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# One Woman's Empowerment Is Another's Oppression: Korean Migrant Mothers on Giving Birth in Aotearoa New Zealand

**Ruth DeSouza, PhD, RN**[1]

**Abstract**

**Purpose:** To critically analyze the power relations underpinning New Zealand maternity, through analysis of discourses used by Korean migrant mothers. **Design:** Data from a focus group with Korean new mothers was subjected to a secondary analysis using a discourse analysis drawing on postcolonial feminist and Foucauldian theoretical ideas. **Results:** Korean mothers in the study framed the maternal body as an at-risk body, which meant that they struggled to fit into the local discursive landscape of maternity as empowering. They described feeling silenced, unrecognized, and uncared for. **Discussion and Conclusions:** The Korean mothers' culturally different beliefs and practices were not incorporated into their care. They were interpellated into understanding themselves as problematic and othered, evidenced in their take up of marginalized discourses. **Implications for Practice:** Providing culturally safe services in maternity requires considering their affects on culturally different women and expanding the discourses that are available.

**Keywords**

focus group interview, cultural safety, Korean women, maternal, postcolonial, Foucault

A feature of contemporary maternity is the notion that birth can be empowering for women if they take charge of the experience by being informed consumers. However, maternity is not necessarily empowering for all mothers. In this article, I suggest that the discourses of the Pākehā maternity system discipline and normalize culturally different women by rendering their mothering practices as deviant and pathological. Using the example of Korean migrant mothers, I begin the article by contextualizing maternity care in New Zealand and outlining Korean migration to New Zealand. The research project is then detailed, followed by the findings, which show the ways in which Korean mothers are interpellated as others in maternity services in New Zealand. I conclude the article with a brief discussion on the implications for nursing and midwifery with a particular focus on cultural safety.

## Background

### *Maternity Care in New Zealand*

The New Zealand health care system is largely publicly funded, comprising 21 District Health Boards that provide services to people and communities. New Zealand was the first country in the world to introduce universal health care in the context of a postdepression welfare state (Sheridan et al., 2011). Most women (75.3%) elect to have midwifery care through their pregnancy (Ministry of Health, 2007). Midwifery training commenced in 1904, prior to which trained midwives were imported from Britain. The institution of the Midwives Act from 1938 saw free services offered to all women who could receive midwifery care in their homes and in maternity hospitals (Pairman, 2006). However, medicalization, hospitalization, and nursification led to the erosion of midwifery (Stojanovic, 2008). The late 1980s saw legislative changes occur heralding the return of autonomous midwifery practice, differentiated in scope from nursing due to mutually beneficial political lobbying by consumers and midwives. 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 meant that New Zealand women could choose a caregiver (Lead Maternity Carer) who would either coordinate or provide the care they required from early pregnancy to 6 weeks

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postpartum (Pairman, 2006). Direct access to government maternity funding enabled midwives to 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). At 6 weeks postpartum, the care of women and their infants is transferred to The Royal New Zealand Plunket Society (Plunket) or Public Health Nurses, who provide screening, surveillance, education, and support to all New Zealand children until the age of 5 years and their families.

### *Korean Migrants in New Zealand*

Migration has played a central role in making New Zealand culturally and linguistically diverse. It has also been fundamental to nation building and imperial expansion in the context of New Zealand as a White settler society. Britain assumed governance of its new colony in 1840 when it signed Te Tiriti O Waitangi/The Treaty of Waitangi with Māori tribes. Ensuing settlers were primarily from Europe and the United Kingdom with Asian and Pacific Island migration marked by exclusionary legislation and discrimination. The year 1987 marked a watershed in New Zealand migration policy with new legislation (prompted by global competition for skilled migrants) broadening the range of migrant source countries and increasing the numbers of Asians (Bartley, 2004; Bartley & Spoonley, 2004; Bedford, 2003). The new legislation also formalized the country's humanitarian commitment to refugee resettlement and saw refugees from Africa, the Middle East, South East Asia, and Eastern Europe make New Zealand their home.

The 1987 migration policy favored migrants who had venture capital and had professional, technical, and entrepreneurial skills and led to a dramatic increase in Korean migration. Where 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). Koreans were the 10th largest ethnic group in New Zealand in the 2006 Census (Morris, Vokes, & Chang, 2007). However, unlike Hawaii and Los Angeles, where Korean migration extends to eight or more generations, Koreans represent a new migrant community in New Zealand.

More than half of all Koreans live in Auckland and Christchurch, and half of its population are 24 years of age or less (Chang, Morris, & Vokes, 2006). Of all Koreans in the country, 94% 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 (Dunstan, Boyd, & Crichton, 2004). Migration has resulted in a decline in socioeconomic status for many Koreans in New Zealand, who experience 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 et al. (2006) attributes this decline for Koreans to poor English language proficiency combined with an inability to find equivalent senior managerial and technical positions to those they had in Korea, resorting to underemployment in small-scale businesses such as grocery shops and restaurants primarily serving their own communities.

## The Study

Discourse analysis was used to analyze the power residing in discourse and to consider the ways in which nurses are engaged in power techniques and social regulation using Foucault's conceptualization of modes of power. Discourse analysis refers to a number of qualitative, language-focused approaches concerned with analyzing talk, text, and other signifying practices (Malson, 1998). 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, p. 383). In the wake of postcolonial theory, discourse analysis in a White settler society such as New Zealand must consider the cultural hegemony of European knowledges and the epistemological value of subjugated knowledges (Gandhi, 1998).

### *Design/Method*

Poststructural and postcolonial theories were used as a theoretical lens through which to conduct a secondary analysis on empirical data from a focus group with Korean mothers. The data were part of a larger Families Commission study (DeSouza, 2006) that was jointly undertaken with The Royal New Zealand Plunket Society (Plunket). Five ethnocultural groups of new mothers (including Korean) were interviewed about their maternity experiences. Mothers who were migrants and who had given birth to healthy babies within the previous 12 months were selected to participate. Ethics approval was received from both the AUT Ethics committee and the Plunket Ethics Committee.

### *Recruitment*

Plunket nurses selected women to take part who had identified as Korean. Information sheets and consent forms were provided in Korean and the former was posted to the mother, who was given 2 weeks to consider the invitation. Plunket volunteers fund-raised to provide child care and transport for the women taking part in the focus groups.

### Data Collection

Focus groups were selected as a method for data collection for theoretical, practical, and therapeutic reasons. Theoretically speaking, focus groups are compatible with discourse analysis because texts are viewed not as a reflection of "true" experience (Scott, 1991) but of the discourses available in the social, cultural, and historical context of the speakers (Gavey, 1989). Practically, groups allowed access to large numbers of women, and talking with other women about their experiences also offered therapeutic benefits for the participants. Drawbacks to using focus groups included having to manage dominant voices so they did not prevent quieter members from being heard or influence the contributions of others (Krueger & Casey, 2008). Two highly skilled group facilitators conducted the Korean focus group in the Korean language. The focus group discussion was recorded and transcribed, then translated into English and verified by an independent translator. The eight Korean participants included (all names are pseudonyms)—Mee-Young, Ji-Eun, Jung-Ja, Young-Ja, Young-Mee, Mee-Sook, Young-Hee, and Yoon-Mee—who were aged between 29 and 34 years. They had lived in New Zealand for between 1 year and 5 years; and six of the eight women were first time mothers. One woman had her first baby in Korea and another woman had two of her three children born in Korea. The mothers all had undergraduate qualifications and were employed in roles including receptionist, office worker, and teacher and two were self-employed prior to the birth of their babies. The Korean participants had migrated primarily for their husband's work and one woman had migrated for her children's education.

### Data Analysis

Once the speech in the focus group discussion was converted into written text, I attempted to identify speaking positions and relations of power in common with a discourse analytic approach (Parker, 1999). I noted how Korean mothers operated in and against discursive constructions promulgated by health professionals (midwives and nurses), paying particular attention to power relations and how the Korean mothers described their resistance to these. In particular, I was interested in the way in which the women spoke about the embodied experiences of becoming pregnant, labor, delivery, and the postpartum period and how they established and negotiated their relationships with health providers.

### Secondary Analysis

The desire to undertake a secondary analysis reflected different audiences, theoretical modes, and methodologies. Although the aim in the original research report (DeSouza, 2006) was to describe and inform, the purpose of the secondary analysis was to scrutinize the discourses applied by nurses to migrant mothers and open up alternative discourses. The primary analysis provided important findings, but did not allow for a critical analysis of why 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.

### Rigor and Validity

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). Nairn (2003) proposes several ways for making a discourse analysis rigorous. First, prefacing the perspective or locations that shape ones analysis and providing "a clear analytic path" (p. 29) that can be scrutinized. Nairn proposes that this path should have three key components: a clear theoretical rationale, the inclusion of analyzed data, and connecting analyses with literature and research. 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.

## Findings

### Centrality of Biomedicine

Korean women saw biomedicine as having a central role in ensuring their own well-being and that of their baby. Careful surveillance through reproductive technologies provided them with knowledge of the health of their baby.

> 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. (Young-Ja)

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 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 also perceives health personnel as being too relaxed and casual, although the midwife is positioned as a gatekeeper who prevents access to services that would provide reassurance:

> 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. . . . 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. (Ji-Eun)

In the technologically mediated surveillance of pregnancy, Tremain (2006) suggests that the governing of impairment in utero is connected with the governing of the maternal body. Ji-Eun's account highlights a dialectical process where engaging in the surveillance of her fetus 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 counterdemands 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 unfavorably 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 behavior 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 and requesting further ultrasounds.

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

> 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 12 a.m. 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 5 cm 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? (Jung-Ja)

This excerpt can be read as Jung-Ja expressing a positive norm of going to hospital early and laboring there, but it could also be read as the micro-institutionalization of biomedicine (Morgan, 1998), representing a desire to transfer the power and responsibility for birth to her carer. Jung-Ja must interpret what is happening in her body and has difficulty in knowing whether labor has begun. Her request about the progress of the birth illustrates how the state of labor 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 medicalization 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[1] offers subject positions that assist women to judge their performance through the quantification of norms (Payne, 2001). The quantifiable nature of labor 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 labor. Cervical dilation is valorized as an indicator for arrival at hospital, over women's own perceptions of their pregnancy and labor. The issue of when to come to the hospital highlights a gap between the needs of women in labor 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 who view women who are not "in labor" as making illegitimate demands and crowding the space. The role of the Lead Maternity Carer becomes one of "translation," to decipher/read the events that are inscribed in the mother's body.

The inability to get one's needs met leads to finding ways to get one's needs met outside the system:

> 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)

Young-Mee constitutes and structures her pregnancy experience through biomedical discourses and challenges midwifery

rebuffs to her requests. Her discursive resistance is seen in her quest for an alternative space to talk with other Korean women who might support her beliefs. The Internet provides a space for people to do things that they might not be able to do before and can be empowering (Tang, 2010); people with marginalized 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 her perception that limited help and support are available. Her desire to see the baby through the ultrasound is a way of obtaining some certainty about the baby's health and integrity.

## *Being a Problem*

Participants were interpellated into understanding themselves as problematic and othered, through a process where their legitimacy to birth in New Zealand was questioned. They perceived that they were viewed as illegitimate migrants trying to attain citizenship through childbirth rather than recognized as middle class with citizenship status, even though from January 1, 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 (Department of Internal Affairs, n.d.). Young-Mee articulates this connection between sociological and psychological devaluing:

> 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. (Young-Mee)

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" are from but perceives that she is given the same (poor) standard of care that they receive. The act of putting the "foreign mothers" together could be read as corralling or quarantine, that is, 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:

> 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 toward 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)

Despite experiencing "a cold shoulder" (intentionally cold or unsympathetic treatment, a nonverbal action where a person is ignored), 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.

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. They experience being devalued as an economically unproductive "other," who is seen as a liability (Stratton & Perera, 2009). The dominant response to otherness is normalization, and there are specific sites of Pākehā culture and tradition where the Korean mothers experience normalizing practices.

Normalizing practices in New Zealand extend to the expectation of mobilization and the Pākehā practice 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, especially if she has had a baby before:

> 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)

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. She perceives the nurse as angry at being interrupted from her "real" work and sarcastic and disbelieving about Young-Ja's need for help. There is an expectation that as a multigravida, she should know better. 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.

### *Deviant Practices*

The space of the maternity ward is a contested site, where maternity discourses about what constitutes a healthy environment (in this case fresh air and sunshine) are in tension with the desire to keep warm to prevent subsequent illness.

> 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)

Mee-Young's narrative constitutes an example of how prevailing discourses about Western maternity (such as the healing properties of fresh air and rooming in) create "truths" about Korean women as mothers that have an impact on how they see and experience themselves. Mee-Young 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. The closed window representing her need for warmth is seen as a threat and highlights the continuing relevance of germ theory, where ventilation and fresh air keep a space healthy. The easy mobilization of barefoot Pākehā women reinforce the universalized framing of birth as a natural event that requires a rapid resumption of old roles and the incorporation of new roles. Mee-Young decides to go home sooner than indicated, feeling unsupported by the system, which does not respond to her needs and that is limited to the baby's needs.

Food as a site for the disciplining and normalization of maternal subjectivity is evident in the following excerpt as well.

> 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. (Young-Ja)

The lack of acknowledgement of the special status of the new mother is represented in the small size and the perceived poor quality of the portion. Young-Ja is concerned whether it will allow her to adequately 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 nonverbal feedback about the odor of her food. Young-Ja exercises vigilance with regard to her own behavior, monitoring whether what she does fits the norm, and thus that regulation becomes self-regulation as Young-Ja subjects herself to an internalized 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.

## Discussion

Language and discourse bring into being and normalize particular versions of the world and relations of power between social institutions and actors. The findings show that there is a discursive gap between the ways in which health professionals and migrant Korean women in this study understand maternity. Midwifery discourses position birth as natural and the maternal subject as physically capable of caring for her baby from the moment it is born, requiring minimal intervention and protection. The maternal body is represented as strong and capable for taking on the tasks of motherhood. In contrast, many of the Korean women in this study discursively positioned birth as a process that made the body vulnerable, requiring careful surveillance and monitoring and a period of rest and nurturing before the new mother could take on new or additional responsibilities.

Korean mothers drew on two main discourses with which they understood their experience of maternity. They framed the maternal body as a body at risk (Mahjouri, 2008) through biomedical discourses, and the maternal body as vulnerable and in need of special care through traditional cultural discourses. These discourses collided with midwifery, nursing, and Western liberal feminist[2] discourses in the New Zealand maternal system. Practices based on a dominant discourse of birth as a normal physiological event and neoliberal[3] 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 with themselves. As racialized maternal subjects, Korean women's bodies were subject to modes of governing that were both empowering and normalizing. However, they experienced these modes as disempowering because they were not defined in their uniqueness and particularity, but in relationship with technical knowledges deployed by nurses and midwives, and the

mothers were made to regulate themselves accordingly. These Western maternity discourses incite disciplinary and normalizing 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. Normalizing 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 a subject position that is unavailable to Korean mothers, and they are made indistinguishable from less desirable racial others despite their citizenship status. These processes have two key impacts. First, Korean women experience a differential quality of care, which contributes to dissatisfaction with their maternal experiences. Second, nursing and midwifery reproduce detrimental practices associated with colonial and assimilatory discourses.

## Implications

The maternity experiences of migrant women are worthy of scholarly, policy, and clinical attention given that most migrants are of childbearing age. This article enriches the literature on maternity and migration by illustrating how social dynamics and discourses produce distress and influence the differential quality of health services delivered to some groups. The findings must be considered in the context of colonization and exclusionary migration legislation, which are the historical antecedents of current inequities in the New Zealand health care system. Cultural safety has been a part of the nursing curriculum since 1990 in New Zealand; however, little is known about its effectiveness with non-Māori populations. I conclude this article by advancing moves that facilitate the kinds of outcomes and transformation that nurses and midwives hope cultural safety can provide. Cultural safety typically requires reflecting on one's practice, values, and assumptions (Browne et al., 2009) to challenge the status quo and make institutions more inclusive (Ng, 1995). However, to make such reflection practically available would require greater support in the harried and demanding health contexts in which nurses and midwives are situated. Strategically transforming nursing and midwifery practice to produce equitable outcomes would require that reflection becomes less an individual process undertaken by a nurse or midwife to change understanding and practices, to a collective examination of the social and political factors that produce knowledge and practices. Nursing and midwifery leaders need to create spaces where uncertainty can be explored to develop "a more human and emotional investment to connect successfully with those whose world differs from one's own" (Kai, Beavan, Faull, Dodson, & Gill, 2007, p. 1772). Such spaces could support collective dialogue so that nurses could work together to enact their collective values and recognize that their practice is embedded within a broad sociopolitical context, where they are implicated in power relations that might do the very opposite of what they hope for (Varcoe, Rodney, & McCormick, 2003).

## Conclusion

This article has examined how the insertion of culturally different women into the Pākehā maternal system and its discourses incites disciplining and normalizing processes that render cultural practices deviant and pathological. South Korean migrant mothers in this study took up biomedical discourses with respect to delivering a baby, viewing associated technologies of the self such as being monitored and surveilled as empowering. They experienced the contemporary Western ideals of maternal independence and autonomy as coercive in the context of their culturally different framing of the maternal body as vulnerable. This article shows how nursing and midwifery knowledges produce subjectification into particular kinds of racialized and gendered subjects. These knowledges are linked with colonial legacies and assimilatory discourses that circulate in postcolonial institutions that work to maintain the hegemony of Pākehā discourses and the othering of other mothers. Creating spaces for collective dialogue where practices can be grounded in a broader sociopolitical context could resource nurses to adequately respond to difference and support the aspiration for empowering outcomes for all mothers.

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### Notes

1. Technologies of power are the diverse strategies that shape individuals' conduct and "submit them to certain ends or domination" (Foucault, 1988, p. 18). Foucault defined biopower as focused on the control and management over life in contrast with sovereign power, which operated through the threat of death (Foucault, 2004). Biopower evolved into a bipolar technology, made up of anatamo-politics and biopolitics. Anatamo-politics is a type of power relation where individual human anatomical bodies/subjects are made docile through discipline within institutions. Biopolitics refers to a biological and political notion of population, where power is focused on the population or species body through interventions and regulations.

2. Liberal feminist discourses mobilize concepts such as empowerment, choice, and control to decolonize patriarchal practices of maternity. They produce a universal maternal subject who claims her individual rights. However, understandings of social class, ethnicity, race, and culture can be obscured (Ringrose, 2007).
3. An assemblage of ideas constitute the category of neoliberalism, which can be categorized roughly into four with their own methodological, epistemological, and ontological differences (Springer, 2012): Neoliberalism as an ideological hegemonic project, neoliberalism as policy and program, neoliberalism as state form, and neoliberalism as governmentality. These understandings of neoliberalism are often merged in scholarship. Springer advocates for a discourse approach where political economy and poststructuralist approaches are merged, avoiding the privileging of "top-down" Marxist ideological hegemony understandings, or "bottom-up" poststructuralist governmentality notions. Therefore, viewing neoliberalism as a process that circulates through the discourses it supports, for example, that of the informed consumer or productive subject. Neoliberalism can be understood as a discourse because neoliberal subjectivation works on individuals who are subjected to relations of power through discourse (Foucault, 1982).

## References


Armstrong, E. M. (2003). Lessons in control: Prenatal education in the hospital. In P. Conrad & V. Leiter (Eds.), *Health and health care as social problems* (pp. 267-294). Lanham, MD: Rowman & Littlefield.

Bartley, A. (2004). Contemporary Asian migration to New Zealand: Challenging the "Settler" paradigm. In P. Spoonley, C. Macpherson, & D. Pearson (Eds.), *Tangata, tangata: The changing ethnic contours of New Zealand* (pp.157-173). Palmerston North, New Zealand: Dunmore Press.

Bartley, A., & Spoonley, P. (2004). Constructing a workable multiculturalism in a bicultural society. In M. Belgrave, M. Kawharu, & D. V. Williams (Eds.), *Waitangi revisited: Perspectives on the Treaty of Waitangi* (2nd ed., pp. 136-148). Auckland, New Zealand: Oxford University Press.

Bedford, R. (2003). *New Zealand: The politicization of immigration*. Retrieved from http://www.migrationinformation.org/Profiles/print.cfm?ID=86

Browne, A. J., Varcoe, C., Smye, V., Reimer-Kirkham, S., Lynam, M. J., & Wong, S. (2009). Cultural safety and the challenges of translating critically oriented knowledge in practice. *Nursing Philosophy*, *10*, 167-179.

Chang, S., Morris, C., & Vokes, R. (2006). *Korean migrant families in Christchurch: Expectations and experiences*. Wellington, New Zealand: Families Commission.

Davis, D. L., & Walker, K. (2009). Case-loading midwifery in New Zealand: Making space for childbirth. *Midwifery*, *26*, 603-608.

The Department of Internal Affairs. (n.d.). *Changes to citizenship by birth in New Zealand from 2006: Frequently asked questions*. Retrieved from http://www.dia.govt.nz/diawebsite.nsf/wpg_URL/Services-Citizenship-Changes-to-Citizenship-by-Birth-in-New-Zealand-from-2006-Frequently-Asked-Questions?OpenDocument

Department of Labour. (2006). *Skilled migrants in New Zealand: A study of settlement outcomes*. Wellington, New Zealand: Author.

DeSouza, R. (2006). *New spaces and possibilities: The adjustment to parenthood for new migrant mothers*. Wellington, New Zealand: Families Commission.

Douglas, M. (2002). *Purity and danger: An analysis of concept of pollution and taboo*. Oxon, England: Routledge.

Dunstan, S., Boyd, S., & Crichton, S. (2004). *Migrants' experiences of New Zealand*. Retrieved from http://www.immigration.govt.nz/NR/rdonlyres/257DBD3C-E649-4E31-9A4B-F8F61173CF44/0/LisNZPilotSurveyReportMarch2004.pdf

Foucault, M. (1982). The subject and power. In H. L. Dreyfus & P. Rabinow (Eds.), *Michel Foucault: Beyond hermeneutics and structuralism* (pp. 208-226). Brighton, England: Harvester.

Foucault, M. (1988). Technologies of the self. In L. H. Martin, H. Gutman, & P. H. Hutton (Eds.), *Technologies of the self* (pp. 16-49). Amherst: University of Massachusetts Press.

Foucault, M. (2004). Right of death and power over life. In N. Scheper-Hughes & P. I. Bourgois (Eds.), *Violence in war and peace* (pp. 79-83). Malden, MA: Blackwell.

Gandhi, L. (1998). *Postcolonial theory: A critical introduction*. Crows Nest, New South Wales, Australia: Allen & Unwin.

Gavey, N. (1989). Feminist postructuralism and discourse analysis: Contributions to a feminist psychology. *Psychology of Women Quarterly*, *13*, 459-475.

Geiger, S., & Prothero, A. (2007). Rhetoric versus reality: Exploring consumer empowerment in a maternity setting. *Consumption Markets & Culture*, *10*, 375-400.

Green, M. J., & Sonn, C. C. (2006). Problematising the discourses of the dominant: Whiteness and reconciliation. *Journal of Community & Applied Social Psychology*, *16*, 379-395.

Kai, J., Beavan, J., Faull, C., Dodson, L., & Gill, P. (2007). Professional uncertainty and disempowerment responding to ethnic diversity in health care: A qualitative study. *PLoS Medicine*, *4*, 1766-1775.

Kim, J., & Starks, D. (2005). Language diaries: A case study of language use in the New Zealand Korean community. In A. Bell, R. Harlow, & D. Starks (Eds.), *Languages of New Zealand* (pp. 343-369). Wellington, New Zealand: Victoria University Press.

Krueger, R., & Casey, M. (2008). *Focus groups: A practical guide for applied research*. London, England: Sage.

Mahjouri, N. (2008). Techno-maternity: Rethinking the possibilities of reproductive technologies. *Thirdspace: A Journal of Feminist Theory & Culture*, *4*(1). Retrieved from http://journals.sfu.ca/thirdspace/index.php/journal/article/viewArticle/mahjouri

Malson, H. (1998). *The thin woman: Feminism, post-structuralism, and the social psychology of anorexia nervosa*. New York, NY: Routledge.

Ministry of Health. (2007). *Notice pursuant to Section 88 of the New Zealand Public Health and Disability Act 2000*. Wellington, New Zealand: Author.

Morgan, K. P. (1998). Contested bodies, contested knowledges: Women, health, and the politics of medicalization. In S. Sherwin (Ed.), *The politics of women's health: Exploring agency and autonomy* (pp. 83-121). Philadelphia, PA: Temple University Press.

Morris, C., Vokes, R., & Chang, S. (2007). Social exclusion and church in the experiences of Korean migrant families in Christchurch. *Sites: A Journal of Social Anthropology and Cultural Studies*, *4*(2), 11-31.

Nairn, R. G. R. (2003). *Madness, media & mental illness: A social constructionist approach* (Unpublished doctoral thesis). University of Auckland, New Zealand.

Ng, R. (1995). Teaching against the grain: Contradictions and possibilities. In R. Ng, P. Staton, & J. Scane (Eds.), *Anti-racism, feminism, and critical approaches to education* (pp. 129-153). Westport, CT: Bergin & Garvey.

Ong, A. (1999). *Flexible citizenship: The cultural logics of transnationality*. Durham, NC: Duke University Press.

Pairman, S. (2006). Midwifery partnership: Working with women. In L. Page & R. McCandlish (Eds.), *The new midwifery: Science and sensitivity in practice* (2nd ed., pp. 73-97). Philadelphia, PA: Elsevier/Churchill Livingstone.

Parker, I. (1999). Introduction: Varieties of discourse and analysis. In I. Parker & B. D. Network (Eds.), *Critical textwork: An introduction to varieties of discourse and analysis* (pp. 1-13). Buckingham, England: Open University Press.

Payne, D. (2001). *The elderly primigravida: Contest and complexity: A Foucauldian analysis of maternal age in relation to pregnancy and birth* (Unpublished doctoral thesis). Massey University, Palmerston North, New Zealand.

Powers, P. (2001). *The methodology of discourse analysis*. Mississauga, Ontario, Canada: Jones & Bartlett.

Ringrose, J. (2007). Successful girls? Complicating post-feminist, neoliberal discourses of educational achievement and gender equality. *Gender and Education*, *19*, 471-489.

Scott, J. W. (1991). The evidence of experience. *Critical Inquiry*, *17*, 773-797.

Sheridan, N., Kenealy, T. W., Connolly, M. J., Mahony, F., Barber, A., Boyd, M. A., . . .Moffitt, A. (2011). Health equity in the New Zealand health care system: A national survey. *International Journal for Equity in Health*, *10*, 45. Retrieved from http://www.equityhealthj.com/content/10/1/45

Springer, S. (2012). Neoliberalism as discourse: Between Foucauldian political economy and Marxian poststructuralism. *Critical Discourse Studies*, *9*, 133-147.

Stojanovic, J. (2008). Midwifery in New Zealand 1904-1971. *Contemporary Nurse*, *30*, 156-167.

Stratton, J., & Perera, S. (2009, June 16). Surely that's not racist? *New Matilda*. Retrieved from http://newmatilda.com/2009/06/16/surely-thats-not-racist

Tang, L. (2010). Empowering or disempowering? Online support among seafarer-partners. *Sociological Research Online*, *15*(2), 6.

Tremain, S. (2006). Reproductive freedom, self-regulation, and the government of impairment in utero. *Hypatia*, *21*(1), 35-53.

Varcoe, C., Rodney, P., & McCormick, J. (2003). Health care relationships in context: An analysis of three ethnographies. *Qualitative Health Research*, *13*, 957-973.

Weir, L. (1996). Recent developments in the government of pregnancy. *Economy and Society*, *25*, 373-392.