

# **A Fine Balance**

Children's Community Nurses perceptions and practices regarding children's rights to health: A Discourse analysis.

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## **Attestation of Authorship**

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material published or written by another person nor material which to a substantial extent has been accepted for the qualification of any other degree or diploma or university or other institution of higher learning, except where due acknowledgment is made in the acknowledgments.

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**Key**

For the purposes of confidentiality numbers and letters are used to identify participants. These are: 1A, 2B, 3C, 4D, and 5E. These prefix abbreviations that are used to denote the occupational group of the participants

PN = Plunket Nurse

PHN = Public health nurse

HCN =Home care nurse

[ ] denotes researcher inserted words to enhance the meaning of participants verbatim excerpts .

... indicates abridged passages



## ***Abstract***

The aim of this study is to analyse the discourses drawn upon by community paediatric nurses in relation to children's rights to health. The philosophy of Michel Foucault has been used to underpin the analysis of the interviews and exemplars of five experienced community nurses, revealing conflicting power relationships and discourses.

Rights are formalised morality and so from a children's rights perspective, discourses reflect both the moral and ethical positions of the nurses. Children are constructed as developing human beings whose moral status gradually changes and who, through a lack of developmental autonomy, entrust their decision-making to their representatives (parents and caregivers) as their trustees. Rights are correlative with the obligations and duties toward children by both families and society. Society constructs legislative and politically organised structures to govern raising children because children are an intrinsic social concern.

Whilst representing society's interest in children's rights to health, nurses in the home act as a conduit for multiple governing structures. The nurses in this study construct their "truths" and knowledge about children's health rights from nursing, medicine, law, education, and social policy. However, the values of individual parents can conflict with universal values for children's health and wellbeing. Therefore representing society positions nurses as "agents of the state", a role that potentially holds power over parents and children and leads to the epithet of "the health police". Within the institution of the family, and in the privacy of the home, there are also mechanisms of power that can resist the mechanisms of the state and its representatives. Therefore the discourse "it takes a village to raise a child" competes with the "my home is my castle" discourse. Nurses negotiate a fine balance between these power relations. Nurses are challenged with using power productively to promote children's rights whilst respecting the role of parents and families. I argue that children's rights are central to the moral and ethical work of nurses but that such work is often obscured and invisible. I propose that children's community nurses are excellent at negotiating networking and connecting at a micro level, but need to create a more sophisticated and cohesive entity at a macro level to become fully political children's rights advocates.

## Chapter 1: Introduction

### ***Background to Study***

Article 24: States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.

(United Nations Convention on the Rights of the Child, 1989)

The United Nations Convention on the Rights of the Child (1989) (UNCROC) is the most widely ratified international convention. It is an aspirational and formalised moral code for the fair treatment of children. This study looks at what a commitment to the principles of UNCROC, particularly Article 24 cited above, really means for children's community nurses. This thesis uses a Foucauldian discourse analysis approach to reveal the regimes of "truth" articulated in the debate regarding children's rights to health. Rights claims make visible a situation's network of power relations, so that the moral connections might be strengthened, and people might become more committed to one another's moral agency, authority, and responsibilities. Moral rights consist of an ethical principle or condition that customarily governs behaviour granting all members of society a particular claim or liberty, and all of the associated rules that constitute the protection of that liberty or claim. Such rights are morally justified as being in the best interests of the individual members of the society. Basic human rights are those of life, liberty, property, and freedom from harm (Freeman, 1997; Johnson, 2004). Foucault defines ethics as how people behave in relation to moral norms which are the sets of rules prohibitions and codes for society (Danaher, Schirato, & Webb, 2000).

The aim of this study was to identify and analyse the discourses articulated by community children's nurses when they described barriers to children achieving their right to health. Foucauldian discourse analysis allows for texts to be deconstructed to uncover the discourses and practices between nurses and families. It has the potential to illuminate the complex interactions between nurses and families and highlight the essential tensions between the public and private worlds. In particular Foucault's ideas about: power and resistance, knowledge, discipline, governmentality, and pastoral power are significant to an analysis of children's rights to health from a nursing perspective.

I have chosen this topic because I am passionate about my work as a children's community nurse. The literature on children's right to health from a nursing perspective is scant; I have found no other published research involving interviews with a selection of children's nurses working for different services in the community child health in New Zealand. Article 24 of the United Nations Convention on the Rights of the Child, cited at the start of this chapter, suggests that positioned within the children's rights discourse, I am an agent of the "states parties". The inference from reports on the status of children's health in New Zealand is that the "system" (which includes nurses), is failing in its obligation to meet the rights of the child to health. Children's health status in New Zealand lags behind many developed countries as demonstrated through epidemiological measures of preventable disease, mortality, morbidity, and injury (UNICEF\*, 2007). Evidence that many childhood deaths and hospitalizations in New Zealand are preventable suggests that the health system is not adequate (Ministry of Health (MOH), 1998a; 1999; 2002a; 2002b). An added consequence of the failure to meet the moral obligation of ensuring children's rights to health is the impact on society as a whole. A number of studies from the internationally acclaimed longitudinal studies from the Dunedin cohort have contributed to the discourse of the "long reach" of childhood. The "long reach" discourse indicates that childhood health contributes to violence, criminality, mental health and sexuality issues, and poor educational achievement (Ministry of Social Development (MSD), 2004). Nurses are implicated in the national failure to achieve a healthy childhood, and as a consequence contributing to societal malaise. Thus, I believe it is vital to look at what nurses perceive as the barriers to meeting their obligations.

### ***Assumptions***

In a postmodernist approach to discourse analysis it is important to situate the researcher firmly in the research and acknowledge my partiality and reflexivity. Understanding ourselves and our experience depends on the discourses that shape our behaviour and influence our insights (Cheek & Porter, 1997). The use of personal pronouns

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\* UNICEF is now known by acronym only

will be interspersed throughout this thesis as it is important to be explicit from the outset that I share the occupational speaking position of the participants of this study.

I come to this study with nearly thirty years of experience in nursing children. I have worked in public and private institutions and been employed as a private nurse in homes, and worked as: a neonatal nurse, paediatric oncology nurse, child disability nurse, paediatric liaison nurse, research nurse, public health nurse, and currently as a children's visiting nurse (home care). I have worked in both metropolitan areas and provincial areas: in New Zealand, England, and the United States; and with the children of the wealthy and the poor. Despite my years of experience at the "coal face" my consciousness of children's rights activism is only just evolving. I am aware children's rights are an ethical and moral field and that there are no black and white solutions. My views are coloured by the intertwining of my professional and private lives. As a mother and a daughter I know that there are multiple "truths" and where children's rights are concerned none of us are "perfect"

The right to health in particular is a specific area in the rights discourse that concerns nursing practice. There are numerous definitions and analyses of the concept of health (Seedhouse, 2001). The dominant definition of health within nursing is that health is not merely the absence of disease, but a holistic and all encompassing phenomenon (Jones & Meleis, 1993). My personal conception of the role of disease must be acknowledged, since my understanding of disease colours my approach to children's right to health. I have a subjective understanding of what illness does to quality of life. I therefore acknowledge that I am a bearer of discourses. I have had personal experience of acute and chronic illness and its physical, mental, and emotional impact upon personal potential, equilibrium, and wellbeing. Nursing care of individuals and families dealing with illness, disability, and death, has given me a passion to help alleviate the impact of the phenomenon by using both professional and personal insights and competencies. Whilst I acknowledge that adversity can create remarkable life enhancing experiences, I believe that it is preferable not to have a sick or injured child. Therefore whilst I accept I work "for health", my primary concern is to work "against disease."

Based on experience, my basic assumptions are that nurses are situated uneasily between often competing discourses, and are often isolated from dialogue with those working in other disciplines. I believe that nurses may experience power struggles and conflicts of interest when working for morally justified, best interest principles, for children's health. These struggles appear at both a macro level within the profession and government, and a micro level within organisations and within families.

### ***Current relevance for the study***

I have used the controversial events around high profile child abuse cases as a springboard into an analysis of the interplay between the children's rights discourse and the power relationships in children's community nursing. Recent high profile child abuse and neglect cases in New Zealand have raised public questions about the role of health care professionals in relation to the realization of children's health rights. On occasion these questions have been directed toward community nurses who enter the private realm of the family home, or are present in schools.

In the aftermath of the death of twin ex- premature babies in South Auckland, I attended a hui to discuss what had occurred and what could be done to prevent such tragedies in the future. It is standard practice in healthcare institutions that nurses and other health workers do not speak directly to the public, in order to protect nurses' identity and to maintain patient confidentiality. A District Health Board spokesperson from the communication department delivered an official statement at the hui to assert that there was no culpability by medical and nursing staff. There was also an address by a politician who had entered the home to offer liaison support for the family after the homicide. The politician described the resistance and barriers to his presence in the home after the event. This led me to question the nature of the resistance and barriers to the presence of the children's community nurse visiting the home in the weeks leading up to the tragedy.

The hospital communication officer was responding to a public perception that "somebody" should have intervened before the family of the babies murdered them. The New Zealand Herald (25th June, 2006) noted that nurses had raised concerns about parental lack of visiting while the babies were in hospital, but that this did not reach the

“threshold” required for intervention by welfare authorities. There was also an inference that the home visiting nurse had failed to identify the risk potential or assess for signs of abuse, since autopsy had revealed an historical rib fracture, whereas the nurse had recorded healthy well-fed babies. To me this points to the vulnerability of nurses working independently behind the closed doors of the private realm of the home.

Throughout the public debate nurses have been referred to by others but nurses themselves have been silent. Silence is used in many ways; it can be seen as a position of power by withholding information from the public, and it is also a powerless position when oppressed groups are forbidden to speak. I believe there is a hidden discourse around the nursing relationships with families that only gets heard in the court rooms when such cases come to trial.

### ***Children’s community nursing***

#### ***Definition of children’s community nursing***

Foucault defined discourse as systems of; ideas, attitudes, beliefs, practices, and courses of action, that shape people as to who they are and what they do (1972). He emphasised how current truths are constructed and maintained and what power relations they carry with them. Therefore, from Foucauldian perspective, the discourse of children’s rights, or the moral place of children in society, conforms with, circumvents, or contests existing power-knowledge relations. Who Plunket, public health nurses, and home care nurses are, and what they do, is relevant to situate the analysis of what they think and do about children’s rights. The practical use of nursing knowledge, in order to prevent and treat disease using biomedical and psychosocial knowledge and to foster individual behaviour modification, is a form of governmentality (Foucault, 1979) and biopower (Foucault, 1990; Perron, Fluet & Holmes, 2005).

It is estimated that 90% of health care services are provided in the community and only 10% in hospital inpatient settings (Compton & Ashwin, 1992). Children’s community nurses come under the umbrella term of “primary health care nursing” (Cain Hyde & Howkins, 1995; Hughes & Calder, 2006; McEwan, 2002; McMurray, 1993; Sidey & Widdas, 2005). This refers to the practice of registered nurses who provide care in the

community and outside the hospital in a variety of settings, including community based clinics and people's homes (MOH, Primary Health Care Strategy, 2001). While the Primary Health Care Strategy has an ambition to create integrated teams based in Primary Health Organisations (PHO's) the practice of community nurses currently occurs across a range of stakeholders: District Health Boards (DHB's), General Practices (GP's), Public Health Organisations (PHO's), and Non Government Organisations (NGO's) (Kent, Horsborough, Lay, Davis & Pearson, 2002).

Primary health care nurses for children include: public health nurses, Plunket nurses, practice nurses, home care nurses, midwives, district nurses, rural nurses, nurses providing care to specific groups (e.g. respiratory and diabetic patients), nurses in Accident and Medical centres, school nurses, and Māori and Pacific health provider nurses. The range of activities may be quite narrow for some nurses, while others will have broad roles encompassing health promotion, prevention and surveillance activities, home-based care, disease management, and wellness care (Kent et al., 2002). The vision and the new directions of the Primary Health Care Strategy involves moving to a system where nursing and other community services are organised around the needs of a defined group of people (Hughes & Calder, 2006; MOH, 2001). The role of a generic Family Health Nurse (FHN) is one of the alternative roles being examined and has been trialed in other parts of the world (Thompson, 2008).

The concept of a generic family health nurse is not new. As with other specialisms in nursing, community health nursing has evolved with different types of service responding to specific needs at specific times (Cain, Hyde & Howkins, 1995; Hughes & Calder, 2006; McEwan, 2002; McMurray, 1993; Sidey & Widdas, 2005). The role and function of services is variable between areas. In the 1980's Massey University Department of Nursing Studies attempted to rationalize the role of the community nurse, using a process study that combined the public health and district nursing roles. Their conclusion was: that immediate health needs took precedence over prevention and promotion activities, and that generalist nurses were unlikely to be able to provide the scope of practice that communities deserve (Kinross, Nevatt & Boddy, 1987). Current thinking is that the complexity of community health care needs requires multiple approaches that collaborate

(Cain, Hyde & Howkins, 1995; MOH, 2001). Whiting and Miller (2005) argue for a “common knowledge base across different children’s community nurse practitioners that acknowledges the crossover of the primary functions of health promotion and clinical treatment” (p.158). In the following pages I examine the roles of the three different nursing services sampled for this study in order to situate the study within the discursive practices that dominate each sub discipline.

### ***Plunket nursing***

Plunket nurses have a brief to see most families of children under 5 years in their own homes initially, and then in clinics or other community settings (MOH, Well child/ Tamariki Ora National Schedule, 2003). Plunket Nurses assess children's developmental progress. They also give parents information about keeping children safe and support families by linking them to community networks. Currently, Plunket hold the contracts for approximately 85% of the Well Child service provision (Plunket Society, 2007). As a nation-wide health provider, Plunket supports the key national child and family health goals established by the New Zealand Ministry of Health in 1998. The dominant discourse of Plunket movement promotes the concept of the “well child,” thereby inherently endorsing the child’s developmental, survival and protection rights. Using a children’s rights framework I interpret Plunket nursing as having a particular focus on the developmental processes of infants and young children. This is symbolically and functionally represented by tools employed by Plunket nurses to weigh and measure growth, and to test cognition and physical maturation. The psychosocial care provided by Plunket nurses is not as tangible, but it is clear from the strategic guidelines and history of Plunket that it is an essential part of the ethos of the service (Bryder, 1998; 2002; 2003; Plunket Society, 2007)

### ***Public health nursing***

Like Plunket nursing, public health nursing is also defined as “primary prevention,” which means preventing disease, injury, disability and premature death (MOH, 2002a; Nies & McEwan, 2007). It also follows a “well child” approach. As members of a multidisciplinary team, public health nurses work with local communities to assess and prioritize the major health problems, and work on a plan to alleviate or eliminate these problems, and the conditions that contribute to their development (Smith, 2002). As with



the recent trends across the health care system the emphasis is now on the multidisciplinary nature of public health work as evidenced by the recent formulation of generic competencies (Public Health Association (PHA), 2007). All of the disciplines involved in public health are required to be familiar with international and national legal and ethical principals such as the Ottawa charter, and the Treaty of Waitangi under the cultural competency requirements (PHA, 2007).

Public health nurses are able to assist individuals and families to take action to improve their health status. Often this takes the form of teaching about healthy lifestyle choices in the home, the school, and in community settings. Public health nurses assist people in applying improved health behaviour choices to their everyday lives (Nies & McEwan, 2007; Stackhouse, 1998). The specific roles of Public health nurses vary across the twenty one District Health Boards (DHB's) due to the nature of the contracting environment. Public health nurses may specialise in a particular area of public health, such as communicable disease control, caring for refugee families in New Zealand, housing project work, teenage clinics or as de-sac nurses (with sexually abused children). Interestingly, the Auckland District Health Board (ADHB) also has a contract for an under-five year old Well Child service for "at risk" families, indicating an overlap with Plunket. Banks Peninsula has no Plunket service, and the public health nurse covers both preschool and school aged children. This highlights the regional variability and contestability of the current contracting system.

Using a children's rights framework it is clear that public health nursing has a particular focus on the protection rights of the child. Public health nurses use strategies guided by the government including health promotion, and also population health strategies such as immunisation. When public health nurses work individually with families under their personal health contract, it is primarily with what are perceived to be "at risk" children. Such children are arguably the most likely to require state intervention to ensure parental obligations that correlate with their rights to survival development protection and participation.

### ***Home care nursing***

In contrast with Plunket and public health nurses, the home care nurse is essentially a “sick child” nurse. Therefore, from children’s rights perspective the latter has a greater focus on survival rights. Home care nurses are expected to primarily provide personal health care services for children with a medically diagnosed illness or condition (Horsburgh, Smith & Kivell, 2002). The home care nurse is a relatively new development internationally. Currently the name and nature of the service varies throughout the country. The nature of the contracts that they fulfill is also variable, the home care nurse is also known as the children’s visiting nurse, the ambulatory paediatric nurse, and the outreach nurse (Open Discussion: 1st Community Visiting Nursing Services Conference, Napier, 2006). Overseas literature describes how a national strategy and corporate identity for children’s home care/visiting nurses is not evident to either practitioners or service users (Sidey & Widdas, 2005). Until relatively recently sick children in New Zealand were seen by the generic district nursing service. Long established services such as public health nursing and Plunket nursing appear to have more visibility than home care nursing.

Home care is commonly referred to in international literature as ambulatory care and is one of the fastest growing branches of health care in Western societies. The management of disease, disability, and illness is increasingly away from the institution and within the community. Internationally the duration of hospitalisation is decreasing (Spradley & Allendar, 1997). Among the child population this is apparent from the increasingly early discharge of the premature neonate, to the increasing expectation that children with medical needs be managed in their own homes. Previously considered “specialist therapies”, intravenous therapy, artificial feeding, and breathing technologies are now provided in the home by lay people (usually mothers) with support from community nurses (Glasper & Richardson, 2006; Sidey & Widdas, 2005; Spradley & Allendar, 1997). Caring for a sick child adds an additional dimension to the obligations of parents for their children. The parents as trustees of children’s rights to health do not necessarily share the same perceptions about health or treatment with health care professionals (Dickinson, 2004; Henry, 2004; Woods, 2007).

### ***Research Focus***

The focus of this research is on the discourses of parental rights, children's rights, and state responsibilities that impact upon the day to day work of children's community nurses.

### ***Presentation style***

This research is presented partly as a personal journey as it indicates the reflexivity of my own practice as a children's community nurse. While this is a departure from the traditional academic style of social research, it is consistent with postmodernist approaches (Powers, 2001).

### ***Structure of thesis***

The thesis is divided into seven chapters. Chapter One, has explained why I came to this study and my rationale for choosing a discourse analysis approach. The discourse of children's rights has a particular resonance for me as a children's community nurse.

Chapter Two, discusses the methodology and methods used in the research. Examining power and knowledge in children's community nursing is complex. The social, ethical and political dimensions of work in this field create a relationship between governmentality, biopower, and pastoral power through disciplining techniques such as surveillance. Foucauldian discourse analysis methodology reveals the power relationships that exist between people and across social structures. The method of transcribing and analysing in depth recorded interviews of children's community nurses and maintaining trustworthiness is also discussed.

Chapters Three and Four constitute the literature review. The literature review is divided into two chapters and is a broad reading of the subject positions of the main actors in this thesis: the child, the family, the nurse, and the state, and society. Chapter Three looks at literature around children's rights using a brief genealogy of childhood, then an overview of children's rights from: the legal perspective, government policy and economic perspectives, and an epidemiological view. Chapter Four reviews literature from community child health nursing including nursing theory particularly the family centred care model, and the ethics of nursing that underpin practice. This chapter includes a brief

review of current nursing literature from New Zealand nursing journals and academic sources. There are some references to international literature but essentially the literature review relates to the New Zealand context. The literature review is limited to a broad overview since the potential scope is vast and beyond the limitations of a master's thesis. Additional insights can be gained from sociology, social work, ethics and philosophy, and political science.

Chapters Five, Six, and Seven, constitute the analysis of the data from interviews with nurses. The analysis is divided into three chapters. Chapter Five covers the discourse of perceptions of needs and rights of the child using the metaphor that it “takes a village to raise a child”. It explores how nurses construct the position of children and their health needs and the different subject positions of the nurse's in negotiating the fine balance between helping and interfering. Chapter Six explores context of nursing in the home using the “my home is my castle” metaphor and examines the nature of the public /private divide and the role of the nurse-family relationship in bridging the divide to promote children's right to health. Chapter Seven looks at the systemic barriers and limitations to nursing practice for children's rights to health and in particular the impact of the fragmentation of health services for children.

The final chapter provides a discussion of the implications of this study, debating the notion that nurses are the “health police” and linking the analysis of what nurses in the study say about children's health rights with the wider implications from the literature review. A recommendation for an online practice community to open up the debate about the practices and perceptions of children's nurses is made and the limitations of the research are discussed.

## **Chapter 2: From methodology to method**

### ***Introduction***

For this thesis I am drawing on the work Michel Foucault because his conceptual tools have the potential to trouble the ideology of children's rights and to bring to light the complex nature of children's community nurses' relationships with children and their families. In the first section I discuss Foucault and the development of his philosophy and describe a postmodernist theoretical perspective. I then go on to describe the central Foucauldian concepts that informed my research process.

### ***Philosophy***

According to Danaher, Shirato and Webb (2000) the life and works of French philosopher Michel Foucault (1926-1984) can be summarised as an attempt to demonstrate that human beings can challenge the constraining values and institutions of their societies (the status quo). Foucault suggested that people must first recognize the constraints, and view them as constructed rather than natural. Furthermore, he suggests that historical circumstances have constructed such seemingly eternal concepts as: madness, crime, sexuality, and even humanity. Doubting the naturalness of norms Foucault, following Nietzsche's lead, pioneered the study of the history or "genealogy" of norms (Danaher, et al., 2000). Danaher et al. describe Foucault's theoretical work as having been based on his own experience and always in relation to processes he saw around him. Foucault blended philosophy, history and social criticism:

My field is the history of thought. Man is a thinking being. The way he thinks is related to society, politics, economics, and history and is also related to very general and universal categories and formal structures. But thought is something other than societal relations. The way people really think is not adequately analyzed by the universal categories of logic. Between social history and formal analyses of thought there is a path, a lane - maybe very narrow - this is the path of the historian of thought (Foucault, 1982, in Martin et al, 1988, p.9)

His experience during three years working as a psychologist in a psychiatric hospital in the 1950's, combined with insights from personal experience as a psychiatric patient, inspired Foucault to explore the discourse of madness. Foucault's doctoral thesis

*Madness and Insanity: History of Madness in the Classical Age* (the basis of his first major book) was first published in English in 1961:

It is because I thought I could recognise in the things I was in, the institutions with which I dealt, in my relations with others, cracks, silent shocks, malfunctioning.... that I undertook a particular piece of work, a few fragments of autobiography (Foucault, 1988 p.156).

This description of the inconstancy of how an individual constructs social and personal knowledge resonates with my own experience. I also recognise the “cracks, silent shocks, and malfunctioning” that challenge the way that I think and practice as a community nurse. I have a sense, but not a comprehension, of the interplay between politics, law, economics, history, and medicine that constructs the contradictory ways in which society views children and their rights to health, and also how society shapes the role of nurses.

Reading Foucault's work it is possible to see how he used reflexivity as a tool to analyse personal, inter-subjective and social processes. One area that Foucault explored extensively was the discourse of sexuality. Foucault's reflexivity drew upon autobiographical elements based on his experience as a homosexual man over a period in his early life when homosexuality was considered both a crime and an illness (Foucault, 1984). One central term which Foucault employed to analyse the production of knowledge is that of discursive formations. Miller (1994) interprets discursive formations as discourses that change over time and uses Foucault's homosexuality as an example, describing that Foucault grew to adulthood as a "pervert" and died as an "orientation." Miller's biography of Foucault was controversial partly because of his analysis of the relevance of the autobiographical content in Foucault's work, in particular, Foucault's interest in sado-masochism. Miller interpreted that interest as a personal challenge to the constraining values and institutions of society (Halperin, 1996; Kimball, 1993).

Crotty (1998) describes how theoretical perspectives interrelate and how epistemology informs theoretical perspectives. Crotty also describes how theoretical constructs are contestable. For example, the relationship between postmodernism and poststructuralism is contested by scholars; the complexity of the debate however, is beyond

the scope of this thesis. The prefix “post” means to come after modernism and structuralism, and so postmodernism and poststructuralism therefore challenged the modernist and structuralist movements. Modernists argued that the new realities of the industrial and mechanized age were permanent and imminent, and that people should adapt their world view to accept that the new equaled the good, the true, and the beautiful (Levenson, 1999). Structuralism refers to the mental models built from concrete reality. Structuralism became one of the most popular approaches in academic fields concerned with the analysis of language, culture, and society (Crotty, 1998). The work of de Saussure (1857-1913), concerning linguistics, is generally considered to be a starting point of 20th Century structuralism. The anthropologist Claude Lévi-Strauss (1908- ) is credited with influencing the structuralist movement (Culler, 1981). Foucault’s earlier work is often seen as structuralist because of the influence of philosophers like Marx (Foucault had been a communist in his 20’s) and Althusser who was also one of Foucault’s teachers (Danaher, Schirato & Webb, 2000).

What can be seen by both modernism and structuralism is that movements based on the rejection of tradition become traditions of their own and are in turn open to challenge. Foucault challenged structuralism’s neat assertions of the “truth” of systems of knowing which brought him under the postmodernist umbrella, despite his disdain of the normative practice of labeling (Danaher, Schirato & Web, 2000; Payne, 2002). Foucault is also seen as a postmodernist because he believed that reflexivity is integral to the process of intellectual endeavour (Cheek, 2000).

Postmodernism and poststructuralism developed in the 1970’s in the wake of Marxism and phenomenology (Crotty, 1998). The development of postmodernist/poststructuralist theories appears to correspond to the human rights movements in a period that challenged the social position of marginalised groups from the 1960’s onwards. Of particular relevance for this study, postmodernism expanded at the same time as the escalation of the children’s rights movement in the 1980’s. Postmodernist research rejects the notion that universal truths about human society and its modes of organisation are possible and maintain that the construction of the society is therefore pluralist (Cheek, 2000). I believe that the complexity of life observed by clinical nurses in the community

would support this postmodernist pluralist view, but nursing is also constrained by both its structure and empirical foundations. The notion of children's rights as a moral code is fundamentally universalist, therefore potentially oppositional to postmodernist viewpoint. The construction of children's rights to health as with any human rights issues lends itself to a postmodernist critique of the nature of rights. Cheek (2000) argues that: "Rights talk can generate beneficial results, particularly in mediating conflicts between the allocation of resources that enable both positive and negative freedom and through ameliorating the consequences of relative powerlessness and deprivation" (p.60).

The most essential Foucauldian premise is that power is inherent in all social relationships. The relationship between nurses and children and families therefore has a power dimension. Discourse analysis emphasizes the power that permeates all social relationships. As Foucault (1980) describes:

Power must be analysed as something which circulates, or rather as something which only functions in the form of a chain. It is never localized here and there, never in anybody's hands, never appropriated as a commodity or piece of wealth. Power is employed and exercised through a net-like organisation. And not only do individuals circulate between its threads; they are always in the position of simultaneously undergoing and exercising power (p. 96).

Foucault's concept of discourse was played out in his work in three main areas: the question of knowledge, relations of power, and the question of the subject. The three areas support postmodernisms' disruption of the ideas of rationality and truth. In the following pages I explore a range of Foucauldian concepts that are relevant to this thesis.

### ***Discourse***

It can be seen by the brief description of Foucault and the intertwining of his life experience with his philosophy that "discourse" is central to Foucauldian analysis. Discourse in Foucauldian terms has a range of meanings which can be contradictory. Foucault rejects the idea of self-governing subjects pointing out that what comes between us and our experience is our action, speech, and thought (Danaher Schirato & Webb, 2000). Therefore the most significant force shaping our experience is language. Foucault calls the broader field in which knowledge is formed "the discursive formation". For Foucault an "episteme" is not tied to a community but to a "discursive formation". After 1970 he



modifies this view. “By episteme, we mean [...] the total set of relations that unite, at a given period, the discursive practices that give rise to epistemological figures, sciences, and possible formulated systems” (Foucault, 1972, p.91). Foucault later replaced “episteme” with the term “discursive formation.”

Discourses can be seen as language in action which allows us to see things and make sense of them. For example, nurses “see” health care, illness, and disease in a certain way. Foucault referred to this as the medical “gaze” and other commentators have described a nursing “gaze” or “look” which extends the purely medical gaze and encompasses an additional aspect of intuitive evaluation (Cheek, 2000; Lupton, 1995b; Edwards, 2007). Discourses distinguish how we construct the world in terms of right from wrong, and true from false (Danaher, Schirato & Webb, 2000). Discourse refers to both structures of knowledge and systematic ways of constructing reality at a particular historical moment (Foucault, 1982). This view is supported by Cheek (2004) who sees that a discourse consists of a set of common assumptions that are often taken for granted and rendered invisible or assumed to be common sense. An example is the assumption that children have a right to be well cared for by adults. This is considered a “normal” way of thinking and highlights how norms are constituted by discourses. Discourse analysis allows interpretive claims about oppression and empowerment within a specific context like the healthcare for children, without claims of generalisability (Lupton, 1992). The primary focus of this research was to look at the relationship between power and knowledge. Power is a fundamentally Foucauldian concept and has different sub- categories such as governmentality, biopower, and pastoral power.

### ***Power and resistance***

For Foucault power is everywhere because it is the field in which we move, like the space around us. Power is a necessary constraint in the same way that properties of space allow us to do anything in space but within the laws of physics. Power is therefore a condition, not a state to be remedied (Loesberg, 2005). Foucault points out that power should never be thought of in purely negative terms, and that unlike force (which is repressive); power is primarily productive (Chambon, Irving & Epstein, 1999). Power is

diffused throughout the social system and disguised through covert means. It exists only in relationships as relations of power (Danaher, Shirato, & Webb 2000).

Foucault posited that where there is power there is resistance. This is an aspect of the relations of power. It is sometimes easier to identify power through the manifestations of resistance (Foucault 1990, p.95). Furthermore, Smith (2002) maintains that the presence of resistance to the intrusion of law and ethical codes, and the discourse of rights into family relationships, therapeutic encounters, and community relations, indicates a power relationship that needs to be explored. Power is divided into further subcategories by Foucault- the most relevant for this study are the notions of bio-power and pastoral power.

### ***Bio-power***

Bio-power is a conceptual tool that makes it possible to historically analyse how power has come to work in relation to the body (Foucault, 1984). The “body” and “life” have become objects of intervention. Foucault sees that the helping professions are constituted by their technologies of intervention: observation, measurement, assessment, and administration (Foucault, 1984). These are essentially the elements of the nursing processes. The rise in bio-power is seen as “indispensable to the development of capitalism compelling the state to manage its population without coercive action...the new form of power on life is the right to life, and the right to discover all that one is and all that one can be” (Foucault, 1990, p.145). Rabinow and Rose (2006) describe three elements essential to biopower. Firstly, “one or more truth discourses about the ‘vital’ character of human beings, and an array of authorities considered competent to speak that truth” (p.197). The second element is seen as “strategies for intervention upon collective existence in the name of life and health” (p.197). The final element is described as “modes of subjectification, through which individuals are brought to work on themselves” (p. 197).

Various institutions have been created to exert biopower. Medicine is perhaps the most pervasive of these. Disciplines through which power is exercised provide a power whose intention is not death but an investment in life. Foucault (1990) describes how the body is viewed as a machine for which discipline, optimization, utility, docility and integration into efficient systems, and economic controls are all ensured by the procedures

of “anatomy-politics” (p.139). This is a process of normalization, of eliminating that which is outside of the “norm.”

Children’s community nursing is an example of part of an institution that uses bio-power to regulate children’s bodies and parental behaviour. Bio-power, however, shapes way that nurse think and act and so nurses are therefore the both; the users of power and also the tools (instruments) that power is using. One vital aspect of power is resistance to the technologies of power that are inherent in biopower (Perron, Fluet, & Holmes, 2005).

### ***Pastoral power***

Foucault’s understanding of power as a productive practice, which is relational and permeates all of society, enables consideration of power relations beyond the limitations inherent in a mere oppressor/oppressed scheme (Mills, 2003). In particular, Foucault’s (1982) concept of pastoral power provides an interesting backdrop upon which to project the practices of helping agencies. Pastoral power is a form of power that ensures that citizens are supported with the knowledge and freedom of how to, shape their own lives. Pastoral power is an individualizing power technique, which since the 18<sup>th</sup> century has been central to the conduct of a variety of institutions. It is salvation oriented, whereas salvation can take on a number of different meanings. Pastoral power can include for example health, but also monetary wealth, economic progress, access to a certain type of information, or whatever else is considered to be a desirable state in different settings, at different times and by different actors (Dreyfus & Rabinow, 1983). Pastoral power requires the government to know its subjects in even greater detail, as Foucault (1982) argues: “This form of power cannot be exercised without knowing the inside of people’s minds, without exploring their souls, without making them reveal their innermost secrets. It implies knowledge of the conscience and an ability to direct it.” (p. 783).

The agents of pastoral power include institutions such as the state, the police, the family, or the hospital, in particular welfare institutions and more generally their benefactors. In short, defining what constitutes a salvaged state means exercising power, while providing salvation or aid, is an act of control and domination, which is never uninterested. However, since it depends to a large degree on the agreement of those subjected to it, it exceeds being merely an act of oppression (Foucault, 1982).

While disciplinary power is an “objectivizing force”, pastoral power is a “subjectivizing” one (Foucault, 1982). In other words, disciplinary power involves a process that transforms individuals into objects or, as Foucault terms it, “docile bodies” (Foucault, 1977). Pastoral power however, means that people must learn to know themselves. They participate as active, conscious and autonomous beings. This means that they are also able to challenge and resist power.

What may be different in the resistance of marginalized groups are the consequences. For example, Caughlan (2005) describes how teachers see that the consequences of non compliance for working class students is a further disadvantage, because they do not understand or resist well-meaning pastoral controls. In other words by resisting education students only hurt themselves. Resistance to the pastoral power of child healthcare can also be seen in the same light, for when the less authoritarian pastoral controls do not engage people in learning to understand their obligations toward their children, they may suffer from the consequences. Child death, disease, or disabilities are negative consequences. Punitive disciplinary consequences include the referral to welfare authorities and possible loss of custody of the children, or even prison, for failure to recognise a child’s right to life. The concept of discipline as a means of governing behaviour is a central Foucauldian concept related to power.

### ***Discipline***

The term discipline is used by Foucault to describe how power operates to guide behaviour. Discipline is a technique of power that “makes” individuals. Within discourse, discipline has multiple meanings, from acts of punishment and correction to fields of knowledge that identify deviance from the norm and interventions to correct deviation (Danaher, Schirato & Webb, 2000). The notion of disciplinary power embedded within Foucault’s writings has been widely applied to the sociological analysis of health care professions. Disciplines turn individuals into objects of study and invite individuals to willingly participate in the process of self construction. We become our own object of study and an instrument for disciplining ourselves. Once categories of “normal” “healthy” and “good” are created the corresponding categories for those not conforming to these categories are also brought into being: “deviant,” “unhealthy” and “bad” (Danaher et al.,

2000). Nursing is considered a discipline because nurses are educated and trained in the art and science of nursing (Daly, Speedy, Jackson & Darbyshire, 2002). Disciplinary techniques are used by nurses to observe and assess clients the most relevant Foucauldian concept that recognises this is the panopticon.

### ***Panopticon***

The role of nurses in the community as a state mechanism for surveillance and monitoring of the health of citizens can be viewed from the Foucauldian concept of the panopticon. The panopticon is an example of a disciplinary technology and is a term Foucault coined from Jeremy Bentham's prison design to illustrate the disciplinary power of surveillance and monitoring (Foucault, 1977). It stands as a mechanism that monitors the effects of interventions to train or correct people. Self discipline replaces coercion as the method of social control, when having internalized the "gaze" rather than being seen by others individuals come to monitor and thus regulate themselves. A Foucauldian perspective has been used by many researchers to analyse community nursing and the model of the panopticon has been described as a symbol of the surveillance and monitoring that occurs in the home (Gastaldo & Holmes, 1999).

The progression of Foucault's concepts can be viewed from a historical perspective which is what Foucault refers to as genealogy. For Foucault, the panopticon integrates power and knowledge, the control of the body and the control of space into a technology of discipline. Bodies of people can be made productive and observable. Foucault remarks "Is it surprising that prisons resemble factories, schools, barracks, hospitals, which all resemble prisons" (1977, p.44). The perfect disciplinary apparatus, according to Foucault "would make it possible for a single gaze to see everything perfectly" (1977, p.173). Foucault views the mechanism of panopticism as both efficient, since surveillance was everywhere and constant, and effective, because it was "discreet", functioning "permanently and in silence" (1977, p. 177). It also provides the scope for the supervision of those who were entrusted with the surveillance of others. For nurses this takes can be interpreted in the form of professional supervision and performance review of practice.

### ***Knowledge***

Foucault's work is enlightening about how ideas that guide professional practice came into existence and how they acquire power. In Foucault's terms power and knowledge form a nexus. Foucault puts a twist on Bacon's "knowledge is power". One of his most startling revelations was his concept that power produces knowledge and uses it to disperse itself. Truth is not something that liberates. Without power, no "truth" could exist. "Knowledge is what power relations produce in order to spread and disseminate more effectively" (Caputo & Yount, 1993, p.7). This means that knowledge claims are always linked with power, and that knowledge only exists if power relations allow it to. Nursing aligns with powerful large institutions that tend to produce a lot of knowledge which tend to exert an enormous amount of power. In modern society such institutions include psychology, medicine, economics and sociology, these institutions, however, do not exert their own power, but instead are the means that power uses (Caputo & Yount, 1993).

The history of culture is, in the familiar terms of Thomas Kuhn, the history of "paradigm shifts," or cultural revolutions. New disciplines or discourses continually emerge and then implant themselves as if they had always been there, like "normal science" for Kuhn (Danaher, Schirato & Webb, 2000, p.19). One significant paradigm shift for this study is the move away from authoritarianism towards a liberalism that embraces the concept of humanism and human rights.

It can be seen therefore that discursive practices of nurses define what can be known, said, or thought about them, in relation to their work. The silence that nurses are required to maintain about sensitive topics such as the child homicide described earlier, demonstrates how nurses knowledge is constrained by others. Foucauldian analysis shows there are many ways in which historically and socially conditioned nursing identities endanger nurses, by increasing our vulnerability and closing us off from possibilities. The specific identity and subjectivity of nursing, can expose, limit, and place us and perhaps others at risk. These subjectivities can be explored using Foucault's concept of the self.

### ***The self***

Foucault posits that subjectivity is fragmented and also that "self" is an outcome of historical developments and is not an essence. Forms of knowledge that constitute the "self

as an object” are significant for this thesis. Nurses have multiple fragmented and contradictory selves. For example, we have a “medicalised self” that pathologises deviations in children’s physical and mental being. We have an’ “occupational self”, the nurse whose job it is to engage in relationships with families and to intervene with health practices. We may also have a “parental self”, in which we construct ourselves as parents (or non parents) in relation to other parents.

There are two meanings of the word “subject” the first is to be a subject to someone else’s control. The second meaning relates to subjective knowledge which means being tied to one’s own identity by conscience or self knowledge (Chambon, Irving & Epstein, 1999). Fundamentally therefore, the power dynamics and disciplinary mechanisms in children’s community nursing are not explicit. Technologies of the self are techniques of power that permit individuals either by themselves or with the help of others to transform themselves in order to attain a certain state (Foucault, 1984). One particular way in which power is exercised is the political focus on the health of children. Governmentality is the link between the techniques of power that are applied to oneself and to others (Foucault, 1988).

### ***Governmentality***

With the concept of governmentality Foucault expands the realm of what is seen as political state power to encompass a wide range of everyday practices. A population is ruled through the existence of diverse techniques. To govern is to structure the possible fields of action for others (Foucault, 1982, p.221). For example, nurses are employed by the state to enact government policies for the health of the citizens of the state; therefore nurses are both governed and governing. Power, and in particular biopower, refers to the power over life, and is particularly pertinent to the technologies of self used by nurses to transform others and of government policies that aim to control the health of citizens

### ***Genealogy***

The genealogical approach is a refinement of an earlier Foucauldian concept of archaeology (Chambon, Irving & Epstein, 1999). Foucault first used the metaphor of archaeology to characterize the approach that he used to explore the origins of contemporary medical practice in *The Birth of the Clinic: An Archaeology of Medical Perceptions* (1975). Archaeology refers to uncovering fragments of the past by uncovering

layers of accumulated knowledge (Chambon et al., 1999). Genealogy refers to the history of the present, tracing the history of practices and knowledge from the present to the past (Foucault, 1977). In this study it is used as a means of exploring how experienced children's community nurses in particular have developed a body of knowledge, and the language they use to describe this knowledge.

This thesis approaches its subject matter – children's rights to health – by drawing on aspects of a genealogical method in the Foucauldian sense. Such an approach seeks not to discover any “truth” in children's health rights, but rather to unsettle and disrupt assumptions that there is a continuity of meaning. Similarly it seeks to disrupt the idea of fixed essences. A genealogy aims to reveal that what appears to be “the truth” is but an interpretation or series of interpretations of, in this context, bodies and subjectivities which each have their own historical specificity (Dreyfus & Rabinow, 1983; Rabinow, 1997).

### ***Summary***

In this section I have broadly identified who Michel Foucault was and why his philosophies might be pertinent to my analysis of the data around children's rights to health from a children's community nursing perspective. Concepts of knowledge, relations of power, and subjectivity have been shown to be interrelated and relevant to the study and shape the research process. The following section describes the steps involved in the research. I explain procedures used to identify and contact participants, ethical issues, the data collection process and the means to assess trustworthiness.

### ***Method***

Foucauldian discourse analysis can be guided by the work of Parker (1992) whose base is in poststructuralism, and who views discourse, or discursive practices, as a “system of statements, which constructs an object, usually power relations” (p.3). For Foucault, discourse analysis can take a number of different analytic forms, including: examining the order of statements and how they are positioned to each other, investigating how a system of statements works, and describing the “formation of objects” (Kendall & Wickham, 1999).



I have found that that applying discourse analysis to nursing research is difficult and confusing. Papers that offer a minimal discussion of the approach or which embody contradictions, fuel the confusion (Buus, 2005; Cheek, 2004; Crowe, 2005; Traynor, 2006) There are different ways of “coming to” a discourse analysis that have the benefit of demonstrating the decisions that are made and their basis, either using a structured framework or a personal narrative.

### ***Ethical approval and ethical considerations***

Ethical approval was sought from the Auckland University of Technology Ethics Committee (AUTEK) in the first instance (Appendix i). Simultaneous ethics applications were made to two different District Health Boards and the Plunket Society as employers of the nurses approached for the study. In addition Maori ethics approval was required from the two District Health Boards. The ethics process was both complicated and time consuming because of the multiple sites being accessed.

Ethical considerations submitted to the various ethics committees included confidentiality and anonymity. The use of identity numbers rather than names, and the removal of any identifying data ensure that the individual nurses are not identifiable. In the transcripts any material that could identify the nurses or their clients was either removed or obscured.

Debriefing and supervision was offered by appropriate counselling services if issues occurred but have not been required. In particular cultural safety was ensured by offering each participant culturally appropriate support of their choice. Particular acknowledgement was given to the rights of participants and the responsibilities of the researcher under the Treaty of Waitangi.

It was stated in my information sheet (see appendix ii) that I would refer a participant to the appropriate channels if any information divulged or contravened good practice, showed unresolved ethical dilemmas, or uncovered child abuse and neglect. Possible referral channels included: service management, clinical ethics advisory group; New Zealand Nurses Organisation; Child Youth and Family Service; the Health and

Disability Commissioner; or Commissioner for Children, as appropriate and after consultation with my supervisor. However, no such cases were talked about in my research.

The study was voluntary and all interested participants were assured on information sheet and consent form (Appendix iii) that they could withdraw at any time. Four interested participants did withdraw interest during the consultation process, which indicates that nurses approached felt free to choose to participate.

### ***Recruitment***

The means of approaching the participant group was initially through the nursing management of District Health Board (DHB) employers for home care nursing and public health nursing, and the Regional Plunket Society. I had intended to attend workplace staff meetings to describe the study, approach, and describe the criteria, aims, and benefits of researching the topic. However, I was asked to meet with managers and they decided that the recruitment information was to be disseminated through them. Information sheets given to managers contained details about how to confidentially contact the researcher. The impact of a delayed ethics process upon a one year time frame for this research, limited the time available to recruit, interview, and transcribe interviews to ten weeks. I was also thwarted in the recruitment of participants by the stipulation that I could not directly approach participants. It is possible that management became gatekeepers to contacting participants and became a drawback to the study. Four people who initially showed an interest in the study withdrew citing time constraints and heavy work schedules. This may indicate that community nurses are very time-poor and taking time out from a busy work schedule for research may be perceived as a burden.

### ***Participants***

I had intended to interview a cross section of six to eight willing nurse co- research participants. I managed to recruit only five nurses however, as Sandelowski (1995) posits, a small sample size can generate a lot of in-depth data and is consistent with discourse analysis methodology. The five participants included: two Plunket nurses, two home care nurses, and one public health nurse. In addition I conducted a personal interview with my supervisor for my own reflexive analysis and critique. My desired number of participants was not reached due partly to the delay in consent process restricting the time available to

both recruit and interview. The participating nurses were all European and aged between 35 and 65. The maximum amount of community nursing experience was 27 years and the minimum was three years. All participants had been nursing for over ten years.

### ***Time and place for interviews***

The managers of the three services agreed to the interviews being conducted during paid work hours as they were able to see the benefit to practice of reflexive dialogue with the researcher. Conducting the interviews during work time was seen to be advantageous to participants since community nurses are very time pressured, and to have been interviewed in their own time would have caused them further stress. Many community nurses are working long hours (Beatson, 2007). Practice portfolio and professional development education already encroach upon personal time and family commitments. Three participants opted to be interviewed at work during work hours. One disadvantage of onsite interviews was work related interruptions, further signifying the time constraints of the job. Two participants chose to be interviewed off -site, one during work hours and one on her day off.

### ***Interview process***

Firstly, participants were invited to write descriptions of their practice. This was an optional element in the data collection and writing could take the form of an exemplar from a practice portfolio. Three out of the five participants submitted a written reflection on their practice. As noted, interviews were conducted off-site for two participants and at the worksites of three participants. Participants chose their own venue for convenience and personal preference. Tape recorded 90 minute semi- structured in depth interviews were conducted with each participant. An interview schedule (Appendix iv) was used to guide participants through the interview and ensure that topics were consistently addressed.

The five specific guiding questions were: How do you define children's rights to health? What are your impressions of whether children have those rights upheld? What do you see when you go into peoples homes? How do you engage with families to work for children's rights? What could the system do better? These questions were asked to elicit discourses regarding nursing and children's rights and to establish what sort of "gaze"

nurses employ as part of their everyday practice-how they see themselves and how they see children and families that they visit. The final question was asked to elicit the nurse's views around the influence of governmentality on their practice.

The interviews were transcribed by a professional transcriber who had signed a confidentiality form (Appendix v). The time frame for transcription was too limited for me to transcribe them personally due to inadequate secretarial skills. Transcribed interviews were sent to participants for verification. Any amendments made did not significantly alter the meaning of the interviews and essentially only clarified inconsistencies from verbatim speech.

### ***Data Analysis process: reading, coding analysis***

Discourse analysis is a qualitative interpretive methodology that examines the way people construct experiences through language and visual imagery. It focuses on talk and texts as social practices, and on the resources that are drawn on to enable those practices (Potter & Wetherall, 1987). Stevenson (2004) opines that it is not important to have a fixed hypothesis as might be required in more experimental or quasi-experimental approaches to research. Rather the researcher begins with a number of questions that guide the investigation and are consistent with its aims. My interest lies in how nurses construct meaning when implementing bio-psychosocial interventions in the home (Gamble & Brennan, 2000). The analysis looked at the ways the participant nurses constructed meaning concerning official policies in relation to everyday practice. In other words it sought to identify patterned ways of thinking in textual and verbal communications that can also be located in wider social structures (Lupton, 1992).

Traynor (2006) conceptualised four discourse analysis approaches: *identifying code* which focuses on language properties and linguistics; *use and interaction* which is a conversational ethnomethodology; *interpretive repertoires* which are studies of occupation and social discursive practices and *use and interaction* which are studies of discourse and power. It is this latter approach I have used to analyse my data. This required an analysis of the patterns of language and related practices and an examination of how such patterns constitute aspects of society (Traynor, 2006, p.63). Data immersion in this study consisted

of re- reading the written narratives and verbatim transcripts, and replaying audio tapes interviews (Sandelowski, 1995). The transcripts were scrutinized and practice descriptions for the discourses identified. Firstly, the data was scrutinized to see how nursing, children rights, and health were being represented. Then the data was scrutinized for the subjectivities and power positions evident in each discourse. Finally, the disciplinary strategies imbedded in the discourses were identified.

As well as analyzing the larger texts/discourses/dominant stories/ideologies from the literature I wanted to analyse written and audio data from nurses telling stories from clinical practice. Nurses' discourses in clinical practice may question the taken-for-granted acceptance of education, policy, and practices. Focusing on nurses' accounts of their work will go some way to recognizing their practical knowledge, interpersonal skills, and the clinical judgments they make when caring for clients (Poirier& Ayres, 1997)

## ***Assessment of Trustworthiness***

### ***Dependability***

Dependability means findings in a study are consistent and accurate. The analysis by the researcher can be understood by the reader because the decision making processes of the researcher are succinctly described. While the study cannot be replicated, by describing each step in the research process, it can be repeated using different subjects and researchers (Denzin & Lincoln, 2003).

### ***Credibility***

Credibility corresponds with internal validity and means that the participants recognize the truth of the analysis from their data. I have utilized an interview guide and sent transcripts back to participants. The explanation offered by the researcher fits their description. Remembering that there is no one way of interpreting phenomena, Edwards (1993), argues that researchers should not be trying to replicate interviews faithfully between participants. She encourages the researcher to work toward the same quality in each interview. The aim is to obtain as much of a complete representation of what each individual subject means as possible.

### *Transferability*

Rather than lumping participants in a generalizable aggregate the need to recognize the individual is the essence of qualitative study. Thus no two studies would have identical conclusions. Transferability assesses how the knowledge acquired in one context can be transferred to another and the concepts recognized. I have engaged in conversations with other children's community nurses, and presented at three conferences as well as reading widely from contemporary research.

### *Authenticity*

Authenticity demonstrates that the findings are representative of participant's perspectives, and that the study is fair. Authenticity also helps participants to understand their social world and therefore improve it. Authenticity is described by Denzin & Lincoln (2003), as fairness to the participants meaning the informed consent process is ongoing. The participants must express acceptance of the nature of the interview throughout, and the context in which the participants work and live must be taken into account. Sparkes (2001) suggests that terms such as evocation, impactfulness, authenticity, fidelity and believability are useful concepts to test rigour in this type of research. I have presented aspects of my research findings to a national children's nursing forum (NZNO, November 26, 2007). There I had verification from other clinical community nurses that the discursive elements that I have uncovered resonate strongly with their own practice suggesting credibility and believability. My evocation of metaphors such as the "castle" and the "village" to describe the essential tension between the public and private domains was identified in feedback from hospital nurses at the forum as useful metaphors for understanding the tensions for nurses in the home. I believe this feedback supports the notion of impact.

What feedback at the conference also suggested was that the Foucauldian concepts of the "panopticon" and the "gaze" became more comprehensible when applied to the practicalities of community children's nursing by using the verbatim quotes from participants. The use of descriptions of how nurses "see" what they see in homes and how it affects the health of the children within the homes was apparent by the level of agreement in the room. The limitations of nurse surveillance when related to Foucault's description of the panopticon were also confirmed.

Peer review consisted of fortnightly meetings with my two supervisors competent in the research procedures to re-analyse raw data, provide feedback and debrief during the research process. I also met once with a discourse analysis and narrative enquiry group and twice informally with members of the group to discuss the methodology.

### ***Negative cases and alternative explanations***

Identifying data that does not fit the patterns and challenges themes and patterns provided additional analytical dimensions (Denzin & Lincoln, 2003). With data that doesn't "fit" the consideration of alternative explanations, particularly contrary ones, demonstrates the complexity of the research. Contradictory data is included rather than being rejected since I recognise that different discourses add to the depth of the analysis.

### ***Confirmability***

Confirmability in qualitative research is used rather than objectivity, a term which is redundant in a study of subjective phenomena. An audit or decision trail where the reader can follow the source of the data assists the requirement for openness and is a means for intellectual honesty to be scrutinized. Details of the decision-making processes and conditions of the study have been recorded throughout the research process in the form of field notes, written records of my observations, and notes on political and social context. These include notes from three relevant conferences and three symposia related to children's rights and children's health. In addition I have archival records of email conversations with national and international children's rights commentators and with interested nurses nationally. Methodological documents have been kept in order to review the process and theoretical changes over time. Analytical documents have been kept to document the analysis process. Finally, my personal responses to notes I have made, and in particular observations of current affairs and the wider socio political context of my study have been recorded in a diary-type record of self awareness and to describe my emotions and thought processes.

Potter and Wetherell (1987) propose that there are often many versions of reality and the study of a phenomenon involves looking at the way it has been constructed. I have a predetermined idea of the nature of the nurses' reality based on my own experiences. It is important for me to examine my personal pre-understandings. I have therefore undertaken

to journal my insights from practice, and to transcribe and analyse an interview with my principal supervisor to highlight my own subjectivities and discursive practices. In addition I have been candid about my own assumptions to enable transparency for readers.

### ***Thick description***

Linked to the audit trail, thick description adds to the richness and creativity of the data. Attributed to Geertz (1973) this type of detail contains minutiae of observation that display the vitality, trauma, and uniqueness of a case. Thick description provides a basis for readers' evaluation of quality.

### ***Reflexivity***

Using a self critical stance allows the researcher to challenge her own role, relationships and assumptions. This makes the study more dependable as the multiple voices of the participants and not just the voice of the researcher can be heard. Every stage of the research process relies on the researcher negotiating complex social situations. Participants are active in this process, and reciprocity occurs at many different levels. The relationship between trustworthiness and reciprocity in relation to the researcher, the research process, and the write-up are problematic because as a practicing community nurse I am therefore a colleague with the potential to "lead" or misinterpret data (Harrison, MacGibbon & Morton, 2001). The possibilities, demands, and obligations of reciprocity, required a careful exploration of my "framing questions", as well as the nature of the access to participants and the rapport established within my insider-outsider status. In addition, I was aware of my passionate participation and the need to acknowledge this in the data production, data analysis, and authorizing accounts. Personal reflexivity required insight into my own experiences, values, beliefs, interests, and politics. As a practicing children's community nurse detachment was impossible. My experiences and interpretations and tales from and of the field shape and are shaped by my understandings of reciprocity and this influence on the research must be taken into account (Powers, 1996). Reflexivity is not merely egotistical self-absorption, introspection, or an antidote to the problems of qualitative research (Adkins, 2002; Skeggs, 2002). Reflexivity involves political and moral positioning and social practices, which, as Skeggs argues, means reflexivity is not a property of self, nor a confession, but a practice and process concerned with power,



responsibility, and accountability. As she suggests, “the ability to be reflexive via the experience of others is a privilege, a position of mobility and power, and a mobilisation of cultural resources” (p.361)

Wood and Kroger (2000) propose a series of “warranting” claims to provide justification for the interpretation of data in the analysis. These claims fulfill the criteria for soundness, plausibility, coherence and trustworthiness. Maintaining coherence in my analysis proved challenging for me as a novice researcher. As a qualitative methodology this study aimed to follow research guidelines for trustworthiness identified by a variety of respected sources as outlined below.

### ***Summary***

I have outlined the major philosophical concepts of Michel Foucault that are relevant to this research. I then described the design of the study and the research process in detail. This was followed by an account of the steps taken to ensure data collection rigor. Finally, I described the modes of analysis used in the study. Integral to the discourse analysis process is the review of the literature that frames the data analysis and research aim. In the following chapter I provide an overview of the two main focus areas for this study of children’s rights and children’s community nursing.

## **Chapter 3: Literature review: Children rights**

### ***Introduction***

The literature review is divided into two chapters. The first chapter establishes the historical, legal, social, and political place of children and children's rights in New Zealand and the current status of child health from epidemiological studies. It also refers to socio-cultural theories of disease. The first chapter illustrates the Foucauldian concepts of governmentality and biopower and the influences of social disciplinary systems on nursing. The second chapter looks at the history of children's community nursing using Foucault's concept of genealogy, ethical theories in nursing that support a children's rights approach, and the underlying discourses of needs and risk that drive nursing interventions. It also provides a review of relevant current New Zealand literature from nursing journals and scholarly papers.

Children's rights to health are a challenging subject area for scholarly review. I have found scant literature specifically about children's rights to health from a nursing perspective and a plethora of literature from law, social work, and public policy. There are no contemporary New Zealand children's community nursing text books. This absence is notable when reviewing the children's community nursing texts from the United Kingdom and the United States. Overseas texts have significantly different health care systems and populations and the absence of local textbooks suggests that New Zealand children's community nurses have been particularly silent about the reality of their practice.

This literature review will build a picture, in broad brushstrokes, of how childhood is constructed and what children's rights are. It will then outline the political will of governments to provide protection and recognize children's rights to health, and finally construct a picture of how nursing has responded to children's needs and what children's community nursing does in relation to children's rights to health. For this literature review I have accessed information from a wide source of electronic and written texts. It is useful to utilize different disciplines theories as lenses through which to view the phenomenon of children's rights in an attempt to enhance understanding rather than as tools for explanation.

## ***The child***

### ***Genealogy of childhood***

Childhood at first glance seems like a social and biological “truth” yet Foucault (1984) maintains that historically the origins of Western childhood lie in the seventeenth century. Following the work of Phillipe Aries, historians have acknowledged that childhood is in part a social category rather than an immutable stage of life (Tennant, 1994). According to Dalley (1998) the conceptualization of children as the extension/ property of parents can be traced back to the Roman concept of ‘pater familias’, which gave fathers the legal right to administer their own form of justice. A Roman father could kill, sell, or otherwise dispose of a child as he did with his slaves (DuPont, 1994). As Naude (2005) points out the narratives of patriarchal society were controlled by men and therefore child-adult sexual relations for example, were often posited as normal, commonplace, and even beneficial to a child.

The roles of children have changed throughout human history and across different levels of social organization. Children in agrarian and early industrial societies were expected to participate in the work of the family from early childhood, helping other family members in household activities and caring for one another (Anderson, 1995; Zelizer, 1994). Many children died while still very young, and those who survived were expected to contribute to the family’s economic situation and, eventually, to the support of their aging parents. Zelizer asserts that there was little collective commitment to the provision of education or services to improve health, and only limited knowledge of the environmental factors that influence healthy development. By contrast, modern societies generally have less urgent need for children to enter the workforce, and the technological age demands a longer period of schooling and greater skill level and fitness from its workforce (Dalley, 1998; Freeman, 1997; Tennant, 1999; Wyness, 2000).

### ***Genealogy of the children’s rights in the 20th century***

The concept of “right” is so thoroughly ingrained in our way of thinking that we tend to think of the concept as a universal truth about humanity, but it too is a modern invention (Foucault, 1996). In European culture its origins go as far back as the Middle

Ages as landed nobility struggled with monarchs over the question of how much authority a monarch should have, and how much autonomy (self-law) the nobility should have (Hooker 1996). The concept of "rights," which can be provisionally defined as "principles of autonomy" determine which areas in life an individual is free to make his or her own decisions and which areas in life an individual can be coerced into a decision by either society or government. Hooker maintains that the history of modern Western culture has by and large been a history of the conflict between principles of "autonomy," through which we define ourselves individually, and "authority," between conflicting self-interests, and between groups that have certain rights and groups which are denied those very same rights.

Awareness of, and commitment to, protecting the health of children and to their nurturance has increased in recent decades (Zelizer, 1994). Observational and empirical research in the 20th century led by individuals such as: John Watson (behaviourism); Arnold Gesell (maturational stage theory); Sigmund Freud (psychoanalytic theory), Jean Piaget (cognitive development theory), Erik Erickson (psychosocial theory), John Bowlby (attachment theory), Urie Bronfenbrenner (ecological theory), and Arnold Sameroff (transactional theory), have created the conceptual basis for understanding the cognitive, emotional, and social importance of childhood and the roles played by both family and societal forces ( Keenan, 2002).

The social transformation of childhood in modern Western societies reflects a retreat from the view that parents have full and unlimited jurisdiction over their children to one in which the welfare of children is increasingly understood as a shared social responsibility which requires state investment in education, health care, and other institutions (Dalley, 1998; Flekkoy & Kaufman, 1997; Freeman, 1997; Giddens, 1997; Wyness, 2000). At the same time, there has been a growing body of evidence that children's development is influenced both by their families and by the social forces and cultural norms that society produces (Jack, 2000). Thus, children's health, development, achievements, and social attainments have come to require the interest, guidance, and protection of both families and society—not just for the intrinsic value of children but for society's collective future (Freeman, 1997; Smith Taylor & Gollop, 2000). Since the end of

the nineteenth century, following the period of social upheaval brought about by the industrial revolution, society has sought to have control over its social capital which included children. Child rearing was deemed to be too important to be left to the discretion of the family (Freeman, 1997; Smith et al., 2000 ). This view of childhood is embedded in the very foundation of such social institutions as schools and the health care system, which play important roles in preparing children for the challenges of modern times and ensuring that as they grow and develop into adults, they are prepared for life in an increasingly complex world (Chambon, Irving & Epstein, 1999; Dalley, 1998; Smith, et al., 2000).

From a public policy perspective, this emerging view of the child was crystallized in the major social changes that took place in the nineteenth and twentieth centuries. It was manifested in national policies: for providing health care to indigent populations; free and compulsory public education; mandatory immunizations to both protect individual children and provide group immunity against widespread epidemics of infectious diseases; policies for protection of the welfare of children; and the creation of the juvenile justice and child welfare systems (Cravens, 1993; Katz, 1997; Levine and Levine, 1992). The passing of the Public Health Act in New Zealand in 1900 followed by the establishment of a Public Health Department in 1901 seemed to confirm New Zealand's self perception as a social laboratory. The elevation of the physical welfare of the people to first place in the consideration of the government was considered a matter of national pride (Tennant, 1994).

### ***Definition of childhood***

Freeman (1997) proposes that the law tends to think in binaries (guilty/not guilty, capacity /incapacity) and creates the arbitrary distinction of where childhood ends. The law offers an example of rules which construct a discourse of the child. The definition of a child by the United Nations covers all human beings under the age of 18 unless the relevant national law recognises an earlier age of majority. However, the United Nation Convention emphasises that the substitution of an earlier age of majority must be in conformity with the spirit of the Convention and its guiding principles and thus should not be used to undermine the rights of a child.

There are no definitions of other terms used to describe young people such as "adolescents", "teenagers" or "youth" in international law. Some organizations have adopted working definitions to facilitate their programmatic work. The World Health Organisation (WHO), for example, has adopted the following working definitions: "adolescent" refers to any individual aged between 10-19 years; "young person" refers to any individual between 10-24 years; and "youth" to persons between the ages of 15-24 years (WHO, 1989, p.3)

In everyday language, the word "children" usually implies young children, especially those less than ten years of age. It is important to note however that UNCROC refers to all children by this term including those that one might normally refer to by other terms, for example, adolescents. The extensive provisions of the UNCROC apply to all persons under 18, but it may be that certain articles are of more relevance to young children, for example, basic survival, while others are more significant for older children, for example, protection from sexual exploitation and military recruitment (UNCROC, 1989).

## ***The State***

### ***Governmentality***

As described in Chapter 2, Foucault describes how a population is ruled by the techniques of power that govern how people conduct their everyday life. Therefore it is logical that the idea of being governed and the mechanisms of governance have always concerned people. Trading aspects of personal autonomy for reduced risk of harm is a concept radically illustrated in Margaret Atwood's dystopian novel *A Handmaid's Tale* (1984). The role of the state in protecting people from each other paradoxically restricts autonomy. Through an analysis of the novels of Atwood, George Orwell and other dystopian writers, readers are aware of the effect of the excessive power of government, and can draw historical comparisons with Nazi Germany, Stalinist Russia, and Maoist China. Gramsci's view of *power to* and *power over* reflects the types of government power used in Atwood and Orwell's literary examples (Haugaard & Lentner, 2006). The conceptual model of the autonomous, free individual was a foundation for the evolution of

human rights in the modern era. Foucault challenges us that we must severely check the state as an oppressive or potentially oppressive agency (Danaher, Shirato & Webb, 2000).

Foucault traces the tension between autonomy and privacy in the regulation of social and economic sphere back to the juxtaposition of two contradictory developments in the seventeenth and eighteenth centuries (1991). The Enlightenment, with its ideals of freedom and autonomy, aimed to limit state intervention in the private affairs of citizens. On the other hand a new rationality of government emerged, which took the welfare of the population as its primary and ultimate goal and thus provided an active and interventionist role for the state:

In contrast to sovereignty, government has as its purpose not the act of government itself but the welfare of the population, the improvement of its condition, the increase of its wealth, longevity, health etc. . . . the population is the subject of needs, of aspirations but it is also the object in the hands of the government. (Foucault, 1991, p.100).

Freeman (1997), challenges the idea that autonomy is a relevant determinant in the government of children. In Freeman's view children (and most other people) are not autonomous, free individuals; so that the ideal government is one which balances the rights of individuals and the rights of the collective. It should be fair, and just, and moral. In an "ideal moral world" relationships are based on significant values like "love, compassion and altruism" (Keinig, 1976; in Freeman, 1997 p.23). Such values raise relationships to a higher plane than duty. In an ideal world the relationships in a family are harmonious and children require neither rights nor external governmentality. However, as Freeman (1997), points out this is not an ideal world and he argues that children need their rights legislated to protect their integrity, dignity, and constitutions. In fact, this is essential to the realisation of the human rights of most people

There is an argument that children's rights are better served by governments with strong socialist democratic processes such as the Scandinavian countries. These countries feature prominently in the literature as having a primary commitment to promoting the health and well being of children (Freeman, 1997; Smith, Gollop, Marshall, & Nairn 2002; Muscroft, 2000; UNICEF, 2007). They do however accomplish this through rigorous governmentality, and legislative control of risk factors for adverse childhood conditions

including mandated nurse home visiting (Nilssen, 2005; Hassall 2007). There is a liberal attitude toward sexuality and sex education and a strong commitment toward making every child a planned and wanted child (Lin & Rantalaaho, 2003). Family planning is strongly supported and abortion and teen pregnancy rates are low (Kosunen & Rimpelä, 1996). Well child checks in many Scandinavian countries have almost universal uptake. Child homicide is also considerably lower than in New Zealand (UNICEF, 2007). Managing the values and attitudes of the conduct of individuals in these societies is, however, balanced by other controls such as limiting immigration which make these countries particularly homogeneous (Hagelund, 2005).

In contrast with Scandinavia, New Zealand identity politics has played a central role in the reconfiguration of governmental forms (Larner, 2001). A particularly powerful impetus has been the growing recognition of the politics of tino rangatiratanga and widespread acknowledgement of the claims of Maori as tangata whenua in both political and institutional contexts (Durie, 1998; Walker, 1999). The fact that New Zealanders are no longer treated as if they were culturally and ethnically homogeneous marks a qualitative shift away from the assimilationist and integrationist assumptions of earlier policy formulations (Larner, 2001). This has important implications for children's rights, since the proliferation of laws created to address the imbalance of power between children and adults in New Zealand, must also be recognized in policies regarding children across cultural groups and in particular with reference to The Treaty of Waitangi.

### ***Children's rights to health and neoliberalism***

It is worth considering how economic models impact on government policies toward children. New Zealand has had a strong social democratic history that is reflected historically in pioneering the introduction of universal suffrage and welfarism. The significance of economics on government policy cannot be understated, and in New Zealand the current health status disparities between groups of children is often described as an outcome of neo-liberal policies introduced in the 1980's (Blaklock et al., 2002; Child Poverty Action Group (CPAG), 2003). Neoliberalism briefly can be understood as increasing privatization and reduced government ownership of social structures. Restructuring of the public sector is widely attributed to the rise of neo-liberalism,



particularly after 1984, although it is also important to acknowledge the changing international context.

Larner & Craig (2002) argue that New Zealand's economic restructuring project has now been through three distinct 'phases': Firstly, in the 1980s the state withdrew from many areas of economic production, while at the same time attempting to preserve the welfarist and social justice aspirations associated with social democracy. The second phase was the more punitive era of the early 1990s when the market economy was extended and accompanied by the introduction of neo-conservative social policies. Most recently, there has been a distancing from the "more market" philosophy and individualised approaches of the earlier phases of neoliberalism. Now local partnerships are advocated as initiatives that embrace pluralism and inclusivity. The growing power of treasury and finance departments and "new managerialism" is seen in the rising importance of audit (Powers, 1997) and the new significance of contractualism (Ashton, Cumming & Mclean, 2004). For those working in the health care system the auditing process has manifested as the accreditation processes, competency requirements, and contractualism has significantly altered traditional nursing services with increased competition and managerialism.

The most obvious outcomes of two decades of neo-liberal restructuring in New Zealand has been a marked socio-economic polarization. This has given rise to the increased visibility of geographical "pockets" of poverty and ill health (Craig, 2002). In turn, increased spatial differentiation and geographical visibility of poverty is likewise showing a new middle class geographical space division based on "new prudentialism" (O'Malley, 1996). This new prudentialism is interpreted as the privatisation of risk as exemplified by burgeoning private health insurance and "cocooning" which includes the flight of middle class children to "good schools", accompanied by a growing likelihood that poor communities will slip into local crisis (Larner & Craig, 2002).

New Zealand is now entering a post neo-liberal phase. The split between policy and operations is now widely recognised as problematic, and there are sustained calls for more collaborative approaches involving multiple agencies to develop solutions to apparently intractable social problems. There is also a recognised need for increased interaction with local institutions and community organisations, through the building of successful models

of local coordination (Larner & Craig, 2002). This move toward local partnerships has strengthened the ambit of nurses, who I believe can be involved in locally based initiatives to address social issues. This emergent form of social governance is challenging accepted understandings of the policy making process and transforming institutional cultures (Larner & Craig, 2002). Moreover, the new form of social governance places a premium on the technical skills, personal goodwill and political activism of the locally oriented professional advocates –which I would suggest includes community children’s nurses, who are increasingly recognising the need for collaborative practice.

### ***Other Economic Discourses***

Children are seen to have an economic value which varies between cultures (Nauk & Klaus, 2007). Economic formulae that “calculate” the value of children seems an alien concept to me as a nurse, but from a Foucauldian perspective it is interesting to reflect upon the multiple different ways of interpreting the world and constructing “truth”. The discourses provided by economists include how they calculate the “value of life” of children (Birchenall & Soares, 2007; Heiland, 2001). Birchenall and Soares use economic formulae to evaluate the welfare implications of mortality reductions in which individuals choose the number of children they have, and are altruistic toward their children. In a similar vein, Heiland (2001) calculates the economic value of children based on birth order. The inference appears to be that economists can ‘measure’ variables like altruism, fertility choice, or birth order of children, and demonstrate how they are strongly predictive of the health and wellbeing of multiple generations.

Maverick economists Levitt and Dubner (2005) created a storm of controversy in the wake of their populist book *Freakonomics*. They extrapolated data to suggest that the violent crime rate in America had dropped partially as a direct result of the legalization of abortion. The premise was that the children aborted would have gone on to become criminals (in other words the “at risk” children of poor uneducated and young mothers). How disciplines construct knowledge and then use their knowledge as a source of power to formulate laws and rules illuminates Foucault’s idea of discursive formations, and his view of the nexus between power and knowledge. The neo-liberal economic forces have been credited with the breakdown of traditional society, and with creating the agenda of human

rights which are necessary in the face of the depersonalizing forces of the modern state and market economy (Smith, 2002). I believe that this is illustrated by the wave of youth crime reported in the news recently in New Zealand. The resultant political backlash and moral panic seems to suggest a discourse that children, and adolescents in particular, are problematised and not valued. Punitive strategies such as lowering the age of criminal responsibility and “boot camps” are being proffered as the solution to the perceived threat by children to national stability (John Key, State of the Nation Speech, January 29, 2008). Therefore, it can be seen within the wider context of society that economic discourses are a powerful tool as they are evident in both the prediction of the welfare of future generations, and in the evaluation of current government policies.

### ***Children’s Rights and the law***

The legal and ethical frameworks that enshrine children’s rights to health in New Zealand reflect international ideological shifts in the perception of the place of children in society. Children in our present society are given legal rights that were not accorded to children in previous generations (Dalley, 1998). There are many conflicting viewpoints about whether rights are appropriate or attainable for children. Some see that affording rights by themselves will not give children what they need unless they correlate with adult responsibilities and obligations (Guggenheim, 2005; O’Neill, 1988a). Wyness (2000) argues that within rights discourse there is a dichotomy between protectionism and liberated self determination. Wyness (2000) considers that the interpretation of “children’s rights” as “children’s liberation” conjures perceptions of undisciplined and unruly children challenging adult authority. Children’s liberation is also sometimes linked to the “loss of childhood innocence” through the exposure of children to the adult world.

Crossing the boundaries of child behaviour and adult behaviour, and in particular child sexual behaviour, is seen as harmful to childhood (Wyness, 2000). Childhood and sexuality are Western sacred cows of the present age (Kleinham, 2002). When combined as “childhood sexuality” the result is a taboo which when violated invokes swiftly punitive reactions. Naude’s (2005) analysis of the alternative discourses of convicted paedophiles, resonates with Foucault’s discussion with Hocquenghem and Danet when they presented a case for the decriminalization of sexual relations between adults and children (1988, p.271-

285). For me, putting an alternative discourse that might offer a rationale for paedophilia highlights the potential for discourse analysis to be highly provocative and discomfiting.

In the Western world, the legal right of children to be protected from sexual relationships with adults, as well as the right to not have to work, indicates that they have some rights that are specifically for children. On the other hand children's exclusion from the rights enjoyed by other members of society, as in the case of corporal punishment represents for Freeman (1997) a grave infringement of their basic human rights. Some like Guggenheim (2005) argue that children deserve the same rights as adults while others argue that they deserve special rights because they are children.

### ***Defining children's rights***

Rights are "entitlements, valuable commodities which we do not have to grovel or beg to get" (Freeman, 1997, p.70). A legal right may also be defined as any advantage or benefit conferred on a person by a rule of law. One legal definition of rights includes four essential elements: True claims or demands, liberties or privileges, powers, and immunities (Johnson, 2004, citing Hohfield, 1923, p. 67). Smith (2002) identifies two central ways in which rights talk has escalated throughout modernity and into late modernity with the consequential effect of marginalizing moral thinking in human affairs. The first concerns the association between moral and legal rights. Moral rights are routinely converted into legal rights as a means of ensuring compliance. Pre-modern social relations were more likely to rely upon trust as a motivational attitude towards promise-keeping and social exchange required by ethical codes. Similarly, from early contracts between citizens and the state, there has grown a complex array of international conventions and treaties.

### ***UNCROC***

The over-arching framework for children's rights is the 1989 United Nations Convention on the Rights of the Child (UNCROC). This was the first treaty specifically concerned with the rights of children and marked an important shift in thinking towards a rights-based approach which held governments legally accountable for failing to meet the needs of children. The Convention created a new vision of children as bearers of rights and responsibilities appropriate to their age rather than viewing them as the property of their

parents or the helpless recipients of charity (Flekkoy & Kaufman, 1997; Smith Taylor & Gollop, 2000)

UNICEF (2007) describes the Convention as the most universally accepted human rights instrument in history – it has been ratified by almost every country in the world (the two exceptions are USA and Somalia), and therefore uniquely places children centre-stage in the quest for the universal application of human rights. It is, however, an instrument that carries with it a number of reservations that inhibit full compliance on matters of protection, participation, and provision, of children and young people's rights. That children have "positive" rights does not settle the question of whether they do or should have moral rights. The idea of children as rights holders has been subject to different kinds of philosophical criticism. The various debates shed light on both the nature and value of rights, and on the moral status of children (Archard, 2006).

Children's rights are commonly viewed by children's advocates as falling into three categories: provision rights, protection rights, and participation rights (UNCROC, 1989). These are the same basic general human rights as adults although protection rights lie at the crux of the children's rights controversy. Children have specific human rights that recognise their special need for protection, in other words rights that recognise the developmental vulnerability and dependency of children on adults (Franklin, 2002; Freeman, 1997; Lansdown, 1994; Smith, Taylor & Gollop, 2000). Under UNCROC, children's rights cover four main domains of a child's life: the right to survive; the right to develop; the right to be protected from harm, and the right to participate, each of which is discussed below (UNCROC, 1989).

### ***Survival rights***

These rights are the right to life and to have the most basic needs met (e.g., adequate standard of living, shelter, nutrition, medical treatment). Children cannot choose the circumstances of their birth, nor where they live and generally do they not get to choose the food provided for them. Most importantly for this thesis, children cannot directly access health care (Freeman, 1997; UNCROC 1989).

### ***Development rights***

Developmental rights encompass rights enabling children to reach their fullest potential (e.g. education, play and leisure, cultural activities, access to information and freedom of thought, conscience and religion). Again children have limited ability to choose their access to activities, nor their cultural and religious orientation. Parental influence governs such freedoms (Freeman 1997; UNCROC, 1989).

### ***Participation rights***

Participation rights allow children and adolescents to take an active role in their communities (e.g., the freedom to express opinions; to have a say in matters affecting their own lives; to join associations). This is particularly pertinent to consent issues in child health (Freeman 1997; Flekkoy & Kaufman, 1997, UNCOC; 1989)

### ***Protection rights***

Protection rights are essential for safeguarding children and adolescents from all forms of abuse, neglect and exploitation (e.g., special care for refugee children; protection against involvement in armed conflict, child labour, sexual exploitation, torture, and drug abuse). The success of legislation to safeguard the health of children can be expected to have a considerable effect on the overall population because of the long reach of childhood on a society's health (National Research Council, 2004). Children's rights are comprehensively protected by a wide-ranging set of international and regional instruments spanning human rights, humanitarian and refugee law (Freeman 1997; Smith, Taylor, & Gollop, 2004; UNCOC 1989).

### ***New Zealand's commitment to UNCROC***

New Zealand has attempted to meet its obligation to UNCROC, through policy and legislation. Notable and relevant legislation includes the Children Young Persons and their Families Act (1989), The Children's Commissioners Act 2003, The Care of Children Act (2004) and The Families Act (2003). Frontline workers such as health workers, teachers, police, and social workers supported by the legal system, are mandated as officers of the state to enact policy and legislation.

Legislation and policy dictate that the States' response to the rights of children be balanced with the rights of adults. Debates in New Zealand look at both our compliance with UNCROC and the relevance of a rights based approach to child health. Governments are required to take appropriate measures to diminish infant and child mortality. This links with the Foucauldian theory of governmentality as the political state power to encompass a wide range of everyday practices. In this case- to provide medical assistance and health care to all children, to combat disease and malnutrition, to ensure appropriate prenatal and post natal health care for mothers, and ensure access to information that will promote health and prevent health problems (UNCROC, 1989). It is in "ensuring" "promoting" and "preventing" that the role and vocation of community nursing is invariably entwined. Based on the paucity of nursing literature on this subject, I would argue that this role is both inadequately analysed and inadequately recognized.

### ***Opposition to UNCROC***

UNCROC is one expression of children's rights that contains a number of competing aspirations. Burman (1997), for example, offers a reminder that upholding children's rights may be at the expense of familial or parental rights. She also alerts us to the potential of political manipulation in upholding rights. Burman says:

The call for children, like development, can be recruited for a host of other (including anti-feminist) purposes. And while children provide the rallying cry for aid to 'developing' countries, women become the means by which this aid is administered (1997, p.237).

To highlight these tensions it is helpful to take a wider look at the concept of children's rights, both historically and philosophically. Wringer (1981) argues that the discussion of rights has a long and chequered history and it is necessary to understand this to appreciate the conflicting reactions to its use now.

It is important to acknowledge the place of public opinion and its relevance to discourse analysis methodology. Public opinion as a concept gained credence with the rise of "public" in the eighteenth century. It dates back to the eighteenth century and was derived from the French 'l'opinion publique', which was first used in 1588 by Montaigne (Cutler, 1999). This concept came about through the process of urbanization, industrialisation and other political and social forces. For the first time, it became important

what people thought, as forms of political contention changed. Jeremy Bentham developed liberal democratic theories of public opinion that he saw would have the power to ensure that rulers would rule for the greatest happiness of the greater number (Cutler, 1999). He introduced Utilitarian philosophy in order to define theories of public opinion. Cutler also describes how Habermas contributed the idea of "Public Sphere" to the discussion of public opinion which has three features as to how public opinion *should* be formed: universal access, rational debate, and disregard for rank and status. According to Cutler, Habermas believed that these features are not in place in Western democracy but rather that public opinion is highly susceptible to elite manipulation which I think resonates with the Foucauldian notion of discourse formation.

The manipulation of public opinion regarding the children's rights discourse can be analysed from the different factions that have spoken about it. The degree of state intervention in child rearing is viewed by some commentators as a fundamental public interference in the private domain (Fraser, 1999; Gran & Daub, 2005). One example of the manipulation of public opinion is the move by the government to bring New Zealand into greater compliance with the terms of UNCROC by amending the law on corporal punishment for children (Watkinson, 2005). The repeal of Section 59 of the Crimes Act (corporal punishment using "reasonable" force) created a heated counter discourse that resisted the norms of the Convention. A public opinion digi-poll (New Zealand Herald, July 02, 2005) claimed that 71% of New Zealanders polled were against the repeal Section 59. Many parents objected to what they consider to be the inalienable right to decide what is best for their child (Black, 2006; Watkinson, 2005).

An example of the kinds of objections to the concept of children's rights comes from the right wing lobby group, the New Zealand Education Development Foundation. In their published anti- UNCROC report they state that the United Nations ignores evidence:

that the basic family unit of; married parents who worship, yields far superior social outcomes for children's health, intellectual development, and educational and income attainment, and lower rates of crime welfare dependency and teenage pregnancy. They also ignore polls that show that most mothers would prefer staying home to raise their young children [sic] (NZEDF 2001, p.1).



Another source of opposition to UNCROC can be seen in publications of the neo-liberal political group Libertarianz. Their welfare spokesperson recently called for the resignation of the Children's Commissioner as a protest against her support for compulsory well child checks for all New Zealand infants (Osborne, 2007). Thus it is clear that some societal groups oppose the structure and function of many of contemporary New Zealand laws related to children's rights under the terms of UNCROC. The contested nature of children's rights may have implications for nursing practice and was evidenced by the response by some opponents to the Plunket society support of the repeal of Section 59 of the Crimes Act. The abuse and neglect of children is a health issue and as has been described in Chapter 1, it leads to untimely death and long term psychological, emotional, and physical damage to children.

### ***Child Abuse***

Notions of trust, protection, and dependency, are evident in those discourses that venerate a sacred relationship between parent and child (Wyness, 2000). Abuse flagrantly breaches the fundamental tenets of that relationship. Theories on abuse and prescriptions for treatment rest on altering, breaking, and renewing the relationship. Parental responsibilities are seen as rights, or obligations, or blame if responsibilities and obligations are not met (Wyness, 2000). An analysis of the vast array of literature on domestic violence and child abuse - which is a social disadvantage in childhood – is beyond the scope of this study. However, there are strong correlations between violence and other health indicators for children, and so is integral to the work of the community children's nurse. It is a professional responsibility to act as an advocate for victims of abuse (Nursing Council of New Zealand, 2001). The Office of the Children's Commissioner has written guidelines on the role of primary health care providers in identifying and referring child victims of family violence (Maxwell, Barthauer & Julian, 2000). Some studies have described that many patients have identified that abuse screening is acceptable and that the health professional is someone who can support victims who disclose abuse (Friedman, Samet, Roberts, Hudlin & Hans, 1992; Koziol-McLain, Giddings & Rameka, 2005). Health professionals who adopt an abuse screening practice within their usual health assessment increase opportunities to provide early intervention and education on family violence (Koziol-McLain et al., 2005). Child abuse and neglect legislation such as the Children Young

Persons and their Families Act (CYPFA) (1989) also has implications for nursing practice in New Zealand.

### ***The Children Young Person and Their Families Act 1989***

The Children, Young Persons and Their Families Act (1989) is strongly based on the central tenets of UNCROC. The object of the Act is to provide for the care and protection of children and to maximise a child's opportunity to grow up in a safe and stable environment and to reach his or her full potential (CYPFA, 1989, section 7). The Act reflects the view that all efforts should be directed towards accurately balancing assessment of safety and risk with strengthening positive aspects in the individual, family and community systems (CYPFA, 1989). CYPFA has explicit implications for children's community nurses because it marked an official departure from the previous welfare focus that removed children from homes where they are at risk. Connolly and Doolan (2007), note that New Zealand child welfare legislation had previously followed trends from overseas particularly England, and the innovative new legislation marked a brave step toward greater family decision making, and reflected New Zealand cultural beliefs. Connolly and Doolan see that the discourse of "family support" has won over the discourse of "child rescue", but that the controversy continues when a child dies in the care of a family. One ministerial review found that care and protection services have long been seriously under-funded and troubled and there is an urgent need for a change in adult attitudes towards children (Brown, 2000). Donaldson (2007) suggested that there are too many unnecessary notifications to welfare authorities for issues that could be effectively resolved using existing community resources. Maxwell, Barthauer & Julian, 2000, suggest that Plunket nurses alone (no references have been found for the welfare screening by public health nurses or home care nurses) are in effect screening CYFS referrals because only 50% of the children seen as potentially at risk for abuse were reported by nurses. Nursing has therefore supplemented the under resourced social welfare service but this does not seem to be widely recognised.

Children's community nurses have an un-mandated and tacit role as a surveillance mechanism and referral source for the Child Youth and Family Services (CYFS). Kiro believes that the Act does not provide sufficient guidance on the point at which a family

requires notification to CYFS (Kiro, 2005). Therefore community health agencies use discretionary judgments which do not necessarily ensure preemptive action. Kiro cites the example of a mortally abused child- James Whakaruru, who is reported to have had forty contacts with health professionals during his four years of life, none of whom identified a need for referral to the authorities for investigation of potential child abuse. Munro (2005) sees that reports have the potential to fulfill a societal need to find a scapegoat, “focusing primarily on whether any professional was at fault” (p.378). Connolly and Doolan (2007) argue that the child maltreatment reviews have played a part in the risk-averse practices within child care and protection and is undermining the CYPF Act (1989). When adverse events occur in health care the mechanisms of the Health Practitioners Competency Assurance Act (2003) provides the review and disciplinary measures.

### ***The Children’s Commissioner Act 2003***

The Office of the Children’s Commissioner (OCC) monitors the performance of the state, individual officers of the state (including nurses), and individuals (parents in particular). I have found much of the literature, both web based and in the form of reports pertaining to the Children’s Commissioner has specific relevance to policy, politics and social work. However, my review of the literature revealed that there is little literature that relates to the specific roles community nurses play in children’s lives. This suggests that health is not perceived as a strong focus for the OCC, Last year only 2.5% calls to the Children’s Commissioner were about health related matters whereas 39% were about the CYFS (Kiro, 2007). This suggests that the OCC in New Zealand is more social work than health oriented. It also suggests that the role of nurses as one of the largest groups accessing children in their homes and filtering referrals to CYFS is largely invisible. The Children’s Commissioner is a statutory advocate for the best interests, welfare, and rights of children and young people in New Zealand. The general functions of the Commissioner include promoting and monitoring compliance with UNCROC. The Commissioner considers New Zealand is making great gains in the work towards addressing child poverty, violence, and children’s rights and supports the collaboration between government bodies and non-government organisations for its potential to offer a more comprehensive approach to meeting the needs of children (Kiro, 2005).

Policy development work by the Children's Commissioner aims to integrate planning and service delivery for children in New Zealand (Kiro, 2005). Specific recommendations include disaggregating health service data to provide better data on spending in child health services. For example, 14 percent of the health budget is allocated to the 27 percent of the New Zealand population that are under 18 years. The Commissioner aims to monitor hospitalisation and mortality rates for children annually, aiming to create greater responsiveness to trends. Devolving responsibility for child populations to geographical areas requires all health boards to provide measurable child health strategies. A vital aspect of a functioning and cohesive child health strategy requires integration of services with inter-sectoral collaboration. For example, The Aplin Report (2003) highlighted areas of convergence between the different Ministries of Justice, Health, Education, Police, Social Development, and Child Youth and Family Services (CYFS). The health status of children is significant to all domains of their life and should therefore be an integral consideration for all of the different ministries.

## ***Children's rights to health and medicine***

### ***Epidemiology***

The "long reach of childhood" (Silva & Stanton, 1996) essentially means that childhood experiences impact upon the life course of all individuals. The multiple publications from the maturation of the Dunedin cohort provide insights into environmental determinants of the genesis and progression of ill health; including social, physical, political, and health service delivery (Belski, Jaffee, Sligo, Woodward, & Silva, 2005; Fergusson, 1994; 1998; Jaffee, Moffitt, Caspi, Fombonne, 2002; Moffitt et al., 2007; Silva & Stanton, 1996; 1998; Starfield, 2005). The Dunedin cohort is hailed as one of the most significant longitudinal studies in the world today.

In addition, epidemiological standards are used by governments and international bodies to measure the health status of children in different jurisdictions. These measurements include indices such as: hospital admissions, child deaths, infectious diseases, chronic illness, immunization uptake, and accidental and non accidental injury rates. Examples of the status of New Zealand children include the rate of accidental injury which is second highest in the twenty-five OECD countries. New Zealand's teenage birth

rate has now passed Britain's, moving from third to second-highest among developed countries with 30 births for every 1000 young women aged 15 to 19 in 2003 - almost double the OECD average of 16 (UNICEF, 2007). Blaiklock (2000) reported that social and economic policies have undermined families, despite the evidence of the importance of communities and social capital to health. Furthermore, New Zealand has become an increasingly fragmented and troubled society. Blaiklock uses our WHO ranking of 41<sup>st</sup> in international standards for our health system as evidence that our struggling frequently restructured services could do much better.

*More than an Apple a Day* (Office of the Children's Commissioner, 2006) provides an excellent snapshot of the current status of child health through a comprehensive review of a range of publications from 2000. The report discusses the progress of the Child Health Strategy (1998), which is a fundamental guiding policy document targeted at achieving child health goals by 2010. The report points out that there have been some improvements in child health indicators, such as a reduction in the number of children dying in their first year of life, and reduced teen suicide rates. However, on the whole there are many worrying signs that the nation's health is worsening or likely to worsen. The 7th Innocenti report on the wellbeing of children and young people in the world's advanced economies shows New Zealand consistently scoring in the bottom third of countries on a number of measures including: immunisation, spending time with our children, teenage pregnancy, child homicide and having parents out of work (UNICEF, 2007). The epidemiology of child health in New Zealand has significant implications for the different cultures in New Zealand.

### ***Cultural differences in child health***

Nursing in New Zealand in the 21<sup>st</sup> Century is increasingly multi-ethnic and multi-cultural. Disproportionate numbers of both Māori and Pacific Island children in New Zealand have high health needs and are therefore high users of both community nursing services and hospitals. This creates moral and ethical challenges when working within and across groups that have distinctive cultural mores and values (Conrad, 2006; Leininger & McFarlane, 2002; Miers, 2003). This is particularly evident when nursing children from families that do not conform to the concepts of children's rights and their correlative social

obligations embodied in UNCROC. Across cultures there are variations in how children are viewed and valued which makes children's rights issues contestable (Conrad, 2006; Freeman, 1997).

Māori children's health statistically lags behind that of non Māori (NZ Ministry of Health, 2002b). In 1999 approximately 46% of children and young people with substantiated findings of abuse and neglect were Māori 34%.European, and 11% Pacific Island (NZ Ministry of Social Development, 1999). In a narrative of her experiences as a public health nurse, Ramsden (2002) suggested that non- Māori nurses and health systems were contributing to the lack of trust that acts as a barrier to indigenous families engaging with nursing services. In addition Kamira, Campbell, and Campbell (1999), identified that health education resources needed to be specifically targeted at Māori from a Māori perspective. Ratahi (2001) also supports the Māori model of care for a culturally specific health service.

Immigration has influenced health inequities in New Zealand with measurably poorer health demonstrated in children of immigrants from less affluent countries, such as the Pacific Islands (MOH, 2002a). There are some interesting paradoxes however for example, child mortality and morbidity rates in the Pacific Islands, while improving, are significantly higher than for the same ethnic groups living in New Zealand. The example of childhood illness and death rates in Tonga, suggest that it is partly as a result of the dominance of traditional healers over the Western model of disease treatment and partly because of the limited health care resources in that country. One of the reasons for the falling death rate though, is attributed to universal Tongan immunisation uptake in part because of the societal pressure to conform (Moate, 2007). From a Foucauldian perspective, Tonga has strong sovereign, tribal, and church, authorities that dictate the rules of behaviour, and which viewed from a cultural relativist stance is how the "truth" is perceived in Tonga.

There are moral principles that frame the complex minefield of transcultural nursing and it is important that these principles are discussed briefly as they facilitate an analysis of the moral position of nurses. The principle of ethnocentrism (one truth) is the viewpoint that one's own group is central and superior to everything against which all other groups

are judged (Stanhope & Lancaster, 2006). Cultural relativism (multiple truths) was in part a response to Western ethnocentrism and acknowledges that cultures are different and that the differences have equal value relative to each culture (Zammito, 2001). Universalism (also referred to as monism) on the other hand recognises that while there are cultural differences there are universal human truths which transcend those of culture. UNCROC can in some ways be viewed as an example of the ethos of universalism (Freeman, 1997; Zammito, 2001). Pluralism is the principle that cultural “truths” can be transferred to create a workable compromise (Freeman, 1997).

Freeman (1997) gives a cogent analysis of the different and conflicting moral principles that can apply to nursing in the dynamic multicultural environment of the urban New Zealand communities. Freeman uses the positions of cultural relativism, monism and pluralism to debate the practice of female genital mutilation. The practice is culturally imbedded in some Muslim countries particularly in North Africa. A cultural relativist’s view maintains that since it is a cultural practice, it is therefore acceptable for those who practice it. The monist view is that physical mutilation of a child is not acceptable under any circumstances. The pluralist view is that there are potential means to negotiate a reduction in the physical damage to a child whilst also acknowledging the social norms of a culture to alter genitalia. Freeman uses the example of the symbolic technique of nicking the female genitalia as practiced in Muslim Egypt as a pluralist solution to a complex children’s rights issue.

### ***Access to health care***

There are social influences in the children’s right to health relevant to nurses working in the community and a brief review of some of these influences are highlighted in the sociology of health care literature. Conrad (2006) describes Fuch’s (1974) research which concluded that the population of Utah had considerably less disease than those of Nevada, not because of economic differences, but because of the predominantly Mormon lifestyle choices and values of the former. Therefore, Fuchs concluded that the greatest potential for improving health lies in what people do and don’t do for themselves. Whereas, Tesh (1981) argues that the life-style hypothesis approach to disease treats ill health as the result of personal failure, and therefore is a victim-blaming approach that dismisses most

environmental toxins, and ignores the crucial connection between individual behaviour, and social norms and rewards. Glanz, Rimer, & Lewis (2002) note that programmes which focus on system change must ultimately be concerned with both the behaviour and health of individuals. Moreover, system-change approaches ultimately rely on the consent of the governed in a democratic and pluralistic society, and must deal with the issue of conflicting values. Bloomfield (2002) argues that targeted culturally specific health promotion to marginalized groups is an effective means to change behaviours. Bloomfield uses the example of a public education campaign to reduce Sudden Infant Death Syndrome (SIDS). The incidence of cot death amongst European New Zealanders reduced several years before Māori and Pacific Island rates- which fell only after targeted campaigns aimed to redress the imbalance.

The inverse care law contributes to the argument that a democratic and pluralistic society must be concerned with both behaviour and health of individuals. Proposed by Julian Tudor Hart (1971), this law states that: "The availability of good medical care tends to vary inversely with the need for it in the population served" (Tudor Hart, 1971 p.405). There is much evidence in the literature that the socially deprived are more prone to ill-health but are less likely to obtain access to high-quality medical care (Barnett & Coyle 1998; Webb, 1998). Related to this is the concept of *distributive justice*: the idea that healthcare resources should be allocated fairly (Barwick, 1992; Webb, 1998). In reality, it is often those who shout loudest who get heard first. Health professionals are urged to look beyond the patient's capacity to "shout" and assess their true level of need (Webb, 1998).

Rationing of medical resources is a fact of life in most health systems to a greater or lesser extent, and there are clearly no simple criteria for just resource distribution however, services should be targeted at children in need (Webb, 1998). Community nurses are in a position to take health care services to the children in their homes and schools, regardless of whether parents have actively sought their service. Once at the home the nurse is able to identify the lifestyle choices and stressors that create barriers by assessing both needs and risks and then work out strategies to overcome the barriers to the right of children to health (Nies & McEwan, 2007). Some of the lifestyle choices and stressors are seen to reflect the economic policies of New Zealand described earlier.



## ***Summary***

In this chapter I have given a brief overview of the genealogy of childhood and defined childhood. I have then reviewed literature from law, government policy, economics, children's rights, and sociology. This has provided a broad overview of the discourses that have been constructed in contemporary New Zealand society around the subject of children's rights to health. This part of the literature review frames analysis of the perceptions and practices of children's community nurses in the context of children using the Foucauldian concept of governmentality and biopower. Foucault uses the concept of government in a comprehensive sense referring to an art of directing people and includes the interaction of forms of knowledge, strategies of power, and modes of subjectification. Foucault saw that neo-liberal political rationality aimed to extend the economic form to the social, beyond the critique of the welfare state (Lemke, 2001). The children's rights movement notably galvanized by the United Nations Convention on the Rights of the Child, has led to greater government involvement in the daily realities of childhood and is led to the establishment of further government structures such as the Children's Commissioner. The literature around the role of the children's community nurse within the children's rights discourse will be reviewed in the next chapter.

## **Chapter 4: Children's community nursing**

### ***Introduction***

In this chapter I look at the genealogy of children's community nursing in the context of children nursing in general. Since children's rights are an ethical concern I look at some of the ethical theory behind children's nursing. I then outline the discourse of surveillance in community nursing and the underlying construction needs and risk assessment that drive community children's nursing practice. What nurses do involves the technologies that they employ to manage the needs and risk that they assess, this includes the family centred care model, the use of therapeutic communication techniques, the relevance of the space that community nurses practice in, and the techniques of health promotion. I conclude with a brief review of the children's community nursing issues that have been discussed in two New Zealand nursing journals in the last decade and some relevant New Zealand research theses.

### ***History and genealogy***

As described earlier Foucault's concept of genealogy recognises that past discourses are always present in contemporary discourses. Delving into the genealogy of children's rights uncovers a discourse of children's "welfare" that predates the children's "rights" movement. Child welfare also focused on the central domains of survival, development, and protection but did not include participation in its mandate (Dalley, 1998). The development of children's nursing in post colonial New Zealand has followed many of the developments in Britain. The establishment of Foundling Hospitals in the United Kingdom in the mid eighteenth century was a response to the plight of the abandoned children of the poor (Glasper & Richardson, 2006). Glasper and Richardson describe how separating children from their families in order to scientifically treat illness illustrated the dichotomy of the separation of the psychosocial from the biological. High mortality rates in institutions, coupled with the belief that children should remain with their families, led one Dr George Armstrong (1719-1789) to develop community dispensaries. As a result he is considered by many as the "father of ambulatory care" (Glasper & Richardson, 2006, p.7). Like Britain the New Zealand public hospital was initially established for the "deserving poor", whilst those who could afford to pay employed doctors and nurses privately in their

homes (Pybus, 1984; Tennant, 1994). Over time, and with the increased sophistication of medical knowledge and technologies, particularly after the First World War, hospitals became seen as places of cure, rather than places for the poor to die.

Children's community nursing in New Zealand began in the late 19th and early 20th century and was often led by the medical profession. Eugenics and social Darwinism were dominant ideologies in the early history of the public health movement in New Zealand (Tennant, 1994). Despite eugenics later progressing down the slippery slope to human rights violation seen in Nazi Germany, one of the positive consequences of the eugenics movement was the attention to national fitness and public awareness of child health issues (Bryder, 1998; Dalley, 1998; Tennant, 1994). In response to high infant mortality and poor child health the eugenics movement underpinned the benevolent paternalistic discourse of the era and was evident in the language and histories of New Zealand institutions like the Plunket Society, the school health service, free school milk, and the health camp movement (Bryder, 1998; Pybus, 1983; Sullivan, 2007). It also translated into the construction of state maternity hospitals by Richard Seddon's government (1893-1906) to combat the high rate of perinatal mortality, and heralded the medicalisation of childbirth (Wood & Foureur, 2005).

Infant mortality in the early 1900's was running at 73 per 1000 live births for European and 230 per 1000 for Māori infants (Tennant, 1994). At the beginning of the 20th Century, the illness and mortality rate amongst Māori infants was particularly high as a result of introduced European infectious diseases and the economic and social effects of colonisation (Bryder, 1997; Pybus, 1984). By 1936 the European rate was down to 9.5 per 1000 and Māori 103.8 per 1000 (Bryder, 2001). Tennant noted cynically that the States' interest in the social capital of children was prompted "more by the need for hardy cannon fodder than benevolent regard for child health" (p.23). As can be interpreted from the infant mortality rates, prior to the introduction of the welfare state in 1938, they had improved by 87% for European and 55% for Māori, and the disparity between ethnicities was still marked.

The paternalistic style of delivery of services may have created ambivalence and mistrust, however from the statistics cited above; the nature of the health system may have

contributed to the salvation of almost decimated indigenous population. James Pope wrote in his 1901 edition of the Inspectorate of Native Schools manual “Health for the Māori” that Māori would only avoid extinction by following English laws and abandoning traditional customs. Pope wrote that by following the “rules” of hygiene and modern sanitation, Maori would become “healthier, happier, more useful and better people” (1901, p.3). The humiliation experienced by Māori through this period of welfare colonisation may arguably have been the genesis of the ambivalence described by some Māori toward European nurses today (Ramsden, 2002).

Child health texts throughout the 20<sup>th</sup> century continued to follow a paternalistic and prescriptive tone. The diagnosis of the problem and the solutions put forward were the same everywhere – mothers were ignorant of the correct methods of childrearing and needed to be educated (Bryder, 2003). This corresponded with the very powerful discourse of motherhood as a natural condition of femininity. This language was not exclusive to healthcare professionals, but reflected the authoritarian communication style of the times. Education for example, previously only for the elite in society, became available for all. Authority and discipline were considered essential and so prescriptive schooling involving rote learning and corporal punishment were the socially accepted norms (Lowe, 2000). The discursive style of the language of authority in society changed with the development of the human rights movements of the 60’s and 70’s (Bryder, 2003).

Dalley (1998) points out early that 20th century “Industrial schools” established to deal with socially deprived and “delinquent” children tended not to cater for Māori children. In addition, Bryder (1998) describes how rurally based Māori mothers had traditionally been looked after by health department district nurses whose role evolved from the native nurse service in 1911. Plunket maintained a particularly Eurocentric and middle class culture and reputation (Bryder, 2003). Often Māori families chose the services of the public health nurse over Plunket until the contract for services barred Public Health nurses from the care of under 5 year olds in the early 1990’s (Bryder, 2002). Until the acceleration of Māori urban migration from the 1960’s, Māori children that came to the attention of the social authorities tended to be dealt with by their tribal groups.

A reflection of the marginalisation of Māori can be seen in Dr Watt's "Practical Paediatrics: Guide for New Zealand Nurses", where he extolled public health Nurses to "bear the responsible burden" of "raising the health of the Māori to the same generally satisfactory level of the European" by improving housing, hygiene, immunization, and health education (Watts, 1964, p.196). Foucault (1977) describes how genealogies demonstrate "new continuities and discontinuities amongst the ideas and practices of a field" (p.146). For example, the genealogy of the Māori health discourse in New Zealand can be seen in the thread that runs from Dr Pope's (1901) desire for Māori to become "healthier happier more useful and better people," through to Dr Watts (1964) desire to "raise the health of Māori to the same generally satisfactory level as Europeans", and with the Māori Health Strategy (2002) which states that: "If Māori are to live longer, have healthier lives and fulfill their potential to participate in New Zealand society then the factors that cause inequalities in health need to be addressed" (p.2).

Pope (1901) and Watts (1964) both encouraged nurses to be the bearers of the discourse of health to the homes of the disadvantaged. Although as Bryder (2003) describes, the medical profession was anxious to maintain control over the scientific content of the discourses. Despite criticism of the performance of individual nurses, there seems to be a theme throughout the history of the Plunket Society that it was the individual nurses' ability to relate to mothers that has been key to its contribution to child health. Plunket committee reports suggest that Plunket nurses established close relations with many mothers (Bryder, 2003). Similarly, native nurses then district and public health nurses were commended for the respectful relationships and trust that they developed within the communities they served (Pybus, 1984). The necessity for a relationship of mutual trust and respect is at the core of much effective community nursing and is highlighted in textbooks and papers on the subject (Davis, Day & Bidmead, 2002; Saucier-Lundy & Janes, 2003; Sidey & Widdas, 2003; Spradley & Allendar, 1997). At the core of a trusting relationship between nurses and families is a conception of rights and duties or the ethical relationship. As described earlier in the thesis, children's rights are a formalised moral position toward children.

### ***Ethical Dimension of nursing***

The study of ethics deals with what is good and bad, right and wrong, fair and just, and with moral duty and obligation (Rogers & Niven, 1996). It is therefore useful to review the relevant nursing ethics literature because it reflects upon the moral position of nursing towards children's rights. It also highlights how the discourse of the nursing relationship that can obscure power relationships between nurse and parent. In a critique of community nursing education, Zahner (2000) calls for future community health and public health nursing textbooks to include more emphasis on our ethical responsibilities to "advocate policies that promote human rights and social justice" (p.186). Furthermore, Zahner argues that nurses should be conversant with ethical theories and perspectives such as utilitarianism, deontology, human rights, and distributive justice. This is echoed by Chafey (1997) who calls for "...a community-based practice ethic that can address the just allocation of scarce resources, universal access to health care, and benevolent public policy governing the distribution of social goods" (in Spradley & Allendar, 1997, p.220). Racher (2007) sees that inclusion, diversity, participation, empowerment, social justice, advocacy, and interdependence create an evolving ethical foundation to support community practice. Marcellus (2004) recognizes the intimacy of the ethical dimension in nursing and suggests an ethical framework for children's community nursing to be the 'ethics of relation.' Marcellus cites Dillon (1992) in describing relational ethics as a movement away from strictly justice based bioethical principles and Kantian individual autonomy. Within this ethical framework the nurse responds on an individual level with a family, "relation is reconstructed as the ethical moment where people connect with each other" (Marcellus, 2004, p.417). Marcellus notes that themes of mutual respect, engaged interaction, embodiment and creating an environment of freedom and choice are necessary for a relational ethic to flourish. Similarly, as Bauman (1993) notes, people behave morally every time they act spontaneously to help another, or oppose certain actions because they know intuitively that it would be wrong to do otherwise. However, this presupposes that intuitive morality and what people constitute as "truth" is universal. Also, radical political and religious ideologies can justify actions as morally right. This understanding of morality is not one that "constructs the autonomous moral subject and, in place of its lived relations

with others, hands it back rights” (Kerruish, 1991, p.147), but one that is necessarily grounded in lived relations, experience and human connectedness.

The assumption of an ethically harmonious relationship between the community children’s nurses and parents is challenged by Peckover (2002) who sees that increased engagement with the personal spaces of clients lives has been described as a “discourse of the social” or as a medicalisation of the social space. Peckover interviewed both English health visitors and mother/clients in her study and found that alongside the empowering and non-hierarchical relationships emphasised as the preferred professional discourse, there is a coexisting disciplinary and surveillance mechanism that undermines the relational ethic and “friendship” aspect of the relationship. In this context Peckover identifies Foucault’s notion of pastoral power which allows us to see the regulatory role of health visiting work, as mothers become the subject and object of the health visiting gaze.

### ***Surveillance in nursing***

In describing the politics of health in the eighteenth century Foucault (1980) sees the privilege of the child and the medicalisation of the family as a series of obligations imposed on of illness outside the corporal space of the body (Armstrong, 1995). It is argued that this new medicine has important ramifications for parents and children. These obligations are of a physical kind such as care, contact, hygiene, cleanliness, attentive proximity, and suckling. Health and principally the health of children became one of the family’s most demanding objectives. Furthermore, Foucault sees that the private ethic of good health as a reciprocal duty of parents and children required a professional medical corps recommended by the state. Surveillance medicine involves the problematisation of normality, the redrawing of the relationship between symptom, sign and illness, and the localisation implications for the constitution of identity in the late twentieth century (Armstrong, 1995).

Surveillance techniques have become a fundamental part of life in western societies (Danaher, Shirato & Webb, 2000, p.54). In routine daily work the nurses are required to carry out assessments of family function and therefore use what Parker and Wiltshire (1995) refer to as the nursing “look”. The nursing “look” is an extension of the Foucauldian

concept of the “gaze” which refers to the medico scientific abstractions that normalise, constrain, and control. Contrasted with the medical “gaze” nurses both scan (reconnoiter) the environment to survey the terrain and maintain an embodied relation with individuals (connaissance). The challenge is seen as “looking to care or caring to look” (Sandelowski in Hein, 2001, p. 283). In community nursing the nursing “look” identifies the “abnormal” and contextualizes it in the home environment. The searching nursing gaze in many ways has the potential to be even more penetrating than traditional understandings of the medical gaze. Holistic ideology is seen by some to counter criticisms of the dehumanising nature of health care, as well as being a technique of surveillance designed to discipline patient’s bodies (Lupton, 2003). In addition, community nurses are often used to gather the data for epidemiological and managerial purposes in order to identify the genesis of illness or the direction of service management (Mitchell et al., 1997; Tonkin, 1986). This demonstrates both the surveillance of individual bodies with the surveillance of populations, a set of practices that mirror Foucault’s conceptualization of biopower (1979).

Nurses describe feeling moral discomfort at having to play the part of “health police” (Marcellus, 2004). In preferring to maintain a trusting relationship with parents that emphasize caring and nonjudgmental attitudes, they can become targets of criticism for failing to intervene appropriately with “families at risk” (Kiro, 2005). However, as Parkinson (2003) points out in a critique of the debate around adoption law in Australia “pitting children’s rights against parental rights is altogether too simplistic a notion... Even dysfunctional and abusive families have complex patterns of interrelatedness, which make it problematic to conceptualize issues in oppositional terms” (Parkinson, 2003, p.148). From an impersonal distance, the law, the media, and the general public may take the moral high ground when a child’s life is harmed by parental actions. In the intimate sphere of nursing, such simplistic views of children’s rights confuse more than illuminate, furthermore children’s rights cannot be examined in isolation from the family context. Surveillance is also fundamental to nursing assessment of needs and risk which may or may not be congruent with the perceptions of the child’s caregivers (Cain Hyde & Hawkins, 1995; Nies & McEwan, 2007).



Appleton (1996) found that nurses are the most likely to identify vulnerable families who are experiencing crisis, ill health and child abuse. The nurse's ability to support families at risk was found to depend on their being able to utilise six inter-relating factors. These factors were: knowledge of the family's community, reflection-on-action, situations/families which caused the nurse to be concerned, the nurse's own knowledge base and experience, past history of the family, and a degree of gut feelings and instinct.

### ***Family Centred Care discourse***

The philosophy of family centred care espoused by the children's nursing community since the 1950s is based on the premise that parents are a constant in a child's life (Lawlor & Mattingly, 1998). The philosophy focuses on working in partnership with families to support the family to manage the care of the child (Valentine 1998; Whyte, 1992; Wright & Leahy, 2005). Thus, the child's family must be included in the planning and decision-making related to the care of the child. The "family centred care" model focused on the child in the context of the family; latterly this has evolved into a "family systems approach" which focuses on the care of the whole family (Glasper & Richardson, 2006). The family systems orientation focuses on gathering information about the whole family to assist the family develop strategies to meet the needs of its children.

Assessing a family includes: mapping a genogram/ecomap, assessing the developmental stages of the members of a family using developmental theorists like Piaget and Erickson, and using functional assessment to observe how the family members interact and communicate and what alliances and boundaries exist (Glasper & Richardson, 2006). As described in Chapter 1, Thompson (2008) analysed a new nursing role being trialed in Europe- the Family Health Nurse (FHN). The FHN is a generic community nurse combining the roles of health visitor and district nurse in a role that also resembles that of a public health nurse. Thompson challenges the intensity of the use of in-depth assessment in the model that includes the use of genogram and ecomap. The use of the intensive assessment is a surveillance strategy that aims to facilitate the identification for "at risk" families. Thompson sees this as a shift in power relations between the nurse and family, since once a family is labeled "at risk" they become the subject of even greater surveillance.

Family centred care can be viewed as idealistic and difficult to implement, especially in situations where family members are abusing children (Lawlor & Matting, 1998). Information between parents and health professionals can be undermined when abuse is suspected. The potential also exists for health professionals to unwittingly collude with parents or caregivers. When the best interests of the children are paramount, the fundamental concept of parents as constants in a child's life may become compromised if they are also the perpetrators of abuse (Wilson, McBride-Henry & Huntington, 2004).

## ***Needs and Risk***

### ***Needs assessment***

Children's rights to health are closely aligned with the discourse of need and the discourse of risk. The concept of needs is challenging to those who work in children's community nursing because the definition of needs is contestable. Appleton and Cowley (1999) discuss the debates in Britain to define "need" since assessment of need determines who should fund services (social or health providers). The authors go on to point out that only individuals with specific illnesses or risks are viewed as a legitimate focus for a "needs led" health service. In this way families who display no overt problems have no need for health services. This is reflected in New Zealand by the contracts for health services including Plunket, public health, and home care nursing (Macfie, 2006). Many contracts that increase flexibility of service for high deprivation areas have also reduced services to the more affluent areas (Beatson, 2007; Macfie, 2006). Macfie concludes that all children and families have needs and all needs matter. Macfie also recommends that socio-ecological frameworks and capacity building approaches for health needs assessment ensure appropriate, contextual and effective health strategies.

Public health policy hinges on the notion that health is a crucial public good that heads society's hierarchy of needs (Appleton & Cowley, 1999). Health care policy predominantly deals with treating "downstream" ailments, and is demand driven, in contrast with public health policy which focuses on "upstream" conditions that promote a healthy population. Reviewing definitions of public health is beyond the ambit of this thesis (useful discussions can be found in Baum, 2002; Beaglehole & Bonita, 1997; Hunter, 2003). It is important, however, to acknowledge that different views exist about what public

health is. From a broader perspective King (2001) sees that public health is influenced by a wide range of determinants: economic, social, cultural, educational, lifestyle, and so forth. In this view, differing combinations of determinants (and related public policies and activities of government) will affect differing health states (Gauld, 2004).

Some see the discursive trajectories of health care as following fads and fashions, what Foucault terms discursive formations (1972). In the 1970's nurses were encouraged to identify clients and patients needs, in the 1980s to provide quality services to consumers and now the focus is on protecting users from risk or harm (Alaszewski, Alaszewski, Ayer & Manthorpe, 2000)

### ***Risk Assessment***

Nurses, as with all professionals in a technologically driven society, are collectively preoccupied with assessing and managing risk (Alaszewski et al. 2000, p.1). Risk can be seen as a threat that has a potential to result in harm, loss, or negative consequences, and is interchangeable with the concept of hazard ("Risk." *Merriam-Webster online dictionary*, 2007). In addition unintended or unexpected outcomes of decisions or a course of action are integral to the concept of risk for health and welfare services (Alaszewski et al., 2000, p.4). Within risk theory, Houston (2001) sees that a key fissure has emerged. On the one hand, objectivist theories continue to treat risk as a measurable entity, while on the other, subjectivist accounts approach risk as a socially constructed phenomenon. Houston argues for the reconciliation of objectivism and subjectivism within the critical realism perspective to redirect our attention to the deep-seated causes of harm or the underlying mechanisms that, when activated, give rise to situations involving risk. Lupton (1995; 1999) has extensively looked at the discourse of risk as a power and control mechanism to govern behaviour through fear. Lupton sees that risk is an attempt to tame uncertainty.

Professionals are socialized into viewing risk in particular ways and are aware of the legal obligations and disciplinary forces such as the Health Practitioners Disciplinary Tribunal (HPDT) established under section 84 of the Health Practitioners Competence Assurance Act (HPCAA) (2003). Health authorities are held accountable for the quality of professional decision making and overall risk management in an agency. Alaszewski et al (2000) discuss the community nursing care of vulnerable groups (mental health clients,

learning disabled, and elderly) which can also be applied to children. They argue that a narrow definition of risk assessment and management has the danger of restricting nurses to the role of community “police force”. In contrast with Maxwell, Barthauer & Julian’s (2000) report for the Children’s Commissioner, described earlier, there is a criticism that nurses have too wide a definition of risk assessment and management, and are expected to be a community police force but are not adequately fulfilling this tacit obligation.

Giddens (1984;1991) who defines risk as a threat to security and wellbeing identifies that the powerlessness and anxiety experienced by individuals when responding to risk are counteracted by trust. Giddens argues that the nature of modern societies disrupts the highly personalized and localized trust relationships that supply the support and expertise that shield individuals from risk. In modern societies the resources and expertise required to deal with major threats need to be supplemented by a safety network of agencies. The reliance on the impersonal support provided by welfare agencies and professionals creates the paradox; that highly intimate domains of an individual’s life become dependent on strangers. Giddens sees that in order to build trust in professionals lay people need to fully be able to understand how and why decisions are made and to feel that they are involved in the process and thus maintain their locus of control.

The “risk discourse” literature applied to children is strongly represented in the child abuse and child protection frameworks. Hussey, Marshall & English et al., 2005 study has found that there is no difference in adverse behaviours between children that have had substantiated child abuse reported and those with unsubstantiated child abuse. This suggests risk factors that lead to a report continue to be detrimental to children even when they have not reached a threshold for action. Therefore the protective, non mandated presence of children’s nurses in the home can have the potential to ameliorate risk factors (Olds, Sadler, & Kitchman, 2007; Olds, Eckenrode, Henderson, et al., 1997; Olds, Henderson & Cole, 1998).

### ***Neglect and parental competence***

Neglect is the most common form of child maltreatment internationally (Dubowitz & Bennet, 2007). Dubowitz and Bennet maintain that it can be caused by insufficient parental knowledge as some commentators maintain that intentional negligence is rare.

Paavilainen and Åstedt-Kurki, (2000) found that lack of resources for caring within the family emerged as the core category in the phenomenon of child maltreatment and was connected to all other categories of family functioning.

One North American paper describes the legal concept of parental competence (Nair & Morrison, 2000). The assessment of competence is indicated when infants and young children are at risk of serious harm. This occurs particularly when parents are unable to identify or respond to a child's physical mental and social needs (Abosh & Collins 1996; Alanen, 1998; Aldridge & Becker, 2003; Barankin & Greenberg, 1996; Booth & Booth, 1998; Nair & Morrison, 2000). Risk factors that have been attributed to parenting difficulties include parental intellectual disability, physical disability, and mental health issues that include problem gambling and substance abuse and a history of physical and sexual abuse (Chase, 1999; Aldridge & Becker, 2003; Barankin & Greenberg, 1996; De Chillo, Mantarin, & Hallahan, 1987; Barnes, 1996; Gopfert, Webster, & Seeman, 1996; Blaiklock et al., 2000; Blackford, 1999; Booth & Booth, 1998; Caton, Cournos et al., 1998; Darbyshire, Oster & Carrig, 2001). The overwhelming body of literature suggests that children that are disadvantaged and less likely to have health needs met when parents are struggling. The desirability of parental fitness and control of fertility may be an unspoken discourse when the subject of parental competence is described, and one which may be more apparent in responses from the public in the media (such as talk back radio) than from the professional literature.

There are many examples of literature that suggest that protective factors for children "burdened" with parental problems include the concept of resiliency, and the protective factor of connectedness with significant other adults and peers (Beardsey & Podorovsky, 1988; Bibby & Becker, 2000; Campbell-Heider, Tuttle et al., 2003; Chase, 1999; Jurkovic, 1997). There are other researchers who question the resilience and burdened childhood discourse aimed at buffering children from adverse or deficient parenting. For example, Gladstone, Boydell and McKeever (2006) critique the literature that established the risk/resilience discourse and noted that the research about parenting with a mental illness children are surprisingly absent. Gladstone et al. summarize recent thinking about children arising out of the "new" social studies of childhood illustrating an

evolving resistance to the hegemonic image of children as passive, developing, “unfinished” persons. They maintain that recasting of children as complex young persons who have competencies as well as vulnerabilities linked to their developmental stages, would lead to different lines of inquiry about children's experiences of mental illness in a parent.

Needs and risk are closely aligned discourses since a needs assessment assesses the degree of risk as well as the desires of parents. The risk discourse is highly visible in the government strategies that guide service delivery. This is highlighted by the needs assessment requested of Well-Child nurses as described in the Well Child Strategy (2003). The needs assessment is a very comprehensive assessment not only of the child but also the family which establishes the family as the context for community children’s nursing.

Recognising inequalities in health care provision is seen by many commentators as an essential skill (Hart & Lockey, 2002; Hart, Hall, & Henwood, 2003). Cowley and Houston (2003) however, researched the use of a standardized needs assessment tool for health visitors in London and concluded that the use of such a format was perceived as judgmental and disempowering to clients with high needs, and adversely affected the therapeutic relationship. What is more Cowley and Houston found that many experienced practitioners were sensitive to the potential harm caused by their use of the tool and would use the tool indirectly to obscure the surveillance nature of their work. Needs assessment is central to the child health nursing model of family centred care.

### ***“At Risk” families***

#### ***Risk Interventions***

Nursing in the community with a children’s rights focus creates a tension between the nurses’ conceptualization of parenting and family function and the reality of a child’s home life as a potential risk to health and wellbeing. Absence of positive attention by parents, coupled within consistent and inappropriate discipline, is a known cause of anti-social behaviour, conduct disorder and delinquency (Marshall & Watt, 1999, Shonkoff & Phillips, 2000, Stewart-Brown et al, 2005). Because of this known impact of parenting on crime and violence, parenting education is believed to be more cost-effective than dealing

with antisocial offending behaviour (Scott et al., 2001a). The underpinning ideology of parenting education is to help parents understand the effects of their behaviour on their children and to feel empowered and confident in their parenting roles (Gaze 1997; Gibbs et al., 2003; Miller & Sambell, 2003). Literature from such proponents of parenting education maintain that parents need help to identify the early signs of disease, as well as lifestyle choices such as diet, smoke free environment, accident prevention, and parenting strategies. Evidence from the literature suggests that nurses in many parts of the world play a key role in supporting parents (Gaze, 1997; Gross & Rocissano, 1988; Olds et al 1997; 1998; 2007; Gibbs, Underdown & Diabo, 2003; Long, McCarney et al., 2001).

The strategies for improving child health and well being outcomes in New Zealand encourage a multidisciplinary approach (MOH, Well Child Strategy, 2002). Community children's nurses are encouraged to utilize programs introduced to New Zealand from overseas including Family Start a version of the SureStart program in the UK. Government sponsored parenting programmes are included in the selection of resources nurses are able to offer when identifying children's needs the risks attendant with gaps in parenting competencies. One of the advantages of having such programmes is that they can be offered as a remedial alternative or adjunct to a referral to CYFS. The findings of an evaluation of the SureStart government-funded programs, which support parents to improve the health and development of young children, revealed that families attending SureStart gained in confidence (National Evaluation of Sure Start (2005). The findings of a study on the HIPPY program introduced from Israel to New Zealand had similar results (BarHava-Monteith, Harre, & Field, 1999).

### *Poverty*

As described in Chapter 1, poverty is linked with risk to child health. Bloor and McIntosh (1990), interpret that surveillance and provision of unsolicited parenting interventions for marginalized poor families by health professionals as an oppressive domination by the middle classes. They see that poverty, low social status, and high vulnerability to emotional and physical violence, are rarely compatible with middle class ideals such as parental investment in education. Gillies (2006) Scottish study identified that different values and attitudes are reflected in the kinds of emotional investments parents

make for their children such as: disinvestment from education (sanctioned truancy), defence and protection of their children's behaviour, and provision of “inappropriate” treats and comforts (e.g. designer clothes, play-stations, and junk food). These investments are described by poor mothers in Gillies study as their way of being “good” mothers and the reason why they resist and reject the interference of social workers and health visitors. Gillies put forward an argument for health professionals to be aware of cultural differences in parenting and adopt a nonjudgmental stance. In order to accomplish this she suggests they need detailed knowledge of values grounded in material and social deprivation. Gillies recommends that research into community nursing of parenting has an important role to play in supporting their future input into the continuing development of sustainable and effective health policies.

Studies of health visiting in England are the most often cited critiques for children's community nursing. Health visiting has a similar basis as Plunket nursing as it is a preventive service concerned with monitoring the physical and emotional well-being of infants and young children and with promoting healthy lifestyles and “appropriate” practices of child care (Bloor and McIntosh, 1990). A health visitor's main role has been identified as that of a non-judgmental health education, screening, and health promotion officer (Abbott and Sapsford, 1990; Dingwall and Robinson, 1993). Health visitors are also concerned to establish good working relationships and build rapport with the families that they visit, so that their health advice will be followed and adhered to. However, health visitors can also be seen as observant state officials who directly monitor, and intervene into, family life. Abbott and Sapsford maintain that “in their mode of intervention they can be seen as targeting the mother, working with definitions of “good” and “bad” mothering and attempting to shape mothers in particular directions ... In general they work with a set of ideas about the family and child development which are patriarchal and middle-class. In this way health visitors can be said to “police the family” (1990, p: 120).

Health visitors are seen by Abbott and Sapsford (1990) as agents of social control in by unconsciously attempting to shape the behaviour of individuals by encouraging conformity to wider societal norms and through disseminating individualistic, as opposed to economic, political and structural explanations for social problems. In other words they



encourage the notion that problems can be solved at a personal level. Abbott and Sapsford argue that this is because health visitors are not aware of the ways in which they police the family they accept as “truth” the discourses that inform their practice and therefore fail to recognize the ways in which they are used to shape the behaviour of clients” (p. 148). Health visitors also conduct routine surveillance on families to check-up on a child’s physical and mental well-being, the adequacy of her/his environment and whether treatment regimes and advice are being adhered to. Overall, therefore, health visitors perform a key surveillance and socialisation role so as to ensure “normal” child development, encourage certain patterns of mothering and child care and identify, discipline and identify and target “poor”, “bad” or “inadequate” mothers. Yet health visitors also serve as crucial agents of social control in order to promote and sustain behavioural change and to protect the health rights of the most vulnerable members of society – children.

Due to the increasing policy rhetoric that emphasises health visitors’ primary objective as being “supportive family agents”, coupled with a growing social awareness about and pressure to detect child abuse and neglect, a further tension that health visitors must continuously negotiate is the delicate balance between overtly supporting a family and covertly monitoring and policing them. For example, health visitors in Abbott and Sapsford’s study felt that if too great an emphasis were placed on surveillance, then this would reduce the efficacy of the health visitor role, as it would make establishing a good relationship with a family exceedingly difficult. Furthermore, health visitors lack appropriate legal powers to explicitly intervene and have no command over financial resources to aid and support families in need (p. 122). The number of tensions, contradictions and ethical issues that plague the health-visiting role Abbott and Sapsford argue, creates a “problem of identity” brought on by their: medical/nursing background; ambiguous role in relation to social workers; and domination by medicine. The health visitor’s contradictory role of, on the one hand, supporter/educator, and on the other, observer/policewomen identifying the “inadequate mother” and making “normalising judgments”, creates tensions and resentment amongst mothers (Peckover, 2002 p. 371)

In the United Kingdom Gillies (2006), points out that an ongoing raft of proposals and initiatives being targeted at parents tend to be aimed at socially excluded parents. The

intention is to guide and regulate their childrearing activities. This support can shade into the realms of authoritarian control if it is resisted. Parenting orders have been introduced in Britain to compel wayward parents to attend weekly classes to learn parenting skills. Other measures include fines and imprisonment, and even more severe proposals are currently being considered, including benefit cuts for errant families, and sending parents to residential homes for intensive support (Gillies 2006). This coercive and punitive turn has some cautionary relevance for New Zealand. Rather than punishing parents communicating effectively so that parents will engage in behavioural modification and self surveillance is seen as potentially a key to countering the potential for health care to become overtly authoritarian.

### ***Communication: the therapeutic use of self***

From a Foucauldian perspective the nature of power particularly pastoral power is less coercive if the power is shared and negotiated. For nursing the concept of interrelated power relations leads to new approaches. Polaschek and Polaschek (2007) describe a new therapeutic strategy for Plunket telephone nursing that uses “solution- focused conversations” rather than “problem- solving advice”. The provision of premature advice is seen as both prescriptive and polarizing in the client- practitioner relationship (Corcoran, 2005). The strategy involves asking parents to identify their concerns and potential solutions themselves assisting them to identify what would work for them. The strategies have been influenced by psychology and psychotherapy (Davis, Day & Bidmead, 2002; De Shazer, 1985). The Family Partnership Model was initially developed to enable effective support for parents of children with disabilities. It has since been extended to children and families across all disciplines and agencies, including those concerned with the prevention of psychological difficulties (Davis, et al., 2002).

### ***The spatial relevance of the home***

Nursing geographers have noted the relevance of the space in which nursing occurs (Andrews, 2006). Liaschenko and Peter are two pioneers of nurse geographies and their writing provides a firm theoretical foundation for others (Liaschenko, 1994, 1997, Peter, 2002; Peter & Liaschenko, 2004). While the importance of context has been acknowledged in healthcare ethics, the importance of place specifically, has generally not been explored

(Liaschenko, 2000). Arising during an era where hospital care was the norm, healthcare ethics has focused upon ethical concerns and dilemmas in hospitals, leaving issues arising in other places relatively unaddressed (Peter, 2002).

Peter argued that place has relevance to nurses' moral agency through restricting or enhancing care and justice, and through effecting both personal and power relationships. Although nurses often thought of themselves, and continue to think of themselves, as guests in the homes of patients- implying a lessening of their authority, they also find themselves at a greater distance from the traditional professional hierarchy (Peter, 2002). Consequently, the home setting has both the potential to limit and enhance power. Both Liaschenko and Peter use historical examples to suggest that the home offered a place to increase the power of nurses because they were further away from the supervision of their superiors and had more latitude. Currently, it is more likely that the home limits the power of nurses (Peter, 2002).

Most recently, Peter (2003) considered boundary and privacy issues in home care and the appropriateness of transferring values and meanings from hospital to home. Historically the home was constructed as a difficult geography to negotiate. Peter (2002) found examples from the early 20<sup>th</sup> Century that illustrate how place restricted the ability of nurses to act upon their motivation to care for their patients using descriptions of dirty and crowded homes with a lack of basic furniture, cooking utensils, medical equipment, and linen. Moreover, the isolation of homes presented difficulties for nurses in maintaining the emotional well-being of not only their patients, but also themselves. Peter used historical examples but did not draw upon contemporary discussion of the conditions faced by home visiting nurses today. I have been unable to find other nurse geographers who have specifically looked at the contemporary spatial context of the home.

### ***Health promotion***

Effective communication skills assist in the sharing of knowledge and educational role that is integral to nursing work. It is assumed that: health education and health promotion are one and the same and that health promotion is only about getting people to do "healthy things". It is assumed that people can and will change their behaviour because a

nurse tells them to (Gott & O'Brien, 1990). The authors found that generally, nurses seem enthusiastic about health promotion, and sure that they have a role to play. What is less certain is what this role is (Gott & O'Brien 1990).

Health promotional strategies in turn focus attention on life-style modifications and minimizing risk. Gott and O'Brien (1990) maintain that work of this type colludes in the victim-blaming approach, remarked on earlier, by ignoring the political, economic, and social pressures that make people behave as they do by laying the blame for risk-taking entirely at the door of the individual. Community nurses are seen to be working actively to reduce inequities in access to health care services and to satisfy the needs of whole populations, especially the underserved (Gott & O'Brien). However, as Clay (1987) points out nurses are unlikely to achieve this when they have so little real power in health policy planning and practice. Health education work within nursing may also be seen as enabling people to be more autonomous in relation to their health by imparting knowledge about health risks (Dines, 1994).

Naidoo (1986) argues that individualism is the main assumption underlying modern health education practice. Naidoo interprets individualism as the belief that individuals are agents of free choice and health status is a matter over which the individual has control. This is supported by Leichter (1991) who asserts that people should have the freedom act in "irrational and foolish" ways and Lupton (1995), who argues that risk taking, may be a desirable activity for some people. This does however have implications for children's rights, for as Freeman states in Chapter 3, children are not agents of free choice. The underlying premises of the children's rights discourse are: that children are individuals and not merely the extensions or property of their parents and that they exercise no choice over the, sometimes potentially harmful, actions of adults.

Lowenberg (1995) warns of the dangers of the "ideology of choice" that currently accompany lifestyle-change attempts. The "ideology of choice" is inherent in pervasive views that individuals are "responsible for" and "choose" their disease. The rhetoric of individual responsibility pervades the discourse around both health promotion and health care reform. Without continual awareness of both the complex and multifaceted nature of

such life-style "choices," and the balancing of a compassionate stance toward human frailty, health promotion attempts easily degenerate into a victim-blaming stance.

### ***Children's community nursing: New Zealand nursing journals***

The complex and multifaceted lifestyles of New Zealanders defines how the health rights of New Zealand children are rooted in a locally specific social, political, economic, and cultural climate. Whilst there are no contemporary New Zealand children's community nursing textbooks there are local nursing magazines and scholars that can add a to the literature review. New Zealand nursing journal articles tend to fall into four broad categories. Human resource and employment relations issues, clinical management, relational /humanist issues, and education issues. A narrow focus of literature review looking at two New Zealand nursing journals "Nursing Praxis in New Zealand" and "Kai Tiaki" from 1996-2007 identified three key themes in articles discussing the nursing care of children in the community during this period. Family centred care and partnership model of practice, invisibility and political silence of children's community nurses, and descriptions of nurse led initiatives to improve service delivery.

### ***Family Centred care in New Zealand***

The family centred care model is associated with case management, partnership with families, and coordinating care for the chronically ill and technology dependant children (Campbell, 1998; Chenery, 2004; Culbert, Cocks & Smaill, 1996; Horsburgh, Smith & Kivell 2002; Morgan, 1999; O'Connor, 2001b; Thomsen, 1999). In the community the Family Centred Care approach is not as widely discussed possibly because the situation of a child within their own social milieu changes the balance of power that gives the health care professionals domination within the hospital environment (Mulvey, 2001). Russell (1997) suggests that community nursing moves away from a medical reductionist model, to a practice reflecting the tenets of the Ottawa Charter; equity, voluntariness, participation and empowerment as a community and a family centred approach. Manchester (2000c) suggests there is a need to work collaboratively within a multidisciplinary team and to avoid duplication and gaps in services to children's families as a key to coordinated health care. The family centred care model has potential for conflict when the health care professionals' values and beliefs do not reconcile to parental or child's

wishes. In turn this can become a legal issue unless effective communication overcomes the barriers (Johnson & Trim, 2001).

### ***Political invisibility***

Some articles referred to how the work of children's community nurses remains invisible to the bureaucrats, management and the general population (Bracefield, 1997; Clendon & McBride, 2001). This invisibility is sometimes due to the intimacy and privacy of working with sensitive issues in children's homes. These commentators maintain that the flexibility required to meet client needs contributes to the general lack of awareness of the social work, care, coordination, and counselling that blurs the boundaries of nurses' work in the community. Bolitho and Huntingdon (2006) raised the issue of the difficulty some Maori parents have in accessing care for children with acute respiratory illnesses and suggested that these factors should be highlighted to policy makers, but did not indicate what political action nurses in particular would take to ensure these issues were adequately lobbied.

There are also articles that describe the responses by nurses to perceptions of potential threats to child well-being such as cannabis use, abuse and neglect, and poverty and poor intersectoral collaboration (Doncliff, 2001; Evans, 2003; Heap, 2001; O'Connor, 1999; Woodbridge, 2001). These articles encourage nurses not to be silent witnesses and to assume an advocacy position on behalf of children. Other articles promote action for example increasing nurse awareness and responsibility to initiate interventions for the reduction of domestic violence and child abuse (Everingham, 2000; O'Connor 2001; Heap 2001). The International Council of Nurses president visiting NZ in 1999 encouraged nurses to become more politically active states that nurses:

“...can raise the questions, tell their stories and give examples of what is happening that are understandable. Nurses speak the language of the people, not academic language and that is what is needed ...Nursing is about politics, nursing is about who has power” (Stallknecht, 1999, p.6).

### ***Nurse led practice initiatives.***

Other articles discuss specific interventions or changes in practice that have potential to improve child health outcomes. Initiative articles do not speak of children's rights per se, but by implication the aim is to improve the accessibility, effectiveness, and

appropriateness of the response to children's needs. This type of article challenge Gott and O'Brien's (1990) claim that nurse are enthusiastic but unclear about their role in health promotion. These articles include: developing a bio-psychosocial model to identify and support children with Attention Deficit Disorder - ADD (Fairbairn & Wilson, 1997); extending public health nursing's scope of practice in order to prescribe for diseases such as impetigo (Clendon, 1997); ensuring the right for a baby to be breastfed (Manchester, 1997); teen clinics to improve sexual social and emotional health of teenagers (Jones- Parry, 2000; Anderson 2000); and, providing free nurse- led clinics to improve access by poor families (Manchester, 2000a). Further support for the importance of teaching families how to identify and manage children's illness was highlighted (Prentice & Hathaway, 2001; Webby, 2001). The health promotion and health education aspect of the role of nurse included modifying practice to meet New Zealand needs for example using culturally appropriate and language specific care was also identified in several articles (Prentice & Hathaway, 2001; Webby, 2001; and Manchester, 2002). These specific examples suggest that New Zealand nurses are striving to be innovative and responsive in their practice. However, there is an alternative discourse within New Zealand nursing journals that nurses are not ideally situated to improve health outcomes.

### ***Alternatives to nursing.***

The assumption that children's nurses are the most appropriate personnel to work in community health is challenged by Manchester (2007) when describing one community initiative; Otara Health Incorporated (OHI). OHI sees the community becoming more capable of looking after itself, rendering the professionals such as community nurses obsolete. "The essence of Otara Health has always been about the community, rather than health care professionals, deciding what is needed." (McCarthy interviewed in Manchester, 2007, p.13). McCarthy sees that Community Health Workers (CHW's) engage with high needs' patients to work holistically and address their social, health and cultural needs. CHW's aim to work closely with patients and families to provide education, support, and advocacy around many issues, including asthma, skin conditions, medications, breast screening, sexual and mental health, family violence, budgeting and income support. This is a challenge to the validity of nursing experience and knowledge. Some results from analysis of the Sure Start program in Britain indicate that with the most vulnerable clients

health professionals are more effective than community workers (Belsky, Melhuish, Barnes, Leyland, & Romaniuk, 2006)

It is going to be interesting to see whether the relationships between the individuals, community, and the CHW's develop along the same lines as community nursing. Historically as stated earlier in this chapter, nursing education and the creation of the role for nurses sprang from the community in response to the self same needs identified over a century ago. Thus, the development of the community health worker may be interpreted as either challenging, reinventing, or complementing nursing. Some results from analysis of the Sure Start program in Britain indicate that with the most vulnerable clients nurses are more effective than community workers.

The cultural imperatives for nursing in the 21<sup>st</sup> Century are again highlighted by Manchester (2007b) when she describes the development of a more culturally relevant professional model. The first nursing course specifically designed for Pacific nurses graduated from Whitireia at the end of 2006, and indications are that this is potentially going to continue to strengthen the integration of skill, knowledge, and cultural appropriateness of the nursing workforce (Manchester, 2007 b). Another interesting development is the newly created Parish nursing workforce (Kaitiaki, 2007 p. 10). The use of nurses within Pacific Island church communities will presumably increase the authority of nurses. As described in Chapter 3 it was noted at the paediatric Society conference in 2007, that in Tonga children all get immunised and that the influence of the sovereign authority and power of church is significant in the levels of uptake (Moate, 2007). Foucault (1996) sees that the Christian pastoral directs an individual:

...to let himself be governed, that is to say, be directed toward his salvation, by someone to whom he is bound in a total, and at the same time meticulous and detailed, relation of obedience (p. 382)

### ***Discourse from New Zealand nurses research***

From a small sample of recent academic research theses that looked at the role of children's nursing in the community, four essential themes emerge: precarious relationships with parents, negotiated boundaries, parental resistance to health professionals' interventions, and the need for collaborative practice and strong community networks.



In *Power and partnership an analysis of the surveillance discourse in Plunket nursing* Wilson (2001) challenges the partnership discourse asserting that a relationship that is both complex and precarious where there is often a lack of transparency and honesty cannot be a partnership. Wilson asserts that revealing and concealing information and negotiating between nurse and mother results in a relationship in which the ebb and flow of power moved between the two parties but is never assured. Information is offered to parents based on the nursing discourse of healthy evidence-based child rearing practice. Maternal rejection or acceptance of information is based on their acceptance of the relevance of the information or of the openness to challenges to maternal authority over their child. The experience of the Plunket nurse has particular relevance to the analysis of other home visiting nurses perceptions and practices of visiting the home. The child is the focus of the relationship and so Wilson's research is relevant to the study of children's rights to health.

The experience of the relationship between health professionals and parents in well child nursing is echoed by Henry (2004) in *Negotiating an unstable ladder: The experience of Māori families caring for a technology dependent child*. Henry describes the relationship between Māori parents of technology dependant children and health professionals. She used the metaphor of an unstable ladder to illustrate how negotiating the knowledge and skills required to become independent in caring for technology dependant children is problematic and crosses the boundaries of "normal" parenting. She describes how useful parents found knowledgeable home care nurses in mastering the skills required to care for their children at home, but at the same time how the exposure to intensive nursing and medical support was invasive and created tensions and control issues. It is interesting that the tensions and the relationship challenges while more technically challenging than with the partnership challenges of the Plunket nurse/parent dyad appear to have similar power dynamics and insecurities. What is also notable in Henry's study is the relevance of Māori cultural support as has been described earlier in this literature review.

In a similar vein Dickinson (2004) uses the metaphor of a web to illustrate the complexity of the relationship between health care professionals (not only nurses), and the child with chronic health concerns and their family. A variety of health care settings

including the home are discussed in her thesis entitled: *Within the web: the family/practitioner relationship in the context of chronic childhood illness*. Dickinson demonstrates how the interplay of nursing and medical scientific knowledge competes with the lived experience and personal locus of control expressed by mothers. What Dickinson particularly highlights is the marginalized voice of the child and the lack of recognition of their participation rights.

Hetaraka (2006) looked at Māori rural health nursing in Northland concluded that the nurses she interviewed work at a complex and expert level in order to identify the “windows of opportunity” to build relationships with Maori families. In *A study of Nurses working in a community development model* the ‘windows of opportunity’ metaphor indicates the oblique and often opportunistic nature of the therapeutic relationship. Ramsden’s (2002) view that Māori nursing is best delivered by Māori nurses is expanded upon by Hetaraka’s study which found that despite being non- Māori the nurses she interviewed worked for a kaupapa Māori service and supported the use of a community development model. The public health nursing background of all of her participants seemed compatible with Māori kaupapa.

Woodbridge (2002) identified the role of children’s rights activist for nurses working with children in the community. *From Child Savers to Child Activists* identified the need for nurses to work at both a micro level facilitating children’s rights within their immediate social setting, and also at a macro level. This unpublished thesis was the only study that I identified that had interviewed a cross section of community nurses and focused on children’s rights as defined by UNCROC. In this participatory action research group of four, three were well-child providers representing: Plunket, Tamariki Ora and public health nursing, as well as one child health nurse educator. The findings of Woodbridge’s study were that a participatory action research group enhanced the participant’s sense of information sharing and indicated that nurses can be powerful child advocates if they become more collaborative and visible. Woodbridge’s study also indicated a need for greater interagency collaboration.

One study is particularly relevant to the legal and ethical tensions that face nurses when negotiating the rights of a child to be seen as an individual and the rights of the child

to be a part of a family. Woods (2007) titled his thesis- *Parental Resistance: Mobile and transitory discourses. A discursive analysis of parental resistance towards medical treatment for a seriously ill child*. Woods argued that parental resistance is an omnipresent but transitory occurrence that affects many of the interactions between the parents of seriously ill children and clinical staff. “Seeds of this resistance” are sown in both critical decision making situations *and* in everyday occurrences between doctors, nurses and parents within healthcare institutions. He proposes that parents, who resist treatment for their child, illustrate how normative healthcare relationship issues are codified, constructed, and crafted, through everyday discourses and practices within the health care setting. Radical cases that had high media profile and those which resulted in criminal prosecution of parents highlighted the tension. The relevance of this study is its strongly Foucauldian emphasis on power and resistance and the construction of the medico-scientific discourse. Children’s rights are shown to be complicated within Woods thesis because on the one hand he describes an older child whose parents supported his right to refuse treatment for a cancer with a poor prognosis. Yet on the other hand parents who refused treatment for a nutritional deficiency that their extreme diet had inflicted upon their child. Woods’ study also highlighted how vital communication is in the health context.

## **Summary**

The literature review has identified the history of childhood and the discourse of children’s rights. The roles of government to monitor, guide, and provide, for children’s right to health is outlined. The place of nursing in this scheme is historically based and the history of nursing is reflected in the practice of nursing today. The nurse is constructed as a tool for the government to use to meet its aims for a healthy and productive society. The strategic aims of the government are discussed with reference to the practice of community nursing from textbooks and professional journals. Finally, some current research by community nurses is discussed with reference to complexity and insecurity. Contemporary New Zealand children’s nursing research uses metaphors that describe the power dynamics in the relationships between the state nurses’ families and children. This leads to the next chapter which analyses what the community nurses I have interviewed have to say about their work and their perceptions of children’s rights.

## **Chapter 5: Analysis: It takes a village to raise a child**

### ***Introduction***

In this chapter I will present the various subject positions identified in my analysis of the nurse-participants discourses. I identify how they see that the children's rights discourse has created the obligation for the community to be concerned with the raising of children. A community is people who are linked together by mutual need and covenant (Clinton, 1996). In such settings families rely on one another, and the institutions the community creates and sustains, to participate in the process of child raising. The community however is made up of a heterogeneous array of individuals and groups, who do not necessarily share the same interpretation of what they need, particularly in the acceptance of the notion of biopower. In interviewing children's community nurses the dominant discourse that powerfully drives the participants practice can be elucidated using the African proverb "It takes a village to raise a child."

This proverb was the title of a book by Hillary Clinton (1996) who concluded that how children are raised can impact upon our lives and our children's futures. At the core of Clinton's book is the conviction that parents are the most important influence on the lives of their children but that no family exists in a vacuum. Many parents need support to become the best parents they can be, and sadly, not every child has a parent as a champion. Clinton wrote to promote the concept that it takes more than loving committed parents and a family to raise children, it takes a community.

### ***The "entitled child"***

The first question asked of all of the participants was to define how they interpreted children's rights to health. The nurses universally corroborated with the United Nations Convention fundamental tenets: survival rights, developmental rights, protection rights, and participation rights. It is important to note that while none of the nurses referred explicitly to the United Nations Convention, the ideology of the Convention appears to be embodied within the ethos of their practice.

Only the public health nurse referred to the guiding principles for her service, which were from the Ottawa Charter and not UNCROC, yet gave very clear definitions of

children's health rights that affirmed the Convention's central tenets. The public health nurse was the only participant who particularly emphasised participation rights, reflecting the older age of the children she sees and the nature of her work she stated:

I'm very strong in my practice on children being informed about their health care and making decisions when it's appropriate about their healthcare (2B PHN).

Throughout the transcripts the priority focus of all of the nurses understandably is to save life (survival rights), and minimize risk (protection), over the less immediate concerns of developmental, and participation rights. All of the children's community nurses saw that they work for children and this commonality suggests that the boundaries between "well child" nursing and "sick child" nursing are less distinct. However, the nurses did demonstrate emphasis on particular children's rights consistent with the nature of their job descriptions (as described in Chapter 1). Plunket nurses were particularly concerned with developmental rights, the public health nurse with protection and participation rights, and the home care nurses with survival rights.

The nurses were all asked to define children's rights to health and the responses analysed all referred to meeting needs and maximizing potential. For example, 1A PN defines children's rights to health as:

the right for the necessities of life of course, and the right to be reared; it's the right to be reared to live happily in the real world, that's what it is (1A PN).

The necessities of life correspond with the UNCROC description of "survival rights." Although not referred to there is an inference that the nurses interviewed used a framework such as Maslow's (1954) hierarchy of needs to inform their construction of children's needs. One definition of "reared" means to bring to maturity or self-sufficiency, usually through nurturing care and a state of happiness, is a state of well-being and contentment ("Reared." *Merriam-Webster Online Dictionary*, 2007).

The use of words like nurture, cared for, raise, grow, develop, happy and loved were all included in the various definitions that the nurses spontaneously offered. The use of the expression the "real world" and "reality" were used by all of the nurses. The "real" world is a colloquialism often used in this context to describe the practical world as opposed to the

abstract world. One interpretation is that most ethical views hold that the world we live in (the *real* world) is *not ideal* — and, as such, there is room for improvement. Therefore this statement sees that children should be nurtured to attain a state of wellbeing, whilst recognising that an ideal world does not exist, and so the ideal of child's rights to health must be tempered with realism.

The right to be nurtured is echoed by another Plunket nurse who responded to the question of what are a child's rights to health by stating:

I think a healthy child is one who is loved and nurtured within a family context and offered every opportunity to maximise their potential, physically and emotionally...Right to shelter, love, attention, food, clothing, and freedom from violence They need to have opportunities to develop through play, education... the right to a family and to feel safe... the right to healthcare too (3C PN).

Words like opportunities, optimizing, and maximized potential, uncover the fundamental “truth” behind Foucault's (1984) notion of bio-power that the state extracts the most value from its human resources. Health potential is a key construct in the literature from social sciences and allied medical sciences and is reiterated throughout the literature from international bodies (for example WHO, 1989; UNICEF, 2007). Building on strengths, seeking opportunities, minimizing weakness and identifying threats, are inherent in health discourse. Nurses see children as having a future which can be shaped by the opportunities they are given throughout childhood.

Within the “well child” discourse there is an assumption that all mothers have an inherent desire that their child will be the best that it can be. The mother it is presumed will also share the universal concept of health that is constructed by nurses, society, the State, and the United Nations Convention. Health is constructed as a holistic, all encompassing, multi- faceted concept. The Plunket nurse 3C PN elaborates on a wide conception of health by describing how she provides information on libraries, toy libraries and other free resources in the community. This is to enable a mother to meet the developmental needs of her child- a guiding concept for Plunket nursing practice. The concept of opportunities is also used by the next home care nurse participant:

They [children] should have full access to everything that adults should have and in fact they should have even more really because we should be striving to make sure

that they're well served and given the best opportunities to become healthy adults (4D HCN).

The child is portrayed here as both entitled and dependant since they are not autonomous, therefore adults have an obligation to provide for children. The child is also constructed as an emerging adult but that this emergence is contingent on being provided for. The inference from this statement is that "we" includes all adults, not just nurses, but parents and the rest of the adult population. This sense of collective obligation for all children reflects the notion that it "takes a village to raise a child."

### ***The suffering child and the nurse witness***

In the "It takes a village..." discourse the nurses in a sense, assume the subject position of "village witness" to child suffering. Once participants had established their definition of children's rights to health, they were asked to identify if they thought children were achieving their rights to health as they had previously described above. This is when nurses demonstrated what Foucault describes as dividing practices (Foucault 1975, p.36). They distinguish, separate, and categorise children creating classes of features and categories of people. The binaries of sick/well, normal / pathological, and functional /dysfunctional became apparent in the discursive practices of the nurses. However, the nurses all also describe how, in the real world, binaries are overly simplistic.

Sometimes things are not black and white (2B PHN)

There's such a range of normal, you have to look at the whole picture (3C PN)

Nurses also describe the grey areas regarding the definition of health as "sick child" and "well child." For example, with a description of a child with severe chronic health conditions that is currently well:

"Z had ... had a tracheotomy, gastrostomy, couldn't walk or feed orally ... from a tertiary point of view they [the hospital] didn't want anything to do with Z because Z was *well*" (4D HCN).

This child's has multiple dependencies on others, to breathe, eat, move, and basically survive, he will never be an autonomously functioning being, and yet in the absence of an active infection or "treatable" disease process he is considered "well." The unstable binary

of sick/ well is also demonstrated by the public health nurse description of well children who struggle with “minor” health issues:

They might have several minor health issues that all add up. They’re struggling with glue ear. They’re struggling with not enough food in their tummies when they arrive at school. They might have head lice or scabies or impetigo, they’re all impacting on that child’s ability to learn at school (2B PHN).

The word “minor” suggests that there is a hierarchy of diseases but that while these issues are not life threatening, in sum they impact upon the child’s enjoyment of life, hence the struggle. The nurse responds to the glue ear, hunger, head lice, scabies, and impetigo in order to reduce the impact upon the child’s productivity at school and the significance of biopower and the aim for the future productivity of a citizen is revealed.

The public health nurse also constructs the epidemiological measures of mortality and morbidity in New Zealand:

When we look at our child statistics through abuse and (preventable) death and sexual abuse, it’s not good, it’s appalling. I think that says a lot about our status with our children in New Zealand (2B PHN).

All of the nurses describe the “proof” that children particularly in the district in which they work are not having their health needs met. Nurses see statistics as objective scientific evidence that children were not achieving the health potential that they are entitled to as a collective (village) responsibility in New Zealand. Statistics are not universally accepted as “the truth.” Armstrong (1986) describes the measurement of infant mortality as a composite picture of a series of individual events. These events are assigned to a classificatory framework which is constantly changing. Therefore reality in statistical evidence is represented by the mediation of the prepared gaze of the beholder.

The public health nurse’s view is in keeping with the population health aspect of public health nursing, and its commitment to the Ottawa charter. The focus on the welfare of populations was associated with the emergence of biopower (Foucault, 1980a, p. 143). This term designates a range of technologies, knowledge, and discourses used to analyse, control, and regulate human bodies and populations. These include the disciplines derived from the human sciences which, Foucault argued, centred upon the body as a machine, its



disciplining, the optimization of its capabilities, the extortion of its forces, the parallel increase of its usefulness, and its docility (Foucault, 1980, p.139).

To deny the utility of modern medicine and passively accept needless disease and suffering is a moral position that appalls nurses. The acceptance of preventable diseases is described as a failure on the part of New Zealand society to be collectively responsible for the basic human rights of its citizens by one of the home care nurse (a British immigrant). She describes children that are a reality of her daily practice:

[In New Zealand] I saw rheumatic fever, meningococcal disease and diseases of neglect and abuse, I'd never seen in England. I just about wanted to get on the plane and go home again, I was absolutely appalled, conditions and diseases that just shouldn't really be occurring in this day and age with medical preventative health measures in place (4D HCN).

The home care nurse positions herself as close to the experience of diseases- so close that observing the phenomena makes her emotionally distressed and wanting to flee from the experience as an observer. Danaher Shirato & Webb (2000) describe Foucault's view that the dividing practices also occur at the level of the self. When individuals apply the same criteria to themselves they make judgments and self evaluation. They engage in dividing self between observer (and knowing) self, and observed (and managed) self. Therefore this nurse was seeing herself as both observer (witness) of children suffering, and judges herself as complicit in the system that permits "appalling" unnecessary suffering, this she describes as an urge to escape and not to be part of this complicity. Some of the synonyms for the word appalling include horrible, conspicuous, tragic, and shocking ("Appalling." *Merriam- Webster on line Dictionary*, 2007). As an emotive term therefore the use of the word appalling signifies the magnitude of the degree of suffering, injury, and disease these nurses perceive among New Zealand children. The subtext here is that it should not be happening and reflects a collective shame on the state of the nation.

The children themselves are often seen as unaware that they are object of concern. For the public health nurse this signifies how powerless children are:

Some of the children I deal with I feel sad for them because I think they have a high tolerance, they have built high tolerance sometimes to being unwell (2B PN).

The child is seen as having a high tolerance, and this forbearance is seen as unnecessary by the nurse and makes her feel sad. That the nurse above describes feeling sad indicates that there is a sense of powerlessness for the nurse as well. This powerlessness however, motivates the nurse to address situation, by sharing her knowledge and expertise. She goes on to describe how she encourages children to become active in the management particularly of skin conditions and infections. Among many examples the following description describes her approach:

...a little boy with chronic eczema and it was quite difficult to work with the family and I did the same for him, got some ointment for him at school, so that if he had dry skin at school he could go and access that in the sick bay and take a little bit of self-responsibility for his skin condition (2B PHN)

The family is described as “quite difficult to work with” and so in a way the nurse is resisting the acceptance of the child suffering. Rather than being a passive witness and accepting that the family does not want to engage with her to better understand and manage the child’s eczema, she is takes an active role and circumvents the family. The nurse incorporates other members of the child’s social community (the school) to be involved in his care.

For me, the school and the nurse working with the child represent his village. The child does not have the resources to access health care and secure the ointments by himself, and so the village has identified his need and intervened. A Foucauldian interpretation of this form of moral agency could be seen as a technique of governmentality. A child is empowered to be self-caring, resourced by his community to counteract the neglect and resistance to effective eczema management that he experiences at home. I have interpreted that this nurse appears to see that parental acts of omission are oppressive to children and in this way she has subverted the power of the parents and acted as a covert children’s rights activist. The limited scope of this thesis does not allow for further discussion on consent

issues (for example the Gillick<sup>†</sup> principle) but this part of the analysis lends itself to such a discussion and indicates a subject for further research.

### ***Family centred care discourse versus child centred discourse***

Children's rights create very challenging conflict for the participants. On the one hand there is "family centred care" a model of care described in Chapter 4, whereby the nurse works in partnership with a family ensuring that a child receives optimal support for a healthy happy childhood. However, as described above I suggest that the partnership and shared ideals are illusory, and that the nurses may adopt a "child centred" focus to promote the rights of the child and the moral responsibility of parents. The rights of the child discourse, takes a child out of a collective group "the family" and affords it individual status to enable the "village" access. Rights have no meaning unless the individual is seen as an entity that is able to be separated from their community - it is based in humanism and the whole Reformation philosophy of autonomy of the individual (as described in Chapter 4). This creates inherent tensions in the family centred care discourse creating ambiguities and contradictions for the nurses interviewed for example:

I say family because I think it encompasses the child, the family, the extended family. I think they're pretty interchangeable. I don't think, I mean I've never in my practice just focused on the child, because they're much more, they're surrounded by family. You just don't deal with them in isolation (2B PHN).

The contradiction of being "family focused" is highlighted by the same nurse when she later talks of the child as the focus of her practice:

Sometimes it's quite a big challenge but I think if you've just got the children at the centre of your practice and that's why we're there. We're there to look after children and we're there to look after their health (2B PHN).

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<sup>†</sup> child under the age of 18 years can be can be allowed to give consent for treatment, rather than their parents if the child 'achieves a significant understanding and intelligence to enable him or her to understand fully what is proposed' (Gillick v. West Norfolk and Wisbech Area Health Authority [1985] 3 All ER 402, HL)

This leads to a personal conflict about where the responsibility for children ends. One nurse describes how she experienced a type of moral panic. Oberle and Tenhove (2002) describe moral distress in public health nursing, as the position of trying to establish and maintain a trusting relationship with families whilst simultaneously having responsibility for surveillance of parenting practices and children's well-being and is exemplified by the following statement:

I used to have sleepless nights about them (children) worrying, and then you know you talk over with your colleagues about it and realise that actually ultimately the children aren't my responsibility they're their parent's responsibility...I don't have sleepless nights anymore... I've done what is reasonably expected to be done for that family, (5E HCN)

This is again a contradictory statement and is interesting because it highlights an internal dialogue that all of the nurses alluded to. The home care nurse moves from the subject position of being wholly responsible but over time and with experience and the support of colleagues, she moves to a position where she reasons that she can only have a limited influence over the outcomes for children and that the parents are the gatekeepers since children are "their parents responsibility." In this way the nurse rationalizes her powerlessness to intervene in the parent child dyad. For her the discourse of "it takes a village to raise a child" becomes contradictory. A nurse may be caught between backing away from the conflict of challenging parental authority and negotiating compromises, or becoming a child advocate and challenge parental authority.

### ***Nurse as mother's ally***

The nurses identified a subject position as parental allies. In contrast with UNCROC and its idealistic goals, and the state and its strategies and goals, nurses recognise that "good enough" parenting is a realistic expectation of mothers and of nursing. Throughout the interviews, the Plunket nurses and the public health nurse particularly, described aspects of their work that reflected government strategies to improve child health outcomes. These included reducing smoking, encouraging breastfeeding, advocating immunisation, encouraging healthy eating, and for the home care nurse reducing respiratory illnesses and hospitalisation. These health messages were however, tempered with realism. For example:

She [mother] knew it wasn't ideal, and I did too. But realistically I wasn't going to stop her doing it all the time (3C PN).

The nurses viewed the construction of the "ideal" mother as potentially damaging to mothers who were doing their best with what they have. The discourse of what is "real" and what is "ideal" competes with the rhetoric of government and organisational policy and social expectations, one nurse said:

We're all victims of our own upbringing and our own childhood so our attitudes vary. I believe that as women we're often parents to our children better at a different age. Some women are really good with babies and don't care too much for teenagers or they like the middle years and the babies and the teenagers are bit steep ... If somebody comes in here and she's showing all the signs of not liking her baby too much, I'd be the first to say 'yes' if she says I think I'd like to go back to work, you know that sort of thing. (1A PN)

The nurse here identifies that mothers and nurses have a common humanity and don't have to strive to be perfect or be the same. She stresses that her role is not to blame mothers "we're all victims of our own upbringing." Indicating that the nurse sees includes herself as socially constructed and imperfect being. For Foucault the self does not emerge in society naturally but is constituted through "games of truth and relations of power and relation of oneself to others" (1994, p.117). The comment also supports the discourse of the "long reach of childhood" which is discussed in Chapters 1 and 3. From the above example a parent may have been seen to have deficits in one domain, such as material resource or knowledge, but compensates by being strong in other domains such as emotional connection, or willingness to learn. For example, a parent can be really good with one age of child but not so great with another age group. By nurses supporting mothers, whether it is to affirm their decision to wean, or go back to work, an alliance is created in the face of what a mother feels as a societal pressure to conform and an adverse reflection on her parenting.

Sometime the nurse positions themselves as an ally in the face of spousal or family pressure. As one Plunket nurse described supporting mothers because some fathers:

...have just got an attitude thing and I get annoyed with them on behalf of their wives (1A PN).

Another example is the home care nurse who sees that she needs to support the teenage mother from being dominated by her parents:

...you try to direct most of the conversation to involve the mother, even if it's the grandmother doing most of the care (4D HCN).

This demonstrates that the institution of the home has its own systems of power, control, and governmentality which also constrain the individuals within its boundaries.

### ***The nurse as educator***

Nurses described how they negotiate and educate to offer knowledge to children and parents, particularly interpreting how children behave so that parents can understand them. A Plunket nurse was called away to help a breastfeeding mother during our interview. I asked her to describe what she had just done and her reply indicated the interpretive role she played in describing what the baby was doing to the mother. The following excerpt is a verbatim reply that nicely illustrates the pragmatic and unpretentious language used by the nurse. The power within the relationship is the sharing of knowledge between the nurse and the mother:

She wanted to feed and fling her arms around and groan and carry on. Baby's coat was nearby, and I just put it down over the baby's shoulder so that she had one arm just down a bit and I held her there and she drank and drank and drank. She drank steadily for about four minutes and her legs were starting to go, kicking and then she started to go mmmmmm and that was what was worrying the mother that she made this terrible noise. In the end she came off the breast by herself, looked up and gave me a great big smile, and the poor mother has been worrying herself stupid. And I think, all that's happening is madam finishes in about three minutes flat and wants to come off, plus she is suffering from that developmental distractibility thing that a lot of them get. So I was able to reassure mum that- since she looked so good, she came off the breast smiling. I stayed and watched the second side and it was just the same, perhaps wrap her just to confine the flailing arms and legs and things, and she has three minutes, and look at her she's smiling, she's peeing, she's pooing, she's doing everything (1A PN).

The experienced nurse reads the signs that the baby is demonstrating, but the inexperienced mother has not learned to read these signs yet. The nurse is able to interpret for her and "reassure" her. Here the nurse is encouraging and passing on knowledge that enhances the mother to be more confident and independent. Note: any suggestions made were in the form of tentative suggestions like "*perhaps* wrap her." This description of

routine well-child work demonstrates what I believe to be the benign pastoral nature of some nursing care. This reinforces the Foucauldian concept that power is primarily productive; a concept may be overlooked when describing power since the meaning can often be described as repressive.

In another example, a mother does not particularly like the baby walker her seven month infant has been gifted by a grandmother, but it is convenient, and the baby seems to like it. The grandmother is insistent about the advantages of her gift, and so the mother feels obliged to use it. The mother understood the developmental rationale given by the nurse as to the pitfalls of using the walker, and why they are now banned on the marketplace. She confirmed this understanding by relating a story of a relative's baby being scalded after using the mobility of a walker to get to the table with the hot drink on it. However, the mother is unwilling to stop using the walker for all of the reasons given above. With suggestions from the nurse on how to modify the environment she creates a barrier using some available materials.

Modifying, yeah. That's what you have to do in the real world to make it relevant information. Giving her the information and she could see what I was saying ...maybe she'll take that on board (3C PN)

The nurse now believes the mother has heightened awareness of the risks of the walker. This nurse described how she feels she is being realistic about what behavioural adaptations are adequate to reduce the risk for the child. From the statement "maybe she'll take that on board" the nurse demonstrates a realistic outlook that there is a possibility but no certainty that the mother will accept the information offered and act upon the potential risks for her child.

Coercion means force and while the nurse has wanted to influence the way the mother 'sees' the baby walker she cannot force her to modify behaviour. The nurse has persuaded or negotiated this compromise. The mother is constructed here as morally responsible to reduce the risks for a vulnerable infant. The subtext in this story is that the manufacturer of baby equipment was unethical in manufacturing an unsafe product and the government has taken a moral responsibility by banning this product. There is implied coercion from the grandmother as gift-giver who insists on the use of the walker. The

mother is shown as having been scripted by social forces and institutions around her, but who is active in negotiating her own identity, what Foucault refers to as technologies of the self. The nurse again places her interaction with this family in the context of “the real world”. One of the other nurses commented that tolerance and acceptance of differences is integral to her work:

You have to be prepared to spend time with families and to work out things ...and to be a bit accepting and tolerant of people but also to know that ..., you can do the best that you can but you can't change families (5E HCN).

I see two potential interpretations of this statement. One to mean that the nurse accepts and tolerates different ways that families view the world and recognises that there are limits to her influence and accepts that good enough is adequate. The other interpretation is that there is nothing more that she can do to help a family, and she is resigned to do the best that she can, while recognising that a families way of functioning is intractable.

Nurses describe how the power in the relationship rests with the mothers because the mothers choose parenting practices regardless of the information provided by the nurses. A Plunket nurse described a situation of a mother of children who suffered from severe eczema. The nurse explained to the mother the rationale for delaying the introduction of solids for a six week old infant and the types of low allergen foods that would be less likely to cause eczema, yet by the next visit the mother had started the baby on Weetbix. As the nurse described:

the other children are right there scratching away you know, and you talk ...try and explain the rationale of waiting for solids and things like that and then you go back, - started solids (3C PN).

The nurse finds this frustrating she describes how practices such as early introduction of solids to encourage babies to sleep through the night are common. The underlying moral subtext to the nurse's story is whether the child's right to a developmentally appropriate diet takes precedent over a mother's right to an interrupted nights sleep, but this is not made explicit. All of the nurses expressed some frustration when the type of information that they promote is rejected in favour of demonstrably less child health focused decision making. Practices such as feeding are described by the nurses



as being endorsed by the mother's family and larger social network, and so the "scientific" advice from nurses is sometimes rejected as invalid or lacking in authority in the presence of other sources of power and knowledge. Foucault points out that without a final authority to make people believe (such as God) there is a freedom to shop around for what we will believe or accept (Danaher Schirato & Webb, 2000, p. 79).

By contrast the same Plunket nurse also describes how she felt validated when another mother took up her suggestion to join the library and expose her infant to books. The nurse sees the long term benefits for the family of this "simple suggestion" adding:

...she's pregnant again and she's already talked to me how with this child, she's going to start books really early (3C PN).

It is in these kinds of changes that the nurse demonstrates influence over a parent, but the parent must be willing to see the value of the influence. This example also demonstrates the nurse has a class-based subject position which convinces her of the value of academic capital. The work done inside the family in the transmission of cultural capital in particular Bourdieu argues, is "the best hidden and socially most determinant educational investment" (2004, p.17). These activities contribute to the cultural capital held by and embodied in the family itself and are part of an accrual of class resources (Skeggs, 2004). The work of transmission of cultural capital really is "a labour of inculcation and assimilation" (Bourdieu 2004, p.18). The nurses expend effort to ensure adequacy and advantage and to promote the "best" for that child. In the process the parent become inculcated and assimilated, but only if she sees the advantage of acquiring new skills. The element of voluntariness is what distinguishes these interactions from blatant coercion.

Foucault sees the use of power as indispensable to the rise of capitalism and the productivity of the population (Dreyfus & Rabinow, 1982). I can see that inadvertently nurses may well serve the rise of capitalism and the dominant hegemonic discourse. Yet the primary motivation of the nurses in this study correlates with the humanistic discourse of nursing. Their purpose is to help children to be happy and functioning, primarily for their own sake, but ultimately to become connected members of the community. Foucault talks of an aspect of biopower he calls "anatomo- politics" that imposes a relationship of docility and utility upon bodies (Perron, Fluet, Holmes, 2005). The discursive practices of the

nurses in this study however suggest that biopower rather than imposing *docility and utility* emancipates bodies from the *docility and futility* of the experience of illness, death or disability.

### ***Nurse as a resource and networker***

Nurses construct the effective relationship as one where parents/ mothers recognise them as a helpful resource. The subject position of the nurse as a resource accentuates the nature of the power relationship since as a resource is something made available but not forced upon individuals. In a way the term resource also depersonalizes the nurse and turns her into a usable object. One nurse used the word twelve times. Resourcing parents and being resourceful nurses permeates the discussion of the nurse's roles in this study. There were at least six references to the word resource in each interview for example:

I think having people as a resource, people you can approach as a resource, people whose work you can trust, who will offer you good suggestions I think is a huge help to parents and is part of the children's right to have good parents (1A PN).

This nurse describes how she offers suggestions rather than telling or directing people. The other participants all used words like "suggest" or "offer explanations" and interestingly none used the word "tell" to describe how they speak to mothers, indicating the predominance of a non directive language. The clear inference of the above excerpt is that to be successful, parents need resources and to accept help. They thereby become a part of a social network, and so identify with the ethos that it "takes a village to raise a child". Dictionary definitions of resource help to shed some light on the need for a resource for children to have health rights met. A resource is something that can be used for support or help. An available supply that can be drawn on when needed. The ability to deal with a difficult or troublesome situation effectively; a person with initiative; and a means that can be used to cope with a difficult situation ("Resource." *Merriam- Webster online dictionary*, 2007). The subjectivity of the nurse as a resource correlates with the concept of connectors and networkers. People who have this capacity to move between groups, and who act as social agents, are identified by some commentators as pivotal to community development and change (Westley, Zimmerman, Quinn & Patton, 2006; Gladwell, 2000).

Despite the nurse interviewed working for three different branches of community nursing, there was considerable areas of overlap in psycho- social care. The nurses perceive themselves as having creative latitude to respond to needs which makes them more acceptable. The nurse's also described how they trade on their professional role to be able to ask "difficult" personal questions. For example, by quickly identifying that there is no food in the house and then to have the contacts to provide food, positions the nurse as a useful visitor:

Have you got enough food today? I can help you with that you know? And Yeah sometimes it can kind of put you outside of your comfort zone. But Hey, I'd kind of like you know not trying to upset someone , but I'd rather ask the questions than walk away no knowing if that cupboard is completely bare that week and there's no more food. I'm quite able to go and grab a food parcel for that family.

This nurse sees noticing that someone is too poor to buy food is a bit embarrassing it puts her "out of her comfort zone" to be the one asking if a family has enough food. This indicates that the nurse understands that identifying deficits and particularly pointing out impoverishment, is potentially shaming to a family, and that in her role as a resource she must tread lightly. "I can help you with that you know" and "I'm quite able to go and grab a food parcel" suggests responsivity and an ability to constructively be of use. This flexibility and responsiveness was perhaps not as not as apparent to the researchers in the critiques of health visitors in Britain described in Chapter 5, who tended to report parental views that nurse visitors were as merely inspectors who made judgments based on their assessments of need and risk but did not do anything constructive or encouraging (for example Abbott & Sapsford, 1990; Bloor & McIntosh, 1990; Gillies, 2006).

I suggest that in this example the nurse could be seen as a "Samaritan" which is the helper rather than the saviour interpretation of pastoral power as described in Chapter 3. I suggest that a Samaritan is more likely to altruistically help a person in need because they can. Once the action of helping is concluded both parties carry on with their own lives. Whereas a saviour connotes someone who helps, but then goes on to become a guide or definer of the lives of others denoting a dependency relationship whereby the saviour has greater power over the saved.

The underlying reason for the lack of food was not discussed in the above example however throughout the transcripts there were references to gambling drug and alcohol dependencies in the district.

Some people, I don't know what they spend their money on, and I don't go there with them, but I know that some of them get into problems like with gambling (5E HCN)

This nurse described many instances where she would use her networking and resource modes to help families to overcome immediate problems like a lack of an emergency telephone or substandard housing. It seems clear that she was reluctant to assess the underlying issues that were accentuating the problems associated with poverty and was at a loss as to what else she could do. Wheeler, Rigby and Huriwai (2006) suggest that household poverty has increased since the liberalisation of gambling in New Zealand in the 1990's. In Auckland, the areas with the highest number of Electronic Gaming Machines (EGM) or poker machines tend also to be the areas with the most deprived areas. Wynd (2005) found that approximately 35% of food-bank clients were either problem gamblers themselves or were affected by the gambling of others. Seventy percent of users were on benefits, and 56% were Maori and Pacific Island women. The nurses' discourses reflect their perceptions of the lived reality of these statistics. However, as this nurse suggests there is sensitivity to being perceived by clients as judgmental.

### *Networking*

The nurse as a networker is an important aspect that came through in the transcripts. For example, one nurse described the connecting and networking that she established in a home:

I had a family recently and they were from, recently arrived from the islands I was dealing with a younger person's problem, but then they had an 18 year old boy who's basically been sitting in the house for several months because he had no English language skills. So I did some research about where he could go for some support with that and linked him into XXX Language Programme. I like to chat to people and just form that relationship and you know just checking out hey have you got a primary care provider. It's about offering those choices and just being that link to getting them along and talking about why its important to go and register [with a PHO]. Especially here, because if you don't go and register within a certain month you might not be entitled to that free care- it's quite important (2B PHN).

From this excerpt the nurse describes how despite the fact that she was in the home to see a younger child she recognised the need for social connection for another member of the family. Not only did she recognise the need but she had the knowledge, motivation and contacts to facilitate action. This reflects what Erikson (1996) describes when seeing only ones own social group (as evidenced by the 18 year old in the excerpt) encourages tacit knowledge and concrete language, which is only sufficient within that group. Erikson maintains that people with very limited networks are not only ignorant of many things; they often do not know what they know, or how to express it. This exemplifies the concept that people are shaped and constrained by the discourses around them. Therefore, the nurse can be seen in an ambassadorial and interpreter role particularly with families that are marginalised and powerless. The 18 year old was “basically sitting in the house for several months” because his immediate social network lacked the resources to help him.

Erikson suggests that a serious consequence living within a narrow range of networks is political. In other words, the problem which powerless people typically have is to express their lives, claims, or grievances outside of their own social milieu. So for a family described above that does not understand the process and financial implications of registering with a primary health provider they become further disadvantaged. This nurse demonstrates what Erikson describes as person with widely varied contacts who become self conscious about what they know (because they cannot assume that other people already understand it), and learn abstract general language to convey information to others. Erikson (1996) describes the difference between those with strong community networks by using a television network analogy. This analogy illustrates how people in complex networks actually speak many languages and “zaps” from one to another as they switch social settings, “as easily as people browse 57 TV channels. But people in limited networks have small screens, basic TV service, and no remote control and therefore shift with difficulty between few options”(p.32).

The concept of nurses as networkers and resources is central to their perception of their role in promoting children’s rights. All of the participants described connections and networks. For example: All of the nurses liaised with housing authorities to ameliorate substandard housing. One story was of a nurse organizing pest control because a rodent had

run across her foot during the visit and the family had no telephone (5E HCN). In another case a nurse was able to liaise with an airline to organise particular requirements for a disabled child for an immigrant family (5E HCN). Another described how she linked a family into the library and toy library (3C PN). The home care nurses both described the care coordination role they played in liaising with hospital and clinics (4D HCN; 5E HCN).

These descriptions of what nurses do to “help” families are interspersed throughout the transcripts and highlight the very useful cross sectoral, ambassadorial, and interpreter subjectivities of the nurse. This ability to act in ways that families perceive as useful, may ameliorate to some extent the sense of surveillance that occurs when risk assessments and judgments are made without any tangible help. In their proposal for a new structure for children’s community nursing Carryer et al. (1999) maintain that working with “at risk” families is an example where the primary health care nurse could also work across sectors to improve the health and social situation for the family. They maintain that targeting health services only to families with identified needs (such as a family with a child with asthma) ignores other equally vulnerable families. The insights from practice that nurses have provided in this study, suggest that some nurses at least are already working informally in a flexible needs responsive manner, but this is subtle and is not “targeting at risk” families per se, but is opportunistic and less intensely surveillance focused. By contrast nurses ability to provide so varied a connection with the world outside the home (the village) is not always desired or recognised by families.

### ***The Resistant alternative parent***

The resistant parent created tension for nurses. Sometimes parents resist help because they challenge the dominant hegemonic discourse that suggests what is “good” for children. Examples given from the transcripts included: the use of snail juice as a treatment for a baby’s respiratory tract infection, alternative health knowledge such as osteopathy, and an anti- immunisation stance.

People should get children immunised and I have to guard against open intolerance against the people who don’t (1A PN).

Another example is the story of a Plunket nurse's dilemma, when she assessed a baby to be falling sharply off his growth and development charts, and the mother was resistant to the information:

I had one [case] that was breast feeding but growing very poorly and had a mother who was very anti- doctors and she didn't want her baby to go and have a medical review (3C PN).

In both cases the nurses described how they remained supportive of parental choice. With immunisation the nurse was aware of her personal bias and maintains her professional respectful relationship through self discipline described as "button my lips" (1A PN). In the case of the baby who was not thriving, the nurse sought supervision from her manager and worked out an innovative way to engage the mother in self monitoring the baby's growth. She waited for the mother to realise that she needed to change her management, but this was described as stressful for the nurse, as she was dealing with the uncertainty of not knowing the point at which the baby would be seriously compromised. Whether the nurses are sufficiently skilled so as to disguise their reproach is not possible to analyse.

Foucault sees that resistance is endemic to power and through resistance power gets disrupted (Dreyfus & Rabinow, 1983, p.147). Therefore the resistance of parents to authoritarian control of their parenting styles can disrupt the power relation which in turn can bring about change. Parents with alternative beliefs who resist are therefore seen as redefining and relocating power. The woman who rejected feeding advice was presented by the nurse as a citizen making an active, legitimate, but potentially misinformed choice. From a Foucauldian perspective it is relevant to note that people who are making "choices" in a response to the discourse of alternative medicine discourse are also rendered "docile" through abeyance to the rules of the "alternative" discourse.

### ***The nurse as Disciplinarian***

Nurses described some cases where they perceived that they had been constructed as a disciplinary power by mothers. This occurred particularly when a nurse's expectations for a child's treatment and a mother's conflicted. Avoidance of nurse visits was sometimes seen as avoiding a reprimand for failing to administer prescribed cares. In one example a home care nurse described a mother not administering a child's oxygen therapy:

they know that we come and visit and if the child is not on oxygen we might be having a stern word to them so they might just rather not be there (5E HCN)

The adequacy of parenting is seen by nurses as dependant on how parents perceived their obligations, responsibilities, and capabilities, in a number of domains. The importance of knowledge is stressed here. In his later work, Foucault was concerned with power and knowledge. Foucault maintains that the “biologico-moral responsibility” for the welfare of children is seen as an imposition on mothers (Foucault, 1991). The nurse as a state agent attempts to influence mothers’ practices and operates largely through education and persuasion. The public health nurse demonstrates this when she explains how she educates and influences mothers about children with untreated otitis media. She describes that she says to families:

Hey listen. If your child can hear, if we resolve this hearing problem, then they’re going to be able to learn and do better at school (2B PHN).

The provision of health care services for children and families is in Foucauldian terms an elaborate state-sponsored apparatus, where a strongly medicalised discourse (biopower) is disseminated to mothers (Perron, Fluet & Holmes, 2005). Within the children’s rights discourse are warnings to mothers of the risks of certain parenting practices and the benefits of others. It constrains mothers through a series of “quiet coercions” which discipline them into self-regulating subjects (Foucault, 1991). Nurses in this study maintain that some parents “don’t know what they don’t know” (1A PN) and the risk to children of poorly executed parenting is permanent damage or even death. Parents are seen to need knowledge to understand the work of parenting. The apparatus contains strategies of relations and of forces supporting, and supported by, types of knowledge.

Parents who transgress the norms of nurturing and care for their children are suspect for personal subjective defects in character:

I guess because we tend to see the extreme end of children that are unwell and families that are quite dysfunctional (5E HCN).

These parents are also seen to renege on prioritizing their children’s needs as one Plunket nurse describes:



...drug or alcohol use, money has been put into there, and children haven't been given food or adequate clothing (3C PN).

The nurses describe a degree of tolerance for transgressions of the norms. As already described parents were not seen by the nurses interviewed “ideal” or “perfect” but in terms of good enough.

...in actual fact it's only a very small minority of parents that, well who I think, are actually abusing and neglecting them[children] to the point where their children are really suffering and getting sick enough to have to go to hospital or dying (5E HCN).

This comment by the home care nurse, suggests that parental inadequacies are normal as long as children do not get “to the point” of “really suffering” and getting “sick enough.” Therefore from the subject position of “nurse as disciplinarian” the judgment or gauging the “point” where parenting is not good enough, and identifying the boundaries for intervention is not clear. This potentially could lead to the criticism of the lack of professional intervention described in Chapter 1 regarding the murdered twins, and referred to by the Children's Commissioners report on James Whakaruru's death in Chapter3.

Nurses see that they play a part in the construction of parental attitudes toward a child's right to health. The nurses in my study suggest that it is desirable for parents to receive the benign pastoral surveillance of helping agencies to guide and monitor the successful negotiation of the challenges of parenting. The alternative to learning the skills and self discipline to promote the health of children is to be set up to fail. Both child and parent pay the price-such as social exclusion and ill health. Radical examples of failure, I suggest, include the child homicides that frequently shock the New Zealand public.

### ***Nurse as child advocate***

Foucauldian pastoral power, as described in Chapter 2, describes the notion of a “saviour” which may be partially reflected in the role of “advocate” described by nurses. A saviour is seen as someone who rescues another from harm or danger. However, the nurses describe their role as resource person and parental ally, interpreter, negotiator, and referral agent, not in terms of being a saviour. Nurses identified that it is very important to support parents to be their own children's “saviour.” In discussing the role of Plunket nursing one

of the participants juxtaposed the motto to describe how she saves the mothers to help the babies:

The motto of Plunket was always *help* the mothers and *save* the babies and I figure this work, of all of it, is helping to *save* the mothers because if the mothers are okay the babies are usually fine. That's basically what it is in a nutshell. I don't mean to say it's about rescuing centres... (1A PN).

The nurse constructs "rescuing centre" as an undesirable dependent relationship. She stresses that it is not the Plunket nurse who saves the babies but the mothers, thereby stressing that the dominant position of the mother is upheld. As long as the mothers are looked after then the babies will be fine.

A dictionary definition of advocacy is the act of pleading or arguing in favor of something, or the giving of aid to a cause or the active support for a position ("Advocacy." *Merriam-Webster online dictionary*, 2007). In nursing literature, advocacy is described as an act of informing and supporting individuals so that they may make the best decisions possible for themselves (Hanks, 2007). Hanks see that it is a moral commitment to enhance a patient's autonomy or an action taken to achieve goals on behalf of oneself or another. Simply stated, advocacy is speaking up for someone (like a child or infant) who is unable to speak for him or herself. There is a point at which the balance between children's rights and parent's rights, tips, and the child is seen to be at risk:

If we see anything that is going to be potentially damaging to that child ... we have a child protection /advocacy role (3CPN).

All of the nurses used the term advocacy to describe their role in the children's rights discourse. Advocacy is sometimes criticised for being paternalistic in intent (Gadow, 1980), and certainly for the child, the nurse here is acting "in loco parentis", compensating for what the parent should be doing. This advocate is seen to monitor for the "bottom line" which is the minimum a child can have provided to survive intact. This creates the essential tension for the community children's nurse since the bottom line is discretionary, there are multiple factors, and it requires skill and knowledge to identify. The boundary between personal responsibility and professional responsibility creates the greatest dilemma. For some nurses the burden of responsibility may become less intense over time:

I used to have sleepless nights about them worrying and then you know you talk over with your colleagues about it, and realise that actually ultimately the children aren't my responsibility. They're their parent's responsibility or their caregiver's responsibility so I don't actually feel now that level of responsibility that I used to (5E HCN).

In other cases the burden of responsibility haunts a nurse until there is a resolution. The nurse in this case was constrained in her ability to act in the best interests of the child she has no authority to uplift a child and so must act as an advocate:

I felt very angry, very sad, wanted to go and take the baby myself and give it a drink....Well we tried to deal with it in our way because we brought the child into hospital for five days of feeding assessment to try and prove that it was lack of food and lack of contact really that was causing these issues, and the child thrived, and then went back home. I ended up, did a double nurse visit in the end because I was finding it quite stressful

Int: You didn't let that up; do you ever feel like walking away from it?

No. It's a challenge until its finished (4D HCN).

The emotional strain of seeing a baby denied its basic human rights is clearly described in the above excerpt. Trying to "deal with it our way" meant the therapeutic interventions included trying to educate the mother, and hospitalizing the child to "prove" that it was able to gain weight and develop normally if given regular food and attention. Once the therapeutic approach failed the judicial and social welfare system intervened and uplifted the child. The nurse went on to say:

I think this child is certainly in a better place now, [the child] is loved" (4D HCN).

The nurse felt justified, she had tried alternative ways to ensure the child's basic human right to be fed and therefore survive was upheld, but failed, and the state had then decided to intervene. This nurse described how relieved she is that the child is now "loved"- an emotive and value-laden judgment. The behaviour of the mother by inference was unloving; in other words appeared to lack the tender, ineffable feeling of affection and solicitude. The child was positioned as the powerless and dependant human and the nurse as the child's advocate ensuring that its rights to health (and life) were upheld.

Later in our interview this particular nurse identified herself as once being involved in a case where a child homicide occurred. It called into question for her the ability to identify “at risk” children:

Well it knocked my confidence for a little while. I’m very fortunate that I’m a good writer and my documentation was no problems.” (4DHCN).

The nurse describes being judged by others, the panopticon effect is also therefore seen in the surveillance and performance review of the nurses’ actions. She is relieved that her documentation supported her interactions with the family. She maintains that while the family was poor, other significant risk factors such as domestic violence and substance abuse were obscured from the nurse. The child appeared fed and the parents had appeared to openly engage with both infant and nurse during visits. The nurse in effect was therefore powerless to prevent the death which reinforces that nursing surveillance is limited and episodic in a child’s life. The true power was with the parents to reveal or conceal their homicidal tendencies. Once a crime occurs the state then has the power to punish using the judicial system. The nurses’ potential as a child advocate in such situations is therefore limited

### ***The nurse as the ‘go between’***

As well as being allies of parents nurses have another position where they see themselves as go between. They represent both the parents and the system in health care when they liaise between doctors and the home as described in the following example:

If I’ve got complex children, especially if the parents perhaps aren’t, don’t speak very good English, or you know newly diagnosed child, we often go to clinic appointments with them and the paediatrician (5E HCN)

The also take a go-between position in relationship to other authorities. In some ways nurses position themselves as an intermediary not only between the child and parents but also between the health and welfare services. This in-between position has been noted by other researchers (for example Woods, 2007). One nurse describes that she uses her nursing relationship to “sell” the services of the welfare authorities, by promoting the positive, supportive nature of welfare work, and presumably obscuring the legal authority and policing role of such services:

I guess it's the way you relate to them about what they [CYFS] can offer. You promote it in a way that they're supportive. I've had some very positive outcomes with people still wanting contact in the future even though I made a referral to a child protection agency (3C PN)

The go-between position is also an anomalous position because the child protection activities of the nurse are often obscured or unacknowledged as has been described by many commentators (for example, Abbott & Sapsford 1990, Evans, 2003; Marcellus, 2005) As a go-between, nurses also act as a filter for the social welfare and so in a way are really active referral agents for the state. When a referral should actually be made, creates tensions. Neglect is viewed as much more subtle than physical or sexual abuse:

It's very easy if it's a child protection case ... quite clear that they've been bashed ... that's very black and white (2B PHN).

It is in the grey areas that the most tension is created. Even when a referral has been made the social worker does not necessarily "gaze" at the child with the same lens as a nurse and does not necessarily recognise the significance of some of the physical indicators:

14 referrals to the Child Youth and Family listing our concerns that the child was being neglected- 21 including our social worker referrals before any action was taken (4D HCN).

The nurse went on to describe how she continued to monitor and advise the mother and the welfare authorities until the metaphorical "ball" was picked up by the other players. This in-between time created increased stress and tension for the nurse who identified acutely with the suffering she perceived the child to be enduring. As previously cited the nurse felt torn and wanted to take the baby home with her to ensure that it was fed.

The nurses in the study said that most parents "loved" their children but some needed integrated support because of the complexity of their own issues. This is supported by the literature described in Chapter 4 around parental competence. For example, the public health nurse described a child who was referred by the school for withdrawn behaviour, unkempt appearance, anxiety, and apparent hunger. The school had been quite intimidated by the mother's erratic and hostile behaviour. Interestingly, they then referred the public health nurse to approach the woman, creating some discomfort for the nurse

about her own personal safety. The mother was a woman with complex mental health issues:

If she's not well and she's not taking her medication, how is that impacting on family life for that child to be growing up in that scenario? (2B PHN).

The other children of the woman with mental health issues were no longer in her care, which the nurse interpreted as a sign that the mother had intractable parenting issues. The child welfare authorities and mental health services had a long history of intervention with this parent, but did not appear to reduce the impact on the child. It is significant that the school, General Practitioner, and public health nurse, were not kept informed by the mental health and welfare services for this family. Both the fragmentation between different government agencies and the invisibility of children to the adult mental health system were therefore apparent. It confirms what Gladstone, Boydel and McKeever (2006) note, that information about children remains surprisingly absent, they identified that throughout North America, Europe, Australia and the United Kingdom, mental health clinicians do not routinely collect information regarding the parenting status of patients. Gladstone et al. see that such oversight has been attributed to widespread denial of the sexuality and fertility of people with mental illness. They also indicate that there is a lack of awareness within the mental health service sector regarding the parenting experiences of adult patients and a division of mental health services into separate adult and child services. The "long reach of childhood" discourse that surrounds the Dunedin cohort describes the effect on the long-term mental and emotional health of children with parents that have mental illness (Fergusson, 1994; Moffitt et al., 2007).

### ***The "blinkered" nurse***

Not only are nurses caught in the web of child protection but they also know that the cases they see are only the tip of an iceberg:

Well we know that children are left alone underage because we come across them regularly, so there are a lot of children being left alone and that's just during the daytime hours that we're finding, so I'm sure that there night time hours where children are left alone. We know just from being in the homes that money is often directed to things other than health and food and education, children are often getting a raw deal (4D HCN).

The night time is here portrayed as a dangerous and unprotected time for children. The priorities of the people that manage the finances in the home are also questioned. All of the nurses interviewed described the significance of substance abuse issues impacting upon the children that they see. Children are positioned as economically dependant and powerless. The nurse is positioned as an observer of the “raw deal” that some children get. Some perceive that if they were to refer all of the potential child abuse and neglect cases then the Children and Young Persons Service would be swamped for example:

With CYFS I think they’re often over-burdened and that could be quite difficult working with them at times but it can be very positive as well (3C PN).

The nurses variously describe the position of the child welfare system as either difficult or positive to work with. This contradictory viewpoint illuminates the tenuous and often incongruous space in which child protection occurs. The perception that welfare authorities are over-burdened was reiterated by other nurses who also suggest that the need to protect children is enormous and emotionally difficult to bear:

There’s a lot more that society could do. I think we often wear blinkers because its easier to not deal with it than deal with the real issues out there and I think if we do take the blinkers off some of the problems would be so overwhelming we wouldn’t know what to do and there wouldn’t be the services and the agencies out there to cope (4D HCN).

This home care nurse speaks of society wearing blinkers. This resonates with the value the community places on the inviolate privacy rights of the home, over children’s rights to life and liberty. She says “we often wear blinkers” which may indicate that nurses to some extent must also wear blinkers so that they are not overwhelmed by child protection issues. Blinkers would stop the nurse from ‘seeing what she sees’ using the nursing “look” or “gaze” since nurses are conditioned (sensitized) to see what others (non nurses) may not. The rationale for turning a blind eye can be seen as not wanting to see the extent of the problem, or ignoring what we do see, or willful and self-protecting ignorance.

The children’s rights focus challenges some analyses that assert that judging parenting is an illegitimate incursion into the privacy of family life and an assault upon mothers’ autonomy and self-determination (Lupton, 2003). The implicit assumption of such arguments is that children are an extension of their mothers and that the future autonomy

and self determination of children is secondary to the autonomy of the mother. The children's rights reply to such an argument is that children do not make a conscious choice about being considered as an extension of their parents and not individuals.

### ***Different values and attitudes***

In the "it takes a village to raise a child" discourse the notion of the village appears as a homogeneous entity, which is an increasingly problematic notion. The biggest division in society is seen by all of the nurses interviewed as the socioeconomic division between rich and poor. Two comments highlight the class distinctions that are apparent to the nurses:

I think economically there's a bigger difference between rich and poor, since the time I arrived and now (4D HCN)

I see a big disparity because I work in two very diverse areas (3C PN)

The participants identified that cultural and class differences have a part to play in the potential for negative health but that these differences are not immutable. As one home care nurse notes:

A lot of the families that we go to might be poor, have a broken window, or are dirty, but that actually doesn't make them bad parents. They can be fantastic parents and they look after their children, and the kids aren't going to be abused or neglected" (5E HCN).

In the above quote living conditions are described that may not conform to normative bourgeois judgment of clean and well-maintained households, but the parents do conform to the expectation that they have an obligation to "look after their children". This supports Fuchs (1974) argument described in Chapter 4 that values and attitudes determine health outcomes. The participants all spoke about how the discourses within different socio-economic classes and cultures influenced the values and attitudes toward health and in particular the acceptance or rejection of the notion of biopower. For example:

A middle class white Pakeha family, who might at the first sniffle or cough, take their children to the doctor because they're not worried about the cost or anything like that (4D HCN).



Even with relatively minor ailments “the first sniffle or cough” the “white middle class” has the advantage that they can read the signs and are therefore more powerful in their relationships with the health care professionals. They are seen as having the economic base and knowledge to be active consumers of health services. They therefore conform to a normative “bourgeois” parenting behaviour. Their children don’t get as sick because they have this “medicalised” self. They have faith in biopower and engage actively in their relationship with a doctor or take some action to alleviate or normalize the body.

There is also a sense from the trivialization of “the first sniffle”, that some may be overly medicalised to a point where they over-pathologise and develop anxieties about their children’s well being. On the whole however the white middle classes may have greater advantages to develop the art of prediction and anticipation of the consequences of disease and are strongly influenced by the notion of biopower. Vincent and Ball (2007) see that the active investment in mechanisms of the state such as education is one way of augmenting middle-class privilege for children. I would argue that this is also true of health care. While the nurse above has described “white middle class Pakeha” it seems likely that her reference reflects the demographic of the population she services, where the majority of the lower socioeconomic population is non-white, rather than a racist observation.

By contrast one Plunket nurse describes a group less influenced by the notion of biopower who do not try to manage, control and normalise the body:

Some people don’t understand the concept of a Well Child service and think that they would only access healthcare if they are sick (3C PN).

This suggests that active health promotion and diseases prevention is not as prominent a discourse within some societal groups. This may reflect what Vincent & Ball (2007) constructed as “working class fatalism” in regard to education, whereby the working class is much less likely to see their children as possessing potential for development and improvement. For Vincent and Ball within this group children “just are” and their characteristics are understood as more fixed and static (p.1067). The rejection of biopower and the acceptance of fatalism is reflected in another participants comment that:

Stuff that goes on traditionally- the acceptance of children’s disabilities and things- has its positive side, but also has its negative side. Like there’s still somebody, 10

years ago, somebody in Axxx walking round with a cleft palate because they all figured his parents had offended God somehow... It's broken but we still won't fix it. There was a little bit of that around many Pacific parents too. So there's feet turning but that's alright, its God's will (1APN).

This excerpt is interesting to compare with the discussion on moral principles and Freeman's critique of the practice of female genital mutilation in Chapter 3. There is a suggestion by the nurse that traditional non-Western perceptions see disease or disability as uncontrollable acts of fate or karma. She sees that this has its "positive side" which reflecting the notion of cultural relativism. The spiritual acceptance of illness challenges the traditional Western model of health care. The entire premise of the Western model is the notion of management and intervention and so the monist or ethnocentric view is revealed. If death, disability, and illness are seen as naturally occurring events that one accepts with equanimity, then the notion of medicine and health care is an anathema. The Plunket nurse quoted above sees that children have a right to have medical interventions to repair naturally occurring anomalies like cleft palate and club feet, to allow the child the "normal" functions such as the freedom to walk and talk. In this way some traditional cultural practices can be seen as damaging to a child's potential. The challenge is in finding a pluralist compromise where the child has rights to be able to live, or function without impediment, meanwhile respecting culture.

One of the nurses suggested that described that the increasing cultural education that she had received was improving her practice:

there's a drive to have staff educated and working with Maori and Pacific Island people and I think with that education comes that increased awareness and that ability to look at your own practice and improve your practice(2B PHN).

The paradox described by the nurse however is that there are insufficient Maori and Pacific Island nurses and an increasing number of nurses immigrating from other countries.

We're so short of nurses and we are short of Maori and Pacific Island nurses. We have a lot of South African nurses though, a lot of nurses from overseas coming in...I think its really interesting because they've come from such different cultural background and to come to New Zealand and learn about the Treaty of Waitangi whereas I've had it embedded in my professional career right from going to Tech. (2B PHN).

As commentators such as Ramsden (2002) have described culture is a very important part of nursing practice. It also plays a very important role in the children's rights discourse. There is an essential tension for nurses because there are cases when harm occurs as a result of parental practices that are informed by belief, superstition, or tradition. These are exemplified by Woods (2007) description of radical cases mentioned in Chapter 4. In cases where parents have faced criminal charges for failing to provide the necessities of life and nurses have been called to account for the quality and nature of the information that they have provided for the family.

### ***The nurse as representative of the dominant group***

Just as the nurses see that the different communities within the population have been shaped by the influences that they have been exposed to they tended to see themselves as having been constructed from their own social class, culture, and education:

I think that is probably my quite culturally Pakeha identity coming through there (2B PHN).

Using a Gramscian view as described by Strinati (2004, p.152) the role of nursing, as with other "professional" groups, unintentionally by their socialization, disseminate the bourgeois hegemony of the dominant group in a democratic society (Haugaard & Lentener, 2006).

We're in a helping profession ... You're wanting them [families] to make that choice, hey not to smoke cigarettes or to get treatment if they're unwell..." (2B PHN).

According to Foucault's notion of "pastoral power" within the modern welfare state the rationale of government is to totalize as well as to individualize. The nurse is expressing the desire for all people to be equally well. This concept of egalitarianism reflects Gramsci's argument that suggests that hegemony is a shifting and contested group of ideas, where dominant groups strive to get the consent of subordinate groups, rather than a dominant group oppressing and indoctrinating a subordinate group. The following two quotes show the subjectivities of the nurses who see themselves and their own children as advantaged:

I think I spend a huge amount of time in poor quality homes and it's sad. You don't go to many middle/upper class families with acutely sick children and that's the

reality. What do I have that they don't? I have a job, I have money, and I have a doctor that I can afford to go to. I have access to good quality food and I send my children to education, and I love them (4D HCN).

I think it can be quite hard when you work in these communities and you have this disparity -perhaps in your own life that you, even though you're working hard, you're in a much more comfortable place (2B PHN)

The children, who don't get their health needs met, form the space (the Gramscian subordinate group) in which much nursing practice is created. Disproportionately the children seen for the nurses in this study (and I would suggest nationally since this reflects the epidemiological studies described in Chapter 3) come from disadvantaged backgrounds with parents who are seen as not able to fulfill their obligations. Essentially, all of the nurses perceived that they are in a privileged position in a dominant culture because they are relatively wealthy and educated. In the dominant culture the majority of parents ensure that their children achieve their basic rights to health. They have the impression that most children are healthy because they require minimum intervention by government service providers since (as previously cited) parents who abuse or neglect their children are a minority.

One home care nurse stressed that she believed that families were doing a "tremendous" job with their children when pressed for why they were doing well she responded:

The people that are doing well, I think they've had good things modeled to them in that they know how to budget, that they know how to manage, to feed a family on little money, to still have money to spend on the children's health and education" (4D HCN).

The nurse uses normative values like "good", "know how" and "children's health and education" all significant discursive positions that place the need to be a "knowledgeable manager" therefore in order to do well people need an element of self discipline. Thus reflecting Foucault's power- knowledge relation as described in Chapter Two. What came through from how all of the nurses spoke was that morally they had a sense of egalitarian distributive justice. One in which they understood that they personally had advantages that they would like to see others have and that they believe all children deserve.

## **Summary**

In this chapter I firstly identify the subject positions of the child as “entitled” followed by the notion that nurses witness children suffering. I then look at the tensions created by the family centred care model when it competes with the child centred focus of the children’s rights discourse. The nurse assumes positive subject positions such as ally, educator, and resource, to support the child and family. However, these roles may be resisted and then nurses assume the less positive subjective positions of disciplinarian, advocate, negotiator and silent witness. What complicates the role of the nurse in working for the rights of children to health is that the nurses have a relatively homogenous belief in biopower and share a common value in the rights of children which is not necessarily reflected in the heterogeneous community (village) that they serve.

“It takes a village to raise a child” has an interesting philosophical paradox. On the one hand it exhorts the communitarian and collectivist ideal of the “village” but on the other hand it promotes the primacy of an individual within the collective “the child.” This paradox is reflected in the “Family Centred Care” model promoted in child health where the family is the centre of the care but the child is the focus. It is a fine balance to establish how much nurses should support parents. Too much involvement of the “village” is called paternalism, and too little means that families and children become the victims of indifference. This creates a tension for community children’s nurses from the subjective position as representatives of the “village” because determining how much too much involvement is, and how little is too little, is where they must use their discretion.

From a Foucauldian pastoral power perspective described in Chapter 2, the children’s community nurse is the representative of the community who enters the home to provide knowledge and skills that will be the salvation of the children within the home. Nursing interventions represent technologies of power. The child is dependant on the parent and so the parent is in effect the saviour and as I have previously mooted the nurse is more of a Samaritan helping at a critical time. The primary intervention is the ability to establish a relationship with families, to work with them for the benefit of the child. Within the home the child is constructed as considerably powerless and the parents as considerably powerful and balancing this fundamental relationship requires delicate negotiation. As described in

Chapter 1 Foucault defines ethics as how people behave in relation to moral norms which are the sets of rules prohibitions and codes for society (Danaher, Schirato, & Webb, 2000). This chapter has revealed the moral principles that underpin the nurses reasoning when working within the complex social and cultural divisions within society.

## Chapter 6: ‘My home is my castle’

### *Introduction*

A prominent contradictory discourse to that of “it takes a village to raise a child” exists for which I use the metaphor “My home is my castle”. The origin of this saying can be traced back to a 17th Century legal treatise by Edward Coke (1552-1634) about the right to privacy (Titelman, 1996). It has been paraphrased from the original “An Englishman's Home is his Castle.” The analysis of the original saying has multiple interpretations including a legal and (from a feminist viewpoint) a contested construction that a *man* is a master of his home and those inside within the home are submissive to his authority. This construction traces back further in history to the Roman concept of *pater familias*. Arguably in some homes today a man is still the master (Thiesmeyer, 2003). The original saying also has a colonial interpretation with an emphasis on an *Englishman*. A libertarian view of the metaphor of the “home as a castle” is that it symbolizes the protection of those inside from the unwanted intrusion and meddling from those who do not live there, including state intrusion (Fox, 2007). A children’s rights interpretation of the construction of the home as a castle is possibly that it is a shield that hides the reality of children's lives from the community.

The “My home is my castle” discourse competes with “it takes a village to raise a child” because the basic premise behind the latter is that the nurse as a village representative is both welcome and entitled to access “the castle” to support child raising, and that the “castle dwellers” extend the welcome and recognise this entitlement. However, as I have shown in the previous chapter resistance to public intrusion into the private space can occur. In this chapter I identify and analyse the subject positions and power relations spoken about by nurses when deploying the home as a castle. I suggest that it is the space of the home defines and delimits the notion of children’s rights.

### *Privileged guest*

Within the concept of home there are multiple examples of its construction as an inviolable space as described in the metaphor “my home is my castle.” The presence of fences, gates, security systems, locks, and curtains, may symbolize the marking out of this

territory. Using a castle metaphor the doorstep may be constructed as the drawbridge. A nurse may be perceived an agent of the state or a representative of authority who is challenging the political liberty of the homeowner. To be an advocate for children's rights to health the nurse must enter the private space where children exist for the majority of their childhood. The nurse is an employed public servant whose job is to identify disease potential in the home and for the participants this created particular tensions. The language or discursive speaking position of the nurse in the home is one of a tentative and cautious "guest" careful to avoid confrontation or to offend a "host." Nurses use words like privilege, invited, and respect:

You are in a privileged position. When you go into someone's home you're an invited guest in their home so it is a privilege to be there. You know you're getting an insight into their family lives, how they live, where they live. I think it's a real matter of trust to get over that doorstep (2B PHN)

The construction of the concept of privilege can be seen as a special advantage, immunity, permission, right, or benefit granted to or enjoyed by the nurses. In law the right to privileged communication is demonstrated within confidential relationships like those of between client and attorney, patient and physician, or communicant and priest. For the community nurse it is more than a privileged communication, it is access to the home. You are getting "insight" into the private world and therefore, it is expected that you will pass your "gaze" over the home for the purpose of some form of judgment. Trust is seen as the passport to make the transition from public space to private space:

I think your relationship is deeper with the family in their situation because you're a guest in their house rather than being in your territory. You're suddenly in their territory and I think there's a lot of respect that we have to give to the families to gain their trust and approval and I think if you can do that then generally you can effect change if needs be or make recommendations and I think that the information that you give is better received if you've got that level of respect and trust (4D HCN)

This concept of the trust that is required to let defences down and permit entry into the territory is interesting. Territory is the sense of a geographic area constrained within marked territorial boundaries and permeates the descriptions of home visiting by nurses. The nurse constructs the spaces of "your territory" and "their territory." "Your territory" for the nurse is the hospital the public space where health care professionals assume the



territorial authority by creating the rules. The signs, the locked doors and the security personnel in hospitals are some of the outward signs of the demarcation of boundaries. ‘Their territory’ is described throughout this analysis with the visible and invisible signs of demarcation. The following comment was made by a home care nurse recognising that unlike the hospital the home is a personal and private space that she would also not feel comfortable at being exposed to the gaze of an outsider:

how would I feel if this was my child and I had someone coming to see me? How would I like someone to be in my house? ...you are always aware that you are in someone else’s house (5E HCN).

This is someone else’s house and so the ownership of the space is again reiterated and the nurse feels some unease at the intrusion into this space reflecting on the vulnerability she would feel if the roles were reversed.

### ***Nurse as Intruders***

Nurses are not guaranteed entry into the home because within the guest /host relationship the power of the nurse is tenuous. The parent has the right to refuse engagement with the nurse or entry to the home. Point blank refusal of service occasionally occurs but generally it does not. It is arguable that parents feel unable to refuse as they are intimidated by the nurse as an ‘agent of the state’ or that social etiquette requires civility to a guest. Once allowed (‘let’) into the private realm the nurse is aware that she must take her cues from the host. The nurse offers information but the families choose to accept or reject the information. The nurse in this relationship could be likened to a salesperson. Depending upon her persuasiveness or how intelligible or familiar her information is will determine whether a family will consider the information to be credible.

Plunket nurse’s home visit for a scheduled number of times and then see families at the clinic. Again it is difficult (but not unheard of) during a home visit to strip and weigh babies outside the house. Public health nurses who are often focusing on health promotion do not necessarily require entrance to the house; so by contrast, this nurse identifies the doorstep as a viable alternative to entering a house. Accessing the home is not as relevant as engaging with the parent to facilitate meeting child health needs:

Sometimes we don't get over the doorstep. A lot of the time, the work we do is on the doorstep and that's fine. That's absolutely fine too..." (2B PHN).

To the participants the doorstep is also symbolic of getting over the threshold between the public outside space and the private inside space. Privacy and trespassing are associated phenomena of entering the home:

You turn up on their doorstep and you can see how little they have, or how they're living, they can feel very shy about that, and so often we'll have a neutral meeting ground (2B PHN).

Here again the nurse speaks of the vulnerability of the homeowner at the gaze of the outsider invading the private space feeling shy or embarrassed at the state of their homes as a reflection upon them as people. The inside the home is not considered neutral territory. The use of the word neutral may connote some form of existing or potential for conflict. If the home is not perceived by the nurse as neutral then there are tensions and conflicts within the space:

Occasionally you will meet a family that is reluctant for you to be there and you may feel a little bit, not really threatened, but you may feel a little bit uncomfortable by the initial greeting that you get. It's whether you can talk your way through that and feel comfortable going into the house to continue the assessment or whether at that point you recommend that, well this is what the doctors really wanted so perhaps if you could take Jimmy back to the GP then that would work as well (4D HCN).

This again demonstrates the home as the defended territory but in this instance the nurse positioned herself as the emissary from a higher power (not the actual invader). It is the doctors who wanted the child seen not the nurse herself, she was merely a representative of the health system. If the parents do not want the nurse to do the assessment / treatment they can take the child to a doctor. The choice is there as to who sees the child but the need for the child to be seen is explicit.

The diplomatic role in "talking your way through" the barriers is pivotal in the role of the nurse as an advocate for children's rights to health and was a recurring theme in this study. Nurses needed to communicate to form relationships and one of the most intrinsically delicate phases of the relationship development was engagement. When the nurse first arrived at a home and introduced herself she is in a way selling the service she is

offering. Nurses describe a non confrontational approach when I asked how she “got a foot in the door” one Plunket nurse replied:

Oh that, by standing back from the door often. Standing sideways to the door and chatting and chatting and after a while, I don't know it just is, I don't know how it is. I'm aware of doing the sideways thing. I'd call the Maori card every now and again because my husband is Maori and I speak a little bit of the language and know a bit of the body language and all that sort of thing. I unashamedly use that to be honest, because it makes people feel comfortable. That's the kind of thing and I suppose with practice you just get to know (1A PN).

This Plunket nurses described standing “sideways to the door” an oblique approach “and chatting and chatting”. She presents herself as non- threatening both physically and culturally if she is visiting a Maori client. She is not fully aware of what it is that she is doing and she describes it as an unconscious and innate response whereby she uses herself to establish trust. She went on to describe how she used to wear tinted spectacles until discovering that they darkened and masked her eyes when she was in the doorway and was interfering with her use of eye contact to establish genuineness and trust.

Another example of how nurses “win” families around is given by one of the home care nurses in the following excerpt:

...It's about relationship building, and building the confidence and the trust with the child. I love to get on the floor and play with them, so usually you can win somebody around by doing that. So I always get down to their level, never sit on a chair with a family (4D HCN).

The concept of winning people around and being non threatening by engaging in diversionary talk rather than directly approaching the reason for being in their home, in some part, is related to dispelling some of the preconceptions or suspicion that some people have about the role of the community nurse. When the public health nurse interviewed perceives that she is intruding on the territory of a family she withdraws and then identifies neutral ground (a public space) in which to engage:

I do a lot of standing at the school gate. I call it stalking, waiting for parents because usually it's a pretty comfortable safe place to have that informal 'chit chat' with parents (2B PHN).

The use of the word stalking is interesting. It is also frequently used in the context of hunting animals. Here it means approaching people without their awareness, and as a consequence their defences are down. That she describes herself this way suggests that she has constructed in a way her role as predatory, and that she is strategic in finding times and locations to engage with children's caregivers. It seems likely also that in meeting publicly the caregiver is also obliged to be civil. The informal chit chat to obliquely establish a relationship is therefore a technique for breaking down barriers.

### ***The nurse as vigilant outsider***

Another subject position for the nurse when the castle is a fortress is vigilant outsider. The home is seen as a fortress with visible signs that outsiders should not enter, or that the home is not welcoming or comfortable. The language that nurses used to describe some of homes visited also describe the construction of what is nice (safe) and what is broken or in disarray (risky). The nurse describes how she is "alert" to certain signs when she approaches the home:

You're alert to it the moment you get out of the car. You're driving up to the house and you're looking are the grounds nicely kept? Is there dog poo all over the lawn? Are there beer bottles? Are the grounds neatly done? Are the windows broken? That's before you've even got to the house. They're opening the door. Is the doorway obstructed? Are they open to you being there? Is there some aggression to you being there? You're looking at the house. Is the paper peeling off the walls? Does it smell damp? Is there furniture in the house? Is it cold? Is it clean? Is there dirty washing everywhere? Rubbish on the floors? Are the children clean? Is there a nice relationship going on? Are the carers talking nicely to the children? Is there that feeling of people shouting? Are there lots of extended family there? All sorts (4D HCN).

The vigilant scanning of the environment when approaching a home is echoed by a public health nurse:

High fences that are padlocked, you don't go into those ones. ...Oh it's usually something to do with drugs, yeah drug houses. Well you can tell whether you're visiting a state home or a privately owned home, that can be an indicator that income threshold is not very high. You can get a feel for a place, is it well maintained? Is there a lot of family sitting around smoking outside? What are the recycling bins full of, a lot of booze bottles over flowing? Is there a lot of rubbish generally lying around? Just the general appearance of the place-are there some big dogs? (2B PHN).

The nurses judged the risk to themselves, and the risk to the children and family who are living in the home. The signs define the approachability of the space. Dogs, fences and other symbols construct the nurses' picture of the home. The nurses talked about how they interpret certain signs indicating conditions such as safety or socio economic status. This constant scanning in order to assess risk and needs amounts to surveillance and contributes to the general picture of children's health. This amounts to what 4D HCN referred to as "piecing together a jigsaw".

At times all of the nurses identified that there are homes where illicit behaviour is suspected. In the excerpt described above it is "drug houses." This put nurses in the position of not only being witness to untidy or impoverished homes that people were shy about as described earlier, but also homes that actively protected themselves from the public gaze because they have criminal activity to hide and are potentially dangerous. Similar situations are described in two of the interviews where the smell of marijuana was noted by the nurses but dismissed as something else by the families for example:

...obviously like a marijuana smell, so she made some comment about it, and they said oh no that's chicken cooking (5E HCN).

In neither case did the nurses confront parents with a discussion about the potential negative effects of parental drug use on children. One of the Plunket nurses said that she really did not know how to deal with clients who were obviously under the influence stating:

Speaking as somebody who's more than once been greeted with a customer whose eyes are rolling in different directions when she opens the door, I do not know. I honestly don't know how to deal with that (1A PN).

The same nurse hastened to add that she would call the police if she suspected a "P" lab (methamphetamine) because she knew that the chemicals used were highly toxic and flammable and posed a greater risk to children.

One of the home care nurses who said that visiting families where parents were under the influence made her feel that she was more vulnerable and she would need to balance the potential risk to the child with her personal safety:

I think when you're in someone's house, you're quite vulnerable really and I think if there was a man there that had obviously been drinking -or a woman, I haven't ever confronted anyone about that, but probably should, I don't know (5E HCN).

The nurse questions her judgment, she feels she should confront people but does not feel safe to do so this creates a moral ambiguity. Like the Plunket nurse above there was however a bottom line between under the influence and totally incapable and so one occasion that she had notified CYFS and called an ambulance to take the child to hospital:

There was another family that we ended up calling CYFS [Children and Young Peoples service] and getting the child taken off by ambulance because both parents were so drunk they were really incapable of doing anything, especially looking after the child (5E HCN).

### ***The home as a screen***

At times the home screens the reality of children's lives. A Plunket nurse describes how voiceless and less than human the child's position is in the following statement:

The little guys with no voice, it's like the animals with no voice, there's nobody to speak for them if their parents don't because the rest of the community is so busy making sure that they don't interfere with other people's business (1A PN).

This nurse went on to describe studies that show a correlation between cruel people who harm animals and cruel people who harm children. A lack of empathy for children flies in the face of the hegemonic belief that everyone cares for and protects children "the little guys" because they are vulnerable and lovable. The second part of the statement refers to the failure of the rest of the community to own the "takes a village to raise a child" discourse. The separation of the public and private domains is confirmed in the remark that the rest of the community "don't interfere with other peoples business." This reflects upon recent publicity around the failure of witnesses to intervene in the systematic abuse and subsequent death of a three year old. (Daily Post, January 25, 2008).

### ***Not the panopticon***

That the home is a screen also is significant in discussing the surveillance role of the nurse. Foucault's (1977) disciplining panopticon model described in Chapter 2 suggests that people modify their behaviour because they are conscious of being watched at any time. The nurses all identified that they only have a small window of direct observation in a

home. I would suggest that essentially the nurse has no power to change behaviours, only to offer a point of view. While being a guest and providing a nursing service, nurses were aware of the limitations of their interventions. Particularly that they were only a fleeting presence in the home. As all of the participants point out they are only visitors:

We don't live at home with that family 24/7, but it's just that awareness that things might not be right (2B PHN).

This challenges the notion that home surveillance by nurses represents the panopticon as described previously in Chapter 4 by Bloor and McIntosh (1990). Nurses construct their nursing view of the home as a snapshot, episodic rather than continuous. This is unlike continuous video surveillance of public spaces like hospitals and banks. They generally keep a pre- arranged appointment or negotiate access to a home for a short period of time. They often visit only a small area of a home, usually identified by nurse as the lounge or baby's bedroom which are more visible and neutral spaces in a home:

I mean we don't know half of what goes on I don't think. You go into the room that they show you into, goodness knows what's going on in the rest of the house, who's there when you're not there, I mean you've got no idea really (5E HCN)

Nurses generally visit during daylight, office hours, and interact with only a select few of the householders, most often mother and children. As sensitive visitors the nurses have hunches or intuitions based on what they pick up in the home but these hunches or an awareness that things might not be "right" are not necessarily substantiated or verifiable. The oblique ways of pointing out to parents what they "see" with their nursing look is described by a Plunket nurse who repeatedly visited a baby in a home where school aged children were at home. She describes her conversation thus:

[ nurse] "Oh you're not at school today"

[ mother]"oh no he's got a cold",

[ nurse}"oh looks well to me"... and just leave it like that. Just so they know they've been noticed (1APN)

By "noticing" school aged children not attending school the nurse lets the mother know she has been seen (covert surveillance). However, by not doing anything further, the judgment and authority of the parent is upheld, indicating that parental authority is

dominant over the nursing authority. The nurse has contradicted the mother's claim that the child has a cold but has “left it at that” this action I would suggest aimed not to alienate the family. Her primary business in the home is the baby not the school aged child. The nurse per se had no power. If she exercised her power by association with other government agencies, for example by alerting truancy authorities, then she may jeopardize her tenuous relationship in the home. The subtext of having been noticed is that parents may practice self discipline and self- surveillance when making decisions about school attendance in the future. The key to surveillance described by Foucault in his concept of the panopticon is that if you think people are watching you, you will conform to normative behaviours.

### ***Summary***

In this chapter I have discussed the spatial relevance of the geography of the home as a symbolic a “castle.” The “castle” poses a potential barrier for the nurse to negotiate in order to be able to work for the children’s right to health. I have identified the multiple subject positions spoken about by the nurse participants and shown how the home is constructed as a place where the nurse is a privileged guest for whom the etiquette and social mores require respect, and trust and humility. At the same time in some homes, the nurse is acutely aware that her position is also that of an intruder and vigilant outsider. There is a fine balancing act required by the nurse to maintain the tenuous position between guest and intruder. There are also at time marked tensions that see the nurse balance personal safety with the potential risk to children when parents transgress normal behavioural boundaries. The role of the “village” or the public interest in the child is therefore revealed as potentially undermined by the strength of the “castle” or private discourse. The next chapter looks at the role of the state as a supreme power like that of the sovereign which can override the power of the home as a castle.



## **Chapter 7: The system**

### ***Introduction***

This chapter discusses the responses of the participants when asked to describe how they experience governmentality, and what barriers are within the systems and structures of the state and social apparatus. The nurses were also asked how nurses can contribute to children's rights at a political level. In Chapters 5 and 6 the problematic nature of the nurses' ability to govern the conduct of parents is revealed. There are a range of factors that impact upon the ability of a family to meet a child's needs. One significant factor is the cohesiveness of the community and the services that surround the family and create the notion of the village.

The discourses that inform government strategies regarding children's rights to health are discussed in Chapter 3 and include: law, medicine, economics and politics. These discourses drive the work of children's community nurses but are in a sense removed from the practical implementation of the strategies. The children's community nurses are positioned in the in-between area where the individuals who are contained within their respective "castles" are exposed to the strategies of the state. The "state" theoretically therefore has supremacy over the resistance of the castle, but the state is neither an entity nor an individual and it is not "the state" that is entering the home. When a nurse enters the home, while she represents the state interests, she is an individual bearing the discourse of "it takes a village to raise a child." In addition the nurse bears the biomedical discourses. As alluded to in the previous chapter (using the example of substance use and parental competence) once nurses reach a tipping point in the fine balance maintained between village/public and castle/private, they refer on to state mandated agencies such as the child welfare authorities or the police.

### ***The effect of a neo-liberal economy and contractualism***

As described in Chapter 3, New Zealand has embraced a neo-liberal economic stance. The nurses in this study describe the impact of this economic philosophy on the daily reality of their experiences in people's homes. Within the system the nurses describe a certain degree of powerlessness that they could see things that needed urgent attention but

the system was too slow or less responsive, or couldn't see priorities because as described above unlike the nurse the State is not an entity present in the home:

They [management policy makers] know about it, but they don't actually see how these people live sometimes, and the stresses they have, so probably that's quite different and seeing, I mean you can imagine people living in a garage, all cramped together on a mattress on the floor with a flea ridden dog, but unless you're actually going in there you don't see the impact, the full impact on the whole family's health (3C PN)

They have contracts based on neo-liberal economics, outputs and managerial priorities that do not have the flexibility for a needs responsive service. They often find ways of working around the system as the Plunket nurse describes:

...using professional judgment and having that recognised instead of saying no that doesn't count because that doesn't meet the contract (even if mum's got postnatal depression, you go and see them anyway) but its just always got to be justified to people who don't understand what it's really like (3CPN).

The competitive nature of the contract system highlights the tensions for the different branches of nurses. The Plunket nurse describes how she uses her "professional judgment" and sees them anyway demonstrating her resistance to the rigidity of the contract.

Nurses see that the services for children in the community could serve their needs better by having a greater cohesion. Some have seen new organisations come and go and trial initiatives, then petering out:

I think the system is very fragmented actually. There are lots of fingers in the pie and I don't think we all work well together often. I don't think there's a lot of collaboration or liaising and often there's several organisations trying to do the same work but even finding out who they are sometimes is a nightmare... We're constantly upgrading our lists of agencies out there who are supplying what with what. We get quite a lot of guest speakers come along and inform us of what they're doing and what situations are out there but I mean things come and things go and change and there was well child provider out here doing some work with Maori children, that's gone now, so you know ...(4D HCN).

This confirms discussion from a variety of political and strategic planning departments such as the Office of the Children's Commissioner who warns of the dangers of "silo" thinking and the need for "joined up action" (Kiro, 2005). As I have previously identified in Chapter 4 participants described their "go-between" and advocacy position in

child protection and children and how the relationship with child welfare authorities has not always been cohesive or served children's rights to health appropriately. This enhances the need for the emergent post neo-liberal phase posited in Chapter 3 by Lerner & Craig (2002), when they describe a move toward local partnerships to address social issues.

There are some contradictions between participants as another home care nurse describes services available that she can refer families for intensive parenting education out in the community:

There are some really good services out there now that are getting in with some families that are doing basic things you know, just basic cooking, and hygiene, and teaching, just teaching people the basics of parenting skills (5E HCN).

While this nurse sees the system of referring to other agencies is working well in some circumstances the consistency of the services being offered to families is variable. While some organisations such as *Family Start* in this instance are seen as helping children get a better standard of living it is not universal. The same nurse describes another fragmentary program *Healthy Housing* which was seen as an excellent initiative providing insulation and replacing windows to make houses less damp and cold.

If Healthy Housing get involved then things happen which is excellent but unfortunately, I'm not sure where they are now, but they were only operating in a few pockets around South Auckland, and if your family weren't in that area then they couldn't really help (5E HCN)

The nurse doesn't know if the project is still in operation suggesting again the lack of continuity in the current system. Other nurses describe that they are not kept well informed for example:

I just heard-I'm not sure if this is correct- but through the hospitals they're looking at some of these children that are having repeated admissions and they're going to have a team that goes in and looks at some of these houses which is going to be fantastic. That's just a rumour I've heard (3C PN)

Words like "I'm not sure" "just a rumour I've heard" suggest that for clinical nurses that there are gaps in their information that are frustrating to their role as networker and resource.

The home care nurses perceive that the model that seems to work best for the children with complex needs in the community is the multi / trans- disciplinary approach. At such meetings all of the representatives of the health support services in the community meet together with a family to identify the goals and support package required. She also sees that by grouping the different players the intrusion into the privacy of the home by large numbers of different services can be reduced.

We often have quite a lot of multidisciplinary meetings where we get all the same people in the same place at the same time because that's less intrusive for the family if we can all do it together, often families quite like that, not only do you end up having a child with a disability, you end up losing a lot of your own privacy ...Everybody is there so you can all voice concerns with the family there as well. You're all on the same page, so we know where the child is up to, what the plans are and what the expectations are, so I think they're quite good forums (4D HCN)

However this wrap around service is not always apparent. The home care nurses also see the connection between hospital and community as an area that really needs to be further work to serve families better in order to meet children's needs. All of the nurses discussed the impact of a lack of effective discharge planning on the ability of parents to manage the responsibilities of child care, particularly with children with very high needs. In one instance a family had high dependency child discharged home when the systems were not in place to support the family:

I think the discharge planning was appalling and a lot of their issues weren't really addressed until the family were almost forced to take this child home and the discharge plan is meant to start from the time of the referral as the time of the referral as an inpatient...I don't think we got involved until probably about 10 days before the child was being discharged and 10 days really isn't very much to set up... think the system let the family down (4D HCN).

That the hospital showed little insight into the work of community services was repeated by all of the participants and was identified as a barrier to children having their health needs met. The complexity of providing health care in the community appears to be overlooked in the highly technical context of hospitals. This could be interpreted as the health care system hierarchy of techno-science in the hospital overlooking the psycho-social care in the community.

### ***Invisible nurses***

That the nurses I interviewed felt that their work was invisible was further highlighted by a discussion with the public health nurse. Nurses have found that working in a competitive contract driven health care environment creates tensions. They are not only competing with other providers, which affects collaborative practice as described by the Plunket nurses in the services for newborns, but they also find themselves doing contracts that compete with their existing core business. Obtaining a contract to deliver the meningococcal B vaccination campaign was described by the public health nurse as a mammoth strategy that overshadowed other work:

Really it took out a year and we didn't do any of our core work in health promotion or personal health, it's almost as if our core work isn't important (2B PHN).

This program was a large additional contract and it created a gap in the two core strands of public health nursing which are personal health and population health. In personal health they work with individual school aged children to liaise with homes and resource parents that are struggling to meet children's health needs. In population health they link in with large health promotional strategies:

We're quite innovative, we're quite forward thinking, our core values reflect on decreasing health disparities, especially amongst Maori and Pacific Island communities .... We've got some really cool programmes. We've got let's beat diabetes...Health Promoting Schools which is a fantastic way to engage schools and take a whole school approach to managing problems... you can take it broader and work within the school to increase those health messages so I think there's a lot of positive change there I do think the education really is the key (2B PHN).

To sustain the momentum of both the population health work and the personal health work the public health nurse felt that there needed to be greater visibility of what it is that public health nurses do by service management and the policy makers.

### ***Public Opinion***

How people receive public health messages in particular was described by the public health nurse. The use of the media campaign to sway public opinion and challenge attitudes was seen as a powerful tool that in her experience, however the campaigns needed to be reinforced to maintain public focus:

We did this big campaign, did really well getting our immunisation rates up, and then we stopped the campaign and now we're starting to see the disease rise (2B PHN)

The public health nurse saw the importance of the use of the media to target messages for the community to comprehend what the issues are for children. The public health nurse had a strong sense among that the government has a responsibility to provide resources and generate marketing campaigns for the "village" to change attitudes and values toward children:

....some of the commercials around health messages, around mental health, around nutrition, and around exercise, and stopping smoking; - there are some key messages that are very current on the telly at the moment (2B PHN).

Not only does the communication network constructed by the media influence societal attitudes toward health and disease, but also they affect the attitude of society toward children and families. Understandably the public health nurse is talking about the construction of her view of the need for visible reminders of health promotion messages and the importance of a population health focus. Health promotion as she sees it links to the notion that key to governmentality is the operation of biopower, which is bent on generating forces, making them grow, and ordering them, rather than one dedicated to impeding them, making them submit, or destroying them (Foucault, 1977). The prime object of biopower is individual people conceived of as a "population" (Lupton, 1995). I see Lupton's view highlights the tension between the "village" and the "castle" discourses because it describes the difference between the individual autonomy and collective responsibility.

One of the criticisms of health promotion is that the scientific community is the elite who manipulate public opinion about how health is constructed (Crotty, 1995). For the home care nurses in particular, educating families about disease and management of care is central to the ability of families to cope effectively with sick children (Henry, 2004). However, as one of the other nurses noted some of the information that comes into the home can either supplement or contradict information that nurses are trying to share:

...they've been on the internet and they know way more than I know about whatever. Or, they have found out stuff that you know- I mean internet stuff can sometimes be a bit dodgy (5E HCN).

Therefore electronic and print media were constructed as both useful and confirming, or contradictory and unhelpful.

One of the nurses saw that as well as informing and misinforming about health promotion and education the media informs values and attitudes. The general public was more likely to see children's health issues as black and white because of the bias in the way that the media sways public opinion:

I think it's the media probably make judgements or I mean some of the cases that come up and we kind of know a bit about maybe, the high profile ones, and this sensational thing about you know broken windows and dirty nappies, and you know a lot of the families that we go to might have a broken window or are dirty, but that actually doesn't make them bad parents (5E HCN).

The polarization of public opinion in a negative way was highlighted by the nurse who was involved in a high profile child murder case in Chapter 5 who described:

[the murder]certainly was a hot topic around my neighbourhood. Some of my neighbours said, "oh bloody hell", and I just had to tight lip, it certainly forced betrayal, and its amazing what people believe when they read the papers.

The media can portray the "truth" in ways that do not correspond with the nurses' perception, in turn changing attitudes which negatively inflame moral panic. The nurse describes her "tightlip" which indicates that she had more to offer to illuminate the public than she was ethically permitted to share because of confidentiality issues. This to me indicates that there is a need for a forum where nurse insights can be shared with decision makers and the general public in manner that will not compromise their client confidentiality.

### ***Political issues for nurses working for children's rights***

The nurses generally felt that they were too busy doing what they do to be a political voice for children:

We're pretty busy. It's a topic that comes up again and again. It doesn't change. It's our contract with the government. I'd like to see for example the discharge plan

with the neonatal unit, look at midwifery and well child services more integrated, looking at things, discharge planning much more early on in the process really from birth and thinking about when they get home, what they can do, put things in place, much earlier would be more ideal (3C PN).

There is a sense of the tension between different nursing services because of the way that the roles cross over. In the case of a baby discharged from a neonatal unit the Plunket nurses don't get advised until midwifery services (and home care services for preterm infants) refer the baby on. Both of the Plunket nurses described their frustration that the families that have a contract for an ongoing service for the first five years of a child's life are not referred to them until 6 weeks after a baby is born. The Plunket nurses identify those first 6 weeks are crucial times for identifying support issues and a time of high vulnerability for mothers. Whilst these are currently contracted to midwifery services such services have different focus and to those of the well-child provider. Both of the Plunket nurse would like to see a crossover of services both well- child and maternity but this would require the government to fund it would doubtless see as duplicate services. The rationale is described in the following excerpt:

One I went to today, a young girl, it's her second baby and she had not- not wanted to see the midwife, the midwife had come twice but the midwife hadn't phoned her and so she was actually out, only briefly but she missed her both times and when she tried to ring the midwife wasn't contactable so when I heard about the referral and went in at four weeks later the child hadn't had a Guthrie or anything like, it wasn't because she didn't want to (3C PN)

This Plunket nurse feels the system is exclusive lacks cohesion. She would like to see a cross over of services so that new mothers have access to both well child and maternity providers since the newborn period is the most vulnerable for mother and baby. She sees that the support received at this crucial time could prevent problems developing later. To be effective this system would need to be a high level of collaborative practice to avoid conflicting advice for new mothers.

One nurse described why she felt that it was essential for children's nurses to become more visible politically:

All paediatric nurses or nurses with passion they should join the right groups and they should be making applications to parliament and they should be commenting on documents at that level, its only by people doing that, that its going to make any,



give children the voice that they need and a responsibility to be doing that, absolutely I think you have to (4D HCN).

This particular nurse identified her support and involvement in national child health group initiatives. However, she also recognized that clinical nurses in general tend not to be political animals:

I don't think we're very good at doing it. I don't think we're very good at being a voice for political purposes because it's not something we've ever been strong in doing. I don't think nurses are politically driven generally (4C HCN).

This is reiterated by another participant who feels that she would not have any credibility as a political activist. What she sees and does as a nurse in the community are not sufficiently credible to speak out publicly that somehow there would need to be more authority than the views of a community nurse:

Well I think you've got to have credibility, and so you'd have to say, more than just 'I think'. I suppose it would be part of it, but I would also like to think that if I was going to say something publicly, I could have a bit more just to back up what I was saying (5E HCN).

Experience is positioned here as less important than having the "back up" of the status inherent in being credible, and so the status of the nurse as an authority is questioned. The nurse therefore describes herself as powerless and apolitical. Holmes and Gastaldo (2002) maintain that this is a common perception by nurses. They go on to assert that nursing is a powerful means of governmentality because they are health care professionals who are in direct contact with individuals, groups, communities, and populations. The state and its institutions rely on nurses to use power relations that promote and recuperate life through their interventions, to mould, conduct or affect people and contribute to people's subjectivities. A range of techniques are used by nurses including gathering information, producing and disseminating knowledge, and engaging in therapeutic encounters. As the biggest professional group of the health care system Holmes and Gastaldo concur with the expression of invisibility, unimportance, and undervaluing expressed by nurses in this study.

**Summary**

Limits to nurses' ability to work for children's health rights included: constraints on time, personal commitments, contractual limitations, poor inter-service collaboration, role boundaries, resistance by parents and an under-developed political will. There are areas of the children's rights discourse that nurses see that they can contribute more if they had more credibility or confidence to assert their support for the concept that "it takes a village to raise a child." I will discuss the implications of my analysis in the next chapter.

## **Chapter 8: Discussion and Conclusion**

### ***Introduction***

I chose a Foucauldian analysis for its potential to expose the different discourses that exist in relation to the rights of children to health, and to expose and trouble the role of nurses within the private realm of the home (Cheek, 2000). Using a Foucauldian approach also has the potential to identify new discourses that challenge the dominant discourses. The aim of this chapter is to discuss the limitations and the findings of my study. I also identify the implications of my findings and make recommendations for nurses to become more politically visible as children's rights activists. In Chapter 1 I asked the question whether nurses were failing in their obligation to the United Nations Convention on the Rights of the Child. The subsequent literature review and analysis of transcribed interviews with nurses, has provided more questions than answers and has exposed the complexity of children's rights discourse.

The concept of government derived from Foucault's work means broadly "a form of activity aimed to shape, guide or affect the conduct of some person or persons" (1991, p.2). Governmentality studies take modern liberal acts of government as their object (Dean, 1999). Dean highlights the significance of alliances and partnerships between individuals, groups, agencies and institutions, throughout society. These alliances stretch from government and its economic, health, welfare and legal systems, to the nurse interacting with an individual family. Rose and Miller (1992) suggest that governmental analysis should be centrally concerned with the associations formed between political entities and the "practices of those who endeavour to administer the lives of others in the light of what is good, healthy, normal, virtuous, efficient or profitable" (p. 174). Therefore, identifying the associations between the law, economy, and government strategic planning, in the day to day work of nurses is a complex task. Analysing these associations suggest that nurses are integral to the concept of the panopticon by being the government's "eyes and ears" in the home. Yet this study questions how much nurses how effectively nurses can monitor the home.

This study also complicates an easy reading of Foucault's power- knowledge relations. It challenges the assumption that nurses' power relations with families are fixed

or that the nurse is more powerful. Nurses engage in negotiation between children's rights and parental rights. They also must negotiate the respectful advisory role that proffers knowledge as "suggestions" not directions for parents to meet children's health needs. This is because the analysis suggests that there are two dominant and competing discourses in society today that make nursing children in the home complex. The first I have identified as "It takes a village to raise a child". This discourse can be seen in laws that promote the rights of children to be entitled members of society that must be protected. These laws are particularly relevant in relationship to the United Nations Convention on the Rights of the Child. The "It takes a village to raise a child" discourse has a broad scope and includes the liberal humanistic concept of collective responsibility. The second discourse I have identified I have called "My home is my castle". This discourse can be seen in laws that promote the rights of the individual to privacy and freedom. Politically the "My home is my castle" discourse aligns with the politics of individualism. In economic terms the discourse is relevant to the neo-liberal free market economic theory. Power is in the hands of the individual to make their own way, ownership is central, and includes the ownership of the interests of personal property and family. I see that children's community nurses are caught between these two oppositional discourses. I also argue that children and their rights to health are disadvantaged by the contest between these two discourses.

### ***Limitations of the study***

This study has been limited by time and scale. The sample size is small with only five self-selected participants plus that of the researcher; it is therefore not generalizable but offers one interpretation of the data and the literature review. The participants all identified as European with no Maori or Pasifika voices. The geographical area was limited, and the sample population was restricted to three of the many community health nursing services.

The scope of the study is vast and it has touched upon important issues such as: the relative value of children, health inequality, social structure, victim blaming, the public versus private debate, the role of nurses in health education and promotion, the place of nursing in the governing of the personal space and many other important and widely researched areas.

A different methodology may have yielded other information and so the recommendations made here are tentative and reflect the partiality of the author. The broad sweep of issues that have been touched upon by this thesis have created a pastiche which may be criticised for a lack of depth. However, it must also be said that the ethics and morality of children's community nursing is complex, diverse, and uncertain, and that the ambiguities of the role have been highlighted in this study. If certainty, consensus and simplistic presentations of ethical approaches are sought, then this thesis will frustrate the reader. If conversation about, and engagement with, applied/clinical ethics is desired then this thesis has achieved its aim.

### ***The village supporting parental privilege***

Pitting children's rights against parental rights as discussed in Chapter 3 is a very simplistic notion and one that nurses describe in Chapter 5 and 6 as the most delicate negotiation for their practice. Dwyer (1994) puts forward a succinct argument against parental rights. He promotes the concept that parents should be considered to have parenting *privilege* not parental *rights*. The salient points of the argument are that not having parental rights might lead parents to recognise their children as separate persons, persons whose wellbeing is also the concern of other people. Parents who find it particularly difficult to meet the needs of their children need help, "if we as a society did this successfully there would be a need for state intervention only when parents were determined to take actions contrary to the temporal interests of their children" (Dwyer, p.1047). It is the nature of this help that creates the tensions and complexity for nurses, and resistance to help creates the subject position of the nurse as an intruder and a vigilant outsider. The following looks at the complexity of the panoptic gaze and the fine balance between punishment and support.

### ***Are nurses the health police?***

In the wake of another child murder The New Zealand Herald headlined a letter to the editor. *Weekly visits by Plunket nurse the way to stop child abuse*. The author of the letter demanded mandatory home visiting by Plunket nurses, to inspect the living conditions of all children for the first six months, and then monthly until the child started school. The author then suggested that children would then be taken off non complying

parents, and any further children of non complying parents would be taken from them at birth and adopted by deserving compliant parents (NZ Herald, August 18, 2007, p. A19). The tone of the letter implied that the author constructs nurses as the health police of the state that have the power to force people to comply with the standards of “good” parenting or they will be punished with the removal of parenting privileges. There appears to be a strong belief in the disciplinary technique of the “panoptic gaze”. The style of the writing suggests that the writer comes from a different era in New Zealand, one where authority, including that of nurses, was constructed as incontrovertible “truth”.

My study would suggest that nurses are a far cry from this view of the omnipotent judge of parental standards or the powerful eyes of the panopticon gaze. The participants in this study describe themselves as privileged guests in people’s homes with a limited window of opportunity to view how children live. As highlighted by the participant who had visited a week before a child was murdered, there is not necessarily any indication that a nurse will identify the risk for random violence- regardless of how often she visits. As this study demonstrated the powerful right to privacy inherent in “my home is my castle” discourse constrains the surveillance role of nurses.

Foucault (1991) in his essays on governmentality highlights the significance of different types of governance: liberal self governance, sovereign rule, and discipline. He argues that these rationalities interact in dynamic and sometimes contradictory ways. Illiberal and oppressive forms of power in the context of controlling parenting as suggested by the letter to the editor is what I have used to introduce this section. I use this to illustrate sovereign power and the public misapprehension of the expression of the rule of law in the context of children’s community nursing. I see that community children’s nursing is founded more on liberal modes of government, which recognises that citizens possess the right to practice certain freedoms and responsibilities, particularly within the privacy of their own homes. This is based on the findings of my research in the subjectivities of the nurse as ally, educator, and resource.

When the nurse finds she must act against the parent as an advocate for the child she refers to a sovereign power (social welfare or the police). The authority of a nurse is no more powerful than other concerned citizens (for example a concerned neighbour). I

confirmed this finding with Ian Hassall, former children's commissioner and policy advisor (personal communication December 7, 2007). Hassall asserts that the moral responsibility to intervene if a child is in jeopardy should rest with any responsible citizen and not because being a nurse affords any additional status.

Another children's rights commentator Guggenheim (personal communication, December 6, 2007) describes the role of the nurse thus:

A nurse who is committed to offering services and recommending ideas or new ways to take care of children, plainly, is not engaging in inappropriate intervention and ought not to be tarnished with the label of "health police." But these providers should also remain keenly aware of their purposes, and not allow themselves to shift towards the coercive side of intervention

Nursing is seen to both help and educate thereby legitimatizing the place of nurses within the "it takes a village to raise a child" discourse. However, as Guggenheim points out if the purpose shifts to forcing parents to do things that they do not want to do then the relationship becomes coercive. The question that arises for nurses is what should they do if parental non-cooperation potentially harms their children, and more particularly *when* they should do something?

### ***Coercion or persuasion***

In my opinion the difference between coercion and persuasion seems to be the crucial difference between the opposition of power and its subcategory domination, or the opposition of just relations and coerced relations. Foucault does not see justice as outside power because he does not think there can be a unitary transparent mode of relationship, but this is not to say that there is no basis at all for choosing some relations over others (Loesberg, 2005). The nurses interviewed in this study explained how they strive to advise and not direct, by helping parents understand why the nurse believes the parent should want to behave differently. The difference between persuasion and coercion seems to be the element of choice rather than force. In *Discipline and Punish*, Foucault (1972) describes the genesis of the penal system which moved from using force where criminals were physically tortured and had no choice, to imprisonment where criminals were potentially being watched at all times and therefore "chose" to behave in a certain way (the panopticon). In a

way I would interpret this as a circumscribed form of freedom of choice, which is mediated and governed from a distance.

Foucault also saw that people must constantly be able to connect with culture in as many ways as possible and that teaching should be provided in a way that allows the individual to change at will (1988, p.329). I see that this idea correlates with how I describe the subject position of the nurse as a networker and resource to increase the variety of ways that individuals can connect with culture and in this sense connect with “the village.” In my analysis I have used Erikson’s (1996) study of communication that stresses the importance of broad social networking.

Social networking ties in with the thesis put forward by Gladwell (2000) in *The Tipping Point* that individuals are powerfully influenced by what is happening round them, and that people with a wide range of social networks and a desire to share their knowledge can be effective change agents. One simple example from the data that demonstrates this concept is the Plunket nurse who introduced a mother to the use of the public library. One family’s library using behaviour could possibly then become what Gladwell refers to as an epidemic as it “infects” the wider social group.

### ***Mandatory or Voluntary***

The current Children’s Commissioner was recently advocating for compulsory Well-Child checks. My study suggests that the nurses I interviewed use their experience and interpersonal communication skills to build the goodwill to work with families. Overt coercion and authority would probably therefore cause concern for nurses, particularly if they were handed the responsibility of policing such a requirement. Realistically, all nurses may not share such communications skills and attributes, since nurses are no more homogeneous than any other occupational group. Much of the critique of home visiting comes from overseas studies. Possibly New Zealand nurses have less of an authoritarian style than their British counterparts because of the lessons of colonialism, the relatively small population size, and the history of New Zealand in the evolution of social democracy and liberal egalitarianism. It is also possible that children’s community nursing has been under researched. With experience, the type of communication training described in



Chapter 4, and the positive recruitment of nurses with demonstrable communication skills, the nature of the relationship between nurses and parents can be supportive and resourceful (Polaschek & Polaschek, 2007; Woodbridge, 2002).

The debate as to whether mandatory reporting would benefit New Zealand children has remained more closely in favour of discretionary judgment (Kelly, 2000). In North America where there is mandatory reporting for suspected child abuse and neglect, there is less opportunity for discretion. Therefore, Marcellus (2005), in her study of public health nursing in the United States, sees that the unspoken factor of child welfare assessment for nurses in the home destabilizes the nursing relationship with mothers with social risk factors. This links with Cowley and Houston's (2003) study, that identified a formal risk assessment tool as judgmental and disempowering to clients with high needs, and that it adversely affected the therapeutic relationship. If parental perceptions of the work of home visiting nurses include awareness that the visit will be used to survey the home environment and observe parental care- such as feeding and disciplining they avoid, conceal, and resist when nurses visit (Cowley & Houston, 2003; Wilson, 2001).

### ***In defence of surveillance***

Wilson (2001) identified that whilst Plunket nurses are involved in an implicit surveillance operation this is constituted as a dynamic relationship. The mother participates on her own terms. My study corroborates Wilson's study, which found that nurses engage in a negotiated "gentle" surveillance, where power ebbs and flows between the players. Moreover, my study demonstrates that the experience of the Plunket nurse is shared by other visiting nurses (public health and home care nurses). Therefore, it is the action of home visiting and the dominance of the "my home is my castle" discourse, not the specific role of the different nursing services that determines the power relationships. This study also adds to Wilson's (2001) findings the notion that there is a bottom line. The bottom line is the point at which the rights of children become paramount and the surveillance explicit, and when governing through restraint takes precedent over governing through freedom.

The home is considered the last bastion of privacy, and so accessing the home makes children's community nursing especially prone to the criticism described in the

literature review (Abbott and Sapsford, 1990; Bloor & McIntosh, 1990; Dingwall and Robinson, 1993; Gillies, 2006; Lupton, 2003; Thompson, 2008). Such critiques assert that the adoption of holistic approaches by primary health workers increases their surveillance function. For example, Bloor & McIntosh (1990) contend that surveillance is an essential component of the preventative activities of health visiting, despite nurse claims that they “espouse a non-judgmental and non-directive approach to health education” (1990, p. 162).

Perron Fluet and Holmes (2005) maintain that from the perspective of biopower it is always assumed that nurses are working in the best interests of individuals, and from a position of authority as an agent of the state. I see that this stance denies the position of the nurse as a resource or networker, this subjectivity is essentially establishing that the nurse is a tool for the individual to utilize therefore realigning the power position- in a sense a public servant. Nor does it recognise the power of the privacy discourse that “my home is my castle” that can prevent a nurse even engaging with an individual.

Surveillance is central to the educational aspect of home visiting, and by its very nature surveillance must both be judgmental and directive, in the sense that it must have some point. Marcellus (2005), notes that the etymological basis for surveillance -sur means over and -veillance means vigil or watchfulness, therefore suggesting a more benign and possibly caring connotation rather than the malign “big brother” interpretation. According to Bloor and McIntosh (1990) the ultimate aim of health education is to persuade mothers to conform to the values and attitudes of the nurses. I would suggest that the ultimate aim for the nurses I interviewed is to uphold the moral rights for children to avoid needless suffering, disease, and death. For the nurses in this study it was not all about looking at the mothers and making a judgment, but about looking at the children making sure the resources were in place to meet their needs. Or as one nurse described, asking the “difficult questions” and acting as a resource to overcome obstacles like a lack of food.

Gillies’ (2006), study describes parents’ views that nurses have a heavy handed authoritarian approach that aims to normalize lower socio-economic parents to middle class values. In Chapter 6 the nurses in this study described the power that wealth and education has afforded them and the discourses that shape them creating the subject position as representatives of the dominant group in society. They demonstrated a moral sense of

egalitarian distributive justice, believing that every child deserves to be given the right of access to health, not just the dominant group. They are also aware of the power of the relationships within the social milieu that shape and constrain the values and activities of some parents that have identifiable social risk factors.

The nurses that visited the mothers in Gillies' study may well have been authoritarian. They may on the other hand have been very respectful and the mothers unwilling to countenance alternative points of view reflecting a "shoot the messenger" attitude. Fine and Weiss (2004) liken parenting for parents with high social risk factors to parenting in a spotlight but without a net. I would suggest that nurses can offer a net since nurses in the community have the potential to act as social "resources and networkers" and if there were no dialogue between social groups then it is unlikely that social change through networking can occur. Rather than "blaming" parents, nurses identify both parents and children as "entitled to support." By assuming an advocacy role for children, nurses aim to facilitate parental recognition of children's rights to survival, development, protection, and participation.

Bloor and McIntosh (1990) and Gillies (2006) infer that children's community nurses are not non-judgmental or non-directive as they claim. The term judgmental is a pejorative, said of a person who habitually forms or voices unkind, especially moralistic, opinions of others ("Judgmental." *Merriam-Webster online Dictionary*, 2007). An alternative meaning for judgment however, is the sense of being discerning. I maintain that the nurses that were interviewed for this study described their work as a "thinking and doing" occupation in which judgment is essential. The concept of non-judgmental nursing in this sense is counterintuitive. I believe that the nurses interviewed in this study have ably demonstrated judgment. Judgment has included when and how to intervene: when a child is too sick to be at home; when a family need more support; how to deliver health information; and how to build a relationship. Occasionally nurses must also judge when parental inadequacy is sufficiently harmful that a child needs care and protection from the state.

## ***Utopia?***

In Chapter three I referred to Orwellian literature that portrays the dystopian aspect of surveillance. This “Big Brother” extreme view of surveillance is not how I interpret the nature of nursing children in the home. I believe that the following quote from Foucault supports my argument. Foucault is described as responding to Habermas by saying:

The idea that there could be a state of communication that would be such that games of truth could circulate without obstacles, without constraints, and without coercive effects seems to be utopian. It is precisely not to see that power relations are not something bad in themselves from which one must free oneself. I believe that there cannot be societies without power relations. If one understands them as strategies by which individuals try to direct, to determine the conduct of others. The problem then, is not to try to dissolve them in a utopia of perfectly transparent communication, but to give oneself the rules of law, the techniques of administration, and also the morality, the ethos, the practice of self that would permit us to play the game of power with the minimum possible of domination (Foucault, 1994 p.257)

In the context of how children should be treated I interpret this to mean, that there cannot be societies without power relations and that there need to be some strategies to determine the conduct of others. The best way to ensure that children are treated well and can be as happy and healthy as possible, is for the “morality, ethos, and practice of self” to flow between individuals, in a persuasive rather than coercive manner. Individuals and administrative techniques should not dominate others, and should be rewarding rather than punitive. I have offered a case against compulsory well child checks as I feel that they would tip nurses into the undesirable state of health police. Parents can choose for themselves their rules of parenting, but nurses can play a part in the flow of morality, ethos, and knowledge that those choices will be shaped from, by using the subjectivities that have been identified in this study of: ally, educator, networker and resource.

For parents who might otherwise lose the care and custody or even the health or lives of their children, liberal practices of government can create a space and freedom. A range of institutions, experts, and systems of thought, can “create individuals who do not need to be governed by others to care for themselves” (Rose, 1996, p.45). Reconciling illiberal practices of discipline with liberal practices of freedom creates a fundamental

tension between opposing understandings of subjectivity. Nurses practice a form of governmentality. This governmentality is demonstrated when they assess children's needs or potential risk. Choices made by parents may not be those desired by the authorities or "best practice" recommendations. Governing is about where and when to draw the line and the disciplinary techniques used involve both freedom and restraint. This conundrum is explicit in the findings of the study for example: when the nurse described that just because a house is scruffy does not mean that parent are not doing a good job; or just because a parent has been drinking alcohol does not necessarily indicate a referral to child welfare; when a child fails to thrive and the mother rejects the nutritional advice offered also is a potentially risky situation. Weighing up the situation is a fine balancing act for nurses.

### ***Nurses as moral agents***

By weighing up and judging the bottom line and attempting to remedy an adverse situation for children using therapeutic interventions suggests that the findings of my study are congruent with the role of nurses as moral agents as well as being agents of the state. For example, teaching a child to take care of its own wound, rather than confronting a parent with inadequately managed child health care. Nurses can be seen to be acting morally in a "space" where rights and duties are explicit. The nurses in the study recognise children's rights, but are not constrained by the notion of rights based morality. Critics of rights-based theories of morality point to the significance of other motivators such as kindness, compassion, generosity and love, and to relationships that are characterized by sensitivity, empathy and responsiveness (Smith, 2002).

I do not suggest that rights and duties play no part in personal relationships and social groups, only that they cannot truly reflect the varied and nuanced character of our moral thinking. For Bauman (1995), morality hinges upon its expression through individual and unconditional responsibility for the other. Moral thinking and moral action require direct engagement, empathy, commitment and a concern for the other's wellbeing.

As illustrated in Chapter 5, the notion of binaries and black and white moral determinism are not upheld by the nurses in my study. The position of the nurses is philosophically akin to Derrida's, notion that binary oppositions are culturally and

historically defined, and are ambiguous and fluid (Powell, 2004). Nurses interviewed in my study talked of how life is uncertain and that risk is inevitable, medicine doesn't always have the answers, children sometimes die, and life is unpredictable. What they do not accept is that children should be sacrificed to protect the dominant position of adults. The responsibility for protecting children is a collective one, and so it "takes a village to raise a child."

### ***Passing Judgment and Normalising***

I acknowledge that nurses are trying to "normalise" and have made these judgments based on their own constructions of normal and therefore may be seen as persuading mothers to conform. However, the conformity that nurses in this study have described relates to practical and meaningful subjects like the inadvisability of 'Weetbix' for a 6 week old baby with a family history of allergies, or the dangers of baby walkers, the need for urgent medical treatment, how to manage impetigo, where to go for domestic violence support or housing, or how to best to help a child whose mother is mentally ill. Nurses described how the advice offered was sometimes rejected partially or wholly, but by persevering and respectfully offering alternative points of view, people were offered greater choices and the opportunity to change. I think that the range and scope of children's community nursing described by participants (and experienced in my own practice) is both complex and ethically challenging. From the discursive position that "it takes a village to raise a child" the moral position of nursing advocating for children is justifiable, if the right of a family to privacy is also balanced.

### ***Public Opinion***

As described in Chapters 1, public opinion regarding the decline in children's health status and the public questions about the role of health care professionals in child abuse and neglect cases served as a motivation for this study. In chapter 8, I discussed the role of public opinion in the formation of the social discourses around children's health rights. Nurses are torn between their professional insights and how the general public interprets the types of situations that nurses see on a daily basis.

As described in Chapter 2, it is essential to the methodological rigour of discourse analysis to be transparent about my personal responses and particular observations of the wider socio-political context of my study. During the course of this thesis I have maintained a journal detailing thoughts that I have had about children's rights to health in the context of the wider social and political discourses of today. I found many examples of children's rights issues from national and international press sources which highlight the contradictory discourses about individual rights and social intervention ("castle" versus "village").

One example from my field notes is when I monitored a case in England, where an online debate raged about whether health care professionals ought to have sought the power of the state to intervene with a grossly obese 8 year old. The child had severe health difficulties and his mother was inadequately managing his diet. Public opinion was divided as to whether the family should have the freedom to be left alone, or to be compelled to a therapeutic intervention that would ultimately improve the child's health.

I have concluded that what gets reported in the news represents the "tip of the iceberg." In daily practice nurses negotiate a fine balancing act in private homes to ensure that the rights to health that are enshrined in UNCROC are achievable for children. I believe that most of the work that nurses do in the community is not visible therefore does not get reported in the press. Preventable or treatable health concerns such as: untreated cleft lip and palate or club feet, tuberculosis and rheumatic fever, recurrent respiratory infections, untreated lice and scabies, and malnutrition, the everyday work of community practice, remain unrecognized in the media and therefore by the public at large. Interestingly public health nurses often get criticised for not being allowed to treat head lice in schools anymore partly due to consent issues (personal experience). As described in Chapter 1 public opinion at times criticizes community nurses for their failure to effectively use their pastoral power to be children's saviours. I would suggest that this is contested by the interpretation of the nurses interviewed in this study, who could be described more as Samaritans than saviours, and try to uphold that the role of saviour and champions for children should rest with parents.

### ***More than “just a nurse”***

Franklin (2002) related a parable of a person who finds villagers at a riverbank rescuing babies out of the water and madly reviving and saving them. The villagers were horrified that the stranger would not help them in their task. He replied that he wanted to go upriver and stop the babies from being put into the river. I interpreted the inference of this story is that the villagers rescuing the babies are engaged in a futile operation, and that the person who is going “upstream” is somehow morally superior. I reflected on this analogy and on the basis of my findings in Chapter 8, I suggest that the nurses may be interpreted as the villagers or “just nurses” rescuing children, and the stranger as a political activist or policy maker who will make the difference. As one of my participants (4D HCN) pointed out nurses could do more, but that she did not think nurses are politically driven generally.

As a nurse myself I have looked at the story from another angle, and rather than morally inferior I see children’s community nurses should be considered as equally as important as the upstream policy makers. Inevitably and realistically, children will always be metaphorically thrown in the river. There will always be some parents who struggle. We nurses have the skills to rescue, resuscitate and provide the children with what they need and to teach parents how to keep them safe. However, we are not “just nurses.” We also have the potential to influence policy makers about what is really affecting the children that we are in daily contact with, a position that resonates strongly with Woodbridge’s (2002) study, indicating some transferability between findings.

This leads me to consider the implications of this study. I see the importance of increased participation in the way that the different systems interact with nursing. By using examples from my analysis, I can show this notion that my participants are acutely aware of systemic issues. It is not acceptable for example: that one nurse was left morally distressed and compromised whilst waiting after 21 referrals to CYFS to intervene with a suffering baby; or that CYFS should be swamped with referrals that other agencies could provide responsive and constructive support to resolve stressors; or that families with children with serious medical conditions are sometimes discharged from hospital without adequate supports in place; or that insufficient well child nursing services are provided to some mothers in the vulnerable post birth period; or that school children have minimal access to



public health nurses when large projects like immunisation programmes are instigated; or that adult mental health services should ignore the significance of a client's parenting role. I think that all of the issues highlighted by nurses in my study are important for children's rights to health. There were many more issues described in the rich data provided by my participants but the limitations of my study mean that only a selection is described in my analysis. They should be discussed more.

I started my journey at a hui described in Chapter 1 where I wondered where the nursing voice was. I now come to the point where I can see that the collective voice among the different branches of children's community nurses is not strong enough to have their opinions heard. Reiterating Lerner's (2002) contention that the neo-liberal discourse is moving into a new phase of social governance, it is time to recognise the technical skills, personal good will and political activism potential of locally oriented professional advocates- like clinical community children's nurses.

## ***Recommendations***

### ***Connecting nurses***

Johnson (2004) challenges researchers not to just ask of their research the questions- *what* are the discourses and *so what* do they mean for nurses, but also to ask *now what* do we do with the knowledge and *how* will we change things? (In Noblitt, Flores, & Murillo, 2004, p. 74). What should nurses do to communicate their perceptions and practices to the people who make decisions about children's health, and justify what it is that they do in the privacy of children's homes? Based on both the findings of this study, and the reflective processes that this study has engendered for me as a practicing clinical nurse, I suggest that the practical knowledge and the political will of nurses, like those in the study, could be harnessed.

In this postmodernist approach to research I acknowledge my partiality and reflexivity. As Hannah Arendt identified, the ability to think is the foundation for a resilient and healthy democracy (Kristeva, 2001). Kristeva goes on to describe Arendt's view that thinking is a form of doing, and doing is an opportunity for thinking reflecting and learning.

I see this as a challenge to not only think about what it is that we as nurses do, but to do something constructive. This view is reiterated by Foucault (1982):

How can you imagine that I think change is impossible since what I have analyzed was always related to political action? All of *Discipline and Punish* is an attempt to answer this question and to show how a new way of thinking took place. All of us are living and thinking subjects. What I react against is the fact that there is a breach between social history and the history of ideas. Social historians are supposed to describe how people act without thinking, and historians of ideas are supposed to describe how people think without acting. Everybody both acts and thinks. The way people acts or react is linked to a way of thinking, and of course thinking is related to tradition (In Martin et al, 1988, p.12).

Foucault is making a connection between thinking and acting. In Chapter 8 the nurses interviewed in this study shared the perception that nurses are not traditionally politically active or credible. I suggest that if the nurses working in homes and communities are better informed and united, then the ways they promote children's right to health will become more explicit. Taking a post-modernist stance I want to discard a passive voice and take up the challenges revealed in this research by actively working on strategies to increase the visibility and cohesiveness of children's community nurses. One vision is to energetically encourage an online children's nursing community. It would be used to disseminate and integrate four broad types of knowledge: book knowledge, practical knowledge, cultural knowledge, and moral reasoning. It would create a space to elaborate upon some of the areas touched upon my study with clinical nurses from a range of service providers, as well as New Zealand academics like Hetaraka, Wilson, Dickinson, Woodbridge, Henry and others. This resource would interweave with public policy, government strategies, cultural, and trans-disciplinary sources to facilitate and ensure that children's rights to health are upheld.

Hara (2006) have extensively outlined the advantages of an online practice community. Unlike formal learning opportunities, informal knowledge sharing sessions or "just-in-time" learning, occur in the context of the professional practitioner's immediate curiosity, needs, or desires (Granger, Morbey, Lotherington, Owston, & Wideman, 2002). This need-to-know approach can transform practitioners into active knowledge builders possessing substantial autonomy regarding the specific knowledge or skills required (Granger et al., 2002). As Huysman and Wulf (2005) explain, communities of practice's

greatest strength are that they facilitate informal sharing of knowledge among people (p. 81). In one study of an online community of practice, participation not only served as an avenue for interaction and knowledge sharing situated in the actual context of the nurses' everyday work experience, but also helped to define the identity of practicing nurses (Hew & Hara, 2006). As a result children's nurses should develop a stronger and more cohesive political identity.

At a recent nursing conference this vision was embraced by colleagues and the New Zealand Nurses Organisation Children and Young People of Aotearoa section have elected me onto the national committee to assist with the development of an online community. Using the concept of governmentality this should be seen as a valuable tool for deconstructing nursing as an apolitical practice and a powerless profession (Holmes & Gastaldo, 2002).

For nurses to be social activists they need to look at how other projects have successfully overcome disadvantage. Relationships are critical in shaping behaviour and creating flow (Westley, Zimmerman & Patton, 2006). Once a network of relationships becomes sustainable, support and advocacy flow from it naturally, and isolation and alienation fade away. Emergence is described as the ability to manage patterns and to "create a climate within which a wide variety of strategies can grow" (Westley et al., 2006 p.133). In children's community nursing I see that the face to face interactions, sharing of gossip, and the observation of emotions, convey a rich array of information that helps people to learn quickly and adapt to changing contexts. Therefore, the ability of nurses working locally to build a picture of what is really happening in people's homes and what they see as priorities for children's health has huge potential. Thus, my recommendation for an online practice community so that nurses can: benefit from talking amongst each other and across the different health service boundaries; work out what they could do better, and feed these insights back to the policy makers. It will also give nurse more say in the future restructuring of community children's nursing services that has been touted in the government health strategies discussed in Chapter 1.

Examples of topics that could be debated on an online forum that relate to this study include: What children's nurses think about restructuring and combining different branches

of children's community nursing; What children's nurses think about mandatory well child checks and what alternatives they would suggest (For example I would post a thread to canvas support for bonus payments for well child checks); what difficulties face families after discharge that more comprehensive discharge planning could improve; what models of interagency collaboration work best; what inter-service needs children with parents who have mental and intellectual impairment require; and how to recruit more Maori and Pasifika nurses to work in child health. These are only a few selected suggestions but the prospect of the forum is personally exciting and its scope is endless. It will also provide rich data for nursing research as well as building the identity of a children's nursing community.

## ***Conclusion***

This study analysed the discourses drawn upon by community children's nurses in relation to children's rights to health. Whilst representing society's interest in children's health, nurses in the home act as a conduit for multiple governing structures. The nurses in this study construct their "truths" and knowledge about children's health rights from: nursing, medicine, law, education, and social policy. Contention around laws that have been passed to balance the rights of children with the rights of adults, particularly in relation to UNCROC, demonstrate that parental values can sometimes conflict with universal values for children's health and wellbeing. The intersection between technologies of power and technologies of self become enmeshed in the language of governmentality. In other words from the perspective of governmentality there is a paradoxical tension between coercive powers and civil liberties. Also, society as a whole does not necessarily value the importance of children as a shared social asset.

This study challenges that nurses are not only "agents of the state", but moral agents that use primarily a relational ethic to frame their practice. The driving discourse for the existence of children's community nurses is that it "takes a village to raise a child." The primary barrier to nurses effectively engaging with families is the competing discourse of "my home is my castle." Nurses negotiate a fine balance between these power relations. Nurses are challenged with using power productively to promote children's rights whilst respecting the role of parents and families.

I argued that while children's rights are central to the moral and ethical work of nurses, such work is often obscured and invisible. I proposed that children's community nurses are excellent at negotiating networking and connecting at a micro level, but need to create a more sophisticated and cohesive entity at a macro level, to become fully political children's rights advocates. From the subject positions of nurses as resources, allies and networkers, it is suggested that nurses moving between the homes and institutions can help people learn to accept each other and alternative ways of thinking.

The children's community nurses interviewed for this study describe both systemic barriers and invisibility and a public misconception of what we do, that may undermine our own professional control over the shape of nursing in the future. I suggest that we improve our networking capabilities. Thus, defining what it is that we know and do, and being proactive in presenting our opinions to the policy makers and the public. In this way, nurses can become more effective children's advocates, and contribute more fully to children's right to health.

Binding all of the chapters of this work is a cliché. Like many clichés, it covers a seminal truth. I believe that children are our future, that which we shall leave behind. One of the marks of civilization is the recognition of the sacrifices of our parents and of their parents—for us, and the ethical imperative to pass that legacy onto our own legatees. These sentiments cut across many cultures:

*We do not inherit the land from our ancestors; we borrow it from our children.*

(Native American) [www.worldofquotes.com](http://www.worldofquotes.com)

## References

- Abosh, B., Collins, A. (1996). *Mental illness in the family: Issues and trends*. Toronto: University of Toronto Press.
- Abbott, P., Sapsford R. (1990). Health visiting: policing the family? In P. Abbott and C. Wallace (eds) *The Sociology of the Caring Professions*. Basingstoke: Falmer.
- Adkins, L. (2002). Reflexivity and the Politics of Qualitative Research in T. May (ed) *Qualitative Research in Action*, London: Blackwell
- Alanen, L. (1998). Children in one-parent families. In I. Hutchby and J. Moran-Ellis (Eds), *Children and social competence*. London: Falmer.
- Alaszewski, A., Alaszewski, H., Ayer, S., Manthorpe, J. (2000). *Managing Risk in Community Practice: Nursing Risk and Decision Making*. London: Bailierre Tindall.
- Aldridge, J., Becker, S. (2003). *Children caring for parents with mental illness: Perspectives of young carers, parents and professionals*. Bristol: The Policy Press.
- Anderson, R. (2000). Working with youth brings rewards. *Kai Tiaki Nursing New Zealand*, 6(4):16-17.
- Anderson, M. (1995). *Approaches to the History of the Western Family -1500-1914*. Cambridge: Cambridge University Press.
- Andrews, G.J. (2006). Geographies of health in nursing. *Health and Place*. 12:110-118
- Aplin Report* (2003). Commissioned for the Office of the Children's Commissioner retrieved online March 3, 2007 from: [http://www.occ.org.nz/childcomm/media/files/aplin\\_report\\_2003](http://www.occ.org.nz/childcomm/media/files/aplin_report_2003)
- Appleton, J.V., Cowley, S. (Eds.) (1999). *The Search for Health Needs: Health Visiting Research for Practice*. Basingstoke: MacMillan Press Ltd.
- Archard, D.W. (2006). *Children's Rights*, *The Stanford Encyclopedia of Philosophy* (Winter 2006 Edition), Edward N. Zalta (ed.), Retrieved online on May 3, 2007 from Website: <http://plato.stanford.edu/archives/win2006/entries/rights-children/>
- Armstrong, D. (1986). The invention of infant mortality. *Sociology of Health and illness* 8: 211-232.
- Armstrong, D. (1995). The rise of surveillance medicine. *Sociology of Health and illness* 17(3):393-404
- Ashton, T., Cumming, J., McLean, J. (2004). Contracting for health services in a public health system: The New Zealand experience. *Health Policy*, 69(10):21-31,

- Atwood, M. (1984). *The Handmaid's Tale*. New York: Houghton Mifflin.
- BarHava-Monteith, G., Harre, N., Field, J. (1999). A Promising Start: An Evaluation of the HIPPY Program in New Zealand. *Early Child Development and Care*, 159: 145-157.
- Bartley, M., Blane, D., Davey-Smith, G. (1998). *The Sociology of Health Inequalities*. Oxford: Blackwell.
- Barankin, T., Greenberg, M. (1996). The impact of parental affective disorders on families. In: B. Abosh and A. Collins, (Eds), *Mental illness in the family: Issues and trends*. Toronto: University of Toronto Press.
- Barnes, G.G. (1996). The mentally ill parent and the family system. In: M. Gopfert, J. Webster and M. Seeman, (Eds), *Parental psychiatric disorder: Distressed parents and their families*. Cambridge: Cambridge University Press.
- Barnett, J.R., Coyle, P. (1998). Social inequality and general practitioner utilization: assessing the effects of financial barriers on the use of care by low income groups. *New Zealand Medical Journal*, 111(1061):66-70.
- Baum F. N. (2002). *The New Public Health*. (2nd ed.). Melbourne: Oxford University Press.
- Bauman, Z. (1995) *Life in fragments: essays on postmodern morality*. Oxford: Blackwell
- Beaglehole, R., Bonita, R. (1997). *Public Health at the Crossroads: Achievements and Prospects*. Cambridge: Cambridge University Press
- Beardslee, W.R., Podorefsky, D. (1988). Resilient adolescents whose parents have serious affective and other psychiatric disorders: Importance of self-understanding and relationships, *American Journal of Psychiatry* 145(1) 63–69 (1988).
- Beatson E. (2007). *What did you do at work today? An exploratory study to identify the activities undertaken and time involved in one day of practice by Plunket care delivery staff*. Presentation at NZNO Nursing Research Section conference, 16-17<sup>th</sup> November, 2007.
- Belski, J. Jaffee, S., Sligo, J., Woodward, L., Silva, P. (2005). Intergenerational transmission of warm sensitive stimulating parenting: A prospective study of mothers and fathers of 3 year olds. *Child Development*, 76(2): 284-396
- Melsky, J. Melhuish, E., Barnes, J., Leyland A., Romaniuk, H. (2006). Effects of SureStart local programmes on children and families: early findings from a quasi-experimental, cross sectional study *British Medical Journal*; 332:1476
- Bibby, A., Becker, S. (Ed), (2000). *Young carers in their own words*. San Francisco: Turnaround.

- Birchenall, J., Soares, R.R. (2007). Altruism, Fertility, and the Value of Children: Health Policy Evaluation and Intergenerational Welfare. NBER Working Paper No 12836. Retrieved online on October 10<sup>th</sup>, 2007 from Website: [ideas.repec.org/p/nbr/nberwo/12836.html](http://ideas.repec.org/p/nbr/nberwo/12836.html)
- Black, J. (September 23-29, 2006). Hands off. *New Zealand Listener* p.15
- Blackford, K.A. (1999). A child's growing up with a parent who has multiple sclerosis: Theories and experiences, *Disability & Society* 14(5): 673–685.
- Blaiklock, A. (2000). *Children's health in the next five years (commentary)*. Paper presented at the Seminar on Children's Policy, July 2000, Wellington
- Blaiklock, A J., Kiro, C A., Davenport E., Hassall I.B., Belgrave M., Low W. (2002). When the Invisible Hand Rocks the Cradle: Innocenti working paper 93 Florence: UNICEF Innocenti Research Centre. Available from [www.unicef-icdc.org](http://www.unicef-icdc.org)
- Bloor, M. J., McIntosh J. (1990). Surveillance and concealment: a comparison of techniques of client resistance in therapeutic communities and health visiting. In S. Cunningham-Burley and N.P. McKeganey (eds), *Readings in Medical Sociology*. London: Routledge
- Bloomfield, A. (2002). Why are some people healthy and others not? *Kai Tiaki Nursing New Zealand*, 8(9):22-25
- Bolitho, S., Huntington, A. (2006). Experiences of Maori families accessing health care for their unwell children: A Pilot Study. *Nursing Praxis in New Zealand*, 22 (1):23-32
- Booth, T., Booth W. (1998). *Growing up with parents who have learning difficulties*. London: Routledge.
- Bourdieu, P. (1987). What Makes a Social Class? On the Theoretical and Practical Existence of Groups, *Berkeley Journal of Sociology*, 23(1): 1–17.
- Bourdieu, P. (2004). Forms of Capital, in S. Ball (ed.). *The Routledge Falmer Reader in Sociology of Education*. Routledge Falmer, London.
- Bracefield, H. (1997). Caring for a Community. *Kai Tiaki Nursing New Zealand*, 3(6):22-23
- Brown, M. (2000). *Care and protection is about adult behaviour*. The Ministerial Review of the Department of Child, Youth and Family Services. Wellington.
- Bryder, L. (1998). *Not just weighing babies: Plunket in Auckland 1908-1998*. Auckland: Pyramid Press.



- Bryder, L. (2002). *The Plunket Nurse as a New Zealand icon*. The United Kingdom Centre for the History of Nursing and Midwifery. Retrieved online 29/04/2007 from <http://www.ukchnm.org/seminars02php>
- Bryder, L. (2003). *A Voice for Mothers: The Plunket Society and Infant Welfare*. Auckland University Press, Auckland.
- Burman, E. (1997). Differentiating and de-developing critical social psychology. In Ibáñez T., Iñigue L (Eds), *Critical Social Psychology*. Thousand Oaks: Sage.
- Burman, E. (2004). Discourse Analysis means analysing discourse: some comments on Antaki, Billig, Edwards, and Potter, Submission to *Discourse Analysis Online*. Retrieved February 2, 2008, from: <http://extra.shu.ac.uk/daol/articles/open/2003/003/burman2003003-paper.html>
- Buus, N. (2005). Nursing scholars appropriating new methods: the use of discourse analysis in scholarly nursing journals 1996-2003. *nursing Inquiry*, 12(1):27-33
- Cain, P., Hyde, V., Howkins, E. (1995). *Community nursing dimensions and dilemmas*. Arnold: London.
- Campbell, T. (1998). Caring for the technology dependent child- A Case Study. *Nursing Praxis in New Zealand*, 13 (2):5-10
- Campbell-Heider, N., Tuttle, J. Bidwell-Cerone, S. Richeson G. Colons S.E. (2003). The buffering effects of connectedness: teen club intervention for children of substance abusing families. *Journal of Addiction Nursing*, 14: 175-182
- Caputo, J., Yount, M. (eds) (1993). *Foucault and the Critique of Institutions*. Pennsylvania: Pennsylvania State University Press.
- Carrier J., Dignam D., Horsborough, M., Hughes, F., Martin, J. (1999). *Locating Nursing in Primary Health Care*. A report for the National Health Committee. Retrieved online September 5, 2007, from: [www.moh.govt.nz/moh.nsf/0/7B8611D77164266ECC25705B001BB6BA/\\$File/EvolvNurse.p](http://www.moh.govt.nz/moh.nsf/0/7B8611D77164266ECC25705B001BB6BA/$File/EvolvNurse.p)
- Caton, C.L.M., Cournos, F., Felix, A., Wyatt, R.J. (1998). Childhood experiences and current adjustment of offspring of indigent patients with schizophrenia, *Psychiatric Services*, 49: 86-90.
- Caughlan, S. (2005). Considering pastoral power: A commentary on Aaron Schutz's "Rethinking Domination and Resistance: Challenging Postmodernism" *Educational Researcher*, 34(2):14-17.
- Chafey, K. (1997). Caring is not enough: Ethical paradigms for community-based care. *Plastic Surgical Nursing*, 17(1):43-47.

- Chambon, A., Irving, I. Epstein, L. (eds) (1999). *Reading Foucault for Social Work*. New York: Columbia University Press.
- Chase, N.D. (1999). *Burdened children: Theory, research, and treatment of parentification*, Thousand Oaks: Sage.
- Cheek, J., Porter, S. (1997). Reviewing Foucault: Possibilities and problems for nursing and health care. *Nursing Inquiry*, 4(2):108-19.
- Cheek, J. (2000). *Postmodern and Poststructural approaches to nursing research*. Thousand Oaks: Sage
- Cheek, J. (2004). At the margins? Discourse analysis and qualitative research. *Qualitative Health Research*, 14(8):1140-1150
- Chenery, K. (2004). Family Centred Care: Understanding Our Past. *Nursing Praxis in New Zealand*, 20 (3): 4-12
- Child Poverty Action Group (CPAG) (2003). *Our children: The priority for policy*. (2nd Edition) CPAG: Auckland. Retrieved online on 6<sup>th</sup> April 2007 from [cpag.org.nz](http://cpag.org.nz)
- Christie, J. (2002). Managing Febrile children: When and how to treat *Kai Tiaki Nursing New Zealand*, 8(4):15-17
- Clay, T. (1987). *Nurses, Power and Politics*. London: Heinemann.
- Clendon J., McBride K. (2001). Public Health Nurses in New Zealand : The Impact Of Invisibility *Nursing Praxis in New Zealand* 17(2):24-32
- Clendon, J. (1997). Should Public Health Nurses Prescribe? *Kai Tiaki Nursing New Zealand*, 3(7):13-16
- Clinton, H.R. (1996). *It takes a village to raise a child*. New York: Simon & Schuster.
- Cohen, B.E., Reutter L. (2006). The role of public health nurses in addressing child and family poverty: A framework for action. *Journal of Advanced Nursing* 60(1):96-107
- Compton, A., Ashwin, M. (1997). *Community Care for Health Professionals*. Butterworth-Heinemann: Oxford
- Conrad, P. (2006). *The Sociology of Illness and Health*, (7<sup>th</sup> Ed). New York: St Martins. Press.
- Corcoran, J. (2005). *Building Strengths and Skills*. Oxford: Oxford University Press.
- Cowley, S. (2002). *Public health in policy and practice: a source book for health visitors and community nurses*. London: Harcourt Publishers.

- Cowley, S., Bergen, A., Young, K., Kavanagh, A. (2000). Taxonomy of needs assessment, elicited from a multiple case study of community nursing education and practice. *Journal of Advanced Nursing*; 11: 640-650.
- Cowley, S., Houston, A. (2003). A structured needs assessment tool: acceptability and effectiveness for health visiting. *Journal of Advanced Nursing*; 43(1):82-92.
- Craig D. (2003). Re-territorialising health: inclusive partnerships, joined up governance, and common accountability platforms in Third Way New Zealand. *Policy and Politics*, 31 (3):335-352
- Cravens, H. (1993). Child saving in modern America 1870s–1990s. In R. Wallons (Ed.), *Children at risk in America: History, concepts, and public policy*. Albany: State University of New York Press.
- Crotty, M. (1995). *Good Nutrition? Fact and Fashion in Dietary Advice*. Allen and Unwin, St Leonards: NSW.
- Crotty, M. (1998). *The foundations of social research: meaning and perspective in the research process*. NSW: Allen Unwin.
- Crowe, M. (2005). Discourse analysis: towards an understanding of its place in nursing. *Journal of Advanced Nursing*, 51(1) 55-63
- Culbert, E., Cocks, P., Smaill, T. (1996). Innovations in Paediatric Children's Assessment Unit and Developing Outreach Service. *Nursing Praxis in New Zealand*, 11(3):9-13
- Culler, J (1981). Structuralism and Since. In John Sturrock (Ed.), *From Levi-Strauss to Derrida*. Oxford: Oxford University Press.
- Cutler, F. (1999). Jeremy Bentham and the Public Opinion Tribunal. *Public Opinion Quarterly*, 63 (3): 321
- Daily Post (January 25, 2008). *Neighbours hear screaming from Nia's house*. Retrieved online: February 5, 2008 from:  
<http://www.dailypost.co.nz/localnews/storydisplay.cfm?storyID=3761972&thesecti on=localnews&thesubsection=>
- Dalley, B. (1998). *Family matters: Child Welfare in Twentieth Century New Zealand*. Auckland: Auckland University Press.
- Daly, J., Speedy, S., Jackson, D., Darbyshire, P. (Eds.) (2002). *Contexts of Nursing: An Introduction*. Oxford: Blackwell Publishing, (UK Edition).
- Danaher, G., Schirato, T., Webb, J. (2000). *Understanding Foucault*. Thousand Oaks: Sage.

- Darbyshire, P, Oster, C., Carrig, H. (2001). Children of parents who have a gambling problem: A review of the literature and commentary on research approaches. *Health and Social Care in the Community*, 9 (4):185–193.
- Davis, H., Day, C. Bidmead, C. (2002). *Working in Partnership with Parents: The Parent Adviser Model*. London: Harcourt Assessment.
- Dean, M. (1999). *Governmentality: Power and Rule in Modern Society*. London: Sage.
- DeChillo, N., Matorin, S., Hallahan, C. (1987). Children of psychiatric patients: Rarely seen or heard, *Health and Social Work*, 12(4): 296–302.
- Denzin, N.K., Lincoln, Y.S. (Ed) (1994). *Handbook of qualitative research*. Thousand Oaks: Sage.
- Denzin N.K., Lincoln Y.S (2003). *Strategies of Qualitative Enquiry*. Thousand Oaks: Sage.
- De Shazer, S. (1985). *Keys to Solution in Brief Therapy*. New York: Norton.
- Dickinson A.R. (2004). *Within the web : the family/practitioner relationship in the context of chronic childhood illness*. Doctoral Thesis. Retrieved online May 5, 2007 from: <http://repositoryaut.lconz.ac.nz/cgi/query.cgi>
- Dickinson, A.R., Smythe, E., Spence, D., (2006). Within the web: The family-practitioner relationship in the context of chronic childhood illness. *Journal of Child Health Care*, 10(4):309-25.
- Dines, A. (1994). What changes in health behaviour might nurses logically expect from their health education work? *Journal of Advanced Nursing* 20(2):219-226
- Dingwall, R. Rafferty, A.; Webster, C. (1988). *An introduction to the social history of nursing*. London: Routledge.
- Dingwall, R. and K.M. Robinson (1993). Policing the Family? Health visiting and the public surveillance of private behaviour in A. Beattie, M. Gott, L. Jones and M. Sidell (eds) *Health and Wellbeing: a Reader*. London: Macmillan
- Donaldson, T. (2000, November) *Meeting the increasing challenge of child protection*. Paper presented at the Paediatric Society 59<sup>th</sup> Annual Scientific Meeting, Christchurch.
- Doncliffe B. (2001). Collaboration is Essential in Health Promotion. *Kai Tiaki Nursing New Zealand*, 7(7):26-27.
- Dreyfus, H.I., Rabinow, P. (1983). *Michel Foucault: Beyond structuralism and hermeneutics*. Chicago: University of Chicago Press.
- Dubowitz, H., Bennett, S. (2007). Physical abuse and neglect of children. *Lancet*, 369:1891-1899.

- Dupont, F. (1994). *Daily Life in Ancient Rome*. Oxford:Blackwell.
- Durie, M. (1998). *Te Mana Te Kawanatanga: The politics of Maori self-determination*. Auckland: Oxford University Press.
- Dwyer, J.G. (1994). Parents, Religion and Children's Welfare: Debunking the Doctrine of Parents' Rights. *California Law Review* 82 (6):1371-1447. Retrieved online November 10, 2007 from <http://www.cirp.org/library/legal/dwyer2/>
- Edwards, B. (2007). Walking in: Initial visualisation and assessment at triage. *Accident and Emergency Nursing*, 15 (2):73-78.
- Edwards, J. (1995). Parenting skills: Views of community health and social service providers on the needs of their 'clients' *Journal of Social Policy*, 24:237-259.
- Edwards, J., Popay, J. (1994). Contradictions of support and self help: views from providers of community health and social services to families with young children. *Health and Social Care in the Community*, 2: 31-40.
- Edwards, R. (1993). An education in interviewing: Placing the researcher and the research. In C. Renzetti & M. Lee (Eds.). *Researching sensitive topics*. Newbury Park, CA: Sage.
- Erikson, B. (1996). The structure of ignorance. *Connections* 19 (1):28-38. Retrieved online October 10, 2007 from: [http://insna.org/Connections-Web/Volume19/19\(1\)wdr.28-38.pdf](http://insna.org/Connections-Web/Volume19/19(1)wdr.28-38.pdf)
- Evans, S. (2003). Child Abuse: Nurse Identification of at Risk Children *Nursing Praxis in New Zealand*, 10(3):22-28
- Everingham, W. (2000). Dealing With Domestic Violence. *Kai Tiaki Nursing New Zealand*, 6(2):14-18.
- Fairbairn, J, Wilson, J. (1997). Disclosing the Hidden Handicap. *Kai Tiaki Nursing New Zealand*, 3(1):13-15.
- Fergusson D.M. (1998). The Christchurch Health and Development Study: An Overview and Some Key Findings *Social Policy Journal of New Zealand*, 10:158.
- Fergusson, D. (1994). The childhoods of multiple problem adolescents: A 15 year longitudinal study. *Journal of Child Psychology and Psychiatry*, 1132.
- Fine, M., Weis, L. (2004). Working without a net but a spotlight: Mothering in poverty. In Noblit G.W., Flores S.Y., Murillo E.G. *Post- critical Ethnography: Reinscribing critique*, New Jersey: Hampton Press.
- Flekkoy, M.G., Kaufman, N.H. (1997). *The participation rights of the child: Rights and responsibilities in family and society*. London: Jessica Kingsley.

- Foucault, M. (1972). *The Archaeology of Knowledge*. London, Tavistock.
- Foucault, M. (1973). *Birth of the Clinic*. London, Tavistock.
- Foucault, M.(1977). *Michel Foucault: Language, Counter- memory, Practice: Selected essays and interviews* (Ed) D Bouchard, Oxford: Blackwell.
- Foucault, M (1979). *Discipline and punish: the birth of the prison*. New York: Vintage Books.
- Foucault, M. (1980). *Power and knowledge*. Brighton: Harvester Press.
- Foucault M. (1982). In Martin H., Gutman H., Hutton P.H.(1988)(Eds), *Technologies of the Self: A Seminar with Michel Foucault*. London: Tavistock.
- Foucault, M. (1984). The politics of health in the eighteenth century. In Rabinow P. (ed) *The Foucault Reader*. New York: Pantheon Books.
- Foucault, M. (1988). The dangerous individual. In L. Kritzman (Ed.), *Michel Foucault politics, philosophy, culture, interviews and other writings 1977-1984*. New York: Routledge.
- Foucault, M. (1990). *The History of Sexuality, Volume 1: An Introduction* (trans. R. Hurley). London: Penguin.
- Foucault, M. (1991). Governmentality. In G. Burchell, C. Gordon and P. Miller (Eds.), *The Foucault effect : Studies in Governmentality*. Brighton : Harvester Wheatsheaf.
- Foucault, M. (1996). "What is Critique?" in *What is Enlightenment? Eighteenth Century Answers and Twentieth Century Questions*, James Schmidt (Ed), Berkeley: University of California Press.
- Fox, L. (2007). *Conceptualising Home: Theories Laws and Policies*. Oxford: Hart
- Fraser, N. (1999). Rethinking the public sphere: A contribution to the critique of actually existing democracy. In Calhoun C.(Ed) *Habermas and the Public Sphere*. Cambridge Mass: Massachusetts Institute of Technology Press.
- Franklin, B. (2002). *The new handbook of children's rights: Comparative policy and practice*. London: Routledge.
- Freeman, M. (1997). *The Moral Status of Children*. The Hague: Kluwer Law International.
- Friedman, L.S., Samet, J.H., Roberts, M.S., Hudlin, M., Hans, P. (1992). Inquiry about victimization experiences: a survey of patient preferences and physician practices. *Arch Intern Med*. 152: 1186-1190.
- Fuchs, V. (1974) *Who Shall Live?* New York: Basic Books.

- Gadow, S. (1980). Caring for the dying: advocacy or paternalism. *Death Education* 3(4): 387-398.
- Gage, J.D., Everett, K.D., Bullock, L. (2006). Integrative review of parenting in nursing research. *Nursing Scholarship*, 38(1):56-62.
- Gamble, C., Brennan, G. (2000). *Working with serious mental illness*. RCN Balliere Tindall, London.
- Gastaldo, D., Holmes, D. (1999). Foucault and nursing: a history of the present. *Nursing Inquiry*, 6: 231-240
- Gauld, R. (2004). Public Health and Government in New Zealand Discussion paper for the Public Health Advisory Committee Retrieved September 12, 2007 online from: [www.phac.health.govt.nz/moh.nsf/pagescm/769/\\$File/Othersectors.doc](http://www.phac.health.govt.nz/moh.nsf/pagescm/769/$File/Othersectors.doc)
- Gaze, H. (1997). All in the family. *Health Visitor*, 70: 332–333.
- Geertz, C. (1973). Thick Description: Toward an Interpretive Theory of Culture. (p.3-30) In *The Interpretation of Cultures: Selected Essays*. New York: Basic Books,
- Gibbs, J., Underdown, A., Liabo, K. (2003). Group-Based Parenting Programmes Can Reduce Behaviour Problems of Children Aged 3–10. What works for children group evidence nugget. Retrieved September 22, 2007 from: <http://www.whatworksforchildren.org.uk>.
- Giddens, A. (1984). *The Constitution of Society*. Cambridge: Polity Press.
- Giddens, A. (1997). *Sociology* 3<sup>rd</sup> Ed. Cambridge: Polity press.
- Gillies, V. (2006). *Marginalised Mothers: Exploring Working Class Parenting*, London: Routledge.
- Gladstone, B.M., Boydell, K.M., McKeever, P. (2006). Recasting research into children's experiences of parental mental illness: beyond risk and resilience. *Social Science Medicine*, 62(10):2540-50.
- Gladwell, M. (2000). *The Tipping point: How little things can make a big difference*. London: Abacus.
- Glanz, K., Rimer, B.K., Lewis, F.M. (2002). *Health Behavior and Health Education* (3<sup>rd</sup> Ed). San Francisco: John Wiley & Sons.
- Glasper, E.A., Richardson, J. (Ed) (2006). *A Textbook of Children's and Young People's Nursing*. London: Churchill Livingstone.
- Gopfert, M., Webster, J., Seeman, M.V. (1996). *Parental psychiatric disorder: Distressed parents and their families*. Cambridge: Cambridge University Press.

- Gott, M., O'Brien, M. (1990). The role of the nurse in health promotion. *Health Promotion International*, 5(2):147-143.
- Gran, B., Daub, A. (2006). Mending a public- private gap: Children's rights and the children's Ombudsman *Paper presented at the annual meeting of the American Sociological Association, Montreal Convention Center, Montreal, Quebec, Canada, August 11, 2006* retrieved online on May10, 2007 from: [http://www.allacademic.com/meta/p104057\\_index.html](http://www.allacademic.com/meta/p104057_index.html)
- Granger, C.A. Morbey, M.L., Lotherington, H., Owston, R.D., Wideman, H.H. (2002). Factors contributing to teachers' successful implementation of IT. *Journal of Computer Assisted Learning*, 18 (4): 480–488.
- Gross, D., Rocissano, L. (1988). Maternal confidence in toddlerhood: its measurement for research and clinical practice. *Nurse Practitioner* 13(2):19–29.
- Guggenheim M. (2005). *What's wrong with children's rights?* Cambridge Mass: Harvard University Press.
- Halperin, D.A. (1996). *Saint Foucault: Towards a gay hagiography*. Oxford: Oxford University Press.
- Hanks, R.G. (2007). Barriers to Nursing Advocacy: A Concept Analysis. *Nursing Forum*, 42 (4), 171–177.
- Hagelund, A. (2005). Why is it bad to be kind ? Educating refugees to life in the welfare state: A case study from Norway. *Social Policy and Administration*. 39(6): 669-682.
- Harrison J., MacGibbon L. Morton M. (2001). Regimes of trustworthiness in qualitative research: The rigors of reciprocity. *Qualitative Inquiry*, 7(3): 323-345.
- Hart, A., Lockey, R. (2002). Inequalities in health care provision the relationship between contemporary policy and contemporary practice in maternity services in England. *Journal of Advanced Nursing* 37(5): 485-493.
- Hart, A., Hall, V., Henwood, F. (2003). Helping health and social care professionals to develop an 'inequalities imagination': A model for use in education and practice. *Journal of Advanced Nursing*, 41(5): 480–489.
- Hassall, I. (2007, Nov.3-9). A world of difference. *New Zealand Listener*, 211(3521):15-20.
- Haugaard H.H, Lentner M. (2006). Hegemony and power: Consensus and coercion in contemporary politics. Lanham MD: Lexington.
- Heap, J. (2001). Nurse's Role in Protecting Children. *Kai Tiaki Nursing New Zealand*, 7(3):19-21.



- Heiland, F. (2001). *Measuring the value of children by birth order and infant health*. Paper provided by Society for Computational Economics in its series no: 267. Retrieved online January, 2, 2008, from: <http://ideas.repec.org/p/sce/scecf1/267.html>
- Hein, E.C. (2001). *Nursing issues in the 21<sup>st</sup> century: Perspectives from the literature*. Philadelphia, PA: Lippincott Williams and Wilkins.
- Henry, P. (2004). *Negotiating an unstable ladder: The experience of Maori families caring for a technology dependent child*. Unpublished Masters Thesis University of Auckland, Auckland.
- Hetaraka, B. (2006). A study of Nurses working in a community development model Unpublished Masters Thesis, Auckland University of Technology, Auckland.
- Hew, K.F. Hara, N. (2006). Identifying factors that encourage and hinder Knowledge sharing a longstanding online community of practice. *Journal of Interactive Online learning*. 5(3): 297- 316
- Holmes, D., Gastaldo, D. (2002). Nursing as a means of governmentality. *Journal of Advanced Nursing*, 38(6):557–565.
- Hooker, R. (1996). *Discovery and Reformation*. Washington State University online source Retrieved online, February 4, 2008, from: <http://www.wsu.edu/~dee/GLOSSARY/RIGHTS.HTM>
- Horsburgh, M., Smith, V., Kivell, D. (2002). South Auckland community paediatric nursing service: A framework for evaluation. *Nursing Praxis in New Zealand*, 18(3):40-49.
- Houston, S. (2001). Transcending the fissure in risk theory: Critical realism and child welfare, *Child & Family Social Work*, 6(3):219–228.
- Hughes, F., Calder, S. (2006). Developing primary health care in New Zealand. *Primary Health Care*, 16(9):36-39.
- Hunter, D. J. (2003). *Public Health Policy*. Cambridge: Polity Press.
- Hutchby, I., Moran-Ellis, J. (1998). *Children and social competence*. London: Falmer.
- Hussey, J.M., Marshall, J.M., English, D.J., Knight, E.D., Lau, et al.(2005). Defining maltreatment according to substantiation: distinction without a difference. *Child Abuse and Neglect*, 29(5):479-492.
- Huysman M., Wulf, V. (2005). The Role of Information Technology in Building and sustaining the Relational Base of Communities. *The Information Society* 21(2):81-89
- Jack, G. (2000). Ecological influences on parenting and child behaviour. *British Journal of Social Work*, 30:703-720.

- Jaffee, S.R., Moffitt, T.E., Caspi, A., Fombonne, Poulton, R., Martin, J. (2002). Differences in early childhood risk factors for juvenile-onset and adult-Onset depression. *Arch Gen Psychiatry*, 59:215-222.
- James, A., Jenks, C., Prout, A. (1998). *Theorizing childhood*. Cambridge: Polity Press.
- Johnson, S. (Ed) (2004). *Health Care and the Law*. Wellington: Thomsen Brookers.
- Johnson, S., Trim, S. (2001). Children- Consent Issues for Nurses. *Kai Tiaki Nursing New Zealand*, 7(10):20.
- Jones, P. S., Meleis, A. I. (1993). Health is empowerment. *Advanced Nursing Science*, 15(3):1-14.
- Jones-Parry, G. (2000). Reducing Teenage Pregnancy Rates. *Kai Tiaki Nursing New Zealand*, 6(4):14-18.
- Jurkovic, G.J. (1997). *Lost childhoods: The plight of the parentified child*. Philadelphia: Brunner/Mazel.
- Kaitiaki Nursing NZ (unspecified author) (2007). Caring for Auckland church communities. In News and Events *Kaitiaki Nursing New Zealand* 13(11):10.
- Kamira, R., Campbell, T., Campbell, S. (1999). *Arotake nga rauemi hauora tamariki: A review of Maori-specific child health resources*. Retrieved online on October 10, 2007 from: <http://www.hauora.com/downloads/files/ACF8DB.pdf>
- Katz, M.B. (1997). *In the shadow of the poorhouse: A social history of welfare in America*. New York: Basic Books.
- Keenan, T. (2002). *An Introduction to Child Development*. Thousand Oaks: Sage.
- Kelly, P. (2000). Mandatory Reporting: A paediatrician's perspective. p.10 *DSAC National Newsletter*, 45.
- Kendall, G., Wickham, G. (1999). *Using Foucault's methods*. London: Sage.
- Kent, B., Horsburgh, M., Lay Yee, Davis, P. Pearson, J. R. (2002). *Nurses and their work in primary health care Report 9*. Wellington: N.Z. Ministry of Health.
- Kerruish, V., (1991). *Jurisprudence as ideology*. London: Routledge.
- Kimball, R. (1993). The perversions of Michel Foucault *The New Criterion*, 11(7), March 1993 Retrieved April 5, 2007, from: [www.newcriterion.com](http://www.newcriterion.com)
- King, A. (2001). Foreword to: The New Zealand Health Strategy. Wellington: N.Z. Ministry of Health.

- Kinross, N., Nevatt, E.A., Boddy, J. (1987). *Nurse in an urban community: A process study*. Massey University Dept Nursing Studies, Palmerston North.
- Kiro, C. (2005). *Annual Report* Retrieved online march 10,2007from:  
[http://www.occ.org.nz/childcomm/resources\\_links/reports\\_publications?eZSESSIDchildcomm=4e83d6ece9ad5935d3e47b0dc89c7061](http://www.occ.org.nz/childcomm/resources_links/reports_publications?eZSESSIDchildcomm=4e83d6ece9ad5935d3e47b0dc89c7061)
- Kiro, C. (2007). *Annual Report* Retrieved online May 5, 2007 from:  
[http://www.occ.org.nz/childcomm/resources\\_links/reports\\_publications?eZSESSIDchildcomm=4e83d6ece9ad5935d3e47b0dc89c7061](http://www.occ.org.nz/childcomm/resources_links/reports_publications?eZSESSIDchildcomm=4e83d6ece9ad5935d3e47b0dc89c7061)
- Kleinham, P. (2002). *Criminal Justice Approaches to Paedophilic Sex Offenders Social & Legal Studies*, 11(2): 233-255.
- Kosunen,E., Rimpelä,M.(1996). Towards regional equality in family planning: teenage pregnancies and abortions in Finland from 1976 to 1993. *Acta Obstet Gynecol Scand*, 75: 24-30.
- Koziol-McLain, J., Giddings, L.S., Rameka, M, Fyfe, E. (2005). *Women's Perceptions of Partner Violence Screening in two Aotearoa New Zealand Settings: " What Took you So Long, "* 2005 Oct; Report 3. Commissioned by the New Zealand Ministry of Health.
- Kristeva, J. (2001). *Hannah Arendt*. New York: Columbia University Press
- Krueger,A.B. (May 2, 2002). Putting Development Dollars to Use, South of the Border. The New York Times Economic Scene. Retrieved online December 10' 2007 from:  
<http://www.ifpri.org/media/innews/2002/050202.htm>
- Lansdown, G. (1994). Researching children's rights to integrity. In: B. Mayall, (Ed) *Children's childhood: Observed and experienced*. London: Falmer Press.
- Larner, W. (2002). Neo-liberalism and Tino Rangatiratanga: Welfare State Restructuring in Aotearoa/New Zealand. In C. Kingfisher (Ed), *Globalisation, Welfare State Restructuring and Women's Poverty*. PA:University of Pennsylvania Press.
- Larner, W., Craig, D. (2002). After Neoliberalism? Local partnership and social governance in Aotearoa New Zealand: Fostering Social Cohesion Working Paper No 7. Social Sciences and Humanities Research Council of Canada (SSHRC). Retrieved online December 24, 2007, from:  
<http://www.fas.umontreal.ca/POL/cohesionsociale>
- Lawlor, M. C., Mattingly, C. F. (1998). The complexities embedded in family-centered care. *The American Journal of Occupational Therapy*, 52(4), 259–267.
- Leichter, H. (1991). *Free to be Foolish: Politics and Health Promotion in the United States and Great Britain*. Princeton University Press, Princeton.

- Leininger, M. (1991). *Culture Care, Diversity and Universality: A Theory of Nursing*. New York: National League for Nursing Press.
- Leininger, M.M., McFarland M.R. (2002). *Transcultural nursing: Concepts theories research and practices* (3<sup>rd</sup> Ed). New York: McGraw Hill.
- Lemke, T. (2001). The birth of bio-politics: Michel Foucault's lecture at the College de France on neo-liberal governmentality, *Economy and Society*, 30(2).
- Levenson, M (ed.) (1999). *The Cambridge Companion to Modernism*. Cambridge: Cambridge University Press.
- Levine, M., Levine, A. (1992). *Helping children: A social history*. Oxford: Oxford University Press.
- Levitt, S.D., Dubner, S.J. (2005). *Freakonomics*. London: Penguin.
- Liaschenko, J. (1994). The moral geography of home care. *Advances in Nursing Science* 17 (2): 16–25.
- Liaschenko, J. (1997). Ethics and the geography of the nurse patient relationship: spatial vulnerable and gendered space. *Scholarly Inquiry for Nursing Practice*, 11(1): 45–59.
- Liaschenko, J. (2000). The moral geography of care work. *Home Care Provider*, 5(4),126–27, 132.
- Lin. K., Rantalaio. M. (2003). Family policy and social order: Comparing the dynamics of family policy-making in Scandinavia and Confucian Asia. *International Journal of Social Welfare*, 12:2-13.
- Littlewood, J. (1999). *Current issues in Community nursing 2: Specialist practice in primary health*. London: Churchill Livingstone.
- Long, A., McCarney, S., Smyth, G., Magorrian, N., Dillon, A. (2001). The effectiveness of parenting programmes facilitated by health visitors. *Journal of Advanced Nursing*, 34(5):611-20
- Loesberg, J. (2005). *A return to aestheticism: Autonomy indifference and postmodernism*. Stanford CA: Stanford University Press.
- Lowe, R. (2000). *History of Education: Major themes*. London: Routledge.
- Lowenberg J.S. (1995). Health promotion and the "ideology of choice". *Public Health Nursing*, 12(5):319-23.
- Lupton, D. (1992). Discourse analysis: A new methodology for understanding the ideologies of health and illness. *Australian Journal of Public Health*, 16(2):145-150

- Lupton, D. (1995). *The imperative of health: public health and the regulated body*. Thousand Oaks: Sage.
- Lupton, D. (1999). *Risk*. Routledge, London.
- Lupton, D., (2003). *Medicine as Culture: Illness, Disease and the Body in Western Societies*, (2<sup>nd</sup> ed.). London: Sage
- Lyons, D. (1994). *The Electronic Eye: The Rise of Surveillance Society* Minneapolis: University of Minnesota Press.
- McEwen, M. (2002). *Community Based Nursing: An Introduction*. St Louis : Saunders.
- Macfie, B. (2006). Assessing health needs and identifying risk factors. *Kaitiaki New Zealand Nursing Journal*, 12(6): 16-7.
- McMurray, A. (1993). *Community health nursing*. London: Churchill Livingstone.
- Manchester,A.(1997). Every Baby's Right. *Kai Tiaki Nursing New Zealand*, 3(4):26-27.
- Manchester, A. (2000a). Promoting health and preventing illness. *Kai Tiaki Nursing New Zealand*, 8(8):12-14.
- Manchester, A. (2000b). Bridging the Health Gaps with Plunket. *Kai Tiaki Nursing New Zealand*, 6(8):16-18.
- Manchester, A. (2000c). New Directions in Primary Health Care. *Kai Tiaki Nursing New Zealand*, 6(11):12-13.
- Manchester, A. (2002). A service with a social conscience. *Kai Tiaki Nursing New Zealand*, 8(9):20-21.
- Manchester, A. (2007). The Otara Health Initiative. *Kai Tiaki Nursing New Zealand*, 13(7):12-14.
- Marcellus, L. (2005). The ethics of relation: public health nurses and child protection clients. *Journal of Advanced Nursing*, 51(4): 414–420.
- Marshall, J., Watt, P. (1999). *Child behaviour problems: a literature review of it size, nature and preventive interventions*.The Interagency Committee on Children's Futures, Perth, Western Australia.
- Martin, H.,Gutman, H., Hutton, P.H (Eds.), (1988). *Technologies of the Self: A Seminar with Michel Foucault*. London: Tavistock.
- Maslow, A. (1954). *Motivation and Personality*, New York: Harper.
- Max, L. (1990). *Children Endangered Species?* Auckland, Penguin.

- Maxwell, G., Barthauer, L., Julian, R. (2000). *The role of primary health care providers in identifying and referring child victims of family violence*: Report for the office of the Children's Commissioner, Wellington.
- Melden A.I. (1988). *Rights in Moral Lives*. Berkeley: University of California Press.
- Merriam- Webster on line Dictionary (2007). <http://www.webster.com/dictionary/> accessed: October 2007- December 2007.
- Miers, M. (2003). *Class inequalities and nursing practice*. New York: Palgrave MacMillan.
- Miller, J. (1994). *The Passion of Michel Foucault*. Cambridge MA: Harvard University Press.
- Miller, S., Sambell, K. (2003). What do parents feel they need? Implications of parent's perspectives for the facilitation of parenting programmes. *Children and Society*, 17:32–44.
- Mills, S. (2003). *Michel Foucault*. London: Routledge.
- Mitchell, E.A., Tuohy, P.G., Brunt, J.M., Thompson, J.M., Clements, M.S., Stewart, A.W., Ford, R.P., Taylor, B. (1997). Risk factors for sudden infant death syndrome following the prevention campaign. *Pediatrics*, 100: 835-840.
- Moate, K. (2007, November). *Quality health care in Pacific Countries – challenges and solutions*. Paper presented at the Paediatric Society 59<sup>th</sup> Annual Scientific Meeting, Christchurch.
- Moffitt, T.E., Harrington, H., Caspi, A, Kim-Cohen, J., Goldberg, D., Gregory, A.M.; Poulton, R. (2007). Depression and generalized anxiety disorder: Cumulative and sequential co-morbidity in a birth cohort followed prospectively to age 32 years. *Arch Gen Psychiatry*, 64: 651 - 660.
- Morgan, A. (1999). Reaching out to Babies and their Families. *Kai Tiaki Nursing New Zealand*, 5 (1):14-16
- Mulvay, B. (2001). Negotiating the roles of nurses and parents. *Kai Tiaki Nursing New Zealand*, 7(10):12-14
- Munro, E. (2005). Improving practice: child protection as a systems problem. *Children and Youth Services review*, 27:375-391.
- Muscroft, S. (Ed.) (2000). *Children's rights: equal rights? Diversity, difference and the issue of discrimination*. London: The International Save the Children Alliance.
- Naidoo, J. (1986). *The Politics of Health Education*. London: Routledge and Kegan Paul
- Nair S., Morrison M.F. (2000). The evaluation of maternal competency. *Psychosomatics*, 41(6): 523

- National Research Council (NRC US),(2004). Committee on Evaluation of Children's Health Children's Health, the Nation's Wealth: Assessing and Improving Child Health, The National Academies Press Washington D.C.
- National Evaluation of Sure Start (2004). *The impact of Sure Start local programmes on child development and family functioning: a report on preliminary findings*. London:University of London, Birkbeck.
- Nauck, B. Klaus, D. (2007). The Varying Value of Children: Empirical Results from Eleven Societies in Asia, Africa and Europe. *Current Sociology*, 55(4): 487-503.
- Naude, J. (2005). *Re-constructing paedophilia: An analysis of current discourses and the construction of close relations*. Unpublished Masters Thesis, University of Stellenbosch, Germany. Retrieved online, January 2, 2008, from: <http://ir.sun.ac.za/dspace/bitstream/10019/262/1/Naude.pdf> Elsevier.
- Nettledon, S. (1995). *The Sociology of Health and Illness*. Polity Press: Cambridge.
- Nespor, J. (1998). The meanings of research: Kids as subjects and kids as inquirers. *Qualitative Inquiry*, 4 (3): 369–389.
- NZEDF (2001). *War on the family*: A report prepared for the New Zealand Education Development Foundation, NZEDF: Christchurch.
- New Zealand Herald (July 2, 2005) Smacking Law: Voters say leave it alone. Retrieved online on December 12, 2007, from: [http://www.nzherald.co.nz/section/1/story.cfm?c\\_id=1&objectid=10333802](http://www.nzherald.co.nz/section/1/story.cfm?c_id=1&objectid=10333802).
- New Zealand Herald (June, 25, 2006) *Police look to parents*. p.A.1
- New Zealand Herald (August 18, 2007). *Weekly visits by Plunket nurse the way to stop child abuse*. Letters to the editor, p. A.19.
- Newman, S. (2006). Hegemony and Power. In Haugaard M. & Lentner H (Eds) *Consensus and coercion in contemporary politics*. Lanham MD: Lexington Books.
- Nilssen E. (2005). Coercion and justice: a critical analysis of compulsory intervention towards adult substance abusers in Scandinavian law. *International Journal of Social Welfare*, 14: 134-144.
- Nies, M.A., McEwen, M. (2007). *Community / public health nursing: Promoting the health of populations* (4<sup>th</sup> Ed). St Louis: Saunders
- Noblit, G.W., Flores, S.Y., Murillo, E.G. (2004). *Post- critical Ethnography: Reinscribing critique*, New Jersey: Hampton Press.
- Nursing Council of New Zealand (2001). *Code of Conduct for Nurses and Midwives*. Nursing Council of New Zealand: Wellington.

- Oberle, K., Tenhove, S. (2000). Ethical issues in public health nursing. *Nursing ethics* 7: 426-438.
- O'Connor T. (1999). Linking Poverty with Poor Health. *Kai Tiaki Nursing New Zealand*, 5(7):12-13.
- O'Connor T. (2001a). Responding to violence is not an easy journey. *Kai Tiaki Nursing New Zealand*, 7(5):12.
- O'Connor T. (2001b). Reaching Out to Chronically Ill Children. *Kai Tiaki Nursing New Zealand*, 7(10):20.
- Olds, D.L., Eckenrode, J., Henderson, C.R. Jr, Kitzman, H., Powers, J., Cole, R. et al. (1997). Long term effects of home visitation on maternal life course and child abuse and neglect: 15-year-follow-up of a randomized trial. *JAMA*; 278:637-643.
- Olds D.L., Henderson, C.R. Jr, Cole, R. Kitzman, H., Powers, J. et al. (1998). Long-term effects of nurse home visitation on children's criminal and antisocial behavior: 15-year follow-up of a randomized trial. *JAMA*; 280:1238-1244.
- Olds D., Sadler L., Kitzman, H. (2007). Programs for parents of infants and toddlers recent evidence from randomized controlled trials. *Journal of Child Psychology and Psychiatry*, 48 (3-4): 355-391.
- Office of the Children's Commissioner (OCC) (2006). *More than an apple a day*. OCC Wellington
- O'Malley, P. (1992). Risk, power and crime prevention. *Economy and Society*, 21, 252-275.
- O'Malley, P. (1996). Risk and Responsibility. In A Barry, T Osborne and N Rose (eds) *Foucault and Political Reason*. London: UCL Press.
- O'Neill O. (1988a). Children's rights and Children's lives. *Ethics*, 98(3):445-463.
- O'Neill, O. (1988b). Ethical Reasoning and Ideological Pluralism, *Ethics*, 98(4):705-22.
- Osborn P. (2007). *Children's commissioner embraces KGB mojo*. Retrieved online 11.09.07 <http://www.libertarianz.org.nz/?libzpr=472>
- Paavilainen, E. Åstedt-Kurki, P.(2003). Functioning of child maltreating families: Lack of resources for caring within the family *Scandinavian Journal of Caring Sciences* 17(2):139-147.
- Parker, I. (1992). *Discourse dynamics: Critical analysis of social and individual psychology*, London: Routledge.
- Parker, J., Wiltshire, J. (1995). The handover; three modes of nursing practice knowledge. In Gray G. & Pratt R. (Eds) *Scholarship in the discipline of nursing* (p.151-168) Melbourne: Churchill Livingstone.



- Parkinson, P. (2003). Child Protection, Permanency Planning and children's right to family life. *International Journal of Law, Policy and the Family*, 7(2):147-172.
- Payne D. (2002). *The elderly primagravida: Contest and complexity*. Unpublished PhD Thesis Massey University, Palmerston North.
- Peckover, S. (2002). Supporting and policing mothers: an analysis of the disciplinary practices of health visiting. *Journal of Advanced Nursing*, 38(4): 369-77.
- Peter, E. (2002). The history of nursing in the home: revealing the significance of place in the expression of moral agency. *Nursing Inquiry*, 9(2): 65-72.
- Peter, E., (2003). The home as a site of care: ethical implications for professional boundaries and privacy. *Ethica*, 15 (2):57-69.
- Peter, E., Liaschenko, J. (2004). Paradoxes of proximity: A spatio-temporal analysis of moral distress and moral ambiguity. *Nursing Inquiry*, 11 (4): 218-225.
- Perron, A., Fluet, C., Holmes, D. (2005). Agents of care and agents of the state: biopower and nursing practice. *Journal of Advanced Nursing*, 50 (5): 536-544.
- Pierson, J. (2002). *Tackling Social Exclusion*. London: Routledge.
- Plunket Society (2007). *Annual Report 2006/2007*. Retrieved online on December 6, 2007 from:  
[http://www.plunket.org.nz/Content/NavigationMenu/About/Publications/AnnualReport/DownloadAnnualReports/Annual\\_Report\\_2007.pdf](http://www.plunket.org.nz/Content/NavigationMenu/About/Publications/AnnualReport/DownloadAnnualReports/Annual_Report_2007.pdf)
- Poirier, S., Ayres, L. (1997). Focus on qualitative methods—endings, secrets and silences: over-reading in narrative inquiry. *Research in Nursing and Health*, 20: 551-557.
- Polaschek, L. Polaschek, N. (2007). Solution-focused conversations: a new therapeutic strategy in well child health nursing telephone consultations. *Journal of Advanced Nursing*, 59(2):111-119.
- Pope, J.H. (1901). *Health for the Maori*. Native School Manual (3<sup>rd</sup> ed.), Wellington: Government Press.
- Potter, J., Wetherell, M. (1987). *Discourse and Social Psychology*. London: Sage.
- Powell, J. (2004). *Derrida for Beginners*. London: Random House.
- Powers, M. (1997). *The Audit Society: Rituals of Verification*, Oxford: Oxford University Press.
- Powers, P. (1996). Discourse analysis as a methodology for nursing enquiry. *Nursing Enquiry*, 3: 207-217.
- Powers, P. (2001). *The Methodology of Discourse Analysis*. New York: Jones and Bartlett.

- Prentice, D., Hathaway, M. (2001). Responding to a death from meningococcal disease. *Kai Tiaki Nursing New Zealand*, 7(5):16-18.
- Prout, A., James, A. (1990). *Constructing and reconstructing childhood: Contemporary issues in the sociological studies of childhood*, London: Falmer Press.
- Public Health Association (2007). *Generic Competencies for Public health in Aotearoa-New Zealand*. Retrieved online on January 4, 2008 from: <http://www.pha.org.nz/documents/GenericCompetenciesforPublicHealthMarch2007.pdf>
- Pybus, M. (1983). *The nurse in the Community: Community health nursing in New Zealand*. Auckland: McGraw Hill.
- Rabinow, P. (1997). *Making PCR : A story of biotechnology*. Chicago: University of Chicago Press.
- Rabinow, P., Rose, N., (2006). Biopower today. *BioSocieties*, 1:195–217.
- Racher, F.E. (2007). The evolution of ethics for community practice. *Journal of Community Health Nursing*, 24(1):65.
- Ramsden, I. M. (2002). *Cultural Safety and Nursing Education in Aotearoa and Te Waipounamu*. Unpublished PhD thesis, Victoria University, Wellington.
- Ratahi, R (2001). *Best Practice” in the Management of Maori Health and the Barriers to Delivery of that Form of Care with Particular Reference to the Experience of Te Whanau O Waipareira–Wai Health* Retrieved online on September 2,2007, from:<http://hcro.enigma.co.nz/website/index.cfm?fuseaction=articledisplay&FeatureID=419#Conditions%20Contributing%20to%20Poor%20Health>
- Rogers J., Niven, E. (1996). *Ethics: a guide for New Zealand nurses*. Auckland: Addison Wesley Longman.
- Rose, N. (1996). Governing “advanced” liberal democracies. In Barry Osborne & Rose (Eds) *Foucault and Political Reason: Liberalism, Neoliberalism and Rationalities of Government* : London: UCL Press.
- Rose, N., Miller (1992). Political power beyond the state: Problematics of government. *British Journal of Sociology*, 43(2):173-205.
- Russell, D. (1997). Changing Public Health Nursing Practice *Kai Tiaki Nursing New Zealand*, 5(11):18-20.
- Salmond, C., Crampton, P. (December 2001). NZ Dep.96--what does it measure? *Social Policy Journal of New Zealand*. Ministry of Social Development, 17: 82-101.
- Sandelowski, M. (1995). On the aesthetics of qualitative research. *Journal of Nursing Scholarship* 3:205-209.

- Sandelowski, M. (1998). Looking to care or caring to look? Technology and the rise of spectacular nursing. *Holistic Nursing Practice*, 12:1-11.
- Saucier-Lundy, K., Janes, S. (2003). *Essentials of: Community based nursing*. Sudbury Mass.: Jones & Bartlett
- Scott, S. Spender, Q., Doolan, M., Jacobs B. Apsland, H. (2001). Multi-centre controlled trial of parenting groups for antisocial behaviour in clinical practice. *British Medical Journal*, 323:194– 199
- Seedhouse, D. (2001). *Health the Foundations for Achievement*. Chichester: Wiley.
- Shonkoff, J.P., Phillips, D.A. (Ed.) (2000). *From neurons to neighbourhoods: The science of early child development*. Committee on Integrating the Science of Early Child Development, National Research Council, National Academy Press, Washington.
- Sidey, A., Widdas, D. (Eds) (2005). *A Textbook of Community Children's Nursing*, (2nd Edition). London: Churchill Livingstone.
- Silva, P., Stanton, W. (1996). *From Child to Adult: The Dunedin Multidisciplinary Health and Development Study*, Auckland: Oxford University Press.
- Skeggs, B. (2004). *Class, Self, Culture*. London: Routledge.
- Smith, A.N. (2002). Gale Encyclopedia of Public Health, The Gale Group Inc., New York: Macmillan.
- Smith, A.B., Taylor, N.J. & Gollop M. (Eds), (2000). *Children's Voices: Research, Policy and Practice*, Auckland: Pearson Education.
- Smith, A., Gollop, M., Marshall, K., Nairn, K. (2001). *Advocating for children: International perspectives on children's rights*. Dunedin: University of Otago Press.
- Smith, C. (2002). The sequestration of experience: Rights talk and moral thinking in late modernity. *Sociology*, 36:1.
- Smith, R. (1999). Medicine and the marginalised. *British Medical Journal*, 319: 1589-1590.
- Sparkes A.C. (2001). Myth 94: Qualitative researchers will agree about validity. *Qualitative Health Research*, 11:538-552.
- Spradley, J.A., Allendar, B.W. (2004). *Community health nursing: Promoting and protecting the public's health (6<sup>th</sup> ed)*. Philadelphia, PA: Lippincott Williams and Wilkins.
- Stackhouse, J.C. (1998). *Into the community: Nursing in ambulatory and home care*. Philadelphia P A.: Lippincott.

- Stanhope, M., Lancaster, J. (2006). *Foundations of nursing in community health: Community oriented practice*. St Louis: Mosby.
- Starfield, B. (2005). Equity social determinants, and children's rights: Coming to grips with challenges. *Ambulatory Paediatrics*, 5(3):134-138.
- Stevenson, C. (2004). Theoretical and approaches to discourse analysis. *Nurse Researcher* 12: 17-29.
- Stewart-Brown, S., Patterson, J., Mockford, C; Barlow, J., Klimes, I., Pyper, C. (2004). Impact of a general practice based group parenting programme: quantitative and qualitative results from a controlled trial at 12 months. *Archives of Disease in Childhood*, 89:519-525
- Stallknecht, K. (1999). Nurses need new culture for the millennium. *Kai Tiaki Nursing New Zealand*, 5(9):6.
- Strinati, D. (2004). *An introduction to the theories of popular culture* (2<sup>nd</sup> Ed). London: Routledge.
- Sullivan, (2007). *I was a Plunket Baby: 100 years of the Royal New Zealand Plunket society*. Auckland: Random House.
- Tennant, M. (1994). *Children's health the nation's wealth: A history of the children's health camp*. Wellington: Dept Internal Affairs.
- Tesh, S. (1981). Disease causality and politics. *Journal of Health Politics, Policy and Law*, 6 (3): 369-390.
- Thompson, L. (2008). The role of nursing in governmentality, biopower and population health: Family health nursing. *Health & Place*, 14:76–84.
- Thomsen, S. (1999). Making Family Centred Care a Reality. *Kai Tiaki Nursing New Zealand*, 5(4):14-17.
- Thiesmeyer, L.J. (2003). *Discourse and Silencing : Discourse approaches to politics society and culture*. Philadelphia: John Benjamins.
- Titelman, G.Y. (1996). *Random House Dictionary of Popular Proverbs and Sayings*. New York: Random House.
- Tonkin, S.L. (1986). Epidemiology of cot deaths in Auckland. *N. Z. Medical Journal*. 99:324–326.
- Traynor, M. (2006). Discourse Analysis: Theoretical and historical overview of articles in the Journal of Advanced Nursing 1996-2004 *Journal of Advanced Nursing* 54: 62-72.

- Tudor Hart, J (1971). The inverse care law. *Lancet*. 1(7696):405-12.
- Turner, N. (2007). *Child Health Watch* July 2007 edition 1 Retrieved online September 10, 2007 from: [http://www.wellchild.org.nz/PDF\\_Files/Childwatch\\_July07.pdf](http://www.wellchild.org.nz/PDF_Files/Childwatch_July07.pdf)
- Twinn, S. (1991). Conflicting paradigms of health visiting a continuing debate for professional practice. *Journal of Advanced Nursing* 16: 966-973
- United Nations (1989). Convention on the Rights of the Child. Geneva
- UNICEF (2007). Child Poverty in Perspective: An Overview of Child Well-Being in Rich Countries Innocenti Report Card, 7. Florence, Italy: Innocenti Research Centre.
- Valentine, F. (1998). Empowerment: family-centred care. *Paediatric Nursing* 10: 24-27.
- Vincent, C., Ball, S. (2007). 'Making Up' the Middle-Class Child: Families, Activities and Class Dispositions. *Journal of Sociology*, 41:6.
- Walker, R (1999). *Ka Whaiwhai Tonu Matou: Struggle without end*. Auckland: Penguin.
- Watts, M. (1965). *Practical Paediatrics: A guide for New Zealand nurses*. Christchurch: N.M. Peryer.
- Watkinson, A.M. (2005). *Children's rights are human rights and corporal punishment is a human rights issue* Human rights Day Breakfast Speech. Perth Western Australia. Retrieved online May 3, 2007, from: [http://info.humanrights.curtin.edu.au/print\\_friendly\\_doc.cfm](http://info.humanrights.curtin.edu.au/print_friendly_doc.cfm)
- Webb, E. (1998). Children and the inverse care law. *British Medical Journal*, 316(7144):1588-91.
- Webby, T. (2001). The boy who admitted himself to hospital *Kai Tiaki Nursing New Zealand*, 7(7): 22-23.
- Westley, F. Zimmerman B., Patton M.Q. (2006). *Getting to maybe: How the world is changed*. Toronto: Random House.
- Wheeler, B.W., Rigby, J.E., Huriwai, T. (2006). Pokies and poverty: problem gambling risk factor geography in New Zealand. *Health and Place*. 12: 86-96.
- Whiting, L. Miller, S. (2000). Health Promotion in Community Children's Nursing, in J. Muir and A. Sidey (eds). *Textbook of Community Children's Nursing*. London: Balliere Tindall.
- Whyte, D.A. (1997). A systemic approach to nursing work with families. In D.A Whyte (Ed), *Explorations in Family Nursing* (pp. 1-26), London: Routledge.
- Wilson, H.V. (2001). Power and partnership: a critical analysis of the surveillance discourses of child health nurses. *Journal of Advanced Nursing*, 36(2):294-301.

- Wilson, D., McBride-Henry, K., Huntington, A. (2004). Family violence: walking the tightrope between maternal alienation and child safety. *Contemporary Nurse*, 18: 85–96.
- Wood, L.A., Kroger, R.O. (2000). *Doing Discourse analysis methods for studying action in talk and text*. London: Sage.
- Wood, P., Foureur, M. (2005). Exploring the Maternity Archive of the St Helens Hospital Wellington New Zealand. In MacGann, S. & Mortimer, B. E.(eds). *New Directions in the History of Nursing: International Perspectives*. London: Routledge.
- Wood, P., Schwass, M. (1993). Cultural safety: a framework for changing attitudes. *Nursing Praxis*, 8:4–5.
- Woodbridge, M. (2001). The increasing use of cannabis in family settings -A nursing concern. *Nursing Praxis in New Zealand*, 2:44
- Woodbridge M. (2002). *From child savers to child activists: A participatory action research project with community child health nurses*. Unpublished thesis for the degree of Masters of Arts (Applied) in Nursing. Victoria University Wellington.
- Woods, M. (2007). Parental resistance: *Mobile and transitory discourses. A discursive analysis of parental resistance towards medical treatment for a seriously ill child*. Unpublished PhD thesis, Massey University, Palmerston North, New Zealand.
- World Health Organisation (WHO) (1989). *The health of young people*. Special committee report. Geneva.
- Wright, L. M., Leahey, M. (2005). *Nurses and families: A guide to family assessment and intervention* (4th ed.). Philadelphia: F.A. Davis.
- Wringe, C.A. (1981). *Children's Rights: A Philosophical Study*. New York: Routledge & Kegan Paul.
- Wyness, M.G. (2000). *Contesting childhood*. London: Falmer Press.
- Wynd, D. (2005). Hard to swallow: Foodbank use in New Zealand. Child Poverty Action Group. Retrieved online February 4, 2007, from:  
[www.cpag.org.nz/resources/publications/res1123805616.pdf](http://www.cpag.org.nz/resources/publications/res1123805616.pdf).
- Zahner, S.J. (2000). Ethics content in community nursing textbooks. *Nurse Educator*, 25(4):186-194.
- Zelizer, V.A.R. (1985). *Pricing the Priceless Child : The changing social value of children*. N.J: Princeton University Press.
- Zammito, J.H., (2001). *Kant, Herder, and the Birth of Modern Anthropology*, Chicago: University of Chicago Press.

### ***Ministerial Policy Documents***

New Zealand Ministry of Health. (1998). *Child Health Program Review*. Wellington, New Zealand: Ministry of Health. Retrieved June 6, 2007, from: [www.moh.govt.nz/childhealth](http://www.moh.govt.nz/childhealth)

New Zealand Ministry of Health. (1998). *Child Health Strategy*. Wellington, New Zealand: Ministry of Health. Retrieved June 6, 2007, from: [http://www.moh.govt.nz/moh.nsf/0/0A35B17C8DF465144C25666D007871D8/\\$File/childhealthstrategy.pdf](http://www.moh.govt.nz/moh.nsf/0/0A35B17C8DF465144C25666D007871D8/$File/childhealthstrategy.pdf)

New Zealand Ministry of Health. (1999). *Our Children's Health: Key findings on the health of New Zealand children*. Wellington: Ministry of Health

New Zealand Ministry of Health (2001) Public Health Strategy. Retrieved June 6, 2007, from: [www.moh.govt.nz/publications/nzhs](http://www.moh.govt.nz/publications/nzhs)

New Zealand Ministry of Health (2000). New Zealand Health Strategy. Retrieved June 6, 2007, from: <http://www.moh.govt.nz/publications/nzhs>.

New Zealand Ministry of Health (2002a). He Korowai Oranga- Māori Health Strategy. Retrieved June 6, 2007, from: [www.moh.govt.nz/mhs.html](http://www.moh.govt.nz/mhs.html)

New Zealand Ministry of Health (2002b). Well Child Framework: Service. Retrieved June 6, 2007, from: Specifications [http://www.moh.govt.nz/http://www.plunket.org.nz/AM/Template.cfm?Section=Care\\_Delivery\\_Teams&Template=/CM/HTMLDisplay.cfm&ContentID=2435](http://www.moh.govt.nz/http://www.plunket.org.nz/AM/Template.cfm?Section=Care_Delivery_Teams&Template=/CM/HTMLDisplay.cfm&ContentID=2435)

New Zealand Ministry of Health (2003a). Well Child Service Specifications. Retrieved June 6, 2007, from: <http://www.moh.govt.nz/moh.nsf/238fd5fb4fd051844c256669006aed57/da3fc8c7232151aacc256b88000677b1?OpenDocument>

New Zealand Ministry of Health (2003b). *Child health information strategy*. Wellington, New Zealand: Ministry of Health. Retrieved, June 7, 2007 from: [http://www.moh.govt.nz/moh.nsf/238fd5fb4fd051844c256669006aed57/70f4c5544b6fbdb0cc256d86007fa2a2/\\$FILE/ChildHealthInfoStrategy.pdf](http://www.moh.govt.nz/moh.nsf/238fd5fb4fd051844c256669006aed57/70f4c5544b6fbdb0cc256d86007fa2a2/$FILE/ChildHealthInfoStrategy.pdf)

New Zealand Ministry of Health (2003c). *NZ food NZ children: Key results of the 2002 national children's nutrition survey*. Wellington: Ministry of Health.

New Zealand Ministry of Health (2004). *Child and Youth Health Toolkit*. Retrieved online May 5, 2007 from: <http://www.newhealth.govt.nz/toalkits/childhealth/childand youthhealthtoolkit.doc>.

New Zealand Ministry of Health (2007). *Establishing a VIP program*. Retrieved October 20, 2007, from: <http://www.moh.govt.nz/moh.nsf/indexmh/familyviolence-vipprogramme-part>

New Zealand Ministry of Health (2007) *Monitoring the Health of New Zealand Children and Young People; A Literature Review and Framework Development* and the companion document the 'Indicator Framework' launched by the New Zealand Child and Youth Epidemiology Service. Retrieved November, 30, 2007, from: <http://www.paediatrics.org.nz/>

National Health Committee (1998). *The Social, Cultural and Economic Determinants of Health in New Zealand: Action to Improve Health*. Commissioned for the Ministry of Social Development. Retrieved online October 22, 2007, from: [www.msd.govt.nz/publications/agenda-for-children-public-report/appendices/appendix-5.htm](http://www.msd.govt.nz/publications/agenda-for-children-public-report/appendices/appendix-5.htm)

New Zealand Ministry of Social Development (1999). *Strengthening Families Report on cross sectoral outcome measurements and targets*. Retrieved October 22, 2007, from: <http://www.msd.govt.nz/documents/work-areas/sector-policy/agenda-for-children/seminar/strengthening-families-outcomes-report-99.pdf>

New Zealand Ministry of Social Development (2001). *The Social Report 2001*, p79 Retrieved June 10, 2007, from: <http://www.msd.govt.nz/publications/agenda-for-children-public-report/appendices/appendix-5.html>

New Zealand Ministry of Social Development. (2004). *Children and young people: Indicators of wellbeing in New Zealand*. Wellington, New Zealand: Ministry of Social Development. Retrieved May 5, 2007, from: <http://www.msd.govt.nz/work-areas/social-research/children-young-people/children-and-young-people-indicators-of-wellbeing-in-nz.html>

New Zealand Ministry of Social Development, *New Zealand Living Standards 2004*. 2004, Wellington: Ministry of Social Development.

### **Government Acts**

Children Young Persons and their Families Act (1989), <http://www.brookers.co.nz/catalogue/legislation.asp>

The Children's Commissioners Act (2003), <http://www.brookers.co.nz/catalogue/legislation.asp>

The Care of Children Act (2004) <http://www.brookers.co.nz/catalogue/legislation.asp>

The Families Act (2003). <http://www.brookers.co.nz/catalogue/legislation.asp>



The Health Practitioners Competence Assurance Act (2003).  
<http://www.brookers.co.nz/catalogue/legislation.asp>



## M E M O R A N D U M

### Auckland University of Technology Ethics Committee (AUTEC)

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To: Debbie Payne  
 From: **Madeline Banda** Executive Secretary, AUTEC  
 Date: 27 April 2007  
 Subject: Ethics Application Number 07/31 **Community nurses' perspectives and practices regarding children's rights to health: a discourse analysis.**

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Dear Debbie

Thank you for providing written evidence as requested. I am pleased to advise that it satisfies the points raised by the Auckland University of Technology Ethics Committee (AUTEC) at their meeting on 12 March 2007 and that as the Executive Secretary of AUTEC I have approved your ethics application. This delegated approval is made in accordance with section 5.3.2.3 of AUTEC's *Applying for Ethics Approval: Guidelines and Procedures* and is subject to endorsement at AUTEC's meeting on 14 May 2007.

Your ethics application is approved for a period of three years until 27 April 2010.

I advise that as part of the ethics approval process, you are required to submit to AUTEC the following:

- A brief annual progress report indicating compliance with the ethical approval given using form EA2, which is available online through <http://www.aut.ac.nz/about/ethics>, including when necessary a request for extension of the approval one month prior to its expiry on 27 April 2010;
- A brief report on the status of the project using form EA3, which is available online through <http://www.aut.ac.nz/about/ethics>. This report is to be submitted either when the approval expires on 27 April 2010 or on completion of the project, whichever comes sooner;

It is also a condition of approval that AUTEC is notified of any adverse events or if the research does not commence and that AUTEC approval is sought for any alteration to the research, including any alteration of or addition to the participant documents involved.

You are reminded that, as applicant, you are responsible for ensuring that any research undertaken under this approval is carried out within the parameters approved for your application. Any change to the research outside the parameters of this approval must be submitted to AUTEC for approval before that change is implemented.

Please note that AUTEC grants ethical approval only. If you require management approval from an institution or organisation for your research, then you will need to make the arrangements necessary to obtain this.

To enable us to provide you with efficient service, we ask that you use the application number and study title in all written and verbal correspondence with us. Should you have any further enquiries regarding this matter, you are welcome to contact Charles Grinter, Ethics Coordinator, by email at [charles.grinter@aut.ac.nz](mailto:charles.grinter@aut.ac.nz) or by telephone on 921 9999 at extension 8860.

On behalf of the Committee and myself, I wish you success with your research and look forward to reading about it in your reports.

Yours sincerely

Madeline Banda  
**Executive Secretary**  
**Auckland University of Technology Ethics Committee**

Cc: Jill Sye [jillandtim@xtra.co.nz](mailto:jillandtim@xtra.co.nz)

# Participant Information Sheet



*Produced: May 15<sup>th</sup> 2007*

## **Project Title**

**Community nurses' perspectives and practices regarding children's rights to health. A discourse analysis.**

## **An Invitation**

*Hello, Kia ora, Talofa, Malo, Bula,*

You are invited to participate in a Masters in Health Science research project conducted by myself, Jill Sye a children's community nurse and Masters student at AUT. Your participation in the study is entirely voluntary and you can choose not to participate. Also, you as a participant may withdraw from the study at any time.

## **What is the purpose of this research?**

The purpose of this study is to explore and analyse children's community nurses perceptions and practices regarding meeting children's health needs. Nurses like you have unique insights into the realities of child health in New Zealand. As a result of the research the study will contribute to my Masters in Health Science. It will be used in presentations at nursing conferences as well as submission for publication to professional nursing journals.

## **How was I chosen for this invitation?**

You have been invited to take part in this study because you are a paediatric nurse working in the South Auckland community. I would like to interview 6-8 nurses with a minimum of 2 years community paediatric experience.

## **Is this an approved research study?**

The design and process of this study has been approved by the AUT Ethics Committee, the Plunket Ethics Committee, Counties Manukau DHB Ethics Committee, CMDHB Maori Ethics Committee, and is supported by the Waitemata DHB Maori Ethics advisor.

## **What will happen in this research?**

If you agree to participate there are three parts, one of which is optional. The first part is optional. If you choose I would like you to write down some of your reflections on children's health needs and nursing children in the community. I hope that this will not be onerous and can be in any style that you find preferable for example: notes /journaling/exemplar/poem/cartoon. You may submit a copy of an existing exemplar or case study from your current practice portfolio. You also have the option of purposively writing for this research study which can then be submitted with your next portfolio review.

The second part will be an interview. I will interview you for up to 90 minutes. With your permission the interview will be audio taped and notes taken. The interviews will be typed verbatim and you will receive two copies of the transcribed interview. One is for you to check and return to me, the other is for you to keep if you wish. The interview transcripts will then be critically analysed to identify and examine dominant discourses from community paediatric nursing. This means the way we think and speak about our practice in private and professionally.

Finally, if some elements of the interview need clarification during the analysis phase, I may need to contact you again. You can choose whether you are available in person, on-line, or via phone.

### **What are the discomforts and risks?**

Talking about your experiences from practice may cause some emotional discomfort.

New Zealand children's community nurses are a close and small group; there is a small possibility that someone reading the thesis or listening to a conference presentation may be able to identify you. The confidentiality and anonymity strategies discussed below are designed to protect your identity.

### **How will these discomforts and risks be alleviated?**

I do not envisage many risks from participating however, there is a risk of incomplete anonymity or there may be some distress in recalling some events. Health and counselling services are available from your employers should this occur.

Only the researcher will know that you are participating in my study. Colleagues need not be aware of your participation. However, if you wish to be released for participation during work hours your manager may require being informed.

You will be asked to provide a pseudonym, a name which will be used for the study. Steps will be taken to avoid identification, for example, deleting names and place names. Your assistance is important in obscuring personal and client details so that children's privacy is maintained. Your privacy can also be protected by you choosing a time and place away from your workplace for the interview which suits you.

Consultation with cultural advisors to maintain the integrity of the study has been sought. Should you require the support of a cultural advisor at any stage of the study, this is available.

### **What are the benefits?**

You may enjoy the opportunity to talk about your work. Other nurses and members of the wider transdisciplinary community may benefit from hearing your insights. You may be able to use the written narratives as a part of your professional portfolio. Participation may assist in the supervision/ reflective practice processes in your workplace. Copies of the study may be relevant to children's rights institutions such as the Commissioner for Children. The position and profile of paediatric community nurses can be enhanced if articles are accepted for publication in nursing journals presentation at conferences.

### **How will my privacy be protected?**

All the information will be kept in a secure place. For example, your tapes and computer discs will be kept in a locked cabinet in a locked building. Following the study, the supervisor is required to keep all the information in a secure place for 6 years, and it will then be destroyed. If you withdraw from the study, your information will be immediately destroyed. Only my supervisors and a transcriber (who has signed a confidentiality form) will read the transcripts.

### **What are the costs of participating in this research?**

The main cost of participating is your time. Including writing narratives, a 90 minute interview, re reading transcripts and any communication to clarify data, around 3 hours with maximum of 5 hours should be required over the entire year. I am happy to interview you at a time and place that is convenient for you. I will either organize transport for you or reimburse you for travel costs to get to that venue. It is hoped that your employer recognizes your participation as a valuable tool for reflective professional development and agree for you to engage in this study during working hours or as time in lieu.

### **What opportunity do I have to consider this invitation?**

If you would like to contribute to this study it would be great to hear from you by the 10<sup>th</sup> July. If you decide to proceed, written narratives would be required by the middle of July and interviews carried out by late July.

### **How do I agree to participate in this research?**

If you are willing to tell your story, and meet the selection criteria could you please send the attached consent form in the self addressed envelope or email [jillsye94@aut.ac.nz](mailto:jillsye94@aut.ac.nz) for further information.

# Consent Form



*Project title:* Community nurses' perspectives and practices regarding children's rights to health. A discourse analysis.

*Project Supervisor:* **Debbie Payne**

*Researcher:* **Jill Sye**

- I have read and understood the information provided about this research project.
- I have had an opportunity to ask questions and to have them answered.
- I understand that the interview will be audio-taped and transcribed.
- I understand that I can write in my additional thoughts on the subject in any manner that I see fit.
- I understand that all efforts will be made to protect my privacy identity and confidentiality.
- I understand that I may withdraw myself or any information that I have provided for this project at any time prior to completion of data collection, without being disadvantaged in any way. If I withdraw, I understand that all relevant tapes and transcripts, or parts thereof, will be destroyed
- I agree to take part in this research.

Participant's ..... signature:

Participant's ..... name:

Participant's Contact Details

.....  
 .....  
 .....

Date:

**Approved by the Auckland University of Technology Ethics Committee on 2th April**

# Confidentiality Agreement



*Project title:* Community nurses' perspectives and practices regarding children's rights to health. A discourse analysis.

*Project Supervisor:* **Debbie Payne**

*Researcher:* **Jill Sye**

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- ☐ I understand that all the material I will be asked to transcribe is confidential.
- ☐ I understand that the contents of the tapes or recordings can only be discussed with the researchers.
- ☐ I will not keep any copies of the transcripts nor allow third parties access to them while the work is in progress.

Transcriber's

signature:

.....

Transcriber's

name:

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Transcriber's Contact Details (if appropriate):

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Date:

Project Supervisor's Contact Details (if appropriate):

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