

Capability-Based Framework for Incarcerated Women's Health: Building on Amartya Sen Approach

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Un cadre fondé sur les capacités pour repenser la santé des femmes incarcérées : approche d'Amartya Sen

Abstract

The Capability Approach (CA) offers a useful way to evaluate prison health that goes beyond service provision or patient satisfaction. Researchers have applied it in public health, prison health, and criminal justice, but rarely to the health of incarcerated women. This paper begins to fill that gap. It proposes a gender-responsive, rights-based capability framework to evaluate women's real freedom to achieve good health. The research question is: how can the Capability Approach help evaluate and strengthen incarcerated women's health freedoms? The paper uses a targeted narrative synthesis and a conceptual framework analysis, following Jabareen (2009). This method combines theoretical clarification, purposive selection of capability domains, and a critique of conventional indicators. This review argues that we should assess incarcerated women's well-being through two lenses: capabilities, the real freedoms to reach valued states of health, and functionings, what women actually achieve with dignity and autonomy. Drawing on international reports and qualitative studies, the paper suggests that standard indicators may understate how institutional constraints, coercion, stigma, and unequal conditions restrict women's agency. In some settings, reported satisfaction may simply reflect adaptation to deprivation rather than genuinely adequate care. These are interpretive claims drawn from the literature, not new findings from this study, and they still need empirical testing.

As a preliminary conceptual proposal, the paper sets out six capability domains, presented in Table 1, without claiming to define a universal set; the abstract illustrates four of them, bodily integrity, reproductive autonomy, psychosocial well-being, and health-related agency, and examines their link with concrete functioning such as dignified menstrual care or respectful maternity services.

This preliminary framework helps structure a rights-based, gender-responsive model of prison health. It can serve as a starting point for empirical research and for evaluating reforms in low- and middle-income settings.

Keywords: Capability Approach, capabilities, functioning, incarcerated women, prison health, justice

JEL Classification: I18; I31

Paper type: Conceptual review and analytical framework proposal

Résumé

La santé des femmes incarcérées est souvent évaluée à partir de l'offre de soins, de leur utilisation ou de la satisfaction déclarée ; selon la littérature mobilisée, ces indicateurs peuvent ne pas rendre pleinement compte des libertés réelles dont disposent les femmes pour atteindre des états de santé valorisés. Bien que l'approche par les capacités ait été mobilisée en santé publique, en santé des détenus et en justice pénale, son application systématique à la santé carcérale des femmes demeure peu développée. Cet article examine comment cette approche peut contribuer à évaluer et à renforcer ces libertés réelles. Il adopte une démarche de synthèse conceptuelle et de construction d'un cadre analytique, fondée sur une clarification théorique, une lecture critique des indicateurs conventionnels et la mobilisation de rapports internationaux et d'études qualitatives sur la santé en détention. À titre exploratoire, il propose six domaines de capacités présentés au Tableau 1, sans prétendre définir un ensemble universel, et en illustre quatre : l'intégrité corporelle, l'autonomie reproductive, le bien-être psychosocial et l'agency en matière de santé. Cette proposition conceptuelle préliminaire met en relation ces domaines avec des fonctionnements tels que l'accès à des soins menstruels dignes ou à des services de maternité respectueux, et offre un point de départ pour de futurs travaux empiriques ainsi que pour l'évaluation de réformes fondées sur les droits et sensibles au genre dans les pays à revenu faible et intermédiaire.

Mots-clés : santé carcérale des femmes ; approche par les capacités ; justice de genre ; autonomie reproductive ; bien-être psychosocial.

Classification JEL : I18 ; I31

Type d'article : revue conceptuelle et proposition de cadre analytique

1. Introduction

Women and girls remain a minority of the global prison population, but their numbers have grown substantially since 2000 (Fair & Walmsley, 2022). WHO and UNODC evidence shows that women in detention often have complex, overlapping health needs. These include a higher risk of HIV and other infectious diseases, chronic conditions that need screening and continuous care, and mental-health effects of past violence and trauma, including post-traumatic stress disorder (WHO & UNODC, 2011, 2014; WHO, 2022). These burdens build up over time. Disadvantage before incarceration—rooted in poverty, homelessness, and gender-based violence—combines with health shocks at arrest, disrupted treatment, delayed screening, and poor prison conditions such as overcrowding, bad sanitation, lack of privacy, and gender-insensitive rules. Despite growing awareness of these overlapping factors, prison-health evaluation still tends to rely on input and process metrics—counts of clinics, staff, consultations, or medicine stocks—and on satisfaction surveys. These tools rarely ask whether women actually achieve bodily integrity, reproductive autonomy, mental well-being, confidentiality, and dignity in care (Penal Reform International & Thailand Institute of Justice, 2022). From a Capability Approach perspective, such measures risk confusing means with ends and can misread constrained consent as free choice. In some contexts, reported satisfaction may simply reflect adaptive preferences or an internalized sense of deprivation rather than genuine achievement (Robeyns, 2017; Sen, 1999). These claims summarize and interpret the literature we reviewed; they are not new empirical findings from this study.

To address this blind spot, this study uses the Capability Approach as its conceptual lens. Developed by Amartya Sen and extended normatively by Martha Nussbaum, the approach shifts attention away from resources or reported satisfaction and toward the real freedoms people have to reach valued states of well-being (Nussbaum, 2011; Sen, 1999). This article organizes the approach into five parts—functioning, capabilities, resources, conversion factors, and agency. This five-part structure is our own analytical reconstruction, based on Robeyns’s modular reading of the approach (2005, 2017), not a fixed list from Sen himself. The next section defines these concepts, explains how they relate, and discusses what they mean for prison-health standards, including the Bangkok Rules and the Mandela Rules.

This article moves the agenda forward in three ways: it identifies policy-relevant capability domains for incarcerated women, maps how conversion factors shape the move from resources to functioning, and proposes a pluralistic but practical strategy for identifying capabilities when institutions are opaque and data is scarce. The central research question is: to what extent, and through which mechanisms, can the Capability Approach reshape how we evaluate incarcerated women’s health? Three sub-questions guide this: Which capability domains matter most for women’s health in prison? How do resources, agency, and personal, social, and institutional conversion factors shape whether entitlements turn into real achievements? And how can we identify and use these domains without treating them as a universal or final list? Existing scholarship has established the Capability Approach as a normative framework in health and health economics (Coast et al., 2008; Ruger, 2010; Venkatapuram, 2011), and prison-health research has documented gendered needs and rights constraints (van den Bergh et al., 2009; Van Hout & Mhlanga-Gunda, 2018). However, the literature we reviewed does not show a study that systematically combines these two strands into a gender-responsive capability framework for incarcerated women’s health. Because this article is not a systematic review, this is a scoped positioning of our contribution, not a claim that no such study exists anywhere. The framework we propose is therefore a preliminary, policy-oriented scaffold for gender-responsive, justice-oriented prison health.

This article adds value in three ways. Theoretically, it defines the five components of the Capability Approach—resources, conversion factors, capabilities, agency, and achieved

functioning—and organizes them into a preliminary grid of capability domains for incarcerated women's health. Practically, this grid gives a structured basis for building future assessment tools: it links institutional resources and constraints to observable health-related functioning, while remaining open to validation and participatory refinement in context. Contextually, the framework addresses the specific challenges of low- and middle-income countries—institutional opacity, data scarcity, gendered deprivation, and limited accountability—and shows how the Capability Approach can support more rights-based, gender-responsive evaluation in these settings.

Morocco and the wider MENA region give this framework a concrete rationale. Morocco's prison system is run by the Délégation générale de l'administration pénitentiaire et de la réinsertion (DGAPR). In 2023, Morocco held 2,535 women among 102,653 prisoners (2.47%); women are housed in separate units within mixed prisons rather than in women-only prisons (Association for the Prevention of Torture, 2024). The same country profile shows that the Ministry of Health and Social Protection monitors pregnancy and that women are entitled to medical consultations and medication, although external monitoring has also found gaps in access to specialists, privacy, and quality of care. At the regional level, recent scholarship describes the evidence on incarcerated women's right to health in MENA as fragmented and limited (Alhasan, 2024). These features make Morocco a useful institutional anchor without turning this article into a single-country case study: the framework is meant to be transferable across LMIC and MENA settings, though its domains and indicators would need country-level validation against national prison governance, referral pathways, legal safeguards, and available data. The article therefore pursues three objectives: first, to clarify the conceptual distinction between resources, capabilities, agency, conversion factors, and achieved functioning in assessing women's carceral health; second, to build a preliminary framework linking these elements to policy-relevant capability domains; and third, to examine what the framework means for gender-responsive evaluation and prison-health reform. The article first reviews the Capability Approach and its use in women's carceral health, then builds the conceptual framework around functioning, capabilities, conversion factors, resources, and agency, and then turns to implications for practice and policy, including capability-based targeting and participatory health governance. It ends by summarizing the framework's contribution and its limits.

2. Literature Review

This section proceeds in two steps. First, it reviews the literature on the Capability Approach and clarifies its core concepts and theoretical foundations. Second, it examines how the approach has been applied to women's carceral health.

2.1. Core Concepts of the Capability Approach

The Capability Approach has five distinct components—functioning, capabilities, agency, resources, and conversion factors. Together, they shift evaluation away from simply providing services and toward the real freedoms people have to live lives they value. In Sen's Capability Approach, functionings (also called achievements) are the “beings and doings” that people actually realize in their lives (Sen, 1985; Sen, 1999)—for example, being nourished, being healthy, having self-respect, or taking part in community life. Unlike resources or utilities, which focus on means or satisfaction, functionings capture what a person has actually accomplished. Sen distinguishes functionings from capabilities, which are the substantive freedoms or opportunities to achieve different functionings.

Capabilities are the real freedoms or opportunities a person has to achieve valued functioning. For Sen, they are the different combinations of functioning a person could achieve (Sen, 1992), which puts the focus on choice, agency, and context. Martha Nussbaum shares this foundation but goes further: she defines capabilities as the essential opportunities for a life with dignity,

and she proposes a universal list of ten central capabilities as a minimum threshold of justice (Nussbaum, 2011).

Agency is women's ability to make health-related decisions freely. This includes the right to choose or refuse treatment, take part in care planning, and express preferences that match their own values and well-being (Sen, 1999).

Resources are the internal and external assets that shape a person's ability to turn entitlements into capabilities. They include individual-level assets, such as health literacy and psychological resilience, and external factors, such as the availability of trained healthcare providers, sanitary products, or medication (Robeyns, 2005).

Conversion factors—such as fear of retaliation, lack of privacy, stigma, or coercive institutional rules—strongly affect whether available services actually become valued outcomes (Robeyns, 2005). The Capability Approach is useful here because it recognizes that internal factors (such as mental health, knowledge, or biological needs) and external conditions (such as institutional culture, legal safeguards, or social status) together shape whether a person can access and benefit from care (Sen, 1999).

A further issue is aggregation and weighting. Multidimensional capability assessments must decide whether to report domains separately, combine them into one index, or weight them using expert judgment, public deliberation, or the preferences of affected groups. These choices are not just technical: they can hide trade-offs and quietly embed evaluative priorities. The literature therefore warns against assuming that a single aggregate score transparently represents justice or well-being (Sugden, 1993). The approach also separates agency from well-being: a person may value an outcome but lack the freedom to choose it, or may exercise agency in ways that do not maximize their own welfare. Finally, preferences formed under deprivation can look voluntary while really being adaptive preferences; Nussbaum (2001) and Khader (2011) stress the need to examine how socialization, oppression, and constrained choice shape the preferences people express. For this article, the key implication is that capability assessment should keep resources, real opportunities, achieved functioning, agency, and the institutional conditions that structure choice analytically separate, rather than collapsing them into one satisfaction score.

The literature also shows important disagreements about how to specify and apply the approach. One concern is methodological individualism: although we attribute capabilities to individuals, relational, institutional, and structural conditions shape how they form—so an individual-level analysis can hide power relations and collective disadvantage. A second disagreement concerns Nussbaum's list of central capabilities. Its universal threshold gives normative clarity and a basis for claiming minimum entitlements, but critics ask whether a fixed list risks paternalism or misses local priorities; Sen's more open-ended approach instead emphasizes public reasoning and context-specific selection (Nussbaum, 2011; Robeyns, 2005). This article takes a critical, non-foundational position between these two poles: it treats universal norms as revisable standards of dignity and non-domination, while keeping the selection of domains context-sensitive and open to public reasoning. The universal element works as a protective floor, not a complete list or a license to override local knowledge; the contextual element concerns interpretation, priorities, and implementation, not whether basic rights apply at all. In prison health, this means using the six domains in Table 1 as a provisional evaluative grid rather than a fixed, universal list—while still checking independently whether locally expressed priorities reflect genuine agency or adaptation to coercion.

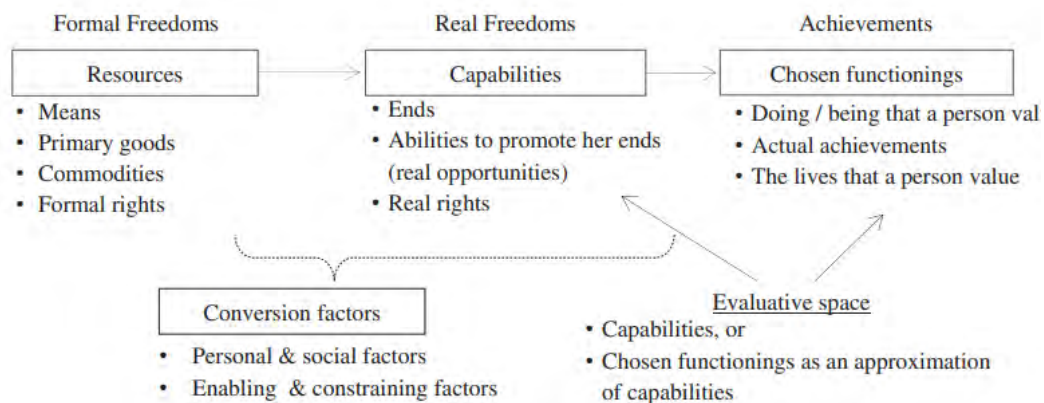
- ***Gender, intersectionality, and cumulative disadvantage***

We treat gender here not as a simple attribute but as a structural and relational part of how capabilities form and convert into outcomes. Feminist capability scholarship shows that gendered divisions of labour, embodied vulnerability, reproductive expectations, and unequal

power shape which capabilities are available and whose preferences count (Nussbaum, 2000; Robeyns, 2003). An intersectional view also warns against treating incarcerated women as one uniform group: gender interacts with race or ethnicity, class, age, disability, motherhood, migration or language, HIV status, and other forms of disadvantage, producing distinct patterns of exclusion that we cannot capture by simply adding separate variables (Crenshaw, 1989). Kabeer's distinction between resources, agency, and achievements is useful here, because empowerment is about the process through which women gain the ability to make strategic choices—not just their formal access to services (Kabeer, 1999). Finally, the idea of cumulative and corrosive disadvantage shows how deprivation in one area can undermine opportunities in others, over a woman's life course and through incarceration (Wolff & De-Shalit, 2007). A gender-responsive capability framework must therefore examine these mechanisms and trajectories, break down outcomes by subgroup, and keep formal entitlements, agency, and achieved functioning analytically distinct.

This figure gives a visual summary of the Capability Approach's key components and shows how they connect.

Figure 1 Core components of the Capability Approach linking resources, conversion factors, capabilities, and achieved functioning.



Source: Authors' adaptation of Sen's (1999) Capability Approach.

2.2. Limitations of Utility-Based Evaluation in Women's Carceral Health

In the Capability Approach, utility-driven frameworks reduce well-being to "well-feeling"—often measured through short-lived emotional states or adaptive preferences shaped by deprivation and coercion. Subjective metrics may capture part of the experience, but they miss structural inequalities and the loss of autonomy typical of carceral settings. Sen (1999) argues that utility-based metrics are especially unreliable when people lower their expectations in response to lasting deprivation. This risk may be particularly strong in prisons, where reported satisfaction can coexist with unmet needs, and where surveillance, stigma, and limited agency shape what people expect and how they respond. For example, a woman might report satisfaction with gynaecological care while still lacking the ability to choose her provider, decline procedures, or seek a second opinion—all basic entitlements outside prison. Expressions of satisfaction may also reflect compliance rather than empowerment: in carceral settings, reporting contentment can be a survival strategy rather than a true sign of well-being.

2.3. Empirical Literature on Women's Carceral Health and Its Relation to the Capability Approach

To situate our conceptual proposal, this section maps the empirical and policy literature cited in the manuscript in a targeted way, rather than through a formal systematic review. The mapping covers four strands: descriptive and qualitative evidence on women's health in prison;

analyses of rights and standards, especially the UN Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders (the Bangkok Rules); studies of access, stigma, privacy, reproductive care, and mental health; and work that applies the Capability Approach to health or social justice. The goal is to show what each strand documents, where the strands overlap, and what remains unconnected.

The empirical literature on women's imprisonment shows similar patterns across regions. In sub-Saharan Africa, the scoping review by Van Hout and Mhlanga-Gunda (2018) documents unmet reproductive, mental-health, infectious-disease, and continuity-of-care needs, and highlights weak data systems and institutional barriers to change (Ackermann, 2015; Topp et al., 2016). In broader international and MENA-focused work, the Bangkok Rules and related scholarship stress gender-responsive care, privacy, non-coercion, maternity protection, and access to services—but the evidence stays fragmented across legal analysis, policy reports, and local studies (Van Kempen & Krabbe, 2017; Barberet & Jackson, 2017; Alhasan, 2024). The literature we reviewed contains relatively little sustained empirical work from Latin America, which limits our geographical coverage and points to a need for future comparative research.

Across these studies, the same mechanisms recur: services may exist without guaranteeing real access; formal entitlements may be weakened by surveillance, stigma, retaliation, language barriers, or lack of privacy; and reported satisfaction may not show whether women can refuse treatment, take part in decisions, or get dignified care (Ahmed et al., 2016; Erickson et al., 2021, 2022; Watt et al., 2018). These findings line up with the Capability Approach's distinction between resources, conversion factors, capabilities, agency, and achieved functioning. However, the prison-health studies we cite generally do not frame these mechanisms as a capability framework, and capability-based health scholarship is rarely applied to the specific conditions of women's incarceration (Burchardt & Vizard, 2014; Coast et al., 2008; Ruger, 2010; Venkatarapuram, 2011).

The resulting gap is not a lack of knowledge about women's prison health; it is the limited integration of two bodies of work. Prison-health research documents needs, violations, and institutional constraints, while Capability Approach scholarship offers a normative vocabulary for evaluating real freedoms and achieved functioning. This article builds a preliminary bridge between the two, while recognizing that the proposed domains are illustrative and need empirical validation through comparative, participatory, country-specific studies. Identifying the capabilities that matter for women's health in incarceration requires dedicated empirical work and context-sensitive engagement. This is especially hard in low-income prison systems, where gender-specific health needs are poorly recognized and institutional data on care quality, access, or rights violations are often missing or unreliable (Van Hout & Mhlanga-Gunda, 2018; Ackermann, 2015). This paper does not aim to define a universal capability set, but it offers a starting point. Resource- and utility-based metrics are administratively convenient, but on their own they may not capture incarcerated women's lived health realities. They can hide evidence that some women cannot refuse treatment, lack privacy, or adjust their expectations under chronic deprivation. The Capability Approach addresses this by shifting the evaluative focus toward the freedoms women have to achieve health-related functioning with dignity—including the capability to access reproductive care without coercion, receive trauma-informed and confidential mental-health support, manage menstruation with dignity, and refuse invasive procedures without fear of retaliation.

3. Methodological Approach

This article is a theoretical and conceptual study. It uses a targeted narrative synthesis and a conceptual framework analysis, following Jabareen (2009). The method connects two bodies of literature—women's prison health and the Capability Approach—and translates their points

of overlap into a preliminary, gender-responsive framework. The unit of analysis is any concept or mechanism relevant to women's health-related capabilities in incarceration, including resources, conversion factors, agency, achieved functioning, rights, participation, privacy, reproductive autonomy, and psychosocial well-being.

We built the corpus through a purposive search and citation-chaining strategy. We used combinations of the following terms in English and, where relevant, French: "capability approach," capabilities, functioning, agency, conversion factors, women's prison health, incarcerated women, female prisoners, reproductive health, mental health, HIV, privacy, consent, Bangkok Rules, Mandela Rules, gender, intersectionality, empowerment, and Morocco/MENA. The search covered the period from the first Capability Approach publications in 1985 through 2025, and drew on peer-reviewed articles, books, international standards, policy reports, and institutional documents. Because this was not designed as an exhaustive database review, we do not report a PRISMA-style count of records identified, screened, and excluded. The final corpus comprises 77 sources in the reference list. This number describes the analytical corpus we used, not the yield of a reproducible systematic search.

We included sources that met at least one of four criteria: (i) they developed or critically discussed the Capability Approach; (ii) they addressed gender, intersectionality, agency, empowerment, adaptive preferences, or cumulative disadvantage in ways relevant to the framework; (iii) they documented the health, rights, or institutional conditions of women in prison; or (iv) they set out relevant normative standards, especially the Bangkok Rules and the Mandela Rules. We excluded sources that concerned prison populations with no gender- or health-related relevance, used "capability" only in a technical or clinical sense, duplicated a source we already had, or added nothing to the conceptual or normative analysis. Selection was therefore based on relevance, not prevalence, and we did not apply a formal quality-scoring tool.

We built the framework in four stages. First, we coded the literature thematically around the distinction between resources, conversion factors, capabilities, agency, and achieved functioning. Second, we compared recurring mechanisms of gendered deprivation across the prison-health and capability literatures. Third, we screened candidate domains for non-redundancy, irreducibility, intrinsic value, observability, and compatibility with rights standards; this step produced the six provisional domains in Table 1. Fourth, we linked each domain to an observable functioning and to relevant Bangkok and Mandela Rules, while keeping room for contextual adaptation and revision through protected, participatory validation. This shows how we built the framework—without presenting it as a universal list or an empirically validated set of indicators.

To reconcile data scarcity with the need for operationalization, the framework should be implemented through a graduated evidence strategy rather than a single all-or-nothing survey. Level 1 is a documentary and normative audit, based on available administrative records, inspection reports, complaints data, clinical protocols, prison-health statistics, and the Bangkok and Mandela Rules. This level can identify formal provision, documented gaps, and rights-relevant risks without direct access to prisoners, though it cannot establish lived experience or genuine agency. Level 2 is a protected consultation with formerly incarcerated women, community organizations, clinicians, and, where appropriate, families. Confidential interviews, focus groups, or capability-mapping exercises can refine what the indicators mean, reveal barriers missing from official records, and test whether proposed thresholds make sense—though retrospective accounts may carry recall bias, selective access, or effects from life after release. Level 3 is direct research inside detention, combining confidential interviews or surveys with observation, record linkage, and, where ethically and institutionally allowed, repeated measurement. This level gives the strongest basis for assessing current conversion factors and achieved functioning, but it needs authorization, trained independent researchers, safeguarding procedures, secure data management, and resources that may not exist in low-capacity prison systems. The

three levels build on each other but are not interchangeable: Level 1 supports a preliminary rights-based assessment, Level 2 supports contextual refinement, and Level 3 is needed for claims about current prevalence, subgroup differences, or change over time. The framework should be treated as non-applicable—or limited to a descriptive normative audit—when records are too incomplete to identify even basic inputs, when access cannot be made independent and confidential, when participation could expose women to retaliation, when the relevant population or subgroups cannot be defined, or when clinical and administrative data cannot be linked ethically. In these cases, the article's six domains should be treated as hypotheses for future inquiry, not converted into a numerical score or used to target individuals.

4. Women's Carceral Health: A Conceptual Framework Based on the Capability Approach

This section introduces the conceptual framework based on the Capability Approach. It distinguishes capabilities—substantive freedoms valued as ends in themselves—from resources and achieved functioning. Conversion factors are the conditions that determine whether resources actually turn into those freedoms and outcomes. In this article, we use five analytical components as a reconstruction, not a fixed list: functioning, capabilities, resources, conversion factors, and agency. The framework therefore avoids treating resources, enabling conditions, or specific outcomes as separate capabilities—they are better understood as means, conversion mechanisms, or achieved functioning.

4.1. Functionings Relevant to Women's Health in Incarceration

In the Capability Approach, functionings are the concrete states of having and being that give substance to well-being (Sen, 1999). They shift the focus from what health resources are available to what women actually achieve in daily life. This matters in carceral settings, where the logic of security and punishment often undermines health outcomes—especially for women, whose needs differ significantly from men's. For incarcerated women, key health-related functionings include safe childbirth free from shackling and mistreatment, managing chronic illnesses such as HIV or hypertension with continuity of care, receiving trauma-informed mental-health services, having dignified access to menstrual and reproductive health, and being protected from infectious disease. Yet the evidence shows persistent gaps: medication may be available but dispensed without privacy, which discourages women from taking it (Erickson et al., 2021, 2022); maternity services may exist, but childbirth can still happen under degrading conditions (de Oliveira et al., 2024; Nieva, 2024), and reproductive health needs are often minimized in male-centered prison systems (Plugge & Fitzpatrick, 2005). Placing functioning at the center of the framework highlights this mismatch between service provision and lived achievement. It asks whether women in prison are genuinely healthy, safe, autonomous, and treated with dignity—not just passively receiving services.

4.2. Relevant Capabilities for Women's Carceral Health

Operationalizing the Capability Approach in carceral health means shifting focus from providing services to what incarcerated women can actually achieve with them. This requires looking not only at resources but also at the institutional and gendered barriers that shape whether resources convert into real health freedoms. Debates about the Capability Approach go beyond theory into questions of empirical operationalization—especially how to identify and measure the capabilities that matter in a given social context. For incarcerated women's health, this is harder still because of systemic underreporting, institutional opacity, and limited agency, all of which complicate data collection and participation (Burchardt & Vizard, 2014). Robeyns (2005) points to several persistent problems in selecting capabilities for applied research: tension

between normative theory and empirical feasibility, difficulty applying multidimensional measures in policy settings, and limits from restricted or low-quality data, especially in low-income prison systems. Alkire takes a more optimistic view: capability selection is genuinely difficult, but the methods available for choosing relevant domains are more practical and varied than often assumed (Alkire, 2007). She outlines five methods commonly used in capability-based empirical work, several of which can be adapted for prison health:

1. Using existing data—for example, indicators from WHO's prison health assessments or national criminal justice reports—to infer relevant health deprivations.
2. Researcher judgment, where experts define capabilities based on context and professional judgment—for example, prioritizing reproductive autonomy where forced examinations are common.
3. Public consensus and normative frameworks: drawing on global standards such as the Bangkok Rules, CEDAW, or national laws that recognize detainees' health rights.
4. Deliberative participatory processes: engaging formerly incarcerated women, health workers, and prison staff in focus groups or structured capability-mapping exercises.
5. Empirical evidence on expressed values: gathering qualitative or survey data on what incarcerated women value in their health experiences—for example, dignity in childbirth, confidentiality, or access to female providers.

Alkire notes that selecting capabilities needs a pluralistic toolkit, adapted to the research purpose, context, and ethical limits (Alkire, 2007). Because participation is limited in prison health, this article combines human-rights norms, expert judgment, and partial empirical data as a practical choice—not as a method we attribute to Van Kempen and Krabbe (2017). This approach must also account for power imbalances, gender dynamics, and structural constraints that shape what we can measure (Van Hout & Wessels, 2021). Capabilities, not just functioning, should therefore guide carceral health policy. The debate continues: Sen (2005) calls for context-specific, participatory selection, while Nussbaum (2011) proposes a universal list as a baseline for dignity.

To reduce overlap, we selected the domains in Table 1 using three criteria: non-redundancy (each domain captures a distinct evaluative concern), irreducibility (losing it cannot be fully captured by another domain), and intrinsic value (the domain is a substantive freedom or form of agency valued as an end, not just a resource or input). On this basis, access to medicines, menstrual products, and language support count as resources or conversion conditions; respectful maternity care counts mainly as an achieved functioning under reproductive autonomy; and privacy, dignity, consent, participation, and protection from retaliation are grouped by whether they express bodily integrity, agency in care, or voice and redress. The resulting grid is therefore lean and provisional, while the underlying resources, conversion factors, and functioning remain available as separate layers for empirical assessment.

Table 1 should be read as our preliminary synthesis, not as an imposed or exhaustive list. Its selection follows a hybrid procedure based on three of Alkire's (2007) strategies: (i) review of public consensus and normative frameworks, including the Bangkok Rules and Mandela Rules; (ii) use of existing empirical and policy evidence on women's prison health; and (iii) researcher-led conceptual judgment to remove overlaps and keep domains with distinct normative content. We conducted no Delphi panel or original participatory study; participatory validation is a necessary next step. The six domains link to observable functioning and to relevant standards as follows. (1) Bodily integrity and dignified care—Bangkok Rules 10–11 and 20–21; Mandela Rules 24, 27, and 31—means receiving care without coercion, degrading treatment, or breaches of privacy. (2) Reproductive autonomy—Bangkok Rules 10–12 and 22–24; Mandela Rules 28 and 30—means voluntary reproductive decisions, safe childbirth without restraints, and respectful postpartum care. (3) Psychosocial well-being—Bangkok Rules 12–13 and 16–17; Mandela Rules 25 and 30—means access to confidential, trauma-informed mental-health care

and protection from self-harm. (4) Health-related agency and participation in care—Bangkok Rules 8, 10–11, and 25; Mandela Rules 31 and 56–57—means informed consent or refusal, participation in care planning, and the ability to raise concerns safely. (5) Effective access to essential health care—Bangkok Rules 10, 14, and 18–19; Mandela Rules 24–27—means timely, continuous access to medicines, menstrual products, screening, referrals, and maternity services. (6) Voice, redress, and protection from retaliation—Bangkok Rule 25; Mandela Rules 56–57—means filing complaints, getting an effective response, and doing so without punishment or loss of privileges. These links are indicative, not exhaustive; they are meant to make the table auditable and open to country-level validation.

Table 1. Capability Domains Relevant to Women's Health in Incarceration

<i>Capability domain</i>	<i>Substantive freedom description</i>	<i>Key references</i>
1. Bodily integrity and dignified care	Ability to receive safe, private, respectful, and non-coercive healthcare, including protection from sexual abuse and degrading treatment.	(Heise et al., 1995; Dapaah & Senah, 2016; Shalowitz & Ralston, 2023)
2. Reproductive autonomy	Ability to make informed and voluntary decisions concerning contraception, abortion, pregnancy, childbirth, and postpartum care.	(Yang, 2024; de Oliveira et al., 2024; Nieva, 2024)
3. Psychosocial well-being	Ability to obtain culturally responsive, trauma-informed, and non-punitive mental-health support.	(Im & Swan, 2020; Ranjbar et al., 2020)
4. Health-related agency and participation in care	Ability to give or refuse consent, seek information or a second opinion, participate in treatment planning, and express preferences in health decisions.	(García Guerrero, 2018; E. Shaw, 2019)
5. Effective access to essential health care	Ability to convert available services and goods, including medicines, menstrual products, chronic-disease treatment, and maternity care, into accessible and continuous care.	(Ahmed et al., 2016; L. Shaw, 2019; Plugge & Fitzpatrick, 2005)
6. Voice, redress, and protection from retaliation	Ability to raise health concerns, use complaint or grievance mechanisms, and seek accountability without punishment or loss of privileges.	(Halliwell et al., 2022; Kubiak et al., 2017; Robertson, 2009)

Source: Authors' preliminary synthesis based on the Capability Approach, targeted prison-health literature, the Bangkok Rules, and the Mandela Rules; not an exhaustive or universal taxonomy.

Identifying the health-related capabilities that matter most for incarcerated women needs context-sensitive, participatory deliberation—but participation cannot be assumed to be freeing inside a coercive institution. Prisoners may face surveillance, retaliation, dependence on staff, limited confidentiality, and unequal access to collective forums. Under these conditions, silence, apparent consent, or expressed satisfaction may reflect adaptive preferences rather than genuine agreement. The goal is therefore not to impose a fixed, universal list of capabilities—but it is also not enough to simply reproduce preferences formed under deprivation. This article uses a reflexive procedure: it combines a revisable universal floor of dignity and non-domination with contextual inquiry into lived experience, while subjecting locally expressed priorities to independent scrutiny, triangulation across methods and groups, and explicit attention to dissent and non-participation. The six domains in Table 1 are therefore illustrative and open to challenge, not a final taxonomy. The literature suggests that prison-health evaluations based on service availability, clinical throughput, or self-reported satisfaction may not fully show whether women can actually achieve health-related functioning. Incarcerated women may receive healthcare yet still lack privacy, informed consent, autonomy in reproductive decisions, or protection from stigma (Dapaah & Senah, 2016; García Guerrero, 2018; Erickson et al., 2021, 2022). Evaluation must therefore look at both achieved functioning and the real freedom to choose, refuse, or contest care. Defining health-related capabilities in prison requires institutional ethnography, consultation with lived experience, and the use of international human-rights standards such as the Bangkok Rules (Barberet & Jackson, 2017; Van Kempen & Krabbe, 2017). Participatory methods should include safeguards—confidential settings, independent

facilitation, protected refusal, and comparing accounts across subgroups and documentary evidence—so that participation informs contextual specification without displacing basic rights or normalizing coercive conditions.

4.2.1. Conversion Factors

As noted above, conversion factors shape how people turn health services into actual well-being. For incarcerated women, personal conversion factors—such as poor mental health, low literacy, trauma, and substance use—often reduce their ability to access and benefit from care (Bartlett & Hollins, 2018; Harner & Riley, 2013; Morken et al., 2023). Many women enter prison with chronic conditions and limited health knowledge, which further limits their engagement with treatment (Harner & Riley, 2013; Topp et al., 2016). Social factors—including stigma, lack of family support, gender bias, and power imbalances with staff—affect trust in the system and willingness to seek help (Ackermann, 2015; Topp et al., 2016). Social isolation and discrimination often widen existing gaps in access. Environmental conversion factors, such as overcrowded facilities, understaffed clinics, and a lack of gender-specific services, directly hinder timely, appropriate care (Topp et al., 2016; Woodall et al., 2021). Many prison systems are simply not designed for women's health needs, which leaves them unable to realize the functioning of being healthy.

4.2.2. Resources (Means)

Resources are the goods and services available to people, but their value depends on whether they can be converted into substantive capabilities (Sen, 1999). Simply having resources—medication, medical staff, or hygiene products—does not guarantee well-being; what matters is the freedom to use them to achieve valued functioning. In carceral health, evaluations often rely on input-based measures: the number of consultations, the presence of clinics, or medicine stocks. But these metrics risk confusing provision with achievement. For example, antiretroviral therapy (ART) is ineffective if dispensed without privacy, and maternity services lose their meaning when women give birth in shackles (van den Bergh et al., 2009). In such cases, resources exist but capabilities do not expand. As Robeyns (2005, 2017) and Ruger (2010) argue, resources only matter in relation to conversion factors and agency. For incarcerated women, health goods must come with dignity, confidentiality, and autonomy. Human rights instruments such as the Bangkok Rules (2010) and the Mandela Rules (2015) confirm this: resources are necessary but not sufficient—they must also be usable, accessible, and empowering in practice.

4.2.3. Agency

Agency is another key component of the Capability Approach: the freedom to make meaningful choices and shape the conditions of one's own well-being (Nussbaum, 2011; Sen, 1999). In carceral health systems, this dimension is critical, yet it is routinely undermined by coercive rules, gendered hierarchies, and institutional opacity. Women may have formal access to reproductive or HIV care but still lack the autonomy to refuse invasive procedures, choose a provider, or voice complaints without retaliation—reducing healthcare to compliance rather than empowerment (Erickson et al., 2021, 2022; van den Bergh et al., 2009). For Sen, agency is distinct from well-being: it concerns a person's ability to pursue goals they have reason to value, which requires conditions that allow meaningful choice and action (Sen, 1999). Human rights frameworks such as the Bangkok Rules further treat informed consent, privacy, and participation as non-negotiable standards in women's prison healthcare. Expanding agency therefore reframes carceral health not as service delivery, but as the protection of dignity and substantive freedom (Bonvin & Laruffa, 2018).

5. Implications for Practice and Policy

The Capability Approach (CA) is widely used in public health and development, but it remains underused in prison health research—especially for incarcerated women in low- and middle-income countries. The approach leaves open important questions about how to select, weight, and complete evaluative information (Sugden, 1993). Still, successful applications in fields like poverty and gender equality show that it adapts well when grounded in context (Robeyns, 2005). Standard prison health evaluations focus on inputs, consultation rates, drug availability, and satisfaction scores—but they fail to ask whether women genuinely have the freedom to access care with dignity and autonomy.

Qualitative methods—such as narrative inquiry or capability mapping—can help identify what incarcerated women value but cannot achieve because of institutional constraints. We propose these as context-sensitive empirical tools, not as something drawn from Sen’s (2009) theoretical account of justice; their use fits pluralistic approaches to capability selection and health evaluation (Alkire, 2007; Burchardt & Vizard, 2014). It is essential to check whether different groups—for example, pregnant women or those living with HIV—have fair access to key health functionings, such as pain relief or psychological recovery (van den Bergh et al., 2009).

5.1. Capability-Based Targeting: Identifying Vulnerable Subgroups

One promising use of the Capability Approach in prison health policy is identifying priority groups through multidimensional health-related deprivation, rather than through categorical criteria alone—such as age, sentence length, or offense type. This does not mean capability measures automatically reveal vulnerability; it requires explicitly specifying relevant domains, indicators, thresholds, and decision rules, then validating them against women’s lived experience and institutional evidence (Alkire, 2007; Burchardt & Vizard, 2014). This matters because biomedical risk categories and administrative eligibility rules can overlook the intersectional and institutional conditions that shape whether incarcerated women can turn available services into real well-being (Topp et al., 2016; Kelly-Corless & McCarthy, 2025). Participatory qualitative tools—narrative interviews and life-history methods—can complement quantitative targeting by documenting stigma, discrimination, confidentiality failures, and other conversion constraints. For example, women in sub-Saharan African prisons may face barriers to care even when services are formally available, because of fear of stigma, gender-based discrimination, or lack of confidentiality (Van Hout & Mhlanga-Gunda, 2018).

Alkire and Foster’s (2011) dual-cut-off method offers one possible—but clearly provisional—way to operationalize this targeting strategy. First, each woman would be assessed across the six domains in Table 1: (1) bodily integrity and dignified care; (2) reproductive autonomy; (3) psychosocial well-being; (4) health-related agency and participation in care; (5) effective access to essential health care; and (6) voice, redress, and protection from retaliation. A small set of observable indicators could represent each domain—for example, confidentiality during consultations, freedom from coercive reproductive procedures, access to trauma-informed mental-health support, informed consent or refusal, continuity of essential medicines and menstrual products, and the ability to complain without retaliation. We would define a deprivation cut-off for each indicator in advance, using rights-based standards, clinical requirements, and context-specific evidence. For instance, a woman could be coded as deprived in confidentiality when consultations routinely happen within earshot or view of unauthorized persons, or deprived in continuity of care when essential treatment is repeatedly interrupted. The indicators would get transparent weights—equal weights as a starting point, with participatory or expert-informed weights tested later in sensitivity analyses—and a second, cross-domain cut-off (k) would identify women facing multidimensional capability deprivation once their weighted deprivation score reaches a pre-set threshold. The method should not be read as a universal diagnostic, or

as proof that a woman is institutionally constrained; it would simply flag cases for further qualitative assessment, rights-based audit, and context-sensitive action. For example, a woman receiving antiretroviral treatment (ART) could still meet the multidimensional deprivation criterion if her treatment comes without confidentiality, meaningful consent, or protection from stigma. This design makes the proposed shift from formal equality to substantive equity testable: priority would go not just by nominal service availability, but by the combined deprivation of real opportunities to get care with autonomy and dignity (Alkire & Foster, 2011; Sen, 1999). We propose participatory ranking with former detainees and confidential community-based interviews as ways to refine the indicators and thresholds where direct access to current prisoners is restricted; these are not methods used in Van Kempen and Krabbe's (2017) discussion of the Bangkok Rules. For the South African context, Van Hout and Wessels (2021) offer more directly relevant evidence on incarcerated women and the implementation of the Bangkok Rules—though that source should not be treated as evidence on life after release.

5.2. Participatory Health Governance

In practice, participatory methods in prison health governance offer a concrete way to operationalize the Capability Approach. Creating spaces for incarcerated women to express their needs and help design health interventions treats them as agents, not passive recipients. These participatory processes can reveal the diversity of health-related deprivations—especially those linked to trauma, reproductive care, or mental health—and help policies respond to lived realities instead of bureaucratic assumptions. The goal is not just to document what women want, but to foster empowerment and deliberative engagement with institutional actors. Bonvin and Laruffa (2018) argue that, in deliberative democracy, participation should expand people's capability to influence decisions that affect their well-being. For women in prison, this could include voicing concerns about coercive medical practices and hygiene-related dignity. Still, participatory practices need careful design: the risk of performative engagement—participation that looks real but changes nothing—is significant in hierarchical, punitive environments.

6. Discussion: Comparative Contribution and Scope

This comparison works best when we treat each alternative as addressing a different evaluative problem. The biomedical model is strongest for diagnosis, treatment effectiveness, and clinical risk, but it can leave the institutional conditions of consent, privacy, and dignified access outside its main focus. A rights-based approach gives non-negotiable duties and accountability standards, but formal entitlement alone does not show whether women can safely use, refuse, or contest care. Equivalence-of-care models give an important benchmark for continuity and parity with community services, but equal provision can still produce unequal outcomes when trauma, disability, language, pregnancy, stigma, or coercion change women's ability to convert services into health. Health in All Policies widens attention to cross-sector determinants, but the capability lens adds a prison-specific account of how custody, surveillance, and restricted agency mediate those policies. Restorative justice offers a language of repair, accountability, and relationships, but on its own it does not specify how to assess health resources, conversion factors, and achieved functioning. Finally, Liebling's moral-performance approach (Liebling, 2004) is especially close to our framework, because it evaluates the ethical quality of imprisonment through respect, humanity, trust, and legitimacy. The capability contribution is to connect these moral qualities to women's concrete opportunities to get care, take part in decisions, preserve bodily integrity, and exercise agency. The proposed framework therefore adds an evaluative bridge, not a rival model: it links institutional conditions and normative standards to lived health freedoms, while keeping clinical, legal, public-health, restorative, and quality-of-life assessments as complementary sources of evidence.

This framework is not meant to replace existing approaches to prison health. Its value lies in

making explicit an evaluative question those approaches do not always answer: whether institutional resources and formally available services actually expand incarcerated women's substantive freedom to achieve valued health functionings. In this sense, the Capability Approach complements—rather than replaces—biomedical assessment, rights-based standards, equivalence-of-care models, Health in All Policies, restorative justice, and quality-of-care frameworks.

Compared with the biomedical model, the framework broadens what counts as evaluation—beyond diagnosis, treatment, and service use—to include dignity, privacy, reproductive autonomy, psychosocial well-being, and agency. Compared with a rights-only approach, it bridges formal entitlements and lived achievement: a right to care matters, but the key question is also whether women can use that right without coercion, stigma, retaliation, or institutional barriers. Compared with equivalence-of-care models, the framework keeps the focus on continuity and comparability, while recognizing that equal provision can still produce unequal capabilities when women face different conversion factors, such as trauma, disability, language barriers, pregnancy, or discrimination.

The framework also differs in scope from Health in All Policies and restorative-justice approaches. Health in All Policies looks at how policies affect outcomes across sectors, while our framework specifies how those policies turn into health-related freedoms inside a coercive institution. Restorative justice foregrounds accountability, repair, and relationships—goals that are compatible with our framework, but that do not, on their own, give a structured account of health resources, conversion factors, achieved functionings, and agency. Finally, quality-of-care approaches that study the moral performance of prisons—attention to humanity, trust, respect, and legitimacy—are especially close to our proposal. The capability lens adds a systematic account of how these moral and institutional qualities affect women's actual opportunities to get care and influence decisions about their health.

Our framework therefore claims to complement existing approaches, not to outperform them empirically. Its contribution is to connect three levels that are often assessed separately: the resources and standards the prison-health system supplies; the institutional, social, and personal conversion factors that shape whether those resources are usable; and the functionings and agency that women actually achieve. This synthesis helps explain why apparently adequate provision can coexist with poor privacy, constrained consent, untreated trauma, or limited participation. It also gives a basis for comparative empirical research—it is not evidence that the capability framework works better than competing models.

This comparison also shows the framework's limits. It is not a validated measurement instrument, a universal list of capabilities, or a substitute for clinical indicators, legal monitoring, or institutional quality assessment. Simply recommending participation does not solve the problem Sugden (1993) identified: selecting domains, setting thresholds, and assigning weights are still contestable normative decisions, and the resulting framework may favor researchers' or administrators' judgments over women's own priorities. In prison settings, this problem is made worse by restricted access, surveillance, fear of retaliation, adaptive preferences, and the difficulty of telling genuine agreement from compliance. A capability index can also be costly to build, especially where records are incomplete, confidentiality is fragile, and repeated interviews put participants at institutional risk. The approach can also become bureaucratized: a multidimensional checklist or score could turn into another eligibility device, hide individual stories, or reward measurable compliance instead of improving care. Finally, the framework cannot assume that expanding choice is always feasible, because security rules, staffing limits, segregation practices, and emergency procedures may restrict privacy, movement, choice of provider, or the right to refuse treatment. These tensions do not invalidate the approach, but they do limit what it can claim: capability assessment should remain a decision-support tool, not an automatic rule for allocating resources.

Its usefulness therefore depends on explicit safeguards: report domains separately before combining them; explain the reasoning and sensitivity of thresholds and weights; combine administrative indicators with confidential qualitative accounts and independent rights monitoring; keep data collection to a minimum and protect refusal and anonymity; and distinguish clinical urgency from broader capability deprivation. Participatory validation should be repeated across subgroups and should include dissenting and non-participating voices, and security justifications should be documented and checked for proportionality, not simply assumed. Future studies should test not only whether capability-informed assessments catch forms of deprivation that conventional models miss, but also whether they improve decisions without increasing surveillance, administrative burden, or unequal treatment.

7. Conclusion and Recommendations

The Capability Approach gives a coherent lens for analyzing how institutional, social, and personal factors shape the real freedoms women have to achieve health and well-being in carceral settings. Rather than equating service provision with actual well-being, the framework shows how conversion factors—such as poverty, stigma, lack of privacy, or coercive institutional practices—shape whether formal health entitlements turn into meaningful health outcomes. The experiences of incarcerated women show that constraining factors (overcrowded facilities, unsafe environments, limited autonomy in reproductive decisions) severely limit their ability to achieve core capabilities like bodily integrity, psychosocial well-being, and reproductive autonomy. Enabling factors—such as trauma-informed care, supportive social networks, or gender-sensitive health services—do the opposite: they create conditions in which women can exercise agency and dignity.

Building on our contribution, future studies should move beyond documenting service availability and start testing whether specific reforms expand the core capabilities identified in this paper, such as bodily integrity, reproductive autonomy, and psychosocial well-being. For example, pilot research could test whether private spaces for medical consultations reduce fear of stigma during HIV care, or whether training female healthcare staff leads to fewer coercive practices in reproductive services. Interventions like menstrual dignity programs or confidential complaint systems could be evaluated with capability-based indicators—for example, the freedom to refuse invasive procedures or access mental-health support without retaliation—rather than with administrative metrics alone. Comparative studies across low- and middle-income prison systems could then examine how these concrete reforms align with the Bangkok Rules and Mandela Rules, producing evidence-based recommendations for rights-oriented prison health policy.

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Declaration of Generative AI and AI-Assisted Technologies in the Manuscript Preparation Process:

Artificial intelligence tools were used exclusively for translation and language editing purposes, without contributing to the research design, data analysis, or interpretation of results. The authors take full responsibility for the final content of the article and have reviewed and verified all modifications made.