Original Article

From the Ground Up: Improving Pregnancy and Birth Experiences Through the Provision of Extraordinary Learning Opportunities in Australia

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ABSTRACT

A collaborative project formally titled "Working together to improve pregnancy and birth experiences for women and provide extraordinary learning opportunities for midwifery students" was launched in April 2017, after several years of consultation and planning. The opportunity to adopt an integrated response to the needs of incarcerated pregnant women and the learning needs of midwifery students was identified and supported by the university offering a graduate-entry midwifery program, a women's correctional center, and a health service in a regional area of Australia. Incarcerated women who are pregnant require pregnancy, birth, and postnatal support distinct from their clinical care, while at the same time, midwifery students need to recruit pregnant women for continuity-of-care experiences. This article presents an overview of the implementation of the pilot project. It also discusses the project team and the challenges and successes of and unanticipated opportunities for practice modification and change.

KEY WORDS:

Birthing in prison; continuity of care; incarcerated pregnant women; midwifery students; pregnancy support

Equity in health is a social justice issue. The basic premises of midwifery practice align with the four basic principles of social justice: access, equity, rights, and participation. Incarceration, a means of punishment for crimes against society, includes limitations to persons' rights and abilities to engage with their community. However, the limitations imposed by incarceration should be exclusive of quality health care, and thereby, incarcerated pregnant women should be afforded equitable access to health services. Local and global data indicate that the number of incarcerated pregnant women is increasing (Australian Bureau of Statistics, 2017a; Fritz & Whiteacre, 2016; Williams & Schulte-Day, 2006), promoting a sense of urgency to implement strategies to address equity in access to maternity services.

Incarcerated pregnant women often remain in correctional facilities for the duration of their pregnancy and the postnatal period, leaving the facility only for antenatal appointments and to give birth. The current lack of research-based evidence about incarcerated pregnant women's pregnancy

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and birth experiences is reflected in the subsequent lack of strategies and innovative programs to provide support for these women. Furthermore, because of the strict protocols surrounding incarceration, pregnant women are not able to rely on the support of their partner, family, or friends during the antenatal, birth, or postpartum period. Women who have birthed while in prison report feeling a lack of support during pregnancy, especially at the time of their baby's birth, due to their incarceration (Fritz & Whiteacre, 2016; Kotlar et al., 2015; Mukherjee, Pierre-Victor, Bahelah, & Madhivanan, 2014; Sufrin, Kolbi-Molinas, & Roth, 2015). Ferszt and Erickson-Owens (2008) present a comprehensive list of stressors related to pregnancy and birthing while incarcerated. This list includes, but is not limited to, stress related to the need to visit an offsite care provider, absence of emotional support, anxiety about placement of infant, isolation, parenting concerns, and powerlessness. Although it may not be possible or practical for onsite care provision, it is possible to intervene to reduce stress related to isolation, lack of support, and powerlessness.

It is generally considered that a woman's worldview is influenced by her pregnancy and birth experiences (Grigg, Tracy, Daellenbach, Kensington, & Schmied, 2014). Therefore, it could be postulated that, if the woman has a more positive experience, it may reduce her chance of recidivism, improve health outcomes, and enhance her mothering skills and experiences (Fritz & Whiteacre, 2016). One such strategy is to prepare a suitably skilled future workforce as the providers of such care.

A mandatory component of midwifery education in Australia is to complete a set number of continuity-of-care (CoC) experiences over the student's course of study to meet the requirements for registration for practice as a midwife. The midwifery students are expected to recruit and follow consenting women in their own time, in addition to the expected class attendance, study obligations, and clinical practice. Students often recruit CoC participants from their clinical areas or social networks, which may limit the opportunities for recruiting the required number of participants as well as limit the scope of their experiences. To meet current and future needs of incarcerated pregnant women, an experienced workforce of midwives who are familiar with the unique challenges for this vulnerable group is mandated.

This pilot project, at its inception, had two stated aims. First, it aimed to enhance the quality of the pregnancy and birth experiences for the incarcerated pregnant women. Second, it aimed to extend the learning experiences and professional understanding of the midwifery students while assisting them in recruitment of the CoC participants. The intent was not to challenge or advocate for changes to the existing security and legislative policies but rather to work within existing parameters to improve the pregnancy and birthing experiences of this vulnerable group of women during their current pregnancy and for future pregnancies and to prepare a future midwifery workforce that is cognizant of the specific issues and challenges of working with this group. Overall, it is hoped that this project will contribute to better birth and mothering outcomes, which in turn may impact on social outcomes in the future.

Background

The midwifery profession in Australia has undergone significant changes in the past decade. Despite its historic origins, midwifery has only recently been formally recognized as a profession, distinct and independent from nursing. However, like nursing, midwifery education has transitioned from a vocational training model to tertiary education with clinical practice components over recent years. Now, to be eligible for registration as a midwife with the Australian Health Practitioner Regulation Authority, midwives must complete a program of study accredited by the Australian Nursing and Midwifery Accreditation Council. There are three options for midwifery study in Australia. There are two undergraduate options: Bachelor of Midwifery (direct entry) or a dual-degree Bachelor of Nursing/Bachelor of Midwifery. The successful completion of the Bachelor of Midwifery allows the midwife to register as a midwife with the Australian Health Practitioner Regulation Authority. The successful completion of a Bachelor of Nursing/Bachelor of Midwifery allows the graduate to register as a nurse, midwife, or both. There is considerable debate in midwifery circles about which option is preferred, and it is beyond the scope of this article to enter this debate. The other option for midwifery study is postgraduate studies in a Bachelor of Midwifery (graduate entry) or a graduate diploma. The graduate entry means that students have already completed an undergraduate degree in nursing and receive credit for a portion of the program, recognizing their existing nursing knowledge. Like the graduate diploma, they are registered nurses undertaking postgraduate study in the profession of midwifery (Gray, Taylor, & Newton, 2016).

Regardless of the pathway taken, all midwifery students are required to complete a set number of CoC experiences over the course of their study (Browne, Haora, Taylor, & Davis, 2014). The aim of the CoC experiences is for the students to follow a number of women through their pregnancy to better understand the individual journeys for women, thereby understanding that midwifery care must be individualized and woman centered. In this way, students are exposed to the essential midwifery philosophy of woman-centered care from the very beginning of their midwifery career (Tierney, Sweet, Houston, & Ebert, 2017). Tierney and colleagues (2017) describe CoC experiences as providing a "holistic framework for students to gain diverse midwifery experience and facilitates a nexus for theoretical knowledge and practice" (p. 4). When this program was

implemented in midwifery programs in Australia, students were required to complete 30 CoC experiences in addition to successful completion of their studies and clinical practice requirements to be eligible for registration as a midwife. Over recent years, the professional accrediting bodies have reduced the number required to 20 and then further to the current requirement of 10. Despite the reduction in the number of CoC experiences required, recruiting and fulfilling the requirements for each CoC experience remain challenging for midwifery students. For each completed CoC experience, the student must attend four antenatal visits, two postnatal visits, and, for most women, labor and birth (McKellar, Charlick, Warland, & Birbeck, 2014; Tierney et al., 2017).

Recent research by Tierney and colleagues (2017) and McKellar et al. (2014) highlight the challenges of CoC experiences for midwifery students as identified by experienced midwives, educators, and students. However, despite the educational and philosophical intents of CoC experiences, there are inherent challenges and barriers to successful recruitment and completion for students. The challenges, identified by both students and educators, range from practicality, accessibility, and achievability to encroaching on ill-defined professional boundaries (Browne et al., 2014; Gray et al., 2016; Tierney et al., 2017).

Table 1 highlights the key challenges for CoC experiences and how this project addresses these challenges, thereby showing how the project meets specific educational needs of the midwifery students.

The management of the women's prison had observed over a period of years that there were an increasing number of pregnant women in the facility at any given time. The staff questioned how the current processes and support impacted on the pregnancy outcomes and experiences of the women and their babies. It appears that their observations were consistent with the global trend of increasing numbers of incarcerated pregnant women (Fritz & Whiteacre, 2016; Williams & Schulte-Day, 2006). Current data suggest that up to 10% of the global prison population are women (Bard, Knight, & Plugge, 2016; Ferszt & Erickson-Owens, 2008; Fritz & Whiteacre, 2016; Knight & Plugge, 2005). This is representative of Australia where women account for 8% of the prisoner population as of June 2017 (Australian Bureau of Statistics, 2017a). There was a 7% increase in the number of incarcerated women in Australia in the 12 months up to June 30, 2017 (Australian Bureau of

TABLE 1. How This Project Addresses Current Concerns About Continuity-of-Care (CoC) Experiences

Challenges for CoC	Strategy to address
Lack of recruitment strategies	The opportunity for students to meet with, explain the program, answer questions, give written information, and follow up with the women within the next fortnight.
Lack of university support	Active involvement, consultation, and supervision for the students in a program that is under the auspices of the university, corrective services, and health department.
Time taken for recruitment	The student attends a midwife-run clinic at the prison and is given the opportunity to discuss the program with the pregnant woman, if the woman chooses to.
Poor understanding of the experience by women	There is written information for the women to keep and peruse again at their convenience; "champions" among the corrections officers can answer questions as well as provide written information.
Establishing clear, professional boundaries	There is an increased risk to personal security and safety for students in this environment. However, full training and induction with corrective services are mandated for all students and noncorrective services staff. This also supports the adherence to professional behaviors. Because of the women's incarceration, there is limited opportunity for any social interaction. However, if the woman is discharged before birth, the student is, by signed agreement, only to meet with the woman at the place of birth/appointments.
Women have unrealistic expectations	Informed consent is required for participating women. Written information sheets are provided, and the students, under the supervision of a registered midwife, explain the CoC to the woman, providing the opportunity for the woman to ask questions and clarify concerns.
Students' lack of confidence	At the medical center in the prison, the student is supervised at all times by a registered midwife. If the student accompanies the woman to external appointments, supervision is by the attending medical and midwifery staff. For birthing and postnatal contact, registered midwives supervise the student. Students keep a reflective journal for their CoC experiences and are offered a reflective journal specific to the project. Students are also offered debriefing, the protocol for which is clearly outlined in the project documents, after each visit. Students report that these strategies have improved their confidence in the maternity setting.

Statistics, 2017b). Of these, approximately 80% globally are of childbearing age, and of those, around 10% are pregnant on admission to a correctional facility (Bard et al., 2016; Eliason & Arndt, 2004; Ferszt & Erickson-Owens, 2008).

The current literature about incarcerated pregnant women is limited, with most of the articles from the United Kingdom and the United States. There is an apparent lack of research-based evidence on which policies and processes for incarcerated pregnant women are based. This may be due, in part at least, to this group being a vulnerable group, with challenging social circumstances both inside and outside the prison. The risk factors for vulnerability that are present for most female offenders include those associated with their female gender as well as poor educational levels, poor socioeconomic background, an increased risk of mental health disorders and substance abuse, increased reported sexual abuse (including childhood sexual abuse), and an increased incidence of domestic violence (Abbott, Magin, & Hu, 2016; Dumont et al., 2014). Furthermore, because of the social circumstances and risk-taking behaviors of these women, they have been reported to have an increased number of pregnancies at younger ages, poor obstetric histories, and high-risk pregnancies as well as a lack of engagement with healthcare providers and an associated lack of antenatal care (Kotlar et al., 2015; Price, 2005; Walker, Hilder, Levy, & Sullivan, 2014). For these reasons, it is reasonable to assume that the comparative lack of research with these women may be due to the significant barriers these risk factors pose to the ethical conduct of research.

Perinatal data related to incarcerated pregnant women birthing are relatively difficult to identify within the broader perinatal statistics. This is in part due to the fact that the data do not record the incarcerated status of women. The statewide data relative to this project were taken from the numbers of birthing women who were either admitted or discharged to or from a correctional facility. Although there are fluctuations in the numbers across some years, there is clearly an increase in the annual overall numbers of incarcerated pregnant women birthing from 1999/2000 to 2016/2017, as shown in Table 2.

At the same time, the challenges for midwifery students recruiting CoC experiences in a regional area with comparatively few options for care during pregnancy and childbirth were recognized. Facilitated by mutual contacts, management of the women's prison and the academics involved in the midwifery program met to discuss how the needs of two very different groups could be addressed through development of a mutually beneficial collaboration. As the provider of health and maternity services for the women's prison, the local health service, part of the state health department, was engaged in the discussion. It was quickly identified that, by working together with a common vision to improve outcomes for the women and their babies as well as providing learning opportunities for midwifery students, this small group, with the support of their organizations, may make an impact.

TABLE 2. Episodes of Care for Patients Who Gave Birth in a Queensland Hospital and Were Admitted From or Discharged to a Correctional Facility, Queensland, 1999/2000–2016/2017 (Department of Health, 2017)

Financial year	Episodes of care
1999/2000	7
2000/2001	3
2001/2002	6
2002/2003	12
2003/2004	14
2004/2005	9
2005/2006	9
2006/2007	8
2007/2008	15
2008/2009	13
2009/2010	18
2010/2011	14
2011/2012	7
2012/2013	12
2013/2014	14
2014/2015	28
2015/2016	11
2016/2017	21

Conceptualizing the Project

The conceptualization of the project is represented in Figure 1. The project is built on collegiality, collaboration, and consultation. These processes facilitated agreement on a common philosophy and goals for the project. Each column represents the organizational goals for each of the partners involved in the project. For example, the overarching goal for the corrective services is to correct offending behavior, whereas the goal of the university is to engage with communities through education and research. Finally, the goal of the health service is to optimize health outcomes for an at-risk population. Furthermore, the capstones of the project highlight key values for each organization. For corrective services, the value of learning and working together is presented. From the university's perspective, the value of doing, not only talking, is presented, while promoting well-being as a value of the health service is highlighted. From the outset, this project intended to meet the individual needs of a vulnerable group of women and their babies as well as provide valuable experiences for the future midwifery workforce,

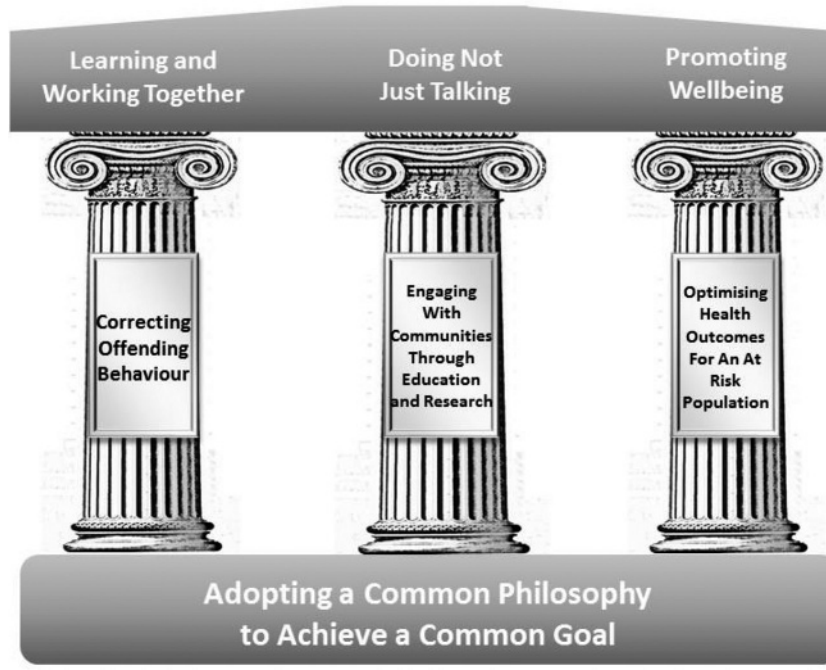

FIGURE 1. Working together to achieve project outcomes.

which clearly aligns with the strategic intent and organizational values for the partner organizations. Moreover, it further illustrates that, when a group of likeminded individuals with similar worldviews and professional goals come together and have open discussions, instigating change need not be overwhelming or onerous. It is the belief of the project team that it is because of this foundation that the project has contributed significantly to the relatively smooth implementation and initial successes of the program.

How It Works

This project revolves around providing nonjudgmental, unbiased support and advocacy for a vulnerable group of women. As such, the midwifery students and the supervising midwifery academics do not access the woman's medical or custodial history. When students recruit women for CoC experiences in the community, they do not have access to confidential medical histories. In this way, the project more closely aligns with the community-based experiences for students. Awareness of medical and social histories is important when planning and providing midwifery care as healthcare professionals. However, as the students are providing support and advocacy, rather than a clinical service, this information is gained from the woman as the relationship builds. Interestingly, to date, the women's disclosures to the students have been open, frank, and honest. All members of the project team, including the midwifery students, who were not employees of the prison, completed security checks and a full induction/orientation to the facility. The midwifery students attended the medical center in the facility fortnightly (every 2 weeks), as supervised by a visiting midwife from the local health service. If this midwife is not in attendance, one of the midwifery academics from the university supervises students for their meetings with the women.

The smooth implementation of the project appears to be primarily a result of the project team members adopting a similar philosophy. This attitude to achieving the desired outcomes, supported by each organization, has allowed for innovative and prompt responses to potential challenges to the ongoing success. For example, the process for transferring laboring women to the local hospital has been altered slightly to allow for relevant custodial staff to phone the midwifery student to meet the woman at the hospital to provide support for labor and birth (if the woman has invited the student to attend). In this way, this project is rare, if not unique, in that it is organic, driven by those at the coalface (frontlines) who could see a gap and were willing to work together to achieve change.

The Project in Place

As outlined previously, the key aim of this project was to provide support for incarcerated pregnant women and extraordinary learning experiences for midwifery students. However, as the project unfolded, a third essential element was identified. This project required engagement with custodial officers. Most of the custodial officers embraced the concept and were eager to take an active role in the project. At this point, the project team realized that we had an opportunity to influence procedures and practice to

optimize outcomes for the mother and her baby. This became the third aim of the project. As described by Ferszt and Erickson-Owens (2008), positive relationships with custodial officers can positively influence the women's experiences. Thus, it was imperative to gain the support and active participation of the corrective service officers who work alongside the women. Ten custodial officers volunteered to be "champions" of the project.

These volunteers have been provided with additional in-service education about the project and its aims and objectives as well as education about imminent birth and supporting the women. However, given the nature of the custodial role and shift work, it has proven very difficult to bring all of the champions together for training sessions. The project team considered how to provide relevant education and access to resources to ensure that the champions were supported in their role. The development of online resources was considered, but the resources needed to be easily accessed, often external to secure organizational networks. The team adopted e-learning strategies to meet the needs of the officers within the scope of the project.

Contemporary advances in computer processing, unit development, and information sharing mean that education can be made readily available to users. The reality that most people in developed countries use some form of portable device has enabled education delivery to be responsive to individual needs (Hills, 2003; Hwang & Tsai, 2011; Ingle & Duckworth, 2013). Correctional officer access to mobile devices is dependent on facility policy, procedure, and level of security. In any case, the software is downloaded onto the desktop computers in the officers' work areas for them to access. The advantage of the mobile learning resources is evident when officers are able to access information in a timely manner or outside the work environment. The pilot project employed the use of industry-recognized online publishing software, Atavist. This software allowed the project team to provide educational materials and resources to all participants on a range of devices from desktop computers to handheld devices. The educational and resource materials can be printed within minutes, ensuring all participants are accessing the most up-to-date information, using a minimal number of steps for access. External links ensure that, as well as providing the most up-to-date information, copyright and intellectual property rights are adhered to.

The students participating in the project to date have described the experience as a wholly positive one on a number of levels. Both written and verbal feedback received from students has shown a great enthusiasm for being part of this innovative project and an eagerness to further extend their learning experiences by continuing to support this group of women. As part of the midwifery program, midwifery students are required to maintain CoC reflective journals for each of the women who they recruited and cared for throughout pregnancy, birth, and the postnatal period. These journals are accessed and graded by the midwifery academic team as part of the students' summative assessment. The students feel that participation in the project has benefited them on both professional and personal levels. A positive impact has been described on the development of both their interpersonal skills and confidence levels and, furthermore, has given them a sense of purpose and a feeling that they are really making a difference.

In addition to the students' reflective journals, which are part of their formal studies, all project team members, midwifery students and champions, have been issued with reflective journals to record their thoughts, impressions, and understandings over the course of their involvement. The added insights gained from the reflective journals may, in future, lead to further practice change. Reflection is a tool to promote learning and understanding of a specific situation, a purposeful activity that requires the reflector to ask questions of themselves and their interactions with others, which focus on what happened and what they did (Thompson & Pascal, 2012). As well as considering a particular interaction or event in the context of everyday duties, consideration should also be given to how it relates to the project. The most effective time to reflect is as close as possible to the situation to enable accurate recall of events, supported by the mobile nature of the simple journal.

It is recommended that a clear model of reflection be used to assist in guiding reflective thought (Nicol & Dosser, 2016). Incorporated into the educational sessions and online resources, Gibbs' (1988) Reflective Cycle was used to guide reflections. Using the step-by-step approach of the Gibbs model develops self-awareness and emotional intelligence by prompting the reflectors to explore their emotional response to a particular event. Engaging with the positive and negative aspects of an event can be challenging and requires a level of honesty with self (Nicol & Dosser, 2016). Using Gibbs' Reflective Cycle requires the reflectors to describe the interaction or event and identify their feelings about the situation before analyzing the situation through seeking information and clarification. The final step is to create a plan to deal with future situations and consider changed approaches, using what has been learned through this reflection and lived experience (Gibbs, 1988). The value of using a reflective cycle is that it will improve self-awareness, skills, and knowledge for the project champions, improving their professional practice and self-development (Leigh & Bailey, 2013). In this way, reflection plays a pivotal role in the ongoing project development, implementation, and evaluation.

Implications for Clinical Forensic Nursing Practice

There are significant implications for clinical forensic nursing practice when providing care, within this project

framework, for incarcerated pregnant women as well as the possibilities to provide learning experiences to enhance midwifery students' knowledge and understanding. Furthermore, the potential for better outcomes for mother and baby and the potential for changes in behavior and recidivism are apparent. A large-scale change in socioeconomic and family situations for at-risk populations needs both a top–down and a bottom–up approach, and the possibility is that this project and others like it may contribute to a noticeable change in circumstances for women and children in this demographic.

This project shows that supportive woman-centered care can be implemented and embraced in correctional centers that do not impede or obstruct custodial practice. There may be workforce/workload implications related to skill set and scope of practice for the supervising midwives and the midwifery students. However, as shown in the framework of this project, if consideration is given to the potential implications at the planning phase, there is minimal effect for staff. Generally, the tasks/duties required of project team members can be well achieved within their usual work.

This project also shows that staff from all areas embrace the opportunity to make a difference, receive additional training, and contribute to ongoing practice review and quality improvement. This project was done on a zero budget, with team members working with the knowledge and consent of their employers as appropriate around core responsibilities. For the university staff, their employment contracts include mandatory community service hours, which has supported their time on the project. Furthermore, the provision of in-service training for corrective service officers by the university, security induction/orientation for university staff and students by corrective services, and supervision of the midwifery students by health department midwives visiting the prison were done "in kind." Although it is not an expensive endeavor, the potential outcomes are invaluable.

Future Directions

The full potential and scope of this project were not apparent at its inception and implementation. Perhaps, this was fortuitous. In this way, the project team was not overawed or disheartened by the potential scale of what lay ahead. However, it was expected that the collaborative approach across diverse disciplines would highlight key areas, challenges, and solutions as the project evolved. What was not anticipated was the genuine interest in the project by the incarcerated pregnant women, which has been pivotal to the project success to date. Ethics applications are being finalized and will be submitted in the near future. The initial research arm will involve the corrective service officers, seeking to understand if involvement in the project has influenced or changed their worldview and if, as a result, there have been any changes in custodial practices.

The project team is working with Birth Companions UK to develop an Australian version of the Birth Charter, based on the UK Birth Charter that is endorsed by the World Health Organization, Royal College of Midwives, and United Nations Children's Fund (Kennedy, Marshall, Parkinson, Delap, & Abbott, 2015). It is anticipated that this document will provide the framework to guide practice and ensure consistency and quality in maternity services for incarcerated pregnant women. Throughout the project, the team has been fortunate to receive consistent support from all stakeholders both internal and external to the organizations. Communication, usually via email or team meetings, has been open, timely, and constructive.

The project team continues to be astounded by the impact of the project. It could be argued that by establishing a common philosophy and commitment for all project team members at the outset preempted many possible challenges and barriers. Furthermore, linking together a team of experienced professionals in the specific fields associated with the project allowed for the multifaceted and multidimensional view, again from the outset. The success to date of this project and potential influences on future practice indicate that making a difference is not a difficult concept when the key stakeholders all have a similar declared philosophy—making a difference can be achieved from the ground up.

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