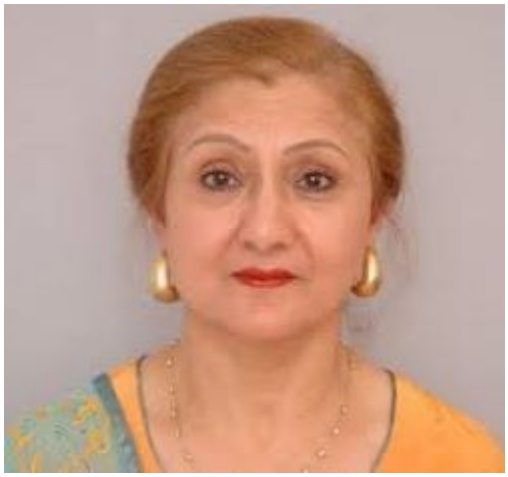
AIMS For a better birth...

An Interview with Kuldip Bharj by the AIMS Campaigns Team

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Kuldip Bharj

Many different organisations and individuals play a part in the mission to improve UK maternity services for all, and midwifery educators play an important role in the maternity services improvement community. In this interview, the AIMS Campaigns Team talks to Kuldip Bharj, who has spent over 40 years of her career in midwifery, including roles in education, research and practice. Throughout her professional life, Kuldip has been dedicated to excellence in healthcare services, with a particular interest inthe provision of services which are responsive to the needs of local communities. Kuldip was awarded an OBE in 2009 for her dedication and services to healthcare for communities in Leeds.

Interview by Jo Dagustun

Thank you for agreeing to be interviewed by AIMS, Kuldip. To start, can you tell us more about what drives your interest in a well-functioning maternity service and what first attracted you to the idea of becoming a midwife?

I have a keen interest in the social fabric of maternity services and the colourful threads of women, their babies and families, midwives, obstetricians and other healthcare professionals which weave through it, making beautiful designs.

I am deliberating as to what a well-functioning maternity service looks like. This would be a maternity service that is woman- and family-focused, culturally sensitive and appropriate to maintain health and reduce inequalities of health. A well-functioning maternity service is critical for the health and wellbeing of women, their babies and their families, as well as the clinicians who care for and support them.

At a very young age, I was attracted to caring, being inspired through early readings about the role of Florence Nightingale, I did not know about Mary Seacole then! It therefore came as no surprise that I entered nursing. During my nurse education, experience on the maternity wards, I was inspired to pursue a career in midwifery. Essentially, it was the privilege of being part of women's most sensitive journey that touched me most.

You have had a distinguished career as a midwifery educator, latterly at the University of Leeds. Why did you move into teaching, and what for you are the essential qualities of a good midwifery lecturer?

The best part of my professional life has been spent in midwifery education and I have very fond memories of it. Becoming a midwifery lecturer was not on my career radar. My talent in facilitating learning and teaching was identified in the early stages of my midwifery career, coupled with my ability to work with diverse communities and deliver culturally sensitive care. I was made responsible for delivering antenatal education classes for 'Asian' women – a role that I quickly extended by developing specialist classes for Asian women who had a limited ability to speak fluent English. I intuitively took on the role of interpreter and assisted many women and their families to overcome language barriers. I developed particular expertise in working with families who experienced disadvantage, for example women from poorer backgrounds, those from the Black, Asian and minority ethnic (BAME) communities and with teenage women.

In addition, I took particular interest in the education of learners on the wards, ensuring that they received high-quality clinical experience. My aptitude was recognised when I was seconded to work in the School of Midwifery. I demonstrated commitment to my own development through undertaking continuing professional/educational development programmes. In those days, such programmes were not easily accessible and support to undertake them was not readily available. I worked hard to convince senior managers to support me.

In terms of the essential qualities of a 'good' midwifery lecturer, I firmly believe that a midwifery educator is the orchestrator of creating a learning environment within which learners acquire the competence of 'becoming a midwife'; essentially, midwifery educators need the competence to 'be with the learner.'. The learners must be seen as equal partners and should be treated with respect, kindness and compassion. Some of the qualities of good midwifery educators are open-mindedness, approachability and – importantly – the ability to develop constructive and trusting relationships. The midwifery educator should operate fairly and equitably, meeting the learners' individual needs. Over the years, the needs and expectations of midwifery learners have changed, bringing about a radical shift in pedagogical engagement, including student-centred inquiry and problem solving. Good midwifery

educators need to be everything for the learners that a good midwife is to the women and their families.

Since the late 1990s, AIMS has been concerned that the UK maternity services do not always work from a physiology-informed perspective. How did you seek to address this issue during your teaching career?

I have seen a colossal transition in midwifery services over the past decades; they have altered beyond all recognition. Midwifery learners need to have a good understanding of physiology, as well as a good understanding of when and how medical intervention might be required, so that they are effectively prepared to work in complex settings. Many midwives' narratives highlight that they often come into conflict with organisational demands, due to their desire to provide physiology-informed care. Such conflicts do little for the delivery of woman-centred care and leave midwives dissatisfied, adversely affecting their confidence.

The philosophical underpinnings in my teaching and learning that address the above tension have been that midwives should work 'with women,', identifying women's personal and maternity needs; based on these, they develop care and management plans that suit the women and their families. There is a significant amount of evidence which confirms that whilst interventions in childbirth prevent harm and save lives, many women are subjected to unnecessary interventions which can be harmful too. Clearly, achieving a balance is important.

In 2007, you completed your PhD studies, in which you explored the experiences and context of Pakistani Muslim women birthing in Northern England. Can you tell us a little about your key learning from that?

Throughout my professional life, I have championed the equality agenda and have sought to bring the voices of all women and students, in particular those whose voices are seldom heard, from the margin to the centre. In my doctoral thesis[1],

I set out to provide a platform for the voices of Pakistani Muslim women, promoting and enhancing their role as consumers of maternity services to shape future maternity services which respond effectively to their needs. Some of the key learning points highlighted by this study were: a) Pakistani Muslim women do not have unique needs during childbirth; however, their needs continue to be unmet; b) for Pakistani Muslim women, there were persistent service quality issues, despite many attempts to modernise maternity services; and c) ethnicity is an important marker, in that experiences of women from a Pakistani Muslim background are worse than those of their 'White' counterparts.

Whilst some Pakistani Muslim women in this study communicated positive experiences during their encounters with maternity services, many narrated negative experiences. Many women in this study valued their relationships with the midwives. They saw midwives as being instrumental in their birth journeys, either making or marring their birth experience. When they did not secure professional support, they turned to 'Allah' during their uncharted birth journeys.

This work paved my way to working in strategic roles within the healthcare sector to shape and develop services to provide appropriate and relevant care to women and families from diverse backgrounds. I was instrumental in developing and ensuring that healthcare education prepared future healthcare practitioners to provide anti-discriminatory, culturally competent care. Furthermore, I engaged in research activities to generate knowledge in the field of ethnicity and diversity.

In 2008, you co-authored a briefing paper for the Race Equality Foundation, 'Addressing ethnic inequalities in maternity service experiences and outcomes: Responding to women's needs and preferences'[2]. Thirteen years on, against a backdrop of continuing inequalities, the key messages in that paper seem remarkably familiar. What do you think have been the key barriers to the much-needed progress in this area and are you optimistic that the current focus on the very same issues will now lead to some resolution?

I have been an advocate for equality in education and practice from as early as the 1970s, with publications in this field dating back to the 1990s. Disappointingly, despite numerous interventions the body of evidence persistently highlights that women from the BAME backgrounds experience poor clinical outcomes in terms of mortality and morbidity and that their satisfaction levels and maternity experiences are worse than those of their White counterparts.

The continuing ethnic disparities is without doubt disturbing; however, it is important to acknowledge that this is not due to inertia of the UK's NHS. One of the challenges for the delivery of equality in contemporary maternity services is that the UK is increasingly ethno-culturally and linguistically diverse This creates opportunities and challenges for its economy and its social welfare system, including the delivery of maternity services.

The 'equality, diversity and inclusion' agenda is enormous and complex. When organisations attempt to address all the protected characteristics collectively, in my opinion, this dilutes the issues and potentially adversely affects the achievement of outcomes. Nevertheless, the agenda of 'Race' equality now appears to have been renewed; there is a focus on structural racism within the NHS, and there is a spotlight on maternity services through Parliamentary debates, the Birthrights inquiry[3] and campaigns such as Five X More[4].

A considerable synergy is needed between national commitments and the local provision of maternity services for women from the BAME backgrounds. Commissioners of maternity services need to play a central role in the translation of central government policies into service configurations and delivery of maternity services. Equality or inclusiveness are not add-ons; they **must** be embraced wholeheartedly with a paradigm shift in the culture of the organisation.

Midwives and other healthcare professionals need to work differently, reaching out to all women and providing the care they want. Midwives are the bedrock of maternity services and essentially contribute to improving outcomes for women and their babies. There are, of course, numerous challenges, such as how to promote midwifery as a career of choice and how to create a culture that encourages midwives to

remain in the profession. Evidence confirms that a significant number of midwives from the BAME backgrounds do not enjoy the same promotion prospects as their White colleagues and are not always treated with dignity and respect. Much is needed in this area: for organisations to have an open-door policy, reaching out to midwives from diverse backgrounds and improving promotional prospects for staff from the BAME backgrounds, including by looking at their own organisations to see who is at the upper and lower echelons. I have argued that for staff in the NHS and the higher education sector, it is not a glass ceiling but a concrete ceiling.

In England this year, we are marking the fifth anniversary of the 2016 'Better Births' report. In your opinion, how much of an impact has that report had in driving maternity service improvement so far, and what parts of its agenda are you keen to see delivered still?

Over 20 years ago, the 'Changing Childbirth' report was a watershed in maternity services, enshrining the concept of woman-centred care; humanised and responsive care including the three 'Cs': choice, continuity and control. Disappointingly, the aims of 'Changing Childbirth' were not fully achieved due to a number of constraints. Nonetheless, what is exciting is that the publication of 'Better Births' has been underpinned by financial resources and people to deliver its aspirations. There have been several achievements within the Maternity Transformation Programme: for example, continuity of carer has been rolled out in some areas.

I would like to see this model of care rolled out for all women from the BAME backgrounds. I would like to see 'personalised care' become a reality for women, where they experience kind, compassionate and respectful care. For this to happen, it is essential that maternity services communicate effectively with those women who do not fluently speak and understand English. The evidence continues to highlight that the use of interpreters remains less than satisfactory, and if the ambitions of the 'Better Births' report are going to be realised then this issue needs to be a priority.

The campaigners for improved maternity services need to continue with their efforts to ensure that the maternity services are effectively resourced, so that they can provide and deliver safe and equitable services.

What do you think is the biggest challenge faced in maternity service improvement work in the UK today?

First of all, we must recognise that the British maternity services are the envy of many countries and are one of the safest at a global level. However, this does not mean that all is well. Maternity services have been under the limelight because of recent scandals where midwifery has been found to be seriously sub-standard. Investigation reports into maternity services persistently highlight the toxic organisational cultures which drive inertia, making organisations dysfunctional. This clearly must feature high on the improvement agenda.

One of the biggest challenges faced in maternity service improvement work is to look beyond 'hard' clinical outcomes such as perinatal mortality and consider the factors, including human factors, which

propel effective working within organisations; namely, respectful relationships between clinical teams and women and the services.

The UK has some of the best evidence, policies and targets for maternity services: the challenge is to embed these into practice, so they become part of maternity services' fabric.

AIMS celebrated its 60th birthday last year. Looking forward, how do you think AIMS might best focus our limited resources to help ensure improved maternity services for all?

What an achievement reaching a prime age of 60 and 61 now – well done for this. The work of AIMS has been phenomenal and has made remarkable inroads in maternity for the rights of women and for the betterment of women's childbirth journeys.

Currently, many women and in particular women from the BAME backgrounds are experiencing horrendous inequalities and it would be great to see AIMS further engage and strengthen its work with women from the BAME communities, ensuring that their voices are really heard and acted upon.

I wish AIMS all the best to keep the impetus and energy to champion and astutely drive the change to improve maternity services.

Thank you for giving me this opportunity to share my thoughts with you.

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[1] Bharj, Kuldip K. (2007). *Pakistani Muslim women birthing in Northern England: Exploration of experiences and context*. Doctoral thesis, Sheffield Hallam University: http://shura.shu.ac.uk/20627
[2] Race Equality Foundation, 'Addressing ethnic inequalities in maternity service experiences and outcomes: Responding to women's needs and preferences': https://raceequalityfoundation.org.uk/wp-content/uploads/2018/03/health-brief11.pdf
[3] Birthrights, 'Inquiry into racial justice in maternity services: Call for evidence': www.birthrights.org.uk/inquiry-into-racial-injustice-in-uk-maternity-services
[4] Five X More homepage: www.fivexmore.com