baggy clothes as a means to hide or not give attention to their growing bumps. Women also explained how they needed to hide certain emotions, which they noted, created mental distress.

Being in prison is not meant to have an impact on the quality of healthcare women experience. Women should be able to access antenatal classes and clinics, often held in prison, and the usual scans and pregnancy care provided in clinic settings (North, N.D.). However, research has consistently shown that care of women who are imprisoned during pregnancy and childbirth has been grossly inadequate (Abbott, 2018; Abbott et al., 2020; Ginn, 2013; North, N.D.; Price, 2005). Research has uncovered that there is variability in services both across prison sites and between the care available in the community compared to that provided to imprisoned women

(North, N.D.; Price, 2005). Short notice on prisoner release or relocation also causes difficulties for continuity of care. Shortages of prison staff to accompany women to antenatal appointments has an impact on the quality of care women receive (Ginn, 2013; North, N.D.). Ensuring timely scans and investigations to detect health concerns for the woman and/or her foetus is an essential aspect of healthcare during pregnancy. Disturbing reports of women's lives being endangered due to delays in transfer to hospital for treatment of urgent medical conditions, such as an ectopic pregnancy, are peppered throughout the literature (Plugge et al., 2006). Women's concerns about their ability to access the medical care they need when they need it have led some women to elect medicalised modes of delivery so as to alleviate fears over whether they will be transferred to hospital in time once labour starts (Abbott et al., 2020).

As most women are serving short prison sentences, with over 65 percent of women who enter prison each year serving 6 months or less (Ministry of Justice, 2020, p. 31), many pregnant women will be released from prison before the birth of their baby. For those who do give birth in prison, MBUs allow women to keep their babies with them in prison for up to 18 months (see XXX chapter of this Handbook for details of…). Of the 12 women's prisons in the UK, six have MBUs, with 64 places available nationally. Despite the available places, HM Inspectorate of Prisons for England and Wales reports have detailed that in various prisons MBUs are underused, with a steady rise in the rejection rates since 2012 (Sikand, 2017). Of the women admitted to MBUs, Sikand concluded that women have limited prospects of having their application to access a MBU place if she had a history of imprisonment. The uncertainty of obtaining a place and delays during the process of applying for a place on a MBU is reported to create a high level of stress and anxiety for women (Abbott, 2015; Birth Companions, 2016; Codd, 2012). Negative experiences of pregnancy and poorer health outcomes as a result (direct or indirect) of imprisonment is a clear violation of women's reproductive rights.

The end of a pregnancy in prison

While there has been a reasonable level of research on women's experiences of continuing a pregnancy in prison, there is very little written about women's experiences of ending a pregnancy while in prison. There is little to no research focused on abortion, miscarriage or stillbirth experienced by imprisoned women. The report by

Maternity Alliance (North, N.D.) offers one of the few examples of published research that includes a focus on women's access to pregnancy termination medical care. The report concludes that it is difficult to determine how easily women are able to access abortion or what support women are given in relation to decisions to terminate a pregnancy.

While our knowledge and understanding in this area is limited by the lack of research, available data would suggest that women are not being supported to terminate their pregnancies while in prison. A Freedom of Information Request to the Department of Health and Social Care (FOI-11107442) in 2017 asking how many women who reside in prison obtained abortions over the period 2006 to 2016 revealed that, on average, 30 women access abortion while in prison each year (Table 1). Across the UK, approximately one in three pregnancies end with an abortion (Edwards, 2015). While we do not know the exact number of women who are pregnant while in prison each year, Birth Companions (2016) estimate approximately 600 women who are imprisoned are pregnant. Assuming that women who are imprisoned obtain abortion at the same rate as women in the general population, then we would expect to see a third of those pregnancies ending in a termination: 200 abortions a year. As can be seen from the data in Table 1, the number of abortions granted to women who resided in prison at the time of their abortion is notably lower than that estimate.

Table 1: Number of legal abortions for women with a recorded residential postcode the same as that of a prison, 2006-2016.

Year	No. legal abortions
2006	27
2007	47
2008	30
2009	23
2010	26
2011	37
2012	44
2013	20
2014	29
2015	25
2016	20
Average	**30**

Source: Department of Health and Social Care (FOI-1107442)

It is difficult to know what conclusions can be drawn from this stark disparity in rates of abortion between women in the general population and those women who are in prison. However, it does seem unlikely that women who are imprisoned seek abortion significantly less frequently than those who are not imprisoned. Instead, it seems likely that women who are confirmed to be pregnant on arrival in prison are offered limited support or advice around their options for the outcome of their pregnancy while they are imprisoned. Maternity Alliance, for example, found conflicting accounts from prison staff about the approach taken to counsel women about ending a pregnancy, with a midwife in one prison commenting that the possibility of termination is always raised by the mother, not by the staff. An officer in another prison however noted that it was not 'entirely' left to the mother to bring up (North, N.D.). Birth Companions (2016), rightly note in their Birth Charter that women should have appropriate support from health professionals and health workers if electing for a termination of their pregnancy. The report recommends that prison staff should have limited involvement in the decision-making process as they are not appropriate people to advise on such situations and may put undue pressure on women. However, if no one advises a woman that an abortion is a possibility and so the question is never raised with her, then how will she know that she does have the ability to end the pregnancy if she wishes?

The situation is likely exacerbated by the short custodial sentences served by women – 50 percent imprisoned for 3 months or less (Ministry of Justice, 2020). For these women their release date will likely be reached while the pregnancy is still within the legal limit for an abortion. In England and Wales under sections 1(1)(a) of the Abortion Act 1967 women can be granted an abortion if two doctors are of the opinion, formed in good faith, that the pregnancy has not reached the 24th week of gestation and that:

> the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of the pregnant woman or any existing children of her family.

Most abortions – within and outside of the prison population – take place under this statutory provision: 98 percent (202,975) in 2019 (Department of Health and Social

Care, 2020). In instances where a woman's custodial sentence will end while she is under twenty-four weeks pregnant, engaging a woman in a discussion about her decision to continue a pregnancy is perhaps not seen as a priority by prison staff, as they know she will be able to legally obtain an abortion upon her release. The potential consequence is that no positive steps are being taken to assist women who want to access abortion to end their pregnancies while they are imprisoned. As a result, women are possibly being required to remain pregnant for an extended period of time, harmful to them both in the short and long term for physical and mental health, and a clear violation of reproductive rights.

Clearly, more needs to be known about women's experiences of accessing abortion while in prison. Temporary[2] changes to the provision of early medical abortions in 2020 due to the COVID-19 pandemic have generally had a positive impact for women due to increased ease and privacy of accessing both abortion medications at home through the post, following a phone or video consultation (Aiken et al., 2021). Yet, it is unknown whether this increased accessibility has been extended to and thus experienced by imprisoned women, or if abortion access would still require women to travel to a clinic (accompanied by prison officers). If the prison in which a woman is held is classified as her 'home', and so both pills could be issued to the prison, then this could potentially vastly increase women's access to medical abortions. Logistical issues around how women receive the medical consultation prior to the prescription of the pills would need to be considered and may still result in women being required to travel to a clinic for that part of the medical care. Furthermore, for women who are over 10 weeks pregnant and those wishing for a surgical abortion, in-clinic appointments would still be required, thus having resource implications for the prison, and so potentially resulting in this aspect of reproductive health continuing to be negated.

Even less information is known about women's experiences of their pregnancies ending due to miscarriage or stillbirth. Figures as to the number of miscarriages or

[2] In 2021 the UK Government consulted the public as to whether home use of early medical abortion medication should continue (https://www.gov.uk/government/consultations/home-use-of-both-pills-for-early-medical-abortion/home-use-of-both-pills-for-early-medical-abortion-up-to-10-weeks-gestation). At the time of writing the outcome of this review is unknown and currently the temporary approval for home use are set to expire on the day on which the temporary provisions of the Coronavirus Act 2020 expire, or on 30 March 2022, whichever is earlier.

stillbirths are not kept by the Prison Service. As Codd (2012) outlines, it is valuable to understand what support is available in prison for women who miscarry. She further notes, 'if terminations are not necessarily easy to obtain in the prison setting, then a proportion of miscarriages may in fact be self-administered terminations, although the current lack of literature makes this impossible to prove one way or the other' (2012, p.9). Poor pregnancy health and inadequate antenatal care may be contributing to rates of miscarriage or stillbirth, another unknown in this area.

What else we know (and don't know)

Outside of pregnancy, and the ending of a pregnancy, knowledge is limited in the area of women's reproductive health. There are a small number of reports and/or research papers that report findings on the health issues of incontinence (Drennan et al., 2010) and cervical screening (Harris et al., 2007; Plugge and Fitzpatrick, 2004; Plugge et al., 2006). The lack of attention given and data available on these issues is surprising considering that studies regularly find that women in prison are either at the same or greater risk of ill health in these areas, compared to the wider female population. For women who are imprisoned for longer periods (more than three months) they may be more likely to receive health screenings for issues connected to reproductive health compared to if they were living in the community (Plugge and Fitzpatrick, 2004). It is important, however, to question the framing of this conclusion, as, arguably, the findings show that more needs to be done to increase the number of women who access screening opportunities provided in the community, rather than viewing prison as a 'positive opportunity' for screening to occur.

A small number of studies suggest that prison contributes to issues women face with menstruation. For example, Baroness Corston (2007) noted in her report on women's experiences of prison that women had limited access to personal hygiene products, clean and hygienic sanitary conditions and suitable nutrition. Toilet facilities were cited as being inadequate, particularly for women during menstruation. Similarly, Gulberg (2013) reported that women's sanitary needs were not always remembered or respected by prison staff. A further example of prison creating a situation that can have severe detrimental impact on women's physical and mental health.

There are substantial areas of women's reproductive health while in prison that simply seem to be missing from the literature, such as diagnosis and treatment of health conditions such as endometriosis, fibroids and heavy and painful periods. There is no discussion of contraception for imprisoned women – while they may not need to prevent birth and/or protection against sexually transmitted infections or diseases while in prison, most women serve very short sentences, meaning that if, for example, they use long active reversable contraception (LARCs), such as a coil, intrauterine device (IUD) or implant, then they may need assistance with this form of birth control while imprisoned. Similarly, there is an absence of discussion of women's ability to access assisted reproductive technologies such as IVF in prison. A comprehensive understanding of women's reproductive healthcare, and thus their reproductive rights, requires further knowledge about women's experiences of such aspects of reproduction while they are in prison.

Summary

Women's ability to access reproductive healthcare is a fundamental aspect of their reproductive rights. Reproductive health encompasses a broad spectrum of physical, mental and social aspects of women's health and wellbeing connected to their reproductive system and to its functions and processes.

What is known about women's experiences of reproductive healthcare in prison is a fractured picture, with large, gaping holes. The limited research that has been conducted on women's experiences of accessing their reproductive healthcare while imprisoned suggest that rather than seeing women's reproductive rights as a central aspect of women's experiences it is seen as 'conditions' and 'issues' that need to be 'managed'. Furthermore, there is clear evidence that points to prison being a site of reproductive rights violation.

Experiences of pregnancy in prison is the area most known about. The research suggests that the conditions of prison make pregnancy a far more stressful and dangerous experience compared to pregnancy in the community. Similarly, in relation to women's ability to access abortion and support and counselling about decision-making upon the discovery of a pregnancy, the limited available research indicates that little provision is made to assist women with this key aspect of their reproductive

healthcare. Potentially, the structures and limits of prison, as well as the culture, approach and ethos of these institutions are working to prevent women exerting their right to request an abortion. We have very little information about other key areas of women's reproductive health and rights, notably experiences of miscarriage and stillbirth, gynaecological healthcare, menstruation and menopause.

It is clear that more research is needed into women's experiences of reproductive healthcare and rights while in prison. We are unable to truly assess the extent to which prison acts as a site of reproductive rights violation without this research. For such research to take place we need support of prison services. Future research must also focus on the intersections of women's identity and how these have an impact on women's access to reproductive healthcare and thus their rights. As SisterSong (N.D.) noted, reproductive rights must be assessed in the context of social, cultural, economic and political factors of individual women. Imprisoned women are not a homogenous group who will experience healthcare uninformedly. The prison population is diverse; women's health outcomes and experiences are dependent on their class, ethnic and racial background, as well as their geographical location. Yet, too often such an intersectional understanding has been absent within the literature, with most research in this area simply taking the category of 'woman' to be the only marker that determines experience. Thus, their findings have limited ability to tell us about structural concerns that might be hindering women, or the approaches that might work to improve women's health outcomes and differing experiences.

Prison has always been designed as a rights-limiting institution. One of the stated purposes of prison is that it will deliver 'reform [of] offenders to prevent more crimes from being committed' (Ministry of Justice, 2016, p. 20). Ignoring the fact that there is limited evidence that prison works to 'rehabilitate', particularly in cases of women who are sentenced to short custodial sentences (reference chapter in the handbook), it is important to consider whether limiting women's reproductive rights is an appropriate and 'fair' aspect of punishment. Reproductive healthcare is central to women's rights, with substantial implications of rights violation, for example: being prevented from keeping a pregnancy due to poor pregnancy outcomes caused by the prison environment; required to continue a pregnancy due to abortion not being available; the indignity of menstruating without suitable sanitary items. The consequences are

severe. This is an important area of women's rights that must be explored and understood. We need to know more, conducting detailed empirical work into women's experiences, and feeding findings into government and institutional frameworks and policies. No longer can women's reproductive health and rights be seen as little more than 'issues' to be 'managed', as is illustrated in the current approach adopted in the Women's Policy Framework. It may also be that the findings from future research provide yet more evidence to support the calls to stop sending women to prison. Until we understand what is happening for women on the ground, we simply will not know.

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