Pregnancy and Parenting Support for Incarcerated Women: Lessons Learned

Rebecca J. Shlafer, Erica Gerrity, Grant Duwe

Progress in Community Health Partnerships: Research, Education, and Action, Volume 9, Issue 3, Fall 2015, pp. 371-378 (Article)

Published by Johns Hopkins University Press
DOI: 10.1353/cpr.2015.0061

Pregnancy and Parenting Support for Incarcerated Women: Lessons Learned

Rebecca J. Shlafer, PhD[1], Erica Gerrity, LICSW[2], and Grant Duwe, PhD[3]

(1) University of Minnesota; (2) Minnesota Prison Doula Project; (3) Minnesota Department of Corrections

Submitted 6 January 2014, revised 3 July 2014, accepted 24 September 2014.

Abstract

Background: There are more than 200,000 incarcerated women in U.S. prisons and jails, and it is estimated that 6% to 10% are pregnant. Pregnant incarcerated women experience complex risks that can compromise their health and the health of their offspring.

Objectives: Identify lessons learned from a community–university pilot study of a prison-based pregnancy and parenting support program.

Methods: A community–university–corrections partnership was formed to provide education and support to pregnant incarcerated women through a prison-based pilot program. Evaluation data assessed women's physical and mental health concerns and satisfaction with the program. Between October 2011 and December 2012, 48 women participated.

Lessons Learned: We learned that providing services for pregnant incarcerated women requires an effective partnership with the Department of Corrections, adaptations to traditional community-based participatory research (CBPR) approaches, and resources that support both direct service and ongoing evaluation.

Conclusions: Effective services for pregnant incarcerated women can be provided through a successful community–university–corrections partnership.

Keywords

Community health partnerships, community-based participatory research, women's health, prisoners, health disparities

Since 1990, the number of women incarcerated in the United States has more than doubled.[1] Today, there are more than 200,000 incarcerated women in U.S. prisons and jails.[2] Although much has been written about the overall poor health of incarcerated individuals,[3] most of this work has focused on incarcerated men. Far less is known about the health of incarcerated women, despite their increased risk for physical and mental health problems[4] and added considerations regarding their reproductive health.[5]

Three out of four incarcerated women are of childbearing age,[4,6] most are mothers,[7] and it is estimated that 6% to 10% of incarcerated women are pregnant.[8,9] Pregnancies among incarcerated women are often considered high risk and have poor outcomes (see Poehlmann and Shlafer,[10] for a review). When compared with women in the general population, pregnant prisoners are more likely to have risk factors associated with poor perinatal outcomes, including preterm and small-for-gestational-age infants.[11,12] These outcomes are likely a result of exposure to a combination of risk factors, including lack of access or failure to attend prenatal care, substance use, toxic stress, domestic violence, poor nutrition, and sexually transmitted infections.[13] In addition, African American, Native American, and Hispanic women are disproportionally represented in the prison system[2]—three groups that are also at greatest risk for poor birth outcomes.[14]

These risks clearly compromise women's health, and also

have important implications for the health of their future offspring, making intervention and research with pregnant incarcerated women an important area for public health inquiry. Yet, this topic has remained relatively unexplored, at least in part because of the challenges encountered when implementing intervention programs and conducting research in correctional facilities.[15–18] Of paramount concern is gaining (and maintaining) access. Once access has been granted, researchers often face additional barriers developing positive relationships with corrections staff and inmates.[17] Such relationships are essential for successful program development and implementation, as well as ongoing research and evaluation. The goal of this article is to describe the development, implementation, and evaluation of one prison-based pilot program and to identify lessons learned from this program.

DEVELOPING A PREGNANCY AND PARENTING SUPPORT PROGRAM

The Minnesota Prison Doula Project (formerly *Isis Rising*) is a prison-based prenatal and parenting support program for incarcerated women at the Minnesota Correctional Facility–Shakopee. The impetus for the *Minnesota Prison Doula Project* came from requests from incarcerated women at Minnesota Correctional Facility–Shakopee. Nearly a decade ago, the second author of this paper was working as a graduate intern at the prison and observed a significant lack of attention and concern for pregnant women. She created an informal survey and held talking circles in which women were able to express their thoughts, concerns, and hopes for parenting while in prison. Through these groups, she aimed to understand the women's strengths and needs, as well as the current resources and potential opportunities for action. During the talking circles, incarcerated women expressed a general lack of information and education around prenatal development and the birth process, as well as a desire to have opportunities to share with, learn from, and support other women in the prison. Women also expressed sadness, fear, uncertainty, and anxiety about delivering their babies alone, because prison policy prohibited them from having any contact with their partners or family members when they were transferred from the prison to the local hospital for delivery.

This formative work was guided by the second author's training in social work and built on the underlying principles of the field related to service, social justice, and the importance of human relationships. Without explicitly doing so, this process built on key principles of CBPR, including recognition of the prison community as a unit of identity, building on incarcerated women's strengths and resources, and facilitating involvement in the earliest stages of the project.[19] This formative research guided the initial development of the program, which consisted of weekly support groups for pregnant and parenting women, and one-on-one support from a trained and certified doula that provides nonmedical support during the prenatal, labor and delivery, and postpartum periods.

In 2010, nearly 3 years after prison administration was first approached, the prison granted permission for the *Minnesota Prison Doula Project* staff to facilitate weekly support groups for pregnant women and mothers with young children. Later that year, doula support was approved and the first pregnant woman received doula support. This first year provided an opportunity to reassess and refine the program's model, based on the second author's clinical observations, women's informal feedback, and explicit discussions among the staff and participants about the program's structure, format, and content. Consistent with a CBPR approach, this part of the program development process was cyclical and iterative.[19]

BUILDING A COMMUNITY–UNIVERSITY PARTNERSHIP

During that same year, a researcher at the University of Minnesota (UMN; first author), with expertise in parental incarceration and child development, learned of the *Minnesota Prison Doula Project* and contacted the program director (second author) to learn more about the program's work and any evaluation activities that were underway. Through several initial meetings, the partners had a rich opportunity to learn about each other's professional background, personal passions, career goals, and shared interests in working with incarcerated women.

Two months later, in January 2011, the Clinical and Translational Science Institute (CTSI) at UMN solicited proposals for pilot funding for new community–university partnerships aimed at improving community health. The funding opportunity represented a major effort on the part of the CTSI to build significant long-term partnerships between university investigators and community representatives. The vision for the CTSI was for a "new model of engaged scholarship to be co-developed by community and university partners that gives

a high priority to community-based knowledge and expertise." The CTSI required that proposals included at least two co-investigators: one from a community health organization (health care provider/system or community-based organization) and a researcher affiliated with UMN.

This solicitation was released within months of the initial meeting between the first and second authors, and provided a timely and unique opportunity to formalize a new partnership between the *Minnesota Prison Doula Project* and researchers at UMN. In preparing the proposal, the first and second authors sought guidance and involvement from program staff on defining the initial research questions and identifying the program's priorities for research and evaluation. These meetings were held at the nonprofit organization's office, which provided a central location for most of the staff, allowing them to participate more easily than if the meetings had been held at UMN.

After meetings with program staff, the first and second authors co-wrote and submitted a proposal in March 2011. The proposal outlined a plan for ongoing research, evaluation, and dissemination that aimed to balance the priorities of the program, the partners, the participants, and the prison. After collectively developing the core research questions, the university partner was responsible for identifying appropriate study instruments and protocols, guided by the constraints of the prison environment (e.g., restrictions on recording interviews) and the program (e.g., limited time to administer surveys). The university partner was also responsible for securing approval from the human subjects review committees, consenting participants, and data collection, management, and analysis. The community partner was responsible for staffing, identifying a referral process, developing program materials, and implementing the program. At the proposal stage, they also discussed an initial plan for dissemination, including target audiences (e.g., doulas, corrections administrators, public health professionals, academics) and potential strategies (e.g., social media, newsletters, conference presentations, peer-reviewed publications) for dissemination.

Although they never formalized "ground rules" for the partnership, the university and community partners did have specific conversations about which partner would lead each element of the project based on their experience and expertise, with an explicit understanding that each partner would welcome input from the other. These conversations provided a foundation for the partnership and emphasized shared influence and control in the decision-making process.[19,20]

METHODS

The proposal was funded in June 2011 and data collection began later that year. Between October 2011 and December 2012, 48 women participated in the *Minnesota Prison Doula Project*, 19 of whom were pregnant and matched with a doula. At the start of the 12-week support group, participants completed a brief survey regarding their demographic characteristics, physical and mental health, parenting status, and goals for their participation in the program. At the end of the program, participants completed a parallel survey that included additional questions about the support they received from program staff, their satisfaction with the program, and perceived benefits from participation. Pregnant women completed a brief survey after the birth of their babies about their satisfaction with the birth process, the care they received from medical and corrections staff, and the support they received from their doula. Doulas also maintained a log of all one-on-one contact with their clients (e.g., the length of the meetings, concerns addressed), documented objective birth outcomes (e.g., delivery type, interventions used, infant birth weight, APGAR scores), and prepared written reflections of the participants' birth stories.

RESULTS

Although data analysis and dissemination of the project's findings are still underway, initial results are promising. Incarcerated women reported more parenting confidence, more support from other inmates, and more support from prison staff after their participation in the weekly support group. Group participants also reported receiving high levels of support from program staff. Of the 19 women who were pregnant and matched with a doula, 18 received doula support (one woman was released before her delivery). All of the women who received doula support had healthy babies—none were born preterm or low birth weight. One woman had a cesarean delivery; all others had typical vaginal deliveries without complications. Doulas' perspectives on providing support to incarcerated women and information on the logistical feasibility of this program have been published recently.[21] Additional results on women's outcomes are forthcoming (and are avail-

able by request from the first author). What we describe next are three key lessons learned from our community–university pilot study of the *Minnesota Prison Doula Project*.

LESSONS LEARNED

Lesson 1: Community Health Partnership Involving Prisoners Requires an Active Partnership with the Department of Corrections

The CTSI pilot grant brought the community and university partners together and set the stage for a partnership to flourish. Important factors underlying the success of the partnership included a passion about the topic, commitment to doing good work, and contribution of different areas of expertise. What they did not expect—or perhaps fully appreciate at the time—was the critical importance of a successful partnership with Minnesota Department of Corrections (MnDOC). Although the warden of the facility had approved the program, adding a research and evaluation component required approval from the MnDOC Human Subjects Review Board (HSRB), in addition to the approval required by the UMN Institutional Review Board (IRB). Although the partners had anticipated additional provisions for their work with prisoners[16]—particularly because participants were also pregnant—they had not anticipated some of the additional challenges they would encounter in this process.

In 2003, the MnDOC suspended the IRB process it had established owing to budget cuts and, more specifically, the dissolution of its Research and Evaluation Unit. After a 2-year moratorium in which it flatly rejected any research project proposal with human subject considerations, the MnDOC reinstituted an IRB process led by the Director of Research (third author) and began to slowly rebuild its research and evaluation capacity. However, when it reestablished its IRB in 2005, the MnDOC HSRB developed a review process that is, in some respects, more rigorous than that typically found for IRBs within academic institutions. Rather than limiting its review strictly on the basis of whether the proposed research would protect human subjects, the MnDOC review process also considers the overall quality of the proposal, the credentials of the researchers, and whether the research would help to improve correctional practice or make a significant contribution to the criminal justice field in general.

Thus, for the work with the *Minnesota Prison Doula Project* to proceed, it was not enough to ensure that the program was protecting the rights of the women participating; it was essential for the partners to demonstrate the merits of their proposal based on MnDOC's additional criteria. Doing so meant that the community and university partners needed to work closely with the corrections partner to understand MnDOC's priorities, policies, and processes. This required ongoing communication, particularly before the study was approved, between the first and third authors about the human subjects review process (i.e., timelines for when applications would be reviewed, strategies for responding to stipulations, clarifying requests between UMN's IRB and MnDOC's HSRB). After the study was approved, regular communication between the first and third authors was essential for reviewing changes in protocols, ensuring the work fit with MnDOC's research priorities, and brainstorming ways to integrate administrative data (e.g., criminal history, health care costs) into future research questions.

There are several reasons why the MnDOC decided to implement a more stringent IRB review process. First, the MnDOC has, like many correctional agencies, increasingly embraced the concept of evidence-based practices. As a result, research is not viewed as something that merely collects dust while sitting on a shelf, but rather should be used as a guide for helping to improve correctional policy and practice. At its core, the *Minnesota Prison Doula Project* sought to support this goal and aimed to have the research inform the policies and practices that affected pregnant incarcerated women. Second, even though the MnDOC's research and evaluation capacity has improved since 2003, the amount of staff resources available for the review and monitoring of human subjects research proposals has been, and continues to be, limited. Finally, in an effort to maximize the use of these limited resources, the MnDOC only approves human subjects research projects that demonstrate a high likelihood of protecting Minnesota prisoners, while also generating findings that help to increase understanding of what works (and what does not) with offenders and provides a benefit to the state. To that end, the program documented objective birth outcomes (e.g., rates of cesarean deliveries and preterm births) that could provide important information to the MnDOC about potential cost savings through reductions in medical expenditures, in addition to measures of women's perceptions of their participation in the program.

Because staff resources are limited, the MnDOC does not have a rolling review process for research projects involving human subjects. Instead, it reviews proposals on a quarterly basis. This was, perhaps, one of the most difficult hurdles encountered. Given the timeline for the HSRB review, approval was first sought from the UMN IRB. After receiving approval from the UMN IRB, there were another 2 months before the next HSRB committee meeting. Upon receiving a conditional approval from the MnDOC HSRB, the proposal had to be revised and resubmitted as a change in protocol for all of the required HSRB changes to the UMN IRB. We have learned to expect the entire approval process to take 3 to 6 months to allow time for revisions and resubmissions through both the UMN IRB and the MnDOC HSRB.

Working with multiple university IRBs to approve a study is not uncommon in multisite trials,[22] but researchers may face unique challenges when working with human subjects committees outside of academia or in restrictive settings. This may be particularly true for researchers who aim to conduct CBPR with protected populations (e.g., residential drug treatment programs) or in community settings with partners that have their own IRBs (e.g., local hospitals, tribal communities).

Lesson 2: Identify Ways to Adapt Traditional CBPR Practices to Work Within the Prison Context

CBPR offers a valuable approach to studying and addressing health disparities, particularly when community members can be fully engaged as partners in identifying and addressing the health problems most relevant to their communities.[23] When community members are prisoners or members of other highly vulnerable groups (e.g., residents in a drug treatment program), key CBPR principles must be adapted to fit these unique contexts. Traditional CBPR approaches emphasize that "participatory research fundamentally is about who has the right to speak, to analyze, and to act"[24(p.22)] and the importance of community members' active and equal involvement throughout the research process.

Prisoners, however, are part of a community characterized by rules and regulations, restricted freedom, and unequal power, and thus present unique challenges when using a CBPR approach to study their health needs.[25,26] Thus, in our work with incarcerated women, we had to identify ways to engage incarcerated women without violating facility rules or policies, or inappropriately challenging existing power structures within the prison environment. We have also had to work to develop trusting relationships with staff and inmates. This is particularly challenging when working with a vulnerable population of women, many of whom have experienced a history of abuse and trauma, and have great distrust in the criminal justice and social service systems. Such challenges may be faced in research with other vulnerable or otherwise restricted populations, such as residential mental health programs, group homes for delinquent youth, or inpatient eating disorder clinics.

To build trust with women and develop a shared understanding of the program's goals, we used time during the first group session of each 12-week cycle to discuss the university's role and the importance of ongoing research and evaluation, making it clear that our goals were to learn more about what works, what does not, and how women can be best supported in this context. Women were receptive to this and several women expressed gratitude for our attention to their needs. None of the women declined to participate in the research and evaluation, offering additional evidence of their support for our work. We continue to find ways to actively engage women in the development of the program and research process, with keen awareness for the context in which we are working. For example, as part of the original dissemination plan, we identified potential strategies for providing participants with regular updates about the program and ongoing evaluation. To do this, we prepare a quarterly newsletter that contains an educational component of interest to the group and ideas for topics are often solicited from the group (e.g., the importance of exercise during pregnancy). In the newsletter, we also provide an update on the research and evaluation components (e.g., summaries of recent conference presentations). Women have said that they appreciate the newsletter and that they have shared the information with fellow inmates, including those who are not participating in the *Minnesota Prison Doula Project.*

We also inform women in the group of the program's accomplishments. For example, we recently had a research poster selected for an award at a local conference. We took a picture of the poster with the blue ribbon attached and included it in the newsletter. Upon seeing the picture, the women in the group clapped and cheered; it was clear that they felt a sense of shared pride and accomplishment. To

outsiders, this may seem like a small and perhaps trivial act, but in a context in which women rarely have opportunities to contribute in meaningful ways or have their achievements recognized, this was particularly powerful moment.

We also strive to be as responsive as we can to the concerns and questions women raise during group sessions about their physical and mental health, and issues related to parenting during incarceration. In the first year, for example, many women expressed concerns about diet and nutrition during pregnancy. In response, the group facilitators added content to the curriculum and provided additional information and resources around this topic. Women were given information about nutrients that were important for pregnant women (e.g., calcium) and the group identified foods in the prison environment that were rich in these nutrients (e.g., yogurt, enriched breads). We are also in the process of developing guides that would help pregnant women to identify foods available through the prison's commissary that are rich in nutrients needed for healthy fetal growth.

Many women also expressed that they experienced considerable stress related to child protection and custody issues. Recognizing our staff's limited training and expertise in these areas, we invited colleagues from legal aid to co-facilitate sessions on family law. Women came to these sessions prepared with questions, actively engaged, and requested that the guests join the group in the future. Being responsive to women's needs in this way helps to build trust and respect, while also increasing the program's capacity to improve women's health and well-being. In all of these ways, we aimed to use the power of the group to explore incarcerated women's needs and identify resources in a targeted way, without compromising the MnDOC's responsibility to maintain a safe and secure prison environment.

Lesson 3: Identify Funding Sources to Support Both Direct Service and Ongoing Research and Evaluation

The original CTSI pilot grant was instrumental in building our partnership and launched the program to a new level. Before receiving the pilot grant, the *Minnesota Prison Doula Project* was operating on a very limited budget. Revenue was generated through small grants, private donors, and grassroots fundraising events. The program director (second author) was not taking a salary and the doulas were volunteering considerable amounts of their time and effort. The pilot grant funds provided support for both the program (e.g., doulas' salaries, reimbursement for travel to and from the prison, doula training costs) and the research (e.g., costs for printing surveys, research assistants' salaries), creating a critical infrastructure on which the program could thrive.

We have more appreciation for this type of community–university pilot grant, particularly now that we know how uncommon it is for traditional funding mechanisms to allow funds to be used for direct service *and* research. Given that we are fully committed to conducting ongoing research and evaluation of the services the *Minnesota Prison Doula Project* provides, means that we must seek funding from multiple and varied sources. We have learned to identify funding opportunities through both community (e.g., foundation grants, fundraising events) and university (e.g., intramural and extramural awards) sources that can collectively benefit both the direct service and ongoing evaluation of the program. To date, we have been successful in securing additional funding for our work at the prison and for expansion to two local county jails. We also secured funding to explore the issues of diet and nutrition more closely. Using pilot data from this project, we anticipate applying for a large foundation grant and federal funding within the next year.

CONCLUSIONS

In this article, we have highlighted three lessons learned from our pilot study of the *Minnesota Prison Doula Project*, a prison-based pregnancy and parenting support program. First, we learned that providing quality services for pregnant incarcerated women, and evaluating those services, requires an effective partnership with the MnDOC. In working with a unique population, in an uncommon setting, we learned to make critical adaptations to traditional CBPR approaches. Finally, we learned to identify and secure funding that supports direct service, as well as funding for ongoing research and evaluation, while recognizing that funding for both direct service *and* research is sometimes hard to come by, but ultimately essential when working to meet the health needs of vulnerable populations. Through an effective community–university–corrections partnership, programs and services aimed at meeting the health needs for incarcerated individuals can be developed, implemented, and evaluated. Such lessons may have relevance

to partnerships in other nontraditional settings, particularly with vulnerable populations (e.g., residential drug treatment centers). Engaging these populations in a genuine way may be harder than in traditional settings, but doing so may have a more profound impact on their health and the health of communities.

ACKNOWLEDGMENTS

This work was supported by the Program in Health Disparities Research and the National Center for Advancing Translational Sciences of the National Institutes of Health Award Number UL1TR000114. The content is solely the responsibility of the authors and does not necessarily represent the official views of the National Institutes of Health. This project was made possible by the willingness of women incarcerated at the Minnesota Correctional Facility-Shakopee, the Minnesota Department of Corrections staff, and the doulas' efforts in facilitating groups and supporting incarcerated women during their pregnancies and parenthood. The authors also thank Dr. Cathy Jordan for reviewing an earlier version of this manuscript.

REFERENCES

1. Beck AJ, Karberg JC. Prison and jail inmates at midyear 2000. Washington (DC): U.S. Department of Justice Office of Justice Programs, Bureau of Justice Statistics; 2001 Mar. Report No. NCJ 185989.
2. Glaze LE. Correctional populations in the United States 2009. Washington (DC): U.S. Department of Justice Office of Justice Programs, Bureau of Justice Statistics; 2010 Dec. Report No.: NCJ 231681.
3. Fazel S, Baillargeon J. The health of prisoners. Lancet. 2010 Mar 12;377(9769):956–65.
4. Greenfeld L, Snell T. Women offenders. Washington (DC): U.S. Department of Justice Office of Justice Programs, Bureau of Justice Statistics; 1999 Dec. Report No.: NCJ 175688.
5. Ferszt GG, Clarke JG. Health care of pregnant women in U.S. state prisons. J. Health Care Poor Underserved. 2012 May;23(2):557–69.
6. Mumola CJ. Incarcerated parents and their children. Washington (DC): U.S. Department of Justice Office of Justice Programs, Bureau of Justice Statistics; 2000 Aug. Report No.: NCJ 182335.
7. Maruschak LM, Glaze LE, Mumola CJ. Incarcerated parents and their children. In: Eddy JM, Poehlmann J, editors. Children of Incarcerated Parents A Handbook for Researchers and Practioners. Washington (DC): Urban Institute Press; 2010. p. 33–51.
8. Snell T, Morton DC. Women in prison. Washington (DC): U.S. Department of Justice Office of Justice Programs, Bureau of Justice Statistics; 1994 Mar. Report No. NCJ 145321.
9. Bloom B. Imprisoned mothers. In: Gabel K, Johnston D, editors. Children of incarcerated parents. New York: Lexington Books; 1995.
10. Poehlmann J, Shlafer R. Perinatal experiences of low-income and incarcerated women. Oxford (UK): Oxford University Press; 2014.
11. Bell JF, Zimmerman FJ, Huebner CE, Cawthon ML, Ward DH, Schroeder CA. Perinatal health service use by women released from jail. J. Health Care Poor Underserved. 2004 Aug;15(3):426–38.
12. Knight M, Plugge E. Risk factors for adverse perinatal outcomes in imprisoned pregnant women: a systematic review. BMC Public Health. 2005 Jan;5:111.
13. Clarke JG, Hebert MR, Rosengard C, Rose JS, DaSilva KM, Stein MD. Reproductive health care and family planning needs among incarcerated women. Am. J. Public Health. 2006 May;96(5):834–39.
14. Lu MC, Halfon N. Racial and ethnic disparities in birth outcomes: a life-course perspective. Matern Child Health J. 2003 Mar;7(1):13–30.
15. Apa ZL, Bai R, Mukherejee D V, Herzig CTA, Koenigsmann C, Lowy FD, et al. Challenges and strategies for research in prisons. Public Health Nurs. 2012;29(5):467–72.
16. Brewer-Smyth K. Ethical, regulatory, and investigator considerations in prison research. ANS Adv Nurs Sci 2008;31(2):119–27.
17. Fox K, Zambrana K, Lane J. Getting in (and staying in) when everyone else wants to get out: 10 lessons learned from conducting research with inmates. J Crim Justice Educ. 2011 Jun;22(2):304–27.
18. Wakai S, Shelton D, Trestman RL, Kesten K. Conducting research in corrections: Challenges and solutions. Behav Sci Law. 2009;27(5):743–52.
19. Israel BA, Schulz AJ, Parker EA, Becker AB. Review of community-based research: assessing partnership approaches to improve public health. Annu Rev Public Health. 1998 Jan;19:173–202.
20. Israel BA, Eng E, Schulz AJ, Parker EA, editors. Methods in community-based participatory research for health. San Francisco: Jossey-Bass; 2005.
21. Shlafer R, Hellerstedt W, Secor-Turner M, Gerrity E, Baker R. Doulas' perspectives about providing support to incarcerated women: A feasibility study. Public Health Nurs. 2014 Jul. 1 [Epub ahead of print].
22. Menikoff J. The paradoxical problem with multiple-IRB review. N Engl J Med. 2010 Oct;363(17):1591–3.
23. Minkler M, Wallerstein N. Introduction to community-based participatory research. Community-based participatory research for health: From process to outcomes. San Francisco: Jossey-Bass; 2008. p. 5–23.
24. Hall BL. From margins to center? The development and purpose of participatory research. Am Sociol. 1992 Dec;23(4):15–28.
25. Perez LM, Treadwell HM. Determining what we stand for will guide what we do: community priorities, ethical research paradigms, and research with vulnerable populations. Am J Public Health. 2009 Feb;99(2):201–4.
26. Hatton DC, Fisher AA. Using participatory methods to examine policy and women prisoners' health. Policy Polit Nurs Pract. 2011 May;12(2):119–25.