# MIGRANT MATERNITY

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# Abstract

Maternity is central to the development of healthy populations (biopower), capitalism, nation building, imperialism and globalisation. Liberal feminist discourses have mobilised concepts such as empowerment, choice and control to decolonise patriarchal practices of maternity. These discourses have instituted the knowledgeable and empowered maternity consumer who takes charge of her experience of childbirth. However, the uptake of these discourses into the public health system has unintentionally recolonised the birthing experiences of visibly different mothers.

Using Foucauldian, feminist and postcolonial methodologies, this thesis investigates how the 'empowering' practices and structures of maternity can be normalising and disciplining, acting to reinforce the centrality of whiteness. A discourse analytical approach describes the historical and contemporary relations of power through which discourses of migrant maternity are constituted through speech and practice. Foucault's theorisation of diffused and productive power implicates nursing and midwifery practices in modern state goals to regulate and maximise the efforts of individuals and the social body. The neoliberal internalisation of technologies of disciplinary control by hyper-responsible 'good' mothers translates the institutional goals of public health into the 'positive choices' of individuals— a moral discourse where non-Pākehā migrant mothers are found to be wanting by the public health system.

These theoretical findings were examined in three New Zealand focus groups, where both Pākehā /white migrant mothers and Plunket nurses drew on liberal and neoliberal discourses of maternity, while for Korean mothers biomedical and cultural discourses provide alternative understandings. In response to this misalignment, nurses and midwives take up normalising, disciplining and acculturating roles in order to socialise migrant mothers into the role of an ideal and implicitly white maternal service user. When normalisation is challenged, culturalist discourses allow professionals to shift responsibility for the misalignment from institution to mother, in a clear departure from nursing's ethic of patient-centred care. These findings demonstrate that the liberal foundations of nursing and midwifery discourses are inadequate for meeting the health needs of diverse maternal groups. In response, the thesis advocates for the extension of the theory and practice of cultural safety to critique nursing's Anglo-European knowledge base, extending the discipline's intellectual and political mandate with the aim of providing effective support to diverse groups of mothers.

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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 previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

# Chapter 1: Migration and Maternity

Empowerment is a central concept in maternity, where the decolonising of maternity from patriarchal strictures of obstetric practice has been premised on the figure of the knowledgeable maternity consumer who takes charge of her experience of childbirth and is subsequently empowered (Ehrenreich, 1993). Ironically, however, this decolonisation of maternity from patriarchy has recolonised the birthing experiences of visibly different mothers. The appropriation of pregnancy, birth and the post-partum by Western knowledges can limit the sovereignty of 'other' mothers in migrant receiving societies. These 'other' mothers are separated not only from their cultural knowledges, but also from their support systems and traditions. Rarely are the latter legitimised institutionally resulting in the disempowerment of both mother and family.

This thesis suggests that if maternity scholarship and the macro-processes involved in maternity and motherhood were decolonised, empowering outcomes might be available for all women. Maternity might include not only reproduction, but new political and theoretical imaginings. The development of theory and method might lead to new epistemological possibilities and new kinds of interventions (Weinbaum, 2004). Following Weinbaum's lead, this thesis contends that such possibilities are available if maternity is studied in all its registers, in a broader theoretical and interdisciplinary neighbourhood in order to deconstruct and reconstruct maternity. It poses interdisciplinary questions to previous studies of maternity in health that have often been confined by disciplinary concerns and protocols. This thesis aims to displace dominant forms of knowledge production within health where the empirical is valorised at the expense of the theoretical; using a postcolonial feminist approach to scrutinise maternity within the philosophical concepts and systems underpinning liberal feminism.

Maternity scholarship has typically either been marginalised and pathologised by dominant discourses, or centralised as the source of women's oppression by feminist scholarship. This thesis contributes intellectually and politically to the latter, but differs in that it does not aim to locate the role of maternity in defining femaleness. Instead, it builds on a growing scholarship that goes beyond interrogating the role of maternity in social relations between men and women, to examine the role of maternity in social relations between women and 'other' women (Manderson, 1998). More specifically, this thesis examines the ways in which maternity is implicated in systems of domination and classification, such as racism and imperialism (Weinbaum, 1998). The thesis

contends that liberal feminism is grounded in processes of racialisation whereby people are grouped according to particular physical characteristics or ethnic or racial categories, and then managed according to beliefs that are held in relation to those assigned labels (Agnew, 1998 cited in Browne et al, 2009). These processes of racialisation within liberal feminism can be analysed genealogically and as such reproductive practices, policies and politics are contextualised within the frame of transnational[1] inequalities (Ginsburg & Rapp, 1995). In particular, the importation of labour in the West has often been in response to low birth rates, and consequently concern with the conditions and regulation of immigration (Bannerji, 2000). Migrant maternity foregrounds the three ways through which new populations are acquired: colonisation, migration and reproduction (Luibhéid, 2002).

Production and reproduction are interdependent because migration policies are responsive to demographic crises of depopulation, where the need for labour is addressed through increasing immigration (Camiscioli, 2001). Global capitalism drives migration flows and governmental policies support industries to obtain 'new' workers. However, global shortages of skilled workers have led to changes in migration policies around the world and the homogeneity of migrant and receiving country can no longer be assured. Countries now compete for migrants, searching beyond traditional source countries for newcomers (for example in the case of New Zealand, migrants traditionally came from the United Kingdom and Europe). Where homogeneity was once a migration filter, the competition for migrants globally has required migrants who, as well as their children can be assimilated (Camiscioli, 2001). Consequently, the racialised and gendered aspects of immigration sustain and simultaneously recreate in the public imagination both the ideal and the undesirable citizen. As the reproduction of the citizen begins through childbearing, the racialised migrant woman constitutes a potent threat to the racial continuation of the nation and presents a disruption to the bounded construction of the nation as home and family (Luibhéid, 2003).

Migrant maternity thus brings into sharp relief broader issues such as racism, nation building and imperial expansion. Maternity provides the conditions of possibility for the production, surveillance and regulation of identities and difference at local and national levels. The politics of maternity reveal that the "seemingly natural processes of swelling, bearing and suckling, the

1. Transnational refers to where specific arenas of knowledge and power escape the communities of their creation to be embraced by or imposed on people beyond those communities (Ginsburg & Rapp, 1995, p.9).

flows of blood, semen and milk are constituted and fixed not just by the force of cultural conception but by coagulations of power"(Jolly, 1998, p.2). These coagulations of power flow across community, colonial and international regimes (Thomas, 2003), getting to the "heart of questions about citizenship, liberty, family and nation" (Haraway, 1997, p.37). Reproduction with its biological, sexualised and racialised aspects has also organised knowledge about nations, modern subjects, and the flow of capital, bodies, babies, and ideas within and across national borders (Weinbaum, 2004).

My foregrounding of the term maternity rather than the related terms 'mothering' and 'motherhood' (although all three terms are inextricably intertwined) reflects an intellectual and political emphasis on the body. Maternities refer to the initial life-changing journey of being pregnant, giving birth and nurturing and the corporeal processes of the transition to motherhood (Longhurst, 2008; Ram and Jolly, 1998, p.1). In contrast, 'mothering' refers to the maternal work of being a mother and meeting the needs of and being responsible for dependent children. Maternities engender self-discipline and self-sacrifice given that 'motherhood', (that is the context where mothering occurs) is shaped not only by the historical, the cultural, the political and the social, but also the moral (Miller, 2005). This thesis draws on a wide range of scholarship to map the history of complex discursive frameworks within which migrant maternity is currently known and enacted and the power relations inherent in these understandings and practices. This 'genealogical' mapping of maternity is complemented by a local empirical study that explores the different experiences of two groups of migrant women (Korean and White) who are positioned differently in the local discursive landscape and the ways in which a group of Plunket nurses discursively construct migrant maternity.

## The context of migrancy in Aotearoa

Migration has been central to nation building and imperial expansion in the context of New Zealand as a white settler society. Sherene Razack (2002, pp.1-2) describes a white settler society as:

> " ... one established by Europeans on non-European soil. Its origins lie in the dispossession and near extermination of Indigenous populations by the conquering Europeans. As it evolves, a white settler society continues to be structured by a racial hierarchy.

Razack suggests that fundamental to the mythologies of a white settler

society is the notion of white people as the first to arrive and develop the land, and a view of colonisation as benign force rather than a process enacted through conquest and genocide which have displaced the indigenous and led to the exploitation of the labour of peoples of colour.

The term 'white settler society' is salient in New Zealand given the dispossession of indigenous Māori through the processes of colonisation, the persistence of racist thinking, the justification of colonisation as benign and the view that socio-political inequalities are individual rather than historic and structural (Cormack, 2007). Colonial settlement, which began in 1840, has had a deleterious impact on Māori tribal resources, leadership, knowledge, structures and identity leading to poor health for Māori. Steps are being taken to redress the structural injustices that have been the legacies of colonisation (Nursing Council of New Zealand, 2002; Swindells, 2006). In the context of this uneasy and unresolved bicultural colonial relationship, some Māori view migrants as unwelcome guests with a collusive role in usurping indigenous rights (Walker, 1995). Meanwhile, many in the dominant culture view migrants as being in need of careful management and modernisation so as not to lower cultural standards ('our way of life').

For the purposes of this study, the term 'migrant' refers to a group of people that in varying contexts, countries and literatures are also referred to as 'racialised' and 'ethnic'. The latter is a more idiosyncratic policy term used in New Zealand to refer to people who do not fit into the categories of Pākeha, Māori nor Pacific (Office of Ethnic Affairs, 2002)—that is people from Asian, Middle Eastern and African backgrounds. The term 'migrant' in this thesis refers to someone who was born in one country and then moves to another country through an immigration programme. In New Zealand this consists of three main streams:

- Skilled/business – relates to attracting migrants with qualifications and skills, or the potential to create business opportunities in New Zealand;
- Family sponsored – New Zealand citizens or permanent residents can sponsor family members to enter the country;
- Humanitarian – this includes refugees and allows for family members to be granted residence if there are serious humanitarian concerns.

The process of migration is a primary driver of New Zealand's cultural and linguistic diversity (there are also temporary movements of people such as tourists

and international students). The focus of this thesis is on new migrants, rather than people from migrant backgrounds who might have been in New Zealand for more than a generation. Recent migrancy shapes expectations and the extent to which cultural rituals; knowledges and practices are adhered to. For example, a newly pregnant 'ethnic' woman who has arrived from rural India less than two years ago will negotiate maternal health services in New Zealand differently from a newly pregnant 'ethnic' woman whose parents migrated from India but who has grown up in New Zealand and had her formative experiences and education in New Zealand.

New Zealand's reputation for fairness (Sheridan, Kenealy, et al., 2011), has disguised the discursive and material legacies of colonialism and neoliberalism, which have positioned indigenous and migrant groups inequitably. Progressive social policy to address health and social equity including attempts to honour the Treaty of Waitangi signed in 1840; granting women the right to vote in 1893 and the introduction of a 'no fault' workers compensation system for work injuries in 1990 (Sheridan et al., 2011) has failed to rectify sharp disparities between the overall well-being of a dominant Pakeha group and indigenous and migrant others. Pacific and Asian migration policy have been shaped by economic drivers and the settlement of both these diverse population groups has been marked by exclusionary legislation and discrimination.

Demand for a growing manufacturing and service industry workforce precipitated Pacific migration after the Second World War (Spoonley, 2001). Meanwhile, global competition for skilled migrants broadened the range of migrant source countries and increased the numbers of Asians beginning in 1987 (Bartley, 2004; Bartley & Spoonley, 2004; Bedford, 2003). To a lesser degree (numerically speaking), the New Zealand context of migrancy has also been shaped by a formalised humanitarian commitment to refugee resettlement (from 1987), which has seen refugees from Africa, the Middle East, South East Asia and Eastern Europe make New Zealand their home. I now examine these demographic changes and the health status of these groups in more detail.

Pacific peoples make up six percent of the New Zealand population and represent over 20 different cultural groups (Mental Health Commission, 2001). Semi- and unskilled Pacific labourers were encouraged to migrate to urban areas of New Zealand, to meet manufacturing and service industry demands which accelerated in the 1960s and early 1970s (Spoonley, 2001). However, two factors in the mid-1970s contributed to migration becoming an emotive issue and to many Pacific people losing their jobs and homes. The first was the economic

downturn, and secondly a record annual net migration gain (33,200 people) in the year ended 31 March 1974. A campaign targeting Pacific Island migrants and their rights to permanent residency in Aotearoa New Zealand saw the advent of 'dawn raids' on the homes of Pacific peoples by the Government (Cormack, 2007). These factors and the socio-economic positioning of Pacific peoples has resulted in their experiencing poorer health status, greater exposure to risk factors for poor health and barriers to accessing health services (Ministry of Health, 2004a). Pacific peoples in New Zealand have a lower life expectancy at birth (about four years less than the national average of approximately 62.5 years) and an avoidable mortality rate of nearly double the total New Zealand population.

Asian migration has been characterised by exclusionary legislation and anti-Chinese and anti-Indian discrimination. Historically members of these population groups (primarily comprised of men) were viewed as competitors for jobs, and a threat to sexuality and morality (Ip & Murphy, 2005; Leckie, 1995). The Immigration Act of 1987 diversified what had been an unofficial White New Zealand policy favouring White migrants. The new points system led to the selection of migrants on the basis of skills, diversifying the migrant pool and increasing migration from Asia. These shifts plus the rise of the export education market have made Asians more visible and central to the national economy (International Division & Data Management and Analysis, 2005). Asians make up 9.2% of the total New Zealand population (Statistics New Zealand, 2006) and are perceived as a group who have similar or better health than European New Zealanders (Harris, et al., 2006). 35% of Asians in New Zealand have a University undergraduate or postgraduate degree compared with about 20% of non-Asian groups, however Asian people (along with Pacific Peoples) are distributed more than Europeans towards low household income categories and evidence of health inequalities is growing (Scragg, 2010).

New Zealand accepts the fifth highest number (equal with Canada) of refugees per capita, but rates most poorly in terms of resettlement support and services (Lawrence & Kearns, 2005; Young & Mortensen, 2003). In 1987, the New Zealand government began systematically offering 750 resettlement places to the most vulnerable refugees and created specific high health and social needs categories to provide active resettlement support within the quota to include 'Women-at-risk' (75 people), 'Medical/Disabled' cases (75 people) and protection cases (600 people) (Mortensen, 2007). However, refugees have not been included as a priority group in policies and strategies aimed at reducing health and social inequalities (Mortensen, 2007).

## Contextualising Korean migration to New Zealand

South Korean migrant mothers are a population group whose talk comprises data analysed for the empirical part of this study. South Korea has a low fertility rate (total 1.08 in 2005) (Chung, Kim, & Nam, 2008) in part related to industrialisation and family planning policies (Doepke, 2004). The influence of biomedicine is reflected in high rates of Caesarean section in South Korea and a rapid decline in the proportion of Korean mothers that breastfeed infants exclusively (Chung, et al., 2008). There is no research on whether these trends are carried over to New Zealand with migration. This section provides a brief overview of the socio- economic and political transitions that have influenced migration to New Zealand from South Korea. The aim of this section is not to give a full account of the 'identity' of the Korean mothers but to provide a historical context for the differences expressed in their statements in the findings chapter of this thesis.

The formation of modern South Korea is related to several turbulent historical developments. They include the Japanese colonial modern period (1910-1945); the neocolonial occupation by the American military government (1945-1948); a proxy war of cold war rivals leading to the partition of the Korean peninsula; postcolonial economic growth under three decades of a Cold War military dictatorship; the emergence of an electoral democracy in 1987 and the growth of the neoliberal state and market governance; and the Asian Debt Crisis and liberalisation of markets (Kim & Choi, 1998). These historical developments have also shaped migration. After the Korean War (1950–1952) and two military coups (1960–1987) the economic focus moved from agricultural production to industrial production resulting in rapid urbanisation, particularly in Seoul, where almost half of the country's inhabitants now live, resulting in demand for real estate and astronomical prices in South Korea (Song, 2010). Industrialisation and urbanisation have comprised the 'push' factors that have led South Koreans to migrate, notwithstanding the highly competitive Korean labour/job market, which has reduced future promotion opportunities in the wake of globalisation, making middle-class status difficult to maintain (Koo, 2004).

The New Zealand migration policy emphasis on attracting capital, professional, technical and entrepreneurial skills and the burgeoning export education industry have pulled South Koreans to New Zealand and uniquely shaped this diasporic community. The importance of education as a means of attaining economic security and status, has also led to the investment of substantial personal and economic resources into the education of children.

Collins (2006) contends that education has been pivotal to the economic and social success of both South Korea and individual South Koreans. The first recorded Korean immigrants to New Zealand settled in the South Island around the mid-1960s as ex-employees of various Korean shipping firms (Chang, Morris, & Vokes, 2006). Korean shipping increased in importance in the Pacific economy from after World War Two onwards, and by the 1960s, Korean ships were regularly visiting New Zealand ports. Numbers of Koreans began to increase significantly from 1991 onwards when the changes to migration policy in 1987 led to an increase in the liberalisation of entry criteria and the removal of previous discriminatory legislation against immigrants from East Asia. An emphasis on bringing in migrants who had venture capital, professional, technical and entrepreneurial skills saw a dramatic increase in Korean migration. In 1986, the Korean population in New Zealand consisted of 369 people; by 2006 it was almost 70 times larger with 28,434 people (Department of Labour, 2006).

The recent arrival of the Korean community in New Zealand presents them with a unique range of advantages and challenges, compared with other ethnic groups in New Zealand. Koreans were the tenth largest ethnic group in New Zealand in the 2006 Census (Morris, Vokes, & Chang, 2007). However, unlike Hawaii and Los Angeles, where Koreans go back eight or more generations, Koreans in New Zealand represent a new migrant community in New Zealand. They have migrated in very small numbers and almost all originate from South Korea (Han & Han, 2010). Over half of all Koreans live in Auckland and Christchurch and the population is youthful with half of its population aged less than 24 years of age (Chang, et al., 2006). 94 % of all Koreans in the country were born outside New Zealand, and 87 % have lived in New Zealand for less than a decade (Chang, et al., 2006). Koreans have founded churches, associations, language schools and a range of media including three Korean language newspapers, two magazines, three radio stations and one TV network (Kim & Starks, 2005). In 2001, more than half of all Korean immigrants in New Zealand described being regular churchgoers, with most identifying as Christian, primarily as Protestant, with a minority identifying as Catholic (Dunstan, Boyd, & Crichton, 2004). Koreans are more likely to live in high decile[2] areas than other Asians (Scragg & Maitra, 2005), which Koo (2004) suggests is in part due to the

2. A decile is a statistical term, where a group or population is divided into ten equally sized groups, giving ten deciles. There are ten deciles starting with decile one through to decile ten. The decile system is a socio-economic rating given to schools to categorise the economic and social factors of the community immediately surrounding it. Decile one schools have the largest proportion of students from low socio-economic backgrounds while schools in decile ten have the largest proportion of students from high socio-economic backgrounds (Valentine, 2007).

migration to New Zealand of mainly highly educated middle class professionals, who arrived in New Zealand with capital realised from the liquidation of expensive Korean real estate. However, migration has resulted in a decline in socio-economic status for many Koreans in New Zealand, as seen by this group having the highest levels of unemployment (57%), underemployment, and the second lowest level of personal median income, at $5,300 per annum (Department of Labour, 2006). Chang (2006) attributes this decline for Koreans who came in through the general skills category to poor English language proficiency combined with an inability to find equivalent senior managerial and technical positions to those they had in Korea. Instead, under-employment in small-scale businesses such as grocery shops and restaurants serving their own communities is increasingly common.

## Overview of New Zealand Health services

The New Zealand health care system health system is a predominantly public based system. The country is divided into 21 District Health Boards (DHBs), which provide services with the objective of improving, promoting and protecting the health of people and communities. New Zealand was the first country in the world to introduce universal health care, in the context of a post-depression welfare state. Such modern health systems have been shaped by the shift to neo-liberal ideologies from the mid-1980s (Crowe, O'Malley, & Gordon, 2001). New Zealand's public service underwent dramatic reforms between 1987 and 1999 (Crowe, 1997). DHBs now plan, manage, provide and fund services for the populations of their districts which include primary care, public health services, aged care services and services provided by other non-governmental health providers, including Māori and Pacific providers. DHBs fund the provision of primary health care through Primary Health Organizations (PHOs). Large numbers of PHOs were established between 2002 and 2005 (Sheridan et al., 2011). Further discussion about the organisation and provision of maternity and infant care is provided in Chapter Four.

## Nursing in New Zealand

Nursing in New Zealand originated in Florence Nightingale's project of Victorian womanhood (Gilbert, 2003), which expanded beyond the imperial centre through the colonial settlement of Aotearoa New Zealand. However, the centrality of whiteness in nursing in New Zealand is being challenged through both the increase in scholarly critique from nurses (Ramsden, 2002; Southwick, 2001) and the changing demographics of the nursing workforce. The workforce is

transitioning from a largely New Zealand-born and European ethnic group to becoming increasingly ethnically diverse. New Zealand has more nurses relative to its population than the OECD average (Zurn & Dumont 2008). However, the education, attraction and retention of nurses is a major issue for employers (Callister, Badkar, & Didham, 2011). There are several contributing factors that implicate migration and ethnicity. The first includes the relatively small numbers of Maori and Pacific nurses in proportion to those communities, requiring that mainstream services develop cultural responsiveness to meet the needs of those marginalised communities. The second is the dependence of the New Zealand health system on overseas nurses, due to having both a highly mobile and an aging nursing workforce. The New Zealand workforce now has one of the highest proportions of overseas-born migrant nurses in the OECD making up 29% of the New Zealand nursing workforce and having a significant outward migration rate (23%) (Zurn & Dumont 2008). Further discussion of nursing and midwifery in maternity is provided in Chapter Four.

## Beyond good intentions: Racism in maternity

Given the growing evidence of health inequalities among the groups outlined earlier in this chapter, an investigation of how migrant maternity is constructed and enacted in the context of health provides an opportunity to examine how clinical encounters reflect broader coagulations of power. To date, the behaviours, dispositions and cultures of migrant mothers have received greater scholarly attention than the institutional and structural contingencies that shape their lives. This can be contrasted with dominant discourses of maternity as a transformative site where women are empowered to take control of their birth experience, through displacing the hegemony of medicine and becoming informed mothers. This emancipatory effect has not been realised for racialised mothers. International evidence shows that racialised mothers are often viewed negatively and receive care from health professionals that ignores or denigrates their cultural needs. Issues at stake include: different conceptions of what constitutes caring; language and communication problems; poor access to appropriate information; barriers to accessing care, cultural competence; tensions between models of care; tensions between professional intervention and family and community involvement (Bowes & Domokos, 1998b; Davies & Bath, 2001; Wikberg & Bondas). Racialised women receive poorer quality care and unequal access through maternity services due to: limited interpreting services; stereotyping and racism from health service staff; and a lack of understanding of cultural differences by staff (Bulman & McCourt, 2002). Such differential care

provision during pregnancy and childbirth leads to differences in birth outcomes (Malin & Gissler, 2009).

Health practitioners construct ethnic users of maternity services negatively and withhold recognition of their needs, seeing cultural needs as belonging to the private sphere, rather than a public health system, providing universal services (Davies & Papadopoulos, 2006). Responses from Western workers to traditional postpartum practices range from "at best insensitivity and at worst derisory" (Barclay & Kent, 1998, p.6). A study of Asian women's experiences of health care by midwives in the United Kingdom found that midwives used stereotypes to pitch their interactions and to make assumptions about appropriate care and service delivery (Bowler, 1993a, 1993b). Midwives saw Asian women as demanding; having a low pain threshold; lacking in a maternal instinct; being difficult to communicate with; and lacking in compliance with preventative care and family planning. They were seen as abusing services by having large families and having unrealistic expectations. Midwives did not similarly acknowledge the positive stereotypes of Asian women such as their abstention from smoking and alcohol. Bowler recommended midwives receive education that challenges racist attitudes and the hegemony of the western medical system (Bowler, 1993a, 1993b). Similarly, Day (1992, p.22) notes that Asian women are typically framed as "oppressed by their role as mothers, suffocated by domesticity and lacking independence" and Bowler's study highlights the incongruous behaviour of health professionals, who held stereotypes of Asian women. That influenced their care delivery even while they saw themselves as sympathetic toward these women.

A number of theories account for the gap between the intent of practices that are thought to be empowering and their actual effects. Institutionalised racism is one such explanation, where health workers see western health practices as superior and come to expect minority women to assimilate to these practices (Marshall, 1992). The use of stereotypes is attributed to the dearth of educational preparation for working interculturally and having minimal social contact with culturally different people. Health visitors with less experience of working with Pakistani women were less likely to speak positively about them (Bowes & Domokos, 1998b). For some nurses and midwives, the development of intercultural expertise comes about through trial and error, but while making mistakes can be a valuable learning experience, it is debatable whether practising on clients is the best way to acquire such knowledge (Bowes & Domokos, 1998b). The ethnocentric and stereotyping behaviour of health professionals has also been called into question by Foss (1996) who accuses the research to date of being 'Eurocentric' and reductionist because of the focus on the mother. Foss argues

that public health nurses base standards of what 'good' parenting is on personal belief, interpretations and stereotypes based on professional experiences with other cultural groups. Grant and Luxford's (2009) Australian study also suggests that migrant parents are subjected to both normative professional discourses of parenting and unexamined personal theories of white western middle-class motherhood dispensed by child health nurses. Foss recommends that nurses avoid judging parenting by the standards of the country of residence and proposes that a new framework be developed to assess 'normal' behaviours and cultural variations in immigrant populations and investigate immigration-related health problems.

## Cultural safety in maternity

Nurses advancing a social justice agenda have suggested that nursing's complicity with oppressive practices is partially attributable to a reliance on poorly theorised and depoliticised frameworks of cultural sensitivity (Browne & Smye, 2002; Culley, 1996). These frameworks promulgate ethnocentric care based on stereotypes; contribute to the creation and maintenance of health disparities; and privilege liberal notions of egalitarianism without addressing systemic and structural issues. This poor theorising is evident in the use of culturalist and racialising discourses, which are mobilised to de-emphasise limitations in liberal commitments to equity and universal access to health care. Culturalist discourses are "the complex practices and ideologies that use popularized, stereotyped representations of culture, often conflated with ethnicity, as the primary analytical lens for understanding presumed differences about various groups of people" (McConaghy, 1997 cited in Browne & Varcoe, 2006, p.158). The political neutralising of a critical anti-racist agenda in care is another effect of culturally sensitive frameworks in nursing (Culley, 2006). The use of de-racialising euphemisms drawing on liberal egalitarian principles reflects a broader societal trend (Lentin, 2008). Euphemisms such as 'culture', 'diversity' and 'ethnicity' have erased politically contentious terms like racism in the construction of racialised subjects, simultaneously editing hierarchy and dominance out of nursing's vocabulary (Culley, 2006). However, what these 'sanitised' discourses haven't removed is the representation of the 'other' as different and undesirable (Saxton, 2006).

The term 'Cultural competence' in nursing originates from the paradigm of Transcultural Nursing developed by Madeleine Leininger. Borrowing from anthropology, the aim was to develop a model that encouraged nurses to study and understand cultures other than their own (Leininger, 1995). The significance

of cultural competence as a concept in New Zealand has grown with the introduction of the Health Practitioners Competence Assurance Act (2003). Cultural competence can be defined as 'the ability of systems to provide care to patients with diverse values, beliefs and behaviours, including tailoring delivery to meet patients' social, cultural and linguistic needs' (Betancourt, et al., 2002, p. v).

In contrast with culturally sensitive and cultural competence approaches, cultural safety represents a pedagogical and practice strategy developed in New Zealand with a specific decolonising agenda. When Britain assumed governance of its new colony in 1840, it signed a treaty with Māori tribes. Te Tiriti O Waitangi /The Treaty of Waitangi is today recognised as New Zealand's founding document and its importance is strongly evident in health care and social policy. As an historical accord between the Crown and Māori, the Treaty defines the relationship between Māori and Pakeha (non-Māori) and forms the basis for biculturalism, which Sullivan (1994) defined as:

- Equal partnership between two groups.
- Māori are acknowledged as tangata whenua ('people of the land').
- The Māori translation of Te Tiriti O Waitangi is acknowledged as the founding document of Aotearoa/New Zealand.
- Biculturalism is concerned with addressing past injustices and re-empowering indigenous people.

Durie (1994) suggests that the contemporary application of the Treaty of Waitangi involves the concepts of biculturalism and cultural safety, which are at the forefront of delivery of health services. This means incorporating "principles of partnership, participation, protection and equity" (Cooney, 1994, p.9) into the care that is delivered. These notions of partnership, protection and participation are explicated in the Royal Commission on Social Policy (1988):

- Maori self-determination and the right to development, autonomy and authority.
- Partnership and the notion of health as a taonga (treasure) that must be protected through ensuring that services are appropriate and acceptable.
- Beliefs and practices are acknowledged and diversity within Maori is noted.
- The rights of Maori to equitable access and participation are prominent leading to equality of outcomes.

The concept of cultural safety was developed by indigenous Māori nurses in response to the poor recruitment and retention of Māori nurses (Nursing Council of New Zealand, 2002). The Nursing Council of New Zealand introduced the concept into nursing and midwifery curricula in 1992 (Nursing Council of New Zealand, 2005; Ramsden, 1997. Hence, there is an expectation that nurses and midwives in New Zealand ensure care is culturally safe (Mental Health Commission, 2001). Simply put, "unsafe practitioners diminish, demean or disempower those of other cultures, whilst safe practitioners recognize, respect and acknowledge the rights of others" (Cooney, 1994, p.6). Cultural safety demands self-reflexivity (unlike the other two approaches), where the gaze is directed at the self, to account for one's own role as a culture bearer rather than displacing culture onto the 'other' as different (Ramsden, 1997, 2000, 2002). Nurses working within such a framework should be active Treaty partners who are able to critically analyse the Treaty and apply its principles. Cultural safety goes beyond learning about such things as the dietary or religious needs of different ethnic groups; it also involves engaging with the socio-political context (DeSouza, 2004; McPherson, Harwood, & McNaughton, 2003).

Cultural safety has been championed in other white settler countries including Canada and Australia (see for example, Anderson, et al., 2003; Grant, Luxford, & Darbyshire, 2006; Racine, 2003; Smye & Browne, 2002). Despite the burgeoning theoretical development of cultural safety, little is known about how well it is operationalised in practice (Johnstone & Kanitsaki, 2005). Or how well cultural safety is put to use with groups other than indigenous Māori (DeSouza, 2004; Giddings, 2005). Cultural safety is described further in Chapter Three as a mechanism for operationalising postcolonial theory in response to liberal and colonial discourses in nursing .

## Reflexively locating the researcher within the cultural field

The commitment to reflexivity—that is, subjecting ones knowledge claims and practices to analysis—in order to open up space for new ways of thinking about practice is also critical in nursing research. The imperative to scrutinise one's own values and beliefs is evident in feminist (and postcolonial) scholarship, where it is acknowledged that knowledge development is shaped by the professional and personal standpoint of researchers, which in turn influences their theoretical inclinations and motivations. Feminist scholars such as Harding (1987) contend that the same rigour with which the researcher applies to the critical analysis of research must also be applied to oneself. Harding argues that

making one's assumptions, beliefs, and behaviours as a researcher open to scrutiny, and acknowledging that they have been shaped by, class, race, culture, and gender makes research more robust and more valid. This acknowledgement of the researcher as a person who has a history and particular interests, contrasts with the fiction of the positivist, neutral and value free researcher (Harding, 1987). In making my own beliefs and practices visible in this thesis and considering how they have shaped my theoretical inclinations and motivations, I contribute to the empirical evidence for the claims that are put forward and paradoxically increase the objectivity and rigour of my research.

My life has been shaped by three versions of colonial capitalism (Portuguese, German and British) and the uneven development that they created with their attendant genres of racism and racial and colonial stratification. Economic under-development in the Portuguese colony of Goa in India led to both sets of my grandparents sojourning to what was then called Tanganyika in the early part of the 20th Century (Tanganyika became Tanzania after forming a union with Zanzibar in 1964). My parents' migration to Kenya in 1966 followed, when the newly independent East African countries of Tanzania (1961), Uganda (1962), and Kenya (1963) moved toward Africanising their economies post-independence and the 1972 expulsion of Asians in Uganda provided the impetus for my parents to migrate to New Zealand in 1975.

My subjectivity as a researcher continues to be shaped by colonialism's continuing effects in the white settler nation of Aotearoa New Zealand. As a subject within an occupation shaped by gendered and racialised imperial hierarchies, my work has aimed to undermine binary colonial discourses such as deficit in the racialised and gendered other. In my nursing practice and research these have taken the form of exposing and critiquing universalist ideas of women and promoting alternative subject positions. My aim in conducting this research is to contribute to creating alternative identities/subjectivities and constituting alternative sites of power and places of political intervention (Gibson-Graham, 1994). These aims have developed in the context of my own experience of migrancy as outlined above and my active involvement in migrant and refugee advocacy through various community and governance roles. My theoretical and political motivations have also been shaped by my professional experience of maternity as a nurse working in maternal mental health. One of the motivations for the intellectual and methodological choices of this PhD project then was to more deeply enquire and deconstruct the limitations of the liberal-humanist understandings of maternity and migration that I had inherited in my nursing and societal education and experience, and instead more broadly scrutinise the

discursive frameworks shaping migrant maternity. As Harding (1987, p.8) has noted, "The questions an oppressed group wants answered are rarely requests for so-called pure truth. Instead, they are questions about how to change its conditions; how its world is shaped by forces beyond it; how to win over, defeat or neutralize those forces arrayed against its emancipation, growth, or development; and so forth."

I have an "affective engagement" (Ginsburg, 1995, p.12) with this work that goes beyond the textual. My research reflects an investment in the social world that I share with the women who have experienced the health system as outsiders (to the dominant culture, to the professional culture of health professionals) and to the midwives and nurses that constitute my professional community. I advance a critical anti-racist agenda with an emphasis on decolonisation in nursing (and midwifery). My desire is to problematise universal maternity, which I contend has represented the concerns of largely white, middle class birthing mothers as paradigmatic of all mothers. My concern is that the unconscious 'reproduction' of the values and norms of 'women' can be oppressive for women from differently raced and classed positions.

This approach can be accused of "conceptual over-determinism" (Lather, 1986, p.64) (and I address these concerns about the trustworthiness of the data, in greater depth when I discuss rigour in Chapter Five), but my desire through the act of research and of writing is to create alternative subjectivities and locales for intervention and move toward the unknown by putting at risk, the 'taken for granted'. As Foucault articulates:

> If I had to write a book to communicate what I have already thought, I'd never have the courage to begin it. I write precisely because I don't know yet what to think about a subject that attracts my interest. In so doing, the book transforms me, changes what I think. As a consequence, each new work profoundly... changes the terms of thinking which I had reached with the previous work. In this sense I consider myself more an experimenter than a theorist; I don't develop deductive systems to apply uniformly in different fields of research. When I write, I do it above all to change myself and not to think that same thing as before (Foucault, 1991, p26-7).

Thus for me, the processes of research and writing put "at risk" what is taken for granted (Haraway, 1997, p.39).

## Aims and approach

This study is located within a poststructural perspective influenced by feminist, and postcolonial scholars and the work of French theorist Michel Foucault. This methodology foregrounds the global and historical contexts of colonisation, migration and maternity and examines how these systems manifest conceptually, theoretically, materially and locally. New Zealand, like other settler capitalist societies, was formed through systems of colonisation and repopulation based on a colonial past, "an imperialist present, and a convoluted liberal democracy" (Bannerji, 2000, p.10). The selected methodologies historicise and politicise knowledge to call attention to the different versions and repetitions of colonial tactics evident in the present, so that colonial dynamics and hierarchies can be transformed (Seuffert, 2006).

Moving away from embodied difference as a given, toward analysing its production is a key characteristic of postcolonial and cultural safety frameworks. These frameworks critique the exclusionary systems and politics that lead to the unreflexive reproduction of the values and ideologies of citizens who are constructed as discursively white (Anderson & Taylor, 2005). Such philosophical perspectives go beyond framing migrant mothers as victims of their culture, and problematise taken-for-granted knowledges and interrogate the codependence of apparent oppositions such as victimised mother and heroic nurse.

Consequently, this thesis examines and analyses discourses of migrant maternities in the health sector, with a view to identifying the limitations in the language and knowledge of migrant maternities within nursing and midwifery and opening up alternative narratives, knowledges, and practices. The goal of this thesis is not to criticise the efforts of individual nurses and midwives who work to enhance the well-being of mothers and infants in complex, constraining and challenging instititutional contexts. As Foucault (1988, p.154–155) contends, the point of a critique is "not a matter of saying that things are not right as they are. It is a matter of pointing out on what kinds of assumptions, what kinds of familiar, unchallenged, unconsidered modes of thought the practices we accept rest." These critical discourses are not about assessing how racist particular individuals are, but instead examining the discursive practices that are common to a community of professionals. As Ringrose (2007a) contends, racism is not only psychic, it is structural, systemic and cultural, representing a phenomenon that is both omnipresent and repressed in health care services and broader society. Consequently, marking out some nurses and midwives as "receptacles of racism" and others as not being racist "works to individualise racism and disavows the

difficulty of political engagement for all subjects implicated in social processes of racism operative throughout the institutionalized structures, cultural domains and psychical spaces of much of Western culture" (Ringrose, 2007a, p.335). An individualised approach neglects the analysis of subjectivity, power and agency and has limited value in developing an ethical practice of assessing co-implication in injustice (Ringrose, 2007a).

## Scope of study

This study adds to the literature on the international discourses that contribute to the construction of migrant maternities as articulated by maternity healthcare providers and migrant mothers in a New Zealand context. Post-structural and postcolonial theories are used as a theoretical lens through which to analyse literature and a small set of empirical data. This empirical data consists of data from three focus groups of participants, comprising Plunket nurses, Korean mothers and 'White' mothers. The latter two groups were part of a Families Commission study (DeSouza, 2006).

In that primary study, five focus groups were held to interview new mothers from five main ethno-cultural/religious groups reflecting the demographic distribution of migrants to New Zealand: Chinese, Indian, Korean, Arab Muslim and 'White' mothers.

The term 'White' was used as a generic majority category subsuming white, western, Anglo-Celtic migrants from Australia, the United States, the United Kingdom and South Africa in preference to using the terms Pākehā, White New Zealanders or European. In using the term white, I was not presuming that they identified as White, or that they were homogenous (Saxton, 2006). I use the term 'White' as a signifier not only to refer to skin colour but with reference to the structure through which white cultural dominance is naturalised, reproduced and maintained (Frankenberg, 1993). The participants participate in the racialised societal structure that positions them as 'White' and grants them the privileges associated with dominant (Pākehā) White culture (Kowal, 2008).

The groups represented a range of migration and settlement experiences (for example Chinese and Indians have been coming to New Zealand since the 1840s while Koreans are a much newer migrant group) and different experiences of marginalisation. The mothers were recruited with the assistance of Plunket services in Auckland. Mothers who were migrants who had given birth to healthy babies within the previous twelve months were included. The focus group

interviews were conducted in 2006. One semi-structured focus group was conducted with each group, in the appropriate first language. The primary analysis, whilst providing important findings, did not allow for a critical analysis of the differences between groups (which showed that Korean migrant mothers in the study were deeply unhappy about their experiences of maternity care in New Zealand in contrast with White mothers who were very happy) and in particular why their views diverged so profoundly. Hence my decision to carry out a secondary analysis on texts from the two focus groups that exhibited the greatest degree of satisfaction (White) and greatest dissatisfaction with their maternity experiences (Korean).

Overall, this thesis is concerned with the question of how migrant maternity can be decolonised. It specifically examines and analyses four key questions. Firstly, what are the range of discourses that are utilised to constitute migrant maternities? Secondly, what is the intellectual history of dominant discourses of migrant maternity? Thirdly, what are the impacts of these discursive constructions in health care service provision? Fourthly, are there alternative discourses, knowledges, and practices that could better serve migrant mothers and their families and health professionals working in maternity?

## Organisation of the thesis

As a research topic, migrant maternity provides a feminist contribution to relationships between women in maternity; and can extend existing scholarship through a focus on the theoretical frames by which maternity is understood and in foregrounding the role of maternity in systems of domination and in the production and surveillance of identities. Research from clinical practice reveals oppressive practices exist where the goals of maternity service providers to provide an emancipatory and transformative experience for migrant mothers have not been realised. However, rather than focussing on migrant mothers as objects of study, this thesis attempts to turn the gaze toward the structural and institutional forces that shape maternal subjectivities. Consequently, the historical and political approaches to knowledge are emphasised, the production of difference (rather than difference itself) is the focus of the enquiry, and the discourses available for making sense of migrant maternities are critiqued.

The central argument in this thesis is that liberal and colonial discourses are embedded in professional frameworks of care that shape migrant maternity in ways that result in differential outcomes for migrant mothers. In the chapters that follow, I trace the struggles over the meaning of maternity within several

intellectual discursive formations-feminism, nursing and nationalism in order to situate maternity as an axis which organises knowledge production and resultant systems of social classification and domination (Weinbaum, 1998).

**Chapter Two: Researching Migrant Maternity as discourse: Theoretical framework**

In chapter two, I use Foucault's formulations of power, subjectivity and discourse to contend that nursing research methodologies and agendas have been shaped by modernist science. These have led to the epistemological privileging of the individual, the reproduction of hegemony and the suppression of critique. In their place, I propose that postmodern intellectual platforms can enable nursing to develop socially just practices by exposing how power is put to work. Further, postcolonial approaches offer a critique of the cultural hegemony of European knowledges and allow consideration of the epistemological value of subjugated knowledges. Discourse analysis is activated as a mechanism for analysing the power that resides in discourse, and I consider the ways in which nurses are engaged in power techniques and social regulation using Foucault's conceptualisation of modes of power.

**Chapter Three: Liberalism, neoliberalism and the colonial health system**

In chapter three, I locate the systems of knowledge available for working with diversity in nursing and health. Examining the centrality of liberalism and its rearticulation in the contemporary neoliberal mode of governing within the health system, I suggest that nurses and midwives have a role in the production and reproduction of neoliberal subjects. I argue that liberalism is implicated in the normalising of exclusion, and these dynamics are visible in nursing education, research and practice where whiteness remains a central organising principle despite a growing proliferation of multicultural models. I then briefly outline the historical processes of colonialism and imperialism, which enabled the development of a public health system within liberal capitalism. I point out the ways in which nursing has colluded with colonial development, and build on the work of other nursing scholars who have advanced postcolonial feminist theory as a strategy for disentangling modern liberal discourses and Western ethnocentrism. I suggest that cultural safety is a useful mechanism for operationalising the postcolonial critique in a health context, particularly through addressing the liberal and colonial impacts of health that is racialisation and culturalisation.

**Chapter Four: The Governing of Maternity**

In chapter four, I show how maternity has been a locus for the production of docile disciplined bodies through industrial, scientific and maternalist discourses originating in the Enlightenment. These discourses became imbricated in modern ideas about maternity through associated ideologies of race and nation as part of a state project to assure labour power for capitalist enterprise and the reinforcement of imperial power. The focus on improving mothers and maternity represented new forms of control in metropolitan and colonial sites where maternity was modernised and rationalised, in the name of 'population'. Interventions beyond the reduction of mortality expanded to the governing of life and the disciplining and surveillance of the pregnant body, new mother and child as neoliberal maternal subject.

**Chapter Five: Adoption and production of discourses: Empirical methods**

In chapter five, I describe how I test the figure of the migrant mother established in the theoretical section of this thesis among three groups of women who are positioned in different relations to that figure. Discourse analysis shows how these groups in a local context elaborate the practices and discursive systems of the colonial liberal health system. Framed by the intellectual agenda of poststructuralist theory, the chapter justifies the value of a secondary analysis of data from two focus groups with migrant mothers, supplemented by data from a focus group with Plunket Nurses. The chapter begins with a description of the data collection and data analysis processes for the empirical part of the study. I account for the ethics and rigour of processes used to collect and analyse data, including the recruitment of participants, the focus group interview process with mothers and Plunket nurses and the stages of data analysis.

**Chapter Six: White mothers and neoliberal empowerment**

In this first of three findings chapters, I focus on the ways in which white middle class migrant women take up subject positions as informed choosing consumers. The experience of birth as transformative, articulating choice and empowerment highlight how the neoliberal requirement for autonomy and adaptability orientates their actions towards the achievement of natural childbirth within a moral discourse of good mothering. Self regulation is emphasised, where intentional actions are viewed as being required to achieve natural birth. In the antenatal period this takes the form of consuming expert knowledge and behaviour modification. In labour this regulation of the self is orientated toward allowing their bodies to perform birth without obstetric intervention. However, in the postpartum period, the neoliberal charge of self-sufficiency results in a gap

between the acquisition of knowledge and empowerment. Women become constrained by the very ideals of autonomy and adaptability as they struggle with isolation in the transition to motherhood.

**Chapter Seven: Cultural and culturalist discourses: Korean mothers and New Zealand childbirth**

In chapter seven, I show how the group of Korean mothers' identities are constructed through locating themselves in biomedical discourses, and in resisting midwifery discourses. They deploy discourses of risk that are located in both biomedicine and in cultural views to frame childbirth as hazardous. In performing the maternal body as a body at risk (Mahjouri, 2008) they engage in technologies of surveillance and actively take part in the disciplinary practices of biopower, internalising dominant biomedical discourses and medicalising their own pregnancies. Through their incorporation into strategies of biomedical self-management, (imbued with neoliberal notions of responsibility, self-control, and self-determination) they perceive themselves as having greater personal power and decision making. The midwifery/natural birth imperative to be independent and autonomous is experienced as coercive for these Korean mothers who experience the body as vulnerable and requiring of rest and care. The Korean mothers also resist being positioned solely as objects of their babies' needs, claiming an identity as women with a new special status and needs of their own.

**Chapter Eight: The maternal health professional as normalising agent**

In Chapter Eight, I show how the mother and new baby are brought into a coercive and persuasive project of maternal improvement through surveillance by Plunket Nurses. These relations attempt not only to improve mothering, but also to change maternal and familial relationships, so that mothers inculcate discipline and do not disperse their affections in ways that might 'spoil' these babies (Ram & Jolly, 1998). These forms of rational mothercraft construct migrant maternity as deficient or irrational. Migrant mothers thus constitute a threat to the notion of the autonomous and self-determining maternal subject. Plunket nurses articulate a gap in their capacity to provide care and services to ethnic migrant mothers. The barriers to providing care and support represented by the gap are externalised, referring to language and communication barriers and to the presence of extended family in the form of maternal authority figures and involved fathers. These differences construct the figure of the migrant mother as interdependent and unable to be self-actualised or 'free'. The gap allows the Plunket nurse a fixed repertoire of subject positions, such as the benevolent benefactress, which

enhances the performance of goodness that is fundamental to feminine/liberal/nursing subjectivity and is influenced by Christianity and liberalism. Normalising techniques are implemented by the Plunket nurses to assist the migrant mother to more clearly conform to the ideal of a liberal Western maternal subject.

**Chapter Nine: Decolonising maternity**

In chapter Nine, I argue that contemporary maternity health services in New Zealand privilege certain practices and subjectivities through liberal feminist discourses that replicate the colonising impacts of the patriarchal colonial health system even as they critique it. These services are designed around the figure of the hyper-responsible maternal self as an ideal neoliberal subject. Within a liberal feminist frame, good mothering is constructed within norms such as being informed, having a partner who is actively involved in the pregnancy and birth, choosing to labour naturally and engaging in motherhood intensively, that is within normative modes of middle class Pākehā behaviour. I contend that the figure of the racialised mother constitutes a threat to the liberal and neoliberal projects of self regulation and improvement and in response to her differences and those presented by her family, nurses and midwives use disciplinary and normalising techniques to enculturate her into the liberal feminist discourses of the New Zealand maternity system which in turn reinforce the centrality of a white world view. I conclude the chapter with recommendations for my discipline of nursing by suggesting that the study of migrant maternity provides an opportunity for the further extension and theorisation of cultural safety, which provides important resources for socially just, equity-promoting practice.

# Chapter Two: Researching Migrant Maternity as discourse: Theoretical framework

Maternity is central to the reproduction of society; therefore it is unsurprising that systems of scrutiny and regulation have been imposed on mothers, especially those identified as 'other' (Cain, 2009). In turn, a good (maternal) citizen has been constituted as someone who is governable, conforms to dominant professional or scientific knowledges and pursues good health (Petersen & Lupton, 1996). Therefore, maternity discourses and practices have been central to the transmission of historical and cultural visions about being a citizen (Petersen & Lupton, 1996). However, the insertion of the racialised or 'ethnic' mother into dominant maternity discourses has typically not problematised dominant discourses and practices, but the mothers themselves, showing that natality does not secure belonging. Michel Foucault's (1980) concern with how knowledge is put to work through discursive practices in institutions serving to regulate people's conduct provides a useful analytical framework for the study of maternity. Both his concept of discourses as producing knowledge that act with powerful effects on bodies, and his notion that phenomena and actions exist but only take on meaning and become objects of knowledge within discourse (Hall, 2001), are central to this thesis.

The purpose of this chapter is to outline the theoretical framework adopted in this study. I begin by describing the opportunities that postmodern methodologies offer nursing as an intellectual movement and a mechanism for developing transformative socially just practice through these methodologies' emphasis on context and exposing power relations. I then consider the contributions of postcolonial scholarship to discourse analysis. To introduce key concepts to this thesis such as discourse, subjectivity and power, I turn to the work of Michel Foucault, who was a French philosopher best known for his critical studies of health and social institutions, particularly psychiatry, medicine, prisons, human sciences and human sexuality. His intellectual oeuvre challenged liberal assumptions from the Enlightenment period, and his theorising of power, knowledge, and discourse has dominated poststructural and postmodern theories of health. His insights include the centrality of discourse in the relationship between power and knowledge, the discursive construction of the self versus an essential self; and breaking and decentring the humanist conception of subjectivity (Fox, 1997). I conclude by bringing the diverse components of the research together by highlighting the concepts and analytical tools that were used

to conduct the study.

## Postmodernism and knowledge

Nursing knowledge has been heavily shaped by the modernist quest for improvement through science and rationality, such as the privileging of objective science as a source of 'truth' and knowledge: viewing human existence as a linear and progressive process; viewing reason as the universal foundation for knowledge; the capacity for reason as fundamental and the basis of people's rights as citizens (Neville, 2005). Furthermore, a central tenet of much nursing research and knowledge development rests on the notion that populations and people can be known. This form of knowing can be traced to Enlightenment ideas of the autonomous rational individual and individual consciousness that have converged through "philosophical, economic, political, theological, scientific and literary discourses" (Crowe, 1998, p.340). Crowe adds that the universal subject of the Enlightenment had a discrete, atomistic core, with discrete, stable and impermeable boundaries separated from the outside world. This separation permitted speaking with some conviction about the nature of society and enabled the separation of body and mind. The capacity to reason established individual consciousness as both the centre and origin of meaning of the world, which could only then be shared with others (Crowe, 1998).

It is assumed in modernist research epistemology that individuals have direct knowledge of their minds. Allen & Cloyes (2005) note that access to this private mind is obtained when a participant talks to us as we are conducting research. The speech that research subjects create is then assumed to be a direct reflection of their 'internal' world. Allen and Cloyes illustrate how these assumptions are reflected in processes such as member checking which are put in place to assess whether the researcher got 'it' right, but there is no equivalent process for checking whether the participant got 'it' right. Other assumptions of modernist research are: the positioning of the author or researcher as a unitary rational subject in order to be credible (Ogle & Glass, 2006) and the reduction of rich interviews into themes decontextualising language from the historical and social —as seen in interpretive nursing research (Allen & Cloyes, 2005).

A key assumption of many qualitative research approaches popular in nursing is the idea that 'reality' can be captured through talking to a person (subjectivity), which can then be represented by the researcher through language (linguistic representation) (Crowe, 1998). However, such approaches leave un-critiqued the socially constructed nature of experience that in turn reproduces

hegemony (Scott, 1991). Therefore I seek to collapse the determinism/voluntarism binary. Rather than a bottom up approach of valuing only the participants' words, or a top down approach where I impose my analysis. I instead acknowledge that individuals have access to certain discourses depending on their social positioning and are subject to power, subjectification and ideology, but also have a degree of agency, choice and potential for resistance (Peace, 2003).

Postmodernism refers to a set of wide ranging changes and transformations that have impacted on both the political sphere and social and cultural theory (Weedon, 1999). A full thesis could be devoted to its description, but key elements include the development of multinational global capitalism; transformations in archivisation and distribution of knowledge; and the rise in alternative social movements that have raised the profile of hitherto marginalised voices. Aligned with these shifts has been the development of new technologies; the relativisation of truth claims; scepticism about universalising theories or metanarratives (theories that attempt to explain the world within a totalising framework such as liberal humanism); and the fragmentation of liberal humanism's unified subject (Watson, 2000). Although the word 'post' in postmodernism appears to refer to a period of time after modernism, modernism is not considered a relic of the past, but a set of assumptions under critique.

Theories of postmodernism have influenced the development of revolutionary forms of knowledge generated by social movements such as feminism, postcolonial, pacifist and gay liberation movements. A key subset of theories aligned to the postmodern is poststructuralism. Structuralism is a philosophical term that has emerged from anthropology and linguistics and is associated with the work of Claude Lévi-Strauss, where "the significance of an item (word, role, practice, belief) is not so much in the particular item but in its relationship to others. In other words, the 'structure' of multiple items and the location of any one in relation to others is most important" (Eller, 2009, p.68). Poststructuralism is a mode of analysis based on structuralism but takes in to account the uneven formation of subjectivity and the impossibility of seeing an entire structure.

The focus of poststructural theories is subjectivity, language, the body, discourse, power and the unconscious (Weedon, 1999). Importantly, they emphasise "the ways in which language, knowledge and power interact to construct and reproduce our way of experiencing ourselves, our bodies and the social and material worlds" (Petersen & Lupton, 1996, p.x). Although

poststructuralism can refer to a range of theoretical traditions, they share the structuralist view that language structures reality and produces truths and power relations, and also that the processes of subject formation result in unpredictable relations to those structures.

Poststructuralist epistemologies or theories of knowledge can provide a way of understanding "how experience is brought into being and has effects in specific social and interactional contexts" (Gunaratnam, 2003, p.6). A key premise of post structural thought is that words do not externally reflect internal meaning but are socially constructed. In the sense that words are a part of a pre-determined system for allocating meaning among a group of people that in turn reflects expressions of group convention and reproduces identities in terms of hierarchies: words are cultural not natural (Crowe, 1998). In such a system, certain vocabularies are deployed which maintain particular values, politics and ways of life (Crowe, 1998). In their repetition, social orders and hierarchies are reproduced. Therefore, social organisation does not occur through external structures operating on people, but structure is an effect of the taking up and reproduction of practices (Allen & Hardin, 2001). People are formed through taking up and enacting practices (Allen & Hardin, 2001). So for example, I am recruited into taking up certain discourses about being a Goan, rather than being innately Goan.

Poststructural accounts see the individual as constituted by multiple subjectivities or subject positions, emphasising the importance of language to the construction of subjectivity. Thus, subjectivity is an effect of discourse rather than an unchanging and objective entity. Foucault's work suggests that the subject is constantly created and recreated through discourse and that the self is a culmination of social and cultural processes. If discourses "make available certain ways-of-seeing the world and certain ways-of-being in the world" (Willig, 2003, p.171), then it follows that the presentation of the self depends on which discourses are accessible or dominant. While subjects might produce individual texts they can only do so within the boundaries of a particular regime of truth. Historicising experience allows for the production of identities to be analysed, through the visibility of the assignment of subject positions through discursive processes (Scott, 1992).

Language and discourse are not just about meaning but also about the production of knowledge through discourse and relations of power (Hall, 1997). Language and discourse bring into being and normalise particular versions of the world and relations of power between social institutions and actors. Regimes of institutionally produced and sanctioned truths are used to govern populations and

produce tact and discretion in us about what can be talked about and how. Each profession or field of knowledge develops officially sanctioned truths that govern ways of acting and thinking. People working within those fields govern and discipline themselves through those truths, and work to perform those subject positions correctly (MacNaughton, 2005). Thus, the idea of subject positions connects the concepts of discourse and subjectivity; whereby persons are produced by institutions but simultaneously retain the capacity to reposition themselves within discursive possibilities (Allen & Cloyes, 2005).

The concept of a discursive formation is a useful mechanism for understanding the links between language, power, social institutions and subjectivity. Weedon (1997) defines a discursive formation as sets of social processes organised through particular institutions and their respective practices. Maternity as a discursive formation contains multiple discourses that compete for dominance and to provide meaning. Subsequently, people are not free in the liberal sense to pick and choose from a range of discourses and subject positions; they can only operate within available discourses. These discourses help us make sense of the world and eventually become internalised, hence rather than constituting some kind of private and 'personal' experience within an individual (a phenomenological view), they are guides we inherit as a product of discursive systems (Allen & Cloyes, 2005).

Accordingly, nurses and midwives have in common discursive practices that determine the scope and values of nursing and midwifery. Therefore, individuals are not "intentional agents of their own words, creatively and privately converting thoughts to sounds or inscriptions" (Crowe, 1998, p.339). The focus of this thesis is the interpretation of the discourses that contribute to the construction of migrant maternities as articulated by maternity practitioners and migrant mothers. This study of migrant maternities is located within a poststructural paradigm, and is concerned with how knowledge is put to work through the discursive practices of health professionals to regulate the conduct of migrant mothers, with an aim to move beyond the narrow and negative constructions of migrant maternities that were highlighted in the introductory chapter. Accordingly, the mode of discourse analysis is valuable for understanding how the raced and gendered subject that is the migrant mother in the health system is formed.

## Postcolonial scholarship

Postcolonial scholars have challenged and critiqued the epistemic structures

originating from the Anglo-European academy, which have been enabled by imperial and national modernities (Shome & Hegde, 2002). In this section I discuss the relationship between knowledge and power in a colonial context. In the next chapter I enter into a more thorough discussion of colonisation and postcoloniality, particularly with reference to the health system and nursing.

Knowledge and power were key tools used in imperial conquest (Ashcroft, Griffiths, & Tiffin, 2006). Knowing other peoples was fundamental to solidifying imperial economic and political control, and it was also the mechanism by which others were compelled to know themselves as subordinate to Europe. The colonial mode of knowledge had two parts; the first was the export to the colonies of European language, literature and learning, whereby colonised cultures were viewed as child-like. The aim of the civilising mission was to assist them to become more mature; therefore colonisation was an educational and developmental project (Gandhi, 1998). Secondly, securing the dominance of colonial knowledges involved the suppression of indigenous cultures (Ashcroft, et al., 2006). The knowing that occurred in the processes of colonisation resulted in appropriation, rejection and the withholding of self-determination, as Smith articulates:

> It appalls us that the West can desire, extract and claim ownership of our ways of knowing, our imagery, the things we create and produce, and then simultaneously reject the people who created and developed those ideas and seek to deny them further opportunities to be creators of their own culture and own nations (Smith, 1999, p.1).

Postcolonial theory has demanded the recognition of how history, geography, geopolitics, and capital converge and are performed through institutionalised knowledge (Shome & Hegde, 2002). Challenges to these knowledge structures take multiple forms but include the inclusion of alternative histories of knowledge that have been hitherto subjugated, that is "a whole set of knowledges that have been disqualified as inadequate to their task or insufficiently elaborated: naïve knowledges, located low down on the hierarchy, beneath the required level of cognition or scientificity" (Foucault, 1980, p.82). The Anglo-European academy's poststructuralist and postmodern discourses have been challenged by postcolonial scholars who problematised the historicising of the human subject as being of imperial Europe, by asking what international histories might have produced the subject (Shome & Hegde, 2002). Foucault articulated that institutionalised epistemes in the West were performed; and the

sovereign rational subject of Enlightenment was constituted, through the lens of the subjugated knowledges of madness, prisons and (homo) sexuality. However, Spivak (1994) questioned whether subjugated knowledges were implicated in a larger history of imperialism and whether assigning a normative stance to these knowledges as 'subjugated' further centralised the subject of Europe. Shome and Hegde note that these European displacements of modernity further marginalised forms of knowledge that were already so "violated by the machinery of imperialism that they cannot even be accessed, let alone subjugated"(Shome & Hegde, 2002, p.252).

An important intervention of the feminist movement has been to advocate for equal access to both the means of knowledge and the production of knowledge (Gandhi, 1998). This furnished recognition of the link between disempowerment and exclusion from typically male-dominated spaces of knowledge production and dissemination (Gandhi, 1998). Consequently, feminist goals have enabled women to become active producers of knowledge rather than passive objects of knowledge. However, the claims to simplistic equality were complicated by postmodern and poststructuralist feminists in the late 1970s and 1980s, who noted that the modern subject was male and of the bourgeoisie. Postcolonial feminist scholars including Chandra Mohanty (1991), Trinh Minh-ha (1989), and Gayatri Spivak (1984–85, 1988, 1993; Spivak & Harasym, 1990) have located postmodern and poststructuralist feminist theorising in the context of colonial modernity, and demanded that race, nation, and imperialism be recognised in postmodern and poststructuralist feminist scholarship. This critique of the cultural hegemony of European knowledges in order to advance the epistemological value of non-European knowledges (Gandhi, 1998) goes beyond epistemological reassertion of such knowledges, instead advocating a political agenda to enable democracy for all (Bhabha, 1994). Postcolonial perspectives "intervene in those ideological discourses of modernity that attempt to give a hegemonic 'normality' to the uneven development and the differential, often disadvantaged, histories of nations, races, communities, peoples" (Bhabha, 1994, p.171).

In the next chapter, I propose a feminist theoretical strategy in a postcolonial mode so that the intersecting effects of race, ethnicity and gender can be acknowledged. To conclude this section on knowledge and postmodernism I outline discourse analysis as a method that has led to the development of colonial discourse analysis.

## Discourse analysis

> If saying is a form of doing, and part of what is getting done is the self, then conversation is a mode of doing something together and becoming otherwise; something will be accomplished in the course of this exchange, but no one will know what or who is being made until it is done (Butler, 2004, p.173).

Discourse analysis comprises a range of qualitative, language-oriented approaches focussed on the analysis of talk, text and other signifying practices (Malson, 1998). It is particularly concerned with knowledge/power interactions and the social, historical and political contexts in which texts occur (Quested & Rudge, 2003, p.555). Discourse analysis is being increasingly used in nursing and midwifery research (Campbell & Arnold, 2004; Cheek, 2004; Crowe, 2000a, 2000b, 2002, 2005; Payne, 2001), providing a counter to popular qualitative approaches in nursing such as grounded theory and phenomenology, which propose a 'reality' from individual lived experiences that can be directly represented in language (Crowe, 2005; Nixon & Power, 2007). Buus (2005) contends that there is some conceptual blurriness in the ways nurses have used discourse analysis to account for a wide range of approaches to analysing meaning and language (Buus, 2005).

Discourse analysis can help to deconstruct how subjects are constituted through discourses and in analysing speech (data from focus groups), which is converted into text. My goal is not to view the text as a reflection of 'true' experience (Scott, 1991) but of the discourses to which speakers have access in the context of their socio-cultural worlds (Gavey, 1989). Although discourses often appear coherent, solid and stable, "discourse analysis aims to deconstruct the relations, conditions and mechanisms of power and identify the production, practices and conditions through which discourses emerge" (Green & Sonn, 2006, pp., p.383). Texts produce particular versions of the social world depending on the context where they are produced with particular impacts; consequently the ways in which these versions are produced and the purposes these serve is of analytic interest (Redwood, 1999).

Foucault historicises discourse, representation, knowledge and truth, locating language and other signifying practices within specific historical contexts involving social structure and its reproduction. This analysis allows the language of personal narratives to be linked with the historical and social contexts from

which they are derived (Allen & Hardin, 2001). Chambers (1990) notes in the reading of texts that a space is created for "oppositional resilience" (cited in Tiffin & Lawson, 1994). Therefore, opening up texts to a range of readings allows power relations and multiple and competing discourses of maternity to be identified. Textual control can be fought with textuality (Tiffin & Lawson, 1994).

Migrant mothers and health professionals employ and define migrant maternities in different ways, which have varying consequences for migrant mothers and health professionals. However, health professionals may use classification processes that reproduce structural relationships between clinician and patient, which points to particular power relations embedded in the social instititutional structures of health. A number of subject conditions follow from this intersection which affect the discursive formation of migrant motherhood; including gender; the pregnant body; and the medicalised or midwifery management of women and as mothers in maintaining the wellbeing of their infants-which is the primary focus of the Plunket Nurses.

### Colonial discourse analysis

> I'm a storyteller. And I would like to tell you a few personal stories about what I like to call "the danger of the single story .. I was an early reader. And what I read were British and American children's books. I was also an early writer. And when I began to write, at about the age of seven, stories in pencil with crayon illustrations that my poor mother was obligated to read, I wrote exactly the kinds of stories I was reading. All my characters were white and blue-eyed. They played in the snow. They ate apples. And they talked a lot about the weather, how lovely it was that the sun had come out. Now, this despite the fact that I lived in Nigeria. I had never been outside Nigeria. We didn't have snow. We ate mangoes. And we never talked about the weather, because there was no need to (Adichie, 2009).

As Adichie suggests, texts not only entertain but they instruct about the hierarchies of the world. For the non-idealised subject, reading such texts in the colonies leads to the internalising of one's own subjection and achieves the "true work" of colonial textuality (Tiffin & Lawson, 1994, p. 4). So while imperial relations might have begun through violence, trickery and disease, these relations were maintained through discourses in writings such as records, letters, documents, fiction and scientific literature (Loomba, 1998).

Postcolonial critique and colonial discourse analysis are two types of intellectual work that attempt to undo colonial discursive hegemony. Colonial discourse analysis is an approach to the 'postcolonial condition', which refers to the structural origins of historical documents, the Foucauldian social formations that generate attitudes and 'fantasies' about the Other. Postcolonial discourses, however, refer to a range of written responses to colonialism (Castle, 2001). These will be discussed in fuller detail in the next chapter.

Postcolonial critique has two archives: the first refers to writing originating from places where subjectivities have been formed by European colonialism and the second, "is a set of discursive practices" that involves resistance to colonialism and its ideologies and their "contemporary forms and subjectificatory legacies" (Barker, Hulme, & Iversen, 1994, p.5). Foucault's work on the discursive construction of regimes of power has contributed to the linkages between anthropological knowledge, colonial authority and the disciplinary regimes that have produced subjugated bodies (Stoler, 1995). Discourse analysis makes it possible to see "how power operates through language, literature, culture and the institutions which regulate our daily lives" (Loomba, 1998, p.45) and in how turn how resistance can take place:

> The postcolonial is especially and pressingly concerned with the power that resides in discourse and textuality; its resistance, then quite appropriately takes place in -and from-the domain of textuality, in (among other things) motivated acts of reading. The contestation of postcolonialism is a contest of representation (Tiffin & Lawson, 1994, p.10).

One of the first texts of colonial discourse analysis was the work Orientalism by Edward Said (1978), who established a Foucauldian reading of British and French scholarly writing about the Orient in the 18th and 19th Centuries and named the discourse Orientalism. Said showed how colonial relations were interwoven with, and constituted, a colonial discourse that could be analysed textually (Slemon, 2001). Said expanded the narrow view of colonial authority to highlight how a discourse about the Orient was produced, creating structures of thinking that manifested in various written works (Loomba, 1998). In a related way, Chandra Mohanty's work has highlighted the predominance of colonial discourses in white feminists' constructions of the 'Third World woman' as 'other' (Mohanty, Russo, & Torres, 1991). Colonialism is an "operation of discourse, and as an operation of discourse it interpellates colonial subjects by incorporating them in a system of representation. They are always already written

by that system of representation" (Tiffin & Lawson, 1994, p.3). Consequently discourse analysis involves "examining the social and historical conditions within which specific representations are generated" (p.97). Hence, any study of colonial discourse "ought to lead us towards a fuller understanding of colonial institutions rather than direct us away from them" (Loomba, 1998, p.97).

## Genealogy

Within the context of post-structural methodologies outlined above, Michel Foucault has been the most significant practitioner of historical-conceptual institutionalist analysis. Genealogy is a methodological device that pays attention to how certain versions of reality, or dominant paradigms of thought have been produced, and attempts to disrupt them by highlighting contradictions and tensions (Rimke, 2010). The genealogical process of understanding intellectual history is recognised as a partial, socially situated and contingent endeavour (Foucault, 1977b). Historicising and politicising the operations of power and knowledge that are present, through their many, changing, contradictory, and diverse manifestations makes new ways of thinking and understanding possible. Epistemologically, a genealogical approach aligns with the rubric of postcolonial feminist approaches which are concerned with critiquing hegemonic European knowledges and allowing consideration of the epistemological value of marginalised or silenced histories and knowledges to be made visible and critiqued.

Maternity, by virtue of being a site of scrutiny and regulation, is suffused with diverse historically and politically constructed knowledges and practices (examples of which are outlined in Chapter Four). By contextualising the dominant paradigms of thought/problematics in maternity through a genealogical process, the discourses and institutions that produce the maternal subject can be outlined to allow the historical production and application of analytic categories necessary to the life of the discourse(s) under investigation to be opened up (Rimke, 2010). Foucault's concept of archaeology, while closely related to genealogy, refers to the process of how expert texts produce and order meaning. In contrast, genealogy is specifically concerned with how texts are ordered and inscribe the body.

Therefore, subjecting maternity to a genealogical analysis enables the relationship between the maternal body, discourses, and power to be explored, so that the ways in which contemporary definitions of maternity have been historically constructed in order to meet particular purposes can be ascertained

and in turn create space for other constructions (Galvin, 2002). Thus the genealogy in Chapter Four exposes how maternal and racialised maternal bodies have been imprinted and impacted by history. Using this methodological manouevre in constructing the history of maternity can lead to new linkages and the redefinition of boundaries of inquiry which can then be carefully used to deconstruct maternity discourses and practices in the form of the analysis of data from an empirical study. This genealogy of the ideal maternal subject—the active/choosing/informed maternal subject informs the data analysis in Chapters Six, Seven and Eight. In this way the modes of thought and associated practices that have become taken for granted and are presumed to be liberatory for all mothers (for example, the individualising of motherhood and the family as nursery) can be more critically viewed as servicing particular political, social and economic interests that unevenly benefit particular kinds of mothers. The compulsory ontology of being a choosing and informed consumer in maternity is not just the outcome of the social and political activism of liberal feminism and consumer movements in the 1970s but was prefaced by a series of other events, as I will show in Chapter Four.

In the following section, I outline how, in the 19th Century, expertise in the form of the development of the sciences and of experts became a remedy for addressing the quandary of liberal societies. Two seemingly contradictory imperatives were at play: the need to govern (to maintain morality and order) and the need to restrict government (to support liberty and the economy) across a newly expanded empire (Rose, 1996). A complex apparatus was developed to regulate both the individual and the social body in order to maximise them as national resources, and strategies of regulation were developed that constitute modern iterations of power. The latter saw the development of complexes that linked the political (forces and institutions) with the non-political, that is apparatuses that shape the conduct of both individuals and groups (such as nurses working in the health system) (Rose, 1996).

## Governmentality

Developments in the 18th Century uniquely shaped the way in which health was viewed and managed, making it an object to be surveilled, analysed, intervened upon and modified (Murphy, 2003). The beginnings of liberalism brought the body "into an increasingly dense and important network of medicalisation that allowed fewer and fewer things to escape" (Foucault, 2000, p.135). Modes of power shifted from authoritarian, repressive and deductive forms of sovereignty to more pervasive and diffuse forms of government. Emphasising

health promotion and healthy robust populations, medicine became a pivotal technology for disciplining the population. The Foucauldian understanding of government is broader than simply the workings of state institutions; and the 'conduct of conduct' is governed through specific 'technologies', or ways in which practices achieve certain objectives.

Foucault's governmentality is a system of power relations emerging in the 18th Century that fuses sovereignty (domination), discipline (disciplinary power) and government as a means for regulating and controlling populations through security (Coyte & Holmes, 2006), linking the health of the population to the economic and political security of the state (Nadesan, 2008). The neologism of governmentality created by Foucault links the words governing ('gouverner') and ways of thinking ('mentalité'). It suggests that the examination of technologies of power is incomplete without analysing the political rationality that underpins them or 'the art of government'. The key point of governmentality is that individual subjects must become self-governing in order to achieve legitimacy in the eyes of a sovereign government. The process of government is combined in the technologies of the self and technologies of power. For disciplinary power to be effective, an ethic of the self is necessary, where individuals are required to manage themselves and produce particular forms of subjectivity and modes of subjectification (Gilbert, 2001, p.201).

## Technologies of the self

Foucault observed how modern forms of power were colonising in method, encompassing the re-ordering of space and the surveillance and control over populations. The target, object and scope of governmental disciplinary regimes that accompanied the creation of the modern subject led to three main changes: a change of focus from the fleshy body to the mindful body, a shift from concern with matters of death to controlling details of life, and from controlling anonymous individuals to managing differentiated populations (Shilling, 2007).

Foucault detailed how the social sciences had developed knowledge and techniques to enable people to understand themselves. He developed a typology of four inter-related technologies of social science (Gilbert, 2003). These were: technologies of production, technologies of sign systems, technologies of power (or domination), and technologies of the self (Foucault, 1988). Each technology invoked forms of domination that resulted in the shaping of individuals. Two of the technologies most relevant to this study are the technologies of power and technologies of the self, which produce useful, docile, practical citizens through

the exercise of governmentality (Foucault, 1988). Technologies of power "determine the conduct of individuals and submit them to certain ends or domination, an objectivising of the subject" (Foucault, 1988, p.18). Technologies of the self are the various "operations on their own bodies and souls, thoughts, conduct, and way of being" that people make either by themselves or with the help of others in order to transform themselves to reach a "state of happiness, purity, wisdom, perfection, or immortality" (Foucault, 1988, p.18).

Individual subjects most powerfully enact Foucault's notion of disciplinary power through the inner deployment of power. These subjects apply it to their own bodies and selves, with external forces such as laws that might enforce such norms being secondary (if ultimately more final) (Feder, 2007). In Western Europe and the United States and Canada, the emergence of the psy-disciplines (psychology, psychotherapy, psychoanalysis and psychiatry) changed the nature of personhood in the middle of the 19th Century (Rose, 1996). These disciplines brought into being a regulative ideal of the self as a discursive object, where under the management of the disciplines humans could understand themselves and do things to themselves. Such a self has to be constituted in such a way that it can be worked on and reflected on (Allen & Hardin, 2001). This has led to recruitment into two levels of discourse. The first requires self-monitoring and the second involves taking up of discourses of normality by reflexively comparing ourselves with the normative:

> This monitoring role accompanied by the capacity it instils are enactments of power. The social processes that support reflection and monitoring and the discursive objects that become normal constitute us as subjects. The processes and the objects are cultural and values laden, embodying particular interests which if an individual is able to create and reproduce them engender privilege and the keys to social organisation (Allen & Hardin, 2001, p.168).

The history of psy is linked with the history of government, where ideals and aspirations of individuals became aligned with wider political objectives of liberal governmentality such as consumption, profitability, efficiency, and social order. These psy discourses highlight the paradox of liberalism where subjects are constructed as free, choosing, and autonomous yet are simultaneously constrained in the modality through which they express. Technologies of the self are practices that involve projects directed at making the self amenable to regulated forms of freedom. These technologies fulfil the advanced

liberal/neoliberal government practices of governing 'at a distance' via the autonomy of individuals, enabling institutional goals to be translated into the so called 'choices' of individuals (Rose, 1996) or practices of the self or self-government (Nettleton, 1997).

Panopticism or the ever-present threat of potential or continual surveillance is a mechanism for translating technologies of disciplinary control into an individual's everyday practices (Rolfe & Gardner, 2006). To describe how bodies become 'docile' through performing self-disciplining, compliant and docile behaviour, Foucault uses the metaphor of the panopticon designed by the philosopher Jeremy Bentham. The panopticon was a prison designed so that a central observation tower could potentially view every cell and every prisoner. However, the prisoners could not view observers or guards, so prisoners could not tell if or when they were being observed. Consequently, they came to believe that they might be always being observed, and disciplined themselves (Rolfe & Gardner, 2006). This threat of surveillance has been transferred to other institutional settings and to power relations in society. Disciplines not only produce distinctive institutions of modern nation states, they also produce the modern individual who is constructed as an "isolated, disciplined, receptive and industrious political subject" (Mitchell, 1988, p.xi) constituted by power relations. For the docile body to be to successfully created, the subject has to internalise and embody disciplines, which consist of social standards, routines, practices, beliefs, behaviours that ensure conformity with society's disciplinary regimes.

## Technologies of power

Technologies of power are the diverse strategies that shape individuals' conduct and 'submit them to certain ends or domination' (Foucault, 1988, p.18). In Discipline and Punish (Foucault, 1977a), Foucault outlines the development of the modern penal system in relation to the development of the disciplines. From about the mid-18th Century, external physical restraint became increasingly replaced by self-restraint. Where previously the control of populations had relied on coercion, command and repression, more localised abilities to infiltrate, rearrange and colonise were expanded (Mitchell, 1988). As a result, the authoritarian, repressive and deductive forms of sovereign power of feudal times were increasingly replaced with more pervasive yet diffuse forms of government. Power was no longer only conceptualised as sovereign, external, coercive, repressive and restrictive or as a possession located in institutions and groups that violated rights (Hook, 2004; Mills, 2004). Power became increasingly focussed on the control and management over life (biopower) rather than the threat of death.

The key mechanism of power as deduction (that is subtraction, where objects and the lives of subjects could be taken away) began to change after the Classical age and was transformed so power worked to:

> incite, reinforce, control, monitor, optimize, and organise the forces under it; a power bent on generating forces, making them grow, and ordering them, rather than one dedicated to impeding them, making them submit or destroying them (Foucault, 2004, p.79).

Foucault's more complex view of power (pouvoir) advanced a view of power as disciplinary, ubiquitous and productive: bringing things into being, constituting subjectivity and social relations (Lupton & Barclay, 1997). Power was not only repressive, it could be productive, positively influencing life, by managing, maximising and increasing it under careful control and guidelines (Foucault, 2004). These forms of power formed the basis of capitalist modernity and spread rapidly to other parts of the modern Western world (Mitchell, 1988) and have in turn characterised the modern nation state and its institutions.

### Biopower and Disciplinary power

A docile body is a "body that can be subjected, used, transformed and improved" (Foucault, 1977a, p.135). Foucault used the term 'biopower' to describe this process of management and development. Nurses are implicated in biopower as they implement power techniques to support the health of citizens and reproduction is a significant site for biopolitical techniques.

The Classical period saw the rapid development of disciplines and techniques for making bodies and populations manageable (including the close scrutiny of problems of longevity, public health and migration), which Foucault termed the era of biopower. Biopower was pivotal to the development of capitalism because it allowed for the "controlled insertion of bodies into the machinery of production and the adjustment of the phenomena of population to economic processes" (Foucault, 2004, p.81). Biopower in the form of the 'administration of bodies' and the 'calculated management of life' came to replace the threat of death associated with sovereign power (Foucault, 2004, p.81). Biopower evolved into a bipolar technology: the first pole was focused on the corporeal body as a machine and in disciplining and maximising its capabilities, including "the extortion of its forces, the parallel of its usefulness and its docility, its integration into systems of efficient and economic controls, all this was ensured by the procedures of power that characterised the disciplines: An

anatamo-politics of the human body (that is the micro level)" (Foucault, 2004, p.81). The second pole of power that formed later he calls the biopolitics of the population (that is the macro-level) (Foucault, 2004). It focussed on the management of the species body population and particularly its health, which became the primary commitment of modern forms of government (Inda, 2002). The management of propagation, births, deaths, and life expectancy became sites of intervention and regulatory control. Thus, disciplining the body and regulating the population became the two foci or poles around which the power of life came to be organised (Foucault, 2004). Foucault saw sexuality as the hinge or discursive interface that linked the life of the individual (anatamo-politics) with the life of the species as whole (biopolitics), therefore linking the management of sexuality and the management of empire (Stoler, 1995). However these issues have since become decoupled, with sexuality disengaged from reproduction, and reproduction from sexuality (Rabinow & Rose, 2003).

Disciplines such as nursing produce the modern individual through tools such as observation, normalising judgements and examination, requiring an ethic of self that is a self that can be worked on and reflected upon. Three main tools are ubiquitously used in health contexts. These are hierarchical observation (the surveillance of people and communities deemed at risk); normalizing judgements (which deem people as fitting into the social order through their adherence with norms, reinforced by seemingly neutral scientific knowledge); and examination (the clinical/panoptic gaze, management of time and space, creation of individual cases) (Gastaldo, 2002, p.558). These tools enable and constrain behaviours, and expert intervention is galvanised for those who don't fit in within normalised categories (Mamo, 2007).

The birth of the clinic represented the medical gaze becoming institutionalised (Foucault, 1973a), so that the body was made the object of the health professional's gaze and scrutinised within the frame of science and medicine (Cheek, 1999), resulting in the subjection of the objectified body to particular regimes of truth and technologies of power. The data or information produced by the body, and the body itself became subjugated to the disciplines of knowledge (Cheek, 1999).

### Pastoral power

Pastoral power is another expression of power in modern Western states, which derived from Christianity and originated in the 3rd Century spreading out into the "whole social body; it found support in a multitude of institutions" (Foucault, 1982, p.784). Like disciplinary power, pastoral power had an individual

and group focus on the development of knowledge. However, disciplinary power differs from pastoral power in that it is an 'objectivising force' incorporating a process where individuals are transformed into objects or 'docile bodies' (Foucault, 1977a) while pastoral power involves people knowing themselves.

Christianity brought into being a code of ethics that differed from the ancient world. The organisation of the Christian church and the designation of pastor to denote a person of 'religious quality' signalled a unique form of power. Pastoral power assured salvation to the congregation in the next world and differed from royal power in that it not only commanded but was prepared to sacrifice itself for its flock (rather than only the flock sacrificing themselves for the monarch). In turn the flock were encouraged to be obedient, exercise self-control and renounce themselves and the world— technologies of the self are also a feature of pastoral care. Pastoral power includes the lifetime care of individuals within the flock; and most crucially for pastoral power to be exercised is the requirement that everything must be known about an individual: "the inside of people's minds…their souls… making them reveal their innermost secrets. It implies a knowledge of the conscience and an ability to direct it" (Foucault, 1982, p.783). Accordingly, pastoral power produces knowledge regarding the individual primarily through a confession rather than overt discipline (Gastaldo, 2002).

Although secularism and decreased religious participation have reduced the power of the Christian church, the dispersal of this kind of power has spread beyond ecclesiastical institutions and is ever present in historically Christian colonies. The pastoral uses of techniques such as "confession, introspection and self-examination" have extended beyond their original religious purposes to the health sector: "There is no need for arms, physical violence, material constraints. Just a gaze. An inspecting gaze, a gaze…which each individual thus exercises this surveillance over and against himself" (Foucault 1980, p.155). The knowledge produced through these social processes that instil self-reflection can be scrutinised by health professionals and allow for the governance of the patient who can be classified as normal or deviant and thus prescribed an appropriate intervention by the health professional.

Research has identified the exercise of both pastoral power and disciplinary power in the policing of families by British health visitors (Davies, 1988; Peckover, 2002). Health visitors provide a universal service to families with young children incorporating child protection couched in the less threatening role of 'mother's friend' (Davies, 1988), a role that appears informal but belies state surveillance. Peckover's work highlights the blurred role taken up by health

visitors, which combines welfare and surveillance, where mothers are subjected to the disciplinary gaze based on normalising judgements derived from middle class and patriarchal interests. Once the health visitor labels behaviour as inadequate, corrective measures are implemented. Visibly different women, among 'other' women, consequently receive more surveillance. These techniques are evident in the New Zealand evolution of mothercraft discussed in Chapter Four, but now I turn to a discussion about nurses and power.

## Nurses and power

The diffusion of modes of power linking health with the economic and political security of the state has enabled health care professionals (especially nurses, who comprise the largest group of health professionals) to carry out activities for the control of populations such as surveillance, categorisation and intervention. In 'disciplining' the population, nurses have the power to define norms, which are taken up, and the right to prescribe intervention (Allen, 2006).

Nursing operates at the intersection of anatomo-political and biopolitical ranges of power over life (Perron, Fluet, & Holmes, 2005). Nurses occupy a strategic position that allows them to act as instruments of governmentality, despite not being employees of the state in some settings (Thompson, 2008). Nursing contributes to social regulation through an array of political technologies (Gastaldo, 2002), enacting government policies, which maximise the productive potential and capacities of individuals (biopower). Nurses are a fully-fledged political entity who are constituted through disciplinary technologies and respond to state ideologies (Thompson, 2008). Nurses have a powerful role in the regulation of populations and individuals and exercise power by subjecting individuals and groups to a disciplinary gaze based on normalising judgements. Nurses are generally respected and relied upon, and their actions have far reaching impacts that shape people through disciplinary technologies "such as gathering information, producing and disseminating knowledge, and engaging in therapeutic encounters" (Gastaldo, 2002, p.563). Knowledge produced by nurses influences the dissemination of regimes of truth that determine access to and through care.

The Anglo-European nursing tradition of the 19th Century has been spatialised to colonial settings and remains dominant today (Mortimer, 2005). Nursing originates in a gendered division of labour with traditions and attributes considered innate to womanhood such as "altruism, virtuosity, metaphysicality and concern for relationships of care" being a hallmark of nursing's discursive

origins (Crowe, 2000b, p.963). This pastoral discourse can be tracked to the foundational myth of the nursing profession and Florence Nightingale's status as the legendary founder of nursing (Gilbert, 2003). Nightingale became widely known during Britain's imperial campaign in the Crimea, where she initiated sanitary reforms and implemented administrative skills that shifted the perception of nursing from a disordered group to being educated and disciplined (Mortimer, 2005). Nightingale's devotion to her work combined with her role in reducing mortality rates among soldiers provided modern nursing with a heroic narrative (Gilbert, 2003). The militaristic context and hierarchy inspired Nightingale to fashion nursing around obeying doctors' orders (Fahy, 2007) and aligning women with 'the natural'. Florence Nightingale's upper class service to poor, working-class soldiers created the gendered notion of a benevolent benefactress. The nurse-patient relationship is characterised by virtuosity and incorporates a hierarchy of dependency featuring a person who bestows and a person who is indebted (Crowe, 2000b). The image of Nightingale (and nurses) as an angel of mercy dominated around this time and came to represent the work of nurses (Hallam, 2000). Caring came to be associated with a feminine identity: traditional 'masculine' values of emancipation, patriotism, heroism and the glorification of sacrifice became differentially bonded to 'feminine' values, leading many nurses to be involved in other episodes of war. However, despite the proliferation of images of sacrificial heroines, militarism did not equate with emancipation (Mortimer, 2005).

Through this legacy, many nurses view themselves as apolitical and powerless, particularly with regard to their gendered relationships with medicine and management (Holmes & Gastaldo, 2002). However, while nurses are governed, they are also governing given their involvement in power relations as employees of the state. Nursing is a product of this state health system and nurses are an effect of its practices, which are legitimated through laws and policies secured by ideologies. Therefore, nurses themselves are implicated in the disciplinary technologies through which they contribute to the system (Murphy, 2003). Nurses are endowed with a moral authority by virtue of their capacity to define problems and pose solutions with which they maintain their surveillance of the population and make normalizing judgements (Gilbert, 2001, p.201), that include "disciplining individuals to promote discourses that construct desirable subjectivities" (Gastaldo, 2002, p.557). In the arena of maternity the roles of nurses and midwives extends to defining norms of good/normal mothering and they are in a position to determine the criteria for interventions on behalf of the state and the kinds of discourses that can be made available. Therefore, the

(migrant) mother is produced through powerful dominant discursive formations of health, which exist within regimes of truth that are difficult to challenge (Cherrington & Breheny, 2005, p.90).

## Conclusion

In this chapter, I have indicated the need for both a postmodern and a postcolonial approach for this study. I have shown how power produces bodies, knowledges and subjectivities based on the notion that language is not neutral or mimetic, but it is constitutive of subjectivities. Language and discourses are a focus for feminist and postcolonial intervention, as discourses are contingent, flexible and alterable. Discourses can be re-described so that the place of language in the reproduction of social and political inequalities and power relations is transformed. I will further relate Foucault's work to the disciplining of the pregnant body, surveillance of the mother and child and the creation of the new and involved father in Chapter Four. In the next chapter I will show how liberalism has shaped nursing and how postcolonial theories interrogate the history and legacy of European imperialism in nursing practices.

# Chapter Three: Liberalism, neoliberalism and the colonial health system

Foucault's analysis of liberalism as governmentality, that is "both a political discourse about the nature of rule and a set of practices that facilitate the governing of individuals from a distance" (Larner, 2000, p.6) has particular resonance in health and in nursing. Neoliberalism has become widespread as a governing technology in the West, albeit with varying configurations in different locales. Policy agendas focussed on optimising wealth, health and security; the privileging of the individual; the transfer of service provision to the private sector from the state sector; and the integration of corporate management practices into the work of government are de rigeur. Through the extension of market values to all institutions and social action, good citizens are constructed as choice-making subjects, who take responsibility for their health without unduly burdening the health care system.

In the first part of this chapter, I provide a brief overview of the history of liberalism and how it has shaped nursing in general and the New Zealand health system. The central tenets of liberalism have influenced nursing knowledge development, nursing curricula and nursing practice responses to diversity. I argue that nursing is implicated in health inequalities through its foundations in liberal humanism, valorising commitments to individualism, egalitarianism and political neutrality at the expense of the critique of nursing practices. The suppression of critique prevents action on health inequalities, individualises racism and creates a racialising agenda where the status quo is maintained. These dynamics have a particularly important role in a colonial nation state such as New Zealand.

## Liberalism

Liberalism refers to a range of political positions and beliefs (Durish, 2002) that are difficult to critique because they are so ubiquitous as to be almost invisible (Browne, 2001). Liberal ideology developed in Europe in the 18th Century and is based on the view that society is enlightened, rational, equitable and populated by individuals who are free and self-determining (Browne, 2001). These conceptions developed in response to political upheaval in the 17th and 18th Centuries, including the break down of feudalism and the development of capitalist societies. Liberalism reduced the effects of religious intolerance and conversion; and was aligned with the development of the sovereign state, which

had exclusive and indivisible authority inside its own borders (Roberts & Sutch, 2004). These state units then became forged into nations, and national identities superseded other identities. The belief that an individual could be guaranteed equal citizenship within a nation state and its institutions gained currency and acceptance. Differences of social status and ethnicity were subsumed into a "universal conception of justice embodied in a unitary concept of citizenship" (Roberts & Sutch, 2004, p.210).

Abstract individualism is a central assumption of liberalism, viewing human beings separately from social, economic, political or historical contexts. This assumption has had an enormous impact in health and is a core concern of feminist critique (Jaggar, 1983). Browne (2001) outlines how philosophers such as Descartes, Bacon and Locke made epistemological individualism fundamental to empiricism. The hegemony of epistemological individualism can be seen in the scientific paradigm of the 'body as machine' where the focus is on individuals and their parts. Central to the notion of the primacy of the individual are the concepts of individual freedom and tolerance, where individuals are free to pursue all that is necessary to have a good life regardless of what other people might think, as long as this pursuit does not interfere with the freedom of others (Browne, 2001). These are defined as neutral civil rights, leading to a liberal ideology that is tolerant of opinions, views, cultural practices and moral choices. However, neutrality generally applies only to dominant views that are compatible with liberalism (Browne, 2001). Egalitarianism is another important component of liberalism, where it is assumed that all individuals have an equal chance of success in life through distributive social justice and a 'level playing field.' Individual freedom is valued above the social good and supersedes factors such as race, class and gender, which frequently impact negatively on opportunity and development (Browne, 2001).

There have been three waves of liberal ideology. The first, also referred to as classical or libertarian liberalism, was characterised by the desire to reduce state intervention to a minimum in order to protect the interests of self-reliant individuals and maintain public order (Goldberg, 2001). Later modern—also referred to as welfare or egalitarian liberalism developed in the context of social inequality where governments took more responsibility for social, educational and health services. The third wave of liberalism, was precipitated by the global recession of the 1970s which saw an increase in state intervention leading Western nations to embrace principles of classical liberalism in the form of neoliberalism (Browne, 2001) or what is termed advanced liberalism.

Governmentality scholars refer to neoliberalism as an extension of liberalism in that it constitutes a mode for governing populations (Schinkel & Van Houdt, 2010). As a biopolitical technology of governing, it is focussed on optimising the capacity and potential of individuals and the population, so that governing regimes can use it. It is a political rationality that "has achieved cultural hegemony" in the West (Davies & Saltmarsh, 2007, p.3), where its influence has spread beyond economic policies to the extension of market values to all institutions and social action. In much of the world, neoliberalism is associated with American domination through military and economic power, subsequently positioning American neoliberalism as radicalised capitalist imperialism (Ong, 2006). Neoliberal economic and social reforms in New Zealand were ushered in during the 1980s and 1990s to align domestic activities into global economic flows. Market oriented restructuring and the transfer of responsibility for social well-being away from the state and to individuals and communities significantly eroded New Zealand's post Second World War welfare state (Larner, 2006). Consequently many public sector activities were privatised and corporatized in the health care reforms inspired by neo- liberal ideology (Kearns, Ross Barnett, & Newman, 2003).

The optimising technology of neoliberalism can be seen in the passing of the responsibility for health or ill-health on to the citizen/consumer creating the 'imperative of health' where the regulation and discipline of the self as an autonomous individual is required (Lupton, 1995). In neoliberal wellness discourses, a new kind of citizen who is concerned, reflexive and ultimately empowered about their health is mobilised (Fries, 2008). The neoliberal subject is conceptualised as rational, autonomous and self-caring, taking up skills and knowledge and adhering to recommended health promoting practices. A crucial feature of neoliberalism is that the state is positioned not as coercive but facilitative, constituting a number of institutions that exist to enhance "personal freedoms and individual development" (Petersen & Lupton, 1996, p.12).

### Liberalism and nursing

Nurses are frequently voted the most trusted professional group in society, and view themselves as a group who do good and transcend the biases of ordinary people (Culley, 2006). Therefore, it is difficult to comprehend how nursing as a profession might be implicated in oppressive practices. As Browne (2001) argues, this is due to the invisibility of the liberal theoretical paradigm, which is deeply embedded in nursing. Browne contends that the ubiquity of this paradigm means that it is difficult to see what aspects form one's culture or professional culture

and in turn to understand how seemingly neutral and egalitarian values can be oppressive. A useful way of conceptualising these forms of oppression is advanced by Iris Marion Young, who conceptualises oppression in the Foucauldian sense as "the disadvantage and injustice some people suffer not because of a tyrannical power coerces them but because of the everyday practices of a well-intentioned liberal society..." (Young, 1990, p.41). For Young, power is the effect of practices of education, medicine, and so forth, suggesting that the actions of many people going about their daily lives contribute to the maintenance and reproduction of oppression, even as few (such as nurses and midwives) view themselves as agents of oppression. Oppression is structural and woven throughout the system, rather than reflecting a few people's choices or policies. Its causes are embedded in the unquestioned norms, habits, symbols and assumptions underlying institutional rules and the collective consequences of following those rules (Young, 1990). Seeing oppression as the practices of a well intentioned liberal society removes the focus from individual acts that might repress the actions of others to acknowledging that "powerful norms and hierarchies of both privilege and injustice are built into our everyday practices" (Henderson & Waterstone, 2008, p.52). These hierarchies call for structural rather than individual remedies (Young, 1990). Although nurses and midwives often view themselves as powerless in relation to managerial and biomedical discourses, their role in supervising and managing biological processes in order to shape the population is powerful (Holmes & Gastaldo, 2002).

Browne (2001) has identified four ways in which liberal ideology shapes nursing: the individualistic focus of nursing science; nurses' view of society as essentially egalitarian; a preference for politically neutral knowledge development; and the economy of knowledge development in nursing (Browne, 2001, p.123). Browne (2001) suggests that, in combination, they individualise the responsibility for health access and maintenance, while rendering invisible the larger social conditions that contribute to individuals' ability to take this responsibility. The valuing of relativism and subjective individualism in nursing means a research agenda has been shaped where context is absent from subjectivity. Phenomenological or personal experiences are valued at the expense of social analysis using concepts such as oppression and marginalisation. In this milieu, advancing agendas to tackle the social conditions that shape health is difficult as the focus is limited to recognising structural constraints and working within them (Browne, 2001). These ideas of voluntarism and mobility are premised on liberal notions of individualism, rationality and freedom of choice, with two impacts. Firstly, nurses do not address systemic health inequalities especially those related

to racisms. Secondly, when racism is addressed it is more likely to be viewed as stemming from individual acts that can be ameliorated through corrective education (Culley, 2006). However, as will be discussed in more detail in the next section, the taking in of cultural knowledge as a corrective contributes to a racialising agenda where dominant discourses of superiority and privilege remain undisturbed (Culley, 2006).

The ideology of egalitarianism rests on the notion that all individuals are on a 'level playing field' with equal access to health services and equal resources to achieve health. Within this framework, if you are unhealthy or have difficulty accessing health care, it is your own fault or an individual deficit (Browne, 2001). Browne contends that the advent of strategies such as multiculturalism, diversity, and indigenous rights can lull us into believing that systemic inequities are being rectified. However, the growing intolerance of difference combined with tepid responses in nursing research and policy analyses highlight the need for continuing efforts (Browne, 2001). Further, as Kundnani (2004) argues, multiculturalism has reified, sanitised, and institutionalised what had previously been a political movement against the state. By turning a living movement into an object of passive contemplation, the status quo has been preserved and an ideology of conservatism has been solidified.

Nursing lacks the capacity to critique ideology because of its reliance on biomedical, psychosocial and sociological theories, and its under-development of political theoretical knowledge (Browne, 2001), not to mention economic self-interest. Browne challenges nurses to move away from politically neutral positions that reinforce a conservative liberal status quo and toward a critically oriented praxis. She claims:

> Critically oriented praxis refers to the ability to link knowledge and theory development to practice-relevant social, political and ethical actions aimed at improving health, health care, and social conditions (McCormick and Roussy 1997). By disassociating praxis from its emancipatory context and by importing it into an ostensibly politically neutral nursing framework, the view of theory and nursing as ideologically neutral is promoted (Browne, 2001, p.125).

Despite the mobilisation of critical social theories by nurse scholars, Browne (2001) argues that such theories are often politically neutralised, denuded of the socialist political assumptions that specifically demand ideological critique and

societal transformation. The neutrality reflects a collective denial and discomfort in nursing about racism, with nurses in denial about their complicity in relations of power, and a view that nurses have of themselves as being 'above' the biases that constrain 'ordinary' people (Culley, 2006). Finally, Browne suggests that the liberal ideological premises of nursing knowledge's neutrality result in the direct marginalising of disadvantaged populations who are sidelined for more accessible populations. Marginalised populations require different capabilities and resources such as more flexible funding arrangements, the engagement of communities, more flexible time lines and alternative methodologies. Conventional research practices in nursing exacerbate inequalities given the emphases on the phenomenological and interpretive, rather than critiquing, changing or improving conditions. The focus on exploring the impact of individual variables (such as depression, social support, cultural differences) on individual lived experiences has similar effects. To address this marginalisation, Browne recommends firstly, that nurses question the assumptions and values of nursing science and interrogate whether they disrupt or maintain health inequalities; and secondly, that nurses utilise unconventional frameworks and theoretical vantage points so that our thinking can be broadened, gaining a knowledge of political theory, so that we are able to better question the implicit political assumptions underlying our science (Browne, 2001). The goal would be "learning to speak, think, see, and be in the world from those places that are elsewhere, other than the dominant, center, colonizing, hegemonic world order" (Thompson, Allen, & Rodrigues-Fisher, 1992, p.xii), with a goal of advancing social justice in health and health care. This colonising and hegemonic by product of liberalism has become an increased focus of critical scholarship.

### Legitimating exclusion

In white settler societies, liberal precepts of individualism and equality have overlaid and subordinated indigenous values (Fisher, 2008). Racist thinking and articulation became increasingly normalised and naturalised in European modern societies in the 16th Century, with the concept of race becoming fundamental to the development of world systems (Goldberg, 2001). The elaboration of liberalism was key to the processes of normalising and naturalising racial dynamics based on European dominance. Goldberg argues: "As modernity's definitive doctrine of self and society, of morality and politics, liberalism has served to make possible discursively, to legitimate ideologically, and to rationalize politico-economically prevailing sets of racially ordered conditions and racist exclusions" (Goldberg, 2001, p.6). Accordingly, one of the paradoxes of citizenship in New Zealand settler history is that it has been bestowed differently between groups,

highlighting race, gender and class differences in access to its supposedly universal character (Ip, 2003a, 2003b; Leckie, 1995; Thakur, 1995).

Liberalism is the product of a specific European culture, which denies difference as being something 'morally valuable' and where the interests of dominant groups are championed at the expense of others who have not only been ignored and excluded, but enslaved and colonised (Roberts & Sutch, 2004, p.211). Although liberal humanist arguments have been mobilised to advocate for the equal value of all humans and for equal rights, they have paradoxically also been a mechanism for subordination, as universalism relies on the suppression of difference (Bondi, 1993). What are suppressed are the differences that mark groups out from the people who occupy positions of power and who also have the authority to legitimate knowledge. Therefore, qualifying for equality requires that that one is assimilated into the worlds of white, western, bourgeois men, yet this maintains exclusion despite the promise of inclusion (Bondi, 1993; Roberts & Sutch, 2004). The assumption of equal status, rights and duties in the liberal tradition makes observations of inequality deriving from gender, ethnic, class or other contexts irrelevant to citizenship (Yuval-Davis, 1993). Pre-existing resources at the starting line are rendered invisible and submerged within the principles of equality, fairness and merit (Augoustinos, Tuffin, & Every, 2005). The egalitarianism that liberalism is premised on is not on equal outcomes but the right to equality and political participation in a democracy (Augoustinos & Every, 2007).

Liberal discourses maintain the centrality of whiteness in nursing. Allen (2006, p.1-2) notes the 'white supremacy' of nursing education, suggesting that its curricular machine with predetermined outcomes and mechanisms is based on an assimilationist agenda, where adding 'other' people into the mainstream creates a multicultural environment. This addition reinforces rather than displaces whiteness from the centre of structures and processes of educational or clinical institutions (p.66). Therefore multiculturalism must encompass "some vision of political negotiation theorized within a historical understanding of cultural dominance if progress is to occur" (p.67). Allen proposes a critical multiculturalism, where representations of difference from multiple, heterogeneous perspectives are developed and democratic conversations with multiple voices are undertaken so that other cultural perspectives can be legitimated and previously suppressed histories made explicit (Allen, 2006). The white supremacy of nursing education can be articulated and resisted through the mobilisation of poststructuralist vocabularies (Allen, 2002). The alternative is to continue to frame difference as only subsisting in the raw material of inputs,

which then get produced into a universal nurse by a white middle class curricular machine.

Whiteness is "a cultural disposition and ideology held in place by specific political, social, moral, aesthetic, epistemic, metaphysical, economic, legal, and historical conditions, crafted to preserve white identity and relations of white supremacy" (Mills, 2003 cited in Bailey & Zita, 2007, p.vii). Although it is a scientific and cultural fiction like other racial identities, it has a real social impact on the distribution of resources due to a 'possessive investment in whiteness' among white individuals (Lipsitz, 2006). A combination of public policy and private prejudice operate simultaneously to create this investment and perpetuate racialised hierarchies that structure access to resources, power and opportunity. Lipsitz contends that white supremacy is less a direct expression of contempt (as usually described by whites distancing themselves from the term), and more a system that protects white privilege and prevents communities of colour from accumulating assets and upward mobility. Complicating any direct identitarianism, Lipsitz contends that non-white people can become agents of white supremacy as well as passive consumers in its hierarchies and rewards and notes that not all white people are equally complicit with white supremacy.

Lacking a theorisation of white supremacy, nursing models such as 'cultural sensitivity' further serve to embed liberal notions of tolerance, which mask without disrupting the underlying power differentials of a more powerful tolerating majority and a tolerated minority. This is why liberal theory "cannot provide an intellectually coherent and morally acceptable theoretical basis of a multicultural society" (Parekh, 2000, p.14). The liberal theoretical paradigm is deeply embedded in nursing, with nurses unable to see how it structures their professional culture, in turn making it difficult to understand how adherence to seemingly neutral and egalitarian values (to white norms) can be oppressive. Viewing everyday practices founded on liberal notions of subjectivity as potentially harmful therefore increases nursing's potential to shift health inequalities related to racism. This emphasis on structural remedies is a counter to the dominant view of racism as stemming from individual acts that can be corrected through education. In the section that follows, I argue that being educated out of racism through taking in cultural knowledge contributes to an essentialising and racialising agenda while leaving dominant discourses of superiority and privilege undisturbed and unchanged. Indeed, negative values of particular groups can be held in tandem with liberal principles of equality, tolerance, fairness and justice by nurses thereby contributing to racial inequality in what is sometimes termed 'new racism.'

## Postcolonial theory

Postcolonial theory focuses on the ways in which modern, liberal discourses are interwoven with Western ethnocentricism (Mookherjee, 2005). This section has three main parts. The first outlines the function and impact of imperial and colonial projects. In the second, I examine the postcolonial condition and in the final part, I conclude with a discussion of how postcolonial theory can assist nursing to revitalise its role in social justice and enhance health outcomes for all.

### Imperialism and colonisation

> I am talking of millions of men who have been skilfully infected with fear, inferiority complexes, trepidation, servility, despair, debasement (Aimé Césaire, 1972 cited in Hook, 2005).

Race and maternity have been central to competitive national imaginaries that are then enacted through the management of biopower (Rabinow & Rose, 2003). Venn (2009) contends that liberal capitalism has been made possible through European expansion and colonisation, and a European mode of imperial governmentality based on its military and sovereign power (power over death). Foucault's lectures at the Collège de France between 1975 and 1979[3]noted the combination of disciplinary and normalising strategies of biopolitical power (power over life) in the period of liberal capitalism. However, Venn (2009) points out that Foucault does not specifically interrogate the centrality of colonial expansion and subjugation for the institution of liberal capitalism.

Contrary to the view of colonisation as a completed historical process, white settler institutions, processes and ideologies continue to frame social relations in Aotearoa New Zealand (Seuffert, 2006; Smith, 1999; Wetherell & Potter, 1993). The continuation of colonial dynamics into the present is seen in "attempts to redress historical racial injustices, in immigration, and more generally in raced and gendered configurations of the nation contained in law and policy, [which] demonstrate the embeddedness of the violence, power dynamics, images and fantasies of colonisation" (Seuffert, 2006, p.9). The term neo-colonialism has been used to denote shifts in relations of colonial rule to market forces that still maintain the ideological and exploitative relations of colonialism that occurred after the dismantling of colonialism as an official doctrine (Coloma, Means, & Kim, 2009). This shift accompanies that from monopoly industrial capitalism to

3. Society Must Be Defended (1975–6; published in English 2003); Security, Territory, Population (1977–8; published in French 2004a, in English 2007) and The Birth of Biopolitics (1978–9; published in French 2004b, in English 2008) cited in Venn (2009).

post-industrial capitalism, which saw a move away from territorial expansion as too expensive and impractical to a colonialism that is more economic than territorial (Spivak, 1991).

McNicholas and Barrett (2005) outline the ways in which imperialism and colonialism are interrelated. Imperialism refers to "the extension and expansion of trade and commerce under the protection of political, legal, and military controls" (Childs & Williams, 1997, p.227). Colonialism refers to "a profitable commercial operation that brought wealth and riches to Western nations through the economic exploitation of other nations" (McNicholas & Barrett, 2005, p.396). Thus, colonialism and capitalism are intertwined with colonialism in the "realisation of imperialism" (Smith, 1999, p.23). Colonialism as the implementation of the ideology of imperialism allows for the settlement of one group of people in the territory of another group of people (McLeod, 2000). Linda Tuhiwai Smith conceptualises the manifestations of European imperialism in four ways: i) as economic expansion; ii) as the subjugation of 'others'; iii) as an idea or spirit with many forms of realisation and iv) as a discursive field of knowledge (Smith, 1999, p.21).

Although the experiences of colonisation have varied in different parts of the world, historical events in Aotearoa New Zealand were "part of trends, practices and structures that have their origins beyond New Zealand's shores" (Byrnes, 2009, p.1), and so the residues of colonialism remain with enduring and omnipresent impacts. Despite any protestations of innocence, none of us are outside of or insulated from the impacts of the postcolonial whether they refer to relations, values or belief systems (Treacher, 2005, p.49) as colonisers or colonised. In this frame, post colonialism involves consideration of colonialism, both past and present effects, and local and global developments as after-effects of empire (Quayson, 2000, p.2). Therefore, that people continue to be invested in the maintenance of colonial hierarchies that create binary oppositions needs consideration (Treacher, 2005, p.49).

Through consideration of this history, migration can be viewed as primarily the outcome of the displacement of populations through colonialism and late capitalism (Razack, 2004). The flows of people and profits that came with European colonialism resulted in the global shifts of populations, of both colonisers and colonised. Colonisers moved as administrators and colonised peoples were moved as indentured labourers, domestic servants and so forth (Loomba, 1998). Regardless of how deeply colonialism penetrated into various societies, the net effect was the production of the economic imbalance required

for capitalism to flourish. This view of migration runs counter to hegemonic neoliberal narratives of individualism and 'choice', where migrants as groups of people are described as foreign newcomers and uninvited guests.

While colonialism as the appropriation of other people's land and goods has recurred throughout human history, European colonialism in the 19th Century introduced new colonial practices that enabled the growth of European capitalism and industry through the economic exploitation of raw materials, cheap labour and profitable land in the colonies (Loomba, 1998; Treacher, 2005). Economies were restructured and multi-directional exchanges of populations and resources took place in the form of indentured and slave labour, raw materials and goods. Profits, however, always returned to the imperial centres. Domination and authority were supported by defence and foreign policies, and then internalised so that ordinary "indeed decent men and women accepted their almost metaphysical obligation to rule subordinate, inferior, or less advanced people" (Said, 1993 cited in Treacher, 2005, p.48). Imperial ventures were justified through notions of progress and improvement, which often had a gendered overlay, for example Indian colonisation was justified on the basis of abolishing sati (widow burning) (Pierce & Rao, 2006). These occurrences provided the benchmark for activities of monetary exchange and globalisation (Treacher, 2005).

Colonisation went beyond economic exploitation to the imposition of wide ranging epistemic, cultural, psychical and physical effects (Treacher, 2005). Colonialism appropriated not only land and territory, but also culture and history, including the means and resources of identity, resulting in powerful psychical impacts that were damaging (Hook, 2005). The colonial world was not only pathological, but also pathogenic through its relations of domination and "its function as a surface of fantasy, ambivalence, hatred and desire" (Hook, 2005, p.480). Frantz Fanon theorised that hostile colonial dispossession, oppression and racism resulted in a kind of identity-violence, where one's own cultural values and understandings were devalued. Consequently, a colonised subject was produced who was in a constant state of agitation and psychological and political anxiety, stemming from the dissonance between the ideals, norms and values of Western culture, and that of the dominated culture, which was viewed as the 'other' of all of these values (Fanon, 1999). Fanon described this as a pathogenic process because it resulted in the subject experiencing a sense of inferiority and problematised sense of identity. As Mamdani (1973, p.16) elegantly articulates, "the success of colonialism lay not just in the colonial structure we lived in, but also in the corresponding consciousness we inherited."

The colonial, therefore, refers to not only a period of history but also an operation of discourse, where colonial subjects are interpellated and incorporated into a system of representation (Tiffin & Lawson, 1994). Similarly, postcolonial projects reflect a variety of disciplines and orientations that go beyond the description of a historical transition to make visible the history and legacy of European imperialism (Carby, 2007; Loomba, 1998). The following section briefly describes the development of the condition of the postcolonial.

### Postcolonial: A contested term

The term postcolonial has been seen to homogenise the diversity of European colonialism; to be dominated by writing from the Indian sub-continent, Africa and the Caribbean (experiences which do not transfer easily to contexts such as Latin America or the Chinese Diaspora); and to not have always adequately engaged with the ongoing colonisation of Indigenous people, who are frequently absent from debates (Ali, 2007). The term is also seen to assume that the imperial project is finished rather than ongoing (Smith, 1999). Indigenous Australian Moreton-Robinson proposes the verb post-colonising "to signify the active, the current and the continuing nature of the colonising relationship that positions [Indigenous people] as belonging but not belonging" (Moreton-Robinson, 2003, p.38).

The term postcolonial is also accused of being anachronistic and inadequate, in an era of the invasion of nations, in the guise of the preservation of peace and freedom, or the many unfreedoms imposed in defence of the metropolitan heart of empire (Carby, 2007). Carby suggests that the term "lacks the political and historical referents to the powerful social movements of the anti-colonial and masks the significant continuities in the history of violence and capitalist exploitation in the modern, modernising and late modern worlds" (Carby, 2007, p.216). Postcolonialism has been accused of re-inscribing binary oppositions of self-other, metropolis-colony, centre-periphery and so forth given its focus on yet another single binary opposition: colonial-postcolonial (McClintock, Mufti, Shohat, & Social Text Collective, 1997; Slemon, 2001, p.103).

The focus on colonial dominance produced within an Anglo/European frame, is another criticism, with limited attention being given to modernities outside of Euro/Anglo modernity (Shome & Hegde, 2002). Therefore, the concern in this thesis with the postcolonial condition of women from South Korea could constitute a contribution to the study of other modernities (such as that of Japan). However, the limited attention given to Japanese colonisation in this thesis reflects the scope and impact of European modernity, which has seen the

spatialisation of relations, practices, and institutional arrangements to the rest of the world in a manner that is unsurpassed (Shome & Hegde, 2002).

In considering the audience for which postcolonial inquiry is most meaningful, Gandhi suggests that it "principally addresses the needs of the Western academy. It attempts to reform the intellectual and epistemological exclusions of this academy, and enables non-Western critics located in the West to present their cultural inheritance as knowledge" (Gandhi, 1998, p.ix). However, Smith (1999) counters that view, arguing that such terminology allows non-indigenous academics to re-inscribe their authority and yet again marginalise indigenous ways of knowing. This concern with the professionalising of postcolonial studies as an institution of cultural critique and producing knowledge is also articulated by Slemon (1994), who asks whether a regulating agenda is being advanced that does not have any connection with an anti-colonial politics.

I acknowledge the value and limitations of the term postcolonial that have been identified, and aim in this thesis to use postcolonial critique to acknowledge the continuing effects of colonial and imperial history, noting Carby's contention that contemporary manifestations of violence and capitalist exploitation also have their histories in colonialism.

### Development of Postcolonial theory

Postcolonial theory brings to the fore matters of colony and empire, and owes a methodological and conceptual debt to a number of 'Western' theories including Marxist anti-imperialist thought. Marxist scholars have pointed out that colonialism was a pre-requisite for the emergence of market society in Europe, and to the globalisation of capital (Gandhi, 1998). However, Marxist theorisations of empire have largely failed to recognise imperialism as an exploitative relationship between the West and its Others. Poststructuralist thought (including theorists such as Foucault and Derrida) on the other hand has provided a useful umbrella for the postcolonial theoretical project through its articulation of a Western critique of Western civilisation (and specifically the relationship of systems of domination with power and knowledge); suspicion toward universalism; scepticism about grand narratives; and critique of Eurocentrism inherent in Marxist and liberal thought (Gandhi, 1998). While Gayatri Spivak's entry to the 'literary-critical pantheon' occurred through her notable translation of Derrida's Of Grammatology in 1977, her most discussed subsequent work has focussed on the dialogue based around Derrida and Foucault in relationship to South Asia in particular. While Spivak avoids the term postcolonial as a label for her style of thought, it is in relation to her analyses of poststructuralism and

postmodernism and their deeply ambivalent relationship with Marxism that postcolonial theory has often been developed. While Derrida's and Foucault's (in particular) oeuvres do not always address colonialism directly, their critiques of the assumed universal validity of Western epistemology and the structure of Western rationality as racist and imperialist have been valuable for postcolonial scholarship (Gandhi, 1998).

Orientalism, Edward Said's book published in 1978, drew upon Foucault's theory of discourse to show that texts written about colonies produced 'the Orient' in a denigrating and negative order to represent an oppositional civilised and positive Britain (Said, 1978). Said showed that categories such as Occident and Orient, colonised and coloniser were mutually constitutive (Ali, 2007). Subsequent texts reinforced the racist knowledge and practices of Orientalism, so that linguistic and textual representations had an impact on material practices. Generalisations were made about groups of people who were treated as a homogenous mass (rather than communities of individuals) about whom knowledge could be obtained or stereotypes created, such as 'the inscrutable Chinese.' However, Hulme (1986) challenges the view of the 'native' as deficient and suggests that there were many different colonial discourses and representations (such as the noble savage and the exotic paradise) and that representations depended on the behaviour of the 'natives' (Mills, 2004). Gayatri Spivak (1994) who locates herself with Marxist feminism and deconstruction also challenges the notion of a unified discourse, suggesting that alternative voices are recoverable within colonialist discourses. Nevertheless, the overall dynamic described by Said has resulted in many responses and renovations of his theory.

### Postcolonial feminist theory

The combination of a postcolonial approach with feminism presents an opportunity to maximise the focus on gender and address the limitations of western feminisms, which have largely been liberal in character and concerned with individual rights to "political and religious freedom, choice and self-determination" (Weedon, 1999, p.13). Crucially, a postcolonial feminist view holds that questions of difference are linked with power relations that are structured by colonial history, race and gender (Gedalof, 1999). A feminist approach emphasises the links between power and knowledge and the links between the personal and the political, so that personal concerns are linked with collective concerns. Kapur (2005, p.3) defines a postcolonial feminist perspective for knowledge development as "an emerging area of scholarship that seeks to account for women's conditions of subordination within the conditions of post

colonialism". A postcolonial feminist vantage point puts at the centre the local, national and global effects of colonialism and interrogates the ongoing impacts of neo-colonialism along the fault-line of gender. Such a view also acknowledges the co-option of feminist discourses as legitimation for expansionist neoliberalism (for example Muslim women needing to be rescued from the Taleban by the Enlightened West in Afghanistan)(Berger & Guidroz, 2010).

The central project of feminism—to build a fairer and more just society for women—has been critiqued for its inability to engage with other axes of oppression such as ethnicity, racialisation and social class (Anthias, 2002). Postcolonial feminists have been concerned that the use of Western epistemic frameworks to explain the experiences of racialised women risks reproducing universalised, essentialised, imperialised and racialised constructions of 'other' women (Min-ha, 1994; Mohanty, et al., 1991; Narayan, 1997).

The call to deconstruct the category 'woman' was a critical intervention in revolutionising feminist theory, reverting the gaze from a male/female focus to address differences within the category woman itself (hooks, 1991; Spelman, 1988). Women's studies and race studies prompted other identity-based critical enterprises, such as gender studies and queer studies, which have deepened and challenged understandings of "social justice, subject formation, subjugated knowledges, and collective action" (Garland-Thomson, 2003, p.1). Hegemonic feminist theory was produced mainly by white, heterosexual, middle class women in the academy, which compelled feminists to look more carefully at the exclusionary, essentialist and oppressive aspects of the category (Garland-Thomson, 2003). Judith Butler (2003) charged that the category of woman represented exclusionary and restrictive normative values that failed to recognise the intersection of gender with race, class, sexuality and other identities that inflected the category of woman. These critiques have resulted in growing acknowledgement of multiple subject positions that women occupy and the limitations of the unitary notion of the classification woman and primacy of gender as a monolithic category.

Ali (2003) contends that the first wave of feminist research focussed on consciousness-raising and problematising tenets of positivist research such as rationality, objectivity and neutrality and the relationships between knowledge and power. These debates established as a critical tenet of feminist politics the notion of more collective forms of knowledge production. As Butler (1992, p.110) contends:

> Feminist theory has sought to understand the way in which systemic political and cultural structures are enacted through individual acts and practices, and how the analysis of ostensibly personal situations is clarified through situating the issues in a broader and shared cultural context... my pain or my silence or my anger or my perception is finally not mine alone, and that it delimits me in a shared cultural situation which in turn enables and empowers me in certain unanticipated ways.

The second wave of feminism saw the fragmentation of the term woman, leading to a focus on the construction of gender and the theorisation of the sex/gender system (Rubin, 2006) and the development of constitutive models where there was an acknowledgement of interlocking oppressions. These were influenced by the globalisation of knowledge, as well as challenges from postcolonial feminists about the universalism of women's experiences that had been assumed in the process of collective political action. Postcolonial feminists (Min-ha, 1994; Mohanty, et al., 1991; Narayan, 1997) pointed out that Western forms of feminism assumed that women were universally oppressed by patriarchy but in postcolonial societies, interlocking oppressions such as colonial experiences, class, and ethnic oppressions were also significant (Ali, 2007). The differences within and between groups of women instigated debates in feminism (Ali, 2003; Grewal & Kaplan, 1994; Lorde, 1984; Mohanty, et al., 1991; Moraga & Anzaldúa, 1981) leading to the decentring of Western feminisms as Western epistemological frameworks were exposed as limited for making sense of women's experiences outside the West (Ali, 2007). As Spivak (Sharpe & Spivak, 2003, p.617) contends:

> Cultural difference is spoken of but, by enthusiasm or convenience, a common human essence is assumed which denies the procedural importance of the difference. There is a related assumption: that the history of a sharing of the public and the private is the same among all groups of men and women as the one that follows through in terms of northwestern Europe or sometimes even Britain. This is the problem it seems to me. It's not so much a universalisation as seeing one history as the inevitable telos as well as the inevitable origin and past of all men and women everywhere.

Feminist projects such as liberal feminism[4] have been a target for postcolonial feminism. Kapur (2005, p.4) contends that postcolonial feminism:

> is in part a challenge to the systems of knowledge that continue to inform feminist understandings of women and the subaltern subject in the postcolonial world and seeks to create a project of inquiry and interrogation that will better inform feminist projects that speak to and for these subjects…The scholarship engages with feminist projects, especially liberalism, that fetishises the third world woman treating her as an object of study or as a subject to be rescued and rehabilitated by the feminist mission.

Constructions of 'other' women derived from liberal values signify particular power relations between Western women and non-Western women (Bredström, 2003). These constructions often have their origins in imperialist and racialised notions resulting in universalising and essentialising frameworks (Kapur, 2005), creating hierarchies that pit western women against non-Western women and elevating Western sexism as less virulent and disempowering than non-Western sexism (Bredström, 2003). Where Western women are represented as educated and modern liberal subjects who freely exercise choice and control over their own bodies, the 'non Western woman' is represented as oppressed by her culture, family and tradition which impinge on her sexuality. Ali (2003) concludes that the idealised portrayal of liberal values such as freedom and equality, hides the destructive and dehumanising practices of slavery, colonisation and expropriation that occurred within liberal frameworks, where liberal values were withheld not only from the colonised but many Western subjects, such as women (Narayan & Harding, 2000, p.84). Udayagiri (1995) surmises that there are three analytic strategies used in Western feminist discourse (when liberal and social feminism are deconstructed). These are: the essentialist construction of the category woman; the assumption of sexist oppression across cultures; and lastly the colonial intentions of these essentialist and universal suppositions. Therefore, a postcolonial feminist theoretical framework is especially valuable for knowledge development in nursing as it bypasses Christian charitable notions of tolerance, fetishised and essentialised representations of women or "facile postcolonialism which threatens to become a form of culturalism" (Bannerji, 2000, p.5).

4. The formulation of demands in feminist struggles ranging from the women's suffrage movement to women's rights to choose in the abortion debate have deployed liberal precepts of equality, autonomy and individual rights (Schwartzman, 2006). However, these same precepts have also undermined women's aims and reinforced not only sexism but also other oppressions.

In this thesis, I take as a starting point that maternal bodies are racialised and classed among other cultural identities and acknowledge that race, gender and class are aspects of social organisation that have been imbricated with each other in the legitimisation of imperial power both at 'home' and in the colonies. Acknowledging that gender is racialised and race is gendered (Burman, 2006) provides an opportunity to produce a sophisticated and nuanced analysis of migrant maternities for nursing scholarship and practice. Therefore, I bring rarely considered debates of gender and maternity into the discussion on immigration, and nationality in New Zealand, and I locate the racialised history and context of maternity into the predominantly white feminist work in maternity in New Zealand.

Focusing on the complex intersections of 'race', class and gender, particularly as articulated through discourses of gender, nation and citizenship, can highlight multiple power relations and prevent the reproduction of colonial racist discourses (Bannerji, 2000). Intersectional approaches prevent a reliance on liberal notions of subjectivity that speak to white, middle-class practices. Instead, I draw on a range of literatures including sociological, feminist and anthropological approaches for theorising migrant maternities. In order to resolve the theoretical and political impasse of categories such as gender under the death of the subject, I utilise a strategy of 'strategic essentialism' (Spivak, 1984–85) where political action is predicated on a shifting and plural subject, provisionally fixed in the interests of changing oppressive political categories and concepts.

### Nursing colonial and postcolonial

There is growing scholarship on the utility of postcolonial feminist theory for nursing theory and practice; however there is a dearth of scholarship on the complicity of nursing with colonisation.

Western medicine has been viewed as superior for curing disease and restoring health because of its perceived body of objective knowledge, and having the values most emblematic of Western civilisation such as enlightenment, benevolence and humanitarianism (Lewis, 1988). This view has come under threat as historians and sociologists have pointed out the political, economic and social imperatives driving medicine and the ends to which it has been put to work (Lewis, 1988). Western medicine from Christian missionary medicine to biomedicine has participated in the advancement of colonialism and imperialism (Nestel, 2006). In addition, medicine has used and continues to use the language of empire through its claims to modernity and universalism (Anderson, 1998). Western medicine lent moral credibility to the colonial enterprise with discourses

of modernity and progress linking medical knowledge and power with colonial rule (Ejiogu, 2009; Stoler, 1995).

Nursing as a profession originated in imperial history and maintains many colonial features (Gilbert, 2003). Florence Nightingale, who developed sanitary reforms and administrative skills during Britain's imperial campaign in the Crimea, is known as the originator of modern nursing in the European tradition. Nightingale made practical contributions to the imperial enterprise, through the founding of the Nightingale Training School for Nurses in 1860 that then became the model for similar establishments throughout the British Empire (Fahy, 2007). However, Pharris (2009) suggests that nursing began up to 2,000 years before Florence Nightingale with the advent of the first school of nursing for men in India, and in Prophet Mohammed's time Rufaidah bint Sa'ad established restorative and preventative care for soldiers and the wider community.

Typically, nursing multicultural models have ignored the historical context of imperialism and racism, and excluded from engagement the very people for whom such models are to be used thus reproducing dominance and ignoring the power to name (Allen, 2002). Nursing's liberal ideological values have been cited as a barrier to the development of a critical and political social conscience, because they have shaped practices that reproduce the dominant social order (Browne, 2001). Furthermore, the adequacy of liberal frameworks for theorising ethnicity and inequality has been critiqued for concealing the effects of gender, race and other categories that inscribe inequality (Hyams, 2004). Hence, new paradigms that consider the historical, cultural, social and economical forces that shape knowledge development have been sought (Browne, 2001; Jowett & O'Toole, 2006).

A postcolonial feminist perspective has been vaunted as a panacea to social injustice and inequality through enhancing both theory and practice in nursing (Blackford, 2003). Carrying an explicit methodological commitment to decolonising knowledge production, theory and practice including that of modern institutions, postcolonial theory "offers nursing scholarship a framework for understanding culture and identity as fluid and complex, historically situated, and discursively constructed" (Mohammed, 2006, p.98). However, operationalising postcolonial theoretical ideas in a research method are not without challenges (Reimer, Kirkham & Anderson, 2002; Raghuram & Madge, 2006) and much can be learned from feminist writing on methodology and ethics. As a researcher, my role is to create representations that "deliberately both acknowledge and unsettle the lingering social, political, and representational effects of colonial domination"

(Butz & Besio, 2004, p.355).

Advocates of a postcolonial feminist perspective suggest that it offers nursing a mechanism for decentring dominant culture, as it can provide a political and collective movement to interrogate how disparities are embedded, revealing taken for granted processes and critiquing oppressive practices (Anderson, 2000). Postcolonial inquiry is not only about understanding the continuing effects of colonialism but about creating a past-colonial future (Butz & Besio, 2004). A postcolonial feminist perspective can assist nursing to disrupt the status quo of politically neutral (conservative) social justice discourses in nursing to move beyond notions of fairness and equality which merely facilitate adaptation to unjust social structures. The goal is to develop a collective strategy based on recognition and participation, where economic, cultural, and political dimensions of a social justice agenda transform and disrupt power imbalances (Anderson, 2000; Browne, et al., 2005; Kirkham & Browne, 2006).

Cultural safety is an approach developed by indigenous Māori nurses that holds promise for operationalising postcolonial feminist theoretical ideas. It is a political discourse that is embedded in the undergraduate national nursing curriculum, and understood to be broadly applied across marginalised groups in New Zealand. Cultural safety originated in response to the poor recruitment and retention of Māori nurses (Nursing Council of New Zealand, 2002). The Nursing Council of New Zealand introduced the concept into nursing and midwifery curricula in 1992, developing the expectation that nurses practise in a 'culturally safe' manner. The focus is on health professional behaviours and institutional responses rather than consumers, and the recipient of those services is charged with describing whether they are safe or unsafe. Put simply, "unsafe practitioners diminish, demean and disempower those of other cultures, whilst safe practitioners recognize, respect and acknowledge the rights of others" (Cooney, 1994, p.6). The Nursing Council of New Zealand's (2005, p.4) definition of cultural safety is:

> The effective nursing practice of a person or family from another culture, and is determined by that person or family. Culture includes, but is not restricted to, age or generation; gender; sexual orientation; occupation and socioeconomic status; ethnic origin or migrant experience; religious or spiritual belief; and disability. The nurse delivering the nursing service will have undertaken a process of reflection on his or her own cultural identity and will recognise the impact that his or her personal

> culture has on his or her professional practice. Unsafe cultural practice comprises any action which diminishes, demeans or disempowers the cultural identity and well-being of an individual.

Cultural safety has been broadened to apply to any person or group of people who may differ from the nurse/midwife due to socioeconomic status, age, gender, sexual orientation, ethnic origin, migrant/refugee status, religious belief or disability (Ramsden, 1997), but the focus remains primarily on ethnicity (Nursing Council of New Zealand, 2005). In New Zealand, the cultural safety model has been integral to nurse education for over 10 years. Cultural safety does not aim to describe the practices of other ethnic groups, because such a strategy can lead to a checklist mentality that essentialises group members (Nursing Council of New Zealand, 2002). Furthermore, a nurse having knowledge of a client's culture could be disempowering for a client who is disenfranchised from his or her own culture, and could be seen as the continuation of a colonising process that is both demeaning and disempowering (Ramsden, 2002) or appropriative (Allen, 1999). Culturally safe nurses focus on self-understanding and recognising the attitudes and values nurses bring to their practice. A key tenet is that "a nurse or midwife who can understand his or her own culture and the theory of power relations can be culturally safe in any context" (Nursing Council of New Zealand, 2002, p.8). The progression towards culturally safe practice occurs in three steps as follows (Ramsden, 2002): i) cultural awareness, which involves understanding that there is difference; ii) cultural sensitivity, where difference is legitimated, leading to self-exploration; and cultural safety, the outcome of nursing and midwifery education where recipients of care define safe service.

Four principles are central to cultural safety. Principle one focuses on improving the health status of New Zealanders and emphasises health gains and positive health outcomes. Principle two focuses on a culturally safe nursing workforce, where nurses undertake a careful process of institutional and personal analysis of power relationships. This requires empowering service users and ensuring that nurses recognise their own diversity and how this might impact on any person who differs in any way. This principle emphasises moving beyond tasks to being relationship-focussed and responsive to the diverse needs of service users in such as way that it is defined as being safe by the recipient of care. Principle three requires a broad application of cultural safety toward recognising inequalities within health care interactions that are reflective of historical and national inequalities in health. It also asks that cause and effect relationships of

history, political, social and employment status, housing, education, gender and personal experience upon people who use nursing services are addressed. It insists that the legitimacy of difference and diversity in human behaviour and social structure is accepted, together with accepting that the attitudes and beliefs, policies and practices of health and disability service providers can act as barriers to service access. This principle includes quality improvement in service delivery and consumer rights. Finally, principle four states that cultural safety focuses on the nurse as a bearer of his/her own culture, history, attitudes and life experiences, and the response other people make to these factors. It challenges nurses to examine their practice carefully; recognising that the power relationship in nursing is biased toward service providers and that there is a need to balance power relationships in practice so consumers receive an effective service.

Cultural safety includes an emphasis on preparing nurses to resolve any tension between the cultures of nursing and the people using services so as to provide equitable, effective, efficient and acceptable service delivery which minimises risk. Lastly, self-understanding as well as the rights of others and legitimacy of difference should provide the nurse with the skills to work with all people who are different from them. Cultural safety has been a highly politicised development in New Zealand, experiencing a trial by media, where Pākehā were constructed as disadvantaged victims of political correctness (Wepa, 2001). There is concern that despite being a compulsory component of nursing and midwifery education, little research-based evidence is available to demonstrate an improvement in cultural appropriateness and responsiveness of New Zealand health care services or direct improvements in the health and care of Māori (Johnstone & Kanitsaki, 2007). Australian transcultural nursing scholars identify as problematic the lack of theorising and critique in cultural safety discourse, and a seemingly narrow focus on biculturalism (Johnstone & Kanitsaki, 2007). However, one could argue that if New Zealanders cannot have a relationship with one 'other', how they can have relationships with many 'others' (Butt, 2005).

Cultural safety provides a counter to race discourse in white settler societies where the race of the 'other' rather than the self is the reference point for difference ("thus whiteness is normalised and remains un-interrogated as a site of power in the oppression and marginalisation of racialised others" (Saxton, 2006, p.35)). Seeing the 'other' as the source of white terror (or threat to the nation) foregrounds issues of security and integrity at the expense of the workings of white power and privilege or nationalist exclusionary practices (Saxton, 2006). However, there is scepticism about the power of cultural safety and other

multicultural models to shift the centrality of whiteness as Southwick (2001, p.2) argues:

> neither position [Transcultural nursing and cultural safety] challenges the hegemonic taken-for-granted assumptions of nursing itself. In the absence of this challenge, both of these positions paradoxically act to reinforce the assumption that nursing is a profession undertaken exclusively by members of the dominant group in the society, and simultaneously reinforces the marginalised position of minority groups in the society as 'exotic other'

In the following section, I will outline the ways in which postcolonial scholars have shifted their interest away from difference in the form of the Othered identity, to examining the processes and conditions by which representations of difference are organised (Dhamoon, 2011). Such an analysis is in line with cultural safety and with poststructural notions that institutions produce subjects through discourses, rather than considering identities as simply pre-existing. This focus on the making of difference shows how subjects are socially produced through institutionalised discursive processes, and allows for the critique of the social production and organisation of relations of Othering and normalisation.

### Racialisation and culturalism in Aotearoa New Zealand

Racialisation is a central theme in postcolonial theory and has material effects including affecting health and well-being. It refers to "the way in which ideas about race are mapped onto particular groups or populations in specific contexts"(Culley, 2006, p.145). Understanding this process can provide a way of understanding why the health status of different ethnic groups varies. There is growing recognition of the link between poor health for Māori and colonisation. The loss of cultural beliefs, practices and language combined with the loss of economic resources for maintenance of these institutions has led to a growing commitment to redressing the structural injustices that have been the legacies of colonisation (Nursing Council of New Zealand, 2002; Swindells, 2006). Māori receive not only fewer but also poorer quality services (Ajwani, Blakely, Robson, Tobias, & Bonne, 2003). Mechanisms for redress include maintaining the principles of the Treaty of Waitangi and having a working bicultural relationship (Webby, 2001). Health professional behaviour is strongly linked with health disparities between Māori and non-Māori (Bacal, Jansen, & Smith, 2006;

McCreanor & Nairn, 2002a; McCreanor & Nairn, 2002b). Māori become sicker for longer periods and have shorter lives (Bacal, et al., 2006). Māori are likely to experience fewer referrals and diagnostic tests than non-Māori. In primary care, Māori are seen for a shorter time, offered less treatment and prescribed fewer secondary services, such as physiotherapy. Other examples include poor quality care in ischaemic heart disease (Bramley, et al., 2004), pain relief during labour and childbirth (Ministry of Health, 2006), depression (Arroll, Goodyear-Smith, & Lloyd, 2002), diabetes (Ministry of Health, 2005), and high rates of hospital adverse events (Davis, et al., 2006). Nursing has a social mandate to improve access for Māori in all aspects, to be responsive and to ensure the Treaty forms the basis of practice. With a unique place in nursing practice in New Zealand, the ability to apply the Treaty principles is fundamental to improving Māori health (Nursing Council of New Zealand, 2002). Deficit discourses and the individualising of health concerns must be challenged and recognition given that poor health for Māori results from colonisation and the loss of cultural beliefs, practices and language as well as economic resources for maintenance of these institutions (Nursing Council of New Zealand, 2002; Swindells, 2006). In alignment with policy agendas where there is a desire to achieve balance between 'realising potential' and 'remedying deficit' (Swindells, 2006), Māori health gain and development must be prioritised, and commitments made to reducing and eliminating Māori health inequalities.

### Culturalist discourses

> ...the paradox of democratic racism is that in the midst of a society that professes equality, there is racial inequality; instead of fairness, there is unfairness, instead of freedom of speech, there is the silencing of voices advocating change; instead of multiculturalism, ethnocentrism. Diversity becomes assimilation, the rule of law results in injustice, service means lack of access, and protection increases the vulnerability of racial-minority communities (Henry et al.1996, cited in Turrittin, Hagey, Guruge, Collins, & Mitchell, 2002, p.657).

One of the ways of accounting for the differential treatment of racialised groups is the concept of culturalism, a common mode for exploring 'difference' that is being identified as central to a new type of racism. 'New', 'symbolic', 'modern', 'cultural' and 'democratic' racism(s) are a group of terms which refer to

the subtle yet systematic practices at institutional or structural levels that disadvantage racialised groups. Culturalism is the narrow assumption that groups of people hold common values, which are compatible or incompatible with that of the dominant group; it is the application of 'commonsense' knowledge when describing behaviours of others, or to justify actions intended for them (Fassin, 2001). This politically acceptable form of racism transpires in two ways: firstly through the reification of culture through the concretising of objects and isolation from a social reality; and secondly, through the dominance of cultural over-determination (Fassin, 2001). This can be seen in the ways in which nurses draw on culturalist assumptions to guide practice. Groups of people are described in fixed and immutable ways; their culture is viewed as static and hermetically sealed, with no regard for fluidity and relationality, or any acknowledgement of how that group is shaped in regard to the dominant culture. Values, beliefs, knowledge, and customs are decontextualised from patriarchy, racism, imperialism, and colonialism (Browne & Varcoe, 2006; Culley, 2006; Razack, 1998).

This 'new racism' contrasts with 'old racism' in several ways (Augoustinos, et al., 2005). The old was based on notions of biological superiority and the hierarchical division of groups into superior and inferior, and expressed in blatant and hostile ways. In contrast, contemporary racism is more covert and subtle, a response to the social taboo against the open expression of racist sentiments. It is also more likely to be denied by majority group members. New racism is more covert because it is clothed in democratic liberal principles including justice, equality and fairness that appear to conflict with outcomes that are discriminatory for certain groups. The valuing of contested symbolic values like individual self-reliance, obedience, discipline and hard work, which are attributed to the dominant culture are a hallmark of new racism (Augoustinos, et al., 2005). Therefore, through a culturalist frame, disadvantage is attributed to the transgression of these symbolic values rather than being the result of structural inequities. Consequently, support for policy to redress economic and social inequality is unsupported by majority group members, who deny that their opposition is motivated by racism. Instead, claims of the moral shortcomings of minority group members are more likely to be put forward (Augoustinos, et al., 2005).

Cultural sensitivity (or transculturalism) is a prevalent individualistic nursing strategy for increasing responsiveness to ethnic groups experiencing disadvantage (Culley, 2006), however nurses mobilise this new racism or democratic racism when they use explanations of cultural difference and

incompatibility to justify health inequalities (Browne & Varcoe, 2006; Culley, 2006). Nursing discourses that support new racism are evidenced in the slowness with which nurses have taken to critiquing a liberal world view, and the disciplinary neutralisation of highly charged concepts such as race and class (Browne, 2001). In a culturalist paradigm, health problems are caused by cultural differences resulting in deviance and pathology. Cultural differences and deficits bear the blame for inequalities in health and access to health, the solution for which is a process of ethnic community integration on the part of the individual and health professional sensitivity in provision (Reed, 2003). However, these strategies are very much focussed at the level of the individual, and mean that personal and institutional racism, along with social, economic and citizenship contexts remain invisible, thus inequalities and the status quo are maintained (Reed, 2003).

Culley (2006) proposes that culturalist health discourses construct and reinforce cultural differences as the source of health problems. Consequently a deficit approach to cultural difference; negative stereotyping of ethnic clients and the invisibility of white ethnicity and racisms is upheld and combine promoting a limited bandwidth of practice (Culley, 2006). Racism has been reshaped in liberal societies in ways that make its expression subtler and more socially acceptable, through the judgement of racialised others in relation to dominant liberal norms in a form of new racism (Saxton, 2004). Nursing is complicit in this reshaping, through the development of frameworks that purport to enhance care while they simultaneously depoliticise racism and conversely embed racism into practice. Postcolonial theory and cultural safety provide mechanisms for departing from culturalist discourses, because their focus are the ways in which racism, imperialism, and colonialism shape encounters between marginalised groups and the dominant cultures, not only of whiteness but of professional culture.

## Conclusion

In this chapter I have outlined the ways in which liberalism is foundational to nursing and the health system. I have argued that a liberal framework is inadequate for the study of migrant maternity given that liberalism makes exclusion possible through its focus on the right to participation and political equality rather than equality of outcomes. Furthermore, the mobilisation of liberal interpretive resources such as individual rights, freedom and equality reproduce unequal power relations. Postcolonial theory and cultural safety are advanced as moves that shift the gaze away from the 'other' to consider 'the larger relations of power' within which migrant maternities occur (Luibhéid, 2003). A postcolonial

feminist vantage point moves the emphasis away from the 'victim blaming' tenor of liberal discourses where health disparities are attributed to people's individual 'choices', to shed light on how the effects of unfairness and injustice are socially, historically, economically, and politically produced. Nurses must recognise their complicity in power relations in frameworks such as cultural sensitivity that neglect structural remedies in favour of individual action, and accept that these culturally sensitive discourses do little to alleviate the kinds of inequalities Māori, Pacific, Asians and Refugees experience with regard to health. In the next chapter, I examine the maternity archive in order to historicise the ways in which colonial and neoliberal subjectivity has been formed in the context of maternity.

# Chapter Four: The governing of maternity

> It is a response to a critical contradiction—that society is dependent for the physical reproduction of its citizenry and workers on a process that is both subject to the vagaries of nature and occurring in the bodies of individual women. Attempts to control the process are not, then, surprising (Fox & Worts, 1999, p.331).

The production of life through biopower involves "knowledge of vital life processes, power relations that take humans as living beings as their object, and the modes of subjectification through which subjects work on themselves qua living beings "(Rabinow & Rose, 2006, p.197). Human reproduction represents a significant location for anatamopolitical and biopolitical techniques. Rates of infant and maternal mortality or average life expectancy are used as powerful political indices of the economic well-being of a nation in a hierarchical global order, prompting state interest in the fields of obstetrics, gynaecology and paediatrics (Georges, 2008). Therefore, as Fox suggests in the quote above, it is not surprising that the reproductive health needs of women have been subordinated in the interests of the collective good. This subordination takes the form of pro-natalist and anti-natalist policies depending on the social, economic and political priorities of the state, resulting in the differential targeting of women on the basis of class, race, ethnicity or nationality, thus reinforcing social divisions (Petersen & Lupton, 1996). Maternal and infant health has also been shaped by state concern about the quantity and quality of population in the context of imperial rivalry, both in the centre of empire and the outer edge of white settlement (Lewis, 1988). The 'health of the race' and infant health have been a central focus for doctors and politicians, where babies viewed as valuable assets to the struggle for imperial supremacy (Lewis, 1988).

Given that the birth of a future citizen is an event, which has emotional, biological, cultural and social significance, its management reflects core cultural values through the rites and routines that organize birth (Fox & Worts, 1999; Reiger, 2008). Therefore, maternity discourses and practices reflect and transmit historical and cultural visions of what it is to be a citizen (Georges, 2008). Health professionals establish the ways in which maternity is socially controlled and the key processes through which hegemonic social subjects are reproduced (Fox & Worts, 1999). For this reason, good mothering and good government are

intertwined (Ladd-Taylor & Umansky, 1998). Furthermore, neoliberal maternal subjectivity develops through discourses of citizenship and science, giving credence to Foucault's claim that models of power and knowledge have taken responsibility for the control of the life processes of modern populations, thus connecting biological and political existence (Hook, 2003). Maternity is a means of governmentality, where women produce themselves as 'good' or 'bad' mothers within normative modes of white middle class behaviour.

The purpose of this chapter is to provide a brief history of contemporary discourses of Western maternity, in order to deconstruct the regimes of power and knowledge that are at work and show how they produce and maintain particular power relations and inscribe maternal bodies. This genealogical process developed by Michel Foucault outlined in Chapter Two allows the tracking of the history of maternity practices and knowledge from the present to the past without assuming continuity. The purpose of this chapter is to provide a lens through which the empirical data in the findings chapters are then discursively analysed. In the first section I outline how citizenship and scientific discourses have been shaped by major Western projects of liberalism, capitalism, imperialism, maternalism, industrialisation and scientisation that have in turn shaped maternal subjectivity. Biopolitical strategies to manage reproduction are highlighted in the development of anti-natalist and pronatalist policies to address 'race suicide' and strategies of eugenics. I then examine the ways in which maternity has been governed through health professionals who assist the state to govern at a distance. I draw the chapter to a close by arguing that these discourses have been fundamental to the production of a 'responsible' pregnant woman and continue to shape contemporary white middle class motherhood, in that they constitute social norms against which 'other' mothers are evaluated. These discourses comprise the boundaries of what is acceptable if women who care for their infants are to be understood as 'good mothers' (Schmidt, 2008).

## Women and nation

Patriarchal ideologies construct the nation as gendered. On the one hand, the public needs of the nation are often identified with the aspirations of men, and in turn male national power depends on the construction of gender difference. Paradoxically, however, the concept of nation resembles that of the family and of the domestic, being derived from the word natio, which means to be born (McClintock, 1993, p.63). The face of the nation is often feminine e.g. 'Mother India', and countries tend to be denoted by the feminine pronoun and language as the 'mother' tongue. Mothers reproduce the nation biologically

through giving birth, and socially by maintaining and transmitting culture within the domestic or private sphere of home and family as keepers of the hearth, home and culture, (Yuval-Davis, 1993, p.627). Citizenship thus brings to mind issues of home, belonging and security, and raises questions about who is entitled to be a part of the home or nation (Chantler, 2007). Women's roles as biological and cultural reproducers of the nation are thus fundamental to the production of citizenship in the context of nationhood, in what Weinbaum (2004, p.5), terms the "the race/reproduction bind." The notion that race can be reproduced is central to the interrelated discourses of racism, nationalism, and imperialism. The concept of nation-as-home constructs the inside of the home and family as a refuge, and the outside as unruly and dangerous, a border requiring policing and surveillance (Chantler, 2007).

The patriarchal framing of the nation as a female body has three implications: firstly, the woman's body can reproduce the nation socially and biologically; secondly, this role emphasises production rather than participation; and finally, the role of men is to protect the nation (her body) (Yuval-Davis, 1993). The protection takes the guise of patriarchal nationalism and male power, 'out there' to protect the boundaries of the motherland (Georges, 2008; Hübinette, 2005). Thus, "women's gendered role as mother is claimed by the nation, movement or state to symbolize the collectivity... women's political importance is only within the context of other people's claim on her socio-biological role"(Gentry, 2009, p.238). The role of women in the private sphere attending to domestic duties is a frequent focus of nationalist propaganda that constructs mothers as "caregivers and nurturers, upholders of traditions and customs, reservoirs of culture" (Chadya, 2003, p.153), rather than as participants in culture.

These nationalist views of culture and history are linked with modernity and possessive Western liberal notions of individualism, an ideology concerned with "boundedness, continuity and homogeneity" (Handler, 1988, p.6). Differentiating culture and history in the model of the nation is essential to maintaining a homogenous group or national identity, which claims rights and powers (Mackey, 1999). The individual self in Western culture is similar to how nationalist ethnic groups are imagined in Western/civic nationalism. Bodies, like individuals and nations, must have firm boundaries and be unified, self-contained and self-regulating. The uncontrolled penetration of bodily boundaries must be prevented. Nationalist discourses with defensive policies and images are most apparent in discussions about immigration, where the egalitarian vision of liberalism, assimilation and citizenship has been unavailable to people who are 'too different' to be incorporated (Camiscioli, 2001).

The contemporary global economic order magnifies particular historical structures of violence and exploitation, as colonisation, patriarchy and capitalism are interdependent. Capital accumulation is fostered by "permanent relations of exploitation, domination and violence between men and women but also by extending patriarchal control over those defined as subordinate, whether women, indigenous peoples or the environment ('natural resources')" (Kuokkanen, 2008, p.222). Women have been vital to the imperial enterprise in two key ways (Seuffert, 2006). In the first, colonisation was viewed as a project that would modernise the sexist treatment of indigenous women (that is, "white men saving brown women from brown men" (Spivak, 1988, p.299), as well as civilising and domesticating colonised women who might be resistant to imperial projects. In the second, white women were constructed as symbols of the colonising nation's identity and honour, bearers of the 'Motherland's' culture into the colonised wilderness (Yuval-Davis, 1997, p.43-45). For these reasons, the investigation of intercultural dynamics must include an examination of the political locations and roles of women and their inclusion and exclusion from citizenship.

## Maternity and Citizenship

The politics of maternity and citizenship are paradoxical and complex (Pateman, 1992). Women have been both included and excluded in citizenship on the basis of their capacities and attributes in the development of modern patriarchy. On the one hand, citizenship has been constructed through the exclusion of women, because their 'nature' as child-bearers and mothers precludes them from taking part in political life (p.15). On the other, motherhood is a political status where women become incorporated into the political order through their service and duty to the state through their capacity for reproducing the nation. This mode of inclusion came about with the development of modern patriarchy, where women were viewed as subordinates and included into the private sphere but excluded from the public sphere (Pateman, 2002). For example in the United States, Republican motherhood was a site of civic virtue, demonstrated through bearing arms if you were a man and producing and rearing sons if you were a woman. These sons would embody republican virtues, even if as a woman you were excluded from citizenship (Kerber, 1976).

Pronatalists, colonialists, and economists viewed Asian reproduction as a potential economic threat (the 'Yellow Peril') because demographic strength was linked with the potential for territorial expansion. High Asian fertility and birth rates were contrasted to the lower fertility rates of the white race as a threat to European imperial hegemony (Camiscioli, 2001). Pronatalist movements often

had nationalist overtones, equating international prominence with demographic strength, requiring both productive and reproductive capacity (Camiscioli, 2001). Fears of 'race suicide' arose in early 20th Century Australia, New Zealand and the United States and made motherhood a political duty for white women in the interests of the nation and the health of the race (Bartlett, 2004). This discourse signalled a shift from Malthusian concerns about over-population and the inability of the environment to support growth (Camiscioli, 2001; Ram & Jolly, 1998). For women, reproducing white citizens in the colonies was a patriotic duty, superseding involvement in public affairs.

Anti-natal racial hygiene discourses have involved not just the quantity but also the quality of the population (Pateman, 1992). The abovementioned concern about 'race suicide' has been attributed to middle class women neglecting their duties by not having children while 'other' women (migrant, indigenous or working class) have been having too many in white settler societies. Interventions have involved the removal of children (most notably in 'the stolen generation' in Australia) and forced sterilisations without consent. Pronatalist and anti-natalist ideologies thus often occurred concurrently: for example, breastfeeding in Nazi Germany was obligatory and women were awarded a medal (called the Mutterkreuz) for rearing four or more children. At the same time extreme anti-natal racial hygiene doctrines were implemented against 'unfit mothers' resulting in forced sterilisations and abortions for women with mental or physical handicaps, or ethnically other women such as Jews, Gypsies and Slavs. Eugenicists viewed social problems as technical problems that could be addressed through biological solutions and the management of reproduction was central to their projects (Inda, 2002). Regulating the reproduction of those considered to be a burden on society meant that the well-being of the population could be secured and controlled. Reproduction as a managed process (biopower) rather than a biological process led to the construction of women's bodies as objects of surveillance and management. However, as I show in the next section, theories of biological evolution were central justifications for the management of that process.

### Individual mothering and the family as nursery

Victorian ideas of the home as a woman's sphere and moral standards of good mothering were specific to white middle class culture. Before the 19th Century women had been primarily associated with "sexuality, cunning and immorality"(Ladd-Taylor & Umansky, 1998, p.7). The pious development of a domestic sensibility gave women a clear role that was linked with more dignity,

authority and opportunities for education (Ladd-Taylor & Umansky, 1998). The new Anglo-Saxon middle class' individualised mothering contrasted with shared child rearing that was more common in other societies. This resulted in women from those communities, for example immigrant and indigenous women, being labelled as bad mothers (Ladd-Taylor & Umansky, 1998). Evolutionary theory played a role in demarcating good and bad mothering: Anglo-Saxon and Northern European women were positioned on the top of the hierarchy of the 'races' and were the only women capable of being good mothers irrespective of what other mothers did (Ladd-Taylor & Umansky, 1998). Such women bore the responsibility for ensuring the well-being of their families, the future of the nation and the progress of the race. Anglo-Saxon mothers were thus both exalted and pressured.

The high infant mortality rates of the time led to a focus on the management of mothers, instead of the politically challenging public health issues that were contributing to these mortality rates (Ram & Jolly, 1998). Foucault (1984) noted that the well-being of children in general was seen as a problem of government, and the family provided a link between private good health and general political objectives for the public body (cited in Petersen & Lupton, 1996). The family became the nursery of citizenship, with the family milieu acting as an exemplar for broader social relations (Petersen & Lupton, 1996). The hygiene of the home became women's work as the emphasis on health implications of domestic space grew in importance from the late 19th Century and early 20th Century (Petersen & Lupton, 1996). Cleanliness, the orderliness of the home and the bodies inhabiting the home became a duty of citizenship for women. Simultaneously, maternity became defined as caring, altruistic and absorbing and laws were developed in the United Kingdom to punish infanticide, abortion, and birth control (Petersen & Lupton, 1996). Schemes to address maternal malpractice such as health visitors (whose job it was to keep surveillance and intervene to educate women) were initiated to ensure that the British working class mother was subjected to the imperatives of the infant welfare movement and became a 'responsible' mother. A proliferation of organisations to promote public health and domestic hygiene among the working class thrived, assisted by upper or middle class women. Several researchers have noted (Aanerud & Frankenberg, 2007; Ram & Jolly, 1998) how this class-based maternalism in Europe and North America reflected a race-based maternalism in the colonies, where Europeans challenged and transformed indigenous mothering in the name of "civilisation, modernity and scientific medicine" (Jolly, 1998, p.1). Similarly, in colonised countries the 'cleaning up' of birth was achieved through both surveillance and improved hygiene and sanitation (Bartlett, 2004).

The moral regulation of the population through the governance of the family remains a contemporary parenting practice where women are considered responsible for producing, maintaining and protecting others' health and wellbeing (Ladd-Taylor & Umansky, 1998). Neoliberalism has further increased the responsibilities that are viewed as private and transferred to women when the government retreats (Berger & Guidroz, 2010). Therefore, the Foucauldian expansion of the art of government to include maximising the well-being of populations has a particular resonance in maternity.

### The neoliberal maternal subject

Being healthy is an important responsibility for a citizen (Petersen & Lupton, 1996). Health is unstable, and requires work, effort and various practices that allow one to be useful and good and fulfil the duties of citizenship. Working on oneself, being able to take control of one's body and emotions and being governable are important markers of dutiful citizenship. Citizenship requires both civic and civil responsibilities that are linked in specific ways (Petersen & Lupton, 1996). The private sphere is the realm of the civil, encompassing security and rights, while the civic refers to public solidarity and obligations. Being civil means being well behaved and reflexive (monitoring oneself with regard for others) and is seen as necessary for participation in the civic sphere of democracy. Thus regulatory technologies "construct an autonomous subject whose choices and desires are aligned with the objectives of the state and other social authorities and institutions" (Petersen & Lupton, 1996, p.64). Within a neoliberal context it is expected that the citizen will voluntarily conform to the goals of the state through self-discipline. The role of the state in universalising citizenship is therefore paradoxically attained through a process of individuation (Ong, 2006).

The discourse of the modern individual rational subject has created a particular kind of subjectivity that is termed healthism requiring the take up of health-promoting activities as a moral obligation (Roy, 2007). Healthist discourse emphasises an enterprising self who takes individual responsibility for health maintenance and enhancement, by engaging in self-discipline and self-surveillance. This ideology of the individual's responsibility to keep healthy is dominant in the media as well as professional healthcare discourses (Donnelly & McKellin, 2007, p.3):

> ..these ideologies and discourses reflect dominant western values for individualism, which, in turn, influence the direction of healthcare practice and the distribution of responsibility and role expectancies between individuals and institutions.

> Individualism has also influenced how responsibility for health is viewed, and thus how health care is being provided and practiced, and the ways in which people manage pervasive issues of blame and accountability.

This discrete, self-monitoring subject that invites and acts upon expert advice is a dominant feature of neoliberal public health policies, where it is assumed that access to information will result in effective self regulation (Stapleton & Keenan, 2009). This ideology is reflected in the way in which maternity health care systems position themselves as being the bearers of expert knowledge without acknowledging the credibility and legitimacy of other sources of knowledge such as family and community networks. A 'rational subject' model is assumed where authoritative professionals transmit information to individual women whose embodied, enculturated understandings and experiences are discounted or devalued. Pregnant and postnatal women are represented as autonomous social actors who are fully in control and knowledgeable about their bodies and 'free' to make and justify choices. Individuals and their caregivers are expected to engage in reflexive techniques and /or practices of subjectification, to be accountable for the choices that are made, and to account for their behaviours to those who are tasked with monitoring and validated for monitoring them (Stapleton & Keenan, 2009). However, these 'universal' concepts of choice and autonomy are socioculturally constructed, potentially coercive and constrained through the intersections of class, race, ideology and resources (Stapleton & Keenan, 2009).

The emphasis on women as primary carers, who bear responsibility for children, parents and partners through cleanliness, remains a dominant theme in contemporary Western societies (Petersen & Lupton, 1996). The individualising of motherhood has led to the dominance of foetal rights discourses, where the supposed interests of the foetus are put before the interests of women and even other children (Booth, 2010). Pregnant women are charged with ever-increasing responsibility over the health of their foetuses, while they themselves are reduced to being a container for their foetuses. This has led to the restriction of women's activities, requiring constant self-surveillance to protect the health of their foetus. This responsibility continues through infancy and adulthood and commits women to maximising the moral, social and psychological development of their children (Schmidt, 2008).

A large amount of work and self-discipline are required in order to comply with middle-class mothering standards, which are shaped by consumerist,

technological, medicalised, and professionalized discourses and fields. Within an ideology of intensive mothering, mothers are expected to devote large amounts of time, energy, and money to raise their children (Avishai, 2007). A corresponding reliance on expert advice in child-rearing decisions for middle and upper class parents accompanies this devotion. Avishai (2007) outlines how white middle-class women in the United States discursively construct the lactating body as a carefully managed site with breast-feeding as a project that takes place at this site. Project management skills such as assessment/research, planning and implementation are supplemented with expert knowledge, professional advice, and consumption. As a project it emerges from a capitalist industrialised patriarchal frame and contrasts with the notion of breastfeeding as intimate and embodied (Avishai, 2007). This valuing of the individual as a site is privileged in nursing as seen in the concept of individualised care, where the promotion of independence from nursing services through the emphasis on self-care, or the transfer of responsibility for care to informal carers or social care agencies (Gerrish, 2001). Nurses have typically believed that patients owned both the origin and the solution to their health problems. Therefore, neoliberalism can be considered to be both an expression of the biopolitics of the state as well and the standard setter for normative citizenship (Ong, 1999). Avishai's research reflects the ways in which neoliberal maternal subjectivity is constituted through scientific and expert knowledge.

## Scientific motherhood discourses

The 'cleaning up' of birth was a colonial and modernist enterprise, involving not only sanitation but also the governance of women's bodies (Bartlett, 2005). The discourses of science and government intertwined as techniques of biopower, and came to increasingly engineer maternity. Scientific motherhood evolved as a combination of maternal love and mechanistic scientific knowledge in the late 19th Century, and was influenced by two major developments in the 17th Century (Dykes, 2005). The first saw a shift from the embodied knowledge of women to science as the source of authoritative maternal knowledge. Science's tenets such as dualism, objectivism and reductionism led to the medicalisation of life and a framing of the body as a machine, predicated on the norm of the idealised masculine body (Donner, 2003). The second trend was the impact of increased population, industrialisation and urbanisation that occurred with the growth of economies and colonies under Western capitalism. Productivity to boost profits, and monitoring for efficiency and outputs was increasingly emphasised. This made possible "the controlled insertion of bodies into the machinery of

production and the adjustment of the phenomena of population to economic processes"(Foucault, 1977a, p.141). Population, production and profit became drivers for the creation of the major disciplines of hospitals, schools and other "techniques for making useful individuals" (Foucault, 1977a, p.211).

In the Victorian era in England, the factory and efficient production reached their peak and the ideologies that made industry productive began to permeate into other spheres of life (Dykes, 2005). Factors that enhanced efficiency such as timing, regularity and scheduling were applied to motherhood and parenting, and in turn women's roles were geared toward producing adults for the factory. Submission to the systems and disciplines necessary on a production line became warranted as part of parenting, eventually joined by tenets from early 20th Century behavioural psychology such as separation, control, routine and discipline. These Enlightenment tenets remain embedded in contemporary health systems and processes. Dykes draws on Martin (1990) to argue that under medicalisation "[maternal] labour is a production process, the woman is the labourer, her uterus is the machine, her baby is the product and the doctor is the factory supervisor." In a Marxist vein, the labouring woman requires an intermediary who can manage and control the process thus separating her from her birthing (Dykes, 2005). Kirkham (1989, p.132) extends the metaphor to suggest that the role of the midwife is as a "shop floor worker" who follows the supervisor's "instructions". Dykes (p.2285) theorises contemporary breastfeeding similarly:

> breastfeeding becomes the production process, the woman is still the labourer and her breasts now replace the uterus as the key functional machines. Now breast milk becomes the product, with her baby assuming the role of consumer. If the breasts (machines) are in 'good-working order' then they will 'produce' the right amount and quality of the 'product', breast milk. If the labourer uses them effectively, then they will deliver the 'product' efficiently and effectively and in the correct amount to the 'consumer', the baby.

This mechanistic view of breastfeeding and birth has two impacts: the first is that because these processes can go awry, a supervisor is needed (such as a midwife or health professional); secondly, the loss of confidence experienced by women as producers through a mechanistic metaphor. The expert/professional discourses of maternity thus produce particular kinds of maternal subjectivities around these impacts.

## Professional discourses

The body is central to struggles between different discursive formations, which inscribe the body according to their regimes of power and truth. Knowledge of how medical, nursing and midwifery discourses have developed is required in order to understand how maternity has been constructed through expert discourses (Papps & Olssen, 1997). I begin with a brief outline of biomedicine, but focus more on the ways in which midwifery has been shaped through its struggles with biomedicine. I then consider the ways in which Plunket nursing has been formed by maternalism and the eugenics movement before I examine the evolution of the midwifery profession in New Zealand, including its shaping by British colonial settlement and its assimilation into nursing and regulation by obstetrics. More thorough accounts of midwifery history in New Zealand are provided elsewhere (Papps & Olssen, 1997; Stojanovich, 2008), and my goal here is simply to provide enough historical material to serve as a platform for the current study. Finally, I problematise the liberal feminist tenets of partnership and choice underpinning such developments and conclude by suggesting that migrant women are marginalised by such discourses.

### Biomedicine

Medicine and related sciences, rather than simply providing neutral and objective facts, have had the social and political power to shape and promulgate particular subjectivities and corporealities over others (Shildrick & Price, 1998). In particular, technocratic and biomedical discourses have had a near-monopoly in representing maternity (Bartlett, 2004), with modern obstetrics positioning itself as the "scientific, prestigious and legitimate alternative" to midwifery since the 18th Century (Reiger, 2008, p.138). Within the pathologising binary logic of the medical model, women have been discursively positioned as lesser and dysfunctional versions of the healthy male norm and objects in need of medical intervention (Bell, 2006; Shildrick & Price, 1998). The technocratic paradigm frames pregnancy and birth as risky events where something could go wrong. However, resistant discourses such as midwifery challenge this dominant discourse.

The biomedical and midwifery/natural birth discourses are more similar than they first appear (Zadoroznyj, 2001). Both are predicated on a Cartesian dualism, that is the split between the res cogitans or the mind (that is intelligence, animation and self-hood), and the res extensa or the corporeal body (which functions mechanistically) (Lim, 1999). It is this modern bio/logical body, which positions women as deficient and disabled in biomedicine (Shildrick & Price,

1998). Zadoroznyj (2001) contends that while the biomedical approach focuses primarily on the somatic dimensions of birth; natural childbirth approaches focus on the psychological, but both require control. In the case of natural childbirth, control involves "disciplinary power over the self, in particular of the mind over the body" where internalised technologies of the self are invoked and where partners/support persons are required to adhere to the disciplinary regime (Zadoroznyj, 2001, p.269) problematising the notion of 'natural'. Skinner (1999) notes another similarity is the tendency for midwifery to model practice on medical models that highlight isolation rather than interdisciplinary co-operation and integration, which has the result of shifting the care for women outside their usual life contexts.

For Davis-Floyd (1994, p.1125) the technocratic model is a "cohesive hegemonic mythology . . . [which] . . . functions as a powerful agent of social control, shaping and channelling individual values, beliefs and behaviours". Davis-Floyd claims that in this technocratic model not only is there a Cartesian separation of mind-body, but also mother and baby are viewed separately and their best interests are viewed as conflicting. However, the tensions between the needs of mothers and babies are evident in natural birth discourses also. Feminists have argued that the biomedical model systematically disempowers women, as birth is constructed as risky, requiring technical management by experts such as specialist obstetricians, who not only control the way in which birth occurs but control birthing women themselves by virtue of their hold on expert knowledge (Zadoroznyj, 2001). One problem with this view is that it represents women as passive objects of medical discipline, who are without agency (Zadoroznyj, 2001) and yet women engage in medicalisation for a range of reasons. These include: maintaining control, alleviating pain and exhaustion and preventing their own and/or their child's death (Crossley, 2007). The development of late modernity has presented maternity practitioners with more expectations and demands and maternity consumers with complex, risky decisions (Skinner, 2006) in a complex biopolitical field. The complexity of this field complicates simple narrative accounts of the development of midwifery in New Zealand into an autonomous feminist profession.

### Midwifery discourses

Midwifery is an ancient profession, with the powerful role of midwives in life and death being a reason for their persecution (van Teijlingen, 2000). Today's 'division of labour' was evident in Roman times where midwives attended births and physicians attended more complex births (van Teijlingen, 2000). The decline

of female-dominated midwifery occurred in direct correlation with the rise of male dominated medicine. Its resurgence more recently has been in opposition to 'biomedical imperialism', and to counter the male appropriation of power in childbirth through discourses of partnership, informed choice and 'natural' childbirth (Foley & Faircloth, 2003; Zadoroznyj, 2001). The New Zealand midwifery profession has attempted to distinguish itself from nurses and doctors and advocated for both equality with doctors (through parity) and difference from doctors (through autonomy). These struggles for autonomy in the face of threats from medicine, hospitals and nursing (Stojanovic, 2008), have seen midwifery refashioned into an autonomous feminist profession valuing the centrality of partnership with women (Surtees, 2003). Midwives have created a point of difference where 'normal' and 'natural' births are emphasised, with women represented as 'naturally' capable and designed to carry and deliver a baby without the monitoring or intervention of physicians in a hospital setting (Macdonald, 2006). Midwifery has claimed the moral high ground, viewing itself as a protector of the health of women from an intervening medical corpus (Reiger, 2008). However, both midwifery and obstetrics have constructed professional 'rescue narratives' of birthing women (Annandale & Clark, 1996, p.31).

In the late 19th and 20th centuries, trained midwives were imported from Britain. Midwifery training began in 1904 with the advent of the Midwives Act, which saw free services offered to all women from 1938 (Pairman, 2006). Women could receive midwifery care in their homes and in maternity hospitals. However, medicalisation, hospitalisation and nursification led to changes to midwifery and New Zealand's maternity services (Stojanovic, 2008). Midwifery's autonomy became eroded due to the increase in medical intervention in childbirth as a result of policy and social changes, and midwives became relegated to doctor's assistants. Interventions to reduce infant mortality coupled with increased demand from women for pain-free childbirth also contributed to the medicalisation of birth. Through legislation, midwifery and nursing were initially combined with the word 'midwife' completely removed from legislation. This resulted in the redefinition of the scope of midwifery practice within nursing and under the supervision of doctors who were legally in charge even if midwives were involved (Longhurst, 2008; Pairman, 2006).

Mutually beneficial political lobbying by consumers and midwives in the late 1980s saw legislative changes occur heralding the return of autonomous midwifery practice, differentiated in scope from nursing. Meanwhile, maternity consumer activists viewed autonomous midwifery practice as a mechanism for gaining increased control over their own birthing (Pairman, 2006). The

subsequent passing of the Nurses Amendment Act in 1990 ushered in an era of choice of maternity care for New Zealand women, who could then choose a caregiver (Lead Maternity Carer or LMC) who would either co-ordinate or provide the care they required from early pregnancy to six weeks postpartum (Pairman, 2006). Direct access to government maternity funding meant midwives could be self-employed; prescribe; access pathology and radiology services, hospitals and other birthing facilities; and consult with or refer women to consultant obstetricians (Davis & Walker, 2009). Numbers of women taking up midwifery care are high, as seen by 2004 statistics which showed that 75.3% of New Zealand women were registered with a midwife to provide lead maternity care (Ministry of Health, 2007b). However, autonomous practice has not been without difficulty politically and philosophically. The midwifery profession is shaped by liberal feminist assumptions, which require the subject to be an enterprising, self who takes individual responsibility for health maintenance and enhancement through continual self-improvement. In this respect, the midwifery model is allied with the dominance of white middle class neoliberal subjects.

*Partnership*

Partnership between women and midwives in midwifery practice is a concept that recognises the centrality of women /consumers in society and to the profession (Freeman, Timperley, & Adair, 2004). Partnership was incorporated into the New Zealand College of Midwives Handbook for Practice in 1993 (New Zealand College of Midwives Inc, 1993) and is named as the first of ten standards of midwifery practice: The midwife works in partnership with the woman. Two key events contributed to the ethic of partnership, the first were the twin forces of feminism and consumerism that gained ground in women's health in the 1970s (as demonstrated by the return of midwifery described earlier). Secondly, the Inquiry into the Treatment of Women for Cervical Cancer at National Women's Hospital (also known as the Cartwright inquiry) in the 1980s identified the omission of informed consent and choices in cervical cancer screening and treatment as evidence of the violation of women's rights by the medical profession (Surtees, 2003). The findings of the inquiry led to a greater emphasis on "accountability, patient-centred care, self-determination and cultural sensitivity in the health service" (Surtees, 2003, p.30). The centrality of the consumer role became instantiated in roles such as patient/consumer advocates in health services and consumer representation on ethics committees. The Cartwright Inquiry and subsequent report led to a discursive shift from 'patient' to 'consumer'. As Judi Strid points out, the Inquiry:

> ...set in place the importance of consumer partnerships. Partnerships between the providers of health services and Tangata Whenua as well as providers and consumer organisations were identified as providing a community development model conducive to a more enlightened and equitable approach to health care. (cited in Surtees, 2003).

The newly formed New Zealand College of Midwives (NZCOM) emerged from the New Zealand Nurses Association (NZNA) in August 1988 and encouraged consumers as members and representatives in decision making (Daellenbach & Thorpe, 2007). This partnership recognised the value of the political and public support of midwifery provided by consumer groups in the return to autonomous midwifery practice, and acknowledged the need for further collaborative.

The midwifery autonomy regained in 1990 allowed for one-to-one practice, and the partnership between the midwife and the woman came to underpin the midwifery model in New Zealand maternity services (Pairman, 2006). Partnership assumed equity between mother and midwife, and acknowledged that both parties were making equally valuable contributions. Midwives provided professional knowledge, skills and experience; and the woman her hopes for her pregnancy and birth and her knowledge of herself and her family. Midwives assert that their point of difference from medicine, nursing and obstetric practice is empowerment and the flattening of the hierarchy assumed in models of partnership and collaboration (Daellenbach & Thorpe, 2007). However, partnership rests on consumers who are informed and want to take responsibility for being informed (DeSouza, 2006).

Critics from within the midwifery profession challenge the idealism of partnership on two counts: firstly, because it assumes a white, middle-class subject; and secondly because the relationship between midwives and clients is more akin to an individualist contract rather than oriented toward a participatory outcome (Skinner, 1999). Skinner's critique of contracturalism contradicts the explicit claim by Guilliland and Pairman (1995) that the concept of partnership originates from their understanding of partnership as it is encapsulated in the Treaty of Waitangi. Instead, Skinnner argues that the Treaty is a contract, which only has a contemporary reading of partnership, whereas more accurately the Treaty's demands for tino rangatiratanga (self-determination), protection and equity remain absent in the midwifery partnership.

Speaking as a practitioner, Skinner (1999, p.14) challenges the concept of partnership when working with marginalised women, pleading that she would be:

> left with a continual sense of failure as I strove toward negotiated control and responsibility but was inevitability left without it...what I have found however, is a great sense of enjoyment and privilege as I build relationships with women whose lives I would never have otherwise touched and who have come to know me enough to trust that I will treat them with respect and honesty. It is not a partnership it is a relationship.

Skinner (p.16) concludes that partnership "reflects a superficial analysis of society, neglecting to identify the dominant underlying right-wing philosophy of individualism, contracturalism and patriarchy. It does not recognise inequalities in power, or access to resources and is culturally elitist."

*Informed choice*

A second contentious tenet of midwifery is the notion of choice and being an informed consumer. Informed choice emerged as a women-centred, feminist mode of health care communication, which provided a contrast to more hierarchical and paternalistic modes associated with biomedical obstetrical contexts (Spoel, 2007). Informed choice became both an ideological principle implicit in midwifery models of care as well as a rhetorical practice of midwives exchanging information with women in order to facilitate decision-making (Spoel, 2007). This led to the advancement of new, empowered and choice-making subjects who were no longer passively recipient patients but active consumers of health care (Tully, Daellenbach, & Guilliland, 1998). In such woman-centred discourses, the mother as consumer takes responsibility for herself and her baby (Marshall & Woollett, 2000). This can be identified as a neoliberal subjectivity in that it relies on an individual who is rational and responsible within the discursive culture of midwifery. The operation of choice is also constrained by a tension within contemporary liberalism, where respect for the autonomy and privacy of individuals is posited against the concern for the regulation of social and economic life, as expert knowledges are a mechanism for regulating the choices of individuals within the limits of government, thereby limiting constraining the choices that are made (Murphy, 2003).

Radical feminist critiques of medicalisation have driven the agenda of choice and empowerment in childbirth in New Zealand and internationally. However, the instantiation of resistance to biomedical dominance and increased control for

women over their reproductive health has taken a more liberal trajectory. Liberal feminists view increasing choice in childbirth as a mechanism for enhancing birthing women's control, but radical and socialist feminists argue that choice has led to the illusion of freedom in an oppressive context where the status quo remains unchanged (Leap & Edwards, 2006). Leap and Edwards outline the limitations of the concept of informed choice. Firstly, the person who is doing the informing has a powerful influence on the decisions that are made. Being given information about a limited range of choices to do with care, does not guarantee involvement in decision-making, particularly when it is in the professional's interest for particular decisions to be made. Ultimately, the decision about what information is relevant rests in the hands of the gate keeping health professional. Leap and Edwards add that women's subject positions can be constraining when they have little control over the decision system and its values. Furthermore, if the mother disagrees with the health professional, she needs to have the resources to find alternative support, including attributes that will allow her to rhetorically challenge the decision (e.g. being articulate, assertive and knowledgeable).

There are also epistemological and ideological constraints that impact on the capability of midwives to provide informed choice, particularly when liberal feminist values (such as individual choice, autonomy/self-determination) are made within neoliberal consumerist rhetoric of health care (Spoel, 2007). Despite the intention to support a non-authoritarian, woman-centred ethic of care, informed consent functions as a key component of consumerist health care can mask new forms of social regulation shaping health care delivery (Skinner, 1999; Spoel, 2006). Spoel argues that even though midwifery has attempted to situate itself outside of such dominant norms, it can't help but be affected by these norms and to some extent reproduce them.

Schmidt's (2008) example of breastfeeding information provided by the Ministry of Health is emblematic of the neoliberal paradox. Schmidt contends that what appears to be the provision of scientific information about the benefits of breastfeeding and risks of formula feeding frames breastfeeding as the only rational option and appropriate choice for a good modern parent to make. Schmidt contextualises contemporary breastfeeding discourses in the new public health model, where neoliberal ideals of individual informed choice are advanced in tandem with a narrowing of choices to those that advantage the state, such as those that reduce costs.

Donna Haraway (1997, p.40) notes that 'choice' is a term that is "encrusted by colonies of semiotic barnacles in the reproductive politics of the last quarter

century". Although choice has been advanced in relation to feminist critiques of medicalisation, and aims to return women to the centre of birthing through information provision and active involvement. Informed choice is constrained by particular constructions of maternity and mothers; power relations; the status of midwifery; and the problematic intersection of liberal feminist values with neoliberal consumer rhetoric.

*Natural childbirth*

The final precept of liberal feminist discourses in midwifery practice to discuss is the idea of 'natural' childbirth, which is strongly intertwined with the discourses of partnership and informed choice and the active, conscious engagement of women in their births (Zadoroznyj, 2001). New Zealand's legislative changes of 1990, which paved the way for greater midwifery autonomy in birthing, also saw the advancement of natural childbirth as a philosophy. Central to this philosophy is the idea of being close to nature, and of returning women to the rewarding aspects of a labour. A core assumption is that pain is a natural part of birth but if women are resourced and informed the pain can be managed without recourse to chemical pain relief (Dick-Read, 1933, 1959; Kitzinger, 1964; Lamaze, 1958, 1984).

Implicit in natural childbirth is the view that the more women can be like other mammals, the more natural and rewarding their birthing experiences will be (Longhurst, 2008). Such assumptions maintain the view that the pregnant body can be separated from culture and social constraints whereas Longhurst (2008, p.92) argues the pregnant body is "always already socially and politically coded through a range of competing discourses." Hence, the feminist notion of taking control of one's life and body can be seen as a middle class perspective (Lazarus, 1997).

In the same vein Brubaker (2009) contends that natural childbirth discourses reflect class and race biases where control over birth and informed consumer choice are emphasised without recognising that these require access to particular cultural and material resources that aren't available to all women. Brubaker notes that the valuing of personal control in childbirth is linked with related middle-class attitudes including non-traditional sex roles and marital closeness that are thought to lead to increased spousal support during labour and contribute to less pain and enjoyment of childbirth. However, evidence is growing that alternative approaches to childbirth do not necessarily guarantee better treatment, particularly for migrant and refugee birthing women (Bowler, 1993b;

Liamputtong, 1994; DeSouza, 2005).

Class issues were observed by Zadoroznyj (2001), who found middle-class women had an expectation that they could exercise choice and control. This was enabled by their access to material resources, which supported choice and control. These manifested in the conscious selection of a technocratic, 'natural' or other discourse. Although there was a range in the extent to which the women subscribed to different discourses of birthing, they adopted a proactive orientation in choice making . On the other hand, Zadoroznyj found that working class women did not exercise choice to the same extent, or even consider issues such as approaches to pain relief or selection of providers such as midwives or doctors. They were fatalistic about their childbearing and relied little on abstract knowledge to inform decision-making. Thus they presented as having little knowledge and choice and invested considerable faith in medical 'experts'. This changed with subsequent births, with working-class women's orientations changing from being fatalistic toward a more empowered, activist role in subsequent maternity care. This was due to 'having' more knowledge, but also making significant shifts in identity. One concern about expert advice is that it tends to be gendered, patronising, and sets normative standards of mothering that render many women 'bad mothers' within a middle-class frame. In the process these standards reproduce racialized, ethnic, and class privileges as they depend on a particular construction of maternity (that is good middle-class mothering) where self-discipline is required (Avishai, 2007).

In a similar vein, Haraway (1997) has critiqued the consciousness raising activities emblematic of the women's health movement. She claims that the activities of vulva and vagina visualising—which aimed to displace medical knowledge dominance by 'seizing the Master's tools' (Lorde, 1984) of gynaecological speculum, mirror and flashlight—were effective mainly for white, well-educated, feminist health activists in the seventies. Although the women's health movement in the United States reflected the diversity of women of colour and cut across colour lines, the discovery and recovery narratives embedded in those activities were not only colonial but were an epistemic practice that did not change the structures of power. Restricting empowerment to within the dominant demographic and leaving differential health outcomes unaddressed (Davis, 2007). Moreover, the use of a speculum and mirror reflected the objectifying medical 'gaze' implicated in the medical appropriation of women's bodies blurring the boundaries between women who engaged in such activity and the male doctors they were attacking. Haraway proposed instead that the 'right speculum' could allow feminist health activists to document these differences and create structures

of accountability between differently located women. This would be a new politics of knowledge for a 'truly comprehensive' feminist politics of health and of techno science more generally (Haraway, 1997, p.84).

This section has shown how the discursive formations of midwifery and biomedicine have struggled to inscribe the maternal body through regimes of power and truth and the deployment of expert discourses. This argument is extended in the next section where I outline the powerful role that the "coalition of state and scientific authority" (Denoon, 1988, p.123) has taken in the form of the Royal New Zealand Plunket Society (Plunket), in enabling maternal and childcare to be professionalised and allowing particular points of view to be viewed as rational, scientific and efficient.

### Plunket

The extension of medico-scientific and instrumental principles to the management of body and self and interpersonal familial relations in New Zealand culture is evident in the work of the Royal Plunket Society (Plunket) that formed in the early 20th Century (Shaw, 2003). The Plunket society came to be a key agent in the surveillance and regulation of an imagined white maternal female subject, with a role in racially based maternalism. This difficult position combines roles as family friend and family inspector with nursing surveillance (Wilson, 2003).

The Royal New Zealand Plunket Society (Plunket) was founded by Doctor Truby King in 1907 to promote breast-feeding, improve bottle-feeding, and support mother-craft in order to address the high rates of infant mortality that were evident in New Zealand at that time. Before 1910 60-90 of every 1,000 white infants died before their first birthday, which had fallen to 50 by 1915 (Lewis, 1988). Plunket nursing was established under this banner and Karitane Hospitals and Karitane nurses were developed where nursing services were offered to all women with newborn babies. A restructuring between the 1950s and 1970s led to a reduction in home visiting and the closure of Karitane hospitals, which were replaced by Plunket Karitane family centres (Plunket, 2010).

The development in 1993 of a national schedule for Well Child care has shaped Plunket nursing practice. 'Well Child care' describes the services offered to all New Zealand children from birth to five years and their family or whānau including screening, surveillance, education and support. "The primary objective for Well Child-Tamariki Ora service providers is to support families/whānau to maximise their child's developmental potential and health status from birth to five

years, establishing a strong foundation for ongoing healthy development. Pregnancy and infancy should be seen as key opportunities to act for change" (Ministry of Health, 2010). From birth to four-to-six weeks, mother and baby receive Well Child / Tamariki Ora services from the lead maternity carer (midwife or GP or both in the case of a shared care arrangement), then between four-to-six weeks to four-to-five years of age, mother and child receive Well Child / Tamariki Ora services from a Well Child provider, who can be: a General Practice team (doctor and practice nurse); Plunket; Māori health provider; Pacific Island health provider or the Public Health Service (public health nurse, community nurse, community health worker, social worker) (The Paediatric Society of New Zealand and Starship Foundation, 2010).

Plunket is a community-based, not-for-profit national organisation and the biggest provider of Well Child/Tamariki Ora services in New Zealand. Plunket provides a range of services for families including: health education and promotion; clinical assessment; family / whānau care and support; and a universal free nursing service to parents of newborn babies taken up by over 90% of families, which includes home visits initially until the baby is three months old. Thereafter, parents take the child to their local Plunket clinic until the age of four for Well Child checks. In addition, Plunket Karitane Family Centres provide extra help and support with parenting issues, such as breastfeeding, infant nutrition, sleeping, child behaviour and other child health concerns. Plunket also provide: car seat rental schemes; playgroups; parent support groups; and a specialist free early childhood health telephone help service called PlunketLine which is staffed 24 hours a day, seven days a week. The Society's volunteer networks are fundamental to resourcing fund-raising efforts. In the 1990s Plunket established a training programme for Kaiāwhina (Māori Health Workers), and established Māori governance roles within its structure.

Plunket has a key role in supporting families and publicly campaigns for children and their interests – at a national and local level. Plunket prides itself on being 'independent' and receives funding through three streams: i) government, to provide Well Child services for the Ministry of Health; ii) community, through local fundraising and volunteer contributions which fund local services such as car seat rental schemes, toy libraries and family centres; and iii) corporate business partners who provide goods in kind and funding for particular initiatives (The Royal New Zealand Plunket Society, undated-c).

## The history of Plunket

Plunket came to be a key agent in the regulation of women, as both a civilising mission among Māori women and a eugenic project promoted among Pākehā women through discourses of scientific mothercraft (Wanhalla, 2007). It was one of many aspects of colonial governmentality where public health practices were used to count, describe and manage the population, with origins in developments in Britain. As Colborne (2009, p.487) suggests:

> the histories of health and medicine link New Zealand… to larger world historical processes and patterns; therefore, particular experiences of illness from colonial times to the near present are illuminated by complex histories of empire and imperialism, and colonialism and 'race'… Like other settler colonial nations of empire, New Zealand's making and remaking of its body politic helped to shape the attitudes towards the bodies within its borders, if not those bodies themselves.

In colonial New Zealand, the well-being of settlers was a priority in order for the maintenance of the reputation of a healthy colony. In addition, the livelihoods of settlers were dependent on the maintenance of good health (Coleborne, 2009). The first public hospitals were established in the 1840s in response to a concern about Māori health decline in the 1850s and 1860s. They were originally intended for sick Māori, as settlers were assumed to be reasonably healthy and the first Europeans were appointed 'Native Medical Officers' (Coleborne, 2009). This concern about Māori health was not echoed in social welfare services and infant welfare services later (Bryder, 2001). For a country that was proud of its race relations, New Zealand's services to Māori in the first half of the 20th Century are eye-opening. Its dual system of infant care (with Public health nurses and Plunket nurses) left Māori underserved, as Plunket provided care to the European population through clinics which did not accommodate Māori. The focus on white women and reproduction related to pervasive eugenic policies in the early 20th Century (Wanhalla, 2007).

The founding of a voluntary organisation, The Royal New Zealand Society for the Protection of Women and Children (with Lady Plunket, wife of the Governor General being the Patroness) by Dr Frederic Truby King was one such example in New Zealand. King had returned from medical studies in Edinburgh and wanted to develop a prescriptive maternal and childcare system that would

halt what he saw as the moral and physical degeneration of the white race (Denoon, 1988). The cause was supported by enthusiastic volunteers throughout the country, who set up branches and sub-branches and fundraised for everything, from salaries and expenses to building clinics and Karitane hospitals (The Royal New Zealand Plunket Society, undated-b). Dr King's organisation developed in response to a declining birth rate among white settlers in New Zealand (and Australia), and a situation where the working classes were having more children (and higher infant mortality rates) than the 'better classes.' Therefore the quality of future citizens was not seen to be up to that of the pioneer stock (Baird, 2006; Richardson, 2004; Wanhalla, 2007). Concerns about 'race suicide' (the differential fertility of white women in comparison with indigenous women) meant that an increase in the white population was pivotal to the defence and development of the nation (Baird, 2006). As Lewis (1988, P.123) quips "costly immigrants could be supplemented by uterine immigration". This anxiety was also linked with recovery from the Great War and the loss of virile men. The success of the new nation was to be derived from the growth of native-born settler families rather than growth from migration and national health was necessary for national wealth (Coleborne, 2009). This 'race anxiety' is evidenced in the slogan of Plunket's 1917 'Save the Babies' Week which was 'The Race marches forward on the feet of Little Children' (Bryder, 2001), a quote from an American Protestant hymnist by the name of Phillips Brooks. The claim was also made that babies were 'our best immigrants' (Bryder, 2001). In contrast Māori infant mortality was four times greater than the European population at this time (Bryder, 2001).

Truby King believed that he could create an Antipodean utopia, given that the new Dominions had abundant resources and did not have the class issues and poverty that were endemic in Europe (Lewis, 1988). King was committed to the notion of eugenics and the improvement of the race through selective breeding (Richardson, 2004). He had been impressed by the prolonged breastfeeding in Japan and attributed the military prowess of the Japanese to this practice. He saw the promotion of breastfeeding as a mechanism for enhancing imperial capability (Lewis, 1988). He ascribed the decline of ancient Greek and Roman civilisations (and modern France) with 'selfishness' and a reluctance to marry and procreate. He also advanced the view that in order for the white British Empire to be sustained, it was the moral responsibility of some women to bear healthy children. Of the children, the boys would become soldiers and girls would become mothers (Richardson, 2004). Bryder (2001) disputes eugenicist views of King given his focus on Pākehā, suggesting instead that the lack of attention given to

Māori was the consequence of territorial disputes between Plunket and the District Nursing service. Bryder adds that he was actually an environmentalist who believed that environment and education could ameliorate the limitations of heredity. Many women health professionals supported this theory of environmental eugenics and race improvement on the basis of creating an opportunity for women's work to be seen as work for the empire and extending their role as 'mothers of the race' (Wanhalla, 2007). However, King was subject to the dominant discourse of race anxiety/suicide.

The Plunket society dramatically reduced infant mortality rates, leading to international renown, however this data did not take into account Māori rates (Bryder, 2001). Their inclusion would have notably reduced the improvement in the statistics and raised questions about definitions of citizenship and health (Coleborne, 2009). The isolation and exclusion of Māori from the health system meant that they were unable to benefit from improvements that were developed for Pākehā. This was due to a demarcation dispute between Plunket and the Department of Public Health who had established a 'backblock' nursing scheme and instituted a 'Native health nursing scheme' so that two different groups were responsible for infant health, with the Department of Public Health keeping control of Māori infant health. The Health Department viewed their role as distinct from Plunket who would look after infants in 'cities and populous areas' only but many white women in rural areas and small towns wanted their own Plunket nurse rather than the District Nurse that was available. District Nurses looked after both European and Māori mothers, and some white mothers were concerned that Māori were potential sources of infection. The racial antipathy expressed by some mothers may have proved a barrier for Māori women to attend clinics. This was exacerbated by the attitudes of some nurses who refused to see Māori babies (Bryder, 2001). Even in urban areas in the 1960s Māori use of Plunket was limited and Bryder suggests that by and large Plunket was a monocultural organisation.

*Supporting Māori*

Plunket began to look for ways to support Māori families in the 1990s leading to an explicit commitment to supporting whānau Māori to achieve and maintain maximum health and wellbeing (National Library of New Zealand, undated). The Plunket vision, Mā te mahi ngātahi e pūawai ai ā tātou tamariki (The Royal New Zealand Plunket Society, undated-a) presents the role of Plunket

as being to work alongside whānau so that all children thrive. The Plunket Whānau Āwhina Whānau Ora Policy 2007-2017 represents three key policy areas corresponding with three Treaty of Waitangi principles– partnership, protection and participation:

1. Advocacy for tamariki Māori, with whānau and Māori communities

2. Integrated Māori capacity and capability within the organisation

3. Engaging and connecting with whānau and Māori communities

Other policies and guidelines to encourage appropriate working practices include: Plunket marae protocol, karakia and waiata booklet; Māori consultation policy and guidelines; Tikanga best practices policy; Koha policy and guidelines; Māori macrons policy and guidelines and bilingual signage guidelines. However, Duhn (2006, p.36) argues that these statements and visions reflect Plunket's function as a pedagogical technology over previously ungoverned (excluded) sections of the population in order to promote the best interests of broader society. This 'grab for power' could also be linked with the rise of iwi-operated health services post-Waitangi tribunal. This critique of Plunket expansion as a governing technology could also be levelled at Plunket's strategic aim to make services relevant and accessible to Pacific communities through the establishment of the role of Pacific services development manager and Pacific Advisory Group in order to better understand and respond to Pacific health perspectives in 2008 (The Royal New Zealand Plunket Society, 2008).

The relationship between mothers and Plunket nurses is central to the provision of well childcare, with evidence showing that frequent home visiting improves health outcomes for children (Clendon & Dignam, 2010). However, Wilson (2001) argues that the role of Plunket nurses is hardly neutral, given that mothers receive unrequested health education and their subsequent compliance with the health education messages that have been provided is then surveilled and monitored. Wilson (2001) goes further and suggests that this form of surveillance is effective because the power relations underpinning it stay hidden and it works through the desire of mothers to do the right thing. Consequently, the absence of direct coercion enables continuing access to families. This surveillance has consequences in light of the claim that nursing services are delivered within a context of partnership in the Treaty of Waitangi. However, it is important to acknowledge that power is relational and multidirectional, that is Plunket nurses are themselves not only governing, they operate in environments where their

work is shaped by pressures, constraints, imperatives and the tasks of governmentality.

## Conclusion

A genealogical approach has shown how a diverse range of discourses (including citizenship, scientific, industrial and professional) of Western maternity has defined what is good for maternal bodies. The authority and rationale for maternity care has been premised on particular discursive understandings utilising a range of techniques such as surveillance and partnership. I have shown that while the liberal maternal subject is required to make her own life, the early modern liberal state made the family a key site for regulation through medicalisation, scientisation and industrialisation leaving women tasked with increased individual responsibility for children. Women were incited to take up a 'biologico-moral responsibility' for their families requiring the advice and guidance of experts. Thus, mothers were incorporated into relations of surveillance and discipline, where they had to compare themselves against normative discourses. These discourses endure into the present as seen by the imperative for good maternal bodies to be produced and maintained through self regulation. An ideal neoliberal maternal subject is one who is scientifically literate, meets normative standards, and is invested in the ideology of intensive motherhood where the consumption of specialty objects and expert advice is pervasive (Avishai, 2007), and these kinds of subjects are vital to neoliberal/advanced liberal societies. Pregnant and postnatal women are positioned as autonomous social actors who are in control and knowledgeable about their bodies and are free to make and justify choices. However, the purported choice as liberal subjects, to choose between different discursive constructions of childbirth is illusory and reflects the paradox of neoliberalism, where the citizen is produced on the model of consumer, while simultaneously being subject to extensive governance. Notions of empowerment and participation central to nursing and midwifery discourses operate at the juncture of anatomo-politics and biopolitics, extending the clinical gaze while constructively managing the population. In the chapter that follows, I present the research design for the empirical part of the research that tests how these diverse discourses are taken up among two groups of migrant mothers and Plunket Nurses.

# Chapter Five: Adoption and production of discourses: Empirical methods

I have shown how maternity is a locus for the exercise of biopolitical strategies and subject to professional and neoliberal discourses in a clinical space that is also a colonial space. I now introduce the research methods for the discourse analysis of secondary empirical data. My aim is to analyse the ways in which three different groups of women are positioned with respect to the discursive figure of the migrant mother. Based on this positioning, the women embody or manage migrant maternity and take up, use and produce different discourses of migrant maternity. The three groups are migrant mothers from Korea; white migrant mothers (from South Africa, the US and Scotland) and Plunket Nurses.

I begin the chapter by outlining the operational aspects of a primary research study, describing the recruitment of participants and the focus group method of data collection. I then move to a discussion of the secondary analysis, which involved a discourse analysis informed by Michel Foucault and postcolonial feminist theory. My focus then moves to the broader politics of the research, starting with an exploration of the ethical considerations that arose in 'the doing' of the research, beyond the instititutional processes of ethical approval prior to undertaking the research. I describe my own 'risk' (Haraway, 1988) and explore how this is linked with my investments in the academy (Raghuram & Madge, 2006).

## Secondary analysis and datasets

One of the two empirical data sets for this study originated from the 2006 Families Commission study comprising five focus groups. Data from two focus groups—a focus group with ten European (White/Pākehā) migrant mothers, and another with nine Korean migrant mothers—were chosen for a secondary analysis. The second data set comprised new data from a focus group with Plunket Nurses, as I wanted to explore and analyse how these practitioners constructed migrant mothers. The application of a secondary analysis to the first data set from the larger study was in order to ask new questions about dominant maternity discourses.

In the primary study, forty women who were migrants to New Zealand and had given birth within the previous twelve months were interviewed about their

experiences of antenatal, labour and post-natal care in New Zealand (DeSouza, 2006). Contestable funding was received from the Families Commission for the project, and a volunteer committee of mothers who had used Plunket fundraised $5000 for the project. These funds were utilised for childcare and transport for the participants. Plunket provided support with logistics such as transport and childcare and Community Karitane and Plunket Nurses recruited women from the specific communities above (roughly reflecting the demographics of women who were accessing Plunket from migrant backgrounds). Prior to data collection, I obtained permission from my PhD supervisors, Plunket collaborators, the AUT ethics committee, Plunket Ethics committee and the funder, to renegotiate the terms of the project to incorporate data from the Families Commission project toward my PhD.

The desire to undertake a secondary analysis reflected different audiences, theoretical modes and methodologies. While the aim in the original research report (The Families Commission) was to describe and inform, the purpose of the secondary analysis was to scrutinise the conceptual and intellectual frameworks applied by nursing to migrant maternity and open up alternative knowledges and frameworks, thereby contributing to building theory. Although, secondary analysis typically refers to the reuse of existing data, which has been collected for previous purposes, in order to scrutinise new questions or apply a new perspective to an 'old' question (Hinds, Vogel, & Clarke-Steffen, 1997). It can also be a mechanism for corroborating, validating, or redefining the original, primary analysis (Gladstone, Volpe, & Boydell, 2007). Secondary analysis is more typically associated with deductive, quantitative research methods than with qualitative research, where the text from primary qualitative data is rarely used as a source of data outside the original research project. There is a lack of discussion on the topic and little in the way of evidence about the benefits and limitations of qualitative secondary analysis (Gladstone, et al., 2007). In qualitative research, data is viewed as the outcome of interaction between researchers and participants, with the primary researcher/s privileged as having an intimacy with the data given that they have collected it, designed the framework, immersed themselves in the field, and analysed it (Temple, Edwards, & Alexander, 2006). Hence in debates that have taken place about the secondary analysis of qualitative data, the data has usually been understood as having been collected by other researchers (Van den Berg, 2005).

The primary data from the white/Pākehā and Korean focus groups were chosen for further discourse analysis for this thesis after the thematic analysis had

been undertaken and synthesised for a report for the Families Commission (DeSouza, 2006). The driver for further investigation of data from these two groups, was that the thematic analysis highlighted a continuum of satisfaction with Korean women appearing the unhappiest with maternity care and white/Pākehā women the most satisfied, despite being constituted by neoliberal health consumption discourses. This dynamic reflected the discursive alignment of white women with midwifery discourses and Korean women with biomedical discourses, indicating a need to consider the colonising impacts of health care provision. It seemed important to consider these findings more carefully through a new conceptual focus and examine concepts, which were not central to the original research (Heaton, 1998). Therefore, it was decided to carefully re-analyse the two focus groups through postcolonial feminist and Foucauldian lenses and supplement this data with new focus groups with health professionals.

### Sampling

As I outlined in Chapter Two, the aim of a discourse analysis is to deconstruct how subjects are constituted through discourses. In analysing the speech, which is made up of the data from the focus groups and then converted into text, the goal is not to view the text as a reflection of any participant's 'true' experience (Scott, 1991) but of the discourses available in the social, cultural and historical context of the speakers (Gavey, 1989). To that end, I build upon a philosophy of sampling and validity established by Harvey Sacks, who founded conversation analysis in the mid 1960's (McHoul & Rapley, 2001). Sacks proposes that social order can be revealed in conversation through the concept of order at all points. This concept helps to explain how it is that people can be enculturated into societal discourses even if they only encounter a small or random portion of that culture. This holographic view means that a culture does not need to be found by sampling all of its venues but is actually present in each venue (cited in McHoul & Rapley, 2001, p. 443). Therefore, any fragment of culture displays the same fundamental order as any other and, indeed, as any 'whole' that the fragments might compose (cited in McHoul & Rapley, 2001, p. 443). Thus a fragment of culture such as a focus group with Plunket nurses inevitably reflects something that broadly happens across Plunket nurse culture as a whole, even if not in every instance of that culture. I now outline how participants were recruited to the original study.

## Recruitment

### Recruiting migrant mothers

A recruiter who was ethnically matched with the group of mothers and employed at Plunket examined the women's records to find mothers that met the ethnic criteria for inclusion in the focus groups and then made phone calls to assess whether women met the criteria for the group (less than one year post-partum and a migrant). In view of the potential for coercion, the Plunket and Karitane nurses were given clear processes for ensuring that women did indeed take part willingly. The recruiter posted the information sheet to the mother and provided her with two weeks to consider the invitation. Information sheets (see Appendices 1 and 2) and consent forms were also provided in English or Korean (see Appendices 4 and 5). Two subsequent phone calls were made. One to see if the information had been received and if the mother was interested in taking part and then a follow up call prior to the group to see if she was still interested in attending. The scope of the project included migrant women from European backgrounds who comprise a large percentage of migrant women but are often not described as migrants as they are absorbed into the designation of Pākehā /European.

### Recruiting health professionals

Following the focus groups with the mothers, I organised a number of focus groups with health professionals in 2007. Focus groups were envisaged as providing a milieu where conversations replicating those that occur in an every day work environment might occur, as spontaneous workplace conversations had been a catalyst for this research. Two key health professionals that offer care to women during the perinatal period are Plunket nurses and midwives, and I planned to interview both.

A focus group was arranged with Plunket staff with the assistance of the local manager who publicised the study. A venue was organised at a Plunket family centre and a focus group held in the afternoon when staff had finished their visits to new mothers and clinics. Eight Plunket nurses attended and all but one came from migrant backgrounds (five from Britain, one from Asia and one from the Middle East) and all were aged 40 and over. In the process of recruitment I had been concerned with getting Pākehā nurses until I realised that what was of analytic interest were not so much the racial identity politics, but the regimes of truth in Plunket nursing 'culture' and therefore the subject positions and discourses available to Plunket nurses. A further concern was whether the

nurses would seek to present themselves as reflexive and self-regulating, in the context of being my peers and in terms of how they might be represented in the research. That is, they might have the desire to narrate themselves through dominant discourses of professionalism or through particular models of subjectivity such as 'the kind caring Plunket nurse' (Alldred & Gillies, 2002). I was concerned that nurses from the same organisation might feel obliged to stay within a particular discursive repertoire out of fear of any deviation being marked as a problem or pathology.

My efforts to organise a focus group of Midwives were unsuccessful, in large part due to their workload issues as has been found in other research (Douche, 2008). Working in close consultation with both the New Zealand College of Midwives, Midwifery leaders at various District health boards and colleagues I organised a focus group. However, the six midwives who had agreed to be present on the day cancelled on the morning of the group because their commitments precluded them from attending the focus group. A further attempt was similarly unsuccessful and given time constraints organising a further group was not pursued. Given my preference for focus groups, which I explain below, I did not pursue individual interviews with midwives.

## Data Collection

This data collection for this thesis took place in a major city. As explained above, it had two data sets. The first data set was collected as part of the Families Commission study. It involved collecting migrant mothers' retrospective accounts of receiving health care during the perinatal period, specifically pregnancy, labour/delivery and the postnatal period (up to one year). Plunket nurses were involved in assisting with the recruitment of participants. The second data set phase involved obtaining data from Plunket nurses about their experiences of working with migrant mothers six weeks postpartum onwards.

### Focus groups

Focus groups were selected as a method for data collection for theoretical, practical and therapeutic reasons. Theoretically speaking, I wanted to shift the emphasis away from the primacy of the individual, and individual consciousness and experience, to an acknowledgement that subjects are constituted by experience (Crowe, 1998; Scott, 1991). The humanist privileging of the individual subject, as someone who knows and understands themselves and is able to communicate about their experiences to a researcher, who can then represent this knowledge through language has been widely critiqued. Instead, taking the

poststructuralist view that language is cultural not natural, I focussed on creating a social milieu where socially available vocabularies within particular groups or communities could be explored (Crowe, 1998).

Focus groups have practical research benefits in that they allow access to large numbers of people at one time enabling interaction within a flexible structure (Hudson, Aranda, & McMurray, 2002). They allow for the expression of many voices, views and experiences and are less expensive than individual interviews. As a researcher and a former clinician, I aimed for direct benefit and value for participants (Krueger & Casey, 2008) which focus groups have been thought to provide. A group can be more satisfying for a participant than an individual interview because participants can 'choose' how much they want to contribute to the discussion and when. Focus groups reduce pressure on individuals because they provide opportunities for reflection and time to frame a response while others are speaking. My goal was to create an environment that mirrored the social world as much as possible, encouraging dialogue between participants and avoiding a stilted question and answer format (Stewart & Mackinlay, 2003).

From a therapeutic point of view as a former group therapist offering support to women who had postnatal depression, I had witnessed the beneficial effects of groups. This strongly influenced the choice of focus groups, because I felt women could provide hope and encouragement for other women. Madriz (1998) claims focus groups have emancipatory potential for people belonging to marginalised groups and I hoped that the sharing that would occur in these groups would be positive and validating for the women who took part. This was a similar rationale for wanting to conduct health professional focus groups (as historically midwives and nurses have viewed themselves as marginalised in relation to the medical profession and to management). In this vein I felt that groups were a format where participants could share and build on each other's ideas, beliefs, and attitudes among other women who had shared a similar experience (Kitzinger, 1994, 1995). Rice and Ezzy (1999) note that these interactions can be complementary or challenging, revealing unexpected insights that would not necessarily be seen in an individual interview. In this way, the social nature of a group interview can enhance the quality of interaction and the richness of data.

There are drawbacks to using focus groups, including the risk of some people dominating the discussion and not allowing quieter members to be heard or influencing the contributions of others (Krueger & Casey, 2008). Furthermore,

the structure of groups is such that it is more difficult to pursue 'forensic' questions that are deep and challenging. I engaged trained and highly skilled group facilitators that had prior experience in research or counselling to mitigate these issues.

### Focus groups with mothers

As part of the primary Families Commission project, I had developed a schedule of open ended questions to generate qualitative data concerning the experiences of motherhood in a new country. The questions were developed and refined in consultation with Australian colleagues Professor Bryanne Barnett and Dr Rhonda Small, and discussion with the research team including the cultural consultants and community researchers who facilitated the focus groups. A self-report questionnaire (completed before the group discussion) gathered socio-demographic information, including age and marital status (see Appendix 8).

Both a facilitator and a co-facilitator were present, the latter acting as an observer/note-taker who also assisted with logistics. Each focus group ran for approximately ninety minutes in order to provide the opportunity to obtain a range of perspectives. Before each focus group began, each participant was asked to complete a demographics form, a consent form and a group confidentiality agreement (translated into Korean for the Korean group). A short introduction was provided about the purpose of the research and structure of the focus group. The semi-structured interview schedule aimed to identify the strategies used by women to manage the transition to parenthood in a new country such as, what formal and informal support systems did they use and how effective were these perceived to be (Appendix 9). After the discussion, the co-facilitator provided a brief summary of the major issues that were raised. Participants then had an opportunity to clarify points or offer additional insights. After the participants had left the room, the two facilitators had a debriefing session where they discussed their overall impressions and the main themes. The focus group interviews were recorded and transcribed, and I met with both facilitators and co-facilitators afterwards to discuss the focus groups.

#### *White mothers focus group*

The data collection for this group of participants took place in 2006. Twenty women were provided with information (Appendix 1) and ten came on the day. The women had migrated from South Africa (Jane and Charlotte), England (Nancy, Annette, Olive, Sarah, Carol), the US (Joan and Mary) and Scotland (Georgina) and were aged between 29-40 years. They had been living in New

Zealand for between two years and ten years and they were all first time mothers. Four had a post-graduate qualification, four had an under-graduate qualification and one had a Trade certificate. Their occupations included: teacher, scientist, project manager, account manager, project manager, lecturer. Their reasons for migrating were primarily for the lifestyle and for their husband's career. All but one of the mothers had her baby present with her. The facilitator and note taker (ethnically matched to the women) greeted the women as they arrived with their babies. The facilitator was an experienced counsellor, so was able to facilitate a safe and effective focus group while also adhering to the guidelines that had been provided. Although a crèche had been organised by the Plunket society and was offered to all the women as they arrived, most of the mothers initially chose to keep their babies with them. As the focus group proceeded and babies settled, the women moved the babies into the crèche popping in and out of the group to check on them and/or settle them. As the women arrived they were introduced to each other and asked to fill out the demographics form (Appendix 8) and to hand the consent form (Appendix 4) to the note taker. The seating was organised into a semi circle with a whiteboard displaying the key headings for the focus group discussion (taken from the facilitator guidelines supplied by me to the focus group facilitator). This group appeared to be a highly educated and articulate group of women. Once everyone had arrived the facilitator welcomed everyone, briefly stated the purpose of the focus group and thanked everyone for attending and contributing to the project. Everyone introduced themselves including the note taker and facilitator. A few minutes was then taken to establish the focus group discussion guidelines including a brief discussion about confidentiality. The women were informed the session would be tape-recorded and reminded that they could receive a copy of the transcript. Two women said they were returning to their home countries, and so although they were interested they wouldn't take up this offer.

*Korean mothers focus group*

A Korean general practitioner and a Korean counsellor, who also provided cultural advice through the data analysis, facilitated the Korean focus group, which took place in 2006. They were able to facilitate a safe and effective focus group and adhere to the guidelines that had been provided. The focus group was conducted in Korean, recorded and transcribed, then translated into English and verified by an independent translator who signed a confidentiality agreement (Appendix 7). As the women arrived with their babies, the facilitator and note taker greeted them. Although a crèche had been organised most of the Korean mothers kept their babies with them. As the women arrived they were introduced

to each other and asked to fill out the demographics form (Appendix 8) and to hand the consent form (Appendix 4) to the note taker. The seating was organised into a semi circle with a whiteboard displaying the key headings for the focus group discussion (taken from the facilitator guidelines supplied by me to the focus group facilitator). The facilitators were asked to write up their own notes and interpretation of the research discussions. These were included in the overall analysis of the focus groups, to ensure that the cultural context was included. I met with both Korean facilitators afterwards to discuss the focus groups and later to discuss my preliminary findings. This data helped to inform my analysis. The focus group was comprised of 8 women (all names are pseudonyms): Mee-Young, Ji-Eun, Jung-Ja, Young-Ja, Young-Mee, Mee-Sook, Young-Hee and Yoon-Mee and were aged between 29-34 years. They had lived in New Zealand for between one year and five and most of the women were first time mothers, with the exception of two women. One woman had her first baby in Korea and another woman had two of her three children born in Korea. The mothers all had under-graduate qualifications and had occupations that included receptionist, office worker and teacher. Two of the women had their own businesses. The Korean participants had migrated primarily for their husband's work and one woman had migrated for her children's education.

*Focus groups with Plunket Nurses*

Eight Plunket nurses took part in the Plunket focus group held at a Family Centre based in the community. Identifying information e.g. ethnicity and length of time practising is not provided as it could jeopardise their anonymity. Information sheets and consent forms (see Appendices 3 and 6) had been sent electronically to the local area manager who passed them on to her staff. Those who were interested in taking part in the research then were invited to email me about their interest and were provided with information about the date and time of the focus group.

A schedule of open-ended questions was used to structure the discussion. The atmosphere was relaxed and convivial because most of the nurses knew each other. Unlike the mothers' groups, I made the decision not to match the groups ethnically but to conduct the focus group myself as the rationale for matching had been to create a safe space based on language similarity and ethnicity and in the case of the Plunket nurses (who were ethnically diverse), I believed that my relationship with the organisation, as well as my socialisation as a nurse could allow participants to speak freely (In hindsight, I also realise that speaking freely could also have been achieved with a distinterested outsider researcher). Matching

values, beliefs, and attitudes between researcher and participants is generally considered more valuable than matching on the basis of sociodemographic characteristics such as gender, ethnicity, and language (Flaskerud & Nyamathi, 2000).

The focus group questions were divided into three main sections. The first part focused on introducing myself (although I was well known to most of the group and knew most of them), introducing the project and its aims, highlighting the issues of confidentiality and requesting permission to audiotape the interview. Importantly it was emphasised that the project was not about individual opinions but about shared understandings. The second part of the group focussed on views and perceptions of caring for migrant women. My aim in this part of the group was to attempt to elicit the discourses used by the nurses when they talked about their work with migrant mothers. Questions were open ended and exploratory, and the term 'migrant mothers' was not defined in advance.

After personal discussions of practice, the final part of the focus group discussion focussed on policy and education. The group discussed the terms cultural safety and cultural competence, how they understood those terms, how they might assess their effectiveness and whether they thought these concepts had an impact on health outcomes. I also asked questions about processes that might promote safety and quality in nursing for migrant mothers. I concluded with a question about whether there were factors in their own backgrounds or life experiences that might have influenced their capacity to care for migrant mothers. These questions about cultural safety and competence were derived with permission from the work of Megan-Jane Johnstone and Olga Kanitsaki (2005). The focus group concluded with an opportunity for discussion of any other issue that we might not have already covered or that might seem relevant to add. A transcriber who signed a confidentiality agreement, prior to handling the data, then transcribed the focus group interview.

## Data analysis

A focus of this data analysis is the language practices or 'ways of talking' of health professionals and migrant mothers located at a societal level, that is, culturally available explanations rather than individual thoughts (Willig, 2002).

### *Stages*

One of the challenges in analysing the data was moving from a descriptive and thematic style of analysis to a critical and discursive analysis–a move to how

people were positioned within discourses. Willig (2002) distinguishes between two forms of discourse analysis. The first focuses on discourse practices and the performative attributes of discourse. Derived from ethnomethodology and conversation analysis, discourse is viewed as fluid and variable and analyses emphasis in how speakers mobilise discursive resources in order to achieve particular ends in the context of social interaction. Here subjectivities are viewed as transient products of specific and local discursive formations. In the second type of discourse analysis, the scope of inquiry centres on the role of discourses in constructing subjectivity, self-hood and power relations. This work draws on Foucault and other poststructuralist theory to examine the role of discourses in the context of social processes and power relations. As outlined in chapter two of this thesis, Foucault elaborated the microphysics of power, which shape the discourses, produce and regulate subjects within diverse social practices. Of interest here are the range of available subject positions in discourse and what implications those subject positions hold for different groups in terms of their self-hood and subjective experience. This analysis can aid understanding of the relationship between "subjectification (the condition of being a subject) and subjectivity (the lived experience of being subject)" (Walkerdine, 2001, P.20).

Once the speech in the focus group discussions was converted into the written text, I followed the typical procedures of Foucauldian discourse analysis, breaking apart texts into unique and contained discourses and attempting to identify speaking positions and relations of power (Parker, 1999). When I began analysing the transcripts, my focus was on what speakers were doing with their talk and what discursive resources they were drawing upon. In the Korean and white mothers' transcripts, I noted how mothers operated in and against discursive constructions promulgated by health professionals (midwives and nurses) in the perinatal period. I paid particular attention to power relations; how mothers resisted these relations; and how they built different power/knowledge relations in their construction of migrant maternities. Therefore, I was looking at the subject positions and strategies used by the women to negotiate their varying subjectivities as mothers in a new country. In particular I was interested in the way in which the women spoke about the embodied experiences of becoming pregnant, labour, delivery and the post-partum period and how they established and negotiated their relationships with health providers. As I read the Korean transcript, I asked the question: "How are Korean women deploying technologies of power and self to manage the competing tensions of their own cultural beliefs that are strongly embedded within biomedical discourses and dominant midwifery discourses?" As I read the white focus group transcript, I was searching

for ways in which women were aligned with midwifery discourses. I also looked at the different discourses in relation to birth in the mothers' transcripts, for example 'birth as risky' and 'birth as normal' and also how the women resisted the normalising practices of nurses and midwives.

I loosely drew on Willig's (2003) Foucauldian approach to discourse analysis consisting of six stages.

Stage 1: Discursive constructions. In this first step, the different ways in which migrant mothers construct birth and the ways in which Plunket nurses construct migrant maternity/mothers are identified.

Stage 2: Discourses of birth/migrant maternity. Having identified how women constructed birth and how Plunket nurses construct migrant motherhood, Stage 2 focuses upon the differences between the constructions of birth/migrant motherhood which analysis revealed and locates the discursive constructions of the object within wider discourses.

Stage 3: Action orientation. In this step, a closer look at the discursive contexts where the different constructions of motherhood are deployed was required. I asked, for example what was being gained from constructing birth as risky/normal and migrant mothers as a problem and how this related to other constructions in the text?

Stage 4: Positionings. This stage explored the subject positions available to speakers within networks of meaning (Willig 2001, cited in Burr & Chapman, 2004).

Stage 5: Practice. This stage was concerned with representing the relationship between discourse and practice. I attempted to explore the ways in which the discursive constructions of motherhood and the subject positions of the women interviewed open up, or close down, opportunities for action.

Stage 6: Subjectivity. The final stage of this discursive analytic approach is one Willig (2003) considers the most speculative. Here I sought to make links between the discursive constructions of motherhood and the implications for subjective experience and asked, "What could be felt, thought and experienced?"

The nurses' focus group transcript was read through a postcolonial analysis, drawing on the theoretical findings of the previous chapters. I asked how statements about maternity and perinatal practices operated as strategies of bio-power. Attention was paid to the way in which the nurses spoke about migrant

mothers with regard to material practices such as breastfeeding, sleep and support from family. Questions asked included: 'How are the nurses in this study deploying technologies of power with regard to migrant maternities?' 'How are migrant maternities discursively constructed?' I began by reading for fragments of discourse and by looking for inflections of colonialism and associated practices such as racism, culturalisation and normalisation in the talk of nurses, (Tiffin & Lawson, 1994). I considered both how nurses used disciplinary practices to 'constitute' migrant mother's subjectivities in limited ways and how they might generate alternatives. For example, on page 169 I discursively analyse a nurse's talk in the context of Victorian ideals of nurse subjectivity (the battleaxe) and show how the incident is permeated with the Foucauldian technologies of power— of surveillance and discipline. Reading the text of the reported incident through a postcolonial lens points to a missionary and civilising narrative with risk deployed as a justification for redefining the structure of the environment.

When reading all the transcripts, I worked to ensure that I was not 'forcing' the data into pre-determined assumptions derived from the genealogical analysis of the literature, by making sure that I paid attention to exceptions in the transcript and alternative discourses that I might not have already identified. I also used discussions with my supervisors as a way of cross checking and considering potential blind spots.

## Ethics in research

Power relationships are reflected in representations of knowledge (Huntington & Gilmour, 2001). Poststructural and feminist research methodologies are deconstructive and constructive, they are used to disrupt theoretical, moral, and political inadequacies through the lenses of race, gender and other axes of oppression, while opening space for the legitimation of currently delegitimated knowledge and creating new possibilities for professional practice (England, 1994). However, where traditional methods provided "epistemological security"(England, 1994, p.242), or a safe base from which research could be undertaken, these feminist and poststructural methodologies do not provide the same armour for participants or the researcher.

In this project I adhered to ethical guidelines and received ethics approval from both the AUT Ethics committee (AUTEC) and the Plunket Ethics Committee prior to data collection by addressing concerns about anonymity, confidentiality and the protection of participants. Participants were assured of anonymity and confidentiality in the study. Digital recordings and transcriptions

were stored securely in a locked filing cabinet in my office in the Faculty of Health and Environmental Sciences at AUT University. The digital recordings were stored on my computer (password protected) and separated from the consent forms and any information related to the research (both will be safely stored for 10 years in accordance with Health Research Council Guidelines). The use of pseudonyms rather than names, and the removal of identifying data in this document (particularly for the Plunket Nurses) was undertaken to ensure that individual nurses could not be identified. I was aware that the act of talking about personal experiences might raise some psychological discomfort to the participants. In both the focus groups with mothers facilitators were experienced counsellors who were advised to refer the mother to the AUT Health and Counselling Centre. As an experienced counsellor myself I was also able to offer this provision to Plunket Nurses. However, no participants requested any further support, although the Korean mothers did begin meeting regularly as an outcome of the research process due to their identified need for social support.

However, ethical issues permeate the entire process and may not be allayed through the implementation of principles and guidelines, given that they are wide ranging, and incorporate both theoretical and empirical concerns (Mauthner, Birch, Jessop, & Miller, 2002). In this section, I explore the ethical issues that arose in the doing of the research, noting that ethics refers to a theoretical or applied, systematic intellectual reflection (Proctor, 1998). Here I enter the realm of applied ethics and enquire into my own professional conduct.

### Interpretation, representation and power

> Method is not ... a more or less successful set of procedures for reporting on a given reality. Rather it is performative. It helps to produce realities. It does not do so freely and at whim. There is a hinterland of realities, of manifest absences and Othernesses, resonances and patterns of one kind or another, already being enacted, and it cannot ignore these (Law, 2003, p.143).

Methods refer not only to the procedures used to undertake research but methods can also constitute particular subjectivities. Postcolonial critiques suggest that while research, as a contemporary practice of imperialism, mirrors colonial discourses and structures of domination (Butz & Besio, 2004), however, research can also be put to work to deconstruct and critique colonial discourses (as seen in this thesis). In a New Zealand context, emphasis is also placed on researchers to consider the Treaty of Waitangi and to implement Māori and

Pacific health research guidelines. These guidelines are a historical consequence of exploitative and colonial/assimilatory research processes that have benefitted the researcher rather than the communities being researched (DeSouza, 2007).

The interpretation of data in the production of knowledge in empirical research is both an intellectual and a political process implicated in the exercise of power (Ramazanoglu & Holland, 2002, p.116). Making epistemological decisions about which ideas, experience and realities are connected and used and those which are discarded requires skill, creativity, reason, intuition and uncertainty about whether these are justifiable and what the downstream implications will be (Ramazanoglu & Holland, 2002). This political act of interpretation is shaped by and engages with the broader socio-political and historical contexts through which our discursive frameworks and subject positions are formed (Raghuram & Madge, 2006; Tang & Browne, 2008, p.110), Language and discourse not only describe the world but constitute it.

Research incorporates both interpretation and representation, which constitute particular power relations. These are deeply political arenas and the links between power and knowledge (power as desire to know) are key concerns (Haraway & Goodeve, 2000; Harding, 1998). Indigenous and marginalised scholars have argued that knowledge production is a political process and that knowledge has been pivotal to the processes of colonisation and will be to processes of regeneration (Smith, 1999). Because of this history, attention must be paid to the processes by which knowledge is conceived, produced and justified as knowledge. Hence, a postcolonial method needs to be politically engaged and consider who gains from the research that is undertaken (Raghuram & Madge, 2006). Foucault's view is that power relations are productive and that power is relational, it produces knowledge and in turn knowledge is a source of power. As Townley (1993) notes, both power and knowledge are linked with discipline and control (cited in Fotaki, 2009).

This aim of this project is to "unearth, interrupt, and open new frames for intellectual and political theory and practice" (Fine and Vanderslice, 1991 cited in Fine, 1994, p.23). However, in so doing, the act of representation enacts a power relationship whereby I become a producer of knowledge and participants in the research become the objects of knowledge (Butz & Besio, 2004). The textual appropriation of what participants have shared, converted into data and written into something else is imbued with power relations. Minimising misrepresentation is also a problem: while I might include quotes, my analysis and the finished product will not necessarily reflect the intent of participants.

Ultimately there is a power imbalance, a hierarchy with little that can reduce this asymmetry and while reflexivity might alert us to these issues, it will not reduce power differentials andf indeed represents the ethical burden of being a researcher (England, 1994).

Using a postcolonial feminist lens that is not necessarily shared by the Plunket nurses in this context means that I might read racialisation or racism where a participant might not (Kirkham & Anderson, 2002). As shown earlier in this thesis, many nurses assume that colonisation is in the past and that encounters between nurses and their clients are innocent. That is, their everyday practices are not reflected through the lens of colonialism. Viewing social behaviour in the context of structural and political conditions could be viewed as a theoretical imposition onto the work of Plunket nurses. However, as Kirkham and Anderson note, while participants could be experts in their fields of practice, the broader factors that determine the world of practice and subjectivity might remain far from view.

In analysing how enduring colonial relations shape the discursive frameworks of Plunket nurses, readers may interpret me as positioning Plunket nurses and midwives as being bad while mothers are oppressed victims. This is neither the aim nor the conclusion of my research. I acknowledge that Plunket nurses and midwives operate in environments where their work is shaped by pressures, constraints, imperatives and the tasks of governmentality. This occurs in much the same way as the frameworks and processes I am implicated in as an academic, and the attendant values of the academy influence what constitutes knowledge, what is included, excluded and legitimated (Raghuram & Madge, 2006). The work of Plunket nurses and midwives is shaped by disciplinary mechanisms including contracts, policies and regulatory constraints. Government policy offers guidance and Plunket's own policies shape particular discursive resources and institutional practices.

Mechanisms identified by scholars for addressing the unequal power relations in the research encounter include: maintaining tentativeness in interpretation, leaving space for tension between interpretations (Kirkham & Anderson, 2002); and acknowledging our partial vision (England, 1994; Haraway, 1988). For example I have an investment in being a member of the 'ethnic' community in New Zealand and an investment in nursing (and midwifery) in New Zealand. England (1994) contends that researchers ultimately hold interpretive authority and have to take responsibility for the research, not only for intruding into participants' lives but for how data is represented and subjectivities

are inscribed.

## Issues in translation

The act of translation is frequently taken to be a neutral exercise representing a pragmatic solution for dealing with data in another language, capturing words and translating cultural meanings (Temple & Young, 2004). However, translation of the Korean transcript into English requires problematising. The act of translation is both political and methodological and translators play a role in knowledge production and power relations. It is important to make visible both the source language and the translator, because the analysis of cross-language qualitative data highlights similarities with the issues of secondary data analysis discussed earlier (Temple, et al., 2006). Temple and Young (2004) highlight a number of issues in the acts of translation between languages such as whether the translation act is identified, whether the identity of the researcher and translator are the same, and how far into the analysis should one involve a translator? The authors also issue a challenge to researchers who omit the translator and act of translation from their accounts of cross-cultural research. They argue that the value accorded to translators and translation is dependent on the research paradigms that the research is embedded in.

The word or language that is fixed onto paper can hide the values of the translator and disguise power relationships within the research. Despite repeated attention to the Korean transcript this was not apparent to me until multiple readings later when I realised that one of the facilitators used a very directive style with the participants and that she occupied a unique position within a particular language and cultural hierarchy. I had had an assumption that because all the focus groups were conducted using a standard semi-structured interview guideline that this would minimise power differentials, and sticking to script would mean that I was indirectly running the groups. Temple and Young (2006) point out that for those who don't speak the dominant language the notion of language is power takes on rather more significance, particularly if that group are dependent on someone to speak the relevant language. The issue of translation and cross-language qualitative data requires further scholarly exploration in a New Zealand context.

## Rigour and validity

Texts that attempt to represent the processes and results of research deserve scrutiny, as data must be seen as credible and undistorted by ideology or unchecked subjectivity in order for it to be useful (Lather, 1986). However, many

criteria used to ensure rigour in quantitative and qualitative research are problematic when viewed through a poststructural lens. Typically in positivist research, mechanisms to clear and distinct knowledge that ensure reliability and generalisability, require adherence to a method of specific procedures and normative methodological criteria. However, validity in qualitative research is re-oriented to refer to the integrity of research processes rather than the findings and assertions of the research (Rossman, Rallis & Kuntz, 2010). Yet, the criteria for assessing rigour in qualitative research—fittingness, auditability and credibility—pose challenges in poststructural enquiry (Peace, 2003).

Fittingness refers to whether the literature supports the concepts that arise from the data, but in a poststructural approach, the literature itself is important data. Hence, a more apt indicator of fittingness is whether the methodology aligns with the aims of the study, rather than through reframing of theory to achieve a fit with supposedly neutral data. Auditability refers to the provision of an adequate audit trail so that the analytic process used to generate the finished work can be viewed (Wilkinson, 2007). Credibility in the form of 'member checking' of the analysis presents challenges, because analysis is always imposed by the researcher, rather than organised by the participant's orientation. The analyst goes beyond paraphrasing the participants' words and locally constituted meanings to impose theoretical and political judgements. These acts elevate the epistemic authority of the researcher and require that she bear the onus of establishing credibility through her expertness in the methodological issues in the research (Peace, 2003). Ultimately, as Angen (2000, p.392) argues, "validity does not need to be about attaining positivist objective truth, it lies more in a subjective, human estimation of what it means to have done something well, having made an effort that is worthy of trust and written up convincingly".

Reflexivity can be a mechanism for building confidence in the scholarliness, merit or value of a study through exposing the ideological nature of the research, particularly when it has transformative ends. Writing the author into the text acknowledges that a person authors all texts, and this person is gendered, historically situated and political (Rossman, Rallis & Kuntz, 2010). Reflexivity represents the application of a "critical plane" to the researcher's subjectivity, where the beliefs of the researcher are scrutinised to the same extent as that of the participants (Harding, 1987, p.9). Laying open the "ways in which a researcher's involvement with a particular study influences, acts upon and informs such research" (Nightingale & Cromby, 1999, p. 228). To that end, I have included a discussion of how my subjectivities have informed my methodological decisions

in Chapter One and throughout this thesis, but these inclusions are tentative and incomplete.

There are challenges to undertaking reflexivity. The emphasis on examining the identities of the individual researcher, their location or positionality, reflect an edict to know oneself that assumes a 'fixed me'. Yet, if the self is performed, then the many different selves that are brought to the research process must be interrogated (Ogle, 2006). Researchers must consider: how these selves intersect with the institutional, geopolitical and material aspects of their positionality; what investments and conditions enable us to produce knowledge; and the constraints and accountabilities that influence our research (Nagar, 2003; Nicholls, 2009; Raghuram, 2006). Reflexivity also has its limits. We can never be fully aware or conscious of ourselves and the social relations that we are a part of. The nursing and midwifery critiques of explicit reflection and reflective practice are pertinent to this discussion. Greenwood (1998) identifies two assumptions of reflexivity, the first is the requirement of a particular kind of subjectivity, that of the rational autonomous individual in order to be able to examine our own personal and professional culture through self-reflection. The second is the assumption that technorational deliberation can adequately address the messy unpredictable nature of nursing and midwifery contexts. Greenwood also challenges Rolfe and Gardner's (2006) claim that reflection can uncover one's own tacit knowledge, arguing that no amount of reflection will surface it given that much tacit knowledge is embedded in action.

Building confidence in a study is difficult when there is an array of discourse analytic approaches and many readings are possible without claims of absolute truth (Powers, 2001). In this context, Nairn (2003) proposes several ways for making a discourse analysis rigorous. Firstly, the perspective or locations that shape ones analysis should be prefaced and "a clear analytic path that a reader may examine" (p.29) be provided. In the introduction to this chapter I have attempted to show how preferred meanings of migrant maternities advance particular discursive practices. Nairn proposes that this path should have four key components: a clear theoretical rationale (which I have provided in the previous chapter), the inclusion of analysed data (see page 108 in this chapter and Chapters 6-8), and connecting analyses with literature and research (see the links between the genealogical and the analyses in Chapter Four and Chapters 6-8). Nairn concludes that analysis itself is a construction of the social world, and therefore, validation by people who are engaged or have expertise in the area can be considered adequate if through the authority of the reading, the text is viewed as comprehensive and compelling.

## Limitations

The completion of any research project highlights possibilities for the research that were left unexplored. Interviewing other stakeholders might have added to the breadth and depth of this research. My efforts to interview midwives were unsuccessful. It would also have been useful to interview fathers, mothers, and mothers in law who come to NZ to support families. Some more in depth focus on the latter post partum period for the white women could have been useful given my experience of working on the maternal mental health team where most of the women seeking help were white and middle class. Video methods and participant observation could have complemented the self-report of the Plunket Nurses.

A study by Grant and Luxford (2009) found that using video highlighted the discrepancies between how participants represented their work and what they actually did. This discrepancy between self-representation and action was also evident in Bowler's (1993b) research, which highlighted gaps between how midwives caring for Asian women viewed their work and how they undertook it. The midwives saw themselves as caring and benevolent and yet behaved in oppressive ways. Such research might have strengthened this project.

## Conclusion

In this chapter I have shown that a feminist theoretical approach informed by poststructural epistemological perspectives and postcolonial analyses of knowledge, power and language problematises some aspects of qualitative research such as sampling, rigour, and validity. I have accounted for the ethical issues that were generated in the project and have highlighted the issues around translation and interpretation.

Next, I present the first of three findings chapters. Chapters Six and Seven focus on how two groups of migrant mothers position and represent themselves as positioned within the New Zealand health care system as subjects of midwifery and bio-medical discourses. Chapter Eight presents the findings from the focus group with Plunket Nurses and identifies the discourses within which migrant mothers are formed.

# Chapter Six: White mothers and neoliberal empowerment

> Everyone has a role in making health care safe: general practitioners, nurses, technicians, and administrators. It is also important for you to be an involved member of your health care team. Here are some things you can do to actively participate in your care: Be prepared, Get informed, Get an advocate, Speak up if you are unsure... (Ministry of Health, 2007)

Being an active member of one's 'own health care team' through the acquisition of knowledge and skills is a key feature of contemporary health care and for mothers to be, reflects being a good mother and citizen. In this chapter, I present the findings from a focus group with White[5] migrant mothers (from the United States, South Africa, Scotland and England). Their demographics (as white middle class migrants in heterosexual relationships) position them as aligned with dominant discourses of good mothering and natural childbirth discourses (Brubaker & Dillaway, 2009). Their ability to take up neoliberal discourses of consumerism, empowerment, choice and self-efficacy positions them as active agents who demonstrate volition in choosing their maternity pathways. These discourses reflect middle-class discourses where control over birth and informed consumer choice are available, along with the cultural and material resources to make it happen. This chapter examines how these women position themselves within liberal feminist and neoliberal discourses of contemporary maternity.

The chapter is divided into three key sections, which roughly map onto the three perinatal stages of antenatal, labour/delivery, and post-partum. In the antenatal period, I contend that participants take up subject positions as informed choosing consumers, through their interpellation as competent selectors of services. Their first activities are to choose a Lead Maternity Carer (LMC) and to participate in personal disciplinary practices (Foucault, 1977a), such as childbirth education. These practices of responsibilisation (Collins, 2009) represent the acquisition of expert knowledge as constitutive of the preparatory work that must be undertaken to ensure an empowering birth experience. In the second section, I show how mothers engage in natural childbirth discourses in the labour and delivery period, where technologies of the self are deployed to achieve the right kind of transformative birth experience. For fathers, moral value is attached to

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active participation in pregnancy and childbirth. In the final section of the chapter, I argue that the neoliberal obligation to be a self-sufficient consumer who meets their own needs causes distress in the post-partum period, where expert knowledge does not deliver empowerment and discourses of intensive mothering challenge the optimistic stories of mothering.

## Choosing and prepared consumers

Natural childbirth approaches in maternity ostensibly place women in a position to challenge medical hegemony through being informed and in control. However, this medical hegemony has actually been extended through the expanded scope of the clinical gaze as surveillance over individual women's behaviours in the antenatal period, and an emphasis on self-control during labour (Brubaker & Dillaway, 2009). In the excerpts that follow, women construct and present accounts that reflect their desire to be appropriately prepared. They work to find the 'right' Lead Maternity Carer (LMC); attend childbirth education; engage with and accept expert advice; keep good health through taking care of their bodies (for example through yoga) and consume information in the form of expert knowledge, books and the Internet.

The New Zealand maternity care system positions mothers as autonomous selectors of maternity care. The government provides free maternity care to women who are New Zealand citizens; women who have permanent residency; or who have a permit that enables them to stay for at least two years. Each mother has to identify a maternity practitioner to be her LMC and take responsibility for her care throughout her pregnancy, birth and six-week postpartum period. For example, the Ministry of Health maternity website instructs women that:

> You need to choose a lead maternity carer who will be responsible for providing and co-ordinating your maternity care, developing your care plan with you, and attending your labour and birth. A lead maternity carer can be a midwife (independent or hospital based), a general practitioner, an obstetrician or a hospital team. You can get a list of lead maternity carers as well (Ministry of Health, 2004b).

The explicit expectation is that pregnant women will seek antenatal care to ensure their own and their baby's wellbeing. The onus is placed on women to choose amongst the LMCs available in their area and decide which one they would

prefer to have. Therefore, pregnant women are interpellated[6] as competent selectors and consumers of maternity services, and moral value is attached to their ability to engage in self-reliant behaviours. One of the subject positions both imposed on and taken up by pregnant women is that of the 'choosing subject': the subject who decides which maternity practitioner she will have to accompany her during pregnancy, birth and immediately postpartum. Knowledge acquisition and the demystification and democratisation of knowledge play an important role.

In the first excerpt from Mary, liberal tenets of choice, freedom and autonomy are invoked in the form of Western reason when she speaks about her experiences of becoming pregnant through assisted reproductive technologies:

> Mary: Artificial insemination…was something that was incredibly easy in New Zealand whereas in the States it would've been a lot more difficult and more expensive. For us moving to New Zealand was partly a life-style choice, we had a known donor and we found that we went to a fertility class and it was just incredible how helpful and inclusive they are and everything was really easy to do…more information is always good for us and we found that there was plenty of information for us. It's like I said before we've been planning this for over five years so that was, their resources were there for us.

Mary's excerpt reflects the liberal feminist ideal of a planned pregnancy and the control of reproductive processes, even in the context of assisted fertility. The system works for Mary and she works for the system, in that the whole experience appears tailored to their needs and is found to be suitable. Maternity services are regarded as available resources to be used, there for the taking. Mary positions herself as a middle class consumer who can make choices (that include migration) within a system that is caring and available. The excerpt shows how accessible the maternity health system can be for someone who is positioned as educated and capable of using the resources that are available. With careful planning and preparation, one's needs may be met. Mary positions herself as a responsible health care consumer who actively searches for and chooses the appropriate products and services from a global market saturated with relevant information and services. Migration is framed as a space where possibilities for mobility and self-actualisation can be realised, imbricating maternity in local and global

6. Althusser's (1971) concept of interpellation, refers to recognising oneself as having being 'hailed' by particular discourses in the process of being recruited or constituted into subject positions (Phoenix, 2009).

patterns of consumption. Commercial relationships between parents and fertility and maternity providers call attention to the relationships between capitalism and motherhood (Craven, 2007). Mary's excerpt also highlights the liberal ideal of a fully chosen pregnancy with planned reproduction idealized as women's freedom from the body.

Annette also positions herself as a reflexive consumer, produced through the transfer of knowledge from professional to lay, who can both evaluate and challenge expert knowledges (Edwards, Davies, & Edwards, 2009):

> *Annette: Although our doctor suggested certain paths that we could take I wasn't necessarily in total agreement with what he wanted so I was trying to combine his knowledge with the information that I was reading as well. And my closest friend lives in a small town so her experiences were sort of minimum impact for me because of her experiences were down in the South Island while I was living here [in a major city].*

Annette does not uncritically accept the authority of biomedicine: she coordinates and evaluates the diverse sources of information that she has access to and chooses the best combination. Her excerpt displays her insertion into woman-centred discourses, where the acquisition of authoritative knowledge is a mechanism for bypassing medical control and claiming empowerment, subjectivity and agency (Morgan, 1998). Knowing one's own body leads to reclaiming embodied knowledge, decentring biomedical knowledge and challenging the medical colonisation of the female body (Howson, 2001). Interestingly, Annette's first action on discovering she was pregnant was to buy a book about pregnancy in New Zealand, so that she did not have to involve people that she knew and make it public, given her fear of having a miscarriage. Avoiding informal and embodied knowledge in favour of formal knowledge, however, meant she could not ask for a Lead Maternity Caregiver (LMC) recommendation:

> *Annette: When I found that I was pregnant the first thing I did was I bought a book named New Zealand Pregnancy Guide ... although we have a lot of friends here I didn't feel that I was in a position where I wanted to talk to anybody about the pregnancy because it was so early and I felt that the more people that I talked to and asked for their advice then if I did miscarry I'd have to tell everybody that I'd miscarried. So I was in that situation of having to try and discover a lot of information out*

*by myself initially and I found that was a little bit overwhelming at times. But that book was particularly useful and then I phoned I think the Ministry of Health and got a list of midwives. And then to be quite honest it was absolutely useless, because I just looked at this list and I'm going, 'well where do I start'? So you are in this catch 22 thinking do I phone this person? Would they come to me because we're on the other side of town? I don't have any recommendations. It was literally a list and it meant nothing to me.*

Annette's purchase of a book of authoritative knowledge about pregnancy in New Zealand as opposed to availing herself of her networks and friends as resources seems emblematic of the discourses producing an autonomous, composed, rational individual who fears public judgement upon her possible failure to reproduce. The emphasis on 'preparation' as the acquisition of knowledge valorises medically informed knowledge rather than the informal and personalised information or social and emotional support that friends and family can provide (Marshall & Woollett, 2000). Self-help books are a form of cultural intermediary (Hochschild, 2003) that assists with the anxiety of making choices and reflect a "measure of and a salve for individual anxiety and a flag for collective uncertainty" (Pugh, 2005, p.730).

Exposing herself as pregnant before she is certain of the outcome could complicate social relationships. The resulting absence of context is something Annette has chosen, but a choice she is also ambivalent about. There is no space for 'burdening' her friends with something that might not work out, so she loses out not only on social support but also on information and referrals, which could make the transition less stressful. As Freda (2001, p.117) asks of women who keep their pregnancies secret in case of miscarriage: "So if they miscarry they can suffer alone?...but isn't grieving generally better done with supportive love from family and friends?", Annette presents herself as having the 'right' to suffer in silence.

The white mothers generally speak of their experiences positively, avoiding any rupture of discourses of post-feminist, neoliberal self-determination, and constructing individualised narratives that emphasise self-improvement. They take on the neoliberal psychological imperative to improve and transform themselves, even in the most difficult of situations (Baker, 2009).

## Constraints on choice

Although many of the white mothers discursively positioned themselves as resourceful and adaptable consumers who use available resources when they are provided, there was also a 'migrancy gap' in terms of informal knowledge, where information was limited and lacking context. These excerpts confound any assumption that white women will slot in seamlessly into the systems and processes of another postcolonial white system:

> *Nancy: My initial problem was actually finding that midwife. I didn't know how to go about finding, you can look in the yellow pages and pull a number out...and I work with medical people so I was trying to get a recommendation through them, but the people who don't have that...I would find that very hard. I did get some recommendation through the doctor. I rang up a few but I didn't get a response back ...And because at the time I didn't really have that many friends who had babies so again you haven't got anyone to consult who you know, 'oh well I get on with them so will they likely to be the same kind of person'? Cause midwives can obviously differ a lot in character and personality.*

In Nancy's excerpt, the search for a midwife is problematic from the start. Women who do not have a referral system are reliant upon the list of names that can be found in the telephone directory. Although it appears that by looking at a telephone directory that there are many choices, in this context, choice becomes disempowering rather than empowering. The notion that choice provides consumers with exactly what they want, when they want, is contradicted. In fact, the power seems to be in the hands of the suppliers. Pushing the market metaphor further, there is a sense that the marketing is restricted because demand exceeds supply. There is an assumption that the choosing consumer already knows how to access the service, resulting in randomness about the quest. Nancy acknowledges her social capital and location in an elite professional environment that enables a recommendation, rather than having to rely on a random choice. She talks to a doctor and gets several recommendations, but doesn't get called back, which she puts down to being an occasional problem. Although the white women have to work hard to find a Lead Maternity Carer through protracted enquiries, there is a sense of resilience and perseverance in this endeavour. They seem undaunted by the shopping experience.

The list of LMCs did not present Annette with the capability to make an

informed choice, given that lists do not provide information about the philosophy, skills or expertise with which to make an informed decision:

> *Annette: It's finding out that initial information about how do you go about choosing somebody, what sort of...you know I didn't know at the time what criteria I should be looking for with somebody. And I was just phoning up a few midwives initially and that's what you do, you have to sort of cold call them and have a chat with them and see what...*

Annette's account expresses some of the frustrations with the process of finding an LMC and the limitations of the agentic, liberated and disciplined self who cultivates rational thought and is able to get her needs met. Ultimately the mother must sift through the evidence, take charge and make her own decisions.

> *Jane: Yes I had the same experience as Olive whereby because my baby was born or expected to be born by early to mid-January it would've been difficult. The first midwife I called she said, 'well an independent midwife would be difficult to find someone who's available at that time who is independent.' So she told me what the choices were so in the end I got good information and all along my pregnancy I was good information, I had an easy smooth pregnancy, no complications.*

Jane's account highlights the limitations of the consumer model of maternity care, which is dependent on midwife availability. In 'cold calling', the mother's choice is devoid of social context, without a supportive social network to vouch for or evaluate her choice. The options that are provided suit the midwife's schedule rather than her own. However, Jane's response to not entirely getting what she wants is met with equanimity; she does not express unhappiness or dissatisfaction and the service appears to meet expectations. There are concerns that models of care have become midwife-led rather than woman centred, where attempting to attain a work-life balance (and enjoy summer holidays) has the effect of reducing both the availability of midwives and the availability of continuity of care (Foureur, Brodie, & Homer, 2009). The midwife's autonomy to determine her own work-life balance is also something that resonates with Jane.

### Constraints on preparation

Childbirth education (CBE): a specific component of antenatal

> support that aims to provide information on wellness behaviours during different trimesters of pregnancy and to prepare the mother (and usually her partner) for labour and birth. It may include information and advice on foetal growth and development, breathing techniques during labour, what to expect during labour and delivery, caesarean birth, breastfeeding, maternal postpartum issues and infant care (Dwyer, 2009, p.13).

Childbirth education[7] and hospital tours are personal disciplinary practices (Foucault, 1977a) that women undertake to prepare for motherhood, in order to ensure that they are informed and well prepared to deliver a healthy baby. These practices reflect women's engagement in techniques of the self that characterise the management of pregnancy and are typically a middle class endeavour. The white mothers conform to the ideal of the good mother (to be) by discursively positioning themselves as taking appropriate care and responsibility for their pregnancies and maternal care. However, in all the excerpts, what is emphasised is the development of friendships rather than the transmission of knowledge:

> *Annette: I found the antenatal classes were excellent, very informative and I think a lot of the success of the class was revolved around who was in the class as well…We had a great group of people and we learnt, and we interacted really well, and we've met up afterwards and all kept in contact with each other. We did a structure where you went every week for six weeks so you've got an opportunity to sort of socialize a little bit. Some of the antenatal classes where you just do it over one weekend or two weekends that might suit somebody but I guess there's less opportunity for support.*

> *Mary: Joan was the one, who was sending emails…It's very useful to have that kind of support and also like Joan helped because I did go first, Joan bought a meal over to our place and that was really nice to have that kind of support really because not having our parents around you, it was the only meal we actually had delivered.*

In these accounts, the women note the camaraderie and fellowship of the social network in addition to the informational aspects. The social support and

7. I use this term interchangeably with ante-natal classes

network provided by other mothers experiencing the same transition led to the formation of a kind of support group.

The sharing of birth stories also created bonds, connecting them all to a new social world of being parents. In contrast, hospital tours were perceived to offer little in the way of value:

> *Olive: I think it's more to do again with the person who was leading it. I just wanted to know the facts about where I had to go and what I had to do and I just felt that that was a bit of a negative experience.*

> *Mary: I also found that a map of where everything was would've been really useful. The woman who gave us our tour said, 'well you can't go in there, but you go in here.' She said it verbally like in 2 seconds and it was impossible. I think we actually had to go back and re-do it like five times before we actually had the hang of where we had to go and after hours there was another entrance, and between this time and that time you had to go here, there and so on. I found that really not challenging, well it was challenging but a lot scarier rather than comforting.*

Mary's experience of the hospital tour was that it achieved the opposite of what she had hoped: it was disorientating. Meanwhile Jane got the information that she wanted:

> *Jane: Well for me it was completely the opposite of Mary. And that's also the feedback of many mums. The tour that we had was good, my husband was able to be there with me. I got all the information we needed, we got the maps we got the tour...*

These excerpts reflect other findings that services that purport to offer preparation for mothers and fathers, instead appear to reflect the socialisation of pregnant mothers and their supporters into the norms and practices of the hospital (Browner & Press, 1996).

## Birth as growth

Mothers are the core target of pregnancy and labour management and take part in the governance of their own pregnancies and labour and delivery. The rewards of antenatal preparation are realised when women describe feeling

informed and in control of their birth experiences. Their experiences align with natural childbirth's moral discourses of good mothering (Brubaker & Dillaway, 2009) incorporating elements of being informed, having control, autonomy or authority despite various degrees of obstetric intervention.

> *Mary: Well I thought we were going to have a very sort of natural birth with no drugs although I was hoping to take drugs if I was in pain. I found the antenatal explanation of how what happens in a C-section very useful as I ended up having a C-section. And the fact that they explained, 'ok all of these people are going to be there and it's going to be a person on your right is going to be your doctor and the person with the baby', and all of that... I had a really negative reaction to all the drugs and when she explained again who was going to be in the room it was exactly the same as what the antenatal person had said. That was really useful because all of a sudden you were lying down seeing people from below and all these people come and go very quickly and it's really scary from that perspective, and just knowing who those people were and where they were was very useful... I didn't actually panic or feel very scared at that point.*

Mary's narrative links the experience she had antenatally as preparing her for her unintended Caesarean. Rather than feeling cheated by the requirement for medical intervention, she is pragmatic and surfaces the woman-centred natural birth philosophy of feeling in control and informed. As Macdonald (2006) contends, a birth might be considered 'natural' despite medical intervention, as long as the labouring mother chose the intervention (cited in Brubaker & Dillaway, 2009). Therefore, the women themselves define what is natural rather than use a particular set of criteria. Mary's interpellation into natural childbirth discourses reflects middle-class aspirations of control over birth and informed consumer choice with the cultural and material resources to make it happen. The notion of 'natural' aspects of birth into hospitals makes slippery any definitions of 'natural' birth in feminist or midwifery literature.

Charlotte's narrative also captures the two competing discourses of birth that Mary situates herself in. On the one hand, she values having self-control (through being informed and behaving accordingly) and on the other is willing to go with what is happening (rescinding action becomes a choice itself) (Lupton, 1994):

*Charlotte: I just have to say to myself you know we've even had to go with the flow, and then also those booklets that you receive on feeding, those pamphlets. I did a lot of reading and my midwife gave me a lot of information. The information from those pamphlets helped me a lot and so I felt comfortable, like I'm on the right track now so everything is going well. So I was trying to speak to myself and keep calm (speaks quietly). I was in labour for since the Saturday and I gave birth on Monday morning so (laughter) I had to keep my options open as well about taking drugs so you know things like that.*

Charlotte presents herself as able to be disciplined and in control as a self-efficacious middle class maternity subject should be, performing maternity correctly regardless of whether her expectations are being met. She internalizes the information she is given and adapts her behaviour accordingly through self-discipline, self-denial and will power. Subsuming her own distress and fear, her desire to remain calm is well aligned with the needs of the institution, as a calm consumer is more compliant and needs less time and support than a distraught one. However, does it enhance her experience of her labour and delivery?

Being given the right information at the right time made Charlotte feel supported:

*Charlotte: The midwife that delivered my baby is actually from New Zealand but she worked in Cape Town for three years so that was good, that connection. She told me, step by step where and what stage I'm at .. I think that's the biggest support that you really need in the delivery room is to tell you at what stage you are at and what's happening.*

Charlotte constructs her midwife as the person who delivers her baby (rather than facilitates Charlotte's ability to birth her baby) and who is able to link what is happening in her body to an identified physiological process. She discursively positions her midwife as a translator, who is able to decipher the events that are inscribed in her body. This positioning challenges midwifery discourses of the mother as 'expert' and reflects critiques of the consequences of medicalisation, where the deskilling of the populace is claimed as a consequence of the privileging of expert knowledge, in that human experiences are managed and mystified (Brubaker & Dillaway, 2009).

Jane actively and discursively resists biomedical discourses, until she

acquiesces to Entonox:

> *Jane: I had Braxton Hicks contractions from the Friday night, midnight around that time and I delivered just before midnight on Sunday night so the Braxton Hicks also keep me awake. I was trying to still keep my energy up by eating and drinking as much water as possible. My choice was that I wanted to stay at home as long as possible, I didn't want to be in the hospital for too long because when I start thinking of all the other options, and I wanted a natural childbirth, no assistant and also no pain relief. At the end for about 2 ½ hours before baby was delivered I chose Entonox with the gas and that helped. As the pamphlets also say I actually felt distance from the actual experience so if I think back I would've actually chosen nothing but I just felt at that stage I needed something and I chose that. So fortunately baby was in the right position, in a good position so I didn't have to have a Caesarean. I was more scared of the Caesarean than the pain and I wanted a natural childbirth.*

In this account Jane discursively positions herself within the midwifery model of natural birth (Brubaker & Dillaway, 2009). She disciplines her body so that she avoids hospital as much as she can, and engages in deliberate bodily maintenance so that she can maximise the efficiency of her body in order to have the energy to labour. She constructs a natural birth as being one where she has pain relief as a last resort but no other intervention.

Nancy disciplines her body through specific breathing techniques learned outside the health system:

> *Nancy: Yes. At the beginning of my pregnancy I was kind of really worried about actually giving birth. But what really helped me was I went to do yoga in pregnancy and through that they talked a lot about it and they did sort of breathing and just general exercises to help you kind of keep calm and focused. And at the end of it I really wasn't worried about it at all and I thought I might even be able to get through this without drugs but I didn't in the end, I gave in, in the last couple of hours. But to get as far as I did without anything and my husband still is absolutely amazed that I got that far, cause he knows what I'm like with pain. So I certainly found that something like*

*that really helped, cause you don't focus on anything like breathing in the antenatal class and that's one of the things that I thought would be part of that.*

Nancy discursively positions herself as a good mother to be, by taking control and acting to promote her own health and wellbeing by engaging in natural breathing. Nancy had an expectation that her body would be able to cope with birth naturally and without medical intervention. Her framing of her acceptance of a biomedical intervention in the form of pain relief in the last few hours is presented as a capitulation, and reflects her perception of the control she had in the process and her failure to accomplish a natural process.

Nelson (1986) suggests that middle-class women are more likely to receive the birth and/or medical treatments they desire, and pregnancy and childbirth are framed as contributing to their 'personal growth' (cited in Brubaker, 2007). In this paradigm of actualisation, intentional actions are assumed to be what is required to achieve the right kind of birth and technologies of the self-featuring self-discipline, self-denial and will power are emphasised. However, not only are mothers enjoined to engage in preparatory regimes, but prepared fathers are seen as necessary for the well-being of mother, baby and family (Sevil & Özkan, 2009).

## The actively involved father

Fathers are interpellated into discourses of good fathering and encouraged to locate themselves as active and responsible agents of pregnancy. This role occurs in relation to the pregnant woman, who is the core target of pregnancy and labour management, in order to produce a health baby (Collins, 2009). In the accounts that follow, fathers are constructed as active participants. Jane and Nancy's husbands are advocates, supporters, and active members of the team:

*Jane: I actually wanted my husband to be there in the delivery, there was only my midwife's partner and it was my midwife's weekend off ... My husband was there and all I remember is I didn't want to be on my back that was the main thing. I could be in any other position but not on my back and I ended up being in this position just reclining. And my midwife was holding one leg and my husband was holding the other one, he was like my midwife, she was looking at him and he's saying, 'go', and he's just repeating and I had such a positive experience with him being there. And I was happy that he was there.*

*Nancy: My husband faints at the sight of blood. I was thinking "oh my God I'm going to give birth on my own, my mother's not here" but he was amazing. He actually watched her crown, he watched the whole thing because there was just the midwife and my husband. And he cut the umbilical cord and he was just absolutely amazing. It was like wow my husband's new, so he was my biggest support really.*

Jane and Nancy's accounts discursively construct the process of childbirth as more than an embodied process, it is a shared experience with their partners. They work as a team and the partners' participation and support provide strength and security. Shared decision making with an actively involved partner who knows her wishes and desires and can therefore construct the father as a gatekeeper and an advocate. Mary's partner has a similar role in addition to disciplining her mother:

*Mary: I have this fear that, because I would be in so much pain that they would talk me into doing something that I didn't want to do. So having my partner there who I trusted to make those decisions for me was really helpful and I think I. My mum was there unfortunately and part of my partner's duty was to keep my mother out of the room cause she wanted to be there so badly and at the end of the day I think (?) my midwife who basically snapped at my mother and said, "my concern's for your daughter and you have to go into that waiting room and stay in there until I come and get you".*

Mary's account shows how the historical centrality of other women (mothers, sisters and other female relatives) in antenatal education, birth and childcare has been displaced. Networks of women now replaced by educators and midwives (Nolan, 1997) and fathers as birth partners.

This expectation of active involvement changes in the post-partum period, where the involvement of the father is framed as an optional exercise:

*Joan: my husband is such a help to me. You know my mum when she was over here, when she left she said, 'well I'm glad you've got Todd (laughter). He was very helpful to me at a time when I really needed some assistance, so it was very valuable.*

Joan's account positions her in a dominant discourse about fatherhood,

where the father is positioned as a 'part-timer' and mothers are positioned as the main parent (Wall & Arnold, 2007). In using the word 'helpful' in relation to Todd, she implies that the main job of parenting belongs to her and it is taken for granted that she does the bulk of the work.

The societally expected involvement of fathers represents a cultural shift in Western societies, where the 'new father' as co-parent is represented as "more emotionally involved, more nurturing, and more committed to spending time with his children, during infancy and beyond" (Wall & Arnold, 2007, p.510). Paternal birth attendance has become strongly associated with improving the quality of intimate relationships and a 'good' husband and a 'good' father is constructed as one that actively participates in pregnancy and childbirth aligns with middle-class attitudes and values). The described benefits of paternal involvement in labour include: promoting bonding with the infant (Bartlett, 2004); enhancing maternal control in childbirth (Brubaker & Dillaway, 2009) and the disciplining of mothers so that they take up more health promoting behaviours (Ny, Plantin, Dejin-Karlsson, & Dykes, 2008).

### Mothers as primary carers

Where the antenatal period was marked by the acquisition of knowledge, and childbirth viewed as a project, the post-partum period is noticeable for the demands of intensive mothering. The discursive production of oneself as a good mother is characterised by sole responsibility for the well-being of the infant in the context of minimal support and isolation. This intensive form of parenting, is intertwined with a neoliberal rationality, where individual responsibility and self-management are fore-grounded and social support is reduced compared with earlier in the perinatal period (Wall, 2010).

The concept of intensive mothering was developed by Hays (1998) and refers to a pervasive ideology in Western culture that is: "child-centered, expert-guided, emotionally absorbing, labour intensive, financially expensive" (p. 46). The needs of the individual mother are marginalised, as mothers take the bulk of the responsibility for nurturing and development of the sacred child (Johnston & Swanson, 2006). The impact of this ideology is heightened for the white mothers, and the pressure to perform good mothering occurs with limited support and high levels of anxiety and isolation.

The rude transition from women-centred discourses to intensive mothering begins on the post-natal ward, where there is a glaring shift from one-to-one attention from midwives, to competition for support and assistance with other

new mothers:

> *Olive: I mean the actual labour and delivering – fantastic. I couldn't fault them and the staff was superb, the midwife was just brilliant, the obstetrician fantastic. When I got on the ward I found it really hot, I felt really overwhelmed. I was right next to this buzzer and it just went buzzing all the time course everybody wanted help, that found really quite distressing and I was absolutely knackered.*

While this comment could be read as being about the buzzer and interruptions, it is also a consequence of being returned to the factory model of maternity. Olive experiences a shift from care described in superlative terms to feeling overwhelmed, distressed and tired. Meanwhile, Nancy recognises that her expectations were primarily oriented to the birth event with no real preparation for the post-partum period:

> *Nancy: I just want in say in terms of thinking after the birth, and how it was compared to expectations, I didn't really have any expectations of after the birth, everything was concentrated about the labour and, 'oh God, it's going to feel terrible' and after the birth it just hit me like that and it was hell for six weeks more or less it was just hell.*

She adds:

> *Nancy: Yes and I wished somebody had actually told me that it was going to be that hard.*

Nancy assumes that if she had been given the information, this post-partum period would have been easier for her, reflecting cultural discourses that assume that with planning and control of one's circumstances, future success can be ensured (Wall, 2010).

> *Interviewer: What was the hell?*
>
> *Nancy: Mainly lack of sleep, lack of sleep and just coping with a crying baby, and I had my mum and I was lucky she was there for the first three weeks and she did the housework, the cooking and stuff. Group laughter (?)*
>
> *Jane: I also think you also just feel like a robot, cleaning the bottles, making a bottle, breast-feeding, in a little corner all the*

*time, just you and the baby.*

The women identify a collusion or conspiracy of sorts: so much of their preparation into the world of parenthood revolved around knowledge acquisition and maintaining good health during their pregnancies and having control during their labour, but none of this information seems relevant in the postnatal period. Wanting to know what to do and being prepared is a priority. Having the tools to discipline themselves and their babies and exert some control are valuable. There is often a sense of failure and disillusionment with the system and with providers. The responsibilities for infant care and repetitive 'robotic' household tasks seem overwhelming.

There was one time in the focus group that the women made unfavourable comparisons between the support that might have been available in the country of origin and in New Zealand. These quotes highlight the individualising logic of neoliberalism, where care giving moves into the realm of a private family responsibility rather than a social community responsibility. These developments have their genesis in the development of capitalist economies and market production, enabling the separation of private and public spheres with women taking responsibility for childrearing (Kelleher & Fox, 2002). Hence, they highlight the gendered aspects of neoliberalism and the ways in which neoliberalism is experienced differently by men and women.

> *Nancy: It would've been different in that I would've had a lot more support and for me a lot of my anxieties around that was I didn't have anyone to talk to, and particularly (baby crying). And yes ok you meet people at your antenatal group but at that time they're not your closest friends that you can say anything too. And having said that I did, you know ... But I think that was it for me was thinking, 'oh my God, I just need some adult conversation'. And that's what I struggled with most probably.*

For Nancy, the absence of support refers to a range of support, but most critically it refers to people she can confide in about the hard work of being a mother. Establishing a confidant requires time and intimacy cannot be established quickly. However, the desire just to talk to another adult, overrules the anxiety of exposing herself. For Georgina, the loss is felt in terms of not having practical help to give her some time out to do errands or to give her some 'couple time', and people who would be frank with her:

> *Georgina: You know that was, you know. Yes you do miss the*

*support network, friends as well as I've got a lot of friends back home who have got kids and I think you miss that as well…Not just family but friends who would maybe be a bit more candour than you might take from them or what you feel than you take from close family and things. So I definitely miss that and also, we were just back home and it was just so nice…you know tight as you are, what simple things, like I needed to go out and do couple of things and I knew I was only going to be half an hour or so and to actually have somewhere to leave him and it would take me half the time.*

In the following quotes we see how individual responsibility for parenting is placed on the mothers through neoliberal discourses, where costs are moved from public resources to household resources and there is a transfer of the burden of work from the public to the private realm (Clarke, 2004). This is underpinned by several Eurocentric, patriarchal and heterosexist assumptions: firstly that the household is based on a nuclear family; secondly, that gender divisions are in place regarding caring labour, the latter of which is elastic and expands to fit the demands made of it. In turn, the arena of the private is subject to surveillance and regulation to account for responsibilisation (Clarke, 2004). Thus from a governmentality perspective, neoliberalism governs individuals by inciting them to take up particular attributes which are then internalised and used by individuals to govern themselves. Hence risk is redistributed so that its management is the responsibility of the citizen. Responsibilisation refers to the ways in which public tasks become the responsibility of individuals, the private sector and community (Schinkel & Van Houdt, 2010)

The section also highlights how dominant discourses (e.g. intensive mothering) and individualism hide the ways in which constrained resources have an impact on the provision of family care and disguise the role of structural conditions and constrained resources, for example: the need for two incomes; the erosion of a community of caregivers that can support women and buffer against inequality; and the provision of resources that are available to support women to care.

Georgina was able to access services through a contact she made at antenatal class:

*Georgina: My Mum was here for a week that he was born and that was really good but then she went away back and my*

*husband went back to work so all of a sudden just me and him. But I was really lucky one of the girls from my antenatal class and she's just around the corner and we were due at the same time but obviously he was late so she'd had her baby for a couple of weeks. Although she's a Kiwi she's not from Auckland so we were quite supportive of each other. And probably more through her I got support over here because she had been using Plunket facilities.*

Georgina's excerpt highlights how once the initial support is gone and partners return to work and mothers return home, that the isolation hits. While formal organisations can assist, informal social support can be the most meaningful and useful form of help. Here the shared experience of being a mother and sharing information and resources is a pivotal aspect of the support she received (Simich, Mawani, Wu, & Noor, 2004). Under neoliberalism the bulk of unpaid work and caring tends to fall on women (Baker, 2009).

However, having a mother present creates other kinds of tensions:

*Georgina:Yeah and I mean, maybe having people around who like my Mum was, somebody around to help. When I went back home she said that when she was there that week she was just sitting thinking, 'oh put the baby to bed', but she didn't say anything. But I don't know that if my Mum had said that I would've found it that useful, course you know mothers trying to be helpful but don't really go about in the right way that actually is helpful. So although you've got that support network, if you've got your family around I think perhaps having my Mum the way she was there staying with us for a week it was too much (speaks quietly).*

Georgina's narrative shows how support from a health professional can bring advantages, such as expert information, relative anonymity and no demands for reciprocity (Seefat-van Teeffelen, Nieuwenhuijze, & Korstjens, 2009). However, there is a gap in terms of not being comfortable asking for help from her friends:

*Georgina:Yeah back home and having that support and it was nice to actually experience that. Before I went home I had mastitis and felt really really very very sick and I really struggled because they thought they were going to have to take me into get*

*IV antibiotics so basically stuck at home feeling very sick with the baby who I still had to care for, my husband couldn't take time off work so, and we just had nobody. And although my friends were there, but it didn't feel like I could call on them because they are not very close....*

Georgina's story illustrates how critical social support is. The perception of available support enhances successful coping with stressful situations while feeling isolated (Simich, et al., 2004):

*Interviewer: You kind of had a sense you had to battle on and you couldn't really ask people.*

*Georgina: I mean she said to me afterwards she said, 'you should've phoned and I would've helped'. And I knew that she would but I just didn't feel comfortable with asking. So that's probably, I think that hit it home for me was that how alone I was when I actually did need somebody, I really needed somebody and that was hard.*

Georgina and other respondents' accounts signal the implicit assumption that mothers should actively pursue their own adaptation to mothering. Rather than services surrounding the mother, the expectation is that mothers will be active consumers of available services (Simich, et al., 2004).

### Plunket

PlunketLine and Plunket Family centres were identified as valuable sources of support. Mary constructs the Plunket helpline as a safety net:

*Mary: I just want to say that I found the Plunket help line very helpful...You know the fact that you could actually call, even though it's hard to get through, that in the middle of the night you could actually call someone with and for information (?) baby crying and they actually take you step by step what to do. And then finally I just couldn't imagine doing all of this in the US, no I couldn't. I don't want to think, I didn't have a baby there but I just don't think that we have any of these systems...*

*Annette: I spoke to friend when I was in England trying to describe Plunket. They couldn't get their heads around, that you have your own Plunket nurse that you see regularly, that*

*you can come here and coffee groups and they were just like 'wow'... there are others here that support, you just wouldn't get at home.*

The mothers represent Plunket as a nurturing maternal figure, valued for its accessibility and availability, providing support, education and information over the phone, the nurse as someone who 'belongs' to you, that you see regularly and who fulfils a socialising and nurturing function.

Once women were able to access social support, they were able to access services, increase their networks and information sources, share their experiences and feel supported. However, many of the women felt overwhelmed and isolated and reluctant to access help. This silence around difficulties and not seeking help, seems in part due to not wanting to disclose that they were struggling and not measuring up to their internalised ideals of good mothering.

## Conclusion

These findings have considered how white migrant mothers engage with women-centred or midwifery discourses that configure contemporary constructions of 'good mothering'. Women subjected themselves to midwifery frameworks of regulation and knowledge, and produced themselves as informed choosing consumers. This representation of an active process of self-formation into a self-determining and health promoting maternity consumer is predicated on a rational unified self who consciously makes choices. However, their narratives reflect tensions in the neoliberal and feminist intents of consumerhood. In both the antenatal period and through labour and delivery, they are subject to discipline, as they hold themselves responsible for maximising both their own health and that of their foetus. The informed, choosing, prepared consumer of midwifery and women-centred discourses aligns with those of the neoliberal responsible self. The political rationality of power over life can be seen through technologies such as the consumption of expert knowledges and childbirth education that teach women and their partners how to optimise their bodies and produce particular types of maternal, paternal and infant subjectivity. By accumulating information and regulating their behaviour, parents can be healthy and productive and reduce demands on the state by governing themselves and each other. However, the limitations of expert knowledge are highlighted in the absence of social and emotional support in the post-partum period.

In the chapter that follows, I present accounts of how Korean mothers negotiate their subjectivities in the corporeal processes of pregnancy, labour and

delivery and post-partum through institutional practices in New Zealand, and how they engage with discourses of good mothering. I highlight the impact of cultural dissonance between these mothers and institutional maternity discourses and practices, and specifically how the Korean mothers are subjected to a variety of human technologies (not always successfully) to make them a particular kind of maternal subject and moral being. Focussing on Korean mothers provides an opportunity to examine how maternity as a postcolonial institution is experienced by a racialised maternal subject, and the kinds of self-formation that occur within institutional webs of power relations in a settler public health system.

# Chapter Seven: Cultural and culturalist discourses: Korean mothers and New Zealand childbirth

> It seems to me...that the real political task in a society such as ours is to criticize the working of institutions which appear to be both neutral and independent; to criticize them in such a manner that the political violence which has always exercised itself obscurely through them will be unmasked, so that one can fight them (Foucault cited in Rabinow, 1984, p.6).

Maternity appears benign, but power relations function potently in fashioning particular kinds of maternal subjecthood and can be seen in the projects of self-making and being made that Foucault calls 'subjectification.' In this chapter, analysis of the role of race in the experiences of Korean mothers shows the limitations of a liberal feminist perspective. As Crenshaw (1994, p.411) suggests, "the knowledge that the struggle over which differences matter and which do not is neither an abstract nor an insignificant debate among women. Indeed, these conflicts are about more than difference as such; they raise critical issues of power."

Pākehā maternity discourses incite disciplinary and normalising processes for Korean women whose cultural practices are pathologised and ascribed as deviant, resulting in distress. Migration to New Zealand exposes Korean women to the same neoliberal discourses and structures as White migrant women, however the gap between the systems that each are familiar with in their source countries and the New Zealand way of performing maternity differ. In this second chapter of findings, I explore the experiences of South Korean immigrant mothers and show the ways in which they mobilise two cultural discourses. Firstly, Korean mothers incorporate biomedicine into their self-understanding and resist liberal feminist frames inherent in midwifery discourses. Secondly, Korean women's postcolonial subjectivities are formed through processes of normalisation and representation. This builds on the findings of the previous chapter that showed that nursing and midwifery knowledges are far from innocent, but produce subjectification into particular kinds of racialised and gendered reproductive subjects. This chapter shows how colonial legacies intersect with assimilatory discourses in maternity in postcolonial institutions to protect the hegemony of Pākehā discourses, and to perpetuate and justify the othering of new migrant Korean mothers.

In the first part of the chapter I examine how Korean mothers are enmeshed

in biomedical discourses with respect to delivering a normal healthy baby, and view associated technologies of the self such as monitoring and surveillance as empowering. In contrast with the white mothers, their identities are constructed through locating themselves primarily in biomedical discourse and in resisting midwifery discourse. In the second section, I show how the women experience the maternity system as unresponsive to deeply held beliefs around the sanctity and vulnerability of the mother's body in relation to birth. The imperative to be independent and autonomous is experienced as coercive for women who experience the body as vulnerable and requiring of rest and care. Korean mothers also resist being positioned solely as objects of their babies' needs, rather than as women with a new special status and needs of their own.

## The maternal body as an at risk body

Korean mothers' knowledge of themselves as pregnant and labouring maternal subjects is shaped by biomedicine, and they willingly engage in technologies of surveillance (Foucault, 1977a). For many of the Korean women, biomedicine is represented as central to ensuring the well-being and normality of their unborn babies through careful surveillance for congenital abnormalities and complications. Thus reproductive technologies provide women with knowledge of their pregnancies (Root & Browner, 2001) and the maternal body is constructed as a body at risk with 'natural' birth seen as unfamiliar and fear-inducing.

The rhetoric of contemporary maternity constructs the ideal maternal subject as an active and responsible partner through her acquisition of knowledge and skills, however in this study Mee-Sook represents herself as receiving little in the way of information:

> *Mee-Sook: It was not only the midwife who did not give enough information or necessary support. Everyone kept saying, "It is okay, you are doing well" but gave few information or specific support. I had to research my own conditions, such as the size of my tummy at a certain stage or how tight my tummy would feel at the last stage of my pregnancy as the baby drooped down – through reading books.*

Mee-Sook's excerpt illustrates the ways in which pregnant women are enjoined to be informed about their pregnancies, and to engage in processes of self-surveillance to be an informed consumer, highlighting the productive power of neoliberal subjectification. However, she feels she is not maintaining this responsibility because of the scant information she receives. In her desire to be

more informed, she turns to authoritative knowledge from a book to supplement the information she is provided with. The need for a particular kind of re-assurance is also evident in Young-Ja's excerpt:

> *Young-Ja: Overall, I was anxious throughout my pregnancy because of my age. I was worried my baby could be abnormal. Here, everyone assumes that everything will be okay. That was what made me uneasy. However overall, it was good.*

Young-Ja's concern that her age predisposes her to increased risk of having a disabled child is exacerbated by the apparent lack of concern of her health care team. The environment in which women birth and the interactions and actions shared with health care professionals are a common source of childbirth fears, particularly where there is a lack of trust in obstetric staff (Fisher, Hauck, & Fenwick, 2006). The reification of 'age-related risk' is a technique of government that enlists women to become self-regulating and self-disciplining (Weir, 1996). Feminists and ethicists support the availability of screening and testing technologies to test for impairment, on the grounds of enhancing choice and control for women. However, the emerging relation between pregnant women and reproductive technologies is also biopolitical, a calculated mode of influence that constitutes impairment through such practices (Tremain, 2006).

This relation can be seen in the following account, where Ji-Eun relies on empirical and visual technologies and perceives health personnel as being too relaxed and casual, while the midwife is positioned as a gatekeeper who prevents access to services that would provide reassurance:

> *Ji-Eun: I felt something was lacking, as I couldn't help comparing NZ system with the one in Korea. For example in Korea, the mother-to-be don't feel anxious because all kinds of test such as ultrasound, a test for the deformation etc. are offered to them, whereas NZ [maternity related medical staff] keeps telling you that "You are healthy... don't need to worry... the family history is clean... etc". This sounds like lip service. In some sense, it made me feel relieved but I still felt anxious as no figure or numbers were shown. I wanted to see the evidence that everything was all right, and not just from the comforting words. I knew that I could have some additional ultrasounds if I willing to pay, but didn't do it as my midwife did not recommend it...not just because the cost matters.*

In the technologically mediated surveillance of pregnancy, Tremain (2006) suggests that the government of impairment in utero is connected with the government of the maternal body. Ji-Eun's account highlights a dialectical process where engaging in the surveillance of her foetus achieves her own surveillance. Her expectation that a repertoire of tests are universally available in Korean institutions and that in New Zealand only inadequate 'comforting' words are available, reflects the desire for empirical evidence that the baby is healthy (and not disabled). She is able to make political counter demands and request tests to prove the health of her baby in part due to the state's exercise of biopower (Payne, 2001), explicitly comparing the New Zealand health care system unfavourably against that of Korea. She perceives that similar care or interventions are being withheld from her by the midwife without knowing whether this is institutional practice for the midwife who might be operating within standards: she positions the midwife as powerful and herself as anxious and uncertain. Ji-Eun exercises self-governance in the Foucauldian sense, and restricts her own behaviour in accordance with the accepted Pākehā norms of 'doing' pregnancy, becoming a docile body who falls in line with what her midwife tells her by not bucking the system.

Being cared for is discursively constructed by the Yoon- Mee as receiving support and comfort from the midwifery and nursing staff in a way that acknowledges her unique cultural status and allays her anxiety:

> *Yoon-Mee: I think it's the cultural differences. Korean midwives, doctors or nurses and even those not working in the maternity field greatly care for the mum-to-be. They look after the mum so carefully and are willing to give you answers if asked, but here in NZ it seems to be all business... I felt they were unreliable and careless. It was the same with my midwife. In the 20 weeks of my pregnancy I was bleeding and naturally I was so scared of that. I rang my midwife and was told the specialist would see me, but it turned out that no appointment with a specialist had been made. At some stage, I had rashes all over my body and I was very anxious about it, but the same thing happened again – no appointment was made. I was greatly worried, but I felt at the time that my midwife – the person who would deliver my baby – did not care much of it. However, she looked after me well after I gave birth.*

The attitudes and behaviours of caregivers and continuity of care from

individual midwives throughout the pregnancy and birth are powerful influences on women's perception of their birthing experience (Fisher, et al., 2006). Yoon-Mee attributes the lack of caring to a cultural difference, and specifically notes that a hallmark of caring is the ability to answer a mothers' questions. The midwifery relationship seems to be a contractual rather than a caring relationship, yet one where the mother's concerns are not taken seriously or followed through. The mother positions her caregivers (midwives) as untrustworthy and uncaring. The lack of follow up on a referral is taken to mean that the mother cannot delegate control to the system. The excerpt considers the ways in which Yoon-Mee experiences herself as a maternal subject and positions herself as outside dominant Pākehā maternity discourses. She draws upon Korean cultural discourses of caring as resources in her interactions with the New Zealand maternity system. She also turns to the Internet to get her information needs met.

> *Young-Mee: The Internet helped me very much. I joined an Internet café for pregnant [Korean] women and nursing mums. There were so many tests over in Korea, such as amniotic fluid test, which made me feel very envious. Here in NZ there are no tests we can have. Even having an Ultrasound is very hard. So I arranged it by myself, as I wanted to see the baby very much. The Korean [system] offers so many detailed tests so the mums can feel relaxed whereas I in NZ was anxious throughout the whole pregnancy.*

Young-Mee constitutes and structures her pregnancy experience through biomedical discourses and resists health professional rebuffs to her requests. Her discursive resistance is seen in seeking an alternative space to talk with other Korean women who might support her beliefs. The Internet provides a space for people to do things which they might not be able to do before, and can be empowering (Tang, 2010); people with marginalised identities can share their experiences and reduce their isolation, information can be exchanged and monopoly of health professionals over knowledge can be challenged. Being able to share one's feelings and receiving emotional support and a sense of solidarity can help with managing a crisis. Consulting a variety of information sources is considered a beneficial subject position; in that health workers and other service providers can support the desire for knowledge and information (Geiger & Prothero, 2007). However, Young-Mee's actions to get her own needs met outside the system appear less to be about wanting to engage and more a response to the limitations of the system and the limited support it affords her. Her desire to see

the baby through the ultrasound is a way of obtaining some certainty about the baby's health and integrity.

The desire for monitoring, surveillance and intervention is evident in labour too, as seen in Jung-Ja's account where she makes a comparison with what she might experience in Korea:

> *Jung-Ja: In Korea, it is said that you report the progress of your contraction to the doctor every several minutes…It could even be done over the phone. Here, I did it with my midwife but it was not very satisfactory. I said to her the gap between each contraction was several minutes so I felt the birth would be very soon, but was only told it would be long time later like tomorrow or the day after tomorrow. Even so, I wanted to go to hospital and wait there but was refused being told that would do nothing but wait. Clever me, I insisted to go to hospital and she had to let me go to hospital. I arrived at the hospital about 12am to have my first child and my midwife was on her way to go home but changed her trip to hospital as she felt like something might be happening. It (the birth canal) opened by 5cm as soon as a test was done. Even to know this I had to ask. I had to keep asking to have an idea of the progress. In Korea, we are kept informed about the progress of the opening. Have all of you been informed?*

This excerpt can be read as Jung-Ja expressing a positive norm of going to hospital early and labouring there, but it could also be read as the micro-institutionalisation of biomedicine (Morgan, 1998), and represent a desire to transfer the power and responsibility for birth to her LMC. Jung-Ja must interpret what is happening in her body and has difficulty in knowing whether labour has begun. Her request about the progress of the birth illustrates how the state of labour is not only treated formulaically but must be ascribed by an authority. Jung-Ja constructs the figure of the doctor in Korea as the kindly holder of expert and authoritative knowledge, who can allay fear and demonstrate caring and expertise through careful monitoring of an at-risk body. The medicalisation of childbirth is constructed as a benevolent process and, Jung-Ja's take up of associated personal disciplinary practices invokes fear for the well-being of both her unborn baby and herself. Although the midwife contradicts Jung-Ja's felt experience, Jung-Ja exercises her own agency and insists on being allowed to go to hospital, and the midwife concedes.

Anatomo-politics offers subject positions that assist women to judge their performance through the quantification of norms (Payne, 2001). The quantifiable nature of labour that is associated more usually with biomedical discourses is evident in Jung-Ja's account, where numbers rather than sensations are used to evaluate the stage of labour. Cervical dilation is valorised as an indicator for arrival at hospital, over women's own perceptions of their pregnancy and labour. The issue of when to come to the hospital highlights a gap between the needs of women in labour and the hospital (Armstrong, 2003). Jung-Ja's desire to come to hospital (too early) because of the timing of her contractions might not be well received by hospital staff that view women who are not 'in labour' as making illegitimate demands and crowding the space. The role of the LMC becomes one of 'translation', to decipher/read the events that are inscribed in the mother's body.

In addition to lacking access to knowledge, Korean mothers experience the maternity system as unresponsive to deeply held beliefs around the sanctity and vulnerability of the mother's body in relation to birth.

## Labouring differently

In the excerpts that follow, nurses and midwives are portrayed as positioning Korean mothers as deficient and problematic maternal subjects due to their difference from white mothers, highlighting processes of subjectification. Many of the women did not attend antenatal classes, and discussed their own knowledge of traditional practices, highlighting both knowledge and information gaps. They position the midwife as authoritative, and themselves as largely naive and uninformed consumers of New Zealand maternity services:

> *Ji-Eun: I have had experience delivering a baby in Korea so I thought I should set my legs apart and push. I was aware that there were many other options here in NZ. My midwife went through the options from standing up to the aquatic birth and asked me to choose. But how could I choose when I didn't know any of them? The midwife's explanation is limited. It would rather be of more help to have a recommendation from the experienced. That's why I stuck on the way I did in Korea without doing any artificial method like anaesthesia or epidural etc. The midwife double-checked me several times why I did not take advantage of several options, but I couldn't, as I had no idea about any of them. The idea of anaesthesia sounded*

*attractive, but I was scared of it and its side effect. I just inhaled gas as my midwife recommended it, but nothing else. I only had my midwife beside me holding my hand, as my husband was not able to make it because of his schedule. I was ashamed that I didn't have an opportunity for the aquatic birth.*

Ji-Eun prefaces her account by saying she has given birth before but in Korea; she has an idea of what to do and is aware of the range of birthing choices available in New Zealand. However, she is uncomfortable and less able than the White women to take up the role of being an autonomous informed consumer, despite repeatedly being asked and offered a choice. It is unclear what prevents her from taking up the options 'available' to her, although she is 'ashamed' at her inability to take up the role of informed consumer.

For Mee-Young, Korean practices are defaulted to in the absence of other knowledge. There is a perception that the lack of support for Korean cultural practices reflects a lack of care. Mee-Young perceives that not only are Korean cultural practices not supported, but health professionals also construct them negatively:

*Mee-Young: Yes, I did. I was shown an empty room and assumed that the relevant equipment would be installed on the delivery day. In Korea, the mother's hands are tied when in labour. It depends on the hospital, but most of the hospitals encourage pushing. Even a piece of cotton nappy is hung on the corner of a bed and I realised later this really helped to push. The other reason why the hands are tied is to prevent hurting oneself when in labour during which one might scratch her face by accident. When I was in labour, I had my capillary vessel broken for not being able to push properly – according to my midwife. Another Korean mother tried to show how to hang and use a piece of cotton to the other mother in the maternity ward, but had to stop because the hospital staff seemed suspicious of the practice. The hospital staff made rude comments about the practice so the mother took the piece of the cotton from the wall.*

What is striking about Mee-Young's care is the gap between her expectations and her reality of the labour experience in New Zealand. Although Mee-Young

views the practice of hand tying as beneficial both in helping to push and to prevent injury, the practice is adversely commented upon by staff. The women submit to external regulation and surveillance and proceed to regulate themselves, by subjecting themselves to an internalised surveillance. It has been noted that responses from Western workers to traditional postpartum practices range from "at best insensitivity and at worst derisory" (Barclay & Kent, 1998, p.6). Therefore, Mee-Young and the other Korean mother are disciplined into investing in the normalising judgement about what constitutes 'normal' labour and delivery practices. While neoliberal ideology theoretically supports those who 'help themselves' the Korean mother's resourcefulness in obtaining assistance from her peers to undertake a Korean cultural practice is not supported.

## Being positioned as illegitimate

Normalising practices in New Zealand extend to the expectation of mobilisation and 'rooming in', where the mother is expected to be completely recovered and independently responsible for the care of her baby as soon as possible, especially if she has had a baby before:

> *Young-Ja: Also, my vaginal area was swollen and I could not sit because of the stitch, which made me not able to change the nappies and caused dizziness. I rang the bell to call the nurse, and when the nurse came, she sounded annoyed and sarcastically asked me 'if this was my first child and why I acted like it when it was my second one.' I understand that there were a lot of people, but from the way the nurse was treating the Kiwi lady opposite me, I felt very mistreated as I could sense the differences in her attitude.*

Young-Ja's account, highlights how difference is equated with deficiency. In being unable to act independently, her request for assistance and discomfort is denigrated. The nurse is perceived to be angry at being interrupted from her real work and is sarcastic and disbelieving about Young-Ja's need for help. There is an expectation that as a multi-gravida, she should know better and a lack of recognition that while the experience of birth is universal there are cultural inflections that preclude following a standard pathway. Young-Ja gives the nurse the benefit of a doubt, noting that the nurse has other mothers to care for, but is herself unconvinced by the explanation, given the nurse's warmer treatment of a Pākehā room-mate.

Questions of legitimacy are also evident in Young-Mee's account:

> *Young-Mee: I requested a perineal section, but was refused because it opened by 5cm... The baby arrived very quickly. I was told that even the muscles were torn. Later, a doctor turned up at about 1.40am. I am sure that the doctor herself was not a Kiwi either. At that time, there were so many foreign mothers who intended to have a baby in NZ. And yet, the doctor came back after one hour to suture and said to me in a rude manner, "Have you come here to give a birth to a baby?". She treated me very unkindly. In Korea, we are covered after delivering a baby, but I was waiting – like this – for a long time...It was no wonder I bled so much, as I was left alone like that for a good while.*

Young-Mee's request for intervention is refused and a doctor who also appears to be overseas born sutures the resulting tear. The questioning of Young-Mee's eligibility to legitimately receive services is put into question in the context of already being uncomfortable and distressed. She perceives that the treatment she receives is poor, delayed and rude. Young-Mee is interpellated into understanding herself as problematic and othered, being seen as an illegitimate migrant who is trying to attain citizenship through childbirth, rather than recognised as middle class with citizenship status. These psychological and sociological processes operate simultaneously to produce a process of subjectification where she is devalued. Young-Mee adds:

> *Young-Mee: Later on, my midwife told me to wash myself but I was so distressed that I just sat down. At that time, the maternity ward was full of foreign mothers whose sole purpose for coming to New Zealand was to give birth. I don't recall it too well, but the foreign mothers-to-be were put together in one room. I made it clear that I did not come [to New Zealand] only to give birth but the doctor seemed to treat me as if I did. The doctor had not stitched me up properly so I suffered greatly since then. I still remember the doctor's face. Anyway, I was treated improperly and had to wait a long time, and the suture was carelessly done.*

In this excerpt, Young-Mee is not offered assistance to bathe but 'told' to bathe, however, her distress prevents her from carrying out the instruction. In her

account Young-Mee does not explicate where the 'foreign mothers'[8] are from, but perceives that she is given the same (poor) standard of care that they receive. This act of corralling or quarantine reflects practices of separation and demarcation that function to impose order amidst unpredictability (Douglas, 2002).

Similarly, the qualitative difference in care received is noted by Young-Ja:

> *Young-Ja: Well…I was happy because it was my baby and I liked NZ as its environment was very good and relaxed with beaches everywhere…Just the attitudes towards Asians…That's the problem…Maybe it was because of the foreign mothers whose only intention to come to NZ is to give birth, but we were given the cold shoulder. The feeling was disdainful although not the language itself…it was offending.*

Young-Ja is pragmatic, she weighs up the pros and cons of being in New Zealand and is happy with the environment, but remains concerned about how Asians as a group are treated. Her positioning as an 'Asian' indicates the intersection of gender and racialisation. 'A cold shoulder' refers to intentionally cold or unsympathetic treatment, a non-verbal action where a person is ignored.

Young-Ja and Young-Mee are engaged in a struggle over representation, where they try to resist being interpellated as interlopers who have come to New Zealand to have babies. Through the process of subjectification, they experience being devalued as an economically unproductive 'other', who is seen as a liability (Stratton & Perera, 2009). The dominant response to otherness is normalisation, and there are specific sites of culture and tradition where the Korean mothers experience normalising practices.

## The maternal body as vulnerable

### Temperature

Food, warmth and rest are sites where Korean mothers painfully recognise how the intersection of gender and racialisation construct them as other mothers. Furthermore, institutional power relations constrain opportunities for resistance. The following excerpts show that the space of the maternity ward is a contested

8. Until the end of 2005, most children born in New Zealand became citizens at birth (with few exceptions).However, from 1 January 2006, children born in New Zealand could only acquire New Zealand citizenship at birth if at least one of their parents was a New Zealand citizen; or was entitled to be in New Zealand in terms of the Immigration Act 1987 (a residence permit holder or Australian citizen). The rationale for this amendment to the Citizenship Act 1977 was to "ensure that citizenship and its benefits are limited to people who have a genuine and ongoing link to New Zealand"(The Department of Internal Affairs, undated).

site, where competing discourses about what constitutes a healthy environment (in this case fresh air and sunshine) are in tension with the desire to keep warm in order to prevent subsequent illness.

> *Mee-Young: I said I wanted to go home, as nobody was available to help me. The nurse's care was only limited to looking after the baby when I was eating. Isn't it chilly even in December? It was cold for me as the windows right next to me were open. But my attempt to shut the window ended up with a grumbling nurse opening it again while I took a short break. When I said I felt chilly she only gave me another sheet. (Another participant: But in our culture, no windows should be open after you give birth!) Over by the window, Kiwi mothers in the Maternity ward were wondering around in bare feet wearing only a gown and eating apples, which was absolutely impossible for us... (Other attendee: Our body wouldn't allow us to do that!) The draught kept on coming so I decided to go home. I could manage some Seaweed Soup... but the Kiwi [hospital] food did not suit me. Since then, I haven't been well.*

Mee -Young's narrative constitutes an example of how prevailing discourses about Western maternity (such as the healing properties of fresh air) create 'truths' about Korean women as mothers that have an impact on how they see and experience themselves. Mee-Young decides to take action to get her own needs met outside the system because the system does not support her, she feels alone with nobody being available to help her. This reflects the Pākehā discourse of 'rooming in' where the mother is expected to take on mothercraft skills so that she can become increasingly independent, and go home ready to engage in full-time care of the baby. Mee-Young constructs the nurse's help not only as limited and focussed on the baby's needs, but also someone who thwarts her attempts to become more comfortable and to maintain her well-being. She notes that the Pākehā cultural traditions and food are in direct contrast with her own needs. The fight for the control of the hospital environment is evident here, with both universalising and particularising discourses at work. Birth is universalised as a natural event requiring a rapid resumption of old roles and the incorporation of new roles. Ventilation and fresh air are ways in which the space is kept healthy, demonstrating the continuing relevance of germ theory. In contrast, the closed window associated with the need for warmth is seen as a threat.

Ji-Eun highlights this lack of perceived care and attention to both mother

and baby. She was left to be cold and the baby was measured but not washed.

> *Ji-Eun: I remember being cold. It shouldn't have been cold as it was the 4th of September but the draught came straight through the window so it was cold. As I remember in Korea, the nurse takes your baby away right after birth and the doctor comes to examine you. Maybe because it was a Tertiary Hospital, the process was very quick. It was less than half an hour until we moved to the next process. After that, I was given Ringer solution for three hours then moved to a ward. Here, I thought the process was finished after the delivery, which was at half past one, but it was almost six when it did finish. Um... they left me alone and measured my baby, but didn't even wash him/her. So I wrapped my baby in a towel, and they said the placenta didn't come out properly, so it took long, even the stitching took long, and I was very cold. I still have pains all over, starting from my feet.*

The needs of the baby were prioritised at the expense of the mother preventing the enactment of cultural rituals, including keeping warm which were seen as potentially having long-term disabling effects:

> *Jung-Ja: Five nights six days – I wanted to leave but was not allowed because my baby had jaundice, which wasn't a serious condition. On the fourth day, I wanted to go home, I felt depressed, it was cold and dry, and I had to stay alone with my baby at night. The nurse kept coming and asking me this and that even though I couldn't speak English. I couldn't converse with them. I think they were asking whether I had changed the nappies but I couldn't understand... I desperately wanted to go home, but my baby's jaundice was the only reason I couldn't. It wasn't even a critical situation... (Attendee next to her says: "It's because over here, everything is based on the baby"...)*

### Food

Food is another site for the disciplining and normalisation of maternal subjectivity. For Korean women food is more than nutrition, it equips the mother to feed her baby. She is eating for two.

> *Young-Ja: I'm not picky with food and I still enjoyed food even*

*after giving birth. The Kiwis said that the food had all the nutrition, but the portion was too small for me. Kiwis probably eat the same thing, but how would I produce milk with a portion like that? They gave me the same amount of food (it was sort of watery...) as if I was an ordinary person, and it wasn't quite enough. I couldn't bring my own food under the circumstances, and didn't want to bother the other mums with the smell of my own food – when I had my first child, the nurse had told me off for the smell. In both children's birth, I had to share a room with another mother, as there were too many patients, and the midwives showed an obvious sign of dislike. They even said to me if I had "brought fish". This experience after my first child put me off from bringing food again – This is why I was hungry.*

The lack of acknowledgement of the special status of the new mother comes to the fore in the area of food. Young-Ja expresses concern about the size and quality of the portion and its impact on her capacity to provide adequate milk to feed her baby. Her perception is that she is being fed as if she were an 'ordinary' person rather than the special mother that she has become. Her agency to meet her own needs is limited by there being no option to bring her own nutritious food to the ward because of previous negative verbal and non-verbal feedback about the odour of her food. We can see Young-Ja exercises vigilance with regard to her own behaviour, monitoring whether what she does fits the norm, and thus that regulation becomes self regulation as Young-Ja subjects herself to an internalised surveillance. Ong (1999) observes that smells, although invisible cannot be physically contained in the way that bodies can, so the smells of one's humanity have to be erased as a measure of cultural citizenship.

*Mee-Young: even though there are a lot of impolite hospitals in Korea, the mothers are always the main concern, as the baby will survive anyway. Aren't there nurses and other family members to look after the baby anyway? They give you warm water and Seaweed Soup [NB: Nutritious traditional Korean food rich in iron and minerals] and keep on checking you. Here, they abandoned me with my baby*

Mee-Young notes that even though in Korea hospitals and institutions might not always be polite, the concern for mothers is a transcendent constant compared to the priority focus on the baby that is evident here in New Zealand. There are

always other people on hand to take care of the baby, but the mother is nurtured with food and warmth, in contrast to New Zealand where the mother is often left on her own. The previous excerpts illustrate a dominant Western discourse where birth is viewed as a process that women can immediately recuperate from, and then begin the task of mothering. However, many of the Korean women discursively positioned birth as process that made the body vulnerable and required a period of rest and nurturing before the mother could take on new or additional responsibilities. This contrasts with natural birth discourses that frame the maternal subject as physically capable of caring for her baby from the moment it is born. This construction represents the body as strong and capable for taking on the tasks of motherhood. Mee-Young's narrative reflects a belief that because her body is depleted and weakened through childbirth, she needs to strengthen her body so that it can produce enough breast milk through eating the right kind of food.

### Breastfeeding

The imperative to breastfeed makes women's interactions with health services and providers more significant given that the majority of women give birth in hospitals and then receive support in the community. In the case of migrant women in particular, health staff might be their only source of help with breastfeeding as there may be no family members available. Ji-Eun's excerpt illustrates the dependency many migrant mothers have on health services and providers in the absence of family and the isolation they experience:

> *Ji-Eun: I've heard that the cultures are different. In my instance, my mum comes and forced me to eat too much even when I was asleep, then tells me to wake up to eat again. Here, nurses always ask you to feed the baby. In Korea right after you give birth, the nurse takes your baby and feeds him/her formula. Although Korea does have more campaigns for breastfeeding these days. Here, the midwife talks about breastfeeding as something much greater than what I've known. So it's a bit pressurising. Breastfeeding... my breasts wouldn't produce any but the baby keeps sucking so it hurts and bleeds. Apparently, you have to persevere. The midwife came for once a day only, but I had many questions. There wasn't anyone else I could ask about breastfeeding. I searched the internet and it seems many young mothers in Korea breastfeed their babies, and in some cases, biting on towels to ease the pain. This was some comfort*

*to me. Only breastfeeding and no formula milk is called "WanMo" [NB: Abbreviated Korean word meaning purely breastfeeding] which gave me hope.*

Ji-Eun's account highlights how varying maternal authority figures discipline the new mother, signalling differing values about the centrality of mother and baby. Her experience in Korea is that her health and well-being are most important, whereas in New Zealand she is positioned as less important than the baby. Ji-Eun is incited to breastfeed but her excerpt reveals a lack of support for her to do so. Once she gets home she pursues her own strategy to enhance her capability to succeed, and considers extraordinary measures (biting on towels to ease the pain) and 'persevering' with breastfeeding to achieve her identity as a good (breastfeeding) mother. Her use of the Internet, as discursive resistance shows that it replaces or supplements embodied pregnancy advice from mothers, grandmothers or medical professionals (Fox, Heffernan, & Nicolson, 2009) and becomes a key site of maternal discourse. This space has an important role in an environment where there are no easily accessible resources available for Ji-Eun. The experience of pain contrasts with the framing of breast-feeding as a natural practice, reflecting that skill and effort are integral to the process. Relying as it does on one body, breastfeeding can be a lonely experience, and it benefits from sociability and the help and support of others.

In Jung-Ja's account, the prioritisation of the needs of babies over the needs of mothers is apparent in the inconsistency of advice and strategies with regard to breastfeeding:

*Jung-Ja: Nurses were not consistent. I would like it if the nurses change their attitudes. At the hospital, the nurses didn't give me formula even when my baby was crying and screaming. Even though my nipple was bleeding. However at another Hospital, a Chinese nurse asked why I was "starving my child" saying that it was bad for his/her liver level and it wasn't good for him/her, and why I kept breastfeeding him/her when there wasn't anything coming out. She was meant to keep bringing me water... but as I see it, she was inconsistent. At least if there were Maternity nurses they would've known how to treat a mother and would've been more consistent. As there were none, I was anxious.*

The excerpts illustrate the different extents to which the UNICEF–WHO

Baby-Friendly Hospital Initiative (BFHI) are embedded. The New Zealand government became the 133rd in the world to launch this initiative in 2001. A hospital accreditation programme was developed and the first New Zealand hospital achieved accreditation in 2002 (Moore, Gauld, & Williams, 2007). This global strategy to promote, protect and support breastfeeding includes Ten Steps which guide maternity services in how to be 'baby friendly' and instantiate breastfeeding as a universal norm un-supplemented by infant formula (Moore, et al., 2007). Some of the recommendations include: rooming in of infants with mothers to facilitate breast-feeding on demand, latching on newborns to the mother's breast at birth; and the prohibition of advertising and free samples of infant formula.

> *Young-Mee: I also would've liked even three hours of sleep at the hospital, but since my baby didn't have enough milk, s/he kept crying. Even when I regularly called for someone, no one would come and I got no response. It was much much later when they would come, and when I begged on my knees for some formula, it would just go through one ear and come out of the other. Then they would only say what suited them – "If you keep trying, it will come out". Of course, but that wasn't the point. I wanted some formula because I needed just three hours of deep sleep, but they wouldn't budge.*

Young-Mee's attempts at agency are thwarted. She was unsupported in her efforts to get sleep, her calls for help ignored and responses delayed. Begging for formula so she could settle her baby and get some rest provoked no compassionate assistance. Breast-feeding is like an 'emergency', in the sense that timely attention is required at unpredictable times (Bowes & Domokos, 1998a). This can result in women having to compete for the scarce resource of a midwives' time. Women, who are already resourced, articulate and committed to breast-feeding are more likely to succeed in getting help than a less decided woman. Young-Mee's excerpt shows how the relationship between the perceived promptness of response to maternal concerns, efficient and effective interventions, and the mother's satisfaction are related. Call bells are a fundamental communication tool that connects nurses and midwives with mothers. Call bells can represent a source of frustration for nurses because they interrupt planned tasks such as assessments, treatments, medication administration, and teaching and are sandwiched between many other demands (Roszell, Jones, & Lynn, 2009). Clients who disrupt or legitimate nursing work can come to be stereotyped as 'good' or 'bad' (May, 1992) and 'bell pressers' are

subject to nursing discipline.

## Conclusion

Language and discourse bring into being and normalise particular versions of the world and relations of power between social institutions and actors. Korean mothers drew on two main discourses with which they understood their experience of maternity. Both their framing of the maternal body as a body at risk through biomedical discourses, and their framing of the maternal body as vulnerable and in need of special care through cultural discourses collided with the discursive formations of midwifery, nursing and Western liberal feminism in the New Zealand maternal system. Practices based on a dominant discourse of birth as a normal physiological event and neoliberal discourses of productive subjectivity created a gap not only between what Korean women expected in maternal services and the care their received, but also a gap in what they saw Pākehā women receiving compared to themselves. As racialised maternal subjects, Korean women's bodies were subject to modes of government that were both empowering and normalising. However, Korean women experience these modes as disempowering because they are not defined in their uniqueness and particularity, but in relationship with technical knowledges deployed by nurses and midwives, and they were made to regulate themselves accordingly. These cultural maternity discourses incite disciplinary and normalising processes for Korean women as maternity is presented in moral terms. Failing to perform practices (such as rooming-in, becoming independent) or performing them differently results in the women being ascribed with deviancy. Normalising practices function to reduce the gap between the 'foreignness' and dependence of mothers and the required norms, and provoke self regulation. Ultimately, becoming a Pākehā mother is not a subject position that is available to Korean mothers, and they are made indistinguishable from less desirable racial others despite their citizenship status. These processes have two key impacts. Firstly Korean women experience a differential quality of care, which contributes to dissatisfaction with their maternal experiences. Secondly, nursing and midwifery reproduce detrimental practices associated with colonial and assimilatory discourses. In the following chapter, I present findings from a focus group with Plunket Nurses, where these colonial / assimilatory discourses are evident.

# Chapter Eight: The maternal health professional as normalising agent

> In the very struggle towards enfranchisement and democratization, we might adopt the very models of domination by which we were oppressed, not realizing that one way that domination works is through the regulation and production of subjects (Butler, 1992, p.14).

Nurses have typically viewed themselves as powerless and apolitical, however nursing and midwifery knowledges induce subjectification, according to modes of government that both empower and normalise. Plunket nurses provide Well Child services to mothers and children from birth to five years, and despite not being employees of the state they occupy a strategic political position as they make use of disciplinary technologies and respond to state ideologies. They exercise pastoral and disciplinary power in policing families, subjecting mothers to the disciplinary gaze and normalising judgements. Nurses have access to a vast repertoire of practices with which to structure and control the agenda and interactions they have with mothers (May, 1992). The goal of the chapter is to explore these practices and their impact on maternal subjectivity.

This chapter outlines the findings from a focus group with eight experienced Plunket nurses from migrant backgrounds (mainly the United Kingdom), and show that despite this 'diversity', Pākehā liberal feminist discourses are central organising principles. The first part of the chapter discusses the areas of practice that are problematised by Plunket nurses with regard to 'ethnic' migrant mothers. Plunket nurses perceive a gap between their ability to provide care and services to ethnic mothers, and attribute these to i) language and communication barriers, and ii), the presence of extended family in the form of maternal authority figures and involved fathers. These factors pose a threat to the liberal feminist conception of the maternal subject. Her inter-dependence means that she does not carry the burden of mothering solely and therefore is not autonomous; and her perceived subordination to the men in her life prevents her from being self-actualised and free. The second half of the chapter discusses the subject positions available to the Plunket nurse in light of this gap, such as the 'benevolent benefactress' who enhances the performance of goodness that is fundamental to feminine/liberal/nursing subjectivity and is influenced by Christianity and liberalism. I also identifying the normalising techniques (such as the re-ordering of space discussed in the last chapter) implemented by Plunket nurses to assist the migrant mother to become more of a liberal Western maternal

subject.

## Alien and isolated mothers

The ideal service user or 'good mother' is one who is an autonomous individual and easily able to make necessary health related changes by adhering to professional advice and 'mothering by the book' (Moosnick, 2004). However, migrant mothers challenge this notion. The ability of the mother to have mastery over her self and her life is a pre-requisite for health, and migrant mothers are seen prevented from having self-mastery by virtue of their culture. In the neoliberal context of having more responsibility for one's health, the burden of care is difficult to shift back to the mother who is supposed to be an autonomous maternal subject if she is oppressed and alien, because it means she is unable to regulate herself to conform to dominant maternal discourses of autonomy.

This excerpt marks the first response that to the opening focus group invitation to "tell me about your experience of working with migrant mothers":

> *Sheila: It seems like they are living in a different world you know, separate from what is you know going around. When we go to them, they can't even understand yes or no, they understand only about 5% of what you say...Yes, like lack of awareness, lack of information, so that's a big barrier I think...The Indians have been much more exposed to culture.*

Sheila constructs the migrant woman as alien, removed and isolated from the society that she is in. The woman's lack of comprehension extends to the very basic of questions–agreement or disagreement– and she has only a tiny percentage of understanding of what is said. Sheila then opens up the category of migrant mothers by specifically identifying the group she is not talking about. She implies that the woman is East Asian and constructs the home that she visits as a cocoon that is separate from the world that she inhabits. The lack of language proficiency presents a barrier to the acquisition of knowledge, and therefore agency. In using the word culture, she is positioning Western culture as the referent. The problem of communication is attributed to the women's inability to speak English, rather than the inability of the health service providers to meet the communication needs of the women through the provision of translators or written materials in other languages. Communication is an area where Plunket nurses are left un-resourced by the health system: their inability to communicate with some migrant women makes the women seem even more 'foreign'. The difficulty extends to being unable to assess just how much is being

comprehended. The resources available in the health sector generally are only available in English and for some of the women that they visit who may not be literate this presents a large problem.

Unable to communicate verbally Sheila uses other tactics:

> *Sheila: I'm very good at miming. I think we're all very good at miming. But it's getting things across, because the literature that we give them is written in English. And some of my Indian mothers don't have enough education, they can't read their own language, let alone read English. Same with Afghani, some Iraqi, some Somalians, they can't read their own language, so it's really hard.*

The remedy for the institutional information gap is also individualised. There is no that state institutions could make their services accessible and responsive to those who are linguistically and culturally different. Therefore Sheila has to find other ways of informing women and orientating them to the New Zealand maternal system. Sheila perhaps overestimates her capability to get information across through mime, not understanding the impact that cultural variables might play (Johnstone & Kanitsaki, 2008). Intercultural communication is not just about the exchange of words; but also the exchange of shared meanings.

English language proficiency can be used as a social marker for classifying and negatively evaluating people of ethnic backgrounds. As Johnstone & Kanitsaki (2008) point out, language prejudice and discrimination are often disguised, and are sophisticated ways in which cultural racism can work in a healthcare environment. Johnstone and Kanitsaki's research found that negative attitudes toward people who did not speak English as a first language or did not speak it at all were embedded in the health system. This was evident in several ways, including a lack of infrastructure to support language services; a lack of resources; and, paradoxically, a lack of data to support the need for resources that, were difficult to obtain because of a lack of resources and infrastructure. Effective communication depends not only on the knowledge of a second language (which the nurse may not have) but cultural knowledge and skills. There is growing evidence that 'cultural misunderstandings' and failures to use professional health interpreters are implicated in preventable adverse events among people from minority cultural and language backgrounds (Johnstone & Kanitsaki, 2006). At the time of writing this thesis, a new project making available interpreters was

rolled out in the Auckland area to Plunket nurses, which may alleviate these communication issues.

The individualising of this social issue is evident in Jennifer's functionalist argument, where she locates the problem in the poor 'choices' that the mother has made, rather than locating maternity in the context of structural hierarchies where people might be positioned differently and consequently receive different resources, jobs and social privileges (Ringrose, 2007b):

> *Jennifer: When I see these people, they're not long in the country and they have a baby and think if I were you that would be the last thing I'd do, because it's such an enormous responsibility and your insecurity is huge. Your husband has or hasn't got a job, you don't speak English, you're in rented accommodation, you've got no family support, and you're pregnant with your first child. Your own health is not that good probably... and you're pregnant and you're confronted with a totally different system... and maybe your husband's not all that good to you either. So it amazes me that they actually survive.*

Jennifer's excerpt highlights the dominant middle class idea of motherhood as a project, which must be carefully managed and is enhanced with expert knowledge, professional advice, and consumption (Avishai, 2007). Choosing when and how to have your baby reflects the subject position of a rational unified self who consciously makes decisions about their conduct in order to become self-actualised and successful (Lupton, 1995). Jennifer's valorising of self-mastery extends to the assumption that women are in control of their reproductive lives, ignoring the part that biological, material and discursive forces play in the likelihood of reproduction (Harter, Kirby, Edwards, & McClanahan, 2005). Maternal 'choices' construct mothers as if they are morally and causally self-contained units of influence with control over their bodies and isolatable from the broader context in which they are situated (Kukla, 2006). Thus there is little recognition of the structural issues that contribute to the situation. The gap between a woman who is in control of her fertility and one who isn't invokes the notion of a civilised body, which can restrain its impulses and bodily processes. Jennifer constructs the migrant mother as someone who has not made a rational decision in view of her material circumstances. This quote comes in the context of migrant mothers being viewed as having too much support or not enough support.

Jennifer mentions earlier in the transcript that she was a migrant mother herself, and her concern over the well-being of the mother is an argumentative resource that expresses opposition to having a baby under certain circumstances. However, the norms invoked are in the service of Jennifer's own interests and highlight the expectation that the migrant mother must progress socially along recognised and acceptable routes (get a good job, then get married, buy a house and have a child). The dominant expert position of the nurse as the arbiter of when it is appropriate to have a baby is centralised, and the migrant is positioned as not able to make decisions in her own best interests.

Farida, who is matched with ethnically similar clients, notes the limitations of the system and her own powerlessness:

> *Farida: I see one Indian mother and she was a first time mother. And she had stitches at the time of the operation, I don't know what happened, and after that they [the stitches] were opened. And she said I cannot do any work, you know, even I cannot carry my baby properly. ..I said "did you see the doctor?" [and she said] "Yes [the] doctor has written the reference to the hospital but I have to wait. Like the appointment they have given me I think after four, five months or six months" she said ... But the problem is you know she cannot afford the private one. That's another thing you know some mothers I have seen they avoid to go see the doctor, they've got a serious problem with them, and you need to see the doctor. And they say "oh but her charges you know.. you know they cannot afford their fees, and sometimes in their situation it's getting worse and worse, just keep waiting and, and we got some supplementary services to help them, no more than just once a week or twice a week and even, but the problem is, she needs 24-hour service you know.*

At this point other members of the focus group add, "They need their mothers or a mother substitute. But not necessarily a mother-in-law (laughter)." However, as I show in the next section, the presence of authoritative maternal subjects such as the mothers' own mother threatens the performance of normative Pākehā maternity and the discipling of the self into a docile maternal body.

For Farida, there is a sense of not being resourced to deal with the depth and

breadth of the concerns that they are exposed to, being unable to help with the social issues such as isolation and waiting lists. Farida notes the complexities of the ethnic backgrounds of the women she sees and notes that what they have in common are limited finances, isolation and a lack of confidence. She finds her encouragement makes a difference. As she continues her conversation, it is evident that her role also encompasses advocacy and providing information.

### Disciplined babies and self-disciplining adults

The invisible privileging of the maternal subject who is autonomous, self-determining and independent is disrupted with the arrival of broader extended family that is intimately involved in supporting new mothers through maternity. This kind of maternal subject differs from the norm of the Pākehā nuclear family where the mother is the focus of interventions and the Plunket nurse has unimpeded access to shaping the performance of normative Pākehā maternity:

> *Mary: But a lot of the Chinese and Indian women come, and their mother and mother in-law come and I've noticed, particularly with the Chinese, Grandma takes over the baby. She sleeps with the baby at night, she carries the baby all day, and then at six months or nine months her visa is up, she goes back to China and Mother is left with a baby she doesn't know. Because this child had been carried for nine months. And you cannot tell a Chinese Grandmother to put the baby in the bed and let the baby cry.*

Mary constructs the family and in particular maternal support as a problem. The cultural intervention of offering intensive support to the new mother through strategies such as taking care of the baby, co-sleeping and intimate handling are problematised. The negatives are noted about this intervention, but no valuing of the willingness of mothers and mothers-in law to transplant themselves for a significant length of time from one country to another and devote themselves to providing practical help. The grandmother's role as a significant source of support and information about parenting is viewed instead as a displacement of the mother which puts in place a communal type of parenting that is unsustainable once the relative returns to China. Mary finds the Chinese grandmother impossible to discipline, given that the professional authority and expertise of the Plunket nurse carries no weight in this cultural context. Interestingly, the excerpt highlights how the production of the autonomous individual, who is unmarked by culture or community and independent is valued even in infancy (Razack, 2004).

Mary describes how the baby can go from being undisciplined to disciplined, and conveys the norm for how babies are supposed to settle. Mary would be giving all 'her' mothers the same advice based on current policy, that is, she is invoking 'disciplinary power'. Autonomy also structures interactions between the migrant mother and baby:

> *Mary: I've got an Indian girl at the moment, who rings me up and she says my baby is troubling me at night, she's ten months old, she wants to be fed every two hours etc, etc. Now I know what the European solution is for that baby is... The baby is well, the baby is well fed, she is nice and warm, and she knows she's loved, put her in the cot. Yes she will roar, yes she will crank it up, yes she will scream, she may scream for four hours. And then she will go to sleep. These Mothers cannot let their children cry for five minutes.*

Mary's use of the word 'girl' infers that the mother is not yet an adult. The use of 'terms of endearment' (for example girl) by health care professionals reflects a power relationship, where the health professional is in charge of the encounter. Usually it is a parental kind of relationship, where the parent is the health professional and the child is the mother being cared for. Usually a girl has little in the way of experience and knowledge, and not always able to make rational decisions (Furber & Thomson, 2010). On the other hand, use of the word 'woman' is more neutral and reflects maturity and equity. This is especially notable from a postcolonial perspective, as colonised culture was viewed as fundamentally childlike or childish, which led to the logic of the colonial civilising mission fashioned as a form of tutelage, bringing the colonised to maturity (Gandhi, 1998).

The discursive choices of the words 'European' and 'solution' have particular effects, reproducing the power, centrality and authority of Europe. This discourse places the European solution over other solutions in a hierarchy. Using the term 'these' mothers further distinguishes between European and non-European women. This extract highlights two key points. The first is the normative constructions of the Pākehā or 'European' in-group, which serve to exclude the migrant mother. In expecting 'these mothers' to integrate, their condition of being 'unable to let their baby cry for five minutes', positions migrant mothers as 'outsiders' to the in-group. The outsider status of the migrant mother, lacking resources in a new country, legitimates the assertion of assimilatory demands made by the tolerating dominant culture represented by the Plunket Nurse. The

second view expressed is that differences in values contribute to problems, thus the woman and her family are responsible for their own misfortune of the baby being unable to sleep through the night.

Mary continues:

> *Mary: Well I mean four hours sort of grizzling, going to sleep, waking, I don't mean four hours of solid screaming. But this pattern, they (the migrant mothers) cannot do it, they watch the videos, the tired signs, they are educated up to here. But they can't do it, and the latest one rang me up and said where can I get, pay somebody to come into my house to help me with my baby. I almost said look I'll do it, you and your husband can go to a motel for the night. But this is an enormous problem.*

Mary promotes 'controlled crying' and suggests that this 'grizzling' (non-specific genre of crying and not to be taken seriously) reflects the desire for company rather than something more serious. Mary views the crying baby as a reflection of the poor disciplinary practices of the parents, who are misreading the baby's behaviour and unable to distinguish between screaming and grizzling. Her view contrasts with other views that the baby will suffer harm if left to cry. Mary contends that the migrant mother is unteachable, because despite being given all the resources she is unable to adhere to disciplinary practices. There is also a sense of the commodification of maternity (which perhaps also reflects the cultural origins of the mother, where paid help with various maternal duties is often available) in considering payment for help to settle the baby. Mary's frustration at the woman's inability to follow instructions leaves her feeling like there isn't anyone else who might be able to help the mother. She adds that if the mother and her husband leave her to it, she can get on with her job of disciplining the baby. A heroic narrative is deployed; where Mary is certain that her skills and professional expertise will sort out the baby's inability to settle.

Justine references a conference presenter's talk when she was talking about the kind of learning that had been influential:

> *Justine: She [a speaker] said that her Plunket Nurse told her not to put the baby to sleep but to put it to bed awake. And she thought that this Plunket Nurse was absolutely crazy until her extended family that had held this baby for months went home. And she suddenly realised that maybe the Plunket Nurse did know what she was talking about…she said my beliefs and my*

*families beliefs were, was actually not right for New Zealand. Not right for my situation when they all went home and left me to it.*

How a child is allowed to fall asleep is one of the first forms of culturally determined interaction with the child. Sleep practices are embedded in values about childrearing that determine what it is to be a good parent and how the parent is to prepare the child for entry into the family and community (Wolf, Lozoff, Latz, & Paludetto, 1996). Justine's excerpt exonerates Plunket instititutional practices through the migrant mother's rescinding of her cultural practices.

Both excerpts reflect two diverse philosophies on sleep. On the one hand, there is the strategy of 'crying it out' where sleep-related crying is ignored by parents, although reassuring periodic touch and soothing verbal attempts are permitted while solitary sleep is still enforced. This controlled crying is thought to help babies learn to regulate their own sleep. Other approaches advocate close physical contact at all hours of the day and night, including co-sleeping, which are thought to foster secure parent-child attachment (Ramos & Youngclarke, 2006). The two attitudes to sleeping reflect varying emphases on autonomy versus inter-relatedness (Wolf, et al., 1996). The early 20th Century ushered in an era of concern with regulation of children's sleep, both for health promotion and to advance independence and self-control of children. The strong moralism of child-sleep regulation puts pressure on parents, and can be seen in the excerpts above, where 'giving in' to children's bedtime resistance or overindulging infants by rocking them to sleep is viewed as a moral failing. These connections between sleep behaviour and the moral order of the larger society figure among the reasons deep feelings are attached to child sleep behaviours (Jenni & O'Connor, 2005). This section reflects the founding dogma of Plunket that "disciplined, unspoilt babies would grow into health and self-disciplined adulthood" (Denoon, 1988), p.123.

In the following section, I examine the issue of gender inequity, which is posed as a threat to the realisation of liberal subject hood. Migrant fathers are positioned as too involved and on the other as dominating and it is the latter positioning that locates problems of gender equity within the migrant woman's culture, but makes invisible sexism within broader New Zealand society. Razack (1995) calls this 'fighting sexism with racism'.

### Oppressed by men

Liberal feminist discourses position immigrant men as more patriarchal and misogynist than Pākehā men, and immigrant women as more oppressed than Pākehā women. Dominant culture views of gender are seen as neutral, normal and natural (MacNaughton, 2000)

> *Jennifer: They'll [the fathers] definitely be there for the first home visits, and they're usually the better English speaking person and they're concerned for the baby, for the wife. I know they can be quite dominant in that they're translating for me all the time, which might not be the wife's point of view really. But they are there, they're hands-on, and they're prepared to go to the doctor for the immunisations, and they want to learn.*

Here Jennifer is commenting on how (they) migrant fathers are actively involved. She adds a disclaimer about the involvement by expressing concern that they might be gate keeping and dominating their wives because of their role in translating for the mother. Within this paradigm, individual autonomy is valorised and collective decision making marginalised. However, Jennifer does not acknowledge how migration might have an impact on traditional family structures. She does not recognise that paternal involvement is core to Western liberal feminist values of equality and assumes patriarchy and a dominating sexism, constructing fathers as interfering intruders rather than integral to care (Johnstone & Kanitsaki, 2009). Justine discursively constructs Indian mothers as being without agency in the context of Indian patriarchy. However, there is no reflection about patriarchy in a broader context, Pākehā women are implicitly represented as empowered and free of the constraints of patriarchy:

> *Justine: For a lot of the mothers from the Indian continent... they're servants to their fathers, then to the husbands, then to their sons. They perceive that they must do the washing, ironing, prepare the meal, they must do all of this stuff. And they can't nurse the baby as well. So for them it's, they're torn between wanting to do the best for their baby, but they must do what is expected of them, culturally, without any extended family support.*

Justine justifies her comment that women are slaves to men in Indian culture by hinting at a depth of knowledge and experience she has garnered from working with many women from the Indian community. Her language views

culture as static, it has been transported in a fixed and concrete manner and women are to obey the dictates of culture in a subservient and mindless way. She implies that the baby should be the priority rather than the needs of men and Indian women need to make a choice to put the baby first instead of their culture and their men. The husband is not seen in any way as someone who might be an asset to the woman. Therefore, the premise marginalises conditions of freedom that might reside within Indian cultures, and the type of autonomy that is valorised is taken to be a universal property of abstract personhood (Mookherjee, 2005).

In the next section, I examine the ways in which Plunket nurses open up migrant mothers to confessional practices in order to know them better.

### The empathic nurse

In the first quote from a participant, the Plunket nurse positions herself as sensitive and empathic to the plight of migrant families:

> *Farida: I see a lot of migrant families like Indian, Bangladesh, and Pakistani and from here as well Samoan, Tongan and Chinese as well. So they got many issues... if the mother is the first time Mum and she's getting the baby and the very first thing which I feel with them is a lack of support and loneliness and isolation and especially with the first time Mum, sometimes they are just unsure about their ability. Whether they are doing right or wrong you know, and... it does make a difference like our encouragement.*

Farida makes a claim of expertise, by situating her comments in the context of seeing many families and telling the other participants and the researcher that she knows what she is doing. However, the empathy is focussed on the situation of the women and does not require the Plunket nurse to consider her complicity in structures of power relations. Furthermore, this claim of empathy, contradicts later comments on over-involved migrant families.

In the next two excerpts the Plunket nurse invokes the pastoral use of the confessional in order to scrutinise the knowledge that is elaborated by the mother. This practice allows for the governance of the mother who can be prescribed an appropriate intervention:

> *Jo: You sit and talk with them, and I always say can you tell me the story about what brought you to New Zealand? And they*

*will tell their story. And it's very humbling, and very sad sometimes. And this is an enormous thing that we bring into the mix, a different parenting.*

Jo's strategy reflects a holistic view of understanding that is seen as a liberal and enlightened form of care (May, 1992). The nurse as a liberal subject supports other kinds of knowledge through the cornerstones of white liberalism, which are inquiry and open-mindedness (Schick, 2002). It is a routine practice where empathy is invoked as a therapeutic tool. The trope of clinical talk and familiarity, not only work to build rapport for a relationship but also are a tool of patient management. In order to be able to do her job, the nurse needs all the relevant information. The excerpt highlights the importance of 'knowing' mothers as 'individuals' or 'whole' persons (May, 1992) so that a relationship can be established whereby the nurse can apprehend information through intimacy. The disciplinary gaze is extended in order to understand the object of nursing knowledge.

The religious, Western tradition of the confession, a technique for producing truth which usually involves confession to a more powerful other (Foucault, 1993) is transferred into other sites with the aim of knowing oneself articulated as a strategy of self-management. In a nursing context the mode of confession relies on the capability of the individual to self-disclose, and to submit themselves to another for improvement, highlighting their own complicity in facilitating their own subjection and control. However, Boler (1997) challenges the assumption that one can know the other through compassion noting that the belief that anyone can have the capacity to judge what is really happening to others and to assess what others might need is an especially complicated proposition in the context of difference. The migrant women are positioned as the problem and therefore there is a need to understand 'their' problem (Blackford, 2003).

In the next excerpt, Mary responds to a question about how the gap between the cultural issues nurses are confronted with in their work, and the Pākehā /professionalised way in which they are trained in is managed:

*Mary: Well, if they've got their mother here, I will say to them what did you do, back in India? And the answer nearly always is well we had communal living. There was always somebody there for that baby. And we didn't worry about routines, they woke and slept and ate because it didn't matter. But here, it*

*does matter, and it's a, it's a very different cultural parenting style that we've got...*

In asking the mother, Mary is able to identify a different social structure and practice of caring for the infants and clarify the gap between New Zealand and Indian housing, parenting and so forth. She sees her role as to help the mother bridge that gap. In being explicit about the differences, she can try and move the mother into a different kind of parenting. The contrast between the two types of parenting is highlighted, especially the emphasis on individual mothering and the creation of autonomous rational subjectivity, not only for the mother but the baby as well, whereas in collective cultures often other women take on aspects of the mothering role (James, 1993).

The excerpts above highlight how mothers are made subjects, and thus can be normalised into self-directing self-regulated maternal subjects able to take action to keep healthy. Also highlighted are the processes by which the individual is rendered knowable through the confessional. Therefore, what comes under the control of health professionals is broadened, going beyond the realm of the body to examine the mother's sociality. The nurses' accounts of coming to know women reflects surveillance of the social in combination with the observation of the body of the infant and the extension of the nursing gaze. A paradigm shift has occurred from mothers as 'docile' objects, to the interest in subjective health status providing an opportunity for more active participation in the nursing encounter. As Saxton (2004) suggests, being benevolent requires an imbalance of power in the context of a giver and a receiver, therefore, acts of benevolence mean that the nurse can represent herself as good in giving on the giver's terms.

## Colonial practices

To rally middle class women to her cause, Florence Nightingale deployed both the feminine ideal of caring for the sick, and the more aggressive discourse of the nurse as battleaxe, an agent of moral reform who could create order out of chaos (Hallam, 2000). Hallam contends that this military-fashioned authoritarian female had a more colonial aim, which was to reform and recreate the home of the poor sick to a copy of the middle class home. For Hallam, the power of white femininity with its associated cultural values of purity, cleanliness and chastity has been central to Nightingale's nursing reform. Nursing's birth is thus implicated in the colonial and nationalistic ambitions of Victorian society, a legacy that has continued to permeate the identity of professional nursing. In the excerpt that follows, the reform of the home to more accurately resemble that of a white

subject is evident:

> *Sheila: I went to see an African family and Africans double-curtain their houses. They're very dark, and here was this little baby and... I put the baby in the sun... you know to give baby strong bones. I went back three weeks later, I had a medical student with me, she (the mother) spoke very little English. We walked in and she (the mother) said strong bones, and there was the baby lying in the sun (laughter). That was an enormous reward that she's taken on board a suggestion.*

Sheila's advice highlights how migrant mothers are incorporated into relations of surveillance and discipline and in turn take up discourses of what constitutes normality as they internalise a normalising self-regulating gaze. Sheila's excerpt uses the metaphor of bringing light to the darkness in more ways than one. She is pleased that her advice has been acted upon and the mother has placed the baby in the sun, in parallel she has educated the mother into Pākehā norms about the value of sunlight for health. There is a missionary and civilising narrative at play in using the modernising trope of enlightenment, the light of reason illuminating the dark age of superstition.

Notably, Sheila does not question the mother about the reason for the double curtaining of the house. This excerpt highlights the jarring authority of assimilatory discourses, which work to minimise risk and difference between the cultural practices of the mother and nurse. Risk is deployed as justification for redefining how an environment should be arranged to avoid potential problems. This excerpt highlights the political nature of practice and how risk discourses have ordering effects (Ceci & Purkis, 2009). These ordering effects, and especially people's resistance to them, that highlight the contingencies of practice. Resisting advice can mean that the service is withdrawn, refused or imposed (Ceci & Purkis, 2009). Clients (in this case migrant mothers) have to enter into delicate and difficult negotiations of freedom and security.

Sheila establishes a temporary space of professional knowledge, transforming a private space into professional territory for potential knowledge and action (Ceci & Purkis, 2009). She deploys normalising and colonising practices and attempts to reduce difference. Risk discourses are deployed and the re-ordering of the home environment is justified.

In the following excerpt, the Plunket nurse deploys multicultural discourses, where cultural borrowing is hegemonically viewed as a positive contribution to the

multicultural project. Culture can be consumed as socially and culturally enriching, creating a fine line between positive 'enrichment' and problematic 'appropriation' (Velayutham & Wise, 2001):

> *Desiree: I just want to say, that it's so amazing to work with some of these people, because of their attitude towards their children. I really admire it, it is so nice to see people care so much about their kids...I think perhaps if all of us looked at our children as an investment, we might take better care of them.*

Desiree valorises the collectivist, child-focused and relational aspects of culture (which contradicts discourses earlier in this chapter where there is concern about too much family involvement). The valorising of this alternative cultural model represents paternal love in a way that differs from the Pākehā and represents a reversion to an incursive Western solution. In the context of a longer conversation of disqualifying and valorising, the excerpt reflects the binary grammar of Orientalism of 'what is good in us is lacking in them, but what is lacking in us is (still) present in them' (Fuglerud & Engebrigtsen, 2006). The quote illustrates an enrichment metaphor/discourse, where dominant white culture remains central and other cultures function to 'enrich' the core": 'we' value 'their' contributions— which still implies that 'they' are not one of 'us' (Grainger, 2008). Pākehā cultural frameworks are the normative reference point from which care is decided (Blackford, 2003). Consuming diversity is the equivalent of 'eating the other' where diversity is appealing and can be shared and enjoyed (Ahmed, 2007, p.246). As bell hooks (1992, p.21) suggests, "within commodity culture, ethnicity becomes spice, seasoning that can liven up the dull dish that is mainstream white culture". Put simply, the contribution is defined by the Plunket nurse rather than the woman and the woman's culture appropriated as a resource to be managed by the dominant group without its cultural context (Saxton, 2006). The excerpt highlights the fundamental ambivalence towards the other, manifested as oscillations between fascination and disdain, and which are as objectifying as negative stereotypes (Browne & Varcoe, 2006).

The two excerpts above have highlighted how migrant mothers are situated as objects of the nursing gaze, and two different strategies (normalising the home and consuming difference) are discussed.

## Conclusion

Plunket nurses drew on multiple discourses that presented migrant mothers in fragmented and contradictory ways. Migrant mothers were variously positioned

as unknowing, unknowable and knowable. They were constructed as too autonomous from the dominant culture, yet not autonomous enough in terms of their own culture. Liberal feminist arguments were deployed to position migrant mothers as victims of their culture, while enrichment discourses were deployed to shower praise on migrant mothers for qualities that were seemingly lacking in Western culture. This ambivalence is characteristic of racialised attitudes (Augoustinos, Tuffin, & Rapley, 1999). Dominant liberal discourses positioned the migrant mother as the victim of her own culture, which was the cause of her misfortune. Within this discourse, individualization, autonomy, acculturation and modernisation were viewed as solutions. Plunket nurses positioned themselves as rescuers, teachers, and facilitators. The overall effect of drawing on liberal notions of individualism however, was a diversion of attention from social and political factors that contributed to inequalities and therefore the need for structural intervention by governments to redress social and economic disadvantage. Instead, the individual and culturalist focus meant that disadvantage was a result of personal, individual and cultural shortcomings.

# Chapter Nine: Decolonising maternity

Migrant maternity brings many questions into view. What subjectivities and beliefs and values are being reproduced when a woman has a baby in neoliberal Aotearoa New Zealand? How does a maternal health care system provide services for birthing women whose subjectivities have been partially or significantly formed outside a white settler nation context and specifically outside the colonial dyad of settler and indigenous? Does the policy rhetoric of biculturalism in response to Treaty of Waitangi obligations and the requirement for culturally competent practice actually improve the care migrant mothers receive? Do the liberal feminist aspirations for birth as an empowering experience extend to women outside the world of white middle-class feminism? The questions about the routine and institutionalised care available in maternity and the adequacy and effectiveness of available theoretical frameworks for working inter-culturally have inflected my nursing research and practice for the last 17 years and it is to nurse academics and educators mostly that this conclusion is directed.

## Constituting migrant maternities

In this study, two data sets were used as a starting point for exploring how some women (and providers) framed their experiences, as a springboard to discover theoretical perspectives that could show how maternity experiences were imbricated with wider discourses and ideologies. Using genealogical and discourse analytic methods influenced by Foucault, the thesis has examined the history of maternity discourses, and explored the relationship between these and the maternal body, and power, so that the ways in which maternal bodies have been inscribed with meaning produced by a range of discourses could be discerned. These methodological manoeuvres have examined the range of discourses that some nurses mobilise to constitute migrant maternities, and the varying ways 10 white middle-class migrant women and 8 Korean middle-class migrant women took-up subject positions that reflected these discourses.

To summarise, in this thesis my goals were to:

1. examine and analyse the discourses that constitute migrant maternities;
2. examine the intellectual history of these discourses;
3. consider the impacts of these discursive constructions of migrant

maternities in health care service provision; and

4. consider alternative discourses, knowledges, and practices that could better serve migrant mothers and their families and maternity professionals.

## Reshaping personhood

Genealogies of maternity show that its regulation has been pivotal to the production of docile, disciplined maternal bodies through industrial, scientific and maternalist discourses originating in the Enlightenment. Liberal and ongoing colonial discourses are embedded in professional frameworks of care, and shape migrant maternity in ways that result in differential outcomes for various groups of migrant mothers. Nursing with its imperial origins and affiliations with biomedical scientific discourse, and midwifery's alliances with liberal feminist discourse have mobilised concepts such as empowerment, choice and control against the patriarchal strictures of biomedical obstetric practice. The modernising and rationalising of maternity through these discourses in metropolitan and colonial sites has led to the disciplining and surveillance of the pregnant body, and construction of the new mother as neoliberal maternal subject. These discourses have been further instantiated through the new public health, supporting subtle forms of self-regulation among maternal subjects in the interests of producing a healthy baby and robust population, while achieving the neoliberal imperative of reducing demands on the state.

Natural birth discourses have been imbricated with neoliberal imperatives to institute the knowledgeable and empowered maternity consumer as a hyper-responsible maternal self, who takes charge of her experience of childbirth. This subject is constructed within particular norms such as being informed, having a partner who is actively involved in the pregnancy and birth, choosing to labour naturally and engaging in motherhood intensively—that is, within normative modes of middle class Pākehā behaviour. Consequently, these norms have unintentionally recolonised the birthing experiences of visibly different mothers, even as they have been developed to critique patriarchal medical modes of care. Thus, I suggest that the figure of the racialised mother constitutes a threat to the liberal and neoliberal projects of self-regulation and improvement. In response to her differences and those presented by her family, nurses and midwives used disciplinary and normalising techniques to enculturate her into the liberal feminist discourses of the New Zealand maternity system, which in turn reinforce the centrality of a white worldview.

Nursing and midwifery practices represent both therapeutic and helpful aims, while also implicating nurses and midwives in modern state goals of regulating and maximising the efforts of individuals and the social body. Acts and projects of empowerment constitute attempts to reshape the personhood of participants (Henkel & Stirrat, 2001, p. 182). Hence, attempts to empower racialised migrant mothers through liberal feminist discourses are potentially colonising and assimilatory activities. Analysis of the focus groups of migrant mothers (white compared to Korean) showed that they had significantly different experiences of maternity in Aotearoa New Zealand. The white migrant mothers fitted relatively easily into the local discursive landscape while the Korean migrant mothers felt silenced, unrecognised and often uncared for.

Plunket nurses recognised the different experiences of racialised migrant mothers, but were often unable to accommodate culturally different beliefs and practices about motherhood into their worldview. The result was that their practice towards these 'other' women was often marked by efforts to colonise them with the hegemonic values, beliefs and practices about maternity in Aotearoa New Zealand at this time. These findings from the empirical data reinforce support Foucault's (1979) claims that modern iterations of power are diffuse and productive are evident in contemporary iterations of maternity.

## Theoretical importance: Problematising problems

This thesis makes three key contributions to theory. Firstly, it demonstrates how poststructural and postcolonial lenses can be used to advance understanding of: (a) the ways in which 'problems' are constructed in relation to migrant maternity care (and I suggest health care more widely); and (b) the ways that nursing and midwifery are complicit with liberal and colonial ideological tenets that drive maternity care (and health care in general) in New Zealand and other Western nations. Secondly, it illustrates the way in which focus group data were used to make linkages through a genealogical approach with extant theoretical perspectives to understand how maternity experiences are imbricated within wider discourses and ideologies. Finally, this thesis brings gender and maternity (which are rarely considered) to the discussion on immigration, asylum and nationality in New Zealand, and links the racialised history and context of maternity to the predominantly white feminist work in maternity in New Zealand.

Hence this thesis represents a unique contribution, bringing together migration and maternity to analyse a specific, highly-charged site where the forces of colonisation and gender weigh upon specific bodies differently within the

concept of one of the most important institutions of colonial culture: the public health system.

## Translating research: Shifting healthcare practices, attitudes, discourses, and policies

There are challenges in attempting to translate the theoretically detailed analysis and arguments presented in this thesis into language, which can influence and hopefully shift healthcare practices, attitudes, discourses, and policies. It has seemed important to address the disturbing maternity experiences described from the perspective of eight Korean mothers who participated in one focus group. As a nurse-researcher-leader in New Zealand working with nurses, midwives, and health care leaders, it is critical that I utilise the critiques of power relations and the identification of alternative discourses to develop strategic interventions that can transform marginalising institutionalised discourses and practices. However, in order to do this I must use terminologies and discourses (language) that are meaningful to those outside of academia, which sits in tension with the contribution to specialist knowledge that underpins a PhD thesis such as this. One of the ways this question can be addressed is through my role as an academic where I am in the position of teaching the next generation of professionals and another is to continue to take up the many invitations to address practitioners through conferences. Secondly, I must manage the tension of using a strategically essentialist approach to advocate for racialised women without slipping into essentialising claims about Korean women in particular. That is, when challenging gender essentialism (to problematise the terms 'woman' or 'mother'), I should not replace it with cultural essentialism and homogenise women with plural and diverse values, interests and commitments (Narayan, 1998). In positioning racialised women as marginalised, unagentic and/or disadvantaged within a liberal colonial health system, I could replicate the very colonial binaries that I am trying to undo/deconstruct.

Joan Scott suggests that behaving decently and empathetically, can be depoliticising, shifting emphasis from the social and historical to the personal or cultural:

> There is nothing wrong, on the face of it, with teaching individuals about how to behave decently in relation to others and about how to empathize with each other's pain. The problem is that difficult analyses of how history and social standing, privilege, and subordination are involved in personal behavior

entirely drop out (1992, p.9).

In Chapter Eight of this thesis, I have shown how the nurses' deployment of cultural sensitivity frameworks (or transculturalism), reinforced liberal and colonial discourses. Such discourses have individualising and culturalising impacts which maintain the status quo and produce and reproduce inequality. In such a framework, the remedy for the problem of caring across difference is integration. The health professional becomes more sensitive or knowledgeable about other cultures (Culley, 2006) and the person from a racialised group becomes more like the dominant culture (Reed, 2003). Integration assumes an already formed national culture with universal values possessed by the dominant culture into which newcomers must be incorporated. However, the apparent promise of inclusion preserves a racial hierarchy rather than dissolves it (Razack, 2004, p.154), and attenuates demands for structural change.

The discourse of cultural safety, on the other hand, can counter the liberal and colonial discourses that pervade health care. Operationalising feminist and postcolonial critiques through cultural safety can help nurses understand how the discourses they use are shaped by wider social discourses, which can then be critically interrogated (Browne, 2005). In line with feminist methodologies, the call to be reflexive requires that nurses take part in more socially engaged knowledge practices and recognise the limitations of their own knowledge so that they are better able to work across difference (Harding, 1987). This requires the ability to reflect on one's practice, values and assumptions (Browne, et al., 2009), and challenge the status quo and make institutions more inclusive (Ng, 1995, p.199). This might also require nurses to more critically examine the part they play in working in acculturative modes and pedagogical and developmental roles that reinforce discrimination. Yet, as I cautioned in Chapter Five, there are limits to reflexivity.

The implementation of cultural safety in a multicultural context requires that nurses explore the histories and social relations that shape our knowledge and have discriminatory effects. This thesis has shown that the knowledges that underpin the practices of nurses and midwives are neither neutral nor innocent; instead they reflect specific histories and cultural values and are imbued with power. Rather than an innocent decontextualised meeting between clinician and migrant mother, the migrant's maternal body reflects a contested realm inscribed with hierarchical social relations and definitions of good mothering and maternity that are historically and culturally constructed. The decolonising power of feminism can be activated if consideration is given to how maternity and

motherhood in the west have been constituted through relationships with colonialism, capitalism and patriarchy (Lentin, 2004).

In this vein the recognition of nursing's colonial past and enduring continuing colonial relationships within the health system with maternal subjects considered 'other' is necessary. We nurses and midwives must problematise our locations and consider our responsibilities within a social context dominated by whiteness, particularly "the ways in which we are complicitous in the subordination of others" (Razack, 1998, p.159). Engaging with our own cultural beliefs and those of others requires that we reframe culture as contingent, contested, negotiated and open-ended. Nurses must educate themselves about the social context of marginalised groups and call into question our roles as "innocent subjects, standing outside of hierarchical social relations, who are not accountable for the past or implicated in the future" (Razack, 1998, p.10). This will require actions that decolonise and deculturate the health system. There are already models that emphasise collective indigenous sovereignty that show us that when indigenous people have the autonomy to put their values at the forefront of care, better outcomes occur for their people. Extending these models of autonomy and collective sovereignty further to all peoples requires further discussion.

Ultimately, the nursing profession must become more political than its 'supportive' role to biomedicine has traditionally entailed. This thesis calls for nursing to address its conservative allegiances to patriarchal and bureaucratic practices, which have prevented it from engaging in its own transformation (Walker & Holmes, 2008). These allegiances, largely operationalised through liberal discourses, implicate nurses in the maintenance of oppression. Nursing's liberal repertoire should open toward an acknowledgement of the uncertain, contradictory, and highly politicised, nature of nursing's knowledge production and consider "new methodological resources, new metaphors and practical strategies"(Burman, 2006, p.17). Postcolonial feminist theory, operationalised by nurses in cultural safety, provides an opportunity to destabilise taken for granted constructions and practices by questioning the inter-relationship of history, geography and subjectivity, bringing into view the ways in which nurses are implicated in oppressive practices.

## Developing institutional support for diverse maternal practices

White structures and processes are central to nursing educational and clinical institutions (Allen, 2006). Although 'others' can be added to these

structures, systems are never reconfigured to shift white discourses such as liberalism and Western feminism that shape nursing practice. While these discourses promise liberatory ends, and encompass liberal precepts about the rights of the individual to "political and religious freedom, choice and self-determination" (Weedon, 1999, p.13), the Western subject remains the model for the free individual.

Conformity is prescribed and the right of racialised migrant mothers to assert their own cultural identities is marginalised, without any requisite acculturation responsibility on the part of dominant Pākehā culture and institutions. The responsibility for the outcomes of intercultural contact are placed on racialised migrant mothers whose ability to influence acculturation are constrained by wider hegemonic structures (Bowskill, et al., 2007). This marginalisation is legitimised through constructions of cultural practices being thought of as 'unworkable' in the New Zealand context, concealing a hegemonically driven cultural homogeneity (Bowskill, et al., 2007). The paucity of institutional space for alternative cultural practices is glaring, as seen by women's private homes being remade into an institutional space by nurses as seen in Chapter Eight. The practices that are legitimated and given support reflect wider sets of social values around being a 'good mother' (Schmied & Lupton, 2001; Wall, 2001). Consequently, alternative framings and their associated practices are denied institutional support for example the notion in many cultures of the post-partum maternal body as vulnerable and hyper-exposed to potential illnesses requiring particular interventions to restore the vulnerable maternal body to health through rest, warmth, nourishment and the consumption of special foods (Hoang, Quynh, & Sue, 2009; Howard & Berbiglia, 1997; Kim-Godwin, 2003). Reflexive practice would be one of many strategies for opening up alternative cultural practices.

## Remaining questions

The completion of any research project inevitably highlights areas that have been unexplored or are incomplete. Interviewing other stakeholders could have added to the breadth and depth of this research. As explained in Chapter Five, my efforts to interview midwives were unsuccessful. Given the centrality of midwifery to this thesis, the absence of midwifery voices and discourses has meant that I have limited my discussion to more closely focus on the nursing profession, but there are elements of the findings that will resonate for midwifery practice. Interviewing fathers, mothers, and mothers in law who come to NZ to support families would have bolstered these findings. In-depth focus on the latter post-

partum period for the white women could have been useful given my experience of working on the maternal mental health team, where most of the clients accessing the service were white and middle class. Given my professional experience, participant-observation could have complemented the self-report of the Plunket Nurses. Furthermore, while focus groups are an effective and efficient means of gathering data they do not permit the in-depth exploration of issues that one to one interviews would facilitate.

Throughout the project it has become apparent that while there are clear findings from this research, there is also a requirement for further research on the specifics of cultural safety education asking such questions as: how is cultural safety taught in the under-graduate curriculum across New Zealand? How has this changed since the advent of the Health Professionals Competency Assurance Act? What efforts are made in maternity for continuing education and cultural safety and how effective are these mechanisms? How do outcomes compare between nurses and midwives who provide care who have been educated within cultural safety and cultural competence paradigms? A longitudinal study of the factors that shape nursing skill, responsiveness and capability with regard to difference could provide rich data about the nuances of differential care provision and tacit knowledge that have surfaced in the findings of this thesis.

This thesis has both identified and proffered alternatives to discourses that have pathologising and marginalising effects. Troubling the 'truths' that are taken for granted provides a space for thinking about decolonising our practices and scholarship so that we can envisage new epistemological, theoretical and political possibilities and interventions in maternity that support the aspirations of all mothers and their families. My hope is that other researchers use this work to raise new possibilities, ask new questions, and stimulate new dialogue to further validate this work. This thesis represents an invitation to continue the conversation and to extend this work (Angen, 2000).

# Appendix One: Information sheet for White women

# Participant Information Sheet

**Date Information Sheet Produced: 2nd March 2006**

**Project Title**

Becoming a mother in a new country

**Invitation to participate in a focus group**

AUT University and Plunket would like to invite you to take part in a joint research project that is being funded by the Families Commission and Plunket volunteers and which will form part of a PhD thesis. We hope that you will agree to take part in a focus group after reading the rest of this Participant Information Sheet. There is no pressure to take part in this project and you can withdraw from the process at any time, including during the focus group.

**What is the purpose of the study?**

Women who have a baby in a new country often experience the loss of traditional rituals and family support. Instead they might be faced with trying to figure out how to access maternal health services and avoid isolation. We would like to find out what makes becoming a mother in a new country easy or difficult from the mother's point of view. We think that getting a group of women together to talk about their experiences is a good way of finding out what concerns women have.

**How are people chosen to be asked to be part of the study?**

Plunket staff are planning to invite women from five main ethnic/language communities (Arabic, Korean, Chinese, South Asian and English speaking migrants from Britain or South Africa) to ask them to take part in the focus group research. You will be provided with this information sheet and a consent form. The Plunket Nurse who gave you the information will phone you back after a few days to ask you if you would like to take part in the research. If you agree, you will be invited to attend a focus group at one of the local Plunket Family Centres (Albany, Meadowbank, Rose Road, and Landscape Road). We will provide you with a petrol voucher to contribute to your

transport costs. If you have difficulties with transport please contact the Plunket Nurse who invited you to take part in the study. We will provide childcare for your children while you take part in the focus group.

**What happens in the study?**

We will invite you to attend a focus group, which is a group of people brought together to talk about one thing. In this case we will be inviting mothers from ethnic/language communities to talk about their experiences of having a baby and becoming a mother in New Zealand.

**What are the discomforts and risks?**

There should not be any discomforts or risks in your participation in this research, however, some of the questions are personal and could be seen as intrusive, and therefore you can decide not to answer them.

**How will these risks be alleviated?**

In the event that you feel upset or distressed, immediate support will be available through our focus group facilitators during the actual group who are qualified to deal with these matters. Should it be required a free counselling service will be available through Auckland University of Technology or at a mutually agreed provider.

**What are the benefits?**

We think it might be helpful and enjoyable to talk about your experiences with other women who have gone through the same experience of being away from their country of birth and having a baby. We hope that this information will help the staff and services that are available to help ethnic women.

**How will my privacy be protected?**

The information collected from you will be strictly confidential. The tapes will be transcribed and the transcripts will be securely stored at AUT and names will not be attached to the forms. Transcripts will be destroyed after 6 years. No participants will be identified in any reports of the research.

**How do I join the study?**

Please complete and return the Consent form.

**What are the costs of participating in the project? (including time)**

The focus group is expected to last no more than two hours.

**What will happen to the results of the study?**

Three reports will be produced. Two are for the funders of the research (one for the Families Commission, one for Plunket Volunteers) and one will be published as a Doctoral thesis report as part of Ruth DeSouza's PhD. The findings may be also be used in presentations and publications within an academic context. Your identity will not be revealed in any of these reports.

**Opportunity to receive feedback on results of research**

On completion of the project, a report will be completed and summary copies will be made available to you if you wish.

**Participant Concerns**

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor. If you would like to speak to someone in:

Korean: phone Catherine Hong on 021- 2222 032

Chinese: Phone Wanzhen Gao on 921 9999 Ext 7798

Arabic: Phone Rose Joudi on 921 9999 Ext 8629

Concerns regarding the conduct of the research should be notified to the Executive Secretary, AUTEC, Madeline Banda, madeline.banda@aut.ac.nz , 09 921 9999 ext 8044.

**Researcher Contact Details:** Ruth DeSouza, ruth.desouza@aut.ac.nz, 09 921 9999 Ext 7770

**Researcher Contact Details:** Elaine Macfarlane, elaine.macfarlane@plunket.org.nz, 09 849 5652

**Project Supervisor Contact Details:** Professor Max Abbott, max.abbott@aut.ac.nz, 09 921 9894

**Approved by the Auckland University of Technology Ethics Committee on 20th December. AUTEC Reference number 05//240**

**Approved by the Plunket Ethics Committee on 30th November 2005**

# Appendix Two: Information sheet for Korean women

# Participant Information Sheet

참여자 안내서

**Date Information Sheet Produced:** 안내서 제공일: 3월 2일 2006년

**Project Title** 연구 제목

Becoming a mother in a new country 외국에서의 출산 경험

**Invitation to participate in a focus group** 인터뷰 그룹에 참여 초청

AUT University and Plunket would like to invite you to take part in a joint research project that is being funded by the Families Commission and Plunket volunteers and which will form part of a PhD thesis. We hope that you will agree to take part in a focus group after reading the rest of this Participant Information Sheet. There is no pressure to take part in this project and you can withdraw from the process at any time, including during the focus group.

AUT 와 Plunket은 Family Commission 과 Plunket 지원자들의 후원으로 진행되는 연합 연구에 당신을 초청합니다. 이 연구는 또 한 박사학위 논문에 사용됩니다 .다음의 내용을 읽고 인터뷰 그룹에 참여 주시면 감사하겠습니다. 아무 부담 없시 참여할수 있으며 인터뷰 도중 언제라도 참여를 중단하실 수 있습니다 .

**What is the purpose of the study?** 이 연구의 목적은 무었입니까?

Women who have a baby in a new country often experience the loss of traditional rituals and family support. Instead they might be faced with trying to figure out how to access maternal health services and avoid isolation. We would like to find out what makes becoming a mother in a new country easy or difficult from the mother's point of view. We think that getting a group of women together to talk about their experiences is a good way of finding out what concerns women have.

외국에서 아기를 낳는 여성들의 경우, 모국의 전통적인 임신과 출산의 풍습을 따르거나, 가족의 도움을 얻기가 힘듭니다. 대부분 출산 관련 서비스를 어디서

어떻게 받는가와, 어떻게 외국에서 혼자 해결해 나갈지에 대해 걱정을 하게 됩니다. 저희는 외국에서 출산경험을 한 어머니들의 입장에서 볼때 임신과 출산과정 어떤 부분이 어렵고, 또 어떤 것들이 도움이 되는지를 알고자 합니다. 이를 위해 몇분을 그룹으로 만나 그간의 경험과 고충을 듣는 것이 좋은 방법이라 생각합니다.

**How are people chosen to be asked to be part of the study?** 인터뷰 참여자는 어떤 방법으로 선택됩니까?

Plunket staff are planning to invite women from five main ethnic/language communities (Arabic, Korean, Chinese, South Asian and English speaking migrants from Britain or South Africa) to ask them to take part in the focus group research. You will be provided with this information sheet and a consent form. The Plunket Nurse who gave you the information will phone you back after a few days to ask you if you would like to take part in the research. If you agree, you will be invited to attend a focus group at one of the local Plunket Family Centres (Albany, Meadowbank, Rose Road, and Landscape Road). We will provide you with a $20 petrol voucher to contribute to your transport costs. If transport is a problem please discuss this with the contact person. We will provide childcare for your children while you take part in the focus group.

Plunket 직원이 5종류의 민족 / 언어 공동체의 여성들을 이 연구에 초대할 계획입니다. (아랍, 한국, 중국, 남아시아와 영어계의 영국이나 남아프리카에서 온 이민자). 참여하시는 분들은 먼저 정보지와 동의서를 받게 됩니다, 며칠후 플렁켓 간호사가 참여 여부를 묻는 전화를 드립니다. 참여하기로 동의하는분은 지역내 플렁켓 센터에서 진행될 인터뷰 그룹으로 소개를 받습니다.(알바니, 매도뱅크, 로즈 로드, 랜드스케입 로드중 한곳)

휘발유 선사권 ($20)을 마련해 드리니 교통편에 도움이 되시길 바랍니다. 차편이 없으시면 말씀해 주시면 도와드릴수 있느가를 알아보겠습니다. 그리고 인터뷰에 참여하는 시간 동안 당일 유치원을 운영하여 아기를 돌봐드리겠읍니다.

**What happens in the study?** 이 인터뷰 그룹에서는 무엇을 합니까?

We will invite you to attend a focus group, which is a group of people brought together to talk about one thing. In this case we will be inviting mothers from ethnic/language communities to talk about their experiences of having a baby and becoming a mother in New Zealand. 관련주제에 대한 대화를 나누도록

토론모임에 초대를 받으시게 됩니다.  이 모임에서는 뉴질랜드에서 아기를 낳고 엄마가 되는 경험에 대해 이야기를 나누시게 됩니다.

**What are the discomforts and risks?**

참여시 미리 알고 있어야 할 불편한 점과 위험 여부는 무엇입니까?

There should not be any discomforts or risks in your participation in this research, however, some of the questions are personal and could be seen as intrusive, and therefore you can decide not to answer them.

그런 것은 없습니다. 하지만 개인적인 경험을 묻는 질문들이 있으므로 불편하시면 본인의 결정에 따라 답을 안하셔도 됩니다.

**How will these risks be alleviated?**

난처한 질문으로 인해 혹시  참여자가 불편하게되는 상황은 어떻게 처리 됩니까?

In the event that you feel upset or distressed, immediate support will be available through our focus group facilitators during the actual group who are qualified to deal with these matters. Should it be required a free counselling service will be available through Auckland University of Technology or at a mutually agreed provider.

만약 인터뷰 도중 그 내용으로 인해  마음이 불편해 지시는 경우, 즉시 도움을 얻으실 수 있도록 배려 해드립니다. 그 모임을 인도하는 두사람은 당신에게 도움을 드릴수 있는 자격이 있는 분들 입니다.  필요하신 경우엔 AUT의 싱담소를 통해서나 다른 기관을 통해서 무료로 상담을 받으실수 있읍니다.

**What are the benefits?** 인터뷰를해서 받는 혜택은 뭡니까?

We think it might be helpful and enjoyable to talk about your experiences with other women who have gone through the same experience of being away from their country of birth and having a baby. We hope that this information will help the staff and services that are available to help ethnic women.

외국에서 출산 경험을 한 다른 여성들과 이야기를 나누는게 당신에게 도움이 되고 즐거울거라고 생각합니다..

저희는 이 연구 결과가 소수민족의 여성들을 돌보는 직원이나 서비스 단체에 도움이 되길 기대합니다.

**How will my privacy be protected?** 나의 사적인 비밀은 어떻게 보장됩니까?

The information collected from you will be strictly confidential. The tapes will be transcribed and the transcripts will be securely stored at AUT and names will not be attached to the forms. Transcripts will be destroyed after 6 years. No participants will be identified in any reports of the research.

인터뷰내의 모든 내용은 철저히 비밀로 지켜집니다. 녹음된 인터뷰 내용은 영어로 번역되고, 그 내용은 AUT 대학 내에 비밀서류로 철저히 보관 됩니다. 인터뷰 서류에는 참여자 이름이 공개되지 않습니다. 영어 번역 사본은 6년간 (학적 연구 관련 법정 요구 기간) 보관 되었다가 처분됩니다. 연구보고 어디에도 참여자의 실명은 실리지 않습니다.

**How do I join the study?** 이 연구에 어떻게 참여 할수 있읍니까?

Please complete and return the Consent form. 동의서를 완성하신후 되돌려주세요.

**What are the costs of participating in the project? (including time)**

이 인터뷰 참여하면 어느 정도의 시간이 소요됩니까 ?

The focus group is expected to last no more than two hours.

이 그룹 인터뷰에 참여하시는 시간은 2 시간입니다.

**What will happen to the results of the study?**

Three reports will be produced. Two are for the funders of the research (one for the Families Commission, one for Plunket Volunteers) and one will be published as a Doctoral thesis report as part of Ruth DeSouza's PhD. Short articles relating to the study will be published in relevant professional journals and presented at conferences and seminars. Your identity will not be revealed in any of these reports.

세가지의 보고가 나오겠읍니다. 두가지는 이연구 후원자 (Family Commission과 Plunket) 에게 가고, 하나는 Ruth De Souza 의 박사학위 논문에

바표 되겠읍니다. 그 외에 이연구에서 나오는 몇 내용은 전문 잡지나 세미나를 통해 발표 되겠읍니다. 당신의 신분은 발켜지지 않습니다.

**Opportunity to receive feedback on results of research** 연구 결과를 받아 볼 수 있습니까?

On completion of the project, a report will be completed and summary copies will be made available to you if you wish. 원하신다면, 이 연구가 완성된후, 요약된 보고서를 받을수 있읍니다.

**Participant Concerns** 이 연구에 대한 문제점과 참여자 개인의 소견

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor. 이 연구 자체에서 어떤 문제점을 발견하시면 , 이 과제 감독원에게 우선 연락하십시요.

한국인 : Catherine Hong 021- 2222 032

Concerns regarding the conduct of the research should be notified to the Executive Secretary, AUTEC, Madeline Banda, madeline.banda@aut.ac.nz , 09 921 9999 ext 8044. 이 연구 인터뷰 진행에 대한 문제점을 발견하시면, AUTEC 의 행정 비서 Madelien Banda 에게 보고 하십시요.

**Researcher Contact Details** 연구원**:** Ruth DeSouza, ruth.desouza@aut.ac.nz, 09 921 9999 Ext 7770

**Researcher Contact Details**연구원**:** Elaine Macfarlane, elaine.macfarlane@plunket.org.nz, 09 849 5652

**Project Supervisor Contact Details**연구 감독원**:** Professor Max Abbott, max.abbott@aut.ac.nz, 09 921 9894

**Approved by the Auckland University of Technology Ethics Committee on 20 December. AUTEC Reference number** 05//240 AUT 윤리 위원 허가 날짜 12월 20일 2005 참고 번호 05/240

**Approved by the Plunket Ethics Committee on** 30th November 2005

플링켓 윤리 위원 허가 날짜 2005년 11월 30일

# Appendix Three: Information sheet for Health Professionals

# Participant Information Sheet

**Date Information Sheet Produced:** 20th December 2006

**Project Title**

Health professionals' views and experiences of working with migrant women

**Invitation to participate in a focus group**

Thank you for considering participation in this research project which forms a part of my PhD study. We hope that you will agree to take part in a focus group or individual interview after reading the rest of this Participant Information Sheet. Your participation is voluntary. If you decide to withdraw part way through the process, any information you have supplied to us will be will not be used in the research and will subsequently be destroyed.

**What is the purpose of the study?**

This is part two of a PhD study. The first part involved talking with migrant women about their experiences of becoming mothers in New Zealand. The next part of the research involves asking health professionals about their experiences of caring for migrant mothers. The aim of this part of the research is to find out what the shared understandings are of health professionals who work with migrant mothers, in order to identify effective strategies for working with migrant mothers.

The outcome of this research will be to develop a knowledge base to inform workforce development for effective and responsive ways for working with migrant mothers and migrants in general in New Zealand health and social services.

**How are people chosen to be asked to be part of the study?**

If you are a midwife or Doctor who is involved in working with migrant mothers we will have invited you to take part through an advertisement or through contact with a mutual intermediary. If you are a Plunket Nurse in Auckland we will have invited you to take part through an information sheet being delivered

to your mailbox through your employer or you would have heard me speak about the study at the Plunket staff meeting on 11th April.

**What happens in the study?**

If you are a Plunket nurse or a midwife, you will be invited to attend a focus group at a negotiated venue. If you are a Doctor, we will be offering you the option of an individual interview to fit in with your practice demands. The group will take approximately one and a half hours of your time. An individual interview will take no more than an hour. We will provide you with a petrol voucher as an acknowledgement. The interviews will be recorded and transcribed.

**What are the discomforts and risks?**

The only discomforts or risks in participating in this research is the possibility that speaking about your professional experiences will open you up to scrutiny from colleagues but it is equally likely that talking about your experiences will be useful to you and to your colleagues. We will ensure your confidentiality is maintained and provide you with contact details for the AUT Counselling centre should you require the opportunity to talk things over.

**What are the benefits?**

We think it might be helpful and enjoyable to share experiences of working with migrant mothers with other health professionals. We hope that this information will assist staff and services that are available to help ethnic women. We hope that we will be able to come up with some implications and recommend strategies for providing culturally appropriate care to migrant women and their families in New Zealand as well as put in place resources to support health professionals to provide this care.

**How will my privacy be protected?**

The information collected from you will be strictly confidential with only the named investigators and PhD supervisors having access to the original transcripts. The digital recordings will be transcribed and the transcripts will be securely stored at AUT and names will not be attached to the forms. Transcripts will be destroyed after 6 years. No participants will be identified in any reports of the research.

**How do I join the study?**

Please complete and return the Consent form.

**What are the costs of participating in the project? (Including time)**

The focus group is expected to last no more than two hours and individual interviews will take less time.

**Opportunity to consider invitation**

You will have received this information sheet and consent forms in several ways:

1) In a mailing from AUT University
2) Via an advertisement and subsequent contact
3) Via Plunket

Please respond to this invitation within two weeks by contacting Ruth DeSouza: Ruth DeSouza, ruth.desouza@aut.ac.nz, 09 921 9999 x 7770

**Opportunity to receive feedback on results of research**

On completion of the project, a report will be completed and summary copies will be made available to you if you wish.

**Participant Concerns**

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor.

Concerns regarding the conduct of the research should be notified to the Executive Secretary, AUTEC, Madeline Banda, madeline.banda@aut.ac.nz, 09 921 9999 ext 8044.

**Researcher Contact Details:**

Ruth DeSouza, ruth.desouza@aut.ac.nz, 09 921 9999 x 7770

**Co-researcher Contact Details**

Sheryl Orton, Sheryl.Orton@plunket.org.nz, 849 5652

**Project Supervisors Contact Details:**

Dr Debbie Payne, Debbie.payne@aut.ac.nz, 09 921 9999 Ext 7112

Dr Kerry Gibson, k.l.gibson@massey.ac.nz, 414 0800 Ext 41241

**Approved by the Auckland University of Technology Ethics Committee on 20th December 2006 AUTEC Reference number** 06/236.

**Approved by the Plunket Ethics Committee on 13th February 2007.**

# Appendix Four: Consent form for White Mothers

# Consent to Participation in Research

Title of Project: **Becoming a mother in a new country**

Project Supervisor: **Dr Max Abbott**

Researchers: Ruth DeSouza, Elaine Macfarlane

- I have read and understood the information provided about this research project (Information Sheet dated 2nd March 2006)
- I have had an opportunity to ask questions and to have them answered.
- 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.
- I agree to take part in this research.
- I consent for the data to be used in a future study
- I wish to receive a copy of the report from the research: tick one: Yes O No O

Participant signature: .....

Participant name: .....

Participant ID number:

.....

Participant's Preferred Contact Details for follow-up:

……..

……..

……..

……..

Date:

**Approved by the Auckland University of Technology Ethics Committee on 20th December 2005 AUTEC Reference number 05/240**

**Approved by the Plunket Ethics Committee on 30th November 2005**

Note: The Participant should retain a copy of this form.

# Appendix Five: Consent form for Korean Mothers

# Consent to Participation in Research

연구 참여자의 동의서

| | |
|---|---|
| Title of Project: | **Becoming a mother in a new country** |
| 연구 제목: | 외국인 엄마들의 출산경험 |
| Project Supervisor: | **Dr Max Abbott** |
| 과제 감독자: | 맥스 애보트 박사 |
| Researchers: | Ruth DeSouza, Elaine Macfarlane |
| 연구원 | 루스 드수자, 일래인 맥팔래인 |

- I have read and understood the information provided about this research project (Information Sheet dated 2nd March 2006).(정보지 날짜 2006년 3월 2일) .....나는 이 연구 과제에 대한 내용을 읽고 이해하였습니다.
- I have had an opportunity to ask questions and to have them answered. 나는 이 연구에 대한 질문과 답변을 얻을 기회가 있었습니다.
- 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.

  자료 수집이 완료되기전 언제든지 나에게 불리한 조건없이 나는 참여를 거절할 수 있고, 이미 제공한 자료도 취소할 수 있다는 것을 이해합니다.
- I agree to take part in this research. Yes () No ()

  나는 이 연구에 참여 하기로 동의합니다. 예 ( ) 아니요 ( )
- I consent for the data to be used in a future study.

  나는 이 연구 내용이 다른 미래 연구에 사용됨을 허락합니다.

- I wish to receive a copy of the report from the research: tick one: Yes O No O
  나는 이 연구 보고서의 사본을 받기 원합니다. 예 ( ) 아니요 ( )

Participant signature: 참여자 싸인

.....

Participant name: 참여자
성명.....

Participant ID number: 참여자
번호.....

Participant's Preferred Contact Details for follow-up:

참여자의 연락처

.....

.....

.....

.....

Date: 날짜:

**Approved by the Auckland University of Technology Ethics Committee on 20 December** 2005 **AUTEC**

**AUT** 윤리 위원회 허가 번호 05/240 날짜: 12 월 20일 2005 AUTEC

**Reference number** 05/240

**Approved by the Plunket Ethics Committee on** 30th November 2005

Note: The Participant should retain a copy of this form.

알림: 참여자는 이 양식의 사본을 보관하도록 권함

# Appendix Six: Consent form for Health Professionals

# Consent to Participation in Research

Title of Project: **Health professionals' views and experiences of working with migrant women**

Project Supervisor: **Dr Debbie Payne, Dr Kerry Gibson**

Researchers: Ruth DeSouza

---

- I have read and understood the information provided about this research project in the Information Sheet dated 20th December 2006.

- I have had an opportunity to ask questions and to have them answered.

- I understand that identity of my fellow participants and our discussions in the focus group is confidential to the group and I agree to keep this information confidential.

- I understand that the purpose of the research is not to describe the views and opinions of the individual participants but rather to identify sets of ideas that may reflect more widely held beliefs and perceptions affecting migrant health care.

- I understand that the focus group will be video/audio-taped and transcribed.

- 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 while it may not be possible to destroy all records of the focus group discussion of which I was

part, the relevant information about myself including tapes and transcripts, or parts thereof, will not be used.

- I agree to take part in this research.

- I wish to receive a copy of the report from the research (please tick one): ☐ Yes ☐ No

Participant signature: .....……..

Participant name: ……

Participant's Preferred Contact Details for follow-up:

……..

……..

……..

Date:

**Approved by the Auckland University of Technology Ethics Committee on 20th December AUTEC Reference number 06/236. Approved by the Plunket Ethics Committee on 13th February**

Note: The Participant should retain a copy of this form.

# Appendix Seven: Transcriber Confidentiality Agreement

# Transcriber Confidentiality Agreement

**Title of Project:** **Health professionals' views and experiences of working with migrant women**

**Project Supervisor:** **Dr Debbie Payne**

**Researcher(s):** Ruth DeSouza

I understand that all the material I will be asked to transcribe is confidential. I understand that the contents of the tapes 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:

.....
.....

Transcribers name:

.....
.....

Transcribers Contact Details:

.....

.....

.....

Date:.....

Project Supervisor Contact Details:

Dr Debbie Payne, Debbie.payne@aut.ac.nz, 09 921 9999 Ext 7112

**Approved by the Auckland University of Technology Ethics Committee on 20th December. AUTEC Reference number 06/236. Approved by the Plunket Ethics Committee on 13 February 2007**

# Appendix Eight: Mothers' demographic sheet

1. What is your age? _____ Years

2. Which ethnic group/s do you identify with?
   ☐ European/Pākehā $_1$ ☐ Indian$_2$ ☐ Arab$_3$

   ☐ Chinese$_4$ ☐ Korean$_5$

   ☐ Other$_6$ (please specify): _____

3. What is your religion?
   ☐ No Religion $_1$ ☐ Christian $_2$ ☐ Muslim $_3$

   ☐ Buddhist $_4$ ☐ Taoist $_5$ ☐ Hindu$_6$

   ☐ Other$_7$ (please specify): _____

4. What country were you born in?
   _____
5. When you moved to New Zealand, what country did you migrate from?

   _____
   _____

6. How long have you lived in New Zealand? _____ years _____ months

7. What is your occupation (your last job) in New Zealand?

   _____
   _____

8. What was your occupation (your last job) before you migrated?

   _____
   _____

9. What is your highest educational qualification?

☐ High school$_1$ ☐ Diploma or Trade Qualification$_2$

☐ Trade Qualification$_3$ ☐ Undergraduate Degree$_4$

☐ Postgraduate Degree$_5$ ☐ Other$_6$ (specify):

_____

10. How many people live with you?

_____

11. Do you have extended family living with you (tick all that apply)

☐ Your mother$_1$ ☐ Your father$_2$

☐ Husband's mother$_3$ ☐ Husband's father$_4$

☐ Other$_5$ (please specify):

_____

12. How many babies have you had?

_____

13. Not including your newest child, what country or countries were your children born in?

_____

_____

14. Why did you migrate to New Zealand?

_____

15. Is English your first language ☐ Yes$_1$ ☐ No$_2$

**If you answered 'Yes' to Question 15, please go to question 17:**

16. How well do you speak and understand English?

    ☐ Poorly$_1$

    ☐ I can hold a basic conversation$_2$

    ☐ I speak and read English everyday without too much difficulty$_3$

    ☐ I am fluent in English$_4$

17. What language(s) do you speak at home with your family?

    _____
    _____

18. How many people in your home speak English well or fluently? _____

19. How many people in your home do not speak English or speak it poorly? _____

Thank you!

# Appendix Nine: Questions for mothers

# Focus Group Questions

Title of Project: **Becoming a mother in a new country**

Project Supervisor: **Professor Max Abbott**

Researchers: **Ruth DeSouza, Elaine Macfarlane**

---

1. Thinking about before you had a baby
    a. In your culture how important is it to be a mother?
    b. How did you feel when you found out you were pregnant? What did your partner think?
    c. How important was it to you that the baby was a boy or a girl?
    d. How did you make the decision to have a child in New Zealand?

2. Thinking about your pregnancy:

    a. What were your expectations of pregnancy?
    b. What did you feel you needed in order to cope with being pregnant in New Zealand?
    c. Did you use antenatal services?
    d. Are there any special things you would do it you were in your home country that you did/couldn't do?
    e. How did you choose your lead maternity carer? (e.g. GP, midwife, obstetrician)
    f. Did you prefer someone from your own community or a local midwife? Why?
    g. Did you use antenatal services or classes?
    h. What did you think of them?
    i. Did you have any problems with following the programme (e.g. language problems, uncomfortable environment?

    [Prompt for other issues]

---

3. Thinking about the labour and delivery:

    a. What were your expectations of labour and delivery?

b. Were your expectations met?
c. Are there any special things you would do it you were in your home country that you did/couldn't do? Why?

[Prompt for other issues]

---

4. Thinking about after the baby was born

a. What were your expectations of the postnatal period?
b. Were your expectations met?
c. Are there any special things you would do it you were in your home country that you did/couldn't do? Why?
d. Did you stay in hospital? How did you find the food? Service?

---

5. What did you think of the health care you received in New Zealand? Is there anything else that could have been useful? For example bringing your mother/mother-in law over?

---

6. Do you have a General Practitioner? Did he/she have a role during your pregnancy, labour or delivery? How did you choose your GP? E.g. location, language skills, empathy with migrants

---

**7.** What else would else would you like to tell us about becoming a mother in New Zealand?

a. What have been the worst things about having a baby in New Zealand?
b. What have been the best things about having a baby in New Zealand?

---

8. What would you like to happen next time?

---

9. Is there anything else you would like to add?

---

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