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Regulating migrant maternity: Nursing and midwifery's emancipatory aims and assimilatory practices

Ruth DeSouza
Division of Health Care Practice, AUT University, Auckland, New Zealand

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Regulating migrant maternity: Nursing and midwifery's emancipatory aims and assimilatory practices
In contemporary Western societies, birthing is framed as transformative for mothers; however, it is also a site for the regulation of women and the exercise of power relations by health professionals. Nursing scholarship often frames migrant mothers as a problem, yet nurses are imbricated within systems of scrutiny and regulation that are unevenly imposed on 'other' mothers. Discourses deployed by New Zealand Plunket nurses (who provide a universal 'well child' health service) to frame their understandings of migrant mothers were analysed using discourse analysis and concepts of power drawn from the work of French philosopher Michel Foucault, read through a postcolonial feminist perspective. This research shows how Plunket nurses draw on liberal feminist discourses, which have emancipatory aims but reflect assimilatory practices, paradoxically disempowering women who do not subscribe to ideals of individual autonomy. Consequently, the migrant mother, her family and new baby are brought into a neoliberal project of maternal improvement through surveillance. This project – enacted differentially but consistently among nurses – attempts to alter maternal and familial relationships by 'improving' mothering. Feminist critiques of patriarchy in maternity must be supplemented by a critique of the implicitly western subject of maternity to make empowerment a possibility for all mothers.

Key words: culture, discourse, feminism, Foucault, maternal health, migration.

Under the contemporary governmental conditions of neoliberalism in white settler societies,[1] an implicit and ideal (maternal) service user is preferred (Fisher 2008). This user is both autonomous and independent and expected to meet their own needs as individuals within the health system through the imperative of health (Lupton 1995). Against this culturally specific benchmark, the traditional support structures, rituals and practices of migrant mothers[2] pose a challenge to the smooth and efficient running of the health

Correspondence: Ruth DeSouza, Senior Lecturer, Division of Health Care Practice, AUT University, Private Bag 92006, Auckland 1142, New Zealand. E-mail:<ruth.desouza@aut.ac.nz>

1 Sherene Razack (2002, 1–2) defines 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'. A racial hierarchy structures it where European settlers are most entitled to claim the fruits of citizenship and conquest, genocide and slavery are disavowed and the labour of peoples of colour is exploited. White settler institutions, processes and ideologies potently frame social relations in Aotearoa/New Zealand (Wetherell and Potter 1993; Smith 1999; Seuffert 2006). These are both historical (e.g. land confiscations from indigenous Māori and exclusionary poll tax legislation exacted on Chinese communities) and contemporary (e.g. the ethnic inequalities in health between indigenous (Māori) and settler (Pākehā) (Harris et al. 2006) and growing evidence of health disparities among visibly different migrant groups.

2 The term 'migrant mother' refers to visibly different non-white women who were born in one country and have migrated to another country through an immigration programme and have had a baby. As part of a larger research project, I also interviewed white migrant mothers whose preferences and values were well aligned with the maternal health system.

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system, which is dependent on the predictability of an ideal service user. The divergence in how mothering[3] is performed can result in dissatisfaction for both nurses and maternity consumers. Nursing responses to 'other' mothers whose subjectivity has been formed outside western liberal contexts requires further theoretical investigation. This article outlines nursing responses to migrant mothers within western health systems and then describes a research study, which analysed the discourses of a group of nurses in New Zealand who provide care to women and their babies in the community.

NURSING RESPONSES TO DIFFERENCE

The liberal feminist promise of birth as a self-actualising and emancipatory experience for women is experienced unevenly for different groups of mothers. In the case of migrant mothers, a different quality of care is received during pregnancy and childbirth leading to differential birth outcomes (Malin and Gissler 2009). The culturally different migrant mother's arrival into a health system constructed as neutral (Puzan 2003) cultureless, liberal and universal represents a disorderly difference and an unwelcome disruption. In the universal public health system, the cultural needs of 'others' are considered private and not an institutional responsibility (Davies and Papadopoulos 2006) and therefore are ignored or denigrated (Barclay and Kent 1998). The system is predicated on clients who are predictable and conform (Crowe 2000) to the cultural assumptions of the institution. The migrant mother experiences unequal access to maternity[4] care; poor access to appropriate information, and her movement through the system is problematic. Instead of her mothering experience being filled with possibility and transformation, there are a litany of problems including the provision of limited interpreting services, language and communication problems; cultural incompetence; tensions between models of care; and tensions between professional intervention and family and community involvement (Bowes and Domokos 1998; Davies and Bath 2001; Bulman and McCourt 2002; Wikberg and Bondas 2010).

This mismatch between the needs of migrant mothers and what institutions provide can be better understood by considering how difference is understood and produced institutionally. Frequently, health professionals subject migrant parents to both normative professional discourses of parenting and unexamined personal theories of white western middle-class motherhood (Grant and Luxford 2009). These personal beliefs, interpretations and stereotypes guide interactions and decisions about appropriate care and service delivery (Bowler 1993a,b; Bowes and Domokos 1998). The reliance on stereotypes to guide care is attributed to poor educational preparation for working interculturally, combined with minimal social contact with culturally different people among practitioners (Bowes and Domokos 1998). Limited contact with a cultural group also results in more negative framing as seen by health visitors with less experience of working with Pakistani women being less likely to speak positively about them (Bowes and Domokos 1998). Typically, the stereotypes invoked are of suffering victims. For example, Asian women were constructed as 'oppressed by their role as mothers, suffocated by domesticity and lacking independence' in a study by Day (1992, 22). Other discursive constructions of Asian mothers are as demanding; difficult to communicate with; having a low pain threshold; lacking in a maternal instinct and non-compliant with preventative care and family planning (Bowler 1993a,b). In Bowler's research, Asian mothers were viewed as 'abusing' services by having large families and having 'unrealistic' expectations. The 'positive stereotypes' of Asian women such as their abstention from smoking and alcohol were not acknowledged. In these examples, nurses and midwives saw themselves as caring, and yet, they acted towards migrant mothers in oppressive ways. The use of stereotypes is compounded by the Eurocentric and reductionist education and research frameworks that inform professional practice, where the mother is considered outside the context of her extended family (Foss 1996) or broader social, cultural, economic, historical and political contexts (O'Mahony and Donnelly 2010).

One explanation for the gap between supposedly empowering institutional practices and their disempowering outcome is the ubiquity of liberal values in nursing. Liberal values are thought to obstruct the development of a critical and political social conscience in nursing (Browne 2001) because they conceal the effects of gender, race and other categories that inscribe inequality (Hyams 2004). Culturally sensitive approaches in nursing are emblematic of liberal values, where egalitarianism and knowledge of the 'other' are valorised without a corresponding demand for reflexivity and attention to systemic and structural power relations in

3 Miller (2005) defines mothering as the personal, individual [and cultural] experiences that women have in meeting the needs of their dependent children. Motherhood refers to the context where mothering occurs and is not only shaped by history, cultural, the political and social, but also morally shaped.

4 I use the term 'maternity' to refer to the field of power relations that women enter when they have a baby. This research is primarily attuned to the services, policies and practices that shape motherhood and mothering within this field of power relations.

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the dominant culture (Culley 1996; Browne and Smye 2002). Culley (2006) contends that these liberal commitments have had two key impacts in nursing. The first has been the neutralisation of a critical anti-racist agenda, through the erasure of politically contentious terms such as racism, and their replacement with euphemisms such as 'culture', 'diversity' and 'ethnicity'. Culley (2006) maintains that this replacement has edited hierarchy and dominance out of nursing's vocabulary and perpetuated the colonial representation of the 'other' as different and undesirable (Saxton 2006). The second impact has been the use of 'culturalist' and 'racialising' discourses, which justify ethnocentric care provision based on stereotypes, which in turn contribute to health disparities. Similarly, the advent of cultural competence approaches – as enshrined in the Health Practitioners Competence Assurance Act (2003) in New Zealand – emphasises the need to bridge 'differences' between the giver and recipient of care. 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, Green and Carrillo 2002), cultural competence approaches fail to address power relations and the culture of health. However, cultural safety, a pedagogical and practice strategy developed in New Zealand by indigenous Māori nurses, represents a specific decolonising agenda. Central to this strategy is the requirement for nurses to shift the gaze to the self as a culture bearer, rather than perceiving the other as a bearer of difference and in so doing, addressing power issues and the potential for the personal and professional values and beliefs of the nurse to be imposed on to the recipient of care (Ramsden 1997, 2000, 2002; Nursing Council of New Zealand 2005).

THE STUDY

The first aim of the study was to investigate the range of discourses utilised by a group of nurses to constitute migrant maternity. The second aim was to generate alternative discourses, knowledges and practices that could better serve migrant mothers, their families and maternity health professionals. This discursive analytical study was located within a poststructural perspective influenced by feminist, and postcolonial scholars and the work of French theorist Michel Foucault.

A focus group of nurses from the Royal New Zealand Plunket Society (Plunket) were selected to examine the ways in which the figure of the migrant mother was constructed. Plunket is a community-based, not-for-profit national organisation, who provide Well Child/Tamariki Ora services in New Zealand that include: 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 New Zealand families. Plunket was founded by Doctor Truby King in 1907 to promote breastfeeding, improve bottle-feeding and support mothercraft in order to address the high rates of infant mortality that were evident in New Zealand at that time. Plunket came to be a key agent in the regulation of women, conceived in its early days as both a civilising mission among Māori women and a eugenic project of white supremacy promoted among Pākehā[5] (Māori word for European or white New Zealander) women through discourses of scientific mothercraft[6] (Wanhalla 2007). It was one of many aspects of colonial governmentality originating from Britain, where public health practices were used to count, describe and manage the population. In a contemporary context, Plunket nurses still have a regulatory role where mothers' compliance with health education messages is surveilled and monitored (Wilson 2001). As Wilson contends, this form of surveillance is effective because the power relations underpinning it remain hidden, as it operates through the desire of mothers to do the right thing. However, drawing on Foucault's view that power is relational and multidirectional (Foucault 1979), Plunket nurses themselves not only govern but are governed, operating in environments where their work is shaped by pressures, constraints, imperatives and the tasks of governmentality.

Eight Plunket nurses took part in this focus group. A schedule of open-ended questions structured the discussion. The focus of the groups was on perceptions of caring for migrant women, to elicit the discourses used by the nurses when they talked about their work with migrant mothers. Ethics approval was received from both the AUT University Ethics committee (AUTEC) and the Plunket Ethics Committee prior to data collection. Feedback about the findings was also provided to Plunket in a draft of this article and the presentation of preliminary findings to staff.

DISCOURSE ANALYSIS

Discourse analysis, focussing on the analysis of talk, text and other signifying practices (Malson 1998), is used widely in

5 The term 'white' is used in this article instead of the term 'European or Pākehā', which is more commonly used to refer to white New Zealanders in New Zealand. 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). This term is increasingly used in nursing scholarship (Puzan 2003; Gustafson 2007).

6 The term 'mothercraft' refers to the skill in or knowledge of looking after children.

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nursing and midwifery research. It is concerned with knowledge/power interactions and the social, historical and political contexts in which texts occur (Quested and Rudge 2003, 555). Although discourses 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 and Sonn 2006, 383). In analysing speech made up of the data from a focus group transcribed into text, the goal was not to view the text as a reflection of any participant's 'true' experience (Scott 1991). Individuals are not 'intentional agents of their own words, creatively and privately converting thoughts to sounds or inscriptions' (Crowe 1998, 339), but rather, they reproduce particular versions of the social world. These versions depend on the context of where the texts are produced and have particular impacts. Consequently, the ways in which these versions are produced and the purposes they serve is of analytic interest (Redwood 1999). Therefore, the goal of this research was not to criticise the efforts of individual nurses who work to enhance the well-being of mothers and infants in complex, constraining and challenging institutional contexts, but instead to examine the language practices or 'ways of talking' among health professionals and migrant mothers located at a societal level, that is, culturally available explanations rather than individual thoughts (Willig 2002).

Once the speech in the focus group discussions was converted into the written text, I followed the typical procedures of discourse analysis, sorting texts into unique and contained discourses and attempting to identify speaking positions and relations of power (Parker 1999). The focus group transcript was read through a postcolonial critique, which provided a useful analytical tool to examine the rich context of maternity and relationships between the institution of nursing and its subjects in order to consider the continuity of colonial attitudes and relationships. My analysis focussed on not only the privileging of western knowledges and perspectives but also the ways in which nurses constructed an implicit binary and norm (that is of the ideal maternal consumer who independently and autonomously meets their own needs) against which migrant mothers were measured.

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. I read for fragments of discourse and inflections of colonialism and associated practices such as racism, culturalisation and normalisation in the talk of nurses (Tiffin and Lawson 1994). I considered both how nurses used disciplinary practices to 'constitute' migrant mother's subjectivities in normative ways and how they might generate alternative practices.

FINDINGS

Three main constructions were inductively constituted through the analysis of text and talk. Firstly, the migrant mother was constructed as irresponsible by virtue of being passive and uninformed; secondly, the extended family were constructed as a barrier to the mother becoming responsible; and finally, the baby was constructed as undisciplined as a result of the lack of responsibility of the mother. These constructions implicitly invoke culturally specific white norms and subject positions: the ideal mother should be active, resourced and adept; the extended family should be unobtrusive and malleable; and the baby should be well trained and disciplined.

THE MIGRANT MOTHER AS IRRESPONSIBLE

The ideal maternity service user or 'good mother' is autonomous, with mastery over her self and her life. This mastery enables her to have good health and to make health-related changes as needed, through adhering to professional advice or following the pseudo-scientific advice in mothering books (Moosnick 2004). She has the agency, the will, language and the capability to make her life work, and she makes the right choices:

> 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.

In this excerpt, Sheila constructs migrant mothers as specifically Chinese, a group who are alien and isolated. She proposes that lacking language proficiency presents a barrier to acquiring knowledge, which is necessary for agency. In using the word 'culture', she is positioning western culture as the referent. Surprisingly, given Sheila's view of the centrality of knowledge to agency, she does not facilitate a process of enhancing knowledge acquisition by drawing upon resources such as the provision of interpreters or written materials in other languages. She also does not recognise how poor communication might impact on the quality of care that is provided.

The individualising of social forces is evident in Jennifer's functionalist argument, where the migrant mother is identified as a problem for making poor 'choices'. Maternity is viewed outside of structural hierarchies where people receive different resources, jobs and social privileges (Ringrose 2007):

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> 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.

The self-mastery implied in choosing when and how to have your baby valorises rational unified subjectivity, where making conscious decisions enables self-actualisation and success (Lupton 1995). Fertility and maternal 'choices' are constructed as morally and causally self-contained units of influence, isolated from other biological, material and discursive forces (Harter et al. 2005; Kukla 2006). The woman who controls her fertility inhabits a civilised body that is capable of restraining impulses and bodily processes. Jennifer's excerpt highlights the dominant middle-class idea of motherhood as a project that must be carefully managed, then enhanced with expert knowledge, professional advice and the consumption of the appropriate consumer goods (Avishai 2007). Jennifer invokes norms that reflect the recognised and acceptable routes through which mothers are expected to progress (get a good job, then get married, buy a house and have a child). Jennifer positions herself as an expert arbiter of when it is appropriate to have a baby and positions the migrant mother as incapable of making decisions in her own best interests. Migrant mothers are framed as alien to individually responsible modes of western personhood, being neither in control of herself, her body nor her life, and who further alienates herself by choosing maternity at the wrong time.

THE EXTENDED FAMILY AS A BARRIER TO THE MOTHER'S ACHIEVEMENT OF AUTONOMOUS PERSONHOOD

The privileging of the autonomous, self-determining and independent maternal subject leads to the supportive extended family being seen as a problematic disruption to the development of the mother. Maternal authority figures pose a particular barrier to the nurse's ability to shape the performance of normative maternity, because the mother cannot be isolated from her family:

> 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 discursively constructs the family and the culturally nuanced support that they provide as a problem. Their practical help (including taking care of the baby, co-sleeping and intimate handling) is not valued as nurturing, but considered a barrier to the new mother's independence. The willing displacement of grandmothers to an unfamiliar locale for months in order to provide help is unacknowledged – her role as a significant source of support and information about parenting is considered a displacement of the mother. The mother institutes a communal style of parenting, which is regarded as unsustainable, and unable to be maintained once the grandmother has returned to China. The contest between maternal authority figures shows up as a Chinese grandmother who is difficult to discipline, because the professional authority and expertise as a Plunket nurse cannot be assumed in the grandmother's cultural context. The final sentence of the excerpt reflects how the production of the autonomous individual, unmarked by culture or community (Razack 2004) is valued even in infancy.

INSUFFICIENT INFANT AUTONOMY AS A RESULT OF POOR DISCIPLINARY PRACTICES

In the final construction of migrant mothers through what are taken to be 'good' mothering or appropriate disciplinary practices, nurses view mothers' settling and sleeping practices as constituting their infant's predisposition for autonomy in later life. The mothers' disciplinary practices come under scrutiny as they are viewed as inadequate and not likely to prepare the infant for future autonomy. Mary invokes 'disciplinary power' in giving all 'her' mothers the same advice based on current policy. A settled baby is predicated on an autonomous relationship 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 10 months old, she wants to be fed every 2 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.

The use of such terms of endearment (e.g. 'girl' rather than 'woman' or 'mother') by healthcare professionals reflects a

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power relation, where the health professional is in charge of the encounter. In this familial relationship, the health professional is the parent and the mother the child being cared for. From a postcolonial perspective, colonised culture was viewed as fundamentally childlike or childish, justifying the logic of the colonial civilising mission fashioned as a form of tutelage, which would bring the colonised to maturity (Gandhi 1998).

Using the term 'these' mothers creates a 'them' and an 'us' and further distinguishes between white and non-white women. The following extract highlights the normative constructions of the white in-group. The outsider status of the migrant mother, lacking resources in a new country, legitimates the assimilatory demands of the tolerating dominant culture represented by the Plunket Nurse. The different values held by the mother are seen to contribute to her problems; thus, the woman and her family are responsible for their own misfortune, when the baby is 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.

The unsettled baby reflects the parents' poor disciplinary practices, as seen in their misreading of the baby's behaviour and inability to discern between screaming and grizzling (a non-specific genre of crying which is not to be taken seriously). Mary discursively constructs the migrant mother as unteachable and unable to adhere to disciplinary practices despite being given all the resources. Mary deploys a heroic narrative, certain that her skills and professional expertise will sort out the baby's inability to settle.

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 et al. 1996). Justine references a conference presenter's talk in discussion of the kind of learning that had been influential for migrant mothers:

> 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.

In Justine's excerpt, Plunket institutional practices are redeemed through the migrant mother's recanting of her cultural practices. The two attitudes to sleeping reflect varying emphases on autonomy versus inter-relatedness (Wolf et al.1996). The moralism of child-sleep regulation puts pressure on parents, and 'giving in' to children's bedtime resistance or rocking them to sleep is regarded as overindulging infants. These connections between sleep behaviour, infant autonomy and the moral order of the larger individualistic society figure among the reasons that deep feelings are attached to child-sleep behaviours (Jenni and O'Connor 2005). Two diverse philosophies on infant sleep are evident, the first advocating close physical contact at all hours of the day and night, including co-sleeping in order to foster secure parent–child attachment (Ramos and Youngclarke 2006). The second strategy of 'crying it out', requires that sleep-related crying is ignored by parents and solitary sleep enforced, although reassuring periodic touch and soothing verbal attempts are permitted. Controlled crying is thought to help babies learn to regulate their own sleep and historically reflects the founding dogma of Plunket that 'disciplined, unspoilt babies would grow into health and self-disciplined adulthood' (Denoon 1988, 123).

DISCUSSION

The extension of quasi-market values to all institutions and social action sees good citizens constructed as choice-making subjects, who take responsibility for their health without unduly burdening the healthcare system. In neoliberal wellness discourses, a new concerned, reflexive and empowered citizen is mobilised (Fries 2008). Maternal and child health services are orientated towards this neoliberal hyper-responsible autonomous maternal subject situated in a nuclear family. Responsible and productive, this mother self-manages the intimacies of conception and 'chooses' parenthood on the basis of appropriate material conditions. After the baby is born, she is independent with mothercraft and successfully disciplines her baby. The maternity practices that are legitimated and given support are linked with wider normative modes of middle-class white behaviour (Schmied and Lupton 2001; Wall 2001). Consequently, white mothers are more likely to receive care that meets their needs because their preferences and socialisation closely matches the competencies and resources of service providers.

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Plunket nurses deploy culturalist discourses to account for the difference between migrant mothers and the unmarked implicit norm of the hyper-responsible maternal subject. In contrast with the autonomous liberated white maternal subject, the migrant mother is a suffering victim of her culture, which prevents her from being autonomous and independent. Care is provided to her on the basis of the assumed physical characteristics or ethnic or racial categories of her group and the beliefs held in relation to those assigned labels (Browne et al. 2009). She is synechdocally taken to represent her cultural group, which is reified and assumed to be static and homogeneous (Vertovec 2011). She constitutes a threat to the liberal and neoliberal projects of self-regulation and improvement, which require that a good citizen eschews social relations in order to care for herself. Differences are articulated as a civilisational clash between white liberal values of equality and individualism against the communal values of the 'other' where interdependence and extended families are pathogenic (Razack 2004). However, the relentlessly individualising liberal and colonial clinical gaze cast by the professional on to the migrant mother simultaneously fails to register the unique institutional, social, historical and structural contingencies that shape her life.

Nurses use disciplinary and normalising techniques to inculcate autonomy and independence and liberalise 'other' mothers. The gaze on the migrant (m)other as bearer of difference requires that that difference is shed through assimilation, so that she can become a rights bearing liberal subject (Volpp 1996). This deflects attention from the institutional gap, so that 'the problem' is understood to be located within the migrant mother as an individual and more broadly within her cultural practices. The lack of a reverse gaze leaves the question of the inadequacy of the liberal health system and the hegemony of white maternal norms unanswered.

These findings are similar to a New Zealand study where responsibility for differential health outcomes was displaced from institutions to individuals and their cultural characteristics. McCreanor and Nairn's (2002) critical discursive analysis of the talk of 25 general practitioners with regard to Māori health, found that general practitioners drew upon a limited repertoire of ideas to account for poor Māori health status. Blame was placed on the characteristics of Māori and their culture, rather than power relations inherent in the health system.

The findings suggest that nurses provide care to mothers based on culturally sensitive and culturally competent approaches where care is individualised and the focus is on the migrant as a bearer of difference. Nursing's allegiances to practices conceived through these liberal discourses implicate nurses in the maintenance of racialised oppression. While nursing's political allegiances with liberal feminism have developed through challenging the centrality of patriarchal medicine, this study calls into question the adequacy of liberal feminism in engaging other axes of oppression, including ethnicity, racialisation and social class (Anthias and Lloyd 2002). Liberal feminist discourses thus replicate the colonising impacts of the patriarchal colonial health system, even as they have developed to critique it.

Postcolonial feminists suggest that deploying western epistemic frameworks to explain the experiences of racialised women risks reproducing universalised, essentialised, imperialised and racialised constructions of 'other' women (Mohanty, Russo and Torres 1991; Min-ha 1994; Narayan 1997). Just as second-wave feminists critiqued the single subject of feminism, there is a need to critique the single subject of maternity. Questions about domination and colonisation must involve critique of the privileged subject of feminism – the 'white, middle-class, heterosexual woman' – alongside the critiques of patriarchy in maternity. Knowledge paradigms must consider the historical, cultural, social and economical forces shaping subjectivity (Browne 2001; Jowett and O'Toole 2006). Feminist approaches mindful of postcolonial theory can foreground diverse modes of reproductive heteronormativity and advance nursing beyond a liberal preoccupation with individual rights to more reflexively engage with 'political and religious freedom, choice and self-determination' (Weedon 1999, 3). Questions of difference can then be more nuanced and cognisant of power relations structured by race and ethnicity (Gedalof 1999).

Normative maternity is produced within particular racialised and geopolitical hierarchies invoking broader networks of power including migration. This article, in keeping with Foucault's (2003) theorisation of state racism shows how normalising maternal regimes produce marginalised maternal subjects in relation to valorised standards of maternity. New Zealand's implicit white only immigration policy was amended in 1987 to allow skilled and wealthy migrants to enter the country regardless of source country in order to economically strengthen the nation. Fertility structures migration inflows and selection and the presence of different others require the calculated management of maternity to reproduce national heteronormativity, that is, migration and settlement by people who conform or are assimilable (Luibheid 2008). In these calculations of biopower or the power over life made by institutions and the people who populate them (nurses), state racism is exercised through

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the construction of racialised[7] identities, where whiteness as the implicit norm is associated with being liberated, informed/prepared, and visible difference is associated with being oppressed and backward. The migrant mother's reproductive capacity is managed and regulated for the greater good of the species body. The theme of biopolitical racism is instantiated in the amendment in 2005 of the Citizenship Act 1977 restricting citizenship by birth to only the children of citizens and residents of New Zealand (The Department of Internal Affairs undated).

To ensure the health of the social body, any deviation from white heterosexual norms such as unplanned pregnancy must be managed. However, even when she is judged an acceptable citizen, her body remains an object of continued surveillance and management and her mothering practices governed in order that she become a hyper-responsible maternal subject.

LEGITIMISING UNCERTAINTY AND TROUBLING TRUTHS

A discourse analytic approach provides an opportunity to view how individuals reproduce the social, cultural and historical discourses available (Gavey 1989). These discourses and their ensuing discursive practices must be critically interrogated in order for nurses to identify how the discourses they use are shaped by wider social discourses (Browne, Smye and Varcoe 2005). Cultural safety (Ramsden 1997, 2000, 2002) can assist nurses to scrutinise the power relations that underpin their every day practice, so that they can provide equitable care. The paradigm of cultural safety invites nurses to move beyond individual notions of fairness and equality which merely facilitate adaptation to unjust social structures and instead 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, Smye and Varcoe 2005; Kirkham and Browne 2006). However, Southwick (2001, 2) is sceptical about the power of cultural safety and other multicultural models to shift the centrality of whiteness because cultural safety does not challenge the hegemony of whiteness in nursing and the marginality of 'other' nursing worldviews. In the spirit of extending the transformative potential of cultural safety, I offer three interlinked strategies to disrupt the reproduction of the white centre of nursing care and to decolonise research, theory and practice. Firstly, I advocate for uncertainty as a precondition for the production of knowledge about other mothers and the negotiation of care (replacing the habitual imposition of order). Secondly, I suggest that nurses problematise our social and institutional positions to better identify our complicity in the subordination of others. Finally, cultural safety must be organisationally and/or structurally supported to better support effective intercultural care.

The desire for implementable solutions to remedy the uncertainty and disempowerment nurses and midwives feel when they encounter the 'kaleidoscopic, fluid nature' of difference reflects the dominance of expert knowledge in health professional socialisation and education (Kai et al. 2007, 1771). However, despite the plethora of training and manuals on cultural issues that seek certain solutions, nursing's investment in maintaining the status quo can only be shifted by making uncertainty central and valued in the context of intercultural encounters. Uncertainty could become the precondition for enhancing professional development in nursing and assisting nurses to negotiate responsive and appropriate care. Uncertainty creates openness to unfix the frames or ways of thinking and relating that nurses are locked into and creates a space for negotiation. It is in the negotiating of relationships, rather than the habitual role of creating systemic order out of messy realities, that could paradoxically contribute to working more effectively in an intercultural context (Kai et al. 2007). Institutional support must then be put in place to assist professionals to understand the impact of uncertainty and to value its positive effect in developing culturally responsive practices.

'Single authoritative truths' (Das 1995, 54) limit nursing's capacity for culturally safe practice across difference. Uncertainty provides a starting point for opening up new discursive practices, producing alternative knowledges and transforming formal knowledges. Uncertainty is the precondition for a second strategy that is of 'troubling truths' to allow for the transformation of formal knowledge at a collective level. Problematising one's location and responsibilities within an institutional context imbued with whiteness could facilitate an understanding of 'the ways in which we are complicitous in the subordination of others' (Razack 1998, 59). Being prepared to interrogate the attitudes, knowledges skills and values taken up through nursing socialisation and personal beliefs and how these are influenced by broader historical and social structures is also necessary (Chambers and Narayanasamy 2008). Recognising nursing's colonial past and enduring colonial relationships with 'other'

[7] *Smolash (2009) defines racialisation as a process (rather than a fixed identity), which shapes how human bodies are perceived and to which meaning is inscribed marking them with a particular value. Being racialised is the process of being positioned by and within a complex range of discourses.*

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mothers requires that nurses 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, 10). Reflection and dialogue can assist in the development of a critical and political social conscience by disturbing ostensibly self-evident truths; exploring their origins, their creators and whose interests they serve; and obtaining a range of perspectives on these truths particularly from marginalised and silenced perspectives to reconstruct our practices and our thinking, so that these marginalised and silenced understandings are included (MacNaughton 2003, 3).

Changing practice through the transformation of formal knowledge must go beyond individual intellectual engagement and reflection, to be a collective process that is institutionally supported by a professional community (Greenwood 1998). Given that physical care is prioritised over emotional care by the system, nurses' intellectual work is further constrained by institutional scarcity and efficiency imperatives to do more with less (Varcoe and Rodney 2001). There is a need for collective dialogue where nurses can work together to enact their collective values and recognise the embeddedness of practice within a broad socio-political context (Varcoe, Rodney and McCormick 2003). This cannot simply be an individual decision for nurses to become more 'culturally safe', but must be a dialogue among nurses that is effectively supported by organisational and/or structural changes that recognise cultural issues as fundamental to adequate care.

Ultimately, what is required is a profound political shift that involves a transition from the liberal emphasis of measuring equality through inputs towards generating equity in outcomes. Such a shift in the philosophy of health practice would recognise that different investments are required to negotiate care and achieve equitable outcomes (Kai et al. 2007). Cultural safety offers a transformative framework to explore the uncertainty of culture and can help develop 'a more human and emotional investment to connect successfully with those whose world differs from one's own' (Kai et al. 2007, 1772). Such an investment seems to be fundamental in creating nursing practices where all women and their families can be empowered.

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