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**‘婉’与‘通’: Migrant Ethnic Chinese Mothers’ Intercultural  
Communication Experiences with Their Maternity-Care and  
Health Providers in New Zealand**

A thesis

submitted in partial fulfilment

of the requirements for the degree

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## Abstract

In the transition to motherhood after migration, ethnic Chinese mothers in New Zealand experience different health and support systems compared to the ones they have knowledge of in China. At the same time, New Zealand maternity-care and health providers find communicating with Chinese mothers a challenge as their knowledge of childbirth, culture, and communication is different to that of Chinese mothers. In examining the contested discourses of maternity care in New Zealand, and the lopsided dimensions of power embedded in them, this thesis focuses on culture and communication as crucial components of the processes and practices of childbirth.

As a migrant ethnic Chinese mother in New Zealand, I weave my experiences with those of others to understand how Chinese mothers go through childbirth. In parallel, I speak to maternity-care and health providers in the country and observe how they deliver services to this group of women, their children and their families. In doing so, I unravel the communicative processes of socialising Chinese mothers and the role of culture in influencing Chinese mothers' understanding and reactions towards '娩' [childbirth] and '通' [communication] with their maternity-care and health providers in New Zealand.

The key research questions underpinning my study on understanding and interpreting the intercultural communication experiences between Chinese mothers and their maternity-care and health providers include:

- What are the cultural values of Chinese mothers towards childbirth and communication, and how do these values affect their responses to New Zealand's mainstream discourses in the larger health context;

- What are the perceptions and experiences of Chinese mothers during health communication;
- What is the role of power in influencing their health communication;
- How do Chinese mothers (re)negotiate and (re)construct their values and knowledge of childbirth and communication in interactions with maternity-care and health providers and other groups; and
- What is the role of health management structures and practices in facilitating the childbirth process for Chinese mothers and their families?

I develop a theoretical framework – a matrix of difference – which encapsulates key tenets of social constructionism, postcolonialism, and Third World feminism. The matrix guides me to go beyond interpreting the superficial layers of intercultural communication experiences into exploring the complexities and tensions of these experiences within socio-cultural, gendered, and postcolonial contexts. Conceptions of language, values, agency, and identity emphasised in the matrix help map my research analysis.

I use the snowball technique (Patton, 2002) to invite participants, including ethnic Chinese mothers-to-be and maternity-care and health providers. I interview them, observe communication interactions among them and keep a reflexive journal of my journey to record the participants' and my own stories of the cultural and communicative dimensions of pregnancy, childbirth, and maternity health care. To describe, explain and critique how dominant discourses influence socially shared knowledge (van Dijk, 1998), I use the critical discourse analysis (CDA) approach to analyse texts, discourses, and discursive

construction (Fairclough, 1995; 2003).

The research findings demonstrate that values in the discourses of Chinese maternity and health care systems are considerably different from those of New Zealand's maternity and health care systems. Whereas Chinese discourses appear to advance medicalisation, safety of childbirth and directive communication between doctors and patients, New Zealand discourses tend to promote natural childbirth, consumer culture, and partnership-based communication between health customers and facilitators. Meanwhile, different languages and cultures express subjective realities and different expectations towards a trusting relationship. As a result of these differences, many Chinese mothers experience challenges of fitting in with mainstream New Zealand discourses. These mothers struggle with accessing information and participating in decision making and many feel 'othered' due to language barriers, different values of childbirth and communication, and different cultural expectations.

Dominant discourses in contemporary New Zealand maternity and health care systems tend to marginalise and suppress 'other' structures of knowledge production. In critiquing these taken-for-granted mainstream discourses, my thesis makes a case for a more diverse communication climate in the maternity health care sector that incorporates multiple and subjective worldviews, languages, values, knowledge, and identities.

By integrating strands of social constructionist, postcolonial, and Third World feminist approaches, this research makes theoretical, methodological, and practical contributions to the study of health communication and intercultural communication. These contributions are valid not only in the health sector but can also be transferred to other relevant sectors in which people and institutions have to deal with intercultural communication challenges.

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## CHAPTER 1: A REFLEXIVE INTRODUCTION

Do you think, because I am poor, obscure, plain, and little, I am soulless and heartless? You think wrong? I have as much soul as you, – and full as much heart! ... Just as if both had passed through the grave, and we stood at God's feet, equal, – as we are! (Brontë C., 1847, Ch. 23, p. 257)

I am a researcher who studies Chinese mothers' intercultural communication experiences in the New Zealand health communication context. That means I read about migrants' health communication experiences, meet Chinese mothers face to face, listen to their childbirth and communication stories, and write them down. This research process seems to be very rational but, in practice, I have realised that rationality is hard to maintain. My research journey has been filled with emotional struggles, introspection, and critical reflection. As Fonow and Cook (1991) point out, reflexivity allows researchers to be introspective in order to reflect critically and analyse the research process in relation to participants.

I am also a migrant ethnic Chinese mother living in New Zealand. That means I was born and raised in Chinese society, encouraged to socialise into my adopted New Zealand culture, and fit into the mothering identity after giving birth to my children. My transition to motherhood after migration has involved in many changes, adjustments, and challenges. I acknowledge that my perspective as a migrant ethnic Chinese mother cannot be isolated from the perspectives of other Chinese mothers in my chosen field of research. Therefore, I bring my values, emotions, reactions, and contexts into this research journey in order to establish a reflexive research attitude and a reflexive relationship with my

participants.

### **“I am a Migrant Ethnic Chinese Mother”**

At 3 a.m., 26 July 2007, my first contraction started. I was not sure if it was a real contraction or just my imagination. I was already five days overdue with my baby, my first precious baby. I woke up my husband to tell him that I could not sleep a wink because I felt our baby was coming. “Really? What should we do?” asked my husband. How could I know what to do? We looked at each other in speechless despair. “We should call the midwife,” he broke the silence. But I quickly dismissed his suggestion. This was not China. I had to remember that. The midwife had often reminded me not to call her at midnight if it was not urgent, as a first baby would never arrive soon after the first contraction and she needed to have had a sound sleep in order to gain energy before helping with my delivery. So we quietly waited, feeling the rhythm of my contractions and expecting the dawn would come soon.

At 7 a.m., 26 July 2007, I finally called the midwife. She asked to see me in her office in four hours. “Better than nothing,” I mumbled to myself. I told my parents that they might see their grandchild that day. They had been staying with us for almost a month waiting to witness this critical moment and to help me with “sitting the month”, which explains why they were more nervous than me. Four hours waiting at home was not so hard to endure. With every contraction, the pain faded away immediately after the peak. We arrived at the midwife’s office on time. After an internal examination, the midwife gave me two pieces of news. The good news was that our baby was ready to see the world today, but the bad news was that my cervix was only one centimetre open. As a result, we were sent home to wait. “Why did your midwife send us home?”

wondered my Mum. “If you were in China, you would have been kept in the hospital!” my Dad said, raising his voice. “Dad, but I’m not in China,” I tried to explain, “everything here is natural. Women have to stay at home as long as they can in the first stage of labour.” Not expecting them to fully understand the processes here, I saved my energy by not going into any further explanation.

At 4:30 p.m., 26 July 2007, my midwife called me. After five hours of recurrent pain and anxiety, I finally received her call. She asked me to go to the birthing centre for another examination. We knew it could be the moment. When we arrived there, they suggested breaking my waters to accelerate the dilation of my cervix. I agreed. By then the waves of pain were coming one after another and growing stronger each time. Although it was very painful, I was often asked to change my position. There were several times I wanted to shout to the midwife, “I can’t do it!”, but I didn’t. My husband became my only source of support, even though his arms were tortured by my uncontrollable hands. “My dear, I know you are in great pain. Every woman has been through this. You are doing a great job,” comforted my midwife, “Now I need you to make a decision. I have a student doctor here who wants to observe your labour. It’s part of his study and I believe the experience will help him a lot. But I do need your permission.” I looked at my husband. He nodded. “Can I say no? He’s a man.” I tried to clear my mind – “I can’t say no. I don’t want to embarrass her. My midwife was managing a critical moment of my life. I’ve never said no to her. Not even this time.” I smiled and nodded to the midwife.

By 8:30 p.m., 26 July 2007, it was over. My eyes were full of tears but not because of the joy of seeing my baby born. Rather, I was relieved that the entire labour was over. I used my frail hand to cover myself well with a sheet, and watched as the student doctor stepped out of the room to inform my parents.



Cuddling the baby, my husband blurted out, “I think having one child is enough.” “You really think so?” I asked. “Or if we have a second one, we should go for a caesarean,” said my husband. “Can we?” I questioned. The room was soon full of joy with my parents coming to see their precious grandson. Perhaps I was the only one lost in the bitter experience of this first birth.

I was 27 years old when I became a new mother in New Zealand. I was, at the same time, working towards the completion of my master’s dissertation, which centred around the socialisation processes of Asian migrant workers in New Zealand banks. I was always interested in studying the the experiences of migrants in Western society. This interest was carried into the structure of a proposal for my PhD study on the experiences of migrant ethnic Chinese mothers in New Zealand society. My choice of this research topic was not without thought.

Through my first childbirth processes, I had opportunities to meet up with other mothers, mostly ethnic Chinese mothers, and listen to their different childbirth stories. But when I tried to find some literature relating to migrant women’s birthing stories in the Western world, I could find very little. The existing Western literature showed much interest in physician-patient communication in general. While some of the literature directed readers’ attentions to non-Western migrant patients’ health experiences in the Western health settings, migrant women’s experience in the Western maternity and health care systems was vastly underdeveloped. I suddenly realised that I could write an academic research study on Chinese women’s childbirth experiences in New Zealand. Chinese women deserved a chance to tell their stories. Readers also deserved a chance to listen to and learn from stories they had never heard before. I imagined myself as a “bridge” connecting Chinese women to the Western world.

The image of a “bridge” properly interpreted my identities of being a migrant ethnic Chinese mother while also reaching out to the New Zealand culture and values.

My identities and experiences in New Zealand convinced me to finalise the decision to research Chinese mothers’ intercultural communication experiences with New Zealand maternity-care and health providers. I was born in one of the wealthier Eastern cities on the mainland of China. Pursuing further education and fulfilling my parents’ wishes, I joined the student migration army in 2001. The first few years of migration to New Zealand tasted of much bitterness. Through trying to survive study pressures, the language requirements and different cultural expectations, I had gradually learnt to tolerate stereotypes and prejudices stemming from my identity as a Chinese student. I read the contempt in Western students’ eyes when I was persuading them to accept me as their team mate in completing an assignment. I turned my face away when I was verbally attacked by some young men who shouted, “Go back to your country!” I smiled to a bunch of kids asking me whether I was Japanese. Such experiences ran contrary to my previous expectations of New Zealand as being 100% pure and its promotion of nondiscriminatory immigration policies. Luckily, I was not knocked down by these bitter experiences. Rather, I studied harder and worked harder to assimilate myself into the New Zealand culture.

After shifting my role from a student to a mother, I felt struggles, stress, and anxiety deeply because I realised that I would never be treated as the same as other Kiwis. My English was not fluent enough to improve my social interactions with maternity-care and health providers. My Chinese childbirth values and expectations were not appreciated in the New Zealand maternity and health services. And my communication style with health providers was

sometimes seen as a weakness of Chinese women in the eyes of Western people. I was struggling with ambivalent emotions – from one perspective, I was eager to be the “same”, to be treated equally; from the other, I strove for “difference”, for getting my different identities and values acknowledged. Such ambivalent feelings motivated me to find out what happened to my female compatriots. During their pregnancy, labour, and after care in New Zealand, were they experiencing and feeling the same as me? In a manner of speaking, my research journey was initiated with a mix of intellectual and emotional drivers, which in turn, explains my interpretations of the findings, relationships with the participants, and identities involved in this journey.

### **Start of the Journey**

To reach out to Chinese pregnant women in communities, I targeted playgroups, Chinese mothers’ gatherings organised by Plunket<sup>1</sup>, and my social networks. The details of my research were explained to the potential participants and fliers were distributed to them. Many women showed their interest in my research, including those who were planning a baby. One woman in particular called me a few days after she found out she was pregnant with her second baby. Joy permeated her voice down the phone. Commitment to participate in my research was soon confirmed. Looking into the future of my research journey, I felt confident, as it seemed there was no difference between recruiting a pregnant Chinese woman and a worker at a New Zealand bank. What happened weeks after proved that I may have been somewhat naïve.

The woman did not contact me as we had scheduled, so I called her. It

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<sup>1</sup> Plunket is New Zealand’s foremost organisation dedicated to the wellbeing of children under five. It is served by both professionals and volunteers and is partly funded by the government and partly by sponsoring organisations.

was not hard to hear the sadness in her voice on the phone. She kept saying sorry to me as she could not engage in my research anymore. She had had a miscarriage which had knocked her down both physically and emotionally. I was speechless when I found out what had happened to her. As a researcher, I was fully prepared for any participant to withdraw at any stage of the project. A worker at the bank could, without any explanation, always be free to inform me that s/he was unable to be involved. But this time the withdrawal was beyond my expectation. What was I supposed to say to her? I had no reason to blame her for failing to contact me on time. I understood how hard it was to tell me –strictly speaking a stranger – that she had lost her baby. I even started feeling guilty hearing her saying sorry to me for being unable to participate. As a woman and a mother, I sympathised with her. My body started feeling as vulnerable as hers and my voice became as weak as hers. I said to her that I was sorry to hear that she had been through such a miserable experience. I asked her to take care of herself and told her that I was always available if she needed any help. I avoided mentioning anything related to my research because stressing my researcher role could do nothing at that moment.

This unexpected experience urged me to rethink my research journey and foresee the difficulties in the future. I began to be aware of any women's childbirth circumstances that were beyond the scope of my research. I started collecting maternity and health leaflets and carried them with me when meeting the women who might find the leaflets useful. The subsequent recruitment of women participants went fairly well. Some of my friends, their friends, and a few mothers I met in the playgroups contacted me showing their willingness to participate in the project. They also referred me to their midwives who helped me distribute the fliers and they

kept some for themselves. Recruiting midwives to participate in the project was much easier than inviting other health care providers such as hospital doctors, General Practitioners (GPs) and Plunket nurses. I attributed their willingness to the fact that independent midwives were self-employed so that they enjoyed more freedom to make decisions and manage their time. When accessing other health care providers, I encountered challenges such as the facilitator of the organisation trying to dominate my data collection process, or the health care provider who agreed to participate but limited the interview time due to his high workload. Although these challenges affected my recruitment of participants and delayed the data collection, I was not particularly distressed. As a researcher, I foresaw these challenges knowing they commonly occurred in any research process. As a researcher, I knew how to handle the problems rationally to reach my research goals. However, the theme of this research was destined to be a journey which could not be rational, especially when I found out that I was pregnant with my second baby.

I was pregnant in the initial stage of the research journey. Compared to the last experience, I felt happier and more relaxed this time. Learning from the first childbirth experience, I knew where and how to access midwives and other health care providers; I remembered most the English medical terms which had seemed to be Greek to me the last time; and I was more familiar with the maternity and health care procedures and practices in New Zealand. That way, I felt more confident, knowledgeable, and powerful when contemplating my second childbirth experience. Deep down in my heart, I even rejoiced secretly that my pregnancy would draw me closer to my women participants who were also pregnant. With that closeness, I expected the mothers to share more authentic stories with me and to disclose their concerns and expectations without hesitation.

Yet at the same time, I was concerned whether my image as a pregnant woman would be in contradiction with my image of a researcher. Particularly when I was contacting maternity-care and health providers, would I be overlooked and treated as one of their clients? Carrying these complex feelings, I carried on my research journey interviewing mothers and maternity-care and health providers, observing their communication, and reflecting on my intrinsic involvement in the journey.

### **During the Journey**

It would be the second time meeting this woman who I had interviewed two months previously. How could I forget her? She was different from other mothers I had interviewed. She and her husband were newly married. Migrating from a Southern province of China, the woman had been living in New Zealand for only a few months. When I was interviewing her at her home, I was surprised to see that she was living in such a big family, with her husband, parents-in-law, and even grandparents-in-law. This was different to other mothers who were separated from their extended family members during pregnancy. My greatest surprise was when she identified herself as a health care provider. Having worked as a nurse in paediatrics in a Chinese hospital, she was competent in maternity and medical knowledge. However, the woman was scared about her first childbirth experience in this adopted land. She was scared that her medical knowledge was useless in contacting New Zealand's maternity and health care services. She was scared her English competence was insufficient to support her communication with New Zealand maternity-care and health providers. She told me that she trusted one Chinese friend, her only friend, and hence she relied on that friend to take her to a midwifery centre to confirm her

pregnancy, look for a midwife, book her in for the first antenatal visit, and access information on childbirth. I could sense her loneliness and panic during the first interview. As a new migrant, she hardly knew anyone other than her family members. So when I asked her permission to accompany her on a visit to her midwife for my research observation, she happily agreed. She said that she would be more relaxed if I was there, but I was wondering how much I could help or, in other words, to what extent I was allowed to help.

Now I was sitting in her midwife's office waiting for the woman and her husband to arrive for their antenatal visit. Details of my research had been explained to the midwife over the phone and she had no problem having me there to observe their interactions. I did not feel uneasy at all as I had already done three interviews and two observations by this stage. The midwife and I were having an easy conversation on my research and pregnancy before the couple showed up with an apology. I quickly moved my chair into the corner of the room. Today I was a researcher observing their interactions, while they had to take a leading role. The woman smiled and nodded to me before she left the room with a urine test sheet. Her husband quietly settled himself into a chair while the midwife was writing notes in her casebook. Time ticked away. No one blurted out a word. I started feeling uneasy in this frozen atmosphere, which was drastically different to the one before the couple arrived. I tried to control myself so as not to break this atmosphere because I was supposed to be invisible in this observation.

The appearance of the woman did not improve the atmosphere as I had expected. The midwife routinely checked her urine test sheet, blood pressure, and did a tummy check. Simple questions were followed up with simple answers – “okay?”, “yes”, “good”. Suddenly, the midwife asked, “Swelling

feet?” “What?” the woman was confused. Her eye contact swept over her husband and finally landed on me. I hesitated and really hoped that I was invisible in her eyes. The midwife pointed to the woman’s feet and asked again, “Swelling feet?” The woman withdrew her eye contact from me, looked at her own feet, and replied, “Oh no.” I was relieved that she understood the question without my help, but at the same time, I felt sorry for not giving the woman a hand when she was panicking. During the rest of the visit, there were many times when miscommunication occurred due to a language barrier. The atmosphere in the room became intense, but I could do nothing about that. I felt disappointed in the midwife who could have shown more support and care for the woman and her husband. Meanwhile, I felt pity for the woman who was again lonely and panicky as she had been in our first interview.

A 15-minute visit felt as if it had lasted for hours. I let go of all the tension and pressure after hearing the midwife say this visit was over. I joined the conversation with them, chatting about the midwife’s family and explaining the medical terms in Mandarin to the couple who had been confused about them before. We laughed and everyone looked satisfied with this improved atmosphere. Before getting into my car, I waved to the couple who were about to leave as well. I shouted to the woman and asked her to give me a call if she needed further help. She smiled and replied, “Thank you.” I was not sure whether my reaction after the visit was a compensating gesture to the woman for not helping her during the visit, as she had counted on me. But I was sure of one thing: I had to think through my research identities, roles, and relationships with my participants.

In proceeding with my research journey, I had gradually realised that I was no longer restricted to the researcher role but had hybrid identities. My identity



as a researcher was quite distinct when I was interviewing maternity-care and health providers. They barely noticed my pregnant belly, and efficiently completed their interviews. However, when contacting Chinese women and their families, my identity as a researcher coexisted with my other identities – an experienced mother, a pregnant woman, an ethnic Chinese migrant, and a friend of some of the women. My hybrid identities influenced my reactions, in particular emotional reactions, towards other women's feelings and behaviours.

I empathised with four of my participants who had minor depression after giving birth to their babies. I provided them with relevant information and encouraged them to take part in playgroups and other social gatherings. I was concerned about two women who had low placenta and risks in pregnancy. I often called them to make sure that they were well. I felt sorry for a woman and her newborn babies living in poor conditions. I helped her ask around my friends for house renting information and I was happy seeing her and her family later move to a new home in a better condition. My identities also determined the different roles expected of me by my participants. Along with being a researcher, I sometimes acted as a consultant offering maternity and health information to new migrants and new mothers. Sometimes I took the role of an interpreter to facilitate the communication between the mothers and their maternity-care and health providers. At other times, I was a friend to the women so that they could trust and count on me when they were experiencing challenges and emotional struggles in their childbirth processes.

I recall seeing the happiness on the face of the woman I had felt sorry for in the first observation for my project when she was cuddling her baby at a GP's clinic. I felt that happiness too as my second baby had been born four months earlier. The woman wanted to see my beautiful one. I smiled and invited her to

visit me at home the next week, and she accepted. From what I observed, the couple's English was not much improved; however, this time they were fully prepared. They had found an interpreter, an ethnic Chinese acupuncturist working in the same medical centre, to facilitate their communication with the GP and the nurse for the immunisation. They did not demand my help anymore though I was willing to help them this time if they requested. The atmosphere of this visit was more relaxed than the last time, and the woman felt more comfortable surrounded by people who had gained her trust. Fortunately, I was one of them. When the visit was over, the woman and her husband waved to me and said good-bye. Before getting into their car, the woman remembered something and said to me, "I will give you a call before visiting you next week." "Sure, thank you," I smiled and watched them leave. I was sure that I would see her again the next week. I was also sure that I would record her stories alongside my thinking and feelings at the end of my research journey.

### **End of the Journey**

Facing the pile of data which I have collected from the participants' interviews and observations, I remind myself of the need to speak for the participants to acknowledge their stories. Yet at the same time, I would also like to speak from my perspective and to consider my inner involvement in the research journey. The notion of speaking from somewhere encourages the researcher to stand on the same level as the participants by considering the researcher's own emotions, feelings, and contexts, and seeking out equal and collaborative research relationships (McConaghy, 2000). Developing a reflexive understanding of the researcher's context also builds up "between the lines' knowledge" that is advantageous for research findings (Prichard, Jones, &

Stablein, 2005, p. 213). Recalling my research journey, I was experiencing pregnancy, labour, and after care: the same processes experienced by my participants. I was reflecting on my intercultural communication experiences with my maternity-care and health providers, just as my participants were reflecting on their own. However, our experiences of childbirth and reflections on the communication with maternity-care and health providers were relatively different.

My second childbirth experience was much better than the first time, and the second-time communication with my maternity-care and health providers went well. I attribute this improvement to my established knowledge and experience based on the first childbirth experience in New Zealand. My confidence of being an experienced mother influenced me to use my power to make a choice and manage fairly equal relationships when communicating with maternity-care and health providers. Reviewing my research data, I found that only a few Chinese mothers were like me who acknowledged my rights, power, and position this time in contacting the New Zealand maternity and health care services. Most of the mothers, like me in my first childbirth experience, were still suffering from being assimilated into New Zealand's dominant discourses regarding the values of childbirth and communication. Those mothers with stronger cultural identities and expectations were constantly being reminded in their intercultural communication experiences that they did not belong to the dominant culture, and their alternative knowledge of childbirth, culture, and communication would never become part of the centre-stage of knowledge production in New Zealand. Bringing with me a migrant ethnic Chinese mother's perspective, I expect other Chinese mothers to use my project as a platform to voice their perspectives and, in turn, to influence the existing structures of knowledge production in the New

Zealand maternity and health systems.

This longitudinal research contributed to the development of my relationships with the Chinese women and their families. I listened to the women's concerns in pregnancy as I listened to my own concerns. I visited the women after their deliveries with elaborate gifts, and shared their happiness and birth stories. I still keep in contact with most of the women and their families, watching their babies start crawling and then walking, as I am watching my own babies learn to grow. My relationship with these women has shifted from a merely researcher-participant relationship to one of close friendship. My role as a researcher ended when my research journey ended, but my role as a friend is carried into the future.

The topic and the nature of this project determine the difficulties of remaining objective in the research journey. Maintaining the identity of a rational researcher is not what I want to achieve. Rather, I have made use of hybrid identities stemming from my historical, social, and cultural backgrounds. Acknowledging the researcher's own identities, emotions, and contexts, and engaging the researcher with the participants and in the research journey are the nature of reflexivity (Burr, 2003). I adopt the approach of reflexivity to shed light on Chinese mothers' intercultural communication experiences with their maternity-care and health providers because I have been emotionally involved in this research, and I have been affected by conducting this emotionally-charged project.

Before moving from this reflexive introduction to the formal introduction to my thesis, I want to recall the quotation which is used at the start of this chapter, a quotation from a mother's narrative in the interview regarding her relationship with her midwife. She could remember only a few words in Chinese and I later

traced the words back to the original quotation from Charlotte Bronte's novel *Jane Eyre*. In relation to my research, the quotation reminds us that while we may look different, think differently, or do things differently, inside we are all equal.

## CHAPTER 2: THESIS MAP

Ethnic Chinese migrants have become a significant population in New Zealand since New Zealand encouraged migrants from China and other Asian countries and the number of Chinese women is on the rise, according to Statistics New Zealand (2006). This increase has had an effect on the delivery of maternity and health care services to this group of women, their children and families. Coming from a different cultural background and speaking a language other than English, Chinese mothers may encounter challenges when communicating with their maternity-care and health providers in New Zealand. Delivering maternity and health care services to those mothers may also cause challenges for maternity-care and health providers because the New Zealand health discourses may conflict with those of Chinese mothers. Therefore, in this thesis, I investigate Chinese mothers' intercultural communication experiences with maternity-care and health providers in New Zealand, and also the role of culture in influencing Chinese mothers' understanding of childbirth and communication.

In exploring concepts of childbirth, culture, and communication, I was eager to speak with Chinese mothers who would voice our stories, from our knowledge, in our ways and language. Insomuch, I framed the thesis title to start with Chinese characters: '娩' 与 '通'. Each character represents a variety of meanings. The character '娩' (*Mian*) embraces the meanings of childbirth, delivery, and conception. The left component of this character means woman, indicating that childbirth is a woman's business. In ancient China, '娩' (*Mian*) was formed in a phrase with '难' (*Nan*) denoting that childbirth was a disaster for every woman (CEEC, 2009). The basic meaning of the character '通' (*Tong*) is

getting through to the other end but, more significantly, this character embraces the meanings of communicating, building a relationship, getting a message across, reporting, providing information, and describing someone who is capable of knowing and doing things (CEEC, 2009). By connecting these two characters with ‘与’ (*Yu* which means ‘and’), I delve into the tensions between childbirth and communication, with a consideration of culture in influencing Chinese mothers’ and New Zealand maternity-care and health providers’ values of childbirth and communication, their identities and identification, and the power relations within intercultural and maternity care settings.

In this thesis, I define migrant ethnic Chinese mothers as women who migrated from the People’s Republic of China, including those from Mainland China, Hong Kong, Macao, and Taiwan. They would experience childbirth and transition to motherhood after migration in New Zealand. Maternity-care and health providers are identified as those who had direct contact with Chinese mothers and/or had previous experiences of helping Chinese mothers to get through their childbirth processes in New Zealand. The group includes independent midwives, hospital-based midwives, GPs, obstetricians, anaesthetists, Plunket nurses, public health nurses, and other hospital and community health care providers. I next introduce the research purpose and objectives which contribute to the theoretical and methodological development of my thesis.

### **Research Purpose and Objectives**

The purpose of the research is to examine 1) the intercultural communication experiences of Chinese migrant mothers, and 2) how cultural practices in childbirth affect communication between migrant ethnic Chinese mothers, and their maternity-care and health providers in New Zealand. There

are five objectives I intend to fulfil:

- To identify the cultural predispositions of Chinese mothers towards childbirth and communication, and how these predispositions/values/beliefs affect their responses to New Zealand's mainstream discourses in the larger health context;
- To explore the perceptions and experiences of Chinese mothers in terms of their intercultural communication with maternity-care and health providers;
- To examine how power influences communication between Chinese mothers and their maternity-care and health providers;
- To understand how Chinese mothers (re)negotiate and (re)construct their beliefs/values/practices around childbirth and communication in interactions with maternity-care providers and other groups; and
- To investigate the role of health management structures and practices (e.g., maternity, health care agencies and other supportive communities, such as birth centres, medical clinics, hospitals, Plunket) in facilitating the childbirth process (pregnancy, labour, and postpartum) for Chinese mothers and their families.

### **The Rationale of the Research**

This research is important addition to the academic literature on health communication and intercultural communication. I foresee the benefits it provides to migrant women, maternity-care and health providers, and maternity and health care agencies. I also identify myself as an “insider”, one of the migrant ethnic Chinese mothers. So in what follows, I explain the theoretical



and practical contributions of the research. I then discuss how my personal experiences motivated me to explore this research area.

### **Importance of the Research**

Several researchers (e.g., Burke, Earley, Dixon, Wilke & Puczynski, 2006; Cegala, 2006; Dutta-Bergman, 2005; Ellingson, 2005; Shouksmith, 1978) have shown interest in physician-patient communication in the Western health systems. A growing number of communication scholars (Cegala, 2006; Dutta-Bergman, 2005; Dysart-Gale, 2005; Johnson et al., 2004; Kreps & Kunimoto, 1994; Pauwels, 1995; Ulrey & Amason, 2001) have also started to explore non-Western clients' experiences of Western health communication. However, only a few studies have focused on migrant women's childbirth experiences in New Zealand and their communication with Western health staff (e.g., DeSouza, 2005; 2006a; 2006b). My research is thus important in that the intercultural communication experiences of Chinese mothers and their maternity-care and health providers in New Zealand is an area that is relatively underdeveloped. The study builds on existing knowledge of communication between Chinese patients/clients and their health care providers, with particular reference to the childbirth context.

This study strengthens the cultural dimensions of the field of health communication which has traditionally been characterised by quantitative, survey-based questions, statistics, and charts. It contributes to the small but growing literature that puts a sharper focus on culture in health communication (see e.g., Dutta, 2008; Dutta & Zoller, 2008) and pays attention to authentic and multiple voices of patients and health providers within their subjective contexts. At a theoretical level, the thesis draws on the framework of a matrix of difference that I construct by pulling together insights from social constructionism,

postcolonialism, and Third World feminism. My use of reflexivity as a methodological approach too is not commonly deployed in current health communication research.

The thesis also makes an important intervention in the field of intercultural communication which, in its preoccupation with the cultural binaries of the East and the West, men and women, and cultural differences in the business practices of people of different nationalities, often loses sight of the complexities in-between. The thesis makes an effort to train the spotlight on the “spaces in-between” (Nelson-Marsh, Broadfoot, & Munshi, 2008, p. 313). The study, therefore, makes a contribution to the literatures of both health communication and intercultural communication but does not necessarily fit exclusively in one field or the other.

The research also provides practical benefits to a variety of constituencies within the community, such as maternity and health providers, local health agencies and communities, and Chinese mothers. The research outcomes offer opportunities for local maternity groups, health care agencies, and associated industry providers to understand the challenges Chinese mothers face when communicating with health professionals and in health situations. In a practical sense, the research outcomes offer insights into the challenges faced by maternity-care and health providers and local health care agencies as they communicate with people from other cultures more generally.

The beneficiaries of the research are not only limited to the health industry. Education and finances, for example, are also essential services that migrants need to engage with, and communication challenges can be more evident as migrants may not be familiar with the Western system and procedures in these industries. Thus, people and agencies that need to cope with intercultural communication

challenges in these industries also benefit from the outcomes of this research.

### **Personal Rationale**

With a non-English-speaking background and different cultural beliefs, many ethnic Chinese migrants have experienced significant challenges, and in particular, communication barriers in New Zealand. Lack of English fluency is only one of the causes of these communication difficulties. Other causes for these misunderstandings, miscommunication, or even communication breakdown can be attributed to different cultural beliefs, values, and practices. The Chinese culture, for example, values the family, the collective, status, and hierarchy (Gao & Ting-Toomey, 1998; Hofstede, 1991; O’Keefe & O’Keefe, 1997). Chinese tend to be seen as more passive, polite, and uncritical in communication in the eyes of many Western people (O’Keefe & O’Keefe, 1997). Although these descriptions of the Chinese culture tend to point out that the Chinese communicative behaviour contrasts significantly with Western values that emphasise individuality and autonomy, they miss the complexities within the Chinese culture and the Western culture that is critiqued in my research. The communication differences should take into account hybrid identities, cultures and experiences.

These communication differences become more evident when Chinese migrants need to contact essential services such as health, finances, and education. The health sector, for example, is an environment that understandably can become stressful for any individual regardless of ethnicity, especially for Chinese migrants who may feel unfamiliar with and confused by the protocols (Pauwels, 1995). Although some Chinese migrants may have an adequate knowledge of English, they “may not always be familiar with the communicative rules and routines of

English” (Pauwels, 1995, p. 167). In addition, most Chinese migrants are unfamiliar with the New Zealand medical procedures, and they hold different cultural assumptions about symptoms and treatment.

It is not surprising, therefore, that Chinese mothers, who are unfamiliar with New Zealand’s procedures of childbirth and the postpartum, face challenges in communicating with maternity-care and health providers. Also, maternity-care and health providers face challenges in dealing with miscommunication that may result from differences in attitudes towards the practices of childbirth, while at the same time providing these services to Chinese mothers. The challenges faced by mothers and health care providers, and my experience of being a migrant ethnic Chinese mother in New Zealand, have been the motivation to conduct this study.

I was born in China and came to New Zealand as an international student for educational purposes. As a Chinese migrant, I can now identify with the Chinese mothers. After the delivery of my first baby in New Zealand, in 2007, becoming a new mother and feeling unfamiliar with the New Zealand discourse on health and labouring procedures, I experienced, and still experience, uncertainty, stress, and anxiety. I used to experience miscommunication with my midwife and GP because I could not explain the symptoms in the proper English medical terms. I got used to saying “yes” to almost all the requests from the health carers, such as being observed by a male student doctor during my labour, due to my Chinese value of compromise. I changed my GP because she always made decisions on my baby’s health issues without carefully listening to my explanations. Because of holding different cultural values and beliefs, I encountered some communication difficulties when I was interacting with health carers and professionals. I found that good communication with maternity carers,

health providers, and other experienced Chinese mothers played an important role in alleviating my isolation and stress. This experience motivated me to find out what happens to other Chinese mothers during their pregnancy, delivery, and aftercare in New Zealand.

My experience of being a migrant ethnic Chinese mother and communicating with my maternity-care and health providers in New Zealand drew me to find out about the intercultural communication experiences of other Chinese mothers with their maternity-care and health providers. This area has not been studied, and limited research has focused on migrant women's maternity and intercultural communication experiences in a Western country. Therefore, the research contributes to the academic literature in both health communication and intercultural communication, and it also benefits migrant women, maternity and health care providers, and their agencies.

### **Preview of the Thesis**

This thesis is organised into 10 chapters. As outlined already, the first chapter, 'A Reflexive Introduction', records my inner involvement in the long research journey. I recall my childbirth experience in order to discuss my identity as a migrant ethnic Chinese mother. I use examples of my engagement with some of my participants to unveil challenges, emotional struggles, and my hybrid identities, roles and relationships with the participants during the journey. What I have changed and learnt from my participants and the project itself are also recorded in the progress of the journey.

This 'Thesis Map' chapter introduces the research, its purpose and objectives, and the rationale for conducting the research. It is followed by a chapter on 'Migration and Maternity in New Zealand and China' that sets out the

context for the research by reviewing New Zealand's historical migration patterns and the demographical changes in the country with the arrival of newer Asian migrants, in particular ethnic Chinese migrants. A historical context of Chinese migrants and birth-related statistics of Chinese women are described. The chapter also uncovers historical and contemporary contexts of New Zealand's and China's maternity and health care services to uncover their differences and similarities.

The fourth chapter, 'Health Communication', explores existing knowledge on childbirth, communication, and culture. I delve into Western health communication practices and experiences between patients and health care providers by examining Western discourses of consumer culture and partnership communication. I describe changes and challenges experienced by migrant patients during their intercultural communication engagements with their health care providers. The chapter also provides knowledge of migrant women's childbirth experiences in New Zealand, and Chinese women's childbirth values, culture, and health communication styles.

In the fifth chapter, 'Theoretical Framework', I describe the theoretical approaches of social constructionism, postcolonialism, and Third World feminism, which characterise how my research is viewed. Each theoretical approach is explored through its core concepts and features, applications, propositions, and assumptions. Drawing on the theoretical lenses of these three theories, I develop my own theoretical framework, a matrix of difference, to lead my research analysis.

The 'Methodology and Methods' chapter shows my understandings of interviewing, observation, and methodological reflexivity. CDA is used to help analyse the data I collect, so a description of CDA and the rationale for such an

application are given. The chapter then explains data collection and analysis processes ranging from selecting participants and conducting interviews and observations with migrant ethnic Chinese mothers as well as with maternity carer providers, to keeping a researcher's reflexive journal, and to analysing the data. These sections are followed by a description of my research challenges, and ethical considerations of the project.

The next four chapters are devoted to my findings and discussion. In chapter seven, 'Language', I examine language as a construction of realities, experiences, and power in interactions between English-speaking maternity-care and health providers and non-English-speaking Chinese mothers. In chapter eight, 'Values', I question universalised and taken-for-granted mainstream values associated with childbirth and communication, and explore alternative, Chinese values. The exposition of othering in the use of language and values is particularly stressed in these two chapters. Chapter nine entitled 'Choice' centres around how Chinese mothers are institutionally socialised into the Western health discourse of choice. Questions about how much freedom the mothers have and how much information they are provided with to make a choice are addressed in this chapter. In chapter ten, 'Trust', I focus on the importance of trust and ethics in mothers' communication with maternity-care and health providers, and with their support people. More specifically, I discuss the mothers' trust in doctors, *insiders*, partners, extended family members, and cultural networks, giving special attention to attributes and barriers of a trusting and ethical relationship.

The last chapter, 'Conclusion', focuses on key results and highlights their significance as well as theoretical and practical implications. I also point in the direction of further research on intercultural aspects of the health communication

discipline. Finally, I discuss the impact of this study on me and my participants, and reflect on my thinking about my future research.



## **CHAPTER 3: MIGRATION AND MATERNITY IN NEW ZEALAND AND CHINA**

Understanding and interpreting contemporary intercultural communication issues within maternity care settings requires an exploration of relevant historical roots and their socio-cultural and political impacts on society. In this chapter, I first review the history of New Zealand's immigration policies and patterns and their impact on recent demographics of Asian migrants, ethnic Chinese migrants, and in particular migrant ethnic Chinese women. The presentation of historical and social contexts of migration is followed by a comparison of New Zealand and Chinese maternity and health care services in the historical and contemporary contexts.

### **Changing Demographics**

This section sets the context for research analysis by firstly unfolding New Zealand's history of migration which has been influenced by colonisation, globalisation, international migration trends, and the development of national immigration policies. A rise of Asian migrants, in particular Chinese migrants as a result of the recent relaxation of New Zealand's immigration policies is depicted. The section then introduces a historical context of Chinese migrants in New Zealand, along with statistics of Asian women, migrant ethnic Chinese women, and their live births, fertility rates, and the median age of having a baby in New Zealand.

### **Unfolding History**

The first wave of imperialism came to New Zealand in the 1700s when the

British colonisers started to usurp and weaken indigenous Māori power and resources through a variety of colonial strategies (Anderson et al., 2006). In 1840s, the Treaty of Waitangi was signed to achieve partnership between Pakeha (non- Māori in New Zealand) and Māori groups (Kelsey, 1990; O'Reilly & Wood, 1991). The Treaty indicates the withdrawal of British direct domination of the land, its people, and resources by considering Māori ownership of their lands and protecting Māori interests. But a colonial interpretation of the Treaty ensured the continuity of external colonial powers and the maintenance of British status by the establishment of a British Governor of New Zealand (Anderson et al., 2006). As a settler capitalist society colonised by a largely British population, New Zealand has historically modified its immigration policies to explicitly or implicitly favour “traditional source countries” such as Britain, Ireland, and Australia (Kahn, 2004, p. 501). Migrants from the traditional source countries were particularly favoured in the 19<sup>th</sup> and early 20<sup>th</sup> centuries, and migrants from the non-traditional source countries such as China and India were excluded by discriminatory immigration policies during this period (Kahn, 2004).

In response to the international population mobility starting from the mid-1960s and a national shortage in the labour market, New Zealand followed the U.S., Canada, and Australia to relax its immigration policies and encourage migrants from non-traditional sources, in particular Asian countries (Ma, 2003; Ongley & Pearson, 1995). The 1987 Immigration Act ended the specific preference for immigrants from Anglo-European countries, but the Act still linked immigration to occupational demand rather than economic growth. In the 1990s, the Business Immigration Scheme and a Point Selection System were introduced to value the economic benefits of increased immigration (Ongley &

Pearson, 1995). The new policies favoured migrants with entrepreneurial ability, capital and skills (Ongley & Pearson, 1995).

Recently, New Zealand has encouraged migrants from various other non-Western countries to reflect its move towards nondiscriminatory immigration policies. Asia, for example, has been the main source for new immigrants to New Zealand since 1991 (Kember, 2002; Statistics New Zealand, 2006). New Zealand's 2006 Census of Population and Dwellings found that the Asian ethnic group was New Zealand's fourth largest major ethnic group after European, Māori, and Other Ethnicity. The Asian ethnic group grew almost 50 per cent between 2001 and 2006, with Chinese migrants ranked as number one, followed by six other Asian ethnic groups: Indian, Korean, Filipino, Japanese, Sri Lankan, and Cambodian (Statistics New Zealand, 2006). This was a significant change to the earlier migration patterns under which New Zealand only accepted people from Anglo-European countries (Kember, 2002).

This historical context of New Zealand's migration pattern reflects that New Zealand has been traditionally very cautious in terms of the source nations that migrants come from. As a colonial country, New Zealand has historically preferred Anglo-European migrants over non-Western migrants. However, with the urge to bring more business talents and those with good skills and educational backgrounds to accelerate the state's economic growth, New Zealand had to relax its immigration policies to encourage migration from non-traditional sources. Accordingly, the growth in Asian migration, in particular ethnic Chinese migration has become more apparent reflecting the state's movement towards nondiscriminatory policies. Next, I uncover historical Chinese migration in New Zealand, and its impact on changing demographics of ethnic Chinese women and

Asian births.

### **Chinese Migration and Demographics**

Chinese migrants have historically been marginalised with New Zealand being a British colony. A small group of early Chinese, who worked as gold miners, were regarded as undesirable aliens and excluded by official policies (Ip, 2003b). During the 19<sup>th</sup> and early 20<sup>th</sup> centuries, the Chinese were the only ethnic group to suffer the poll tax, the denial of citizenship, and the exclusion from social welfare benefits (Ip, 2003a). Outlining New Zealand's policies towards the Chinese, Ip (2003a) says:

Historically, New Zealand only opened its doors twice to the Chinese: once in the Second World War, and once in the 1990s. In the first instance, it was reluctant and cautious, forced by political circumstances (Fong, 1959). In the latter case, it was unintentional and totally coincidental, because the Business Immigration Policy and the Point System favor immigrants with business acumen, capital, and skills, and many of these people happen to be ethnic Chinese. (p. 340)

The relaxation of New Zealand's immigration policies in the 1990s attracted more Chinese migrants to New Zealand. A dramatic rise of diverse Chinese migrants was also spurred by globalisation and the end of China's international isolation in 1978 (Ma, 2003). Early Chinese migrants were primarily villagers from Guangdong and Fujian Provinces in South China, but more recent Chinese migrants came from urban cities and were well-educated and highly skilled (Ma, 2003). According to Statistics New Zealand (2006), there

were a large number of people in New Zealand who were born overseas. England remained the most common overseas birth place, but the People's Republic of China has moved to the second most common birth place, with the number of people born there more than doubling from 2001 to 2006.

With more Asians, particularly Chinese, coming to settle down in New Zealand since the 1990s, there has been an increase in anti-Asian/anti-Chinese sentiment in the country. Here are just two of the many reports on the issue: In 2003, the BBC News reported that the New Zealand First Party asked 'ordinary Kiwis' to attack the government immigration policy that invited more Asians to come ("NZ tackles growing racism", 2003); and more recently, *The New Zealand Herald* reported that a white supremacist group distributed anti-Chinese flyers in Auckland city, claiming that Chinese migrants would never be Kiwis as they were not born in New Zealand ("Warning on racist campaign", 2013). Despite undercurrents of racism from some quarters, Chinese as well as other Asian migrants have continued to make New Zealand their home.

Early Chinese migrants to New Zealand were predominantly male, but this changed after the Second World War when there was a much higher ratio of females due to the rise of the Asian economies and the gradual relaxation of immigration policies (Ip, 1990). As a result of rapidly changing immigration patterns since the early 1990s, New Zealand is now a multicultural society. Consequently, the number of overseas-born women immigrants who are going through childbirth in their adopted land is growing significantly (Statistics New Zealand, 2006). Chinese women are among them. In 2006, the number of women originating from China comprised 23% of the total number of women originating from Asian countries (Statistics New Zealand, 2006). These

increases have affected statistics on live births, fertility rate, and median age of women having a baby.

There were 59,193 live births registered in New Zealand in the year ended December 2006 (Statistics New Zealand, 2006). Although there were no specific data regarding live births and median age of Chinese women having a baby, the 2006 Census found that the number of Asian children born in New Zealand occupied the fourth place after the number of children born with European, Māori, and Pacific ethnicities. The number of Asian mothers increased further in 2010, with one baby in eight born in Kiwi hospitals having an Asian mother (“Asian births on rise in NZ”, 2011). The Census also reported that the median age of Asian mothers was 30.6 years which was similar to that of the total population which was 30.3 years (Statistics New Zealand, 2006). The total fertility was 2.0 births per woman in 2006, whereas the fertility rate of overseas-born Chinese women was lower: 1.83 births per woman (Statistics New Zealand, 2006). All these data reflect the trend for Chinese women and some other ethnic groups in New Zealand towards delayed motherhood and smaller families. They also have significant implications for the delivery of maternity and health services to these women and their children.

In summary, with the change of New Zealand’s migration pattern, there is an increase of women migrants coming from Asian countries, in particular, China. The growing number of migrant Asian women indicates a growing number of Asian children born in New Zealand. The fertility rate and the median age of migrant Asian women (including migrant Chinese women) having children is consistent with New Zealand’s trend of delayed motherhood and smaller families. This information is helpful for my study in understanding mothers’ perceptions of

motherhood and the care they receive in New Zealand. With this historical background of the changes of New Zealand's migration pattern and demographics, I now move onto to an introduction of New Zealand's maternity and health care systems which are influenced by the state's migrant and demographic contexts.

### **Maternity and Health Care in New Zealand**

The changing demographics in New Zealand show an increase in migrant Asian women deciding to have their children born in New Zealand. These women experience New Zealand's childbirth procedures, and maternity and health services. In this section, I first introduce historical changes in New Zealand's maternity and health care as they are likely to impact upon the context of this study. My aim is to highlight major policies which have forced the development of New Zealand maternity and health care systems in four stages: before 1904, 1904-1970, 1970-1990, and after 1990. I critically examine changes of women's views of childbirth and role changes of midwives. After introducing the historical context, I then detail the current maternity procedures and services a mother will experience in New Zealand.

#### **Historical Overview**

Looking back at the history of New Zealand, indigenous Māori women and their Whānau (extended families) considered childbirth as a normal life event and part of the society (Te Huia, 2005). Viewing childbirth and childrearing as natural was shared by early immigrant women from England, and women's birth were attended by "lay midwives, older women with experience of giving birth themselves, female relatives and neighbours" for knowledge (Kedgley, 1996, p. 7).

In the early 20th century, viewing childbirth as natural and family-centred was still pervasive among European women in New Zealand (Stojanovic, 2008). The majority of births occurred at home or in small private maternity hospitals under the care of midwives (Able & Kearns, 1991). However, those midwives had little maternity training in schools. Most of them were married women who had borne children themselves. They worked independently in the community (Stojanovic, 2008). Various titles – “‘lay midwife’, ‘traditional midwife’, ‘handy-woman’, and ‘the monthly nurse’” (p. 157), were placed on this group of midwives who cared for home births or worked in a few private owned hospitals (Stojanovic, 2008).

This tradition was later gradually replaced by modern, scientific and medical processes of childbirth in the next few decades. The release of the Midwives Registration Act 1904 transferred midwifery from community-based practices to the ones under the control of the state (Cooper, 1998). The Act provided a knowledge foundation for midwifery registration, training, and services (Cooper, 1998), and more importantly, it put midwifery “under the control of medicine and began the introduction of the nursing culture into midwifery by creating the nurse-midwife” (Stojanovic, 2008, p. 157). Although home births were still pervasive around that time, a trend of having hospital births was triggered with the passing of the Act. In the following years, there was a dramatic rise in hospital birth, from 35% in 1920 to 58% in 1927 and then to 82% in 1936 (Donley, 1986). Doctor and nurse care was prioritised in hospitals over midwifery care, whilst the ideologies of “medicalisation, hospitalisation and nursification” were promoted (Stojanovic, 2008, pp. 156-157). Women were perceived as patients who received care from doctors within the hospital domain.



They had to conform to the “military-style hospital environment” (p. 165) and experience “‘medicalised’ childbirth” (Kedgley, 1996, p. 77). Meanwhile, women were told what to do by the ‘experts’ – scientists, hospital staff, and the Plunket nurses in their pregnancy, labour, and postpartum (Kedgley, 1996).

Although there was increasing resistance to the medicalisation and hospitalisation of maternity care in the 1960s and 1970s (Kinross, 1984), midwives were still marginalised in health authority and became more invisible with the passing of the Nurses Act 1971 (Stojanovic, 2008). This Act removed the autonomy of midwifery practices from community-based to hospital-based occupation. Midwifery care was portrayed as a sub-group of nursing care, so midwives were often called by hospital doctors and patients as “‘sister’, ‘matron’, ‘staff nurse’, and ‘nurse’” (Stojanovic, 2008, p. 165). Initiated by prevalent medical ideology, hospitalised birth was supported, and doctors took the position of the gate keepers for maternity care to promote the safety for mother and child (Able & Kearns, 1991).

Since the 1970s, there has been a growing challenge towards maternity care services from women’s groups and midwives, and hence, a demand to change the existing structures of services continued until the passing of the Nurses Amendment Act 1990 with the push of political force (Able & Kearns, 1991; Kedgley, 1996; Stojanovic, 2008). Midwives regained their power which allowed them “to take total responsibility for mothers before, during and after birth, whether the birth was at a hospital or at home” (Kedgley, 1996, p. 281). From then on, midwives were allowed to practice independently in the community again, and provide women individualised and continuous care (Stojanovic, 2008). Midwives, along with the Plunket nurses, GPs, other health professionals, and

those in the women's networks became the main sources from whom women received childbirth knowledge.

It is also important to mention that in the early 1990s, cultural safety in health communication was formally conceptualised in response to power imbalances between health care providers and the customers of health care, in particular Maori customers (Woods, 2010). The concept of cultural safety was derived from the Treaty of Waitangi and was later introduced into nursing and midwifery education by the Nursing Council of New Zealand in 1992 (DeSouza, 2008). A nurse or midwife, therefore, is required to address issues of culture, race and ethnicity in New Zealand, starting from an indigenous perspective. A culturally safe practice is usually progressed through the health provider's cultural awareness and sensitivity, and it is defined by the receiver of healthcare (Ramsden, 2002).

Reviewing the historical era of New Zealand maternity and health care systems, I find that only a handful of studies have examined New Zealand's history of childbirth, in particular, the historical context of childbirth of indigenous Māori. However, the remaining studies have showcased the major changes of maternity and health care services in four stages of New Zealand's history: before 1904, a period of an indigenous, natural and community-based model; 1904-1970, defined by the adoption of medicalisation and hospitalisation; 1970-1990, a reinforcement of medicalisation and hospitalisation; and after 1990, return to natural and community-based model but in a regulated form. In the next section, I explain the contemporary maternity and health care services which are experienced by New Zealand women. The roles and responsibilities of midwives, obstetricians, Plunket nurses, and other health providers in women's

childbirth processes are also outlined in the section.

### **Contemporary Maternity and Health Care Services**

Pregnant women in New Zealand can today access free and subsidised maternity-related services. Most maternity care services are free for women who meet the eligibility criteria, such as being a New Zealand citizen or resident (Ministry of Health, 2012). Pregnant women are required to choose a Lead Maternity Carer (LMC): a midwife, a General Practitioner Obstetrician (GPO), or private obstetrician, who coordinates their maternity care. But most women and their families now choose a midwife as their LMC (New Zealand College of Midwives, 2008). Before 1990, GPOs provided most of the maternity care in New Zealand; however, in 2006, the number of GPOs providing maternity care dropped down to 50%. In 2007, only 5% of women selected a GPO while more than 70% selected an independent midwife (Miller, Mason & Jaye, 2013). The gradual exit of GPOs as LMCs is due to the incompatibility between the LMC model and the general practice model of care in New Zealand. With changing health models and funding policies, many GPOs have discontinued providing an LMC service to women.

In 2010, 85% of women in New Zealand had a midwife as their LMC (Guilliland & Pairman, 2010). Registering with the Midwifery Council of New Zealand, midwives provide women the necessary support, care, and advice from early pregnancies right through until four to six weeks after a baby is born (New Zealand College of Midwives, 2008; Department of Labour, 2005). Most midwives are employed by District Health Boards, with a further 23.6% being self-employed (Department of Labour, 2005).

The maternity services provided by LMC are categorised as primary maternity services which cover the continuity of community-based care for normal childbirth without medical interventions and obstetric services. Secondary care is added for women and babies who have health complications from 20 weeks of pregnancy to six weeks of postpartum, and hence they need to contact the secondary maternity facilities which provide obstetric and anaesthetic services (e.g., cesarean sections). Tertiary maternity services such as the care provided from neonatal intensive care units target women and babies who have complex maternity needs from a health specialist team (Ministry of Health, 2012).

New Zealand's publicly funded maternity services not only allow women to choose their LMC, but also let women choose to give birth in a variety of maternity and health settings including home, primary maternity units (birth centers), secondary and tertiary level hospitals (Anderson et al., 2011). A great number of women give birth in a birthing centre or at home. Only a few women need to give birth in hospital because of complications. This group of women who give birth in hospital also gets support from hospital-based midwives along with their LMC. Women who have medical or obstetric conditions need to have ongoing involvement with an obstetrician but still receive care from their LMC at the same time (New Zealand College of Midwives, 2008).

Once a LMC completes his or her duty in four to six weeks after birth of the baby, a Plunket nurse takes over the care of the mother and her baby. Specially trained Plunket nurses provide parenting information and support through home and clinic visits, mobile clinics, and the Plunket Line (Plunket, 2012). Mothers in New Zealand, meanwhile, can get access to professional and practical support from other health professionals or community workers from

hospitals, clinics, communities such as the Parents Centre, and so on.

As the above account suggests, giving birth in New Zealand nowadays is a natural process. A mother relies on a LMC (mostly a midwife) to get knowledge and support during the period of pregnancy, childbirth, and postpartum. Then a Plunket nurse follows up the case and cares for the mother and her baby in the period of childrearing. Yet, as the following section suggests, these processes are very different from those that Chinese mothers receive in China.

Understanding the changes Chinese mothers go through in moving from receiving maternity and health services in China to receiving the ones in New Zealand is important. In what follows, I explore maternity and health care systems in China, with an examination of its historical context and the contemporary maternity services.

### **Maternity and Health Care in China**

Chinese maternity and health care systems have experienced dramatic changes since ancient China. Such changes are derived from the process of Chinese political, social, economic, and ideological changes. To better understand Chinese contemporary maternity and health care services, I start to introduce the historical context of some major changes in the 1930s and 1980s within Chinese society. I identify how these social and ideological changes beget changes in Chinese maternity and health care systems. Thereby, I interpret the development of Chinese midwifery, and explain the power relationships between midwives and obstetricians. I then move onto the description of current Chinese maternity and health care systems, with a further explanation of the relevant state policies in directing women's childbirth processes and undermining

Chinese midwifery.

### **Historical Overview**

In ancient China, traditional midwives were widely relied on for helping women deliver their babies in the community. *Chan po* and *jie sheng po* were two common titles among many different titles that people used to call midwives at that time (Cheung, 2009; Harris, Belton, Barclay, & Fenwick, 2009). To receive recognition locally, traditional midwives had to be aged, usually over the age of 40, to be reputable in the community, and have personal experience in childbirth (Cheung, 2009). However, the respect did not translate into much power. In the patriarchal society, medicine-men were perceived as having technical authority over midwives and other female healers (Cheung, 2009). Midwives were regarded as “dangerous ignorant charlatans” (Harris et al., 2009, p. 204) whose care was seen as “unprofitable and disposable” (Cheung, 2009, p. 236), which relegated the midwives to a lower class and position in the society.

Since the 1930s, there has been an urge in urban areas of China to learn more about Western medical approaches and management (Schurmann & Schell, 1967). As a result, more midwifery schools were established to improve obstetric care (Xiao, 1995). Different to *chan po* or *jie cheng po* (lay midwives without formal training), the midwives in China after the 1930s have been re-named as *zhu chan shi* who were formally educated in schools (Harris et al., 2009). But it did not last long; a Soviet-modeled education system was prioritised in China in 1952 (Cheung, 2009). Since then, the length of midwifery education was shortened, along with a merger of midwifery schools and secondary nursing schools (Cheung, 2009). Despite that it was a turning point

for midwifery care in the 1930s. Far from regaining power, the midwives as *zhu chan shi* were perceived as second-class health workers in Chinese hierarchical society (Cheung, 2009).

Chinese maternity and health care systems have experienced drastic changes since the 1980s when Chinese leader, Deng Xiaoping advanced economic reforms and opened up China to the Western world (Cheung, 2009; Harris et al., 2009). Since then, China has decided to go on a long transition from a centralised planned economy to a new open market economy. This initiation directed Chinese maternity and health care systems to become more market/business oriented (Cheung, 2009). Influenced by a modern and scientific Western health approach, the post-reform Chinese government promoted a central state policy of total hospitalisation of childbirth in order to reduce maternal death and improve safety in delivery (Harris et al., 2007). Caesarean section rates even reached 100% in some hospitals in urban locations around that time (Huang, 2000). Borrowing an obstetric model from the Western world, in particular the United States, Chinese maternity and health care systems value and are still applying a medicalised and obstetrician-led model (Cheung, 2009; Gu, Zhang, & Ding, 2011). This medicalised and obstetrician-led model has had a profound effect on role changes of midwives, and their power relationships with obstetricians, nurses, and other health providers.

The shift from home birth to public hospital birth, and the priority of the medicalised and obstetrician-led model forced Chinese midwives to change their roles and responsibilities in women's childbirth processes. *Zhu chan shi* were gradually replaced by obstetricians, obstetric nurses, and *doulas* who were privately hired to provide one-to-one care during labour (Cheung, Zhang, Mander,

Xu, & Wang, 2011). The remaining midwives practiced only in labour and delivery rooms in hospitals, but their responsibilities were limited to “obstetric nursing care” in birth (Cheung, 2009, p. 229). The marginalisation of midwives symbolises the challenge to establish a professional and independent identity of midwives in health settings, and at the same time, strengthens the position and power of obstetricians. The role changes of midwives have identified an unequal power relationship between midwives and obstetricians. Obstetricians are perceived as better trained and safer health providers than midwives in birth (Cheung, 2009).

Chinese midwives still find it hard to restore their professional health identity today when China keeps accelerating its pace of modernisation and urbanisation. The disintegration of Chinese midwifery can be interpreted through some major changes within the Chinese historical context. *Chan po* and *jie sheng po* were independent lay midwives who existed in ancient China but they were later replaced by more professional *zhu chan shi* as a consequence of the Chinese pursuit of Western medical knowledge. The 1980s had an epoch-making significance in Chinese history with social and economic reforms motivated by Western technology, modernisation, and market-oriented ideology. Since then, Chinese midwifery has been gradually moving towards its demise. The historical changes in Chinese society indicate the development of maternity and health care systems, and the relative positions of midwives, obstetricians, and other health providers in contemporary China. With the knowledge of this historical background, I now proceed to describe current Chinese women’s childbirth procedures which are guided by government policies, along with a discussion about different roles and responsibilities of midwives and obstetricians



in childbirth processes. The next section ends with an investigation of the implication of government and health policies such as hospitalisation and the One Child policy in China's Eastern urban cities and its Western rural regions.

### **Contemporary Maternity and Health Care Services**

The Maternal and Child Health Department, within the national Ministry of Public Health in China, oversees all maternity and health services. Pregnant women in China are required to contact a hospital or clinic, and they receive check-ups, delivery, and short-period postnatal care from obstetricians, hospital midwives, and nurses (Ministry of Health of the People's Republic of China, 2001). Within the first three months of pregnancy, a mother is required to get a *Wei Chan Bao Jian Shou Ce* (Perinatal Health Booklet) from a local clinic or hospital. The Perinatal Health Booklet is used by a mother's obstetrician to record all check-ups, and the mother has to keep this Perinatal Health Booklet from pregnancy to the birth of her baby (Ministry of Health of the People's Republic of China, 2001).

During the perinatal period, an obstetrician takes authority over check-ups and delivery, so Chinese mothers usually rely on their close networks to look for a good hospital and a good obstetrician (Gao & Xia, 2006). A pregnant woman is asked to do monthly check-ups in the first seven months of her pregnancy, and twice a month check-ups in the eighth and ninth month of her pregnancy, then every seven- to ten-day check-ups in the last month of her pregnancy. Government policy also requires a woman from urban China to complete more than eight pregnancy check-ups, and a woman from rural China to complete more than five check-ups. Obstetrician and nurses follow up a mother's postnatal

check until one week after the birth of her baby. Two other final check-ups need to be done by the 56<sup>th</sup> day after the birth of baby (Ministry of Health of the People's Republic of China, 2001).

According to Gu et al.'s (2011) research of Chinese midwives' experience at the Obstetrics and Gynaecology hospital of Fudan University which is located in Shanghai, the midwives usually provide labour care and conduct normal deliveries in the labour and delivery rooms, whereas obstetricians are involved in women's pregnancy and take authority over caesarean sections. Likewise, Harris and her team (2007) who investigated birthing services in Sichuan and Shanxi Provinces which are located in Southwest China found that in the higher-level hospital facilities, hospital-based midwives manage normal deliveries and sometimes assist obstetricians with complex labours and other emergency obstetric care. The midwives are not involved in antenatal and postnatal care. Nor do they have the right to perform caesarean sections, and vacuum or forcep deliveries. The marginalisation of midwives' roles and responsibilities in childbirth has led to a shortage of Chinese midwives. There are 30, 000 people per Chinese midwife in contrast to 1500 per UK midwife (Cheung et al., 2011).

It is important to stress here that China is a developing country with geographical and cultural diversity. Diversity also applies to the implications of maternity and health care policies, with a wide disparity between wealthier Eastern areas and poorer Western areas (Harris et al., 2009). Over 60% of Chinese women deliver their babies in health facilities. In Shanghai, a large urban city, for example, almost all women have hospital deliveries (Qian, Smith, Zhou, Liang, & Garner, 2001). Women in wealthier Eastern cities have access to qualified health facilities, advanced technology, and they experience highly

medicalised pregnancies and births (Xu, Smith, Zhou, Liang, & Garner, 2001). Ultrasound scans, fetal monitoring, caesarean sections, and other medical interventions are frequently used in Chinese hospitals (Xu et al., 2001). Caesarean deliveries are common in China, with a dramatic rise from 18% in 1990 to 39% in 2002 (Tang, Li, & Wu, 2006), and then to 46.2% in 2007-2008, which was the highest documented rate in the world (The WHO Global Survey, 2010). During this time, 64.1% of babies in urban China were born through caesarean sections, whereas only 11.3% of babies in the poorest rural region were born through caesarean sections (Feng, Xu, Guo, & Ronsmans, 2012). Being unable to access hospitals and high quality health care services, women living in some remote and poorer locations of China still rely on the services of midwives with minimal training, and many of their deliveries occur outside hospitals (Harris et al., 2007; 2009). The fieldwork of Harris and her team (2007) confirmed that “over 80% of births occur outside hospital in some remote ethnic minority populations and frequently in circumstances where women have no access to obstetric emergency services” (p. 118). Another unavoidable reason for fewer hospital deliveries in the poorer and remote region is that some women want to escape from the surveillance of their subsequent births, which is against the government’s ‘One Child’ family planning policy (Harris et al., 2007).

The ‘One Child’ Policy is still advocated nationally in China, so the majority of women delivering in hospitals are first-time mothers. This policy was enacted in 1979 to limit the high increase in population. This policy ties in with other government policies such as the Marriage Law, differentiated approved births and unapproved births (Kartchner & Callister, 2003). According to the policies, China’s maternity and health care services are available to all women

with approved pregnancies at minimal or no cost but women with unapproved pregnancies have to pay additional fees (Kartchner & Callister, 2003). Yet, in practice, China's pursuit of a market/business-oriented ideology "has led to an increasingly privatised and largely unregulated health-care system" (Harris et al., 2009, p. 209). Many health facilities in large Eastern cities feel an urge to provide lucrative health services involving expensive medical technologies and drugs to compensate the reduction of government funding (Hesketh & Zhu, 1997). The 'One Child' policy is also implemented differently across China – it is common for women to have only one child in urban areas whereas women with additional children are under-reported in the poorer and remote areas (Harris et al., 2007).

The above background information has indicated that Chinese maternity and health care services are considerably different from those of most Western countries, including New Zealand. In moving towards modernisation and market principles, Chinese maternity and health care systems prioritise a medicalised and obstetrician-led model. This model, on one hand, accelerates the development of maternity and health care services. On the other hand, it leads to inequalities in accessing health facilities and resources between wealthier urban areas and poorer rural areas. Being historically perceived as lower class health workers, Chinese midwives are still struggling to gain the respect, power, and professional identity compared to obstetricians and other health providers.

In summary, this chapter introduces a context of New Zealand's historical migration and changing demographics, as well as backgrounds of New Zealand's and Chinese maternity and health care services. The relaxation of New Zealand's immigration policies since the early 1990s has encouraged a growing

number of well-educated and skilled migrants coming from Asian countries, especially China. The increase in the number of migrant ethnic Chinese mothers, therefore, impacts on New Zealand's maternity and health care services delivered to this group of women. However, what confronts this group of women is that the Chinese contemporary maternity and health care systems are different compared to those of New Zealand.

Reviewing historical progresses of maternity and health care services in New Zealand and China, I find that both countries rely on lay midwives/traditional midwives in the community to help women deliver their babies in the early ages. Both experienced a drastic shift from natural and community-based childbirth model to medicalised and hospitalised model under the influence of 'modern' Western ideology. However, China adopted medicalisation and hospitalisation a few decades later than New Zealand. Also both have gradually upgraded their policies aiming to provide better maternity and health care services to women in the childbirth processes. Nevertheless, New Zealand decided to return to a regulated natural and community-based model to direct its maternity and health care systems in providing more choices and support to women, whereas China still favoured the medicalised and obstetrician-led model to promote safety for Chinese women and their babies. As a result, LMCs (mainly independent midwives), Plunket nurses, and other health professionals and community supporters share responsibilities to assist a mother in going through a natural process of giving birth in New Zealand. This process of childbirth is different from that in China.

In my research, I identify these differences and investigate how these differences influence Chinese mothers' responses to maternity and health services

in New Zealand. I investigate how maternity-care and health providers cope with these differences, and how they socialise Chinese mothers to New Zealand's maternity and health discourses. Health services are provided differently across different parts of China because urban and rural areas experience different social and economic development. This issue is further discussed because different services Chinese mothers expect to receive in China may result in their having different predispositions to childbirth. Accordingly, mothers' intercultural communication experiences with their maternity-care and health providers may have major differences.

Next, I review the extant literature on health communication between physicians and migrant patients, which sheds light on intercultural communication issues and challenges in the maternity and health care context as well as indicates gaps in our current understanding vis-à-vis my study. Also, childbirth experiences in New Zealand and China are compared and contrasted to draw conclusions about mothers' understandings of childbirth, their childbirth experiences, and their communication processes with health care providers.

## **CHAPTER 4: HEALTH COMMUNICATION**

To explore the roles of culture and communication in childbirth, I attempt to discover the existing knowledge in the literature on the communication aspects of health, migrant groups, and childbirth experience in both the New Zealand and Chinese contexts. In this chapter, four main areas help me synthesise and extend the existing knowledge on childbirth, culture and communication. First, I discuss Western health communication practices and experiences between patients and health care providers. This section provides basic knowledge about Western health discourses which are also valued in the New Zealand's maternity and health care systems. Second, I examine migrant patients' intercultural communication experiences with their health care providers. This section is closely related to my research purpose which is to investigate migrant ethnic Chinese mothers' intercultural communication experiences with their health care providers. The examination reveals what changes and challenges are experienced by migrant patients. Next, I look at migrant women's childbirth experiences in New Zealand and, in the final section, compare and contrast these with Chinese women's childbirth experiences in China. Overall, I focus on mothers' attitudes to childbirth, the factors that influence their understandings, and what communication models and mother-health care provider relationships are valued in China and New Zealand.

### **Western Health Communication**

Partnership communication between health care providers and patients is a part of the Western market-based discourse of consumer culture. The identities and responsibilities of both patients and health care providers are reconstructed to

fit in with the Western health discourses. This first section defines consumer culture and explains the key concepts, in particular, identity and identification, in relation to consumer culture. It then identifies how the discourse of consumer culture influences the health care systems. The section finishes with a discussion about a model of partnership-based communication, and its expected roles, identities, and the responsibilities (including ethical responsibilities) of patients and health care practitioners.

### **Consumer Culture**

Economic, social, political, and technological factors appear to reconstruct a variety of Western institutions and practices to market-based consumer culture (du Gay, 1996; Ritzer, 1998). Bauman (1988) defined consumer culture as “a culture of men and women integrated into society as, above all, consumers... Thus every item of culture becomes a commodity and becomes subordinated to the logic of the market” (p. 220). It is the market that pushes the institutions and organisations to steadily shift from privileging the producer to privileging the individual consumer. The discourse of consumer culture, therefore, shapes organisational discursive practices, and urges organisations to communicate with their customers and employees to (re)construct preferable identities.

First and foremost, the concept of identity and identification needs to be addressed. Beech and McInns (2005) analysed the concept of identity using three modes: “identity as singular and consistent”, “identity as a central unifying conception, which may be expressed and perceived differently in different social settings”, and “an ‘individual’ is a *carte blanche* for multi-authoring, in which others are the primary source of the changeable nature of the self” (pp. 23-24). The first mode holds that an individual has a fixed identity which is unique and



isolated, but this assumption is questioned by the other two modes which conceive identity as fluid, dynamic, and being affected by social interactions, contexts, and other individuals. This argument is supported by social constructionist researchers (Allen, 2005; Burr, 2003; Hackley, 2008a) who identify the crucial role of context in constructing and influencing an individual's identity. Identity is, thereby, constantly negotiated, developed, and challenged in every moment of experience and practice (Meisenback, 2008).

Identity and identification are closely connected to discourse. Discourses provide certain rules and structures to enable desirable identities while constraining other identities which cannot fit in with the discourses (Jack & Lorbiecki, 2007). A metaphor of "a crystallized self" (p. 186) is used by Tracy and Trethewey (2005) to stress that identity can be developed, changed, constructed, or constrained by various discourses. Likewise, Alvesson and Willmott (2002) describe identity negotiation through identity regulation and identity work. Identity regulation sees self-identities being controlled by discourses, whilst identity work depicts the individual's engagement in framing, reacting to, and/or resisting discourses.

Identity regulation indicates that the discourse of market-oriented consumer culture regulates identities of people involved in that culture. So the ideal customer is defined to be "one who is able to rationally access services through the market, 'buying' in services in an effective and efficient way to meet their own needs" (McLaughlin, 2009, p. 1105). The discourse privileges a customer's sovereign position and, in turn, comes to define the roles, behaviours, and relations the customer should have in certain practices and activities. Du Gay (1996) calls such a consumer "the sovereign consumer" who exhibits "enterprising qualities" such as being proactive and self-reliant, taking individual

responsibility, and being willing to take potential risks (p. 56). With a rational and independent consumer identity, the service recipient is expected to make a choice in full awareness of the situation explained by the organisational worker. After a careful analysis of the consequences of each option, the customer makes a decision which mostly reflects his/her best interest (McLaughlin, 2009). In other words, the customer has the freedom and independence to exercise individual choices, whereas organisations are forced to compete to satisfy the preferences of the customer (Keat, 1990).

To satisfy the expectations, needs, and wants of customers, organisational workers are encouraged to identify themselves with individual customers (Hochschild, 1983). That way, workers are encouraged to re-imagine themselves as customers, and thereby upgrade the services they deliver to the customers. This employee identification is necessary in the organisational reconstruction of forming consumer culture. “Through the image of the ‘sovereign consumers’, the relations between production and consumption, between the ‘inside’ and ‘outside’ of the corporation, and most importantly perhaps between work-based and consumption-based identities are progressively blurred” (du Gay, 1996, p. 79). The identities of workers and customers are interrelated and extended. Workers are no longer just employees who provide products and services; customers are no longer just customers who consume products and services. Subordinating to consumer culture, both workers and customers become individual actors in search of satisfaction, responsibility, achievement, and quality life (du Gay, 1996).

However, my concern is that framing a rational and independent consumer identity seems to be challengeable in practice. Organisational workers may also find it hard to re-identify themselves with customers in every organisational practice. As Alvesson and Willmott (2002) point out, identity negotiation not

only includes identity regulation, it also includes identity work which reflects individuals' understanding, interpretations, and reactions to the discourses. Diversity of individuals, and diverse contexts individuals are associated with, signify that they may interpret, react to, and/or resist the discourse of consumer culture and its derived discourses in different ways. Their different feelings and reactions to the identity transitions lead to questions of relationship and power dynamics in the communication context.

Regardless of my concern, consumer culture indeed provides a rationale for the reconstruction of the Western health care systems. This market and economic discourse has shaped the Western health care systems into a more consumer-based model which is believed to improve physician-patient communication and to increase patient satisfaction (Cegala, 2006; Dutta-Bergman, 2005). In this way, hospitals and other health settings are encouraged to transform from simply providing medical advice and treatment to providing quality service and experience. The identities and relations of health care providers and patients are also blurred, that is, patients are re-identified as the sovereign consumers while health care providers are re-directed to view their work through the language of consumer culture (du Gay, 1996). This more consumer-based model attempts to shape the physician-patient communication into more balanced partnership communication (Cegala, 2006; Dutta-Bergman, 2005).

### **Partnership Communication**

Usually a health care provider seems to have more power over a patient in decision making, information giving and seeking, and other practices. The power rests not with the individual health care provider, but with the role s/he is

enacting in the social institution (Martin & Nakayama, 2003). The health care provider then is privileged and dominates the communication processes with the patient, consciously or unconsciously. However, with the emergence of partnership-based communication, health status disparity between health care providers and patients is seen to be eliminated (Cegala, 2006). But partnership-based communication requires that both patients and health care providers take up more responsibilities.

To fulfil the “enterprising qualities” of “the sovereign consumer” (p. 56), patients are re-imagined as consumers with added responsibilities and values (du Gay, 1996). They are expected to be active and take more personal responsibility in patient-physician communication (Cegala, 2006; Thompson, 1994). Cegala (2006) reviewed the literature and identified four areas of need for research into patient communication skills training, and found that there is an increased patient responsibility in the partnership-based communication between providers and patients. Thompson (1994), in her review of the literature on interpersonal communication in health care, added that a patient needs to actively and openly participate in the communication, including decision making and controlling which, in turn, leads to greater patient satisfaction. Ethical responsibilities are shared by patients and health providers. That is, patients also have obligations to disclose their expectations to health providers, to honestly provide complete information, and to participate in the treatment (Guttman & Thompson, 2001). In particular, “the openness of the initial interaction between the doctor and the patient is critical to the accuracy of the diagnosis and the selection of appropriate treatment options” (Eisenthal, Koopman, & Stoeckle, 1990, cited in Dutta-Bergman, 2005, p. 293). In an open and collaborative communication environment, the patient as a customer is at the centre of the

physician-patient interaction, and is kept informed in the following stages of treatment.

While Cegala (2006) and Thompson (1994) focus on patient responsibility and communication skills, Dutta-Bergman (2005) argues that the communication style of the health care provider has to be tailored to satisfy the needs of the patient. Based on a representative sample of 2,636 of the general public gathered in the U.S. in 1999, Dutta-Bergman found that a health care provider is expected to listen carefully and patiently to a patient, allowing the patient time to ask questions, and explain without seeming to be in a hurry. Health care providers usually talk more than the patients do, and the providers show that they are busy and overworked, which are two of the major barriers to communication (Burke et al., 2006; Shouksmith, 1978). To overcome the barriers, the providers are encouraged to create patient/relationship-based interactions (Dutta-Bergman, 2005). Rather than spending most of their time giving and seeking information, the providers can devote more time to “partnership building, social conversation” (p. 104), and to encouraging greater patient participation (Dutta-Bergman, 2005). Guttman and Thompson (2001) relate these physician responsibilities to health communication ethics, by arguing that health providers must understand patients’ narratives first before applying diagnosis and treatment, and health providers must consider various contexts and circumstances in participating in ethical health communication.

Nevertheless, this partnership-based communication model seems to be idealised in practice. In a health setting, where a patient may feel uncomfortable or unfamiliar with communication and information processes and procedures, it may be too hard for the patient to openly and actively get involved in the patient-physician interaction, particularly in the initial stage. It may also be

difficult for a health care provider to devote more time from his/her busy work to partnership building and maintenance. As Cegala (2006) points out, the movement to consumerism and partnership-based communication may result in problematic patient-physician communication, which will finally exacerbate existing health care disparities.

Despite this critique, the consumerist model and the partnership-based communication are still prioritised in most Western health systems. Changes in the Western social, economic capitalist systems, that dismantled previously nationalised industries, saw many organisations increasingly adopt consumer-oriented discourses and values. Du Gay's (1996) work on examining this integration of consumer culture in service industries and health organisations critically comments on the (re)framing of work ideologies to fit within these consumer-based concepts and behavioural expectations. Accordingly, both patients and health care providers are encouraged to align and adjust their identities to meet with the expectations of the consumer discourses – moving from one of dependence to interdependence. Du Gay's (1996) work on consumer culture provides a framework and base to examine these expectations in health care relationships. This study extends and contributes further by examining the communication of these discourses and including in the analysis a more in-depth examination of 'othered' voices and hybrid identities. The health communication literature has, by and large, tended to neglect theoretical insights from social constructionism, postcolonialism and Third World feminism. The benefits of these theories are that they challenge the linear and objective understanding of identities and values that are tied up with these dominant consumer health care discourses.

When disadvantaged groups such as migrant patients come into contact

with a Western health service, they may encounter more challenges due to language barriers, and different cultural values and identities. The research on what migrant patients have experienced in the Western health systems is important to further understand the Western health discourses of consumer culture and partnership communication.

### **Communication with Migrant Patients**

The Western health care systems which advance consumer culture and partnership communication, however, may increase problems in the communication between health care providers and minority patients, especially migrant groups with non-Western backgrounds. In exploring these potential problems and the reasons behind them, this section starts by discussing language barriers and the advantages and disadvantages of using an interpreter. This discussion is followed by an understanding of medical ethnocentrism in judging migrant patients on their different cultural predispositions, behaviours, and health beliefs. Finally, the section explores the concept of othering in relation to difference, dualisms, power, representation, and the ways of avoiding otherness.

#### **Language Barriers**

Language is always a key to communication. People use language to understand their lives and build relationships. Language difficulties and differences can cause communication barriers and even conflicts in relationships. In a study of ethnically diverse groups of employees, Ogbonna and Harris (2006) found that having language barriers is still a major cause of discrimination. The dominant groups admit their discrimination against those who they perceive to have difficulties in speaking English, while ethnic minority groups hold distrust

against the dominant groups and in so doing create a clear boundary between ingroups and outgroups. In a health context, language issues are more apparent. The health sector is an environment that understandably can become stressful for any individual, regardless of ethnicity, and especially for migrants who may feel unfamiliar with and confused by the protocols (Pauwels, 1995). For example, “learning new communication rules and behaviors”, “completing more complex tasks”, and “lacking control in work situations” (p. 453) can also cause high levels of stress, uncertainty, and anxiety for health care providers when they are interacting with patients from other cultures (Ulrey & Amason, 2001).

Stress and anxiety can stem from language barriers on the part of migrant patients (Dysart-Gale, 2005; Johnson et al., 2004; Martin & Nakayama, 2008; Pauwels, 1995). Although some migrants may have an adequate knowledge of English, they “may not always be familiar with the communicative rules and routines of English” (Pauwels, 1995, p. 167). Migrants may also find it hard to understand the range of medical jargon in the health field (Pauwels, 1995; Martin & Nakayama, 2008). The use of technical and turgid language in the health environment can confuse patients and create barriers to communication (Cicourel, 1985). To avoid misunderstandings among migrant patients, health care providers are found to be leaning towards the use of simplified language in the intercultural communication processes (Ervin-Tripp & Strage, 1985). Recruitment of interpreters is also found necessary for migrant patients who do not speak the same language as their health care providers (Dysart-Gale, 2005; Hsieh, 2006; Pauwels, 1995).

According to Martin and Nakayama (2003), an interpreter is usually regarded as one who merely switches languages. The metaphor of “a conduit transmitting information without distortion between provider and patient” depicts



this role of the interpreter (Dysart-Gale, 2005, p. 93). However, using the conduit model to describe the role of the interpreter has been criticised by contemporary communication scholars (Dysart-Gale, 2005; Hsieh, 2006). Complementary roles such as “clarifier”, “culture broker” and “patient advocate” have been proposed (Avery, 2001, as cited in Dysart-Gale, 2005, p. 94). In other words, an interpreter clarifies the meanings of the message, negotiates cultures and culturally different interpretations and understandings, and sometimes directly interacts with the patients without the presence of providers. These criteria of being an interpreter seem to be ideal and different to the ones described in the next paragraph. Applied to the medical situation, a medical interpreter is highly professional in medical knowledge, language abilities, communication skills, and cultural understandings. However, this type of professional interpreter is rare, and seldom used in health care settings. Rather, people usually look for other types of informal interpreters to meet their needs (Hsieh, 2006).

There are five categories of medical interpreters proposed by Hsieh (2006). They are “chance interpreters”, “untrained interpreters”, “bilingual health care providers”, “on-site interpreters”, and “telephone interpreters” (Hsieh, 2006, p. 179). “On-site interpreters” are usually considered to be suitable in facilitating the communication between health care providers and migrant patients in health care settings because these interpreters have experienced formal training about medical interpretation. However, the cost of hiring them appears to be a disadvantage (Hsieh, 2006). Bilingual health care providers, who can speak the patients’ languages as their additional languages, are usually preferred as they are trained in physician-patient communication and have medical knowledge. But Hsieh (2006) argues that using bilingual health care providers cannot guarantee that providers have good language abilities and understand patients’ cultural

beliefs. The fact is that many migrant patients would like to rely on chance interpreters (e.g., family members and friends) and untrained interpreters (e.g., receptionist, nurse), particularly their family members and friends. Not only do patients already trust them, but also the patients feel it is more convenient and comfortable to ask for help from their family members or friends (Hsieh, 2006). Yet, using family members or friends may cause problems when, for example, the power relationships and roles that exist within certain cultures where knowledge might reside with males mean that they feel it is their right to make decisions for their female partners and family members. In this situation, males can be gatekeepers of information and relying on them as interpreters may lead to inaccurate interpretation and behavioural mistakes.

The potential problems derived from using interpreters were also discussed in Cass et al.'s (2002) study. Rather than focusing on migrant patients' communication with health professionals, these researchers investigated communication between aboriginal patients and health care workers in a satellite dialysis unit in suburban Darwin, Australia. By videotaping five clinical interactions, and conducting interviews with five patients, five doctors, and one nurse afterwards, Cass et al. found that health professionals rely on patients' family members as interpreters in the absence of professional interpreters, which is an inadequate practice because of their informal interpreting experience. Another problem emerging from this study is that "[t]he staff decided whether or not interpreters would be required, even when unaware of the patient's fluency in English" (Cass et al., 2002, p. 468). An imbalance of power between physicians and patients exists in this situation. Using an interpreter may manage the issue of language barriers in intercultural communication between health care providers and migrant patients, but it cannot solve the problems stemming from conflicting

cultural predispositions. Next, I introduce the concept of medical ethnocentrism in stereotyping migrant people who hold different cultural values and health beliefs.

### **Medical Ethnocentrism**

As Kreps and Kunimoto (1994) argue, modern Western health care systems tend to be “very ethnocentric and bureaucratic, proselytizing consumers to ‘comply’ with formalized, often technologically based, and scientifically justified forms of treatment” (p. 9). The powerful medical discourses dominate the less powerful knowledge of migrant groups and of women (Coyle, 1999). Based on a questionnaire survey administered to 391 employees in two hospitals and four clinics in a southern state of America, Ulrey and Amason’s (2001) study agreed with these earlier studies and added that health care providers, who are only trained to deal with the dominant culture, also suffer from this “medical ethnocentrism” (p. 452).

Under the influence of medical ethnocentrism, there is a tendency to mark out “good” patients and “acceptable” behaviours (Johnson et al., 2004). The patients who take responsibility for their own health and openly and actively participate in physician-patient communication are labelled as “good” patients (Cegala, 2006; Dutta-Bergman, 2005; Johnson et al., 2004; Martin & Nakayama, 2008). Their behaviours are identified as “acceptable” behaviours. Accordingly, in the eyes of many Western medical professionals, migrant patients are easily labelled as “problematic” patients with “unacceptable” behaviours because they are often characterised as demonstrating less partnership and involvement, lack of responsibility and motivation, and distrust towards the Western health systems (Cegala, 2006; Johnson et al., 2004; Kline, 2007).

Such stereotypes neglect issues of intercultural communication, and that people from different cultures hold different cultural predispositions and ethical standards towards health systems and practices. Kreps and Kunimoto (1994) label these differences as “health beliefs”, and explain that people from different cultures are likely to have “conflicting assumptions and expectations about health and health care due to their culturally based health beliefs” (p. 5). Johnson et al. (2004) and Cegala (2006) similarly indicate that migrant patients’ reactions towards health care practices have to be studied in relation to the larger social, cultural, and historical contexts. Guttman and Thompson (2001) suggest that health care providers need to be aware of different ethical standards existing in different cultures as taking these ethical standards into account in health communication is critical. Additionally, Cicourel (1985), in revealing status and power differences in doctor-patient discourses, found that “social class and ethnic differences can lead to problems of trust and the withholding of information, and a general reluctance to ask direct questions and provide direct answers” (p. 195).

In contrast to people in most Western countries, migrants, particularly those from Eastern countries, are assumed to value collectivism rather than individualism (Chen & Starosta, 1998; Hofstede, 1991; Martin & Nakayama, 2008) and their collectivist orientation influences their health beliefs (Kline, 2007). Under this assumption, migrants from “we” cultures are more likely to defer to the relationship-inequality in an institution (e.g., a health setting) by depending on and respecting people (e.g., health providers) who hold higher social status (Chen & Starosta, 1998; Hofstede, 1991; Martin & Nakayama, 2008). The Hofstedian approach does remind people of cultural differences between Western and Eastern societies and may, in some respects and in some circumstances, help explain interactions of some migrant patients with their health care practitioners.

However, the Hofstedian approach looks at issues primarily from a Western point of view. This binary divide between “we” and “they” in intercultural communication has been critiqued by postcolonial researchers (e.g., Munshi & McKie, 2001; Moulettes, 2007). In my research, I consider cultural differences between Chinese and New Zealand’s societies that influence participants’ health beliefs in some ways. But more significantly, I critique the assumption of a clear distinction between the two cultures and explore the complexities in-between.

As migrants coming to a different cultural environment are likely to experience some forms of culture shock, a migrant patient who is unfamiliar with the Western medical systems and procedures may also encounter culture shock when s/he has to adapt to a new health environment (Kreps & Kunimoto, 1994). The patient may then suffer stress and uncertainty physically, mentally, and emotionally, which leads to patient dissatisfaction, and worse physician-patient communication (Kreps & Kunimoto, 1994). In a health setting which favours mostly Western thinking and communication, migrant patients who have non-Western backgrounds are more likely to be labelled as *others* and be put in a powerless position. So what is othering? What are its implications for health care services? The following section looks at othering, its key concepts, and its relevance to health care practices.

### **Othering**

Migrant patients are often treated as ‘others’ who are different from the mainstream in a Western health environment. Othering is defined as a process that “serves to mark and name those thought to be different from oneself” (Weis, 1995, p. 17). It is the difference that leads to separation and deviance.

According to Grove and Zwi (2006), the difference of others stimulates the core impulse for distance between *us* and *them*. In the process of othering, difference is not just seen as diversity. Rather, it is portrayed in relation to opposition and disparity. MacCallum (2002) points out that *us* is the same which is attributed to a positive value whereas *them* is other which is attributed a negative value.

Power relations between us and them are apparent, that is, 'us' is always superior to 'them'.

The postcolonial literary scholar Gayatri Spivak was the first to coin the term *other*. In her landmark piece, *Can the subaltern speak?* Spivak (1988) discusses power dynamics between the Anglo-European colonisers and the Eastern colonised others by examining the Hindu rite of *sati*, a widow-burning rite after the death of a woman's husband. She critiques the Western colonial discourse in representing *sati* as a cruel crime of the Hindu religion and prohibiting this rite in India, and in so doing silencing the voice of those Indian widows who might choose to die in this rite. Stemming from this postcolonial argument, Spivak believes that the others cannot speak for themselves because the powerful Western colonisers try to represent and speak for them.

MacCallum (2002) further argues that othering is about constructing dualisms. In exploring the theoretical concept of othering in relation to psychiatric nursing, MacCallum directs researchers to link the dualism of 'us' and 'them' to the dualisms of West and East, man and woman, and reason and unreason. In particular, the dualisms of West and East, man and woman, reflect theoretical insights into postcolonialism and feminism. It is the West which positions the East as other; man defines woman as other. The one which has the power controls the process of representation, and steals the voice of others (MacCallum, 2002).

Othering is not only a process of identifying others; it is also a process of self-identification. “Who and what Others are . . . is intimately related to ‘our’ notion of who and what ‘we’ are. ‘We’ use Other to define ourselves: ‘we’ understand ourselves in relation to what we are not” (Kitzinger & Wilkinson, 1996, p. 8). By judging others’ perceptions and behaviours as rare and strange, *we* normalise ours. By attributing others’ culture as negative, we attribute ours as positive. By pushing others away due to their differences, we come to confirm our own identities and sameness.

Those who are defined as others often experience “marginalization, decreased opportunities, and exclusion” (Johnson et al., 2004, p. 254), and this situation is the same in the health care environment. Grove and Zwi (2006) used the framework of othering to explore how forced migrants – refugees, asylum seekers, and irregular migrants – are constructed as others in receiving countries. They found that forced migrants are portrayed as threatening, helpless, and uninvited in many developed countries, which results in restricting their access to health resources and health care services. However, Grove and Zwi argue that there is no health benefit in reducing health services to this group of people. Such efforts can cause more risks to the wider community over time.

Likewise, Johnson et al. (2004) examined othering and being othered in health care. They conducted 50 interviews and six focus group discussions with South Asian women living in Canada, and another 11 interviews and four focus group discussions with health care providers who had extensive experience in working with South Asian women in Canada. They found that migrant women cope with othering by gaining more rights in the context of health care services. Some migrant women make an effort to “fit into the mainstream health care system”, for example, to “be more assertive and ask questions in their health care

encounters” (p. 264) in order to minimise the potential for being othered. The way they do this fits with the mode of “assimilation” in which “the individual does not want to maintain an isolated cultural identity but wants to maintain relationships with other groups in the new culture” (Martin & Nakayama, 2003, p. 272). Other women, in Johnson et al.’s study, mention that they just lower their expectations of their health providers. For example, migrant mothers just expect their health providers to be nice, polite, and to listen to them.

There is a gradual belief that health communication and public health services can be customised to accommodate people’s needs by understanding their cultural characteristics (Kreuter & McClure, 2004). Some researchers (Brislin, 1993; Kline, 2007; Ulrey & Amason, 2001) provide recommendations to health providers to overcome otherness and intercultural communication challenges. Brislin (1993) encourages health providers to deliver the best possible health care in a culturally sensitive manner to patients who may not recognise the value of the services. Similarly, Ulrey and Amason (2001) suggest that health providers be more culturally sensitive, for example, by “using culturally appropriate language, having cultural knowledge, [and] understanding cultural values” (p. 451) when interacting with migrant patients. Kline (2007) extends this cultural sensitivity to health care agencies and indicates that the content in health pamphlets needs to take into account cultural values, beliefs, and practices of minority audiences. However, the researchers fail to explain what specific strategies health providers can adopt in practice and how they, as the ones in power, can help transform health care environments to support equitable health communication. Grove and Zwi (2006) do highlight practical measures to overcome otherness in the health care environment: training for health care providers in cultural sensitivity; an inclusive environment for health care services; and “the resourcing of interpreting



and translating services, outreach workers, and more specially targeted prevention and health promotion programs to complement secondary and tertiary care services” (p. 1940).

To summarise, when migrant patients are contacting the Western health care systems, many of them experience the challenges of language barriers, and different health beliefs and communication behaviours. Language problems may be managed by the presence of an interpreter, but different values and beliefs about communication and health issues are harder to negotiate. To fit in with the dominant health discipline, migrant patients are encouraged to be “good customers” in displaying “acceptable behavior”, even when some of them find it challenging to fit into the prescribed identity, role, and behaviour. The literature reflects that medical ethnocentrism exists in some Western health communication, and that it exacerbates inequality between health care providers and migrant patients who come from non-Western cultures. Migrant patients may also suffer from being othered in a health care environment. They find different ways to survive the othering experience, while health care providers are advised to cope with and manage othering. In the following sections, the literature about communication in the context of maternal health care is discussed, with a particular focus on New Zealanders’ and Chinese cultural views of childbirth.

### **Migrant Women’s Childbirth Experience in New Zealand**

The relationship between a woman and her health care providers is different compared to the one between a patient and his/her health providers. In the process of pregnancy, labour, and postpartum, the woman visits her health care providers for routine and preventive care even when she is healthy (Bylund, 2005). Also, a third person (the baby) is involved in the relationship between the woman

and her health care providers (Bylund, 2005), which makes this relationship distinctive. There is emerging research which focuses on migrant women's maternity experiences in Western societies, and the majority of that research has been carried out in America, England, and Australia (Davies & Bath, 2001; Liamputtong & Naksook, 2003; Liem, 1999; Shin & Shin, 1999). Nevertheless, there is little research that has focused on the maternity experience of migrant women in New Zealand and their interactions with their health care providers (DeSouza, 2005; 2006a; 2006b). From her research on migrant mothers' maternity and motherhood experiences in New Zealand, DeSouza (2005; 2006a; 2006b) concludes that no matter what culture these women in New Zealand come from, they are expected to comply with the New Zealand health discourses. In what follows, I focus on the New Zealand health discourses – largely influenced by Western health discourses – that migrant women have to be institutionally socialised into, and the changes and challenges migrant women may encounter in the socialisation process.

### **Socialisation into the New Zealand Health Discourses**

In parallel to the Western “ethnocentric” health systems, the New Zealand maternity and health care systems favour three Western discourses which are “partnership, being an informed consumer, and natural childbirth” (DeSouza, 2006a, p. 34). The maternity and health care discourses support New Zealand women's view of childbirth – a natural process which women should have more control over (Kedgley, 1996). In the childbirth process, a woman is encouraged to contribute equally to the communication with her maternity and health providers, take the responsibility of obtaining detailed information, and treat childbirth as a natural process (DeSouza, 2006a). Supporting the Western

ideology of consumer culture, New Zealand's Health and Disability Commissioner (2009) officially advances the Code of Consumers' Rights which defines the right of health consumers to have an informed choice. The Code specially claims the right of every health consumer to receive an explanation of the options available and the right to become a reasonable consumer. This code in respecting individual autonomy and informed consent is rooted in "a liberal Western tradition that places high importance on individual choice, both regarding political life and personal development" (Guttman & Thompson, 2001, p. 295).

As well as other women in New Zealand, migrant women are encouraged to fit in with these three health discourses. It is the responsibility of maternity and health care providers to help migrant women socialise into the New Zealand health discourses (DeSouza, 2006a). Maternity and health care providers then are privileged over non-Western migrant women because health providers reinforce and promote mostly Western thinking and communicating when helping mothers socialise into the New Zealand health discourses. Furthermore, what health providers say they do, and what they actually practice, can differ. Also being socialised into the new discourses is not an easy step for migrant women who come from different cultural backgrounds and hold different cultural assumptions about childbirth and health issues. First, to become a mother in a new land, a migrant woman has to experience an identity change. Identities can be discursively constructed through the framing of certain discourses of health and illness (Dutta & Zoller, 2008). Studies have shown that many migrant mothers stress traditional gender roles as wives and mothers after immigrating to Western countries (DeSouza, 2006a; Ho, 2006). Migrant mothers may also struggle with their cultural identities because they have often become separated from the everyday discourses and practices, language, rituals, and norms, etc., of insiders

(Collier, 1998). Along with identity changes, migrant women usually experience three big changes in the process of being socialised in the New Zealand health discourses. It is necessary to explain these changes in detail.

### **Experience of Changes**

Migrant women in New Zealand usually experience three big changes. For many, the first big change is the shift from “‘traditional’ societies to ‘modern’ ones” (DeSouza, 2005, p. 96). For example, DeSouza (2005) studied the maternity care experiences of women from Goa (India) in Auckland, New Zealand. She found that Goan women traditionally value same culture women elders as the experts who pass on the knowledge about childbirth, but many Goan women living in New Zealand have started to privilege “evidence” and “modern” beliefs. Other research also suggests that women from many other Asian societies, such as Thailand, the Philippines, Taiwan, and Cambodia, prefer to rely on women elders as the childbirth experts (Rice & Manderson, 1996). But relying on lay midwives and other older women with experience of giving birth themselves has become old fashioned in New Zealand. Today, women in New Zealand retrieve knowledge about pregnancy, childbirth, and postpartum mainly from health professionals who are regarded as the ones to pass on “modern” information (Kedgley, 1996).

Shifting from social responsibility (i.e., receiving support from the extended family, friends, and other social support networks) to individual responsibility (i.e., relying on self only) is another way of showing how migrant women step from “traditional” societies to “modern” societies (DeSouza, 2005). Like other New Zealand women, migrant women are expected to fit into a proactive, self-sufficient, and informed consumer role (DeSouza, 2005; 2006a;

2006b). For example, a woman and her midwife are seen as “equal and [able to] make equally valuable contributions” (Pairman, 2001, as cited in DeSouza, 2006b, p. 196). Whereas the midwife is expected to take the facilitator role, empowering the woman and helping her get through the pregnancy, labour and postpartum stages, the woman is expected to be more proactive, involved in communication, and to take more individual responsibility (DeSouza, 2006b). In the transition to motherhood, women in New Zealand are privileged to “say” more and are encouraged to “do” more. But their willingness and ability to make an equal contribution to woman-health provider communication are underestimated.

Another change experienced by some migrant women is the shift from medical childbirth to natural childbirth (DeSouza, 2006a). Childbirth in New Zealand is considered as a natural process and pain is a natural part of birth that women can control and manage (Kedgley, 1996). Encouraging higher rates and duration of breastfeeding, for example, has been included as one of the major goals of the New Zealand Ministry of Health and other maternity support agencies. The Ministry of Health (2012) declares that “Exclusive breastfeeding is recommended until babies are around six months.” Plunket (2012) encourages mothers to breastfeed until their babies are one or older. Likewise, La Leche League (2012) stresses in its New Zealand website that breastfeeding is natural and very easy for most mothers. In contrast, medical childbirth, favoured in many Eastern countries, supports the idea that childbirth is risky, and giving birth in hospital is safer and more hygienic (Kedgley, 1996). Accordingly, feeding babies is seen to be guided by medicalisation; for instance, in China the biological mode of breastfeeding is questioned in terms of its neglect of Chinese medical beliefs and mothers’ diverse circumstances (Gottschang, 2007). According to DeSouza (2006a), some migrant women “found the experience of childbirth easier

and empowering in New Zealand” (p. 21); however, others, who are more familiar with medical discourses, may feel conflicts in the information, care, and treatment they receive. It needs to be mentioned here that not every Kiwi woman is comfortable with and is willing to accept the discourse of natural childbirth. Using the example of breastfeeding again, some Kiwi women also felt uncomfortable with the message of “breast is best” which made them feel stressed, guilty, or even angry (Hill, 2012). Women have different attitudes and experiences with breastfeeding which is not always regarded as being a universally wonderful experience (Cripe, 2008).

In summary then, DeSouza (2005; 2006a; 2006b) has identified three major changes experienced by migrant mothers: from “traditional” societies to “modern” societies, from social responsibility to individual responsibility, and from medical childbirth to natural childbirth. What needs to be considered is that not every migrant woman is from a traditional society and not every traditional society favours medical childbirth. As Liamputtong and Manderson (1996) mention in their book on Asian women’s maternity and reproductive health, many Asian societies still favour natural childbirth. In contrast, medicalised childbirth is prevalent in the United States and childbirth there is a medical event controlled by the medical professions (e.g., obstetricians) (Lazarus, 1994). In New Zealand, childbirth is still treated as a natural process in which mothers are encouraged to take more individual responsibilities. The experience of changes after migration makes many migrant mothers experience challenges when they contact the New Zealand maternity systems and communicate with maternity-care and health providers. The key challenges experienced by migrant mothers are introduced in the next section.

### **Experience of Challenges**

In the transition to motherhood, many migrant mothers have experienced challenges when contacting the New Zealand maternity and health care systems. Maternity and health care providers, such as midwives and nurses, may hold stereotypes of migrant women (DeSouza, 2006a). Language barriers can lead to the problem of access, in particular, to information when looking for an LMC. After interviewing Chinese and Korean mothers, DeSouza (2006a) found that these migrant mothers were more likely to rely on their cultural networks to introduce an LMC because the information they are given is not available in their language. Migrant women also suffer from a “vacuum of knowledge” (Liem, 1999, p. 157). As DeSouza (2006b) notes, “[w]hile biological knowledge can be obtained from authoritative sources like experts and electronic resources, social and institutional knowledge are more difficult to access for migrant women” (p. 196) which is sometimes due to their separation from family and friends.

With little support from the extended family members and friends, migrant mothers shift to depending on their partners for support (DeSouza, 2005; 2006a). The partners usually take a peripheral role in the process of women’s pregnancy, labour, and postpartum in their home countries. However, they are likely to be more active in participating in those processes in New Zealand (DeSouza, 2006a). For example, the husbands of Muslim women get more involved in the childbirth process, such as attending the birth, which may not have happened in some parts of their countries of origin. The women’s cultural networks are also found to play an important role in offering support and information to migrant women, such as providing information about an LMC (DeSouza, 2006a).

Lastly, migrant women experience conflicting cultural beliefs and customs about childbirth (DeSouza, 2005; 2006a; 2006b). Some Asian mothers expect

their midwives to take a more authoritative role rather than a facilitative role since they feel more comfortable in accepting information and directions (DeSouza, 2006a). Thus, migrant women with a non-Western cultural background are faced with deciding whether they want to keep traditional views of childbirth and respect taboos or make an effort to fit in with the Western discourses by discarding old ways of doing things.

In conclusion, there is a dearth of research that investigates migrant women's maternity experiences in New Zealand. DeSouza's (2005; 2006a; 2006b) work is the most noteworthy so far. She identifies that the New Zealand maternity and health systems follow Western discourses which encourage natural childbirth processes, modern maternity knowledge, an increase in the mother's responsibility, and a partnership-based relationship between a woman and her caregivers. Migrant women who experience changes around the childbirth process in New Zealand may also encounter stereotypes, language barriers, and challenges in getting access to information when looking for an LMC and other information. Loss of previous lifestyle and independence quite naturally result in migrant women relying more on their partners, cultural networks, and their maternity and health care providers. Although Desouza's work has started to draw people's attention to migration and cultural differences between migrant ethnic women and women from the dominant culture in the New Zealand maternity context, her work mainly focuses on nursing and health perspectives. Her aim is to promote cultural safety in health and social care services. My research has a different angle; it delves into a deep analysis of one particular migrant ethnic group – Chinese women (and their families) – from a health communication and intercultural communication perspective. My purpose in doing this research is not merely to draw awareness to the cultural differences and



challenges experienced by migrant women. Rather, I go one step further and invite alternative maternity and communication values to challenge the current New Zealand health discourses which tend to hinder multiple and subjective voices from *other* groups.

Like many other Asian mothers, Chinese mothers in New Zealand experience different childbirth processes and challenges. These experiences have yet to be studied systematically; hence, the importance of this study is to understand Chinese mothers' intercultural communication experiences with health care providers in New Zealand. Therefore, Chinese mothers' views on childbirth as well as Chinese culture and communication styles need to be discussed in order to facilitate this understanding.

### **Chinese Women's Childbirth Experience in China**

Childbirth, in both the Western and non-Western world, is viewed as a major stage in a woman's life. To a Chinese woman, childbirth is not just viewed as an individual event. Rather, it is closely tied to culture, political, social, economic factors, and Chinese communications styles. In this and the following sections, I cover these factors, and highlight how these factors influence Chinese views of childbirth and mothers' communication with their health care providers.

### **Chinese Attitudes to Childbirth**

Chinese culture and beliefs have a major influence on Chinese women and their families' views of childbirth. Influenced by Confucian philosophy, Chinese women regard childbirth as the purpose of marriage in order to carry on the family line (Lu, 2006). Therefore, Chinese women and their families tend to treat every

aspect of pregnancy, birth, and postpartum as critical. For example, women are forbidden to climb heights or lift heavy things; they are not allowed to watch sad or scary movies in their pregnancy, and they are encouraged to hang beautiful babies' pictures on walls so that their expected babies will be beautiful too (Gao & Xia, 2006). Furthermore, it has become the trend for many Chinese women to choose a caesarean section as it is perceived to be the most reliable birthing option to protect the family's precious offspring (Mazurkewich, 2004).

Family roles and relationships account for childbirth and postpartum care in China (Mazurkewich, 2004). Historically, birth in China was believed to be a private domestic affair (Harris et al., 2009). Only women, be they female family members, neighbours, or traditional midwives, were allowed to be present to help with delivery (Harris et al., 2009). Although most births in contemporary China have shifted from the private domestic sphere to the public domain (i.e., hospitals), the reliance on family and other relationships, in particular female family members, is unchallenged.

Unlike New Zealand mothers who are encouraged to take more personal responsibilities during their pregnancy, birth, and postpartum, Chinese mothers, as well as mothers from India and Korea, heavily depend on their extended family for receiving childbirth knowledge and support (DeSouza, 2006b). This contrast is also partly because New Zealand has many support structures (e.g., the Plunket Society) available (DeSouza, 2005), whereas China provides basic health service (Lu, 2006). Thus, seeking support and maternity and health information from more experienced family members and trusted people, such as mothers and mothers-in-law, are important for Chinese mothers (Kartchner & Callister, 2003; Mazurkewich; Wong & Pang, 2000). Traditionally, women from the extended family, usually mothers or mothers-in-law rather than the husband, attend the birth

as childbirth is considered women's business (Kartchner & Callister, 2003).

Women from the extended family also take the responsibility to care for mother and child for at least one month after delivery (Chu, 1996; Kartchner & Callister, 2003).

The important roles of family and close relationships are taken into account in physician-patient communication in the Chinese maternity and health context. According to Jiang (2005), who analysed doctor-patient communication cases in hospital wards, health providers need to pay attention to their communication with *the third party*: a patient's parents, partner, child(ren), relatives, friends, and a representative from the patient's workplace. Usually, a health provider needs to involve a patient's family members in decision making about the patient's case. Meanwhile, drawing on experience, Xie, Li and Dong (2006) introduced doctor-patient communication in maternity clinical teaching, and Chan and Xiong (2008) also investigated communication between refresher doctors and patients by collecting 182 questionnaires from patients hospitalised in the department of gynaecology and obstetrics in the second affiliated hospital of Chongqing Medical University. Both studies encouraged health professionals to care about the feelings and feedback from patients' family members. Professional-family communication is given greater emphasis in Chinese maternity and health education literature, but an acknowledgement of this communication is often ignored in Western health care (Martin & Nakayama, 2008). Therefore, my study is important in investigating how health management structures and practices in New Zealand facilitate the childbirth process for Chinese mothers and their families. It is also important to know how health care providers communicate with mothers when *the third party* is around; how health care providers communicate with *the third party*; and to what extent

does *the third party* facilitate/s or challenge/s communication between health care providers and Chinese mothers.

Childbirth in China is managed according to a number of important cultural beliefs and practices. During the first month after delivery, a Chinese woman should stay indoors and comply with many rules and taboos in order to recover from birth, regain the balance of *yin* and *yang*, and avoid present and future illness (Chu, 1996; Hao & Moore, 2003; Kartchner & Callister, 2003). This confinement period is called *zuo yue zi*, “doing the month” (Hao & Moore, 2003, p. 47) or “sitting the month” (Chu, 1996, p. 191). The extended family members then take the main responsibility for preparing special food for the mother, doing all housework, looking after the infant, and doing other things to let the mother rest as much as possible (Chu, 1996). For example, Kartchner and Callister (2003) found in their study of mothers in Beijing and Chongqing that nine out of ten couples “had their mothers or mothers-in-law living with them temporarily or permanently during the first postpartum month (*zuo-yue-zi*)” (p. 108). However, while Kartchner and Callister (2003) also found that all their participants followed *zuo yue zi* after the birth of their babies, the degree to which they carried out the rules varied due to different educational backgrounds and the parts of China from which the participants came. Women from rural China are still influenced by traditional beliefs and practices, whereas women from urban China, particularly those with higher educational backgrounds, do not strictly follow rules such as not taking a shower until a month after giving birth (Kartchner & Callister, 2003). Thus, research on Chinese mothers needs to consider differing backgrounds which may influence mothers’ values and beliefs about childbirth.

Chinese women’s decisions on breastfeeding are dependent on their

circumstances and traditional Chinese medical beliefs. Research has indicated that Chinese women, including migrant Chinese women in some developed countries such as Ireland and Canada, have low rates and duration of breastfeeding (Chan-Yip & Kramer, 1983; Zhou, Younger, & Kearney, 2000). Language barriers, a lack of support from family and local health care providers, embarrassment and the inconvenience of breastfeeding in public, and a preference for infant formula in the Western market are perceived as possible reasons (Chan-Yip & Kramer, 1983; Zhou et al., 2000). More importantly, Chinese traditional values and medical beliefs have an impact on women's decisions about feeding their babies. Many Chinese women quit breastfeeding very early because the biological framework of breastfeeding contradicts and overlooks traditional Chinese medical beliefs about the maternal and infant bodies (Gottschang, 2007). The biomedical logic of breastfeeding emphasises the infant's health and the adjustment of women's roles as a breastfeeding mother (Gottschang, 2007). In contrast, traditional Chinese medical beliefs argue that breastfeeding is not without risks. A woman's maternal body after birth is weak and depleted, so the risk of passing on poor-quality milk to the vulnerable infant is a potential one (Gottschang, 2007). Meanwhile, "the very material, bodily manifestations of breastfeeding leakage – larger breasts, milk production, and inadequate breast milk – require mothers to renegotiate relations with husbands, coworkers, and family" (Gottschang, 2007, p. 65).

Chinese women's childbirth experiences are not only influenced by cultural factors; they are also heavily impacted by political, social, and economic factors. The economic, social, and political reform in the 1980s dramatically changed the Chinese maternity and health care systems to target hospitalisation, medicalisation, and obstetrician-led practices (Cheung, 2009; Gu et al., 2011).

Maternity and health policies keep emphasising that childbirth is an important but dangerous event which has the potential for complications (Cheung, 2009). As a result, a great number of Chinese women have hospital deliveries and heavily rely on obstetricians who have technical authority over the childbirth processes. Medical interventions such as caesarean sections are also frequently applied in many Chinese hospitals (Xu et al., 2001).

Meanwhile, the feelings of Chinese women and their families about childbirth are restricted by government policy which encourages couples to marry and have children later in life (Kartchner & Callister, 2003). The government also enforces strict One-Child Policy laws to control the high population in China. All Chinese people from Mainland China, excluding those from Hong Kong and Macao (i.e., regions that have reverted to Chinese sovereignty but have independent laws and policies), have to follow the One-Child Policy (“China defends one-child policy”, 1997).

However, one major consequence of the One-Child Policy is “female infanticide” because in this “once-in-a-lifetime event,” Chinese prefer boys, as they are believed to continue the family line and also care for elderly parents (Kartchner & Callister, 2003, p. 102). To address this problem, “the government has banned the use of ultrasounds to determine the sex of the fetus” (Kartchner & Callister, 2003, p. 103). The policy enforces the idea that female and male babies should be equally desirable. Also, due to China’s One-Child Policy, the birth of a child is identified as the most critical event for a woman (Mazurkewich, 2004). This political factor also influences women and their families to rely on caesarean sections as a safer birthing option (Mazurkewich, 2004). Yet, research indicates that there is a high rate of caesarean sections in wealthier Eastern cities, whereas there is a low rate of caesarean sections in poor rural locations (Feng et

al., 2012). Women with urban social health insurance or government health insurance are also more likely to have caesarean births than those who are uninsured (Harris et al., 2007). The prevalence of caesarean sections also reflects that childbirth in China is a medical event controlled by the medical professionals. Women have to depend on medical and technological expertise to ensure the birth goes well and, ultimately, to have a healthy baby (Lazarus, 1994).

Chinese political, social, and economic factors have a significant impact on the medicalisation of Chinese women's childbirth processes. Chinese women, their family members, and health care providers regard childbirth as a highly risky process which needs consistent and careful monitoring in the period of pregnancy, birth, and postpartum (Xie et al., 2006). Their values of childbirth are also influenced by Chinese cultural practices and beliefs. Believing childbirth is a critical event for the family and women, Chinese mothers are more likely to depend on family and close relationships to receive childbirth information, care, and support. So far, different factors in influencing Chinese attitudes of childbirth have been discussed. In the next section, Chinese culture and communication, the two crucial components of childbirth experience and relationship between women and maternity-care and health providers, are explained.

### **Chinese Culture and Communication in Childbirth**

Some intercultural communication scholars have tried to simplify and divide East and West, resulting in essentialist understandings of cultural difference (Chuang, 2003). For example, China, along with other East-Asian countries, is categorised as a large power distance country, as collectivist, and having a high-context culture (Hall, 1976; Hofstede, 1991). Such societies tend

to be “we” oriented and value relationships with ingroups (e.g., family, relatives, friends, workmates) (Chen & Starosta, 1998; Gao & Ting-Toomey, 1998). Further, Chinese culture is deeply rooted in the legacies left by the Chinese philosopher Confucius. Confucianism emphasises the interdependent self, manifest in harmonious relationships according to hierarchy and status, for example, unequal relationships between father and son, husband and wife, elder brother and younger brother, ruler and subject, and between friends (Gao & Ting-Toomey, 1998). Confucianism also values face saving, and the important position of family in society (Gao, 1996; Gao & Ting-Toomey, 1998; Zhu & Herbert, 2002). For these reasons, Chinese, in the eyes of many Western people, tend to be regarded as more passive, polite, obedient, and reluctant to disclose themselves to those outside their close networks (Gao & Ting-Toomey, 1998; O’Keefe & O’Keefe, 1997).

Yet, such evaluations and interpretations seem to simplify Chinese culture, and neglect the complexities and differences within the same-culture group. They also divide Chinese and Western people, and seem to relegate the status of Chinese people. As Ambler and Morgan (2000) (as cited in Martin and Nakayama, 2003) argue, the Chinese are neither individualist nor collectivist, but both at the same time. While these approaches may help analyse some aspects of Chinese mothers’ communication practices in health care, it is important to be aware that there are significant intra-cultural differences within Chinese society, and that not every Chinese person is a typical Chinese (Gao & Ting-Toomey, 1998). Further, Chinese come not only from the mainland of China, but also from Hong Kong, Macao, Taiwan, Malaysia, Singapore, and other countries, and these national identities result in further differences. Thus, contemporary intercultural communication researchers need to take a more complex view of the



complexities of Chinese culture and society, considering differences brought about by such factors as location, gender, age, education, the past and the present, the influence of Western culture, global trends resulting from worldwide trade, and the influence of English as a world language. In this study, I aim to be sympathetic towards these differences, complexities, and subtleties.

In addition to cultural, political, social, and economic factors, Chinese women's childbirth experiences and their communication with health care providers are also influenced by Chinese communication styles. Chinese communication styles are dominant in the Chinese health context. Traced back to ancient China, a doctor was labelled as the one who owned the Buddha's power to cure every patient's disease (Jiang & Zhao, 2002). Although this apotheosised image of a doctor no longer exists in today's China, the respect towards the doctor's position and knowledge is unchanged. Chinese Confucianism defines the relationship between doctor and patient as unequal. In other words, the doctor has more power over the patient due to their different hierarchical status. Chinese modernising ideology also empowers doctors, in possession of medical knowledge and a university education, to achieve "a pre-eminent position" while marginalising midwives to a less powerful position (Harris et al., 2009, p. 207).

Unlike many Western health systems, which favour partnership-based communication between physicians and patients, Chinese health systems regard good physician-patient communication as a cooperative prototype (Jiang & Zhao, 2002). An equal relationship between a patient and a health provider is not valued, unless the patient shares similar expert knowledge to that of the health provider (Jiang & Zhao, 2002). Under the prototype of cooperation communication, a good patient is expected to cooperate with a health provider in

treatments, follow directions seriously, and fully respect and comply with decisions made by the health provider. Meanwhile, the patient is encouraged to actively participate in treatments, and actively provide information to the health provider (Jiang & Zhao, 2002).

This cooperative physician-patient communication embodies one of Chinese communication characteristics, *ting hua*, described by Gao and Ting-Toomey (1998). “[*T*ing hua (听话) or listening centeredness” (p. 37) indicates that people who hold dominant or superior positions (e.g., parents, teachers, experts, elders) usually take a speaking role while those who seem to have less power are expected to listen to superiors in communication (Gao & Ting-Toomey, 1998). In a health care setting, a health care provider dominates the superior position due to his/her higher social status, medical knowledge, and familiarity with the health communication systems. Thus, the health provider is empowered to take a speaking role in terms of offering information, making decisions, and giving directions regarding treatments, while a patient is expected to listen to the health provider and be told what to do.

The Chinese communication characteristic “*zi ji ren* (自己人) or a focus on insiders” (Gao & Ting-Toomey, 1998, p. 37), is also emphasised in health communication contexts. This communication characteristic suggests that, to insiders such as family, relatives, friends, and others with a special relationship, Chinese tend to be highly involved in communication, while to outsiders such as strangers, Chinese are less likely to initiate and participate in interactions (Gao & Ting-Toomey, 1998). In the Chinese health context, health providers are taught to treat patients and their families as their own family members/insiders (Jiang, 2005). This training suggests that health providers need to offer their patients

information, show them respect and care including emotional care (Jiang, 2005; Jiang & Zhao, 2002).

The Chinese insider theory leads to the importance of trust in health care settings. Trust involves accepting and believing others based on their sincerity, competence, and surety, which leads to a dependence on the communicative behaviours of others (Berry, 2007). It sometimes takes a long time to establish trust, yet it can sometimes be lost in a brief moment (Berry, 2007). Hargie and Dickson (2004) claim that patients do not automatically trust health professionals because of their status. Trust needs to be enhanced by health professionals who use supportive communicative behaviours when they are interacting with vulnerable patients and their family members in health care settings (Berry, 2007). Kreuter and McClure (2004) also indicate that in health communication, if receivers consider sources' attitudes, values, and beliefs as similar to their own, they will develop more trust and respect towards the sources.

Treating patients as family members/insiders does not conflict with the cooperative physician-patient communication. Health providers are like parents who dominate every decision in a traditional Chinese family, and patients are like their children who receive consistent care from the parents. Cooperative communication between physicians and patients is valued as a way to achieve work efficiency and avoid mistakes, but the main contribution is to build and maintain a harmonious physician-patient relationship (Jiang & Zhao, 2002). These Confucian principles of obedience and power are addressed in the research. Given mothers' understanding of Chinese health communication, they are likely to treat maternity-care and health providers as experts who hold superior positions. Thus, mothers may expect health care providers to tell them exactly what to do. Health care providers may then encounter challenges in socialising those mothers

to adapt to the equal partnership-based communication style.

What health providers say they do, in terms of treating patients and their families as insiders, may differ to what they actually do in practice. One of the reasons for this difference is because of the health provider's high patient-doctor ratio (Jiang, 2005). For example, a clinical specialist in China has to take care of more than 100 patients in only eight hours (Jiang, 2005). Some health providers may find it hard to devote time for emotional care and support. Another reason which may lead to a difference between theory and practice is that Chinese are less likely to be highly involved in interactions with outsiders – those apart from family, relatives, friends, and others with special relationships (Gao & Ting-Toomey, 1998). To health providers, patients and their families are outsiders, so it is difficult to treat them as real family members. Similarly, to patients, health providers are outsiders. This contradiction explains why patients tend to keep a distance from their health providers instead of actively participating in physician-patient communication.

While there is little literature on mothers' communication with their health professionals in China, that which does exist points to the importance of cooperative communication (Chan & Xiong, 2008; Xie et al., 2006). Xie et al. (2006) stress that good communication interactions between patients and maternity carers involve trust, respect, understanding, and cooperation. Specifically, they encourage maternity carers to hold polite attitudes when communicating with the patients. “[*Ke qi* (客气) or politeness” is another important characteristic of Chinese communication (Gao & Ting-Toomey, 1998, p. 37). Polite talk and modesty are prioritised in Chinese communication to avoid destroying harmony in groups/relationships (Gao & Ting-Toomey, 1998). In the Chinese maternity and health context, for example, maternity carers normally

avoid asking private or sensitive questions in the first meeting with the patients, and avoid asking those questions in public, because, according to Xie et al. (2006), childbirth in China is also viewed as a private process.

A further area concerns doctors' attitudes towards their patients. Chan and Xiong (2008) found that 65.3% of the patients they investigated were not satisfied with their maternity carers' attitudes. The patients complained that their maternity carers did not care much about communicating with them. The patients were often given simple answers to their inquiries. Chan and Xiong conclude that a lack of trust between those patients and their maternity carers has become a major problem, and they suggest doctors be trained afresh to improve their attitudes when interacting with patients. Therefore, implications for what is the norm in doctor-patient relationships have relevance to my study. When Chinese mothers engage in the New Zealand maternity and health context, they may expect their maternity-care and health providers to be polite, sensitive, and avoid asking private questions, as appears to be the case in China. For this reason, differences in expectations and attitudes may result in Chinese mothers experiencing communication challenges in the New Zealand context.

This section concerning the childbirth experience in China indicates that the Chinese consider childbirth as a medical and private event (Kartchner & Callister, 2003; Xie et al., 2006). The concept of medicalised childbirth is reflected in Chinese maternity and health literature which labels mothers as "patients", and health care providers as "doctors". Chinese mothers' childbirth experiences and their communication with health care providers are influenced by cultural, political/social/economic etc., factors, and Chinese communication styles. Limited research exists which focuses on physician-patient communication or physician-mother communication in China; and the main function of what does

exist is to educate/train health professionals in how to improve their communication with patients. None of the research reported here fully examines patients' perceptions and experiences by adopting qualitative research approaches. For example, Jiang's (2005) study was based on old medical cases and his medical experience. Xie et al.'s (2006) study was entirely experience-based, and, therefore, anecdotal rather than a result of systematic research. Although Chan and Xiong (2008) collected data through questionnaires, the questions (e.g., was your communication with doctors satisfying/common/dissatisfying?) were too general.

Despite these gaps, a major theme derived from this literature is that of cooperative communication between patients/mothers and health care providers. Chinese mothers who are familiar with this cooperative communication may face challenges when interacting with New Zealand health care providers who support partnership-based communication. Another two major themes are that Chinese childbirth processes are not only viewed as medical processes but also private ones, and in the Chinese health context, communication between health care providers and the patients' family is also considered important. My study then is important to identify these communication behaviours and expectations relating to cultural, political, social, and economic factors, and Chinese communication characteristics.

### **Summary of Review**

My review of the health communication literature has highlighted the Western core health discourses which come to define the preferable roles, identities, behaviours, and responsibilities of customers and health care practitioners. Because Chinese mothers mostly hold different values of

childbirth and different expectations around the maternity and health care they receive, they may encounter intercultural communication challenges during their interactions with maternity-care and health providers in the New Zealand context. However, as the survey of literature demonstrates, knowledge in this area is limited. Therefore, my study, which focuses on the New Zealand context, is important in building intercultural communication knowledge in maternity and health care settings, and between maternity-care and health providers and their customers.

Rather than simply providing an overview of existing literature in health communication, I approach the literature critically. I draw on theoretical insights from social constructionism to analyse the dominant discourses of consumer culture and partnership-based health communication and explore how varied identities and socio-cultural contexts may resist these dominant discourses. Looking at health communication through an intercultural lens allows me to understand the dynamics of cultural interactions between Eastern patients and Western doctors. However, I critique the Western representations of cultural binaries that tend to disguise the continuities of colonial and gender oppressions. Theoretical insights from social constructionism, postcolonialism, and Third World feminism enable me to explore subjective experiences of Chinese mothers in their childbirth processes.

## **CHAPTER 5: THEORETICAL FRAMEWORK**

In exploring the context, knowledge, identities, and experiences of migrant ethnic Chinese mothers in the processes of communicating with their maternity-care and health providers in New Zealand, I draw on theoretical insights from social constructionist approaches, postcolonial theory, and Third World feminist theory. I begin this chapter by explaining the core concepts of social constructionism, postcolonialism, feminism, and Third World feminism. The explanation also includes a description about each of their features, applications, propositions, and assumptions. I then construct a matrix of difference on the foundation of these theoretical perspectives which serves as a framework for me to analyse the data I have collected.

### **Social Constructionism**

Social constructionism is a theoretical orientation which provides the logics for postcolonialism and Third World feminism. It is worthwhile to understand social constructionism in the first place. In this section, I describe its key characteristics, that is, subjectivity and multiplicity, context, knowledge, discourse, and scepticism. When introducing these characteristics, I discuss their applications, and make connections to my research questions. In the last part of the section, I outline the propositions and some key debates around the assumption and applications of the social constructionist approach.

### **Key Characteristics and Applications**

Social constructionism takes a stance against positivist ontology which favours objectivity and absolute truth (Lincoln & Guba, 2000), and is also against



the assumption that “the world as we see it is the result of hidden structures” (Burr, 1995, p. 13). Rather, social constructionism is committed to subjectivity and multiplicity with an influence on the positions of interpretivism, postmodernism, and poststructuralism. In other words, it emphasises the idea that reality is socially constructed by variable systems of knowledge and practices (Berger & Luckmann, 1966). Insomuch, maternity and health agencies can be viewed as socially constructed realities with discursive practices that enable and constrain knowledge, identities, and the communication of health carers, mothers, and their families.

Drawing on this fundamental understanding of reality, social constructionism supports the view that individuals’ experience, knowledge, and identities rest upon the historical, social, and cultural contexts individuals belong to (Allen, 2005; Burr, 2003, Hackley, 1998a). Individuals’ behaviour needs to be understood and interpreted in relation to the behaviour of whole social groups, as individuals are members of a variety of social and cultural groups (Guo, 2007). In my study, the communication of Chinese mothers is understood in relation to the communication of social and cultural groups they belong to. One of my research questions was to find out how mothers’ cultural attitudes to childbirth and communication affect their responses to the New Zealand maternity and health care practices; another question sought to understand and interpret mothers’ perceptions and experiences of interactions with their health care providers. The social constructionist approach helps me address these two questions by understanding the impact of different contexts on mothers’ childbirth and communication experiences. This study is not concerned with establishing absolute truth about how Chinese mothers communicate with their maternity-care and health providers but rather understanding and interpreting their intercultural

communication experiences which, in turn, are influenced by their cultural values and beliefs of childbirth and communication.

Social constructionism also stresses that knowledge is what we construct rather than what we discover. In other words, knowledge is derived from what we do, and how we interact and socialise with each other (Allen, 2005; Burr, 2003). As Laird (1993) contends, knowledge does not reflect any proven theory or objective truth but is a social, cultural, and historical product which is constructed in contexts of power relationships. Adding to this point, Schwandt (2001) proposes that we not only make knowledge but consistently test and modify it through our new experiences. The Chinese mothers in my research have been educated and socialised in China to form knowledge about Chinese predispositions towards childbirth and Chinese health procedures for the most part of their lives. When these mothers come to New Zealand, they form knowledge about New Zealanders' predispositions to childbirth, and knowledge about New Zealand's health procedures through interactions with their health care providers and the socialisation with their own cultural group. These new and ongoing interactions and experiences may help mothers construct, negotiate, and modify their knowledge about childbirth and health care. In this way, I am able to answer one of my research questions on how Chinese mothers (re)negotiate and (re)construct their childbirth values and practices in the communication processes with their maternity-care and health providers and other groups.

Discourse is a key part of the social constructionist approach. As a part of discourse, language is not seen as a simple medium for reflecting an objective reality. It is used by individuals to understand their world, their lives, and themselves. Language is the centre of social interaction processes in exchanging meaning that construct and reconstruct identities (Burr, 1995), and

creating power relations (Cunliffe, 2008). Embracing language and other forms of meaning representations, discourse

defines and produces the objects of our knowledge. It governs the way that a topic can be meaningfully talked about and reasoned about. It also influences how ideas are put into practice and used to regulate the conduct of others. (Hall, 2001, p. 72)

From the perspective of social constructionism, our identities, knowledge, experience, and interpretations of the world are all dependent upon the meanings produced and reproduced by different discourses. The important thing is to locate these differences and interpret them in specific sociocultural and historical contexts.

In addition, “social constructionism cautions us to be even suspicious of our assumption about how the world appears to be” (Burr, 1995, p. 3).

Researchers employing social constructionist theory need to analyse and interpret the phenomenon through different angles from a sceptical perspective. One of my research questions was to investigate how power influenced the intercultural communication in Chinese mother-health care provider relationships. To answer this question, I critically consider multiple realities around Chinese mothers and health care providers which have an impact on their relationships and communication. Exploring tensions between dominant discourses/knowledge and alternative discourses/knowledge of childbirth, and their mutual effects on each other in mothers-health care providers’ intercultural communication processes is also what I am committed to.

Social constructionist theory has been used in various contexts such as race in ethnography (Nayak, 2006), sex, lesbian and gay studies (Hegarty & Pratto,

2004; Stanley & Wise, 2004), emotions studies (Gabriel & Griffiths, 2002; Harr é 1986), counselling and psychology (Neimeyer, 1998), social work education (Laird, 1996; Lit & Shek, 2007), the career field (Young & Collins, 2004), environment (Burningham & Cooper, 1999), and also organisation, marketing, and management (Cunliffe, 2008; Hackley, 1998a). For example, both Gabriel and Griffiths (2002) and Harr é (1986) apply social constructionist theory to analyse people's emotions. They stress the social and cultural specificity of emotions so that they can interpret emotions in relation to the social and cultural groups people belong to. In her piece, Cunliffe (2008) discusses social constructionist orientations and focuses on relationally responsive social constructionism and its impact on knowledge about organisations and management, and on management learning. Lit and Shek (2007) apply social constructionist principles in fieldwork supervision of Chinese social work students. They encourage social work educators to highlight the contextual nature of knowledge and to encourage a critical and reflexive attitude in applying knowledge in fieldwork. It needs to be stressed here that having a reflexive attitude in the research process is highly recommended by social constructionist scholars (Allen, 2005; Markham, 1996; Sherrard, 1996). The research process is constructed by both participants and the researcher, so examining both parties' involvement in the production of the discourse they are analysing is very important (Sherrard, 1996).

Social constructionist theory has also been incorporated in communication studies. Interpersonal communication is identified as a collaborative, reflexive, and socially, culturally, and historically constructed event (Alem án & Alem án, 2007; Leeds-Hurwitz, 1995). In relevant studies, in particular, knowledge of interpersonal communication is seen as a collaborative activity derived from

people's interactions, and culture provides a context for communication and so influences communication behaviours (Alemán & Alemán, 2007; Leeds-Hurwitz, 1995). In corporate communication, the design and use of corporate mission statements, is guided by a social constructionist perspective to develop a model of socially constituted meaning-making (Hackley, 1998b). Likewise, crisis communication shifts towards a social constructionist perspective in "interpreting communication processes as relational, contextual, dynamic and ritual" (Falkheimern & Heidenn, 2006, p. 187). Communicative practices within organisations have also been examined with the support of social constructionist theory (Allen, 2005; Guo, 2007; Jablin, 1982). Individual identities and their meanings (Allen, 2005), supervisor-subordinate relationship (Jablin, 1982), and the socialisation processes of Asian immigrant employees in Western companies (Guo, 2007) are critically defined and socioculturally situated. Accordingly, individual and corporate identities, culture, and relationships are no longer stable, but rather are created, developed, and changed through the communication of organisational members.

It is important to acknowledge the nature and processes of socially constructing reality, and the impact of social, cultural, and historical contexts on participants' identities, knowledge, communication practices, and relationships. Social constructionist theory provides me a theoretical and analytical lens to examine intercultural communication experiences within a maternity and health context. Next, I move on to highlight the propositions and assumptions of social constructionism.

### **Propositions and Assumptions**

It is important to note that social constructionist theory draws our attention

to the role of context in constructing our understanding and behaviours.

According to Burr (2003):

all ways of understandings are historically and culturally relative. Not only are they specific to particular cultures and periods of history, they are seen as products of that culture and history, and are dependent upon the particular social and economic arrangements prevailing in that culture at that time. (p. 4)

This insight allows me to see that Chinese mothers' understanding of childbirth, their experiences with mainstream health providers, and their responses to the New Zealand childbirth and care practices are culturally, socially, and historically relative. In other words, the mothers' understandings, experiences, and responses are shaped by Chinese cultural beliefs which are then (re)negotiated and (re)constructed in the context of New Zealand cultural beliefs, social influences and pressures. Meanwhile, mainstream health providers' understanding of childbirth and their communication experiences with Chinese mothers must also be interpreted in relation to their specific historical, social, and cultural contexts.

Not only does social constructionism address the important role of context in understanding the world and ourselves, it also rejects the essential and universal understanding of the world and insists on interpreting the world from multiple and subjective perspectives (Allen, 2005; Berger & Luckmann, 1966; Burr, 2003; Cunliffe, 2008; Lincoln & Guba, 2000). This proposition of viewing the world from various systems of knowledge other than Western taken-for-granted knowledge is particularly useful for my study. Social constructionism cautions me to be suspicious of assumptions about how childbirth should be valued, what

roles should be taken by mothers and their maternity-care and health providers, and how maternity and health discourses should be implemented in practice. Women's childbirth values and experiences are very subjective and should accordingly be interpreted differently.

Another proposition of social constructionism is that it re-interprets identity, knowledge, and experience as being fluid. They are situated in different discourses (Allen, 2005), constructed by social, cultural, and historical contexts (Burr, 2003; Laird, 1993), and they progress and change in social interaction processes. For my study, it is important to find out how different discourses impact on participants' identities, knowledge about childbirth, culture, communication, and intercultural communication experiences. Viewing identity, knowledge, and experience as socially constructed products, I am able to rethink childbirth and communication from a critical and subjective stance.

The features of social constructionism also invite some critiques. One is about its primary focus on the influence of external factors (i.e., historical, sociocultural context) at the expense of internal factors such as an individual's emotions, consciousness, and intention in the development of identity, knowledge, and experience (Gabriel & Griffiths, 2002; De Cecco & Elia, 1993). There is another debate around the commitment of social constructionism in overthrowing the positivist perspective of ultimate truth and power, and attempting to explain every phenomenon from multiple aspects (Gergen, 2006). As Allen (2005) and Burr (1995) indicate, social constructionism cannot help explain some contexts (e.g., war). Nor can it challenge the fundamental consequences of illness, mortality, poverty, or other phenomena.

Despite these critiques, social constructionism enables me to explore, understand, and critically interpret the communication between Chinese mothers

and their maternity care providers in the light of knowledge, discourse, the larger contexts, and multiple perspectives. However, only watching, understanding, and interpreting what is going on is not enough for my research. I am motivated to bring about changes through the use of alternative knowledge that challenge dominant discourses and empowe and benefit marginalised others. To do this, I go on to draw on postcolonialism and Third World feminism, two theories based on the logics of social constructionism.

### **Postcolonialism**

The emergence of postcolonial work can be traced to the fundamentally historical and sociocultural movements in the world. Located in the critical perspective of cultural studies, postcolonialism is transdisciplinary, and is reflected in other critical studies including cultural studies, feminism, postmodernism, Marxism and more (Shome & Hegde, 2002). In the following discussion, I define and introduce the core commitment of postcolonial theory. I then discuss its key characteristics: redoing the historical structures of knowledge, othering, subjugated knowledge/alternativeness, power, representation, and identity and hybridity. At the same time, I interweave applications of postcolonial theory in discussing its characteristics. The distinctiveness and significance of postcolonialism are highlighted, while critiques to this theory are further discussed. I hope to understand postcolonialism in the broader disciplines but also link it to the perspective of communication. That way, I expect to examine the appropriateness and advantages of postcolonialism in helping me answer my research questions.



### **Key Characteristics and Applications**

Postcolonial does not mean an end of colonialism. Rather, the prefix post is a critical response to colonialism, so the concept postcolonial refers to thinking about unequal power dynamics of colonialism that continue to exist beyond the colonial times (McConaghy, 2000; O'Mahony & Donnelly, 2010; Shome, 2009). Postcolonialism is "the product of resistance to colonialism and imperialism" (Young, 2001, p. 15). It is a way of articulating resistance to Western domination and its derived powers (Broadfoot & Munshi, 2007; Chakrabarty, 1992; Said, 1978; Spivak, 1990). Although historical and social movements of colonisation and decolonisation seem to be in the past, postcolonial theorists argue that colonisation is still an active force in today's world but in more intangible and subtle ways, (Young, 2001). Postcolonialism provides theoretical lenses to examine unequal power relations derived from the colonial past and neocolonial present, and challenge the ways in which dominant groups define and represent social meanings and knowledge structures (Anderson et al., 2003).

To a larger extent, postcolonialism seeks to stress the effects of the continuation of colonialism. However, the core commitment of postcolonialism is not merely to theorising the problematic of colonisation, rather, it "attempts to undo (and redo) historical structures of knowledge production that are rooted in various histories and geographies of modernity" (Shome & Hegde, 2002, p. 250). In other words, the goal of postcolonialism is to break through static structures of knowledge production, which have been established by Anglo-Euro/Western intellectual enterprise, by bringing alternative structures of knowledge production from the rest of a world which has been historically conquered, exploited, and is still being ignored by the colonial world.

The spirit of postcolonialism articulates one of its key characteristics, that

is, redefining and rewriting the established social meanings and knowledge structures. Postcolonialism encourages the process of “deconstructing and rewriting taken-for-granted” (Anderson, 2000, p. 145) knowledge which stems from homogenous Western systems and neocolonial ideologies. The theory guides researchers to revisit power relations and privilege as a means to achieve social justice (Racine, 2003). It is not just about allowing the *subaltern* people to voice their perspectives, but also empowering them to further “influence or even supplant” the Eurocentric perspectives which are often seen as a norm (Cheney, 2000, p. 140).

To grasp the nature of other characteristics of postcolonialism, I must weave in the much-cited concepts of Orientalism, decolonisation, and othering. Much of the postcolonial literature has been influenced by Said’s (1978) perspective of Orientalism, which is defined as “a Western style for dominating, restructuring, and having authority over the Orient” (Said, 1978, p. 3). By claiming this, Said (1978) made a binary division between West and East, the coloniser and the colonised. While Said’s (1978) landmark book *Orientalism* was a study of literary discourse, it showed how the dominant colonial frame of the West led to a false representation of the East. The depictions of the Orient in the West were based on false creations and preconceived notions rather than on realities on the ground. Said’s analysis of the colonial discourse demonstrated how entire continents and communities were assumed to have similar characteristics. This pattern is also evident in the way mainstream health and maternity-care discourse views migrants.

However, Fanon (1967) pointed out that colonialism is not merely a relationship between coloniser and colonised. The power imbalances in-between are at the centre of postcolonialism. In other words, Western and non-Western

experiences and their representations are inseparable, and their mutual effects on each other need to be acknowledged (Frenkel & Shenhav, 2006). In exploring Chinese mothers' childbirth values and experiences of their intercultural communication with New Zealand health care providers, I cannot isolate Chinese experiences and representations from Western ones. Rather, I need to understand and interpret their mutual effects and power relations in the intercultural communication processes. So in the eyes of Chinese mothers, what are New Zealand's childbirth values and practices? How are Chinese mothers' childbirth values and practices represented in intercultural communication processes with New Zealand health care providers? How does the mothers' childbirth knowledge conflict or agree with the New Zealand view of childbirth, and what are the consequences for the delivery of health services and mothers' responses towards the New Zealand's health practices? Postcolonial theory provides a strong foundation to address these probe questions.

A separation of the East and the West has been disrupted by conditions of globalisation and migratory waves of decolonisation (Shome & Hegde, 2002). One of the major consequences of decolonisation movements is the emergence of migratory waves from the Second/Third World nations to metropolitan centres of colonial powers. The Western world then confronts its postcolonial history which is interpreted by migrants and refugees (Shome & Hegde, 2002). New Zealand was once a country under British colonialism and its structures of knowledge production were and still are very Anglo-centric. Since 1991, New Zealand has witnessed a new wave of migrations from non-Western countries (Kember, 2002; Statistics New Zealand, 2006). By linking to its own colonial history and the migratory conditions, postcolonialism provides me with a platform to listen to the stories from the migrants in order to challenge established

discourses of Western modernity in New Zealand health and care practices.

Said's (1978) work on Orientalism also addressed the concept of othering in postcolonial studies. According to him, "the Orient" is portrayed by Western discourses as a unified geographical, political, racial, and cultural zone.

"Colonial discourse produces the colonised as a fixed reality which is at once an 'other' and yet entirely knowable and visible" (Bhabha, 1996, p. 41). As referred in chapter four, Spivak (1988) examines vulnerability and power struggles of the Eastern colonised 'others' in representing themselves under the suppression of Western colonialism. Indeed, the notions of othering can also be traced back to Fanon's (1967) *Black Skin, White Masks*. Fanon talked about how black people including himself are positioned as the subject or the other, as being signified for skin and race, in the stereotyped discourse of colonialism. Chow (1996) took the understanding of *natives* and others one step further. When discussing Kristeva's *About Chinese Women*, she commented, "If these others [Chinese women] have been turned into objects, it is because these objects' gaze makes the Western 'subject' feel alienated from her own familiar (familial) humanity" (p. 126). Munshi (2005) also shows how Eurocentric organisational norms construct dominant assumptions which create and suppress *others*.

During the last ten years or so, postcolonial theory has made a significant contribution to the field of management and organisation (Banerjee & Prasad, 2008). Tracing the roots and features of postcolonial theory, both Prasad's (2003) and Banerjee and Prasad's (2008) pieces conclude that postcolonial theory can serve to decolonise taken-for-granted discourses and organisational practices. In particular, Prasad (2003) stresses the role of "defamiliarization" in management and organisation studies (p. 18). "[D]efamiliarization" is used to "turn the seemingly familiar and wellknown into something relatively strange and

unexpected” (Prasad, 2003, p. 18). Postcolonial theory provides a platform for organisational scholars to defamiliarise the normalised organisational phenomenon and thereby, to develop a different understanding of new aspects and meanings.

For example, Westwood (2006), critiques the discourse of international business and management for universalising, misrepresenting, and suppressing different and localised knowledge. Similarly, Jack, Westwood, Srinivas, and Sardar (2011) interrogate essentialism and parochialism in management and organisation studies. They suggest that “a postcolonial interrogative space” needs to “be deepened, broadened and re-asserted” in order to promote hybrid and alternative forms of knowledge (p. 275).

At a more practical level, Mir, Banerjee, and Mir (2008) draw on postcolonial theory to analyse knowledge transfer between a large, US-based multinational corporation and its subsidiary in India. They found that the hegemony of the headquarters privileges Western ways of knowing but devalues local knowledge, value, and identity, which results in certain knowledge loss at the local level. Exploring human resource management problems between Western expatriate managers and their Chinese employees, Cheung (2008) found that “asymmetrical understanding” exists in this supervisor-subordinate relationship (p. 277). That is, the expatriate managers fail to acknowledge the Chinese employees’ perspectives which are largely influenced by Chinese philosophical traditions. The application of postcolonial theory in management and organisational settings is useful for my research in as much as it provides a way of defamiliarising dominant discourses and institutional practices in the New Zealand maternity and health care context.

There are growing numbers of health and nursing research that incorporate

a postcolonial perspective to address health concerns and promote the subjugated/alternative knowledge of diverse population groups (Anderson, 2000; 2002; 2004; Anderson et al., 2003; Browne, Smye, & Varcoe, 2005; Grant & Luxford, 2008; O'Mahony & Donnelly, 2010; Racine, 2003). Postcolonial perspectives have also been usefully applied in indigenous studies to reclaim and reposition indigenous knowledge (Battiste, 2000). For example, research directed by Browne et al. (2005) examines the relevance of postcolonial theory to nursing research in the area of aboriginal health. They found that postcolonial theory provided them with an avenue to understand issues of health, healing, and human suffering in relation to social, historical, and political contexts. More significantly, Bowne et al. (2005) develop postcolonial indigenous knowledge stemming from indigenous ideologies, discourses, and research processes. Although my research is not an indigenous study, the way researchers use a postcolonial perspective to address indigenous health issues in local contexts is transferable to my research. The way researchers develop postcolonial indigenous knowledge motivates me to not only encourage the subjugated/alternative knowledge from migrant ethnic Chinese mothers, but also bond that knowledge with their ways of knowing and behaving.

Engaging with postcolonial concepts of othering and subjugated/alternative knowledge in communication studies allows communication researchers to retrieve the *other* knowledges of communication (Shome & Hegde, 2002). My research questions are not only about the role of maternity and health care agencies in facilitating Chinese mothers to get through childbirth, and the communication between the mothers and health care providers; more significantly, I seek to identify cultural values, beliefs, and practices of Chinese mothers in relation to childbirth. The processes of othering in health

communication between mothers and health care providers are particularly focused. Postcolonial theory provides me with pathways to discover knowledge of childbirth, culture, and communication, other than the dominant knowledge in the Western maternity and health care systems. Postcolonial theory also empowers me to use that different knowledge to influence and challenge the existing knowledge that dominant groups are familiar with. As Racine (2003) says, postcolonial researchers aim to relate contemporary phenomena and relations to the heritage of colonialism and neocolonialism, and to question the dominance of Western systems and structures on subjugated knowledge.

Postcolonialism does not merely examine power imbalances between coloniser and colonised, but also uncovers unequal relations of power existing in our everyday lives. Through the process of deconstructing the dominant knowledge and redefining power relations, postcolonial theory provides an avenue to get closer to equality and social justice (Anderson, 2000).

Unveiling and redefining power relations are also key characteristics of postcolonial theory. This characteristic prompts me to critically think about power relations between Chinese mothers and maternity-care and health providers in my research. I investigate the impact of Western discourses and ideologies on the New Zealand knowledge production of childbirth, health, and communication. I invite the voices and the subjugated/alternative knowledge of migrant mothers to challenge Western norms.

Concepts of othering lead to another important feature of postcolonialism – problematising agency and representation. Spivak (1988), in particular, raises the issues of agency and voice of the colonised others. The Anglo-European colonisers historically tend to represent, translate, and interpret the subalterns through the use of their own language, values, and knowledge (Sharp, 2008). In

the field of organisations, Westwood (2006) argues that “Western-centred IBMS [international business and management studies] claims to speak for and on behalf of the other that it represents to itself” (p. 100). The historical, cultural, ideological, and localised knowledge of management and organisations is therefore, positioned in a marginalised sphere of research.

Questions were cogently asked by Shome and Hegde (2002), “Who can speak? Who can represent? Do we position the colonized as incapable of speech? On the other hand, do we romanticize the speech of the colonized as resistant and thereby deflect the violence of the colonial encounter?” (p. 266). I ask these questions in my research too. My attempt is to understand how cultural values, beliefs and practices of both mothers and maternity-care and health providers are constituted. I intend to find out whether migrant ethnic Chinese mothers have spaces to speak for themselves in the Western health context and, if not, who represents and speaks for them? The concept of representation helps me address communication practices that are used by Chinese mothers and mainstream health providers to position themselves in maintaining, changing, and/or resisting social, cultural, and health contexts. Questioning the authenticity and ethics of representation also provides methodological lenses for my study to create and maintain collaborative and reflexive research relationships with my participants. The approach urges me to take ethical responsibility to “speak with” and “speak from” the participants (Alcoff, 1991/1992; McConaghy, 2000) and avoid misrepresenting them by speaking for them. The further discussion of representation in conducting my research is carried out in the next chapter on methodology and methods.

At the other end of the spectrum, the othering process is “a dialectical process because the colonizing *Other* is established at the same time as its



colonized *others* are produced as subjects” (Ashcroft, Griffiths, & Tiffin, 1998, p. 171). It is from the midst of this dialectical process that the postcolonial notion of hybridity emerges. Bhabha (1990) criticises the essentialist and universalist understanding of identities, and argues that the colonial and the colonised cultures, or Western and Eastern cultures are not in pure forms but more like hybrid cultures. Cultural identities do not conform to a neat, binary distinction between the two protagonists, but instead emerge in a third space or in-between-space where hybrid cultures are negotiated and empowered (Bhabha, 1990). Indeed, “hybridity complicates the dichotomies inherent in colonialist discourse” (Kurian & Munshi, 2006, p.369).

Essentially, hybridity refers to the mixing of different elements and practices between the coloniser and the colonised, and the creation of new identities and meanings (Ashcroft, Griffiths, & Tiffin, 2000). The postcolonial notion of hybridity challenges the stable and homogenous position of the Western colonisers. “[Cultural oppositions and polarities are by no means rigid and fixed” and binaries such as universal/particular “should be suspended, without privileging either since they are both mutually imbricated and constitutive” (Xie, 1997, p. 29). A hybrid epistemology suggests a blurring of cultural boundaries between West and East without denying the unequal relations of power between them, and thereby hybridity can filter in to encourage a multiplicity of voices and possibilities (Frenkel & Shenhav, 2006).

In my research, hybridity needs to be understood as a communicative practice constructed by historical, sociopolitical, and cultural arrangements. Nowadays identities are easily blurred, overlapped and changed in the transnational context (Shome & Hegde, 2002). Postcolonial theory gives me ideas about thinking identities of mothers and maternity-care and health providers,

and cultural identities of Chinese migrants and mainstream Westerners by weaving the issue of hybridity into understanding power relations between these two groups.

I want to point out again at this stage that the critical nature of postcolonialism is to challenge Western ways of thinking and doing by problematising issues of power and production/control of knowledge, and encouraging multiple voices which have been silenced from dominant discourse (Young, 2003). Inasmuch, postcolonialism encourages alternative knowledge, developed outside the West, and different ways of understanding the world in order to produce more equitable relations between the different peoples. I now discuss the propositions and assumptions of this theory.

### **Propositions and Assumptions**

The critical proposition of postcolonial theory, which makes it unique to other critical theories, is that it tends to “disrupt the history of race-thinking” and “address the structural inequities that have been brought about by histories of colonization and ongoing neocolonial practices” (Anderson, 2004, p. 239).

Postcolonial theory urges us to rethink established structures of knowledge production and unequal power relations derived from colonisation and its ongoing effects. The theory further encourages us to challenge and break through static structures of knowledge production, by allowing subjugated knowledge/alternative knowledge from the non-Western peoples (Banerjee & Prasad, 2008; Broadfoot & Munshi, 2007).

In essence, postcolonial theory is against essentialism but is concerned with subjectivity and multiplicity, which are seen as some of its propositions. Postcolonial theory advances an understanding of vulnerable peoples and their

lives through the exploration of their subjective knowledge. Such disenfranchised and subjugated knowledge of those with less privilege has been lost in the suppression from Western hegemonic power, and hence this knowledge has to be retrieved to resist or displace Western static knowledge (Bhabha, 1994; Quayson, 2000). The features of hybridity and representation, which are supported by postcolonial theory, also stress the issues of subjectivity and multiplicity. Western colonial discourses that historically misrepresent non-Western cultures and identities are challenged. The traditional understanding of fixed and stable identities is also questioned. A hybrid epistemology encourages multiple identities, voices, and possibilities in exploring power relations between the coloniser and the colonised (Frenkel & Shenhav, 2006).

Another proposition of postcolonial theory is relating power relations to knowledge and discourse (Foucault, 1975; 1979; 1980), so exploring power relations within particular historical, sociocultural, and neocolonial contexts. Western colonial discourses portray *other* people from the non-Western world as inferior to Western mainstream groups (Said, 1978). Non-Western knowledge is, therefore, othered and subjugated by Western hegemonic intellectual enterprises. The stereotyped Western assumption is problematic in not only creating power imbalances between the West and the non-West, but also continuing to influence different types of communication and relationships in the contemporary world. Postcolonial theory, therefore, contributes to the interconnections between and among power, knowledge, and discourse. The theory provides an analytic lens to critically examine unequal relations of power as the heritage of colonisation and current neocolonial practices.

One of the major critiques to postcolonialism is that “postcolonial work is

overly preoccupied with theory, resulting in scholarship that is obtuse and inaccessible” (Shome & Hegde, 2002, p. 264). The question of inaccessibility is derived from the use of jargon and coverage of complicated areas when carrying out postcolonial studies (Seshadri-Crooks, 2000). However, Grossberg (1982) argues that inaccessibility cannot hide the significance of postcolonial theory. More importantly, the complexity of postcolonial work urges researchers to be more responsible for questioning the historical and geographical phenomenon (Shome & Hegde, 2002).

Further, an emphasis on national identity in postcolonial studies has come to be debated intensely (Kumaraswamy, 2006; Sadiki, 2004). From my point of view, postcolonialism steps beyond national boundaries. It maps the relations of nations and histories. Borrowing Shome and Hegde’s (2002) comments, it can be argued that postcolonialism “entails geopoliticizing the nation and locating it in larger (and unequal) histories and geographies of global power and culture” (p. 253). Postcolonialism is not about any one society but is a transnational process (Hall, 1996; Anderson, 2002).

Another particular drawback of postcolonial theory is that it does not include a gendered analysis (Browne et al., 2005; Gandhi, 1998; Mestry & Schmidt, 2012; O’Mahony & Donnelly, 2010). It has “been critiqued for its preoccupation with questions of race, ethnicity, and culture, sometimes to the exclusion of forms of oppression based on gender or class” (Browne et al., 2005, p. 25). A postcolonial feminist perspective is often used to address this gap. Such scholarship is used to extend the analytical boundaries of postcolonial theory (Browne et al., 2005; Gandhi, 1998) which helps examine different forms of oppression within gendered and postcolonial contexts. In my research, I interweave a postcolonial perspective with a Third World feminist perspective to

address the analytical gap of postcolonial theory.

Additionally, although postcolonial theory has reached various disciplines, the use of this theory in the communication discipline is very limited (see e.g., Broadfoot & Munshi (2007); Pal & Dutta (2008); Shome & Hegde (2002) as some exceptions). In saying so, my research, which incorporates postcolonial insights into intercultural communication study, is important in bridging these two areas in order to apply historical, sociocultural, and geographical perspectives to interpret issues of culture, communication, knowledge, and power in the childbirth process.

In sum, postcolonial theory is useful for my research in terms of investigating cultural power, identity, and representation of Chinese mothers, and intercultural communication knowledge between the mothers and their maternity-care and health providers. To a larger extent, the critical impulse of postcolonial study is to intervene in structures of knowledge production which are subject to colonialism and neocolonialism. Rather than separating Western and non-Western experiences to understand historical and contemporary suppressive conditions, postcolonialism directs researchers to connect the West and *other* parts of the world to invite different and alternative ways of thinking. The drives of postcolonial scholarship are reflected in much of critical scholarship including feminist theory. In recent times, feminist perspectives have often been used to explore different colonial conditions (Shome & Hegde, 2002). My research on women and health thus draws from a postcolonial feminist perspective which focuses on Third World women, their contexts, challenges, and rights. The next section introduces feminist theory, followed by a thorough exploration of Third World feminist theory.

### **Feminism and Third World Feminism**

Postcolonialism is critical of institutional practices that continue to be guided by colonial frameworks. One of the features of such frameworks is the privileging of masculinity which is what feminism critiques. Rather than tracing back to a genealogy of feminist theory, in this section I focus on introducing key aspects of feminist theory, with special attention to feminist standpoint theories, the concept of othering, and its applications in various studies. However, this study goes beyond the theories of feminism. The study applies Third World feminism to help tackle my research questions from a different angle. So in the second part of this section, I move on to discuss Third World feminism in questioning Western essentialised feminism discourse and acknowledging different knowledge, values, and experience of women of Third World descent.

#### **Feminist Theory**

Feminist theory, broadly described, emphasises women's struggles against oppression and injustice in male-dominated societies (Garry & Pearsall, 1996). The theory "seeks answers to how to defeat or neutralize" the dominant forces that construct and influence women's lives (O'Mahony & Donnelly, 2010, p. 445). Sex and gender are differentiated in feminist theory. Whereas sex is a biological-defined category, gender is believed to be socially and culturally constructed (McManus, 1997). The societies we live in are believed to be gendered (MacCallum, 2002). Meanwhile, feminist theory brings about the concepts of knowledge and diversity. Western generalisation and normalisation of men's knowledge in societies are interrogated for its ignorance and suppression of women's diverse perspectives (Harding, 1991). In this sense, feminist theory is committed to de-construct the "malestream" ways of thinking (Chris, 1999, p.

3). Its social and political goal is to remove unequal power relations between dominant and subordinate groups, and to promote equal contributions by different gender groups (McManus, 1997).

Standing not as a single theory, feminism involves different narratives including “liberal feminism”, “ideological or Marxist feminism”, “radical feminism”, “standpoint feminism”, and “poststructuralist or postmodern feminism” (Lindlof & Taylor, 2002, p. 54). Feminist standpoint theories, in particular, direct me to think about feminist principles in criticising positivism and objectivity that neglect women as socially constructed persons whose identities, experience, and knowledge are shaped by social practices and relations in this gender-stratified society (Harding, 1991; Kirsch, 1999). Drawing from feminist standpoint theories, Harding (1991) explains how gender differences give advantages to those who can make use of the differences. Kirsch (1999) further describes standpoint theory as a valuable tool for researchers to “acknowledge that participants’ identities, backgrounds, and locations – as well as our own – can serve as powerful sources of knowledge” (p. 17). All knowledge, therefore, is reflexive coming as it does from subjective experience and influenced by different contexts.

Feminist standpoint theories illustrate how knowledge from a woman’s perspective has been devalued and women’s voices have been discouraged in Western societies. As Kirkham and Anderson (2002) argue, the feminist perspective “recognizes the need for knowledge construction from the perspective of the marginalized female subject whose voice has been muted in the knowledge production process” (p. 10). Feminists argue that our society is gendered, with a division of man and woman, the one of mind and body (MacCallum, 2002), and the one of culture and nature (Alley-Young, 2008). The man’s figure is

associated with mind or culture (e.g., knowledge, logic, public life) whereas the woman's figure is associated with body or nature (e.g., fertile body, family-oriented life). "Mind is privileged over body" (MacCallum, 2002, p. 89), and "logical male as culture is intended to rule illogical woman as nature" (Alley-Young, 2008, p. 311). Inasmuch, women feel obliged to speak out and act in certain ways that accurately reflect their true feelings, thoughts, and situations (Harding, 1991). As to postcolonial theorising, the notion of othering is also central to feminist theorising. From the feminist perspective, women are often seen as others, *strangers* or outsiders to the social order and the production of knowledge (Harding, 1991; Kirsch, 1999). To articulate how women are positioned as others, Harding (1991) clarifies the tensions between natives and strangers:

The "natives" tend to tell a stranger some kinds of things they would never tell each other; further, the stranger can see patterns of belief or behaviour that are hard for those immersed in the culture to detect. Women are just such outsiders to the dominant institutions in our society, including the natural and social sciences. Men in the dominant groups are the "natives" whose life patterns and ways of thinking fit all too closely the dominant institutions and conceptual schemes. (p. 124)

These differences are likely to create a big gap between the natives and the strangers, and to exclude the strangers from dominant discourses which favour the natives. Feminism not only teaches researchers to examine the differences between women's and men's situations, but also requests researchers to understand and interpret these differences from the perspective of an outsider (Harding, 1991). Therefore, a feminist approach focuses on knowledge



construction about women and their diverse contexts, which are often hidden from mainstream society (Hesse-Biber & Yaiser, 2004). Researching on women's lives, experiences, and diverse situations, the feminist approach seeks to produce "feminist knowledge" about oppressive situations for women, and to benefit women at both individual and social levels (Green, Hebron, & Woodward, 1990; Stanley & Wise, 1990; Olesen, 2005; Olesen & Clarke, 1999). Despite the common thread, feminism and feminist research remains diversified; it carries different perspectives and principles, and its approach has been adopted in various research disciplines.

The feminist approach has been commonly used in the fields of social science, education, and health (Olesen, 2005). For example, the feminist scholar Ann Oakley (1981) studies working-class, pregnant women to understand their medical concerns and prenatal care. Oakley's collaborative relationship with her participants has had a significant impact on feminist research, that is, feminist research critiques positivist research methodologies and focuses on methodologies that allow researchers to hear the voices of women and empower them to change their lives. In a study on women and their doctors, Roberts (1981) investigates the possibility that women use their doctors as a source of consultation and sympathy for the frustrations of the women's own lives. Research directed by Kirsch (1993) is concerned with women's roles as others and outsiders in the academic context, and hence she attempts to learn about writing and research experiences of academic women in various disciplines.

Although some feminist scholars (Fishman, 2001; Fosket, 1999; Oakley, 1981; Roberts, 1981) have researched women's health and healing, they mainly problematise the women's physical and psychological health situations and the relations of their social worlds (Olesen, 2005). The identities and knowledge

about women in childbirth and maternity contexts, within the health discipline, have not been stressed. Their relationships with health practitioners, families, friends, and communities in influencing women's construction and representation of knowledge have been silenced. My research explores women's health and relationships with health practitioners in quite a different feminist framework. I seek to create knowledge about a certain group of women by examining their intercultural communication experiences in the maternity and health contexts.

There is not much space in this thesis to outline all perspectives and principles of feminism because they are highly diversified and interdisciplinary and cross a variety of methodological and analytical approaches. For me, the key theoretical insights I have learnt from feminism and feminist research are that the relevant research is beneficial for women to honour the voices of women, to create opportunities for alternative knowledge, and to empower women to change the conditions of their lives (Kirsch, 1999). But my questions here are whether the term "feminism" can capture the goals of my own feminism; does the concept of "woman" represent all "women" including me and my research participants who are not originally from the First World? These questions urge me to redefine feminist epistemology and approaches from a different angle to tackle my research objectives.

### **Third World Feminism**

An enlightened description of Third World feminism can be found in Mohanty's (1996) work. According to her, Third World feminism addresses "two simultaneous projects: the internal critique of hegemonic 'Western' feminisms, and the formulation of autonomous, geographically, historically, and culturally grounded feminist concerns and strategies" (p. 172). Although these

two projects seem to be contradictory, they can be addressed simultaneously. In what follows, I discuss Third World feminism based on the principles of these two projects.

### **Key characteristics and applications**

For a long time, mainstream feminism has been criticised for portraying a white, middle-class woman image that forms “a problematic concept of a universalized ‘woman’ or ‘women’” but ignores “differences among women in terms of race, class, ethnicity, sexuality, and nationality” (Hesse-Biber & Yaiser, 2004, p. 4). As Garry and Pearsall (1996) argue, “some feminists who are western, white, heterosexual, Christian, middle or upper class (or in another dominant position) have failed to recognize the ways in which they are privileged at the same time they are subordinated as women” (p. 2). White Western feminists are criticised for “uphold[ing] structures of white privilege just as they reject structures of male privilege” (McIntosh, 1995, as cited in Alley-Young, 2008, p. 310). Woman is not the only concept any of us lives under.

In my research, for instance, a migrant ethnic Chinese mother moves in the Western world as a woman, a migrant, a Chinese, and a person of colour. The one is someone’s mother, wife, daughter, and a member of some ethnic group, community, institution, or organisation. Despite the idea that commonalities can be found in women’s experience which is shaped by concepts of woman, subjectivity among women is more transparent because women’s lives, knowledge, and experience are socially constructed by the different contexts they belong to. Lewis (2000) contends that the traditional white feminism essentialises women’s identity and erases the subjective experience of women in relation to their race, class, culture, and historical backgrounds. The interlocking of these historical,

social, political, economical, and cultural factors helps explain different forms of oppression, and so does define the multiple identities of women.

To steer away from the shortcomings of Western feminism, postcolonial feminism has emerged as a conjoining of feminist theory with postcolonial theory. The postcolonial feminist perspective argues that the identities and experience of Western women and non-Western women need to be portrayed differently. The image of being modern, confident, and well-educated is usually placed on Western women, whereas the image of being passive and voiceless is placed on women with non-Western backgrounds (Mills, 1998). Accordingly, the experience of Western women stands in glaring contrast to the one of women from non-Western societies. Feminist researchers in the postcolonial mode critique Western feminist discourse and encourage researchers to listen to the voices from the marginalised people – Third World women (Wearing, 1998). Third World feminism, therefore, daws on and delves deeper than mainstream feminism.

The term *Third World* refers to “the colonized, neocolonized, or decolonized countries (of Asia, Africa, and Latin America) whose economic and political structures have been deformed within the postcolonial process, and to black, Asian, Latino, and indigenous peoples in North America, Europe, and Australia” (Mohanty, Russo, & Torres, 1991, p. ix). Johnson-Odim (1999) added more to this geography-based definition, “Third World is frequently applied in two ways: to refer to 'underdeveloped'/overexploited geopolitical entities, i.e. countries, regions, even continents; and to refer to oppressed nationalities from these world areas who are now resident in 'developed' First World countries” (p. 314). To make it simple, Third World women are the women who come from postcolonial and developing countries. This group of women also includes the ones who reside in developed countries. “ Thus, Third World feminism offers

those women the opportunities to express their struggles and experiences, as a form of “self-empowerment” (p. x), and it also reveals historically colonising and contemporary relationships between Third World women and First World peoples (Mohanty et al., 1991).

Third World feminist theory works towards an examination of gender oppression in relation to colonialism and neocolonialism that have silenced women in postcolonial societies (Mestry & Schmidt, 2012). Compared to men subalterns, women subalterns are even more suppressed and vulnerable because they are the victims of both the colonisation and patriarchy of their society (Spivak, 2000; Ibrahim, Nordin, Adzmi, & Jusoff, 2009). As Western women’s historical experiences are tied up with colonial and imperial interests that are different from Third World women’s experiences, there are clear power differences among women in accessing and managing knowledge, and gaining access to socioeconomic and cultural resources (Ali, 2007). Inasmuch, Third World feminist theory provides impetus for new theoretical and methodological lenses to challenge gender oppression within our own culture rather than through the one constructed by the Western colonisers (Mestry & Schmidt, 2012).

To respond to the emerging perspective, some postcolonial feminist researchers (Chow, 1999/ 2000; Dill, 1987; Ladner, 1987; Mestry & Schmidt, 2012; Spivak, 1988; 1990; Wearing, 1998) have begun to capture the subjectivity and complexities of Third World women. Spivak’s (1988; 1990) monumental work on women’s position in colonial India has inspired the feminist movement and thinking. She argues that Indian women, as the colonised and subaltern women, have suffered from the oppression of dominant male and Western discourses, and hence this group of women finds it hard to speak for themselves. Inspired by Spivak’s argument of othering, Wearing (1998) explored leisure

experiences of two groups of women –Australian aboriginal women and Bosnian refugee women in Slovenia – who have been constructed as others in relation to the Western concept of woman. Her argument for including other women’s various leisure experiences in the light of postcolonial feminist perspectives opens up possibilities to rewrite masculinist as well as mainstream feminist ways of viewing the world. A recent piece by Mestry and Schmidt (2012) examines the issue of female principals’ experiences in South African schools. They apply a postcolonial feminist framework to explore gender equity and stereotypes as a barrier for blocking women’s progress as leaders. Gender oppression in leadership is examined in relation to the patriarchal structure of South African society and African cultural beliefs. Chow (1999/2000), who critiques Toril Moi’s 1985 book – *Sexual Textual Politics* – by interpreting an Anglo-American and French fictional narratives, offers a theoretical and political c white feminism by tackling the tensions between dominance and subordination, and between exclusion and inclusion.

In her study of poor black girls in the city, Ladner (1987) uses “deviant perspective” (p. 75) to explain how dominant groups in the society apply their rules to label and judge black people as outsiders. Around the same time, Dill’s (1987) work, emphasised black women’s role in the workplace which generated an alternative perspective of womanhood in American society. Both these scholars address the issue that black women in the Western world have little power to resist the labels and the judgements placed on them by dominant groups. However, the subjective and independent knowledge of black women is valued, and such valuable knowledge can be used as a weapon against forms of exclusion and subordination. An alternative black women’s standpoint deriving from their different experiences and views may challenge dominant knowledge which is

often perceived as the norm in Western masculine society: “An alternative epistemology challenges all certified knowledge and opens up the question of whether what has been taken to be true can stand the test of alternative ways of validating truth” (Collins, 1996, p. 241).

The researchers cited above provide rich insights into intersections of gender, race, class, culture, and other factors to open up a new analytic space. Feminist researchers in a postcolonial mode bring the marginal voices into the centre and make the hidden visible (Anderson, 2004). In recent years, a growing number of health and nursing researchers (Anderson, 2004; Anderson et al., 2003; Grant & Luxford, 2008; Mkandawire-Valhmu & Doering, 2012; O’Mahony & Donnelly, 2010; Racine, 2003; Tang & Anderson, 1999) have joined the line of these Third World feminist researchers. They employ postcolonial feminist theory to examine health and nursing issues of indigenous people and/or immigrants.

The concept of cultural safety has been incorporated in many health and nursing studies (Anderson et al., 2003; Kearns & Dyck, 1996; Mkandawire-Valhmu & Doering, 2012; Papps & Ramsden, 1996; Racine & Petrucka, 2011; Ramsden, 1993; Tang & Anderson, 1999; Woods, 2010). This concept was originally developed by indigenous nurses in the postcolonial climate of New Zealand and it has been acknowledged as a standard practice in other multicultural societies (Racine & Petrucka, 2011). Cultural safety is perceived as a guideline to examine health communication between White health professionals and marginalised ethnic patients, indigenous patients in particular (Woods, 2010). The concept of cultural safety has been revisited by Anderson et al. (2003), Tang and Anderson (1999), and also Mkandawire-Valhmu and Doering (2012) within a postcolonial feminist mode. In recognition of the Canadian

sociocultural, economic, and historically colonial and neocolonial situations, Anderson et al. (2003) examine the power relations and culturally safe or unsafe practice in clinical settings. Taking this a step further, Tang and Anderson (1999) suggest a rewrite of culturally safe nursing practice by engaging nurses in a reflexive process to recognise historical, social, gendered, and cultural backgrounds of non-Western groups. In addition, Mkandawire-Valhmu and Doering (2012) apply a postcolonial feminist framework to the implementation of an American nursing study abroad programme in Malawi, Africa. By reviewing course content, integrating standpoints from instructors as well as students, and recalling students' reflexive journals, Mkandawire-Valhmu and Doering (2012) develop students' understanding of colonisation, neocolonisation, and globalisation. They also look at the sociocultural context of Malawi in constructing health experiences of Third World people. Accordingly, students are encouraged to transfer their study abroad experience to culturally safe nursing care to meet different needs of non-Western populations in the United States.

Meanwhile, the postcolonial feminist approach provides O'Mahony and Donnelly (2010) with an analytic lens to explore immigrant women's mental health care experiences in Canada. They contend that the individual woman's health experience is shaped by the social, cultural, economic, historical, and political context of their lives. Drawing on this argument, O'Mahony and Donnelly intend to improve equitable health care by bringing knowledge about immigrant women's mental health care experiences and increasing understanding to meet those women's health care needs. Similarly, Grant and Luxford (2008) weave insights from postcolonial feminist theory to enable a mindfulness of power, resistance, identity, and marginalisation, which are influenced by colonialist images in intercultural communication practices of Australian child and



family health. To explore Haitian caregivers' ways of caring for ageing relatives in Canada, Racine (2003) also implemented a postcolonial feminist perspective in this nursing research. She addressed health inequities within Canadian health care systems with a consideration of race, gender, power, and social classes which are shaped by the larger social and cultural context. Anderson (2004) extended the breadth and depth of the postcolonial feminist approach in her nursing research by showing a case example of the transition home of an Anglo-Canadian family.

Although my research on health care interactions between migrant ethnic Chinese mothers and New Zealand's maternity-care and health providers is very different to the experiences of women's mental health care, child and family health, and the transition home, as explored by the researchers mentioned above, the thread that binds our research is our use of the theoretical lenses of postcolonial and feminist perspectives to understand and advance health knowledge and practice. My research questions revolve not only around understanding the delivery of maternity care services in New Zealand; the questions also center on exploring different values, beliefs, perceptions, and experiences from migrant ethnic Chinese mothers. Chinese mothers' communication perceptions and experiences with mainstream maternity-care and health providers move beyond individual experiences of childbirth and health. Rather, their experiences need to be addressed within the social, cultural, and historical contexts of their lives. Third World feminist theory is used to illuminate the ways in which race, gender, and class relations influence social, cultural, and historical contexts, which in turn, shape the lives of Chinese mothers.

My research is also used to unveil the influence of power in intercultural communication processes between mothers and health care providers. Third

World feminist theory encourages me to focus on power relations, not only to interpret power issues in relation to gender and simply physician-patient status, but also to analyse the power issue with a consideration of different race, class, knowledge, beliefs, experiences, and discourses. Likewise, to understand (re)negotiation and (re)construction processes of Chinese mothers' cultural predispositions of childbirth in intercultural communication with health care providers, Third World feminist theory guides me to acknowledge the possibility that Chinese mothers may construct new knowledge of childbirth with the influence of the New Zealand health discourses. Chinese mothers may try to maintain their Chinese identities and to resist being assimilated like other mothers in New Zealand. The mothers may also empower themselves to negotiate their values of childbirth in communication with health care providers and thus to influence carers' values of childbirth with their own. With theoretical insights of Third World feminism in mind, I am able to be open to different possibilities and stories from this group of migrant women.

### **Propositions and assumptions**

A key proposition of Third World feminist theory is embracing the postcolonial perspective to help critique the essentialism within Western feminism – that all women suffer from the same suppression of being women. Third World feminism is developed to “resist and work against ‘Western feminist discourse’” (Mohanty, 1984, p. 333). It recognises identities, rights, and necessities of women on the bottom in the world (Chai, 1985; Moraga & Anzaldúa, 1983). To Third World women, their lives cannot be simply perceived as the result of gender relations. Race, class, nationality, and other differences are closely related to the oppressive situations that they experience as women (Sen

& Grown, 1987). In this sense, feminism has different meanings for Third World women from those that it has for First World women. In the Third World feminist perspective, knowledge is constructed about and from the Third World women; by those women; and for producing benefits for those women. The emergence of such feminist work significantly shapes new understanding about feminism and lets other' women's voices be heard, by researching on black or Latin women's situations, Asianness in the west, to women and immigration (Collins, 1990; Espin, 1995; Hondagneu-Sotelo, 2001; Puar, 1996).

Subjectivities or subjective experience is acknowledged by Third World feminist theory in rejecting the essentialism and totalising discourses of Western feminism (Mohanty, 1996). This proposition of Third World feminist theory provides an avenue to extend knowledge regarding multiple identities of Third World women, their fragile and vulnerable life experience, and their alternative ways of thinking. Significantly, Third World feminist theory addresses subjectivities in relation to the cultural, historical, and social contexts which influence gender, race, and class inequities, and so define the identities, knowledge, and vulnerability of Third World women. Applied to the subjectivities of health care experience, Third World feminist theory provides "the critical epistemological platform to address health problems pertaining to race, gender, and class that intersect with historical, economical, political, social, and cultural factors impacting on the health care system" (Racine, 2003, p. 97). The subjective health care experience is context-constructed within a gendered and racialised society.

Another proposition of Third World feminist theory is that it is concerned with more than just gender oppression. More importantly, it challenges gender oppression within one's own culture (Mestry & Schmidt, 2012) and offers Third

World women the opportunities to achieve “self-empowerment” (Mohanty, 1996, p. x). Third World women are empowered to voice their standpoints, experience, and concerns grounded in their diverse and subjective contexts, and so are they empowered to produce their alternative knowledge to question Western continuation of colonialism and androcentricism. Reflexivity, therefore, is encouraged by Third World feminists to “equalize power differentials, to understand the researcher’s racial biases, and to negotiate meanings with participants” (Racine, 2003, p. 98). It is the part of the women’s self-empowerment to reveal their authentic and lived experience.

There are two major, recurrent assumptions of Third World feminism. One of the assumptions is around the term Third World itself. Sangari (1990) challenges the way Third World is used by the West to “unite vast and vastly differentiated areas of the world into a single ‘underdeveloped’ terrain” (p. 217). Similarly, Mohanty et al. (1991) argue that Western feminism constructs the term *Third World woman* as “a singular monolithic subject” to articulate “a discursive colonization” with a construction of “third world difference” (p. 51). Hence, the term, postcolonial feminism is more often employed than Third World feminism in the contemporary research to “provide space for competing and disparate voices among women” (McEwan, 2001, p. 7). However, I prefer wording the theory as Third World feminism rather than postcolonial feminism in my research. I do not want to essentialise migrant ethnic Chinese women into Third World women. Neither do I prepare to set boundaries between Third World women and First World women. More strictly speaking, China, as a communist nation, is usually perceived as a Second World country which is modern and technologically advanced but follows different ideologies compared to those of the First World countries (Sharp, 2009). Despite this, the critical lenses of Third World feminist

theory are relevant to my research. My purposes are to highlight the term to challenge dominant feminist principles that people are familiar with, to acknowledge alternative perspectives from women who live in the Western world but have been socialised with non-Western discourses, and to let those women empower themselves to regain their voices in Western society. The exploration and understanding of stories of migrant ethnic women does not ignore diversity and complexities of their lived experience. Indeed, employing the term Third World feminism contributes to a stressing of the exploration and understanding of gender, race, and cultural inequities within certain cultures rather than viewing these issues through Western hegemonic discourses and culture.

The other assumption of Third World feminism runs counter to Third World feminist scholars who self-identify themselves as Third World women and seem to marginalise their research within Western academia (Brydon, 1989). Suleri (1992) critiques “authenticity” and “representation” in Third World feminist research (p. 760). She questions the way that only Third World women can speak for Third World women, and argues that minority status should not be misused to create division in feminist research. I do not agree with Suleri’s critique. In my research, I identify myself as a migrant ethnic Chinese mother whose knowledge is situated in the context of having been educated in both the East and the West. However, I do not perceive it as a necessity to represent other Chinese women, but I foresee the advantages of being a Chinese woman to get access to other Chinese women, to speak the language they are familiar with, and so to understand their stories with our collaboration and shared common sense. To summarise, I have discussed key features of feminism and Third World feminism, of particular interest in the applications, propositions, and assumptions of Third World feminist theory. Feminism challenges the privileging of

masculinity which is part of the larger context of colonialism; in particular, feminist standpoint theories relate gender differences to individuals' identities, experience, and knowledge. A postcolonial feminist perspective critiques the traditional and essentialist Western feminism by arguing that sexual and gender differences should be related to the larger historical, geographical, geopolitical, sociocultural, and colonial contexts. By this I mean that the core commitment of Third World feminism is to empower the thinking of *other* women to question and/or supplement privileged systems of Western feminist knowledge. Returning to Mohanty's (1996) statement with which I began this section, the two projects of Third World feminism, therefore, are not contradictory but simultaneous.

### **My Matrix of difference**

So far, I have visited social constructionism, postcolonialism, and Third world feminism, and discussed the characteristics, applications, propositions, and assumptions of each. There are important tenets within each theory that characterise how my research may be supported. Yet, I still feel a need for my own theoretical framework, which encapsulates key tenets of the theories, and that can speak more directly to the stories of Chinese women. So I develop a matrix of difference (see Table 1) as my theoretical frame, interlocking areas of social constructionist, postcolonial, and Third World feminist theories to fill in their gaps and clarify influences on intercultural communication within the health discipline.

**Table 1***A Matrix of Difference*

<b>Elements of discourse</b>	<b>Social constructionism</b>	<b>Postcolonialism</b>	<b>Third World feminism</b>	<b>Matrix of difference in my research</b>
<b>Language</b>	Sees language as a convention; examines language as a construction of particular realities	Critiques the power of language to define reality; exposes processes of othering in the use of language	Sees language as a construction of experiences of women in specific local contexts	Examines power in the use of language within intercultural and maternity care settings; specifically in the context of interactions between and among health care workers and ethnic Chinese mothers in NZ
<b>Values</b>	Explores values woven into social and institutional fabrics	Questions taken-for-granted institutional values; exposes processes of othering in the expression of dominant values	Questions universalised values and experiences of women across cultures	Examines and analyses mainstream values associated with childbirth and health care in institutional and cultural settings in NZ; rethinks and reorients values to be more inclusive
<b>Agency</b>	Sees knowledge, experience, and identity as being socially constructed	Challenges colonial grand narratives in representing other perspectives; promotes alternative bodies of knowledge	Challenges universalised knowledge about women; emphasises initiatives and resistances in local contexts	Examines who has the ability to exercise choice (and when) in the childbirth processes; creates spaces for alternative and multiple voices
<b>Identity</b>	Sees individual identity and identification as being based on interactions within a social group	Emphasises expression of identity as resistance; explores hybrid identities	Focuses on cultural differences in women's expressions of identity; emphasises subjective experience	Examines roles of identity and identification in building trust among individuals and organisations in the maternity care context of NZ; reflects on research journey and revisits notions of identity and identification

Table 1 depicts the core elements of discourse within social constructionism, postcolonialism, Third World feminism, and explains my theoretical framework – a matrix of difference – in guiding my way to analyse the research data. Both postcolonialism and Third World feminism are grounded in the logics of social constructionism. They reject essentialism and universalism while supporting the subjectivity and multiplicity of this socially constructed reality. Accordingly, language, values, agency, and identity have to be understood in historical, sociocultural, colonial, and neocolonial contexts. The theories motivate me to take a critical and reflexive stance to investigate the interrelationships between and among power, knowledge, and discourse.

Firstly, social constructionism sees language as a convention, that is, each language has certain structures, patterns, and expressive forms. Different cultural groups have different conventions of language, which needs to be acknowledged in analysing how language constructs particular realities. Postcolonialism does not merely see language as a construction of realities, but also argues that the use of language is a vehicle of power. The theory critiques the power of language to define reality, and uncovers the othered experiences of subaltern groups in the use of language. Third World feminism stresses the subjectivity of language in constructing certain experiences of women in local contexts. In analysing my research data, I interweave these elements of language to examine language difference between New Zealand maternity-care and health providers and Chinese mothers, to understand the subjective realities constructed through the use of language, and more importantly, to reveal and critique the power of language in defining certain privileged health communication and relationships.



Secondly, the discourse of values is embraced in all three theories. In social constructionism, the conception of values is a part of our social and institutional fabrics. Different societies and institutions have subjective and collective values shared by individuals associated with them. How individuals interpret values is based on the socialisation of values through discursive practices within social and institutional contexts. Postcolonialism questions taken-for-granted institutional values in marginalising and suppressing the othered values which are perceived as different and deviant. Likewise, Third World feminism is against dominant and universalised values. Specifically, it challenges universalised notions of women's values and experiences across cultures. The matrix of difference, therefore, directs me to examine and analyse mainstream values about childbirth, communication, and health in institutional and cultural settings in New Zealand. Moreover, I endeavour to problematise colonialism and neocolonialism in which certain ways of viewing the world are assumed as the only ways, and which tend to impose on others. Redressing essentialised values in understanding and interpreting childbirth and communication, I aim to invite multiple and alternative values to make mainstream values more inclusive.

Along with language and values, one's knowledge, experience, and identity are also socially constructed. Postcolonialism raises the concept of agency and critiques colonial grand narratives which represent and silence alternative voices from other parts of the world. Third World feminism challenges essentialised and universalised knowledge about women. It attempts to acknowledge local contexts, and to develop knowledge based on Third World women's epistemologies. The matrix of difference is grounded in Third World

women's discourses and ideologies. The critical contributions of the theories are that their theoretical insights guide me to re-evaluate taken-for-granted notions of knowledge of childbirth, culture, and communication reflected in New Zealand health management structures and practices, and to challenge the established systems by bringing alternative ways of thinking and doing from Chinese mothers and their families. In particular, the discourse of agency directs me to look at my research data and question: who has the power to speak and who has the power to make decisions and when?

Finally, the discourse of identity arises from the tenets of social constructionism, postcolonialism, and Third World feminism. Social constructionism conceives individual identity and identification as being based on interactions within a social group. In other words, one's identity and identification can be constructed by social interactions and different contexts they are associated with. In postcolonialism, identities are seen as hybrid, interrelated, and sometimes overlapped. The expression of identities is seen as an approach of resistance. The exploration of hybrid identities unveils the power dynamics between and among different groups. In Third World feminism, cultural differences in women's expressions of identity and women's subjective experience are particularly focused on. In my research, I use these perspectives to examine identity and identification in building and maintaining trust among individuals and organisations in the maternity care context of New Zealand. I focus on how maternity and health care organisations communicate to their workers and customers to help construct their identities, how individuals identify themselves within social and organisational contexts, how individuals negotiate, react, and/or resist the identities that are expected by the organisations, and how individuals

establish a trusting relationship with a consideration of identities. Meanwhile, the matrix of difference is concerned with establishing a reflexive research attitude and a reflexive relationship with research participants. Reflexivity is largely employed in social constructionist studies in order to subjectively interpret the events with an acknowledgement of the researcher's own feelings, emotions, and reactions. Postcolonial and Third World feminist studies also widely use reflexivity to empower the colonised and Third World women in the research processes, and to facilitate their self-empowerment in regaining their voices. Drawing on these perspectives, the matrix of difference enables me to recall my hybrid identities and involvement in my research journey.

Overall, all three theories are contrary to realism and objectivity and are concerned with subjectivity and multiplicity. Drawing on this critical lens, the matrix of difference guides me to reflect on the subjectivity and multiplicity of Chinese mothers' intercultural communication experiences with mainstream maternity-care and health providers. Also, the matrix of difference juxtaposes postcolonial and Third World feminist angles to extend analytical boundaries of postcolonialism, and to stress subaltern women's vulnerability. I have to rethink the vulnerability of migrant ethnic Chinese mothers regarding different forms of oppression in gendered and postcolonial contexts. Chinese mothers are subordinated as women but also are suppressed and ignored as migrants coming from a developing country and currently living in a Western country with a colonial history. I am open to the voices of those mothers who may be labelled as *others* different to the *natives* (i.e., dominant groups), and may be misrepresented in Western society.

What also makes the matrix especially pertinent to my research is that it

provides me with a context to understand and interpret the intercultural communication experiences within the health discipline. Chinese mothers' communication perceptions and experiences with mainstream maternity-care and health providers move beyond individual experiences of childbirth toward recognition that childbirth experiences of these mothers must be addressed within the social, cultural, and historical contexts of their lives. The matrix of difference encourages me to reflect on this perspective to identify the important characteristics (e.g., gender, race, class, identities, values, relationships) of the mothers, and to explore the impact of these on the social, cultural, historical contexts that then construct the lives of Chinese mothers.

Another core commitment of the matrix of difference is that the matrix leads me to revisit power relations. Rather than viewing power only as visible and explicit in controlling materials and behaviours, I also need to pay attention to the implicit ways in which power is produced, re-produced, manipulated, and resisted. The theory advances my knowledge regarding interrelationships of power, knowledge, and discourse. Aligning the non-Western and Western experiences and representations, I explore their mutual effects on each other in the intercultural communication processes between New Zealand maternity-care and health providers and Chinese mothers. I investigate power relations between mainstream groups and other groups. I take this further to unveil unequal power relations among different cultures, genders, classes, and so forth, which emerge from both explicit and subtle ways within the Western health discourses and practices, as the heritage of a colonial past and neocolonial present.

Table 1 encapsulates the critical lenses of social constructionism, postcolonialism, and Third World feminism, and more significantly, the table

introduces my theoretical framework – a matrix of difference – deriving from the particular insights I get from three other theories. The matrix provides me with an avenue to extend my knowledge regarding language, values, agency, and identity. Rethinking my positions as well as subjective and multiple experiences of Chinese mothers, I aspire to bring these epistemologies to the centre of Western hegemonic knowledge systems.

### **Conclusion**

So far, I have reviewed the characteristics, applications, major contributions, and critiques of the theories of social constructionism, postcolonialism, and Third World feminism. Social constructionism provides the logics for the other two theories. Its commitment to the importance of context in understanding individuals' behaviours is supported by postcolonial and Third World feminist researchers as a means to explore the diverse context of oppressive situations. The emphasis in social constructionism on knowledge as a socially constructed concept has particular relevance to postcolonial and Third World feminist scholarship, especially when researchers attempt to stress structures of knowledge production from subaltern people and their contexts (Sen & Grown, 1987; Young, 2003). Knowledge is constructed by values, beliefs, experiences, social interactions, and oppressive situations of people who are different and alternative to those in core centres of societies. Aligning with social constructionism which supports the idea of alternative constructions and interpretation of events (Schwandt, 2001), postcolonialism and Third World feminism focus on this alternativeness as a means to interrupt established structures of modernity and histories of colonisation (Shome & Hegde, 2002).

Scholars have expanded this critical characteristic, challenging mainstream discourses, investigating the power tensions within the phenomenon, and influencing the mainstream by bringing other knowledge from other parts of the world (Hesse-Biber & Yaiser, 2004; Young, 2003).

Re-reading this chapter, I have realised that my research questions were not merely proposed to observe and interpret the patient-health carer intercultural communication experiences. Rather, the critical impulses of my research questions were to empower migrant ethnic Chinese mothers to speak about their stories, to value their knowledge, contexts, identities, and experiences, and thus to open the door for alternative structures of knowledge production in relation to health communication to step into the established Western centre of knowledge production. That is the reason why I have developed the matrix of difference, borrowing theoretical insights from social constructionism, postcolonialism, and Third World feminism which critique objectivity and positivism, but support multiplicity and alternativeness. This consolidated theoretical frame offers me a platform to challenge the established Western centre of knowledge production, and to bring in alternative and multiple structures of knowledge production of childbirth, culture, and communication. I started to rethink research methodology and methods in a search for those which can best reflect alternative ways of thinking and decided to use interviewing, observations, keeping a reflexive journal, and CDA in my research. In the next chapter on methodology and methods, I explore the details of each methodological approach, and my data collection and analysis processes.

## **CHAPTER 6: METHODOLOGY AND METHODS**

This chapter outlines the methodological design and the methods of this research. The link between methodology and theoretical insights and the reasons for applying these methodological approaches in the study are also explained and discussed. The methods of data collection include conducting interviews and observations with migrant ethnic Chinese mothers, conducting interviews with maternity-care and health providers, and keeping a researcher's reflexive journal. Special attention is paid to methodological reflexivity which is integral to social constructionist, postcolonial, and Third World feminist approaches. The process of data collection is explored in detail. The process of using the CDA approach to analyse the data from interview transcripts, observations transcripts and notes, and a reflexive journal is also described in the chapter. This chapter ends by providing an account of the challenges that emerged in the processes of sampling, data collection, and data analysis, as well as ethical considerations of the project.

### **Methodology**

The matrix of difference, grounded in social constructionist approaches, postcolonial theory, and Third World feminist theory in this study, acts as a reminder to me to rethink a methodology which better reflects alternative and multiple knowledge and experiences of participants. Methodology is defined as a procedure to explore the reality through certain disciplinary or conceptual strategies (Guba & Lincoln, 1994). I interweave the three theoretical perspectives to guide my research paradigm and develop strategies for the selection of methods to explore and analyse intercultural communication interactions between ethnic Chinese mothers and their maternity care providers.

In this research, I aim to avoid generalisations and the one ‘truth’ approach and instead focus on constructions, experiences, and multiplicities. That is, contextual, relativist, critical, and reflexive commitments form the methodological basis of my research. Hence, I interlink interviewing and observations with keeping a reflexive journal, and adopt the CDA approach to stress the quest for alternativeness and multiplicity. Following a discussion of interviewing and observation, I focus on the reasons for applying reflexivity in the study. I then examine the approach of CDA and explain in detail how this approach is directed by my theoretical framework to help analyse my research data.

### **Interviewing**

Interviewing is regarded as a verbal interchange between the interviewer and the interviewee (Arksey & Knight, 1999; Burns, 2000). However, Fontana and Frey (2005) go beyond this view and contend that interviewing is not merely a verbal interchange of asking questions and getting answers but rather “active interactions between two (or more) people leading to negotiated, contextually based results” (p. 698). Gubrium and Holstein (2003) support this point and argue that the interview has moved from being used to get to know individuals to understanding the whole social world. The interview has transformed personal experience into public experience, and it is a significant means to make sense of our lives as we all take part in society. In this sense, interviewing is a good way to explore socially produced knowledge (Allen, 2005; Burr, 1995) as stressed by social constructionism, which moves its emphasis from the person to the social realm. Knowledge is not constructed in isolation but formed with shared practices, language, discourses, and so forth.



I anticipated using the interview method to understand the mothers' knowledge construction about childbirth and to investigate its impact on the mothers' responses to the New Zealand childbirth and health care practices. Meanwhile, conducting interviews with maternity-care and health providers would also assist me in exploring the knowledge of New Zealand medical professionals around childbirth, how such knowledge is constructed and influenced by the Western health discourses, and what its effects are on medical professionals, Chinese mothers' communication, and relationships.

Furthermore, postcolonial theory and Third World feminist theory both rest upon the view of providing an opportunity for subaltern people to voice themselves and their contexts. Conducting interviews with migrant ethnic Chinese mothers would be the best way to listen to their sincere stories, subjective experiences, and concerns. As Arksey and Knight (1999) and Patton (2002) conclude, interviewing helps the researcher capture the participants' multiple perspectives – what they say and think, rather than what they do – their experiences, perceptions, and stories which one cannot directly observe. By using interviews, I would be able to understand and interpret mothers' and health care providers' intercultural communication experiences and perspectives. Comparing data collected from interviews with those from observation would also allow me to “achieve efficiency in data collection” (Lindlof & Taylor, 2002, p. 175). What I have missed in the interviews, such as non-verbal communication and contexts, could be retrieved from the observations.

### **Observation**

A second data collection method I adopted is observation as it helped me

gather firsthand data on behaviours or processes, capture a great variety of interactions, and openly explore the research questions (Lofland & Lofland, 1995). Observation is traditionally described to have four types based on the four roles that a researcher undertakes: “complete participant, participant-as-observer, observer-as-participant, and complete observer” (Gold, 1958, p. 217). The type I chose to employ in my study is “complete observer” which means that the researcher avoids interacting with the observed participants and influencing the observed activities (Adler & Adler, 1994). I considered the complete observer role to be the most appropriate to my study because the observations were carried out in maternity and health care contexts where health appointments were time-limited and thus I did not want to interrupt the mothers’ visits to their maternity and health providers. Nor did I want to influence health diagnosis and treatments.

Social constructionism, postcolonialism, and Third World feminism all emphasise language, situations, experiences, and performance in relation to people’s identities, the larger contexts they belong to, and the power involved in communication (Burr, 1995; Gabriel & Griffiths, 2002; Frenkel & Shenhav, 2006; Hesse-Biber & Yaiser, 2004). Using the complete observation approach would allow me to delve deeper into the use of language and nonverbal communication between mothers and health care providers by taking into account contexts of their social interactions, and the interpretation of performance in front of their audience.

Given that my research questions were about how Chinese mothers’ cultural predispositions of childbirth and communication affected their responses to New Zealand childbirth and care practices, how power influenced

communication between mothers and their health care providers, and what the role of health management structures and practices were in facilitating the childbirth processes for Chinese mothers and their families, I believed I would be able to address parts of these questions by observing the communication within maternity and health care settings. I would use observation to further check the detail between what participants said in interviews and what in fact I observed happen. As Lofland and Lofland (1995) point out, observation allows researchers to understand things that participants may be unaware of or unable to talk about in an interview.

Despite the usefulness of employing the complete observation approach to my study, it still has limitations. By merely focusing on the researcher/observer role, I might not be able to capture my other identities, roles and emotions that emerge during an observation. Keeping a detached relationship from the observed participants might also prevent me from learning the significance of social interactions since I am not allowed to answer questions and ask questions to insiders to justify the observed information (Gold, 1958). To overcome the limitations of both interviewing and observation, I decided to employ an additional research method – reflexivity.

Interviewing and observation are appropriate approaches to use to enter into other people's worlds – to find out what they say, think, and what they do. However, my research is framed by the matrix, which guides me to think deeply about my research identities, roles, relationships, and research processes. In other words, how can I fully represent Chinese mothers' voices in terms of their cultural predispositions, perceptions, and experiences? How can I speak for mothers and empower them at the same time? What is my role of being a

researcher when taking responsibility for participants, making choices, and encountering research challenges and dilemmas? Thinking about reflexivity has clarified my questions. In the discussion that follows, I review methodological reflexivity as a significant theoretical contribution to social constructionism, postcolonialism, and Third World feminism.

### **Reflexivity**

Reflexivity is widely used in social constructionist research, which is, in turn, largely influenced by ethnographic and feminist studies (Burr, 2003). Social constructionism identifies a reflexive relationship between the researcher and the participants (Allen, 2005; Burr, 2003). The researcher can involve himself or herself in the research by acknowledging his or her own identities, emotions, backgrounds, and other contexts relating to the participants and the study she or he is doing (Burr, 2003). Markham (1996), for example, indicates her reflexive relationships with research participants, who are members of a small design company experiencing a work environment with powerful, hegemonic system of control. She talks about ethical dilemmas she faced, and how her presence in the company affected other participants' lives.

Likewise, postcolonial researchers forcefully become engaged in the inter-related contexts of colonialism and neocolonialism, and “remain acutely aware of the history, heritage, and legacies of such methods, and the dilemma that consequently confronts the researcher” (Shome & Hegde, 2002, p. 259). Chow (1996), for example, starts writing her essay with a reflexive example of her colleague holding the stereotypical *native* image towards a modern Chinese candidate for Chinese language and literature. Drawing on that experience, she

further articulates her understanding of native and *other*, and raises more questions of exploitation, resistance, and survival. From a different perspective, Munshi (2005) concentrates on neocolonial discourses of managing diversity in Western society. By interweaving his own personal experience of being discriminated against as an Asian migrant, Munshi examines how Western dominant discourses construct and control non-Western others who are at the periphery of the power zone.

The concept of reflexivity is not only emphasised by postcolonial scholars; it is also proposed by feminist scholars in theorising ethical concerns of how feminist research is able to benefit women (Kirsch, 1999). Kirsch (1999) borrows from studies by Oakley (1981) and Chiseri-Strater (1996) who both encounter research challenges and ethical dilemmas in maintaining objectivity in their initial processes of studying women. According to Kirsch (1999), both researchers acknowledge their intrinsic involvement in the research processes, and later change their research procedures by situating themselves in the research context and approaches. It should, however, be stressed that postcolonial feminist researchers take the concept of reflexivity to another level. A typical example is from Ladner's (1987) study of Third World women – *Black girls in the West*. While also explaining the difficulties of maintaining objectivity in carrying out her research, she reflects on her own experience of being a Black girl raised and socialised by her family and the Black community, and claims “I brought with me these attitudes, values, beliefs and in effect, a Black perspective” (p. 75) in study.

The very nature of reflexivity, therefore, “allows researchers to engage in the kind of critical reflection and analysis” and “enables researchers to be

introspective, to analyze the research process in response to participants, and to adjust and refine their research goals as they learn more about those they study” (Fonow & Cook, 1999, pp. 3-4). One of the outcomes of such theorising is the equal partnership between a researcher and his or her participants (Lindlof & Taylor, 2002; Kirsch, 1999). Since both postcolonialism and Third World feminism are committed to theorising the production of knowledge as an act of power, based on their knowledge and experience, the research processes should empower participants. To do so, the traditional role and responsibilities of the researcher have shifted from simply controlling the research design, process, interpretation, and analysis to creating a more collaborative and interactive relationship with the participants in the research procedures.

Yet, even if this change in research methodology proposed by postcolonial and feminist scholars contributes to striving for alternatives, there are also challenges or so called ethical dilemmas involved in the more intimate relationship between the researcher and the researched: “As researchers and participants get acquainted, establish trust, and form friendships, they become vulnerable to misunderstandings, disappointments, and invaded privacy” (Kirsch, 1999, p. 26). This point reminds the researcher to be aware of these ethical dilemmas, but it does not mean that distanced, detached, and objective relations with the participants are privileged. Rather, the researcher using reflexivity is encouraged to support, empathise, and respect the participants in an appropriate way to avoid disappointments and exploitation (Kirsch, 1999).

Once the researcher makes choices to empower others in the research process, she or he also needs to take into account risks of interpretation and representation, for instance, the risk of misrepresenting or misinterpreting others,

the risk of speaking for others but imposing the researcher's own desires, the risk of giving voices to some but ignoring the others (Kirsch, 1999). Thus, using a reflexivity approach in the study offers a solution to minimise these risks because it forces the researcher to take responsibility for his or her representations of others by being reflexive, self-critical, and "speaking with others" rather than simply "speaking for others" (Alcoff, 1991/1992, p. 23). Although the notion of "speaking with" stresses a collaborative relationship between the researcher and the researched, "it can also imply an 'us and a them' – an us who speaks with, and a them who is spoken with" (McConaghy, 2000, p. 213). To address this concern, a notion of "speaking from" is prioritised to remind us that we all speak from somewhere, and hence we need to consider our own contexts, and our motivations for pursuing equal and collaborative research relationships (McConaghy, 2000). An effort in this direction helps create a less hierarchical relationship between the researcher and the researched, and to make the research truly representative and empowering, for people in a study.

Researchers keep diaries, containing personal records of insights, understandings, emotions, concerns, and decisions, as an integral part of the research processes (Maykut & Morehouse, 1994). By adopting reflexivity in keeping diaries, researchers can incorporate personal experiences, emotions, reactions, and relationships with their participants into the description and analysis of other participants (Ellis & Bochner, 2000). In my researcher's diary, I reflected on my role as a Chinese mother and a researcher, and on my relationships with Chinese mothers, maternity carers, and other health providers. These reflections allow me to compare my understandings of childbirth and responses to the New Zealand maternity and health care practices with those of

my participants, and facilitate a holistic interpretation of participants' perceptions and experiences. I am also able to [re]construct/[re]interpret Chinese mothers' intercultural communication experiences with their maternity-care and health providers with a consideration of the mothers' as well as my emotions and reactions. Together, all these approaches provide a thick description (Geertz, 1983) of Chinese mothers' childbirth experiences.

So far, I have highlighted the key nature of interviewing and observation in understanding participants' perceptions, experience, and interactions in the health communication processes. I have provided a sense of reflexivity which is commonly used in social constructionist research and is also indeed the core of postcolonial and Third World feminist research. Reflexivity requires researchers to acknowledge themselves and their contexts, as well as their interrelationships with those whom they study. To some extent, the approach of reflexivity offers a remedy for researchers to consider their responsibilities, choice, challenges, and ethical dilemmas involved in the research processes. By critically reflecting on my research context and my researcher self, I position myself in an equal and interactive relationship with other mothers, and truly represent our knowledge and experiences in order to benefit the mothers. I now go on to explore the CDA approach which I use to analyse my research data.

### **The Approach of CDA**

CDA, derived from Critical Linguistics, is a social approach to text and talk developed by socio-linguist theorists such as van Dijk (1985; 2008), Fairclough (1995; 2003), and Wodak (2011), to name just a few. These scholars aimed to explore how social and political forms of power and domination were



reflected in the use of language in both written and spoken forms. CDA is “relatively inductive compared to other critical approaches, but it is relatively deductive when compared to its neighboring *discourse* approaches...” (Tracey, Martinez-Guillem, Robles, & Casteline, 2011, p. 242). My research employs the approach of CDA to critically unveil power relationships and social inequalities that are reflected in interactions between ethnic Chinese mothers and their maternity care providers. In this section, I first describe the term *discourse*. I then examine discourse analysis from textual and contextual perspectives. Next, I focus on the approach of CDA through a discussion of interrelations between and among knowledge, discourse, ideology, power, and reflexivity. The section ends with a review of connections between the CDA approach and my theoretical framework.

**Discourse.** A basic definition of discourse, according to Parker (1992), is “a system of statements which constructs an object” (p. 5). Discourse is made up from language, stories, metaphors, images, and other representations of meanings. Burr (1995) goes on to say that “a discourse provides a frame of reference, a way of interpreting the world and giving it meaning that allows some ‘objects’ to take shape” (p. 3). Each discourse tells us a different story that helps us understand and interpret the world differently. Wetherell, Taylor and Yates (2001) make a connection between discourse and social practices, and claim that discourses are positioned in social actions and represent our social life in different ways. For instance, the lives of women are represented through different discourses in social practices of family, organisation, community, and politics, and through different discourses that relate to different social roles and identities of women. Prichard,

Jones, and Stablein (2005) define organisational discourse as “a series of sub-fields linked together by a substantive concern with language and practice in organizations and organizing” (p. 213). Communication and meanings are expressed through discursive practices of organisational discourses.

Discourse is embedded in the health care practices and it can be interpreted within a communicative framework. According to Dutta and Zoller (2008), “[D]iscourse is intrinsically connected with the practice of health care as it sets the parameters, norms, and guidelines for expectations, choices, and actions in the domain of health” (p. 31). Health is constructed and negotiated through discourse (Dutta & Zoller, 2008), which “have specific functions, and rhetoric spelled out in a great detail in the conditions on the effectiveness of discourse within persuasive communicative functions” (van Dijk, 1990, p. 2). The effectiveness of socialising a patient into a health discourse is made through communicative practices such as words, phrases, intonation, gestures, facial expressions, and other norms and practices of the interactions between the patient and the health provider and between the patient and the health management. Understanding the functions of discourse is helpful for researchers to further understand the approach of discourse analysis and how to use it in communication studies.

**Discourse analysis.** The approach of discourse analysis is widely employed in the field of linguistics in which lexicalisation, syntax, transitivity, modality, speech acts, turn taking, and other textual features are focused upon (Fowler, 1985). These linguistic techniques communicate speakers’ attitudes and intentions through certain words, grammar, order, and utterance. However, the

traditional analysis of semantics emphasises only the textual and structural objects, but “disregards the functional relations with the contexts of which discourse is a part” (van Dijk, 1985, p. 4). As Kress (1985) argues, text is derived from the linguistic domain but discourse is derived from the social domain.

Contemporary discourse analysis, therefore, requires an integrated analysis in relation to textual, cognitive, historical, social, and cultural contexts (van Dijk, 1985; 2008). This approach guides researchers to analyse numerous discourses that people are subject to in the society (Burr, 1995). By involving both textual and contextual analysis, researchers using discourse analysis attempt to interpret how people produce and manipulate discourses, and at the same time, how they identify, understand, and resist the discourses they are subject to.

It is crucial to note that context is the key to understanding and interpreting communicative events of the people I research. Context is regarded as “concentric circles of influence or effect of some state of affairs, event or discourse” (van Dijk, 2008, p. 4). No communicative event takes place in isolation. Each of the events is subjectively constructed and influenced by its sociocultural situation and the social actors involved in this event. For instance, a health care environment and the roles and knowledge of a midwife or GP define the appropriate topics, communication styles, rules, and expectations in such a setting. The health care environment and the roles of social actors, at the same time, influence the way a migrant patient communicates with a doctor. The migrant patient’s sociocultural knowledge of communication and health, ideologies, norms, values, and attitudes also have a major impact on the talk and behaviour of the patient. Hence, discourse analysis makes explicit “what contexts are and how exactly the relations between contexts and text or talk are to

be analyzed in ways that explain how language users do this” (van Dijk, 2008, p. 3).

While contexts influence discourse, discourse expresses contexts (van Dijk, 2008). If contexts are expressed by discourse, the individual’s identities, as a part of the contextual features, are also expressed in discourse (Allen, 2005). In other words, identity is constructed and constituted through discourse (Burr, 1995) and its production of meaning (du Gay, 1996). Research directed by Medved and Kirby (2005) is concerned with how corporate discourse defines mothering identity. They argue that mothering identity is constructed subjectively and amidst contradictory and competing discourses such as private versus public, feminine versus masculine, inactive versus active, and so on. In my study, how Chinese mothers think, act, and identify themselves when communicating with the New Zealand health care providers needs to be understood in relation to the discourses of their race, gender, age, class, education, and so forth, since these discourses construct their identities in different and perhaps competing ways. As Davies (1992, as cited in Medved & Kirby, 2005) comments, “We become that which the various discourses in which we participate define or make thinkable as a self (or true self)” (p. 440). A discourse analysis approach then directs the researcher to notice the participants’ different social identities because every participant is a social, historical actor due to his or her own social, cultural background, which can affect text and talk.

Yet, even if discourse analysis inspires me to integrate different perspectives of text, cognition, context, identity, etc. into my study, there are also the issues of knowledge, power, ideology, and reflexivity which cannot be easily stressed by using the approach of discourse analysis. Hence, I adopt the

approach of CDA to help investigate the larger problems such as inequality, othering, power, feminism, and knowledge and ideological construction which emerged from my research.

**CDA.** The core of CDA is “a detailed description, explanation and critique of the ways dominant discourses (indirectly) influence socially shared knowledge, attitudes and ideologies” (van Dijk, 1998, p. 376). Fairclough (1995; 2003) further develops a three-dimensional framework for using a CDA approach. The framework includes analysis of language texts, analysis of discourse practice, and analysis of discursive construction. Under the framework of CDA, discourse is not only a system of statements which represent meanings; it is also reflected in discursive practices and is embedded in and affected by ideologies. Foucault (1980) defines discursive practices as systems and institutions of different meanings drawn from words and phrases. In the exploration of how women take on the role of manager, Rojo and Esteban (1985) regard discursive practices as “an expression of organisational structure and give coherence to everyday practices” (p. 242). As a critical discourse analyst of a communication study, I focus on discursive expressions of verbal and nonverbal forms such as lexicalisation, intonation, facial expression, body language, and so on during intercultural communication between mothers and health carers. I further investigate other discursive practices such as participants’ roles, values, beliefs, knowledge, and maternity and health management structures and practices in reflecting certain discourses.

Discursive practices have ideological effects. That is, they can “produce and reproduce unequal power relations” between different genders, cultures, and

social classes “through the ways in which they represent things and position people” (Fairclough & Wodak, 1997, p. 258). CDA helps investigate the discursive production and reproduction of power and domination that result in social inequality (van Dijk, 1985). For CDA, ideology is viewed as “an important means of establishing and maintaining unequal power relations” (Weiss & Wodak, 2003, p. 14). Inasmuch, discursive practices, discourse, ideology, and power have interrelated relationships.

Henry and Tator (2009), for example, focus on discursive practices, ideological production, and dominant discourses in examining racial bias in the Canadian media. They found that media culture and structures control many ideological beliefs and affect public discourses and responses to the issue of race. In a similar fashion, Medved and Kirby (2005) analyse stay-at-home mothers’ identities in relation to corporate mothering discourses that are embedded in historical ideologies of mothering, and raced and classed ideologies of mothering. Both studies stress the issue of power and argue that ethnic minorities and stay-at-home mothers are in powerless positions in relation to the influence of dominant discourses. This idea points to the argument that groups and institutions produce ideological discourses which favour the groups for whom the ideology is constructed (Fowler, 1985). Applying this thought to the health context, “powerful social actors define and constrain the realm of possibilities for how health is conceptualized, and the ways in which health and illness are understood” (Dutta & Zoller, 2008, p. 34). These powerful social actors play dominant roles in shaping and defining health discourses which help strengthen their dominant positions in the health context. CDA’s particular interest in the ways in which discursive practices manifest ideological discourses in relations of

power in the Western maternity and health care institutions is important to my study.

Knowledge is a discursive practice (Jørgensen, 1985), and hence knowledge and its relations with discourse cannot be ignored by critical discourse analysts. According to Foucault (1975; 1979; 1980), discourse, knowledge, and power are inseparable. Discourses are systems of knowledge that position us in relations of power (Parker, 1999). First, knowledge is formed by discourse, that is, discourse “identifies, explains, and regulates” rules which produce knowledge (Nadesan, 1997, p. 199). In relation to my study, the Western maternity and health discourses such as the discourse of consumerism produces and controls the knowledge of being a good consumer and enacting an appropriate behavior in the Western maternity and health care environment. Meanwhile, the Chinese mothers’ knowledge about childbirth, communication, and health is constructed by the discourses of mothering, medicalisation, and doctor-patient discourse which are valued in China. It must be stressed that my study goes beyond the analysis of knowledge production through different discourses; it further investigates how the dominant knowledge of childbirth and communication empowers New Zealand maternity-care and health providers to control perceptions and behaviours of Chinese mothers, and how the alternative knowledge of childbirth and communication influences and challenges the status quo.

Power is not just the ability of people, groups, or institutions to control the behaviour and visible materials of others: Power is also the ability to access, express, and manage knowledge in public discourse (van Dijk, 1985). Fowler (1985) analyses the area of power through “directive devices” and “constitutive

structures” (p. 67). Directive devices include “explicitly manipulative speech acts . . . such as commands, requests, and proclamations, and interpersonal practices which, while not speech acts, nevertheless carry clearly recognized social meanings in the area of power” (Fowler, 1985, p. 64). Constitutive structures include roles, statuses, discourses and other practices in institutions and which articulate ideologies of power (Fowler, 1985). By using CDA, I am able to analyse how power is managed by directive and constitutive practices. In particular, my aim is to find out who have preferential access to certain knowledge, which group or institution sets the rules for certain knowledge, and how mothers and maternity-care and health providers express and manage their knowledge in revealing their power relations.

Understanding my procedures of knowledge production and how I express and manage my own knowledge in the process of research are also useful for data analysis and interpretation. CDA values reflexivity in terms of the researcher’s identities, knowledge, and worldviews in influencing the analysis and interpretation of the data (Wetherell et al., 2001). Through reflexivity, the researcher is able to explore the context of personal knowledge production and understand power dynamics between the researcher and the researched (Jørgensen, 1985).

Many critical discourse analysts consider their personal standpoints clearly. For example, Mahtani (2008) in her critical communication study of understanding how Chinese-Canadians and Iranian-Canadians perceive and challenge English-language TV news does not shy away from letting readers know that she and her research team have ethnic minority backgrounds and how this affects the process of their research. In another work, Mahtani (2009)



reflects critically upon her research contributions in the fields of media studies and minority representation. She uses the word “transparency” (p. 716) to identify the importance of understanding our personal implications in data analysis and the impact of personal standpoint on our own evaluation. As Prichard, Jones, and Stablein (2005) conclude, knowing the researcher’s own position and context is important for the researcher to choose appropriate “interpretative frame, research strategy, the method of data collection and analysis and the form of research presentation” (p. 232).

In my research, I use critical and reflexive approaches to investigate what role my context plays in data analysis and interpretation. More specifically, I explore my identities and roles in conducting this research, knowledge, and values about childbirth and communication, and my relationships with mothers and health carers, and hence, I am able to understand how my own context influences my evaluation of research analysis and interpretation. The approach of CDA not only directs researchers to be critical in revealing the issues of knowledge, power, and social reality, but also encourages the researchers to be reflexive in considering themselves in doing the research.

**CDA and my theoretical framework.** CDA is one of the approaches developed out of social constructionism, and is commonly applied in feminist and postcolonial studies (Burr, 1995). Social constructionism rests upon the view that individuals and societies are inseparable, focusing on the processes of how individuals’ experience is constructed by historical, social, and cultural contexts (Allen, 2005; Burr, 2003, Hackley, 1998a). That is, constructions of meaning are relative to shared practices, language, discourses, values, and so on in social and

institutional groups. Critical discourse analysts support the idea of the social construction of reality, but expand the understanding by arguing that constructions of meaning “are never neutral but are instead continuously composing precarious ideological relations between power and discourse” (Markham, 1996, p. 391).

Discourse and context are emphasised by the theory of social constructionism, and are also highlighted by the CDA approach. Social constructionism regards discourse as the form of social interaction and as the construction of the phenomena of our world. Discourse “provides a frame of reference, a way of interpreting the world and giving it meaning that allows some ‘objects’ to take shape” (Burr, 1995, p. 3). In this sense, one’s knowledge, values, behaviours, and identities are constructed in the discourses. The perspective of social constructionism seeks to understand and interpret different discourses in specific historical and sociocultural contexts. From this angle, different contextual features such as gender, identities, roles, location, sociocultural backgrounds, and other subjective and social constructions of these dimensions, which emerge from discourses, help explain how certain discourses are formed and how these discourses frame our experience in social realities.

The importance of context in relation to the colonised and Third World women is also considered by the theories of postcolonialism and feminism. However, both theories draw much attention to knowledge construction about marginalised people or groups who have been silenced by dominant discourses, and hence reveal power relationships between different people or groups (Hesse-Biber & Yaiser, 2004; Young, 2003). The issue of knowledge and its connections with discourse and power has been emphasised in the perspective of CDA. Knowledge is formed by discourses which produce and reproduce power

and inequalities in society (Parker, 1999).

Regarding power tensions in social realities, employing the approach of CDA fully reflects the rationale of developing the matrix. Postcolonial theory centres on the resistance to Western dominance and control (Young, 2001). Feminist theory investigates the relationships amongst language, discourse, power, and ideology (Strega, 2005). It further seeks to make a critical “intervention into particular hegemonic discourses” (Mohanty, 1984, p. 173), and to empower the women from the bottom of the world to achieve more equality at both individual and social levels (Chai, 1985; Moraga & Anzaldúa, 1981). In addition, social constructionist theory directs us to be critical and sceptical about the assumptions in the world and to interpret them through different angles (Burr, 1995). CDA, is therefore, useful in analysing my research data as it helps identify discourses emerging from language, text, metaphors, and other communicative situations presented by Chinese mothers and maternity-care and health providers, and investigate how these discourses reveal issues of power, hegemony, struggle, and social realities.

To conclude, my matrix stemming from the three theories of social constructionism, postcolonialism, and Third World feminism guides me in using the methods of interviewing, observations, keeping a researcher’s reflexive journal to collect my research data, and in applying CDA to help analyse the data I have collected. Interviewing is an appropriate method to uncover what others think, experience, and to uncover their socially constructed knowledge. Conducting observations helps frame a deeper understanding of communication processes. Keeping a reflexive journal is advantageous in helping me to thoroughly and subjectively interpret the mothers’ childbirth experiences with an

acknowledgement of my own feelings, experiences, and contexts. CDA, in turn, helps me explore the discourses of language, values, knowledge, and identity from data at a broader analytical level instead of merely focusing on content, text, and language in the data. The next part of this chapter details my sampling, data collection, and data analysis procedures.

### **Methods**

In what follows, I explain the decisions made to select participants and the procedures to recruit them for this research. I describe the actual process of carrying out each method in considerable detail. I also describe the process of my data analysis and the challenges I encountered during the research journey.

### **Participants**

The research lasted from March, 2009 to June, 2011. I took about two years for sampling, data collecting, and data analysing. The participants were expected to be migrant ethnic Chinese mothers, including mothers who had migrated from Mainland China, Hong Kong, Macao, and Taiwan, who would experience childbirth in New Zealand, and maternity and health care providers who had direct contact with migrant ethnic Chinese mothers and/or had previous experiences of working with Chinese mothers. After receiving ethics approvals from both the Waikato Management School (WMS) Ethics Committee and the Plunket Ethics Committee for conducting interviews and observations, I relied on the snowball technique (Patton, 2002) to reach potential participants. The snowball technique was used in Ho's (2006) and Liamputtong and Naksook's (2003) studies. Ho, in a study of Chinese women's experiences of work and

family in Australia, recruited Chinese women and asked them to recommend other women to be interviewed. Laimputtong and Naksook recruited immigrant Thai women through the researchers' personal networks and asked the participants to refer their friends or relatives to the research. Because I am an ethnic Chinese mother, I had contacts with some other ethnic Chinese mothers, women in playgroups, and ethnic Chinese mothers' gatherings organised by Plunket. I, therefore, relied on my networks to identify and invite participants.

I talked through my research with ethnic Chinese mothers in person in playgroups. Information sheets were left with them with a request to pass the information sheets on to other women they knew. I also gave a short speech introducing my research in a Chinese mothers' gathering in the Plunket Society. Information sheets were handed out to the women and their families who were present. They were also encouraged to pass the information sheets to other women who could contact me. Through my networks of friends and some pregnant Chinese mothers, I was referred to midwives who helped me pass on information sheets to their clients, colleagues, and other midwives associated with the College of Midwifery.

Meanwhile, to get access to maternity and health agencies and invite more people to participate, I either emailed or called the person in charge in each maternity and health agency, and followed up with a visit to the agency. I ended up visiting five different midwifery centres, two birth centres, two radiology centres, three medical clinics, one hospital, and one Migrant Centre. A description of the research project was given to the contact person, and information sheets (in English and Mandarin versions) were left with the contact person, and at some reception desks and in staff rooms.

In the end, ten migrant ethnic Chinese mothers and ten maternity-care and health providers, from North Island New Zealand, volunteered to participate in the study. Appendix B provides the details of the Chinese mother participants (p. 378), based on their answers to demographic questions before the interview sessions. All the mothers were pregnant when I approached them for the first time. Half of them were first-time mothers, while the other half were experienced mothers whose first children had been born in either China or New Zealand. Most mothers had migrated from Mainland China with six from Northern China and three from Southern China. Only one mother came from Taiwan.

The participant mothers also covered such variables as age, migration time, educational, and working backgrounds (see Appendix B, p. 378). Seven mothers were aged between 25 and 35, and three mothers were over 35 years old. Apart from one new migrant who had migrated to New Zealand only a few months previously, most Chinese mothers had been in New Zealand for over five years. All the mothers had good educational backgrounds and work experience in China and/or New Zealand. Two of them held diploma or trade qualifications; six mothers had graduated with an undergraduate degree; and another two had completed their postgraduate degree. Further, these mothers worked in a variety of areas including education, government, finance, customer service, management, and health. Five of them were still working and three mothers were studying while they were pregnant. The other two mothers used to work when they were in China, but were now full-time housewives.

These ten migrant ethnic Chinese mothers formed the primary source of the data. The ten maternity-care and health providers from the North Island of

New Zealand who were willing to participate in the research (see Appendix E, pp. 392-394) included four independent midwives, one hospital midwife, one hospital anesthetist, one GP, and another three Plunket nurses. Only one was male, but the rest of them were females. Among these participants, four were ethnic Chinese health care providers, but only two of them could speak fluent Mandarin or Cantonese. The other two ethnic Chinese health care providers did not speak any Chinese.

### **Data Collection Methods from Ethnic Chinese Mothers**

**Interviews.** This research is longitudinal. The first interview was conducted in March, 2009, and the last one finished in June, 2010. Each mother was asked to sign a consent form for agreeing to participate in the research. In the research, each mother went through three-rounds of interviews (i.e., once when she was pregnant, again about one to three months after the birth of the baby, and finally about four to six months later). This approach ensured that I could capture a wide range of the communication processes they had with their maternity and health providers, as well as the communication challenges they might encounter in different periods and how Chinese mothers and maternity-care and health providers tried to overcome the challenges.

At the beginning of the first-round of interviews with mothers, I handed over a sheet with demographic questions (see Appendix A, p. 377) to the mothers for them to complete. The questions were about their ages, educational backgrounds, English confidence, migration time, origin, extended family support, work experience, and current pregnancy and mothering situation. Prompt questions were asked in line with the answers shown in the sheets. The aim of

doing this form of questioning was to construct knowledge about each mother's background, which helped me develop slightly varied interview questions in the processes of interviews with the mothers. The mothers' socially constructed lives could further be used to understand and interpret their intercultural communication experiences and perceptions.

Open-ended interview questions (Fontana & Frey, 2000) were used in the interviews to get more stories from the mothers. The three rounds of interviews were based on three different interview protocols (see Appendix C, pp. 379-388). In the first-round interview, questions were categorised into six themes which were: 'background', 'when you found you were pregnant, communication with LMC', 'communication with other health care providers', 'current impressions', and closing questions. The second-round interview questions covered five themes 'Thinking about the last interview', 'Thoughts about labour and delivery', 'impressions on the birth of the baby', 'current impressions', and closing questions. In the last interview protocol, questions were developed according to five themes which were 'thinking about the last interview', 'communication with the Plunket nurse', 'communication with other health care providers', 'thinking about childbirth in New Zealand', and closing questions. There was no particular wording of interviews questions, but the questions of the second-round and third-round interviews followed a general order, that is, the mothers were asked to recall their last interviews in terms of any further comments they would like to make or any changes they had experienced, and then the mothers were asked to refer to their recent maternity experiences, followed by their overall impressions of maternity experiences in New Zealand. The interview questions varied slightly depending on the specific contexts of different participants; for



example, the mother from Taiwan was asked about her knowledge of childbirth in Taiwan, and the second-time mothers were asked additional questions about their previous birthing experiences. Overall, the design of the interview questions was based on the research purpose, objectives and rationale.

Appendix D shows detail of the three rounds of interviews conducted with the mothers (pp. 389-391). Considering that mothers might feel unwell during the period of their pregnancy, and they might need to bring along their babies to interviews after birth, I allowed the mothers to suggest the interview locations for their convenience and comfort. For the first round of interviews, eight out of ten mothers preferred to be interviewed in their homes for reasons of being unable to drive, having little kids to look after, or being unwilling to be far away from home in the period of pregnancy. One mother, a university student, chose to be interviewed at the university library. Another working mother chose to be interviewed in a café which was close to her workplace. All the second-round interviews and most third-round interviews were carried out in the mothers' homes after they gave birth to their babies. Only one mother, along with her mother and baby, came to my place and did the last round interview.

Interview times were negotiated between the participants and me. Most interviews lasted between half an hour to an hour. Only a few interviews went on for a bit longer as the participants were keen to offer more ideas and comments. The same applied to two particular mothers who wanted to add more comments through short phone interviews after their first interviews. During the three rounds of interviews, I tape recorded the conversations and also took notes. I carried out all the interviews in Mandarin to respect the participants' requests to speak their mother tongue in the interviews. After completing the interviews

with the mothers, I transcribed all ten interviews, and provided copies of the transcriptions to the participants for their comments.

**Observation.** I accompanied the ten ethnic Chinese mothers whom I had interviewed, with their permission, on their visits to their maternity-care and health providers and observed the interactions. The aim of these observations were to examine how Chinese mothers and health providers communicated with each other, what challenges each encountered in communication, and how both parties dealt with and attempted to resolve these difficulties and challenges. In the consent form which was handed over to each mother in her first interview, she was asked to sign the agreement of participating in both interviews and observations. Prior to the mother's health appointment, an introduction about my research project was made by phone to her maternity-care and health provider. A brief description about the research project was also presented to each maternity-care and health provider before the observation. Both mothers and health care providers agreed to my presence in the visits and the recording of my observations. Appendix D describes the detail of the three rounds of observations (pp. 389-391). The lengths of observations varied from 15 minutes to two hours, depending on the function and importance of appointments, the schedules of maternity-care and health providers, and more importantly, the communication processes and relationships between mothers and maternity-care and health providers.

The data collection from observations is longitudinal too. The three rounds of observations (the first when the participant was pregnant, the second, about one to three months after the birth of the baby, and the third, about four to

six months later) for each participant was carried out. I also accompanied seven mothers on their antenatal visits to their midwives. These observations were mostly held at the midwives' offices at the midwifery centres, but only one observation was conducted at a participant's home where the midwife went for a visit. Moreover, two other observations were conducted at a radiology centre where the mothers went for ultrasound scans and had interactions with two radiologists. Another observation was carried out while a mother was consulting with an anaesthetist specialist and an obstetrician in hospital.

Most of the second-round of observations was centred on the intercultural communication processes between mothers and their midwives in order to compare and contrast this communication with the previous one when the mothers were pregnant. I also sought to find out in what ways both parties dealt with the challenges they had encountered before, what new challenges they met, and how their relationships had improved. Therefore, I observed seven mothers' communication with their midwives in the mothers' homes, and accompanied another mother while she was visiting her midwife at the midwifery centre. One observation was conducted in the participant's home where the mother was being visited by her Plunket nurse. In addition, I accompanied another mother to go to the migrant centre where her baby was having a vaccination, and I observed the mother's communication with some public health nurses and a Plunket nurse who were on duty on the day.

About four to six months after the mothers gave birth to their babies, I carried out the last-round of observations which mainly focused on the mothers' intercultural communication processes with their Plunket nurses and some other health providers (i.e., GPs, clinical nurses). Seven observations were done on

the mothers and Plunket nurses. The locations for most of these observations were at the Plunket centre, but two of them were arranged in the mothers' homes. I also observed two mothers' interactions with GPs and one mother's communication with clinical nurses at medical clinics.

Besides tape recording the observations, I took notes on the health setting/context, nonverbal communication, contents of dialogue, feelings, and emotions of the mothers, health care providers, as well as others who were present during the appointments. The first observation was done in April, 2009, and the last observation was completed in June, 2010. After finishing all three-rounds of observations, I transcribed the audio-recording data, and input the hand-written notes to the computer. The field notes I collected from the observations were used to complement as well as to check the interview data from the mothers and their maternity-care and health providers.

### **Data Collection Method from Maternity-Care and Health Providers**

**Interviews.** Besides approaching Chinese mothers as the primary source of participants, I also invited maternity-care and health providers to participate in the research. I received responses from ten maternity-care and health providers (i.e., four independent midwives, three Plunket nurses, one hospital midwife, one hospital anaesthetist, and one GP), who showed interest in participating in interviews after reading my information sheets and/or hearing about the research from their clients or other sources. All the maternity-care and health providers signed the consent form before they were interviewed. Again, open-ended interviews (Fontana & Frey, 2000) were used to gather their perceptions and experiences of the communication processes with ethnic Chinese mothers.

Interview questions were largely around four main themes which were: background, health support, experiences, and closing questions (see Appendix E, pp. 392-394).

Each participant was interviewed only once. The interview time and venue were selected by the participant. The lengths of interviews with maternity-care and health providers varied from half an hour to an hour (see Appendix F, p. 395). Five interviews were conducted in the participants' offices. Two interviews were done in staff rooms. One maternity care provider used a room other than her office in her workplace as the interview location. Further, two other maternity-care and health providers suggested being interviewed in their homes. All the interviews were tape recorded, and copies of transcriptions were provided to the maternity-care and health providers for their comments.

**Reflexive journal.** Since starting my sample selection and recruitment, I have kept a reflexive researcher's journal to record my reflexive, critical, and intrinsic involvement in the research processes. In the processes of sample selection and recruitment, I wrote a log of how I made decisions on the participants, how I approached the participants, got their permission, and the challenges I faced in getting access to the participants. During the process of data collection, I encouraged myself to record my critical reflection after each interview or observation. I reflected on my experience, emotions, and reactions when interviewing the participants and observing their communication in the context of the health sector. I acknowledged my identities, roles, relationships with the participants, and the influence of my presence in interviews and observations.

In my log, I recalled the experience of the birth of my first child in New Zealand. Because I was pregnant with my second child when I started my sample selection and data collection, I also wrote about my second childbirth experience in New Zealand. I compared my experiences of responding to the New Zealand care practices with the experiences of my participants to identify similarities and differences in the same-culture group. Analysing the reasons behind similarities and differences would help me better understand the participants' perspectives about Chinese and New Zealand childbirth experiences within the social and cultural context of this study. In light of my own personal experiences of pregnancy, birth, and mothering, I brought with me the values, beliefs, knowledge, identities, and context of being a migrant ethnic woman.

After my data collection, I added more reflexive insights into and understandings of the whole research journey. By reviewing this longitudinal study, I focused on the changes in my roles and relationships with the participants. I highlighted the ethical dilemmas and other challenges which occurred in the research process. Interview transcriptions were given to the participants prior to data analysis. Several mothers provided their comments and interpretations which were valuable for comparison with my own understandings and interpretations.

### **Data Analysis**

CDA is “analysis of the dialectical relationships between semiosis and other elements of social practices” (Wetherell et al., 2001, p. 230). That is, CDA guides researchers to analyse language, body language, and other discourses within social relations of identities, knowledge, power, and ideologies.

Fairclough (1995; 2003) shapes the procedures of using a CDA approach into a three-dimensional framework – analysis of language texts, analysis of discourse practices, and analysis of discursive construction. Likewise, I embrace this framework in my data analysis procedures.

The first step of my data analysis is the analysis of language texts. When I was reading through transcriptions and notes for the first time, I highlighted words, phrases, and sentences in relation to lexicalisation, modality, speech acts, turn taking, and other textual features. For example, one participant used “shouldn’t” several times in a conversation with another participant. I added notes next to “shouldn’t”, pointing to its utterance of assertiveness, command, and request. The same procedure was applied to other language texts.

The second step of my data analysis is the analysis of discourse practice, but I tended to call it the analysis of discursive practices. Discursive practices are not limited in language texts only; they go beyond linguistic practices and also include nonverbal forms, identities, roles, values, knowledge, context, and other expressions of institutional structures and everyday practices (Rojo & Esteban, 1985). Rereading my transcriptions and notes, I focused on discursive expressions of body language, gestures, context of participants and health settings, participant’s roles, identities, values, beliefs, knowledge, and maternity and health care structures. For example, I highlighted the cases when maternity-care and health providers employed certain gestures and body language to help mothers understand complicated jargon or phrases. I also identified the key or recurrent words and phrases which appeared in the participants’ description of their understanding of childbirth. So words or phrases such as “natural”, “normal”, “no worries”, “go ahead” were drawn on to reflect certain knowledge and values

of childbirth. After adding notes next to discursive expressions in transcriptions and notes, I listed all the discursive practices (including the linguistic practices) I had found on a piece of paper, and I drew lines to connect the findings to the relevant page numbers in the data.

The next step was to analyse discursive construction. Discursive practices reveal ideological discourses which produce and reproduce power and domination in social reality (Fairclough & Wodak, 1997; van Dijk, 1985). Reviewing the list of discursive practices I had summarised, I started to group those findings which had similar ideological effects. For example, the discursive practices such as the identities and identification of customers or health providers, the participant's knowledge about making choices, the information given or controlled, and the health management structures and practices of providing quality services to customers, and the like were categorised under the title of dynamics of choice. I further developed the analysis of this category in relation to different discourses, knowledge, and power. I used the same ways to list and uncover other categories. Then I merged these categories into four major themes – *language*, *values*, *choice*, and *trust*. The subthemes of language were titled “experiencing language barriers”, “coping with language barriers”, and “rethinking language”. The subthemes of values were categorised as “constructing values of childbirth”, “constructing the knowledge of breastfeeding”, “promoting inclusiveness with partnership discourse”, “creating othering through partnership discourse”, and “reorienting values of childbirth and communication”. The subthemes of choice were entitled “freedom of choice”, “control of choice”, “control of information”, and “re-evaluating the discourse of choice”. In addition, the subthemes of “trust in maternity-care and health providers”, “trust in



family and relationship”, and “re-visiting trust” were grouped into the last theme, trust.

However, that was not the end of my research analysis. Researcher’s reflexivity also plays an important role in the CDA approach in terms of data analysis and interpretation (Wetherell et al., 2001). Reviewing my log of the research processes, I also used Fairclough’s (1995; 2003) three-dimensional framework for CDA to carry out my analysis. So I focused on language texts, discursive practices, and related them to discursive construction. I used my research timeframe to develop the themes of reflexivity. The themes were “I am a migrant ethnic Chinese mother”, “start of the journey”, “during the journey”, and “end of the journey” to reflect on my identities, roles, contexts, challenges, evaluations, and implications in my data analysis. The entire data analysis process included countless reviews of transcriptions, notes, and my reflexive journal. By comparing and contrasting the findings from the participants’ data and my reflexive data, I was able to capture different and alternative perspectives of intercultural communication in relation to childbirth.

### **Challenges**

Although this study involved interviews and observation to get rich data of participants’ perspectives, several difficulties and limitations also existed. First, the initial plan of sampling was to invite migrant ethnic Chinese mothers from different regions (i.e., Mainland China, Taiwan, Hong Kong, and Macao), but it ended up with only one mother from Taiwan, and nine other mothers who had migrated from Mainland China. The reason for this limited sample was that the number of pregnant mothers from Hong Kong, Macao, and Taiwan was limited

around the time of data collection in the research area. Participation was also entirely based on individual willingness. Despite this limitation, the research data is still sufficient due to variables in locations (e.g., different cities in Mainland China), age, years of residency in New Zealand, and other individual background information. More importantly, this research does not strictly demand a large number of participants, but rather, it emphasises richer qualitative data retrieved from a longitudinal data collection process.

As this study involved mothers during the period of their pregnancy, and health staff in maternity and health agencies, the project was sensitive, and therefore, ethical issues needed to be taken into account. Confusion occurred in getting permission from the regional Health Board to conduct observations which would involve midwives and other health care providers. I was first told to apply for an ethical approval in addition to the one I had received from the WMS Ethics Committee, but it was later clarified that I would not need this ethical approval. Instead, I would need to get consent from both mothers and health providers before carrying out observations, respect the participants' rights, and negotiate access to observations with both parties. A similar situation happened when I was approaching the Plunket Society which asked me to apply for an ethical approval from the Plunket Ethics Committee before carrying out interviews and observations. Although the research was finally granted ethics approval, I found it difficult to get access to the Plunket nurses as the facilitator of Plunket tried, consciously or unconsciously, to control the data collection process.

Another complication arose when I had to react to some women's emotional or health problems which were beyond the scope of my research. For example, I supported a woman who lost her baby in her pregnancy. Emotional

support was also given to other two women who worried about their low placenta in the pregnancy and the risks involved in labour. Meanwhile, I passed on the information about low placenta to these two mothers after consulting with several health professionals and checking the related information online. Another woman had many unsolved health problems and minor depression left from her first childbirth. Consequently, she was not confident about her midwife and worried greatly about the childbirth this time. Besides supporting the woman, I provided her with information about maternity and health agencies where she could find help with her health and emotional problems. I also provided information and contact details about the optional midwives, so the woman could decide whether she would want to change to another midwife.

Two further limitations occurred in the processes of tape recording and interview transcribing. The tape recorder did not work during two observations. Therefore, the observation data was based on the field notes only. Moreover, Chinese mothers have the same ethnic background as I have. All of them wanted to be interviewed in Chinese. Where interviews were conducted in Chinese, I translated the key findings from Chinese scripts to English when writing up the thesis. Although my translation might not fully represent the participant's intended meaning, I found that participants felt it easier to express their experiences in their own language. Also slight differences may occur in my translation compared to any other person's translation due to different use of Chinese dialects and grammar, but my translation reflects my position and understanding as a researcher who collected the first-hand data. To clearly show the responses from those mothers and to reflect on the matrix of difference in terms of allowing the subaltern groups to voice themselves, I have included

interview quotations in both Chinese and my English translation in this thesis.

### **Ethical Considerations**

As I was in contact with human subjects in the form of interviews and observations, I adhered to the research ethics obligations and practices of the University of Waikato. I applied to the WMS research ethics committee for ethics approval before conducting the research. This research project was also granted ethics approval for research by the Plunket Ethics Committee. Both organisations gave me the permission to conduct interviews and observations with participants. I then approached the participants, such as Chinese mothers, midwives, GPs, Plunket nurses, etc., and people in the organisations connected to this study, such as midwifery centres, the hospital, medical clinics, and so on for their permission to carry out the research. The participants and organisations were guaranteed that their identities and privacy would be protected.

Information sheets in both English and Chinese (see Appendix G, pp. 396-399) and a consent form (see Appendix G, p. 402) were presented to each Chinese mother, and each of them was asked to sign the consent form for agreeing to participate in audio-recorded interviews and observations. An information sheet (see Appendix G, pp. 400-401) was also given to each maternity-care and health provider who would be involved in the observation, and each of them was asked to give his/her permission to my presence during the appointment.

Chinese mothers and most maternity-care and health providers who participated in the research were given their interview transcriptions before I began to analyse the data. They were informed that they were free to comment and/or remove anything which they did not want to be seen in the transcriptions.

I also promised the mothers that they would have access to a summary of the findings from the study when it was concluded. In considering the issue of anonymity and confidentiality of participants, only I and my supervisors had access to the data. I made every effort in protecting the participants' identities and privacy in the writing up of data, and I will destroy all data five years after completion of the Ph.D. Electronic data was saved on my computer at the university and another computer in my home, and they were all password protected. I also informed the participants that I would publish from the data and might use the data for conference presentations.

Additionally, I responded as sensitively as possible, respecting the wishes of the participants as to their continued involvement in the research. The participants were able to withdraw from the project at any time without any explanation. I provided informative leaflets detailing support services for those mothers who needed help, should they experience childbirth circumstances beyond the scope of this research, so that they could know where and how to obtain further help.

### **Conclusion**

The chapter presents the methodology and methods used in the research. Influenced by the matrix, I use interviewing, observations, and keeping a reflexive journal to collect data because they are unique to my research for finding out answers about what contexts my participants belong to, how contexts influence participants' knowledge construction, identities, perceptions and experience, and finally but perhaps most significantly, how these all factors impact on the intercultural communication processes between Chinese mothers and their

maternity-care and health providers. The approach of CDA is applied to analyse my research data. The approach is appropriate for the study to explore the discourses emerging from text and talk in the data. By challenging dominant discourses, I reveal how discourses create power in society. The approach of CDA is also closely bounded with my theoretical framework.

After using the snowball technique to narrow the focus to ten migrant ethnic Chinese mothers-to-be and ten maternity-care and health providers in the North Island of New Zealand, I conducted open-ended interviews, observations, and kept a reflexive researcher's journal to collect the data. The data collection process is longitudinal to capture the whole communication processes during the mothers' pregnancy, birth, and postpartum. Data collection and analysis procedures are specifically explained, followed by a statement of challenges which occurred in the research process and ethical issues taken into account for this study. Following this chapter, I begin to present my findings and discussion; the next four chapters emphasise the themes of language, values, choice, and trust.

## CHAPTER 7: LANGUAGE

Language is a convention which constructs particular realities and is used to reflect certain identities (Burr, 1995) and power dynamics in the social interaction processes (Cunliffe, 2008). In my exploration of language, I attempt to examine and critique power in the use of language to define realities and to expose processes of othering in the context of interactions between and among maternity-care and health providers and Chinese mothers. First, I identify language barriers experienced by mothers and their maternity-care and health providers. Then I explain how both groups cope with language barriers. Finally, I discuss the connections between language and the processes of othering in order to critique the power of language to differentiate ‘others’ from the mainstream.

### Experiencing Language Barriers

Having language barriers is a big challenge faced by migrant patients who are from non-English speaking backgrounds. Challenges of miscommunication, discrimination, and distrust can be caused by language barriers in the communication between ethnic minority groups and dominant groups (Ogbonna & Harris, 2006). Speaking the same or different language(s) is usually judged to differentiate between those who are insiders and those who are not.

In the health sector, especially, migrant patients may find it hard to understand communication rules and medical jargon (Dysart-Gale, 2005; Johnson et al., 2004; Martin & Nakayama, 2008; Pauwels, 1995). Although all the mothers I interviewed had good educational backgrounds (i.e., two with diploma or trade qualification, six with undergraduate degree, and two with postgraduate

degree), and most of them had been in New Zealand for six years or more, they still could not fully understand the terms and phrases used by health care providers. For example, when I was accompanying a mother for an ultrasound scan, I found her to be quiet when doing the scan. Sometimes, she just chuckled, or said, “ok”, “yes”. It seemed that she might not have understood some medical terms explained by the radiologist. A short conversation with the mother after the scan confirmed my guess. The mother said that she had no idea about medical terms such as “cerebellum”, “ventricle”, or “placenta”. She did not ask questions in order to avoid being judged as the one who could not understand English, nor did she want to make things difficult for the radiologist. The only time she listened carefully was when the radiologist told her at the end of the scan that her baby was fine.

Half of the mothers I interviewed admitted that they pretended to understand or ignore what health care providers said or the words written in forms in their first childbirth experience. Although she answered that she was very confident with English in filling in the sheet of demographic questions, one mother still admitted that she pretended to understand the names of diseases in the section on history of family diseases on the form:

她[产婆]给我读的一张表格，哇，那上面[的字]我基本上都不认识，什么这个病那个病，家里有没有这个病那个病的，我都不知道那是什么病。我有过[假装理解]，但是我是觉得不太重要的了，我是觉得说跟我没什么关系的，我也懒的让她给我解释了就算了，比方说我们 go through[问题]的时候表格前边的几项都是心脏病，高血压，diabetes 啊，比较普遍的现象，比较重要的[疾病]在前面，后面不重要的[疾病]你可能就没有了。



A form which she [midwife] read to me, wow, mostly I didn't understand those [words] in it. Like this disease, that disease. Does the family have this disease, that disease? I had no idea what disease it was. I used to [pretend to understand the words], but I thought it was not that important, or I thought it was nothing related to me. I also felt lazy to let her explain it to me so just passed. For example, when we were go[ing] through [the questions], the first few items in the form were heart disease, high blood pressure, diabetes, quite common. More important [diseases] were in the beginning, and the ones that came later were less important [diseases] that you might not have.

This mother decided to rank the names of diseases in the form. The diseases listed early on in the form were regarded as the more important ones which she had to understand, whereas the diseases mentioned later were ignored because they were labelled as less important or decided they had nothing to do with her. It is also interesting to hear that the mother said that she felt lazy to ask her midwife to explain medical terms to her. For those mothers who pretended to understand or ignore the language, understanding the major words or the whole sentence was sufficient in interactions. But they did not realise the risks of pretending to understand the language in a health environment and the consequent implications for treatments they might receive.

Meanwhile, some maternity-care and health providers confronted miscommunication and even communication breakdown that resulted from language barriers. For instance, a midwife described a communication challenge

she encountered when looking after a Chinese mother:

Only the language is the biggest challenge, when you realise that they really don't understand a lot of what you say, yeah that would be the main, and often yeah, I have a Chinese family in...[a small town] and the mother speaks no English, so if the father isn't at home she won't answer the door.

A Plunket nurse expressed her concern about this Chinese mother who “speaks no English” and other mothers with non-English-speaking background because “they really don't understand a lot of what you say”. To the Chinese mother, the language barrier is obviously her biggest fear and embarrassment, which is why she did not answer the door if her husband was not at home. To this Plunket nurse, a language barrier is the “biggest challenge” in establishing a bonding relationship with her clients. But ironically, the midwife used “only” and “main” to describe the language challenge at the same time. She claimed that language was the only and biggest challenge in communication, but also admitted that language was the main challenge which disguised other challenges she thought of as being minor.

Having language barriers has been identified as one of the major challenges in the interactions between English-speaking maternity-care and health providers and non-English-speaking mothers. Maternity-care and health providers found it hard to make sure some Chinese mothers understood them, while half of the Chinese mothers I interviewed had experienced difficulties in understanding their maternity-care and health providers. To avoid misunderstanding and communication barriers, both parties made efforts, which is discussed in the following section.

### **Coping with Language Barriers**

My analysis reveals that the means that health care providers used to overcome the issue of language barriers included talking slowly, using plain language and synonyms, using gestures and body language, drawing pictures, showing books or dictionaries, and providing detailed explanations. One midwife explained what she usually did to handle language difference:

I speak Pidgin English, very simple structure sentences, and I break it down, and I do go much slower with my English...I also show them graphically. I draw pictures a lot...I try even with Kiwi mums to break the terminology down and try to make it simple. I think we have to do this with all clients, it is very easy in this profession and any medical profession we have our jargon, and we can easily say a word and one of my examples is that if you said to a mum oh your child is afebrile, Kiwi mum wouldn't know.

Along with drawing pictures and a slow speaking tone, the midwife used "Pidgin English" to reflect a way of using simplified and broken forms of English to communicate with the mothers who were lacking in English fluency. More importantly, the midwife identified that she not only applied Pidgin English to communicate with Chinese mothers, she also employed this unique language technique to communicate with English-speaking Kiwi mothers. "[A]ny medical profession" has "jargon", and sometimes "Kiwi mums wouldn't know", so the midwife claimed "I think we have to do this with all clients".

Short colloquialisms were also applied by a midwife to make her explanations vivid and understandable. When I was observing a postnatal visit

of a mother and her midwife, I found that instead of applying simplifications which were often found in doctor to migrant patient speech (Ervin-Tripp & Strage, 1985), the midwife employed colloquialism to help the mother to understand childbirth knowledge regarding the postpartum period.

She said, “Sometimes a little voice sits on your shoulder”, which showed her sympathy towards the mother in terms of her concerns about not being a good mum. The phrase “passion does return” was used when the midwife explained that contraception was necessary after giving birth. To teach the mother how to identify with different baby cries and react to the cries appropriately, the midwife used the phrase “crying up or crying down”. And finally, she said, “you have to have eyes at the back of your head”, which reminded the mother to be aware of the baby’s safety. These phrases were more easily understood than the complicated medical terms and explanations. They also contributed to replacing a rigid and routine health communication environment with a more open and relaxed one. It is important to note that the midwife not only applied colloquialism but also used it deliberately. She made sure that the mother understood what she was saying by asking, “They do for Kiwi ones. They do for Chinese women?” or “You have something similar in Chinese?” The context of this midwife needs to be taken into account when analysing the text. According to her interview, the midwife had worked in South Asia and East Africa as a registered nurse or a volunteer for quite a long time. That experience motivated her to be more sensitive to language issues and cultural needs of women. Therefore, the midwife liked using simple and short colloquialisms when communicating with the mothers, and she always invited questions/feedback from the mothers.

There is a more specific example displaying how a midwife used language techniques to help with a mother's understanding of medical jargon. Recording from an observation of a mother's antenatal visit to her midwife, the midwife made an effort to explain what Glucose Tolerance Test was and why to do it:

Midwife: It is called Glucose Tolerance Test. Pregnancy Glucose Tolerance Test.

Mother: Okay (very softly).

...

Midwife: You just tell them [nurses in the Medlab]. I write it down so you will know (the midwife wrote PGTT down as it was abbreviated in the test form), 'cause this here is just abbreviated. You will need to book a Pregnancy Glucose Tolerance Test. Because you say that your Polycoast is positive. Polycoast is high. They will understand why. Okay? This is called Pregnancy Glucose Tolerance Test because your Polycoast is high.

Mother: Yeah, a little bit higher.

Assuming that the mother had difficulties in understanding the medical terms because she was from a non-English-speaking background, the midwife employed specific language techniques with considerable deliberateness. For example, the midwife's explanation was replete with repeated medical terms "Glucose Tolerance Test" and "Polycoast". Although the mother had a good educational background, she still might not fully understood what a Glucose Tolerance Test was as she answered "Okay" very softly after hearing the term for the first time. To further strengthen the mother's understanding of Glucose

Tolerance Test, the midwife wrote down the words which were abbreviated in the form. She also adopted the synonym “high” to replace “positive” in order to explain that the mother’s Polycoast level was above average.

Another practical measure adopted by one midwife to overcome language barriers was creating a less stressful health communication environment.

According to this midwife:

I have had one woman this year who was just so incredibly hard to communicate with, and half the time I wasn’t sure if I was getting any information in there or not, and I ended up just seeing her at home because it seemed that she would be more relaxed there and she would be more able to take on what I was saying, whereas here [midwifery centre] I think she felt intimidated.

Realising that her client was “so incredibly hard to communicate with”, the midwife decided to move the visiting venue from her midwifery centre to the client’s home because this Chinese mother might feel “intimidated” in the midwifery centre, whereas she “would be more relaxed” at home, and “would be more able to take on” the information given by the midwife. In this case, the importance of creating and maintaining a relaxed health communication environment is apparent in improving intercultural communication when language issues are to be considered.

From the perspective of mothers, many of them checked the words they did not understand in electronic dictionaries after their visits to avoid language problems. Three mothers, in particular, did preparations (e.g., checking the words, writing down their questions and concerns) before their appointments with

maternity and health care providers. As one mother said that she often wrote down a list of questions prior to the visits to her midwife because she was worried that she might not explain questions clearly or the midwife might not understand questions properly. Such a method proved to be effective as the midwife gave detailed explanations after reading through the list, and she would also put down notes next to the questions so that the mother would have a better understanding of what she had explained.

Another common strategy adopted by half of the mothers who were interviewed was to rely on an interpreter. When I was accompanying a mother and her husband to contact a health clinic for their baby's check-up and immunisation, I met a clinical acupuncturist who volunteered to be their interpreter. Since language barriers often cause stress and anxiety in physician-patient communication, using interpreters is seen as a remedy for migrant patients who do not speak the same language with their health care providers (Dysart-Gale, 2005; Hsieh, 2006; Pauwels, 1995). Being worried about the language issue, the couple appreciated getting help from a "bilingual health care provider" (Hsieh, 2006, p. 179) who was a trained Chinese acupuncturist, working in the same health clinic where the GP was. The interpreter helped translate the GP's words to the couple in Cantonese when checking the baby. Given that the interpreter came from the same Province of China as the couple did, he understood their dialect, which I could not understand during the observation.

During one observation, the couple and the interpreter chatted a lot about other issues unrelated to the baby's health during the visit. Accordingly, the GP was ignored when she was talking about something which was identified as not

important in the couple's opinion, while the other three were having a different conversation. The mother and father were also less likely to participate in interactions with the GP, which challenged a harmonious physician-patient relationship.

Recruiting a bilingual health care provider was indeed favoured by many maternity-care and health providers and health agencies. A hospital-based midwife and an anaesthetist explained why a bilingual health care provider was preferred in the hospital domain:

They [other hospital health professionals] ask me to interpret, especially sometimes when the interpreters don't turn up. Chinese interpreters are quite limited. Sometimes if they haven't turned up yet so I do help out. In this department, I am the only . . . [ethnic Chinese health provider].

Hospital midwives and some Chinese registrars who can speak or at least can understand what they [Chinese mothers and family] are saying, they might not be able to respond very shortly so if they are around we might, they might be the first call because usually they book an external interpreter, there are some on call but they still take time to come in, so they are not at the hospital and there if you want to do something urgently.

Both the hospital-based midwife and the anaesthetist explained the reason why health professionals in the hospital favoured bilingual health care providers: that is, external interpreters sometimes might not turn up or turn up late. If the interpreters did not turn up or the health situation was urgent, health professionals would ask for help from "hospital midwives and some Chinese registrars". As



this hospital-based midwife said, she was asked to interpret by other colleagues because she was the only ethnic Chinese in her department. However, from the statement of the anaesthetist, it seemed that language and interpretation abilities of bilingual health care providers were not a concern. They might be the “first call” if they “can speak or at least can understand what they [Chinese mothers and families] are saying”, and even “they might not be able to respond very shortly”.

Instead of recruiting medical or trained interpreters, the mothers liked to depend on their partners or relatives who lived in New Zealand to be “chance interpreters” (Hsieh, 2006, p. 179). According to one midwife:

If they want someone to interpret I would get somebody, but usually a family member would interpret, and that is a lot easier for the person rather than bringing a stranger in.

The midwife’s statement indicates that the mothers preferred a family member to be an interpreter. It was “a lot easier for the person” because trust was already established within the group of insiders, that is, the mothers’ family members in New Zealand. An external interpreter was easily regarded as “a stranger” who might make the health communication environment more stressful.

Although it was easier for both mothers and health care providers to find a chance interpreter, challenges might occur. In one case, inaccurate interpretation occurred when a mother asked her husband’s cousin, a high-school girl, to interpret in their first visit with the midwife because the mother had just migrated to New Zealand and she was not confident about her English. In the end, the mother found that the cousin helped little and stopped using her as an interpreter in the following visits. Although the cousin had no problem in understanding the

language of the midwife, she had difficulties in interpreting English to Chinese accurately due to her weak command of spoken Chinese, and lack of childbirth and medical knowledge.

Meanwhile, given that most mothers were separated from their family and friends when they were pregnant, they were more likely to depend on their partners for support (DeSouza, 2005; 2006a). Two particular mothers told me:

如果我不知道[产婆说什么], 我会问我老公。他的英文比我好。他总是陪我一块儿去检查, 除了有一次他生病了。

If I don't know [what the midwife says], I'll ask my husband. His English is better than mine. He always accompanied me for visits, apart from one time when he was sick.

因为日常交流还好啦, 但是涉及到生产什么的有一些医学的术语, 像人体一些结构还有一些药啊[语言就有问题了]。所以我每次都跟我老公一起去, 因为他是学 science, 所以这个好很多, 所以听不懂我就看他, 呵呵, 然后他懂了, 他懂了就好。

Daily communication is fine, but [language is a problem] if relating to say medical terms in childbirth such as anatomy or some medicines. So every time I went with my husband. Because he studied science, it makes communication better. So if I couldn't get it, I would stare at him. Hehe. Then he got it. He got it, it's fine.

The anaesthetist's perspective was consistent with these mothers' views of

favouring their husbands to help with interpretations in the maternity and health settings:

But most of them I think usually have their husbands who are a little bit better, yeah little bit better in English so their Chinese husbands who can speak English a bit better or can understand English a bit better. But we tend to try to avoid using them.

Both the mothers trusted and relied on their partners, their only family members in New Zealand, to avoid language barriers that might occur in their communication with health care providers. The second mother, in particular, would stare at her husband to make sure that he understood the conversation, so he might be able to explain it to her in Chinese later. The mothers' trust was also based on the idea that "His English is better than mine", "Because he studied science", and as the anaesthetist repeatedly pointed out, Chinese husbands were "a little bit better", "little bit better in English", "can speak English a bit better or can understand English a bit better". Ironically, although the anaesthetist said that Chinese mothers liked to rely on their partners with "a bit better English" to interpret, health professionals tended to "avoid using them".

What one midwife has noticed from her visits to Chinese mothers and their partners may illustrate why some health care providers did not like using the mothers' partners as interpreters:

Most Chinese women know a bit of English and sometimes they understand, especially if you go slow, they understand that they don't want to voice it, they don't want to use their voice, so they prefer to talk in their own language to their partner . . . I have noticed a lot of Chinese ladies and

other ethnic groups when they don't have a person there very often they will talk, they will talk more and when they have a person there they will talk less.

According to this midwife, most Chinese women could understand and speak a bit of English if the midwife spoke slowly. However, they did not "want to use their voice" when their partners were present. Instead, Chinese women would "prefer to talk in their own language to their partner". She felt that when their partners were not present, many Chinese women would "talk more" to the midwife. An analysis of these dialectical tensions and power relations in the communication between the mothers and the maternity-care providers with the presence of interpreters is carried out in the next section.

This section has outlined different approaches applied by maternity-care and health providers and Chinese mothers to cope with the language issue in health communication. Most maternity-care and health providers employed verbal and nonverbal techniques to make it easier for Chinese mothers to understand medical jargon and health procedures. But only a few maternity-care and health providers emphasised creating and maintaining a relaxed and open health communication environment to make mothers feel comfortable in speaking and understanding English. Along with checking words and preparing questions for the visits, some Chinese mothers also liked to rely on interpreters in contacting their maternity-care and health providers. Bilingual health care providers and chance interpreters were preferred by health agencies and mothers. Although convenience, comfort, and trust were considered to be the advantages of recruiting these informal interpreters, challenges such as inadequate language abilities and

unequal power relationships were undeniable. In what follows, I take this discussion further to interpret the findings of the use of language in relation to the concept of othering.

### **Rethinking Language**

In New Zealand, the dominant use of English reflects New Zealand's colonial history, and the nation's contemporary realities of ingroups and outgroups. British colonisation from the late 1700s had a big impact on the New Zealand's immigration policies, particularly in the 19th and early 20th centuries (Kahn, 2004). New Zealand has traditionally favoured English-speaking population from Anglo-European countries (Brooking & Rabel, 1995; Kurian & Munshi, 2006). Historically, ethnic Chinese and other Asian migrants who speak languages other than English were excluded or marginalised by discriminatory immigration policies (Kahn, 2004), even though they were later allowed in (Kember, 2002; Statistics New Zealand, 2006). Given that history, English became the official and business language in New Zealand and consequently speaking English is seen as the norm in New Zealand society. In the Western maternity and health environment, speaking and understanding English is portrayed as the norm of "our culture". People from the "other culture" who speak a language other than English are easily portrayed as 'others', leading to process of disempowerment and exclusion (Johnson et al., 2004). Chinese mothers, in my research, experienced this process of being othered due to the language barriers they encountered.

Although most mothers had lived in New Zealand for quite a long time, and all the mothers had good educational backgrounds, many of them still

struggled with English in the medical and health communication context. Difficulties in speaking and understanding English were more apparent for the first-time mothers. These findings are consistent with those of Pauwels (1995) who argued that migrants may struggle with medical jargon, communicative rules, and routines of English even though they are competent in speaking and understanding English at ordinary times. To minimise the potential of being othered due to language barriers, one Chinese mother ignored medical terms which she could not understand during an ultrasound scan, and the other mother pretended to understand the names of diseases in filling the form on family diseases history during the visit to her midwife. The fact is that half of the mothers I interviewed have admitted that they used to pretend or ignore the medical words and/or what they were being told by their maternity-care and health providers. By doing so, the mothers expected their maternity-care and health providers to assume them as “the same” as the ones who understood English and to accept them as the ones in “the same” culture. Nevertheless, what they were doing placed them in a passive and disempowered position while reinforcing the dominant position of the mainstream. Risks might also occur in terms of receiving correct diagnosis and appropriate treatments for the mothers.

Mothers were not the only ones to experience difficulties with language. Maternity and health care providers also acknowledged language as a key challenge in building understanding and relationships with their clients. As a Plunket nurse pointed out, the language issue was the “only and biggest challenge” in communicating with Chinese mothers with language difficulties. The terms “only” and “biggest” were conspicuous in her comment. There must be other challenges in the communication between the mothers and maternity-care

providers, but language can be easily used as a mask for other barriers. Indeed, language barriers can cause miscommunication and even communication breakdown, but I do not agree that having language barriers is the only and biggest challenge in the health communication context. Since othering is a process to mark and name those who are different from the mainstream (Weis, 1995), what I found is that having language barriers can be easily assumed as an explicit difference, just as other explicit differences in one's appearance and colour of skin are, in the processes of othering. Therefore, having language barriers is often used by English-speaking maternity-care and health providers to mark and 'other' those non-English-speaking mothers who are thought to be different from themselves.

To avoid and overcome language barriers, some Chinese mothers use electronic dictionaries and prepare notes and questions prior to their visits to their maternity-care and health providers. They prepare to take a more active role in communicating with English-speaking health providers. In this way, these mothers are empowering themselves within intercultural and health contexts where self-confidence can be quickly established. The responsibilities of avoiding or overcoming language problems not only rest with migrant patients, however; the responsibilities also need to be shared by maternity and health care providers. Maternity and health care providers need to be aware of potential risks involved with language barriers, and make efforts to help migrant patients better understand their interactions. Poor physician-patient communication may happen because the use of technical and turgid language can confuse patients and cause misunderstanding (Cicourel, 1985). Health providers, in Ervin-Tripp and Strage's (1985) study, are found leaning towards a use of simplified language in

communicating with migrant patients. I too found in my research that maternity-care and health providers liked to use simplified verbal and nonverbal language techniques such as Pidgin English, slow speaking tone, synonyms, phrases, visual pictures, gestures, and body language to facilitate the understanding of Chinese mothers. At one end of the spectrum, applying different language techniques in intercultural communication is a way of empowerment. These maternity-care and health providers attempted to empower the mothers, with the establishment of understanding, in information sharing and decision making. The mothers' participation in intercultural communication was also strongly encouraged.

At the other end of the spectrum, as long as the maternity-care and health providers emphasised the language issue more in intercultural communication, they consciously or unconsciously labelled ethnic Chinese mothers as a unified group which was different and subordinate to Western and English-speaking mothers. The colonised is historically regarded as a group produced by the coloniser as a fixed reality which is a knowable and visible other (Bhabha, 1996). The matrix of difference guides me to break through this fixed reality of being an other, and appreciate the diversity that exists within this othered group. The Chinese mothers I have interviewed had different English abilities depending on the lengths of their stays in New Zealand, educational backgrounds, work experience, and having a first or experienced childbirth. Hence, maternity-care and health providers need to acknowledge this diversity, and avoid treating Chinese mothers as the same group with inadequate English abilities. The fact is that only one midwife out of ten maternity-care providers claimed that she applied simplified and broken forms of English to both migrant women and Kiwi women



because she thought medical jargon was hard to understand for any one regardless of where they came from. Against constructing dualisms of us and them or West and East (MacCallum, 2002), this midwife created a sense of inclusiveness in the communication with the mothers by treating every mother as an individual consumer regardless of her cultural background and linguistic ability.

The health environment is indeed stressful for any individual (Pauwels, 1995). For non-English-speaking patients, stress, anxiety, and uncertainty are intensified in the English-speaking health environment (Dysart-Gale, 2005). However in practice, most maternity-care and health providers in my study put an emphasis on using language techniques to cope with language barriers: only one midwife identified the importance of creating a relaxed and open health communication environment by shifting the visiting venue from her office to the mother's home in order to reduce the mother's intimidating feeling of speaking English. Most maternity-care and health providers ignored the importance of creating and maintaining a sense of belonging in a relaxed and harmonious health communication environment. That sense of belonging is beneficial to minimise or avoid language barriers.

Calling for an interpreter to be present with the mother was another common way appreciated by both mothers and maternity-care and health providers. Instead of using outsourced and formally trained interpreters, health agencies such as hospital and health clinics and their health professionals favoured bilingual health care providers and workers who could be on-site, Chinese medical staff, hospital-based midwives, or Chinese registrars. This group of interpreters was thought to be good at medical knowledge and physician-patient communication, and be able to speak and/or understand the patients' language

(Hsieh, 2006).

Further, this group of interpreters was working on site, so it was much easier and quicker to ask these health providers and workers to come for urgent cases. However, it is undeniable that recruiting bilingual health care providers cannot guarantee that they have good language abilities and adequacy in understanding the patients' cultural beliefs (Hsieh, 2006). As I have already identified from the quotation of an anaesthetist, hospital midwives and Chinese registrars were considered as a pool of interpreters because they could at least understand or speak Chinese, though they sometimes could not respond very quickly. Their language abilities and understanding of Chinese cultural beliefs were certainly not taken into account by health agencies.

Another challenge of recruiting bilingual health care providers, in particular, those who spoke the same language/dialect and shared the same cultural values, stemmed from Chinese values of insiders and outsiders. The Chinese concept of insiders and outsiders is derived from Chinese values of *we* orientation and ingroup communication (Chen & Starosta, 1998; Gao & Ting-Toomey, 1998), that is, Chinese tend to be highly involved in communication with insiders including family, relatives, friends, and others with a special relationship, but less likely to involve in communication with outsiders such as strangers (Gao & Ting-Toomey, 1998). In my findings, a mother and her husband relied on an on-site Chinese acupuncturist to interpret their communication with the GP. Identifying the interpreter as an insider because he was from the same area of China, he could speak Cantonese and their dialect, and he knew the couple's parents and grandparents in New Zealand, the couple trusted the interpreter in answering the GP's questions. Interestingly, this was a case of

defensive 'othering' in as much as the couple, sensing their own 'othered' status actually treated the GP as an 'other'. The postcolonial perspective critiques Western power in defining the East as the other (Said, 1978); however, roles of natives and others can be reversed (Chow, 1996). As Kitzinger and Wilkinson (1996) point out, "Who and what Others are ... is intimately related to 'our' notion of who and what 'we' are. 'We' use Other to define ourselves: 'we' understand ourselves in relation to what we are not" (p. 8). In the gaze of the Chinese couple, the GP was constructed as the other who was different and alienated from their culture. This othering process reinforced the couple's own cultural identity by distancing the other. The closer the couple was bound up with the interpreter who was seen as an insider, the larger the distance and the wider the boundary in their relationships with the New Zealand health care provider who was regarded as an outsider.

Chinese mothers were more likely to rely on their partners or family members living in New Zealand to be their interpreters. This supports the insider theory (Gao & Ting-Toomey, 1998) that the mothers' only family members in New Zealand during their pregnancy become their childbirth source of knowledge and support. Hsieh (2006) calls them chance interpreters who have already gained trust from patients, and who are easier to ask for help from. However in practice, interpreting abilities of family members were questioned since they had not experienced formal training in medical interpretation.

Relying heavily on partners to interpret was also critiqued, as one anaesthetist mentioned that hospital professionals tried to avoid using them and the other midwife noticed that Chinese women talked less when their partners were present. Within certain cultures, males can be gatekeepers of information

and they may feel that they have rights and power to make decisions for their partners (Hsieh, 2006). Chinese Confucianism, which defines an unequal family relationship between husband and wife (Gao & Ting-Toomey, 1998), can be used to partly explain why some Chinese women talked less when their partners were present. But more significantly, the concept of othering is embedded in both dualisms of men and women, as well as that of the West and East.

The privileging of masculinity stems from social discourses. The Western health and medical discourses privilege masculinity but suppress the less powerful knowledge of women and ethnic minority groups (Coyle, 1999). Men are treated as natives who define the dominant structures of knowledge production in the society, whereas women are labelled as others whose own knowledge and experience are easily obliterated (Harding, 1991). In other words, a male's knowledge is regarded as public and formal knowledge, whereas a female's knowledge is seen as intimate and informal knowledge. As shown in the previous examples, the husbands were mentioned in association with the mind – better English, medical and science knowledge – which was privileged over the women who were usually associated with bodily ideologies including mothering and being sexual objects. Third World feminist theory not only critiques the gender judgment of “mind is privileged over body” (MacCallum, 2002, p. 89) but also argues that Third World women need to regain their power and speak for themselves against the suppression of masculine and Western discourses (Spivak, 1988). In the context of my research, some Chinese mothers might find it hard to break through this unequal power relationship or they might not be aware of the suppression of their voices, therefore, some maternity-care and health providers attempted to empower the mothers in communication by avoiding using their

partners as interpreters. Although no other findings have shown that the participants' partners who acted as interpreters tried to control information, decision making, and behaviors in communicating with health care providers, one of my observations revealed that a woman's husband, as *the third party*, enjoyed his power advantage over his wife in communication. This finding is developed in the next chapter.

### Conclusion

In summary, the matrix indicates that language is a convention which constructs identities, experiences, and particular realities of a cultural group. Chinese people share Chinese language and dialects to shape their subjective ways of thinking, which is different to how people in New Zealand use English to express their realities. When these different languages come into play in the same context, language difference and language barriers become typical in identifying who *we* are and who *they* are. The power of a certain language then is enlarged to suppress other languages as different and weak. As English-speaking was seen as a norm in the New Zealand maternity and health systems, English-speaking maternity-care and health providers belonged to the mainstream group, whereas Chinese mothers with non-English-speaking backgrounds were categorised as the other group. To help the other group learn and understand English conversation during health visits, the mainstream group employed different approaches but power was still controlled by this group who were more fluent in speaking English and more familiar with the New Zealand medical and health context. To avoid being categorised as the other group, some mothers made efforts to cope with language barriers while others pretended to

understand the language.

My argument here is that language should not be used to mark as deviant those who speak a language different from the mainstream language. Language also should not be used as an excuse for other barriers (e.g., distrust, gender discrimination, different medical beliefs) in intercultural communication. Language is a tool of empowerment when some mothers take an active speaking role and some maternity care providers empower their Chinese clients to get more involved in communication. Yet, language is also an instrument of disempowerment when dominant groups attempt to control interactions and muzzle the voices of Others. To cope with language issues, it is more important to replace a rigid, routine, and a sometimes “intimidating” English-speaking health communication environment with an inclusive, relaxed, and open environment for every mother. The discussion of othering and the ways of overcoming otherness does not end here. In the next chapter, I continue to explore the discourse of othering implicated in the construction of values of childbirth and communication.

## **CHAPTER 8: VALUES**

Values are created to construct people's lives and control their behaviours (Cheney, 1981). In this sense, values are very powerful even though they may be vague abstractions. Values are embraced in social and institutional fabrics, and in turn, they can be understood and interpreted by exploring discursive practices within social and institutional contexts. Values "unify us, but they also conceal differences" (Cheney, 1981, p. 19). There may be different understandings and interpretations of the same values. In this chapter, I delve into the interpretation of different values and knowledge of childbirth and communication through the examination of discursive practices within the New Zealand maternity and health care settings. I focus on difference and the dualisms of Chinese and Pakeha New Zealand constructions of knowledge of childbirth (including breastfeeding) as well as their health communication styles. A case is made to rethink and reorient mainstream values and knowledge associated with childbirth, culture, and communication to make them more inclusive.

### **Constructing Values of Childbirth**

The New Zealand maternity and health care systems value natural childbirth which encourages women to view childbirth as a natural process that a woman should take control over (DeSouza, 2006a; Kedgley, 1996). Childbirth is often portrayed as easy and something that does not need medical intervention. In my study, maternity-care and health providers frequently used positive words or terms in their conversations with mothers to consciously or unconsciously reinforce the discourse of natural childbirth. All the mothers mentioned at least three or four times in their interviews that midwives and other health care

providers they met often comforted them by saying everything was “normal”, “good”, “fine”, or “common”, which made them feel childbirth was an easy process with minor risks to worry about.

One mother gave examples of this in her interview:

我之前有流产过就问她[产婆]这次要注意点什么，产婆说：“流产很正常，很难说，不用太过担心。”我还问过她[怀孕]3个月后可不可以吃 folic acid 因为我还有剩，她说：“这要看你了，如果你想要吃也没关系的。”

I had a miscarriage before so I asked her [midwife] what I should be aware of this time. The midwife said, “Miscarriage is normal. Hard to say. Don’t worry too much.” I also asked her about having folic acid after 3 months [of pregnancy] as there’re some left. She said, “It’s up to you. Doesn’t matter if you want to take it.”

The discourse of natural childbirth is the macro-level conceptualisation of childbirth values, beliefs, and practices, which took effect when maternity and health providers were communicating with Chinese mothers. For example, the midwife gave comments of “normal”, “doesn’t matter” and “don’t worry too much” that reflected her understanding of childbirth as a natural process. As for the mother, she was very cautious about pregnancy after her previous miscarriage experience. Her values of childbirth were constructed by the Chinese health structures of childbirth knowledge, that is, the knowledge of medicalisation and safety of childbirth. Therefore, the mother wanted to get advice from her midwife in terms of what she had to watch during pregnancy, and whether it was



safe to have folic acid after three months of pregnancy. The midwife's response, from one perspective, can be seen as a way of comforting and distracting the mother from her worries. But from another perspective, her response maintained the New Zealand static structures of childbirth values and knowledge, and resisted any other existing but different values of childbirth. In this case, the mother did not challenge the midwife's response regarding their different views of childbirth, but accepted it as a normal way of doing things in New Zealand society.

Two other mothers expressed their dissatisfaction about maternity-care and health providers' comments on childbirth being normal or natural:

他们这边好奇怪问他们什么问题都是说“normal”，我觉得很奇怪哦，他们也没有说要做点什么，他们说正常你还能说什么呢？

They here are strange. They always answer “normal” for any questions. I think it's very strange. They don't say what have to be done. They say normal so what else can you say?

他们解释的不太满意，因为他们都解释 natural，我认为什么事都是应该有原因的，可是他们给我的答案都是没有原因的（笑）。

Their explanation is not satisfactory because they have all explained that it is natural. I think everything has a reason, but the answers they gave me are without reasons. (Laughing)

The competing discourses of childbirth are apparent in both quotations.

Maternity-care and health providers in New Zealand tried to socialise the

mothers to the discourse of natural childbirth. Both mothers had strong impressions of that by hearing the maternity-care and health providers comment that things were “normal” and “natural” when the mothers asked for answers and explanations. However, the mothers were not satisfied with those comments because such comments went against their cultural understanding and expectations of childbirth. As the second mother said, “everything has a reason”, which reveals her childbirth values of medicalisation. Everything in the childbirth process needs consistent care and cautiousness (Xie et al., 2006).

It needs to be stressed here that in both mothers’ identification, New Zealand health carers are portrayed as different. Their values and comments are no longer normal and positive. As Chow (1996) argues in the gaze of non-Western others, Westerners can be turned into subjects and be pushed away. In the eyes of Chinese mothers, the maternity-care and health providers were turned into others, so were their values and comments portrayed as being “strange” and negative. This conclusion can be justified by the first mother’s comment, “They here are strange”, and also in the laugh of the second mother when she said, “the answers they gave me are without reasons”. Although the mothers held different standpoints on childbirth, they had little power to challenge the New Zealand norm of natural childbirth. As the first mother asked, “They say normal so what else can you say?”

To further address different and competing discourses of childbirth, I now give another example drawing from an observation of an interaction between a mother and her midwife in an antenatal visit:

Mother: And may I call 111 to the hospital? Sometimes \*\* [name of the husband] is [does] not stay at home.

Midwife: No, usually 111 is emergency service.

...

Mother: So sometimes I just worry if it happens during the class or on the way to the uni.

Midwife: If it starts on the way to the uni, what I suggest you do is get a bus straight back 'cause it's not far and you still have plenty of time.

Mother: Yeah, sure, I understand.

Dominant discourses construct our understandings and thus legitimise our responses (Grove & Zwi, 2006). This statement is particularly relevant in the above example. The New Zealand maternity and health care systems value the discourse of natural childbirth which shapes the understanding of New Zealand women and maternity-care and health providers (Kedgley, 1996). To respond to this understanding, maternity-care and health providers take responsibilities to encourage women, in particular migrant women, to fit in with the discourse of natural childbirth (DeSouza, 2006a). For example, the midwife in this context tried to convince the mother to believe that having contractions was a part of natural childbirth and that she would not need to call 111; she would not need to worry too much even if she was far from home; she could get a bus back by herself and get hold of her husband.

From the midwife's perspective, that was a normal way women had to react according to the New Zealand rule of natural childbirth. Anything different to the norm such as calling 111 or worrying too much was portrayed as strange and different and had to be discouraged. Although the mother finally said that she understood and stopped talking about this topic anymore, she seemed not to

be very happy with the midwife's answers. The power remained with the midwife who was familiar with and tended to reinforce the New Zealand health discourse, whereas the mother was asked to be silent and conform to the "same" rules.

In an interview, another mother shared her experience of being 'othered' with me:

我问关于穿防辐射服的事情。产婆说：“这是你们中国人的做法，我们新西兰人从来不穿。他们只是想卖了攒钱。”虽然她是这么说啦，我还是每天都有穿的。

I asked about wearing radiation protection suits. The midwife said, "It's your Chinese way. Our New Zealanders never wear them. They just want to earn money by selling them." Although she said so, I still wore it every day.

Discourses set up rules which produce knowledge and regulate our perceptions and behaviours (Holmer-Nadesan, 1997). Similar to the previous mothers, this Chinese mother also viewed childbirth as a highly risky process and treated every aspect of pregnancy as important because her knowledge about childbirth had been constructed by the discourse of medicalisation which was valued in China (Lazarus, 1994). Therefore, the mother wanted to wear radiation protection suits in pregnancy. However, her knowledge of childbirth was different from and in conflict with the dominant knowledge of childbirth which was explained by the New Zealand discourse of natural childbirth. It was the New Zealand knowledge of childbirth that empowered the midwife to control the

mother's perceptions and behaviours in conforming to the rules of treating childbirth as a natural way.

The midwife used "our New Zealanders" and "your Chinese ways" to separate *us* and *them*, which reflected the dualism of West and East. In this case, the midwife confirmed her identity as a member of *our* Western culture by excluding the other. The mother was the other, and her knowledge of wearing radiation protection suits was judged as strange and rare. As the midwife commented, "Our New Zealanders never wear them." This comment aligned with her next comment "They just want to earn money by selling them" again revealing power relations between us and them. Our culture is superior to *their* culture. In other words, the same has a positive value whereas the other has a negative value (MacCallum, 2002). While the midwife subordinated the mother and stereotyped the Chinese way of doing things, the mother resisted against being assimilated into dominant discourses but in a silent way. She did not argue back but still wore the radiation protection suits every day.

Nonetheless, migrant women have little power to influence dominant discourse; however, the following quotations, the first from an independent midwife and the second from a Chinese mother, show that it can be achieved with the contribution from dominant groups:

When I talk to women about their birth plan and what do they, do they have any cultural or spiritual needs that they want to incorporate into that.

I think that is important.

I would always, with my students, what I am telling them is to respect the culture that they have brought with them and let them incorporate things that they want to do into their care, providing it is safe.

她知道做月子，因为她带过很多中国人。。。有时候她走的时候我送她她就说不要送了外面有风。我一个月就基本在家呆着，她都了解的。

She knows *zuo yue zi* as she had many Chinese [clients]... Sometimes I saw her off when she was leaving, she said, “Don’t see me off. It’s windy outside.” I basically stayed at home for the whole month, and she totally understood it.

With their experience of working with migrant mothers, both midwives in the above examples were culturally sensitive in understanding cultural values and having cultural knowledge (Ulrey & Amason, 2001). The midwives did not portray migrant mothers’ behaviours and values of childbirth as rare and negative, nor did they ask the mothers to comply with the New Zealand norm of treating childbirth as natural. Rather, the midwives acknowledged differences among the mothers. The first midwife asked mothers to voice their “cultural or spiritual needs” during their discussions of birth plans. She also taught her students to “respect the culture” and let the mothers bring and “incorporate” cultural things if the mothers wanted to do so and if they were “safe”. Certainly, the determination of a cultural practice as being “safe” or not is made by the midwife who still has to comply with the dominant health principles; however, the midwife’s comment at least reflects that she is willing to accept different possibilities. The second midwife acknowledged differences involved with the Chinese mother as a migrant woman moving from a developing country, and that she belonged to a Chinese ethnic group holding different values and beliefs of

postpartum care. Valuing these differences, the midwife encouraged the mother to interpret things differently and to replace New Zealand's normality with her way of doing things. This cultural sensitivity can be seen in the example where the midwife asked the mother to be careful of the wind, understood, and supported her behaviours of *zuo yue zi* which is a one-month confinement after delivery to regain energy from birth (Chu, 1996; Hao & Moore, 2003; Kartchner & Callister, 2003).

A statement from another midwife synthesises how differences were appreciated and incorporated into the services she provided:

There are midwives out there that are primarily really into the natural childbirth at home, no intervention whatsoever, and I respect them for that. But then they chose those people, and those people chose them for their philosophy, and that is really good that they can do that. But some people don't have that opportunity because of their life experiences, their health, their issues, their social pressures, all that sort of thing, and so on, and their world view and where they have come from, and who they are. So I like to accommodate more for that kind of person, I find it more challenging.

Dualisms of 'us' and 'them' as well as natural childbirth and medical childbirth were shaped in this process of othering. Those midwives and mothers who were "really into the natural childbirth" formed the majority of group which excluded other mothers with a variety of differences. This midwife's narrative interrogated the process of othering. Clearly, the midwife adopted a different "philosophy" from other "midwives out there". She respected those midwives and "their philosophy"; however, she was more passionate about helping some

people who did not have an “opportunity” to choose natural childbirth. To overcome otherness, health providers are recommended to adopt a culturally sensitive stance by using appropriate language, having cultural knowledge, and understanding different values (Ulrey & Amason, 2001). This midwife was very culturally sensitive towards women’s differences. She valued women’s different “life experiences”, “health”, “issues”, “social pressures”, “world view”, “where they have come from”, “who they are”, and so forth. To this midwife, not every woman is the same. Different women experience and interpret childbirth differently. Although it was “challenging”, she would be more likely to “accommodate” these women.

Applying the discourse of othering to the issue of construction of values of childbirth, I find that only a few maternity-care and health providers realised the difficulties faced by Chinese mothers in being socialised into the New Zealand health discourses. In practice, many Chinese mothers were marginalised when they were communicating with their maternity-care and health providers. The mothers’ knowledge of childbirth as a medical event was portrayed as different and subordinate to the New Zealand knowledge of childbirth. Accordingly, many mothers chose to lower their expectations towards maternity-care and health providers and communication, and silently challenged mainstream norms. Next, I explore the construction of the knowledge of breastfeeding. I specifically look at the discourse of *keep breastfeeding* (a subset of the dominant discourse of natural childbirth) and the discourse of *quit breastfeeding* (a subset of the dominant discourse of medicalised childbirth) to discuss the challenges some mothers experienced in communicating with their maternity-care and health providers.



### **Constructing the Knowledge of Breastfeeding**

The discourse of natural childbirth influences people's values and knowledge of breastfeeding at the same time in New Zealand. *Keep breastfeeding* is a slogan stressed by many New Zealand health care providers because it is regarded as a more natural way to keep babies healthy and make connections between mothers and babies (New Zealand College of Midwives, 2008). In this section, I describe the reinforcement of the *keep breastfeeding* discourse by maternity-care and health providers in interactions with Chinese mothers. I discuss the mothers' responses to being socialised into this discourse. Explaining different views of breastfeeding, I also provide an example indicating a decision made by a maternity care provider to stand by her client's point of view to challenge the dominant views of breastfeeding.

*Keep breastfeeding* has been recurrently promoted in many countries including New Zealand since the late 20<sup>th</sup> century. The New Zealand maternity and health care providers are expected to support mothers in breastfeeding. While breastfeeding is prioritised in New Zealand, it is not widely promoted in China. One midwife identified the different Chinese perspective of breastfeeding by saying:

I think what we see is that probably there is more formula feeding in Chinese culture, and we are more breast feeding, so we want some of those mums we know that perhaps their mothers and their mothers-in-law that we can educate them, we can let them have that information.

The midwife set a clear boundary between "we" and "some of those mums". We are "more breast feeding" but they are "more formula feeding".

We “want” those women and their mothers and mothers-in-law to “know” more about breastfeeding, to “educate” them, and to “let them have that information”. The difference between us and them leads to deviance and disparity (Grove & Zwi, 2006), and unequal power relationships (MacCallum, 2002). From this midwife’s perspective, breastfeeding, which was favoured by New Zealand culture, was superior to any other form of feeding babies. Her established knowledge of breastfeeding thus empowered her to educate Chinese mothers and their families, but at the same time, suppressed the mothers and their families as the ones without modern and scientific knowledge.

After Chinese women migrated to New Zealand, they were encouraged to accept the norm of *keep breastfeeding*. A conversation between a mother and her midwife further explains how the discourse of *keep breastfeeding* was emphasised, and how the mother’s views about breastfeeding were modified:

Midwife: And this one [book] is about how long one should breastfeed a baby.

Mother: Forever.

Midwife: That’s right. Hehe. It’s written by an American lady who is a lactation consultant. She lives in New York. It’s just to encourage mothers because sometimes it’s hard work. Just to encourage you what you are doing is a gold standard. If you feel tired, or can’t do this anymore, this encourages you to carry on. You are doing a great job.

According to Martin and Nakayama (2008), culture is a group’s shared values, perceptions, and behaviours. Chinese mothers’ understandings about breastfeeding were framed by their shared sociocultural experiences and practices

when they were in China. When the mothers came to New Zealand and engaged with New Zealand health care providers, they started to learn new cultural patterns. In this case, the mother learned new cultural patterns and knowledge about breastfeeding which was controlled and influenced by the naturalness of childbirth.

Special attention is paid to the description of the midwife about a breastfeeding book – “It’s written by an American lady who is a lactation consultant. She lives in New York”. Such a description highlighted the social class and status of the author. In other words, the book was written by a Western, middle or upper class metropolitan woman, but did those facts give more credit to the book and its representation of breastfeeding? From the standpoint of the midwife, it did, and thus she used this description to persuade the mother to believe that *keep breastfeeding* was the “gold standard” and it was the right and only route to follow. This “gold standard” was unchallengeable. Other different or oppositional discourses of breastfeeding and childbirth were seen as a threat to these norms. The assimilation to the discourse of *keep breastfeeding* was working on this mother who modified her knowledge of breastfeeding; for instance, she made a joke about breastfeeding her baby forever, she read the book after the visit of her midwife, and she did breastfeed her child for quite a long time.

A hospital midwife, however, held a different opinion about the New Zealand “gold standard” of *keep breastfeeding*. Based on her previous experience of being an independent midwife, she commented:

I think people don’t understand especially the Europeans [New Zealand Europeans]. They don’t understand their [Chinese mothers’] situations.

Because here Europeans when they have their babies they express at home. They don't have to work they will be on the benefit. But we Chinese because you are part of the family business, to help with your husband, and usually the brother-in-law is here with them and we look after the babies so that's why they don't breastfeed long. I think it is quite acceptable to do.

Sharing an insider perspective with Chinese mothers, this Asian midwife explained that she understood why some Chinese mothers gave up breastfeeding early and she thought it was "quite acceptable to do". Because many Chinese mothers had to go back to work, to help their husbands in family business, they found it hard to increase the duration of breastfeeding. However, "Europeans [New Zealand Europeans]" as the midwife termed them, could not understand this situation because they did not have to go back to work for a while. When identifying what we are not, we are trying to understand what we are (Kitzinger & Wilkinson, 1996). Pulling herself closer to Chinese mothers and families, this midwife set a boundary between Chinese mothers and New Zealand European mothers. She categorised Chinese mothers as a group having to face financial and family pressures, while New Zealand European mothers were free from such pressures. I do not agree with her stereotyping of New Zealand European mothers and Chinese mothers without acknowledging the diversity within each group. Nor do I believe that the attribution of quit breastfeeding to Chinese mothers helping a family business is still relevant in contemporary society since recent Chinese migrants are not like early migrants who mostly came from villages in South China and hence isolated themselves in family business in New

Zealand (Ma, 2003). Nevertheless, the comment of this midwife questions the discourse of *keep breastfeeding* as the only way and thus something all women have to comply with. By pointing out the difficulties confronting some Chinese mothers, the midwife respects a different choice by the mothers.

There was another New Zealand midwife who acknowledged the potential pressure of *keep breastfeeding* on one of her clients. She described how she dealt with that client who decided to stop breastfeeding:

Midwife: I think we put a very lot of emphasis on breastfeeding here and people find it intimidating. So I had to write in her notes that this woman has chosen not to breastfeed, don't hassle her. Coz it does not worth it [sic]. Coz she's doing great. Her baby is beautiful. She's doing well.

Discourse represents meanings which shape and form objects (Burr, 1995). With the influence of the discourse of *keep breastfeeding*, the values, understandings, and behaviours of the mothers are expected to take on meaning in light of the dominant discourse. Discourse is always aligned with power, which is constraining and enabling (Foucault, 1980). The dominant discourse constrains the mothers' understandings and behaviours in certain ways.

Maternity-care and health providers who value such a discourse then stand in a powerful position to influence the mothers with their emotions and verbal language (e.g., risks to health of child, bad mother) to accept and behave in the ways which are favoured by the dominant culture. Examples can be found when the midwife commented, "a very lot of emphasis on breastfeeding", and she used the word "hassle" which further indicates how health carers exerted their power in "encouraging" the mothers to establish and maintain breastfeeding.

However, the ideological construction of Chinese mothers' predispositions of what it means to be safe, to experience childbirth, and their sense of breastfeeding is different to that of New Zealand health carers' sense of childbirth as being natural and the need to keep breastfeeding. As a result, some mothers found it "intimidating". They were not willing to be assimilated into the discourse of *keep breastfeeding*, like the mother in the example who "has chosen not to breastfeed". The quotation shows that it was the midwife who took the broker role to "write in her notes" indicating the client's desire to resist the dominant discourse of breastfeeding and to maintain the position of being different. Other maternity-care and health providers reading the notes were expected to understand that it would no longer be "worth" persuading the mother.

So far, I have embraced the concept of othering in relation to my discussion of the construction of childbirth values. The New Zealand maternity and health care systems prioritised the discourse of natural childbirth. That is, the processes of pregnancy, labour, and postpartum including breastfeeding that every mother had to face were seen as natural and normal. However, this New Zealand structure of childbirth knowledge deviated from that of some Chinese mothers whose values and knowledge of childbirth and breastfeeding were constructed by the Chinese health discourse of medicalisation and safety. Next, I emphasise different communication styles valued within the New Zealand and Chinese cultural and health contexts to shed particular light on how the Western discourse of partnership communication promotes inclusiveness while at the same time it exposes the processes of othering.

### **Promoting Inclusiveness with Partnership Discourse**

Different cultures and health discourses strongly influenced communication styles taken by New Zealand health carers and Chinese mothers. Whereas a cooperative communication prototype is advocated in the Chinese health systems, a partnership-based communication model is prioritised in the New Zealand (and many other Western) maternity and health care systems. I start this section with a description of the discourse of partnership-based communication which is derived from the discourse consumer culture, followed by a discussion about how the discourse is reflected in the maternity and health services in creating a sense of inclusiveness. The second part of the section is an exploration of othering in relation to the discourse of partnership-based communication. In particular, I focus on how mothers' values of interdependent self conflict with the Western values of the entrepreneurial self, and how mothers suffer from the Western medical ethnocentrism.

Besides valuing natural childbirth, the New Zealand maternity and health care systems advocate the discourse of partnership-based communication (DeSouza, 2006a) which requires both mothers and their health care providers to make equal contributions to partnership building and maintenance (Cegala, 2006; Thompson, 1994). One of the responsibilities of health carers is listening and being patient when communicating with their clients (Dutta-Bergman, 2005). From what I have observed, some health care providers indeed allowed mothers to ask questions and listened carefully to their explanations. For example, when a mother was seeing an anaesthetist specialist at hospital, she spent a long time describing her last labour experience and explaining her current concerns. The anaesthetist specialist listened carefully and patiently to the mother, and showed

that she was listening to her story and empathising with her experience by adding “sure”, “ok”, “oh, I see”, “oh wow”, “fair enough” and the like.

The way one Public Health Nurse reacted to a mother’s question also indicates the discourse of partnership-based communication in eliminating health status disparity between health care providers and clients (Cegala, 2006). The conversation below happened when the mother took her baby to the Migrant Centre for the BCG vaccination (Bacilli Calmette-Guerin vaccine is given to protect against tuberculosis):

Mother: Oh, where is the public health nurse?

PHN: That’s us, me and \*\* [name of a nurse] and \*\* [name of another nurse], and the Hamilton team. I will give you the address here. The address of the Hamilton girls. Here. That’s \*\*. This lady over here. And \*\* is... (pointing to the nurse), and this is me. (Showed the booklet and contact details of PHNs), alright?

With privileged roles and statuses associated with a social institution, health care providers usually dominate the communication process with their patients (Martin & Nakayama, 2003). The introduction of the Public Health Nurse regarding the nurse team to the mother, however, demonstrates a partnership-based communication model which is shaped by the Western consumerist discourse (Cegala, 2006; Dutta-Bergman, 2005). In that discourse, the responsibilities of health care providers are, in essence, to build balanced partnership communication and to maintain equal relationships with their clients. In responding to the mother’s question, the Public Health Nurse introduced her team carefully, without seeming hurried. The Public Health Nurses in Hamilton were referred to through names, “the Hamilton team”, “lady”, and even “the



Hamilton girls”. These noun phrases positioned the health providers as normal individual humans for the patient, and identified feminist features for this mother. Power inequality between the health provider and the patient was weakened, and therefore, closeness and partnership/relationship-based communication were established.

Closeness and partnership between health care providers and mothers are more evident in the following examples. One mother was experiencing a hard and long labour. She was very stressed and tired by her contractions, but she was still not ready to push the baby out. Recalling this experience, the mother said:

我产婆就一直唱歌给我听。英文歌就是很 happy 的那种，她说她给她儿子女儿洗澡的时候她就唱这首歌，[她]唱不同的[歌]，她唱了好多，她唱歌特别特别好听。。。然后另外一个产婆会唱的情况下她俩就一起唱，我就在那儿听，就觉得好放松好放松。

My midwife kept singing songs to me. An English song, a very happy one. She said that she used to sing that song to her son and daughter when they were having a bath. [She] sang different [songs], and she sang a lot. Her singing was really beautiful... When it came to a song which was known by the other midwife, they sang it together. I was there listening. I felt very relaxed.

The other mother recalled her experience of taking her baby to the hospital for jaundice light treatment:

我们去医院的时候照那个冷光，我都不明白是怎么回事儿，后来我才

知道是我喂完他[宝宝]以后要让他睡在那个床上，但是我想天啊我要怎么样才能让他睡到那个小床上呀，我就哭了。。。当晚值班的那个 midwife 特别特别好，那个 midwife 说没关系我教你，她就一直陪着我在那儿，她陪了我两个小时。。。但是后来他还是不 settled，那个 midwife 就把他抱走了，说你需要 get some sleep. You don't worry。。。那个晚上对我来说简直是划时代的了！

We went to the hospital for [jaundice treatment] light, but I had no idea about what's going on. I later knew that I had to let him [baby] sleep in that little cot after feeding him. But I thought oh my god, how could I make him sleep in that little cot, so I cried...The on-duty midwife was really good. The midwife said, "It's fine. I can teach you". She stayed with me for ages. She kept me company for two hours...but he still couldn't be settled later, so that midwife took him away and said "You need to get some sleep. You don't worry"...For me, that night was incredibly epoch-making!

The midwives in both the examples treated the mothers as the centre of communication by supporting, encouraging, and facilitating them to overcome their challenges. In the first example, the midwife and the other hospital midwife devoted time to singing songs to the mother in order to comfort her and distract her from the pain. If the term "midwife" was missing in that quotation, one might guess it was the mother's friend or a close relative who was singing songs to make her feel relaxed. Who would guess that it was a maternity care provider who was singing a song which "she used to sing ... to her son and

daughter when they were having a bath”? In the second example, the mother was anxious about settling her baby into the cot in hospital. The context of the mother should be considered here. She was a first-time mother. She had not slept well with her unsettled baby. She was by herself, separated from her husband and other family members in that situation. And she “had no ideas of what’s going on” about the process of having jaundice treatment light. So the mother cried. The “epoch-making” landmark, as described by the mother, happened when the on-duty midwife offered her help and support so that the mother could take some rest. These mothers complimented the hospital health providers as they were very positive, encouraging, calm, and they kept communicating with the clients. These features epitomised the responsibilities of health care providers in the context of partnership-based communication.

The spirit of the partnership-based communication model is to increase customer satisfaction through an equal partnership relationship between customer and health care provider. My findings have shown that some health care providers successfully promoted a belonging and supportive health environment by patiently listening to the mothers, spending time with the mothers, and supporting and encouraging the mothers in the childbirth process. These measures not only improved mother-health carer’s communication, but also helped avoid otherness in the maternity and health care settings. Next, I focus on the expectations towards mothers in contributing to partnership-based communication. I also discuss how the socialisation of the mothers to fit in with the discourse of partnership-based communication, in some ways, exposes the processes of othering.

### **Creating Othering through Partnership Discourse**

Not only is the health care provider encouraged to sacrifice time in partnership building and social conversation, but the patient is also expected to take a more active and independent role in communication (Cegala, 2006). One mother explained how she fitted into this active role in health communication:

One friend has the same midwife as I do, but she receives less information [about pregnancy], so she always asks me to get the information. It's up to how you communicate with your midwife. I always ask, like can I eat fish? I got lots of information.

Mothers in the Western maternity and health context are expected to form an entrepreneurial self (Cegala, 2006; Du Gay, 1996; Thompson, 1994). In other words, they are expected to behave as independent consumers by actively asking questions, retrieving information, and actively participating in their interactions with their maternity and health care providers. This mother whom I interviewed fitted herself well into this active and independent customer role. She always asked questions of her midwife; in return, she was satisfied with the information she received. However, her friend faced challenges to frame a consumer identity and fit into the role of being independent and active. Although she had the same midwife, she seldom asked questions and received much less information.

As Ambler and Morgan (2000, as cited in Martin & Nakayama, 2003) argue, there is no typical Chinese. The Chinese value both individualism and collectivism. Individuals' knowledge and behaviours are related to the historical, social, and cultural contexts they belong to (Allen, 2005; Burr, 2003; Hackley, 1998a). Although both mothers are ethnic Chinese migrants, their different

contexts shaped their different ways of responding towards partnership discourse and coping with othering. The mother's friend, as introduced by the mother, had little knowledge about the New Zealand maternity and health care systems. Her shy personality and strong Chinese cultural identity isolated her from other groups in New Zealand society. Compared to her friend, this mother had been in New Zealand for a while. She was confident in speaking English because she worked for a local New Zealand company. Her outgoing personality and Westernised cultural identity helped her establish a large social network of Western people. To cope with othering, this mother fitted into with the Western discourse of partnership-based communication by actively asking questions and seeking information. The mother experienced the assimilation process which was seen as a way of prioritising relationships with dominant groups rather than stressing an isolated cultural identity (Martin & Nakayama, 2003). The mother's friend, however, had to lower her expectations of the midwife in terms of giving information. Rather, she shifted to rely on her trusted Chinese friend to get the information that she needed. Being socialised in the partnership-based communication with health care providers, some Chinese mothers felt that they were respected and felt relaxed in the communication processes, particularly at the labour stage. Some of them became more confident and empowered towards their pregnancy and postpartum care. However, other mothers, who were familiar with a cooperative communication model between patients and doctors (Jiang & Zhao, 2002), felt reluctant to pursue an entrepreneurial self in health communication. A similar situation happened when another mother was interacting with her midwife. According to this mother who had just migrated to New Zealand a few months previously:

在中国，我习惯了不问医生太多，所以就算我希望产婆能多说点这里的医疗系统，新西兰的文化，我也不会问她。

In China, I didn't ask doctors any questions. So although I expected the midwife to talk more about the health systems here and New Zealand culture, I wouldn't ask her.

A collective culture expects individuals to be compliant to those who hold higher positions (Gao & Ting-Toomey, 1998; Hall, 1976; Hofstede, 1991; O'Keefe & O'Keefe, 1997). This new migrant mother accepted the relationship-inequality between a patient and a doctor. A Chinese patient is expected to cooperate with a doctor in information giving and receiving, and decision making (Jiang & Zhao, 2002). Identifying herself as a patient, the mother chose "*ting hua* (听话) or listening centeredness" (Gao & Ting-Toomey, 1998, p. 37) instead of asking questions to address her concerns. That is, the mother saw the midwife as a doctor who held a superior position and the power to provide information, while she, as a patient with a lower position and less power had to listen to the superior in communication (Gao & Ting-Toomey, 1998).

Stepping from *traditional* societies to *modern* societies, that is, shifting from social responsibility to individual responsibility (DeSouza, 2005), Chinese mothers are encouraged to socialise in the New Zealand health systems. They are expected to make equal and valuable contributions in the mother-health carer communication, whereas the health carers are expected to take a facilitator role in helping the mother get through their childbirth processes (DeSouza, 2006b). However in practice, many mothers found it hard to fit into the Western consumer

role in the health communication environment. My findings have revealed that most Chinese mothers still leaned towards and felt more comfortable with taking cooperative and compliant roles as patients. Below are the narratives of a variety of maternity-care and health providers who expressed their impressions of Chinese mothers:

Chinese women listen to what you have to say, you know you say to them, “compliant” I guess would be a word, they just want to please . . . I think that Chinese women are quietly spoken and they are not expressive, and they like to think that you are happy, that you are pleased with the experience. So I am not sure whether they would believe it their place to say that they weren’t happy with the care that they received.

Really receptive and very appreciative. Well they listen and they want to do what you, you know suggest that they do . . . very compliant.

Chinese are more open to advice, more compliant. Even like in my family I still tell my children don’t eat this and they will still obey, be obedient.

I think probably Chinese mothers maybe don’t ask as many questions. So it is sometimes hard to identify if there is a problem or not, you know like might be a bit shy or a bit more reserved.

Western people usually regard Chinese as more obedient, polite, and passive (Gao & Ting-Toomey, 1998; O’Keefe & O’Keefe, 1997). Yet, although

these descriptions essentialise and simplify Chinese people as a fixed group, they do provide some lenses to analyse Chinese mothers' intercultural communication with New Zealand maternity-care and health providers. In the statements of the maternity-care and health providers above, Chinese mothers were depicted as being "compliant", "quietly spoken", "not expressive", "receptive", "appreciative", "obedient", "shy", "reserved", "open to advice", and wanting to "please" maternity-care and health providers. In particular, the lexical item "compliant" was frequently mentioned by three maternity-care and health providers. One hospital midwife with Chinese ethnicity further explained how she taught her kids to be obedient, which she believed was part of Chinese culture. In sum, Chinese mothers, in the eyes of many New Zealand maternity-care and health providers, were compliant towards what they were being told, passive in asking for and retrieving information, and they respected a cooperative but unequal physician-patient relationship. These communication characteristics were in stark contrast to those expected by the Western maternity care systems. Two maternity-care and health providers showed concern that there might be a problem or that mothers were not happy with the care, but it was hard for them to identify the issues if Chinese mothers were reluctant to share their true feelings and opinions.

Health communication differences also placed 'othered' mothers and positioned them as deviant from the mainstream groups. The following example reveals a stereotyped and othering assumption made by a midwife towards her client. A second observation with a mother and her midwife occurred in the mother's home. The midwife visited the mother four weeks after she gave birth to her baby. To respect the mother's rights, I was not present when the mother's



body was being checked in her room, but a tape recorder was set up in the room to record their conversations. The first sentence uttered by the midwife, when she saw me after completing an internal examination for the mother, was actually a joke:

Midwife: We had a long conversation this time!

It is crucial to note that the midwife stressed the word “long” and had a smile on her face. She was making a light-hearted comment on language barriers and cultural differences of the mother. The midwife in this case had “medical ethnocentrism” (Ulrey & Amason, 2001, p. 452). She marginalised the mother as a different and odd case. In her judgment, the mother could not speak English well, was passive, and less involved in communication, and thus she did not fit in with the independent customer role which was derived from the dominant discourse of partnership-based communication.

To conclude, the New Zealand maternity and health care systems advocated a discourse of partnership-based communication which expected both maternity-care and health providers and mothers to make their communication balanced. On the one hand, the discourse of partnership-based communication promoted a sense of belonging in the health care services. Health care providers placed mothers at the centre of communication, regardless of the mothers’ ethnic backgrounds. On the other hand, the discourse of partnership-based communication ‘othered’ some mothers who were more familiar with the discourse of cooperative communication and were influenced by Chinese Confucianism. To further understand and interpret mothers’ responses, perceptions, and experiences of constructing the values of childbirth and

communication, I now move on to discuss these findings under the guidance of my matrix.

### **Reorienting Values of Childbirth and Communication**

The matrix develops multiple perspectives to rethink the conception of values and their intrinsic connection with the notions of knowledge. Different societies and institutions have subjective values shared by their members. Such values reflect particular knowledge of thinking and doing which is constructed and reconstructed through the socialisation and education within certain societies and institutions. The findings reveal that the values of childbirth and communication appreciated within the New Zealand and Chinese maternity and health care systems are different. Some mothers experienced the processes of othering because their different values and knowledge are marginalised and suppressed. In the following discussion, my attempt is to rethink and reorient essentialised and universalised values of childbirth and communication, so as to make space for different and alternative knowledge from the subaltern others into a discourse that is currently dominated by taken-for-granted notions of knowledge regarding childbirth, culture, and communication.

After 1990, New Zealand switched from a medicalised and hospitalised model of childbirth to a more regulated natural and community-based model for guiding its maternity and health care services (Stojanovic, 2008). As such, the New Zealand maternity and health care systems prioritise natural childbirth, which encourages women to view childbirth as a process with minor risks (DeSouza, 2006a; Kedgley, 1996). Reinforcement of the discourse of natural childbirth permeates maternity-care and health providers' comments on pregnancy,

contractions, delivery, and breastfeeding as being “normal”, “good”, “fine”, or “common”. The discourse of natural childbirth constructs maternity-care and health providers’ values and understandings of childbirth, and hence sets up certain rules to regulate knowledge, perceptions, and reactions of both maternity-care and health providers and mothers. This is evident in some maternity-care and health providers’ responses towards the mothers’ concerns about previous miscarriage, having contractions, and wearing radiation protection suits. As the ones who have been educated and socialised into the discourse of natural childbirth, New Zealand maternity-care and health providers are more powerful with established knowledge. That knowledge naturally grants maternity-care and health providers with the power to educate and influence mothers, and at the same time constrain their expectations and behaviours.

However, the historical, political, and sociocultural contexts of Chinese maternity and health care services reflect different values of childbirth. As the Chinese character ‘*娩*’ in this thesis title indicates, childbirth is seen as a disaster for a woman (CEEC, 2009). Childbirth has historically been portrayed as being an important but dangerous event with a potential for complications (Chuang, 2009). Influenced by Confucian philosophy, China’s One-Child Policy, and the 1980’s economic and social reforms, the priority of safety and health of childbirth has become unchallengeable. The importance of childbirth in confirming Chinese women’s roles, identities, and statuses in their large families is also undoubted. As a result, obstetricians instead of midwives are heavily relied on in the childbirth process, in particular in urban locations in China (Cheung, 2009). Women and their families tend to trust medical professionals more to ensure having a healthy child (Lazarus, 1994).

Most Chinese mothers in my research migrated from urban centres of China including Guangzhou, Wuhan, Dalian, Qingdao, Tianjin, Harbin, and other cities. The mothers portrayed childbirth as a risky event which needed emergency and medical services. They were more familiar with hospital births, caesarean sections, frequent ultrasound scans, and other medical interventions in childbirth. Their values of childbirth explain why some of the mothers were not satisfied with maternity-care and health providers' comments of things being normal and natural. Given that dominant Eurocentric powers have silenced multiple voices and controlled the production of knowledge (Young, 2003). This is not surprising that ethnic Chinese mothers found it hard to challenge the dominant New Zealand discourse of natural childbirth.

From two mothers' narratives, I learned that they experienced conflicting cultural beliefs of childbirth and conflicting knowledge of maternity and health procedures, which DeSouza (2005; 2006a; 2006b) identified as commonly happening for migrant women when being socialised in the Western maternity and health discourses. These different cultural values and practices towards childbirth made migrant women appear deviant from the mainstream in Western society. In coping with being othered, migrant women may take different actions (Johnson et al., 2004). Both mothers, who held strong cultural identities, found it difficult to be assimilated. The stronger the mothers' identification with Chinese health practices and values around childbirth, the more difficulties they had in fitting into the health discourses used by the Western maternity-care and health providers (Martin & Nakayama, 2003). In response to being othered, one mother chose to be compliant and lowered her expectations of childbirth. The other, however, silently worked against the New Zealand dominant discourse; her

responses deriving from her different understanding of childbirth opened up a way of challenging the mainstream norm. Indeed, ethnic minority women in Western society have little power to resist being identified and judged as *others* by dominant groups (Dill, 1987; Ladner, 1987), but their different experiences and interpretations of realities can be used to question the assumptions made by dominant groups (Collins, 1996).

The othered experience of Chinese mothers was exaggerated in some of the maternity-care and health providers' descriptions. In the light of natural childbirth, the natural process of keep breastfeeding is constantly promoted in the New Zealand maternity and health care services. The Ministry of Health (2012), Plunket (2012), and La Leche League (2012) in New Zealand vigorously promote the benefits of breastfeeding and encourage higher rates and duration of breastfeeding. This physiological and biomedical model of breastfeeding centres on the health of the baby and the woman's identity as a breastfeeding mother (Gottschang, 2007). Every mother's body is assumed to be capable of providing milk for her baby and as such other decisions on feeding babies are suppressed as unenlightened and unscientific. But in practice, not every woman believes breastfeeding is a universally wonderful experience (Cripe, 2008). Even some New Zealand mothers felt stressed with the message of "breast is best" which was widely emphasised in the New Zealand maternity care context (Hill, 2012). For some Chinese women, continuing efforts to keep breastfeeding could make them fit in with the mainstream of the *same* culture (Johnson et al., 2004). But for others, the discourse of *keep breastfeeding* became a tremendous pressure and challenge in the women's postpartum period since their knowledge about breastfeeding was different and the realities of their lives were often ignored.

In China, particularly in urban China, the phenomenon of *quit breastfeeding*, arising from the dominant discourse of medicalised childbirth, is not uncommon. Many Chinese women wean their babies onto formula very early not simply because they lack knowledge of the medical benefits of exclusive breastfeeding, but because *keep breastfeeding* does not fit with their traditional values and particular circumstances (Gottschang, 2007). Meanwhile, as childbirth is believed to be a domestic and woman's business (Harris et al., 2009), breastfeeding as a component of childbirth is assumed to be practised in the home or private sphere. Struggles with balancing the demands of being mothers, wives, and workers partly explain Chinese women's decisions on quit breastfeeding (Gottschang, 2007).

Not only are women in urban China found reducing the duration of breastfeeding early; migrant Chinese women in some developed countries such as Ireland and Canada have low rates of breastfeeding due to a variety of reasons (Chan-Yip & Kramer, 1983; Zhou et al., 2001). From the narratives of midwives in my study, Chinese mothers were more likely to give up breastfeeding and wean their babies onto formula. That is why the midwives made efforts to educate the mothers and their older female kin about the benefits of breastfeeding, and pushed them to keep following this "gold standard" practice. However, the matrix directs me to defamiliarise the discourse of *keep breastfeeding* which essentialises and universalises the notions of breastfeeding. This biological and natural model seems to regard every mother as the same and every mother as being assigned the only identity of a breastfeeding mother without taking into account hybrid identities and circumstances (e.g., inadequate milk production, demand of workplace, weakened health of mother by the birth). The model also overlooks

different cultural values and knowledge of breastfeeding, childbirth, and health issues, by judging other decisions on feeding babies as unnatural.

Two critical events are particularly illustrative in the analysis. One critical event happened when a midwife introduced to a mother about a breastfeeding book written by an American female author. This event can be analysed in two different ways. From one perspective, the midwife showed extra care and information to the mother by lending the book. Rather than merely focusing on the result, the midwife also emphasised the process by encouraging the mother to learn the knowledge of breastfeeding. From the other perspective, my matrix leads me to challenge this misleading normality of breastfeeding which neglects other structures of knowledge production. I critique the image of a Western woman that gives more authority to the maternity care provider to represent and speak for other different women. The problematic of a hegemonic Western woman image is widely criticised by postcolonial feminist scholars (Garry & Pearsall, 1996; Hesse-Biber & Yaiser, 2004; Mohanty, 1996) in neglecting different structures of knowledge production of other women. The midwife's description of the book and her encouragement of breastfeeding not only privileged the Western knowledge production and discourses in the metropolitan centre of colonial power, but also subordinated other women who had different experiences and interpretations of breastfeeding.

In the other critical event in terms of a midwife trying to protect a Chinese mother from being hassled by other health care providers on breastfeeding, the term "we" was used to identify the "same" culture of valuing breastfeeding as a natural way, and "people" was used to represent others with different values of breastfeeding. The othering process subjugates the voice of these "people" who

are portrayed as others (MacCallum, 2002). On the one hand, the midwife who took a broker role made good use of the system to communicate with other health workers to support her consumer's wishes. With the midwife's protection, the mother would not have to (re)state her wishes in each interaction with a different health provider. But on the other hand, I challenge mainstream discourses of breastfeeding and childbirth for leaving few spaces for 'other' mothers to speak for themselves in the maternity and health context. A second thought should be raised for this critical event: Why it was so hard for this Chinese mother to make her voice being heard and exercise her choice of feeding her own baby? And why was the midwife trying to protect the mother from being hassled? Influential postcolonial and Third World feminist scholars (Spivak, 1988; Said, 1978) have explored the power relations between the suppressor and the suppressed in revealing the misleading representation of the Eurocentric norms. Building on these explorations, Shome and Hegde (2002) indicate the issues of representation and agency of the suppressed who are silenced to describe themselves. It was the maternity-care and health providers in the "same" culture who positioned the mother, the colonised, and the other as incapable of representation. It was the New Zealand dominant discourses within maternity and health contexts that prevented the mother from gaining access to the centres of power.

Stemming from my research findings, the contributions of some maternity-care and health providers in overcoming otherness cannot be neglected. A progression towards culturally safe practice includes three steps which are cultural awareness, cultural sensitivity, and a positive perception of health education by the receiver of healthcare (Ramsden, 2002). Some maternity-care



and health providers brought culturally safe practices into their services provided to ethnic Chinese mothers. They acknowledged and appreciated cultural differences such as the importance of *zuo yue zi* in Chinese childbirth. They were culturally sensitive to the needs and expectations of Chinese mothers and, incorporated some cultural needs, and/or accommodated the needs of women who were not willing to choose or not able to choose natural childbirth. A culturally safe health practice requires health providers to recognise historical, sociocultural, gendered, colonial, and neocolonial contexts of marginalised ethnic groups in constructing and influencing their health experiences (Anderson et al., 2003; Tang & Anderson, 1999; Mkandawire-Valhmu & Doering, 2012). And more importantly, a culturally safe practice is defined by the mother who received care service. The mother, in the example of *zuo yue zi*, expressed her happiness and appreciation on the culturally safe service that she received.

Three particular examples (i.e., a public health nurse's introduction of her team; a midwife singing songs to a mother to distract her from contractions; a hospital midwife helping a frustrated mother to settle her baby) further indicate the practical measures to overcome otherness in the maternity and health care environment. The boundaries between self and other were blurred; so were the differences between "health care provider" and "patient", and between "Western people" and "ethnic migrant women". The needs of the mothers, therefore, were satisfied with the reinforcement of the health care environment in creating a sense of belonging rather than difference. These positive acts, however, were part of the dominant discourse of partnership communication.

Under economic, political, social, and technological pulls and pressures, Western institutions and practices have shifted to form a consumer culture to

improve the quality of institutional services (Bauman, 1988; du Gay, 1996; Ritzer, 1998). The model of partnership communication between product/service providers and consumers permeates the New Zealand maternity and health care systems and practices. Maternity-care and health providers are, therefore, encouraged to apply this model in their interactions with mothers in childbirth processes (DeSouza, 2006a).

While health care providers are assigned specific responsibilities to increase consumer satisfaction, patients are expected to take more personal responsibilities and values (du Gay, 1996) to contribute to partnership communication. One mother's narrative indicates that she has been socialised into the discourse of partnership communication. She benefited from it by actively asking questions and participating in interactions with her midwife. Migrant women like other Western women are encouraged to take more individual responsibilities in Western health communication, but many of them are struggling with this change as they get used to having social responsibilities shared with their extended family members, friends, and other social networks (DeSouza, 2005). Sharing social responsibilities with experienced family members and trusted people is widely accepted by Chinese women (Kartchner & Callister, 2003; Mazurkewich, 2004; Wong & Pang, 2000). Chinese Confucianism also stresses this interdependent self and status disparity between the ones with higher positions and the ones with lower positions (Gao & Ting-Toomey, 1998). Accordingly, a cooperative communication prototype is valued to build and maintain a harmonious physician-patient relationship (Jiang & Zhao, 2002).

With the value of cooperative communication, many mothers in my

research felt reluctant to transform from an interdependent self to an entrepreneurial self when communicating with their maternity-care and health providers. One mother expected her midwife to tell her more about the New Zealand maternity and health care systems and procedures, but she was waiting for the information given by her midwife rather than actively asking questions. Actively asking questions was thought to be against her communication values and how she used to react to health professionals in China. Hers was not a unique case. Most of my participants were found to be more comfortable and pleased when taking a cooperative and compliant role as a patient. A variety of maternity-care and health providers also stated that being compliant and obedient was the impression they had of many of their Chinese clients. Chinese cooperative physician-patient communication embodies two particular Chinese communication characteristics, “[*T*]ing hua (听话) or listening centeredness” and “[*K*]e qi (客气) or politeness” (Gao & Ting-Toomey, 1998, p. 37). Essentially, patients have to listen to and obey doctors who dominate superior positions in health communication, and at the same time, both groups are required to engage in polite talk to create harmony in relationships. Due to these different cultural values, many Chinese mothers found it hard to become assimilated into the New Zealand discourse of partnership communication.

Interestingly, it is a paradox that while most Chinese mothers expected a cooperative doctor-patient relationship, they also appreciated a partnership relationship in some situations. A closer look at issues of gender can help analyse these dialectical tensions. In a gendered society, males and females have a relative division (McCallum, 2002): Masculine characteristics are associated with mind, culture, knowledge, public life, etc., which is privileged over feminine

characteristics which are associated with body, nature, family life, etc. (Alley-Young, 2008; McCallum, 2002). A cooperative communication model adds masculine features to health providers. That is, health providers take a fathering/masculine position of power to give directions and information to patients who are expected to take a subordinated feminine position. The mothers' willingness to accept this unequal power relationship is derived from China's historically androcentric/patriarchal social background and the long-time socialisation of Chinese people into the country's cooperative communication discourse within health care settings. However at the same time, the mothers feel comfortable when health providers socialise them into a partnership relationship with a particular stress on feminine features. Indeed, acts such as singing to a mother or helping a mother calm her child are characterised by feminine features. As is evident, gender roles across ethnicity are similar, and this has a significant effect on relationship building.

The process of 'othering' creeps in when cultural value systems come in the way of relationship building. For example, when a midwife joked about "a long conversation" with a Chinese mother in a home visit, she seemed to undermine the mother's communication abilities. Ironically, maternity-care and health providers in New Zealand are expected to take a facilitator role in empowering their customers in their communication processes (DeSouza, 2005; 2006a; 2006b); however, in practice, some maternity-care and health providers are reluctant to devote time to partnership building with migrant patients who are easily identified as "problematic" customers with "unacceptable" behaviours (Cegala, 2006; Johnson et al., 2004; Kline, 2007).

By defining the mother as a passive client, this midwife not only

confirmed her identity as a New Zealand maternity care provider who valued the partnership communication model but also as someone who fell into the trap of “medical ethnocentrism” (Ulrey & Amason, 2001, p. 452). The New Zealand dominant discourses held up who good customers were, that is, proactive, interdependent, and highly involved in communication with health care providers. This empowered the midwife but put the mother who had a non-Western background and knowledge in a powerless position.

### **Conclusion**

In sum, the different contexts of the Chinese and New Zealand maternity and health care systems shape different values of childbirth and communication, which in turn, regulate different understandings and behaviours of people who are socialised within the respective cultures. Perhaps not implausibly, New Zealand maternity care and health providers advocated a natural childbirth and natural breastfeeding as the only right choice for mothers. It is also not difficult to understand the responses of Chinese mothers towards being assimilated into the dominant values which they were not familiar with. The importance is not merely to identify different expectations and practices. Rather, it is important to relate Chinese mothers’ experiences and responses to their historical and sociocultural contexts. The mothers’ socially constructed knowledge based on Chinese Confucianism, traditional communication characteristics, and the discourse of a cooperative physician-patient communication constructed their expectations and intercultural communication experiences with mainstream maternity-care and health providers. My argument then is against New Zealand’s homogeneous discourses of childbirth and communication which

subjugate other, different constructions and interpretations. Understanding the alternative knowledge from Chinese mothers helps open the door for new interpretations.

My discussion of othering ought not to stop here. Concepts of dualisms, gender roles, representation, labelling, discourses, and knowledge, which are discussed earlier, can be seen as practices of power and influence. These concepts, therefore, direct me to further explore the power dynamics between maternity-care and health providers and mothers in decision making processes. The concept of agency in relation to the discourse of consumer choice is examined in the following chapter.

## CHAPTER 9: CHOICE

The concept of agency articulates who has the ability to speak and represent others. Knowledge, values, identities and power dynamics are embraced in the dialectical tensions of representing and being represented. Having an informed choice is seen as a means to express and manage knowledge, to frame and/or resist particular identities, and to exert power and influence. This chapter, therefore, draws on the concept of agency to examine consumer choice as a part of New Zealand's maternity and health discourses. Particular attention is paid to the socialisation of Chinese mothers into the discourse of choice, their responses, and challenges encountered in being institutionally socialised into the discourse of choice.

### Freedom of Choice

Consumer choice in New Zealand's health care system is a part of the Western economic and market discourse and is associated with consumer responsibility, independence, and partnership communication (DeSouza, 2006a). In this first section, I examine to what extent the freedom of choice a consumer has in the New Zealand health environment, and how maternity-care and health providers empower consumers to have a choice.

Under the influence of a market-based consumer culture and the Western ideology of independence and self-reliance, the New Zealand maternity and health care system is shaped along a consumer-oriented model (Cegala, 2006; Dutta-Bergman, 2005). Patients are encouraged to be proactive, independent and have freedom of choice, which is believed to increase patients' satisfaction and to improve physician-patient communication (Cegala, 2006; Dutta-Bergman, 2005).

Based on this consumer-based model, the New Zealand maternity and health care systems advance the discourse of partnership between mothers and their health carers (DeSouza, 2006a). Health carers, therefore, are expected to empower customers to have a choice in decision making. A midwife's narrative below reflects a clear connection between partnership communication and consumer choice:

I think the part of the New Zealand model of midwifery care is a partnership model. And our partnership is with the woman to be empowering her to make decisions about her care.

The quotation below, drawn from an observation, also shows how an independent midwife empowered her customer to have a choice which was grounded by Western discourses of partnership communication and consumer culture:

Midwife: What I always do is like some people may come here and they say, "I'm Chinese. I'm about to have my baby at the hospital. That's what I know and love and understand, and for my mother told me to do." So it's not about where you want to have your baby. And I tell you it's about where you want to have your baby and you feel safe. Ok? So what I say to women is just like "I'm completely open. I'll book you at hospital and you can have your baby at birth centre if you want as well. It's open, totally open."

This narrative uncovers the Western discourse of choice. Independence and self-reliance are regarded as "enterprising qualities" of "the sovereign



consumer” (du Gay, 1996, p. 56). Individual consumers are encouraged to have freedom of choice which is believed to increase customer satisfaction (Keat, 1990). By explaining that the decision was “open”, and the focus on “you want” and “you feel”, the midwife put the mother at the centre of communication and empowered her to have the freedom of choice as a customer.

More significantly, when the midwife asked her client where she wanted to give birth to her baby, the mother told her that she felt safe to give birth at hospital. The expectation of feeling “safe” was embedded in the mother’s social and cultural knowledge of childbirth. Knowledge is a discursive practice that is constructed by discourse (Foucault, 1975), and hence the mother’s knowledge of childbirth was constructed by the Chinese maternity and health care discourse which prioritised medicalisation and safety in childbirth. It is common in China for women to choose to deliver their babies in hospitals (Qian et al., 2001). Feeling safer and familiar with hospital deliveries, eight out of ten mothers in my study decided to give birth at hospital, and only two mothers chose to give birth at a birth centre. No one even considered a home birth.

The midwife expressed her knowledge and understanding about Chinese culture by stressing “That’s what I know and love and understand, and for my mother told me to do.” It also shows that the midwife was culturally sensitive with Chinese values and beliefs of childbirth. She was familiar with the crucial role of family members in Chinese culture and women’s childbirth processes.

During the interview with this midwife, she disclosed herself as below:

Five or six years, and I looked after, I was a case load midwife at the hospital, which means that a lot of our care was for people who had really high needs. Like mental illness, people who had kidney transplants, liver

transplants, you know multiple pregnancies, things like that.

Well I believe that all people do this come from their own life experiences and your life experiences make you who you are. And so my life experience has consisted of having quite a lot of abdominal surgeries when I was a kid and coming from quite an adverse background. And so all my children, my physical children are all IVF [In-Vitro Fertilisation] children from donor eggs, and so I know innately the value of what I am doing when I am supporting people to have children, especially those that find it harder.

I've sailed all over Asia when I was younger, I lived in Singapore for six years, I've travelled all over the world, come from a family with 15 children in it, and so you learn how to communicate or you sit in a corner.

One's knowledge, identities, and experiences are context-oriented (Allen, 2005; Burr, 2003; Hackley, 1998a). "Contexts control discourse production and comprehension" and "contexts are unique experiences" (van Dijk, 2008, pp. 16-17). The midwife's disclosure shows that she had five or six years working experience in dealing with complex maternity cases at the hospital. She came from "an adverse background" – having many abdominal surgeries as a kid, and having IVF babies herself. She had been from a big family, and travelled around the world particularly living in Asia. This midwife's socio-cultural background subjectively constructed her values of childbirth, that is, childbirth could involve risks and complexities, which was different to the discourse of natural childbirth advocated in New Zealand. As she said, "I know innately the value of what I am doing when I am supporting people to have children, especially those that find it

harder.” Her “life experiences” made who she was. As Beech and McInns (2005) say, one’s identity can be constructed by different contexts and other people. Identity is constantly negotiated, developed, and challenged in every moment of life experience (Meisenback, 2008). The midwife’s “life experiences”, that is, her subjective experiences and interactions with other people, has developed her particular identities, and likewise, she understood how “life experiences” of Chinese mothers made who they were and what they chose. The particular knowledge, experiences, identities, and emotions of the midwife influenced the production and comprehension of discourse, and hence made her ongoing communicative processes with Chinese mothers unique.

The above finding of respecting customers’ decision making was also found in other observations when maternity-care and health providers asked mothers to have a final say regarding appointment time, and options in the mothers’ birth plan including birth place, birth companions, or birth positions. As is evident, the discourse of choice expresses an approach of liberation for the mothers to control their childbirth and birth plans. However, not every Chinese mother wanted to be liberated through choice. One mother recalled her first visit to her midwife:

在我们第一次见面的时候产婆就介绍说：“我不是一个 Kiwi midwife, 我是个 medical midwife, [我]不会简单的依靠自然的事情, 我很 bossy 的。在生产的时候我会做决定而不会等在那边。”我们听了很吃惊的, 不过我们觉得更加自信了。

In our first visit, the midwife self-introduced: “I’m not a Kiwi midwife. I’m a medical midwife. [I] don’t simply rely on natural things. I’m

very bossy. At labour, I make decisions rather than just waiting there.”

We were surprised to hear that, but we felt more confident.

Although this Chinese mother was experiencing a second-time childbirth process in New Zealand, she (as well as her husband) still valued Chinese medicalised childbirth and a cooperative doctor-patient communication. They used to regard all New Zealand midwives as casual, unprofessional, and natural-oriented. So they were “surprised” to hear that their new midwife introduced herself as “a medical midwife”, “very bossy”, and “making decisions rather than just waiting there”. Such an introduction on the part of the midwife set a boundary between her and other Kiwi midwives, while it created similarities and closeness between the midwife and the couple. The couple did not mind that the midwife was dominant in making every decision because they did not want to be liberated through choice. Indeed, they felt more confident when hearing the midwife identify herself as a “medical midwife”, “not a Kiwi midwife”. The trust and “confidence” of the mother and her husband were quickly established in the initial contact with the midwife, and contributes to their ongoing relationship in the childbirth process. Similar to this mother, many other Chinese mothers in this study expected their midwives to take a more authoritative and caring role, which was consistent with DeSouza’s (2006a) finding that Asian mothers were more comfortable in accepting directions when communicating with their maternity carers. Clearly, the discourse of choice is riddled with complexities and tensions.

Although some maternity-care and health providers attempted to use the discourse of choice to liberate mothers in the childbirth processes, my findings

revealed that the mothers were not always given the right to choose. They had different stories about the Western discourse of choice. So in the next section, I attempt to find out how Chinese mothers respond to being institutionally socialised into the discourse of choice and how their cultural predispositions of childbirth, culture, and communication influence their expectations and the use of choice.

### **Control of Choice**

Chinese mothers, along with other New Zealand mothers were encouraged to fit in with the discourse of choice, but in some cases, mothers were given the power to make choices but this power was not activated for cultural reasons. One mother told me her first childbirth experience in terms of making decisions on pain relief for birth:

我们上次有参加 antenatal classes。她[产婆]叫我们去参加课程可以得到更多的知识。但是她没有问我们我想要用什么止痛的。只是在上课的时候我们有被介绍说有不同的止痛的方法，但是她说用哪种止痛要看生产时候的情况。。。我上次生产的时候，他们叫我用 Gas[安桃乐笑气]，当医生帮我检查的时候，我有告诉他/她我想要用 epidural[药麻]，但是医生跟我说用 epidural 必须要在生产前就决定的，他/她说麻醉师已经走了。医生不让我用 epidural 只让用 Gas，我就说这没有什么用可他/她还是叫我继续从 mask 里吸气。

We attended antenatal classes last time. She [midwife] asked us to attend the classes to get more knowledge. But she didn't ask us what pain relief

I preferred. Just in the classes, we were introduced different options of pain relief, but she said that using pain relief would be dependent on the actual birth situation... In my last labour, I was asked to use Gas [Entonox]. When I was checked by a doctor, I told him/her that I wanted to have an epidural. However, the doctor told me that having an epidural needed to be finalised before the birth. S/he said that the anaesthetist had gone. The doctor didn't allow me to have the epidural but only Gas. I said it was not useful, but s/he still asked me to keep taking breaths through a mask.

Consumer culture tends to frame a rational and independent consumer identity which requires the exhibition of consumer qualities such as being self-reliant and being willing to take personal responsibilities and potential risks (du Gay, 1996). Organisational workers, at the same time, are encouraged to identify themselves with their consumers to accommodate their needs and expectations (Hochschild, 1983). But the discourse of consumer culture seems to be idealistic in this case as the consumer's choice on pain relief for birth was not activated. This mother was asked to attend the antenatal classes for getting more knowledge about different pain relief options but when it came time for her to make that choice, she was told different stories by her midwife and hospital doctor. While the midwife asked her to wait to see how the birth would be going and then to decide which pain relief to use, the doctor did not allow the mother to choose an epidural instead of Gas. The formal explanation was that "having an epidural needed to be finalised before the birth" and "the anaesthetist had gone". Two different and contradictory explanations were given by the midwife and the

hospital doctor. If the midwife was correct, the mother certainly had the choice in labour as Gas was not useful for her. If the doctor was correct, the mother had no way to redeem the situation as she had missed the chance to make a decision on using an epidural.

Likewise, another mother recalled her labour experience at hospital:

当时已经很痛了嘛，然后我就哭了嘛，我就说我要跟产婆打电话嘛。然后那个女的说你不用跟你的产婆打电话，她说她我人认识的，她人很好，你不要打搅她，1点钟了。就这样子说。我想想也是，是1点钟了嘛，然后她说我给你打个针吧，就是那个止痛针吧。但是去之前我产婆就跟我说不管我打什么之前你一定要跟我说，我确定你是不是可以打这样子。既然我产婆这样讲嘛，1点钟，我就跟\*\*[老公]这样讲：给她打个电话吧，她要给我打针。那个女人就跟我讲：你不要叫她来，1点钟了，她要休息的，她要是休息不好，明天没办法帮你生产了。

I cried because it was so painful at that moment. I said that I wanted to call my midwife, but that woman told me not to call my midwife. She said, "I knew her, a very nice person. Don't bother her. It's one o'clock now." She said this. I thought she might be right as it was one o'clock. Then she said she could give me an injection as a pain relief. But before I went there, my midwife had told me, "no matter what kind of injection you are offered, you must let me know. I have to make sure whether you can take it." As my midwife had said that, at one o'clock, I said to \*\* [name of the husband], "Give her a call. She wants to give me an injection." That woman then told me, "Don't ask her to come. It's one

o'clock. She needs a rest. She can't help your delivery tomorrow if she doesn't rest well."

The hospital nurse used very definitive commands, "Don't bother her", "Don't ask her to come", to prevent the mother and father from calling their midwife to come to the hospital. These manipulative speech acts were attributed to the socially described roles and statuses of health providers and patients, which explicitly established the power disparity between speakers and listeners. Other directive linguistic practices, while not including commands, were also and manipulative. For example, the hospital nurse stressed the time twice, "one o'clock", to explain it was too late to contact the midwife. The nurse emphasised that she knew the mother's midwife, "a very nice person", and explained how important it was for the midwife to take enough rest before helping the mother with her delivery. The purpose of saying this was to persuade the mother and father to believe that she was making the best decision for them and their midwife, and even their midwife would agree with her. The narrative of the mother suggests that her midwife also used definitive commands to exercise her power when communicating to the mother. For example, the midwife highlighted "no matter", "you must", "I have to" to exercise her power.

Meanwhile, the narrative also indicates that natural childbirth is valued by the New Zealand maternity and health systems (DeSouza, 2006a). Therefore to the nurse, giving birth to the baby and the pain involved in labour was a natural process that women could control, and hence, there was no need to bother the midwife at midnight. However, in practice, the nurse did not realise that she was the one who took control of the woman's labour decisions. To the mother, the



labour process was painful and risky. As she saw her midwife in the image of a medical professional who was more knowledgeable in providing advice on taking injections, the mother and her husband trusted the midwife more than the nurse in this case. That's why the mother still wanted her husband to give her midwife a call even though the nurse had told them not to.

Power relations between the hospital nurse and the midwife were also uncovered in the mother's narrative. In New Zealand, according to the 1990's Nurses Amendment Act, independent midwives have been given total responsibility for taking care of mothers regardless of whether the birth is at a hospital or at home (Kedgley, 1996). The Act defines the roles and statuses of independent midwives who own legitimate power in the childbirth process. However, the hospital context privileged hospital health providers such as this nurse in making decisions for the mother without consulting the midwife. It can be seen that the mother and father were affected by power struggles within the maternity care teams. Being treated as passive customers, the couple's knowledge, decisions, feelings, and emotions were ignored. They were located on the lowest rungs of health communication.

Contradictions in the knowledge of childbirth were also evident:

我想要选择剖腹产，但是他们[产护人员]不让你这么做。就算我有那么多的问题，我产婆还是跟我说：“你可能这次就好了。”我问：“要是没有呢？”她就说：“那你可能就会被送去剖腹产。”对于她的回答我是觉得很失望的。

I expected to choose a caesarean section, but they [maternity-care and healthproviders] didn't let me do it. Although I had so many concerns,

my midwife told me, “Maybe this time you will be fine.” “What if it doesn’t?” I asked, and she answered, “Then you may be sent for a caesarean.” I felt disappointed about her answer.

This mother suffered from the consequences of the last natural labour. She had abnormal position of her baby, a very serious tear, and many other problems which she was concerned about and hence this time she wanted to choose a caesarean section to avoid those problems. One’s knowledge is derived from his/her interaction and socialisation with others (Allen, 2005; Burr, 2003). To this mother, childbirth was viewed as a highly risky process because she had been socialised by the the discourses of medicalisation in her country of birth. Her preference, for opting a caesarean was because of the predominant Chinese view of this being a safer birthing option. A high rate of caesarean deliveries, particularly in urban cities of China, was derived from the state policies of total hospitalisation and medicalisation (Huang, 2000). The trauma of her previous labour reinforced her belief that a caesarean section would be safer.

Nevertheless, this knowledge from a migrant woman could not penetrate privileged knowledge structures in the New Zealand health care systems. Knowledge production from the ‘other’ is often ignored and marginalised in Western mainstream society (Shome & Hegde, 2002). In the dominant New Zealand maternity and health discourse of natural childbirth, pregnant women are not allowed to choose a caesarean section unless they have pregnancy complications (New Zealand College of Midwives, 2008). When Chinese mothers, such as this particular mother, migrate to New Zealand, they are surprised to find that they are not allowed to freely choose a caesarean section.

The disappointment was not just because of the conflicting knowledge of what she learnt in New Zealand and what she had learnt in China but also because the Chinese mother's different cultural predispositions of childbirth, her health problems, and concerns were not taken seriously by her maternity-care and health providers. However, although the mother felt disappointed, she did not argue back as, she was more attuned to Confucianism-influenced cooperative communication in which patients are meant to be compliant to doctors who hold higher positions in society (Jiang & Zhao, 2002). This mother accepted the relationship inequality between her and the maternity-care and health providers and decided to cooperate with maternity-care and health providers even though their decisions did not match her preference.

The study pushes me to further explore power relations between Chinese mothers and their maternity-care and health providers in decision making. After the third-round of interviews, I found out that all the mothers had the same Plunket nurse who was also a migrant ethnic Chinese woman. I was interested in finding out how they evaluated this Plunket nurse and why they chose her.

Two mothers described how they found this Plunket nurse:

人家[the Plunket]一介绍给你就是华人的 plunket nurse, 好像[她们]上来就说: 嗯, 你就跟\*\* [华人 Plunket 护士]联系吧。就这样子, 好像他就认为你是华人这个\*\* [华人 Plunket 护士], 她就 particular 专门负责华人的, 所以你也没有 chance 去选择 kiwi 呀。

The one they [the Plunket] introduced was this Chinese Plunket nurse. It's like [they] started saying, "Em, you contact \*\* [name of the Chinese Plunket nurse]". Like this. It's like they assumed that because you

were Chinese, this \*\* would take a particular responsibility of Chinese.

So you didn't have a chance to choose a Kiwi.

就 midwife 说你们中国人一般的都找她，她是一个中国的唯一的  
plunket nurse，那我就接受了。因为当初了解的也不多也没有比较也不  
了解所以就接受了。

The midwife said that you Chinese usually found her and she was the only  
Chinese Plunket nurse. So I agreed. Because at that time, I didn't know  
much and didn't have a comparison, so I agreed.

Encouraging freedom of choice is believed to improve partnership-based  
relationship between mothers and health care providers, and to increase mothers'  
satisfaction (Cegala, 2006; Dutta-Bergman, 2005). Yet, both mothers whose  
quotations I refer to were not satisfied with the process of choosing a Plunket  
nurse. Given that the mothers "didn't know much and didn't have a comparison",  
it was hardly possible for the mothers to have a choice and construct an  
independent and self-reliant customer identity. More strictly speaking, the  
mothers were deprived of the freedom of choice by the Plunket staff and a  
mother's midwife who thought they were making the best choice on behalf of the  
mothers because "you were Chinese, this \*\* [name of the Chinese Plunket nurse]  
would take a particular responsibility of Chinese" and "you Chinese usually found  
her". Such a stereotype and assumption forced the mothers to experience  
'othering'. That is, Chinese mothers were judged on the basis of their ethnic  
background and linguistic ability. They were simply classified into one group

under the assumption that a Chinese Plunket nurse would work better for a group of Chinese mothers. Diversity within the Chinese culture was neglected.

The mothers' narratives were justified by the Plunket nurses who stressed the responsibilities of the only ethnic Chinese Plunket nurse in looking after ethnic Chinese mothers in the community:

It is a big area, yeah more I think, but again the families that I saw who were Chinese and I would home visit them, and then \*\* [name of the Chinese Plunket nurse] would take over.

我接的 cases 都是上面分配给我们的，上面看到名字可能是亚洲人的就会先 refer 给我，还有说我的有些同事可能接到 Cambodian 的如果英文上没有问题的他们可能会继续看，那如果说他们觉得语言上有问题的他们可能就会转给我。

The cases I have were allocated from above. The [people] above assumed they might be Asians when seeing their names, they would then refer them to me. And some of my colleagues might get Cambodians. If there was no English problem, they might keep looking after them. But if they were concerned about a language problem, they might refer [the client] to me.

Apparently, decisions about the allocations of the cases were made by neither customers nor the Chinese Plunket nurse. "The [people] above" in the Plunket Society allocated the cases for their nurses by categorising customers into different ethnic groups. The Chinese Plunket nurse got the clients who were

assumed to be Asians by their names. Clients with language barriers were also referred to her. Responsibilities then were moved from the English-speaking Plunket nurse to the 'other' health care provider. Again, ethnic background and linguistic ability were used in decision-making on the allocations of cases. But such an assumption was very subjective and mistakes might occur:

曾经有过我那时候刚开始上班很奇怪的他们只要一看到那个姓比较怪的就全部给我了，那当时我就想说他们应该给我华人的嘛就没有想到还可能有韩国什么的，我就打起了电话就噼里啪啦讲起了中文，然后对方就没反应，我想咦为什么没反应，然后我才再用英文跟她讲嘛，我就用英文问她是哪里来的，是 Samoan 的是哪里来的。。[从中国以外其他国家来的]。然后我就想说很好笑。

At the time when I just started this job, it was strange that they would refer to me with all the clients whose names looked odd. I thought at that time that the ones they referred to me had to be ethnic Chinese. I didn't think they could be Korean or whatever. So I picked up the phone blablabla speaking in Chinese, but then the one on the phone didn't respond. I thought, well why no response, and then I began to speak to her in English. I used English to ask her where she was from. She was from Samoa; she was from; ... [from other countries other than China]. Then I thought it was so funny.

Mistakes occurred when ethnic Chinese clients were identified simply based on their names. The Chinese Plunket nurse assumed that all her clients had to be Chinese, so she talked to the clients in Chinese on the phone, but she

later found out ‘the assumed Chinese’ included Samoan, Korean, and other ethnic groups whose names looked “odd” to Western mainstream groups. Difference is being used to mark and name others, which is a result of separation and deviance between ‘us’ and ‘them’ (Weis, 1995). An odd name was then identified as a key difference to separate non-English-speaking Asian migrants and English-speaking natives. By attributing others’ culture as different, the Plunket staff allocated others, regardless of their actual ethnicities, to an ‘othered’ Chinese Plunket nurse. From the management perspective, Chinese receiving services from Chinese was a wise way to avoid language barriers and cultural differences. But from the mothers’ perspective, it was not a fair decision because they were denied their right of choice.

The consumers’ right of choice is related to the extent of information the consumers have received. The more information is given, the more understanding of the options is achieved, and in turn, the better choice is made. So far, I have examined the challenges faced by Chinese mothers in being socialised into the Western discourse of choice. Now I intend to find out the impact of withholding information from maternity-care and health providers on mothers’ right of choice.

### **Control of Information**

Giving and seeking information are critical for maternity-care and health providers to understand patients’ situations and provide effective instructions and treatments. They are also important for mothers, in particular migrant mothers, to learn the new maternity care procedures and practices, and also to be able to make the best decisions of childbirth. Yet in practice, my findings indicate that

some maternity-care and health providers ignore the mothers' needs for information. The quotation below is drawn from an observation of a mother and her husband's initial visit to her midwife. The midwife avoided providing the mother and father with complete information, which left the couple with uncertainty:

Mother: When to do the next blood test?

Midwife: ?

Mother: When can we talk about the labour?

Midwife: ? You mean what will happen during the labour? (Then she gave a brief explanation)

Mother: When shall I meet you next time?

Midwife: ? Here.

Mother: I mean when to meet you next time?

Midwife: Next appointment? In four weeks. No other questions?

Mother: ...

Midwife: No other questions?

Father: Which number we can contact you?

Midwife: My contact information is here (She showed the birth plan book).

The context of the mother needs to be taken into consideration when analysing this interaction. As van Dijk (1998) points out, contexts are unique, subjective, and socially and culturally based. Although this mother had a nursing background in China, she, as a new migrant to New Zealand, experienced culture shock when contacting a new health environment. She found it hard to



communicate with the midwife because of language barriers and different cultural understandings of maternity and health practices. Her question of “talk about the labour” could not be understood by her midwife. Given that she was from Southern China where people had their own dialect, the mother had a strong accent when speaking English so that the midwife was confused about “when” and “where”.

Having language barriers is a challenge many migrant patients face when contacting the health sector (Dysart-Gale, 2005; Pauwels, 1995), which is an issue I have discussed in an earlier chapter. In this particular health environment, miscommunication and stress not only occurred due to a language barrier of this new migrant mother, but was also caused by the withholding of information. Research directed by Cicourel (1985) is concerned with “social class and ethnic differences” that may lead to “problems of trust and the withholding of information, and a general reluctance to ask direct questions and provide direct answers” (p. 195). The midwife in question paid perfunctory attention to the mother. She did not listen to the mother carefully and patiently, and did not provide adequate information regarding blood test, birth plan, next appointment, and her contact details. The mother even needed to seek basic information that maternity and health care providers should have given without being asked. Although in theory, the openness of the initial interaction between the patient and the health provider is important to establish a collaborative relationship and benefit the following treatment (Eisenthal et al., 1990, cited in Dutta-Bergman, 2005), in practice it seems to be idealised. Ignoring the mother’s cultural background and perceiving her language barrier as troublesome, the midwife in the example above could have ended up finding her client failing to follow her

instructions and advice in the following visits.

The modern Western health systems which favour consumerism and partnership-based communication tend to be very ethnocentric as they expect every consumer to fit in with the Western ideologies and discourses of health and communication (Kreps & Kunimoto, 1994). The New Zealand maternity and health systems also expect every mother to comply with the New Zealand discourses of childbirth, health, and the way of communication. For those maternity-care and health providers who are not trained or do not have many chances to deal with other cultures other than the dominant culture, can suffer from this “medical ethnocentrism” (Ulrey & Amason, 2001, p. 452). Meanwhile, migrant patients are easily labelled as ‘problematic’ patients with ‘unacceptable’ behaviours due to their unwillingness to take individual responsibilities and contribute to partnership-based communication (Cegala, 2006; Johnson et al., 2004; Kline, 2007). Although the mother and the father seemed to ask questions actively, some of the questions such as the one of labour were not perceived by the midwife as appropriate questions to ask in early pregnancy. Thus, the midwife just gave a brief explanation of what would happen in labour. She was not aware that the questions were asked because of the couple’s different health beliefs of the maternity and health system and practices (Kreps & Kunimoto, 1994). With limited information received by the mother, she was unable to make a choice about her birth plan and in other decision making processes.

The next quotation depicts a situation when a mother made a choice but encountered barriers to realise her choice due to the control of information from maternity-care and health providers:

我看到墙上贴着关于 Lac Latch consultant 服务的[介绍小册],我跟至少

5 个 nurses 讲你帮我申请一下这个服务，他们都说好吧好吧好吧，结果就下班了，就一直拖，拖到我出院了也没有见上一个[Lac Latch 顾问]。。。最后才知道你要通过你的 midwife refer，当初没有人告诉我。到现在都没有见到。

I saw there was [a pamphlet] about a Lac Latch consultant service on the wall. I have asked at least five nurses to help me apply for this service. They all said okay, okay, okay, but in the end they went off duties. So it was delayed even when I left the hospital I didn't get a chance to meet one [Lac Latch consultant]... At last I found out that you had to be referred by your midwife, but no one told me this before. I haven't met one [a Lac Latch consultant] till now.

The pamphlet shown on the wall provided an opportunity for the mother to choose to receive breastfeeding services. However, her choice was not activated because the access to the services was blocked due to the control of information from hospital nurses and the mother's midwife. Ironically, this was in conflict with the Code of Consumers' Rights of Health and Disability Commissioner (2012) which defines the right of health consumers to get information explained before making an informed choice. The discourse of consumer culture encourages employees including health providers to re-imagine their identities as customers so that they learn the way of improving their services to satisfy the expectations of customers (Hochschild, 1983). Health care providers are further expected to upgrade their communication style such as listening to patient's questions and explain patiently (Dutta-Bergman, 2005). Nevertheless in this

context, the nurses provided superficial answers towards the mother's request. The mother "asked at least five nurses", but they "all said okay, okay, okay, but in the end they went off duties." The quotation shows that the New Zealand's discourses of choice, consumer culture, and partnership communication, are uneven. Power usually rests with the role of a health provider in the social institution (Martin & Nakayama, 2003). It is on the strength of this power that the nurses and the midwife disregarded the mother's demands for information on the grounds that they were busy, they expected the next on-duty staff would take up the responsibility, or they regarded the question was not that important, or that the ignorance was due to the mother's ethnicity.

The same mother recalled another experience of experiencing difficulties in receiving information from her midwife before making a choice:

其他妈妈说咦你怎么没有结扎，我都不知道这个问题，要不是别的妈妈告诉我我还不知道你有 caesarean 了你就可以结扎，我可以去问她[产婆]，我可以当面问，但是我不想遇到这样难堪的事情，已经过去了没有挽回的事情了，我不知道她是忘了还是觉得不需要结扎还是觉得结扎对女性的身体不好，还是因为怎么样，但是她就是没有提。

Another mother asked me: "Eh, why didn't you have tubal ligation?" I didn't know this. I hadn't known that you could do tubal ligation in a caesarean until that mother told me. I could have asked her [midwife]. I could have asked her to her face. But I didn't want to embarrass her. This is something which cannot be redeemed. I don't know if she forgot it or she thought it was unnecessary to do tubal ligation or she thought tubal ligation was not good for female body or whatever reasons, but she

didn't mention it.

Cicourel (1985) identifies the factors which influence how much information should be given to the patient by the physician. These factors include "the life circumstances of the patient at the time, the family's wishes, perhaps the family's religious backgrounds or beliefs, and the kind of illness involved" (p. 194). Applied to this case, the contexts of the mother, her and her family's wishes, and the importance of having tubal ligation were not considered by the midwife as key factors when providing relevant information to the mother. This Chinese mother was in her early forties. It was her second birth and also the last one she expected. Therefore, taking the most effective measure of contraception was very important to her. However, her midwife withheld any information about contraception and this affected the mother's right to access information and explore options before making a choice.

Information control by the midwife caused the mother confusion, dissatisfaction, and distrust. The mother was confused about the reasons why her midwife did not pass on the information and she was dissatisfied with the result, as shown in the quotation, "I don't know if she forgot it or she thought I was unnecessary to do tubal ligation or she thought tubal ligation was not good for female body or whatever reasons, but she didn't mention it." The mother's confusion and dissatisfaction led to a distrusting relationship between the mother and her midwife. This mother was the only participant at the last interview stage who revealed that her relationship with her midwife got worse over time. She explained that barriers to information were the major reasons that made their relationship worse.

Chinese Confucianism stresses the role of face saving in maintaining harmonious but stratified relationships (Gao, 1996; Gao & Ting-Toomey, 1998; Zhu & Herbert, 2002). In order to sustain harmonious but stratified relationships, Chinese people tend to value “[*K*]e qi (客气) or politeness” and “[*T*]ing hua (听话) or listening centeredness” in communication (Gao & Ting-Toomey, 1998, p. 37). The mother in this case did not want to destroy a harmonious but unequal relationship with her midwife. Despite her dissatisfaction and with the midwife, the mother chose not to confront her midwife directly. “I could have asked her [midwife]. I could have asked her to her face. But I didn’t want to embarrass her. This is something which cannot be redeemed.” Valuing a cooperative physician-patient communication prototype, the mother respected the dominant superior position of the midwife and took the patient’s position as being modest and obedient. From the mother’s point of view, asking the midwife directly “to her face” was useless because what had happened could not be “redeemed” and it might make both of them “embarrassed”. It seemed to be a better decision for the mother to save face for herself and the midwife, but the mother did not realise potential problems (e.g., distrusting relationships, negative effects in treatment) involved in this communication context. Status and power differences were reflected in the midwife’s control of information and insensitiveness to the mother’s contexts and requests.

So far, the findings have revealed that in some cases, maternity-care and health providers empower mothers to make a choice with a consideration of their Chinese culture and the medicalised values of childbirth. However, in other cases, the New Zealand’s discourses of choice, partnership communication, and natural childbirth produce and re-produce discursive practices, privileging certain

kinds of knowledge and communication practices in the maternity and health care environment. In what follows, I apply my theoretical framework to make sense of the discourse of choice in relation to agency, and its derived concepts of hybrid identities, knowledge, representation, and power.

### **Re-evaluating Choice**

The discourse of choice stems from the Western discourses of consumer culture and partnership communication. The New Zealand maternity and health systems are influenced by these discourses to advocate consumer culture, partnership, and consumer's right to make an informed choice. These discourses tend to control identities and behaviours of both customers and health workers, yet in practice, different customers and health workers interpret and react to the discourses differently. In the following discussion, I examine the power dynamics in the processes of making decisions. I explore hybrid identities, knowledge construction, and representation to understand who has the ability to exercise choice and when, within cultural and health care contexts.

Becoming an increasingly consumer-oriented society, New Zealand has reconstructed its maternity and health care practices to value Western discourses of consumer culture and partnership (DeSouza, 2006a). Such discourses constrain certain preferable identities of customers and health workers, which is called as identity regulation (Alvesson & Willmott, 2002). The discourses of consumer culture and partnership communication regulate a patient to re-identify him/herself as "the sovereign consumer" who exhibits "enterprising qualities" (du Gay, 1996, p. 56). Maternity and health care providers are also asked to identify with their customers (Hochschild, 1983) for providing upgraded services and

experiences. A key essence of consumer culture is empowering consumers to exercise individual choices (Keat, 1990). The mainstream discourse of “being an informed consumer” (DeSouza, 2006a, p. 34) in the New Zealand maternity and health systems regulate such identities of consumers and health workers. The New Zealand Code of Rights (2012) also defines the rights of consumers in making informed choices when receiving any New Zealand health and disability service, and at the same time obligates health care providers to respect the consumers’ rights.

Some maternity-care and health providers in my research complied with the Code of Consumers’ Rights to meet the preferences of mothers. A typical example presented above is that a midwife did not portray a Chinese mother’s knowledge of medicalised childbirth as negative or strange, nor did she assimilate the mother to form the New Zealand way of natural childbirth. Rather, the midwife was open to the mother’s choice and respected her choice of giving birth at hospital. The mother’s choice of giving birth at hospital was derived from her cultural values of childbirth as a dangerous event. A great number of Chinese women, in particular women from urban locations of China, have hospital deliveries (Qian et al., 2001), whereas in New Zealand, only a few women need to give birth at hospital due to health complications (New Zealand College of Midwives, 2008). Respecting the mother’s right to choose the birth place, the midwife allowed the mother to take more individual responsibilities in decision making.

Alvesson and Willmott (2002) introduce identity work aligned with identity regulation in the process of identity negotiation. Identity work is how an individual engages in constructing, reacting, and/or resisting to social and



institutional discourses (Alvesson & Willmott, 2002). This midwife experienced identity work by understanding and interpreting the discourse of choice.

Reacting to the discourse of choice, the midwife identified herself with Chinese mothers, and empowered the mothers to decide where to give birth. Subservient to consumer culture, the identities of consumers and organisational workers are blurred and interrelated to each other (du Gay, 1996). This perspective is similar to an important tenet within postcolonial theory, the prevalence of hybridity instead of pure and essentialised identities and cultures (Bhabha, 1990). The postcolonial notion of hybridity provides a different understanding of identities of the coloniser and the colonised by interrelating and overlapping their identities without denying the unequal relations of power between them (Frenkel & Shenhav, 2006). The disclosure of the midwife regarding her family, work, travel, and life experiences signifies that her identity was not merely confined to that of a New Zealand midwife, but was also connected to and mixed with the identities of migrant women.

The social constructionist notion of context provides me with a platform to revisit identity, knowledge, and experience which are situated in different discourses (Allen, 2005), and shaped by different contexts (Burr, 2003; Laird, 1993). One's identity is constantly developed, negotiated, changed, and challenged in social interactions with others and within a variety of contexts (Beech & McInns, 2005; Meisenback, 2008; Tracy & Trethewey, 2005). The midwife identified herself with Chinese mothers by saying that she was a mother with difficult childbirth, being a member from a big family, a traveller appreciating different cultures, a former patient experiencing health complications, and a health provider dealing with complex maternity cases. Therefore, her

identities, knowledge, and values of childbirth and communication were constructed and developed through her social interactions with others. The midwife's historical, social, and cultural contexts constructed her understanding of childbirth as risky. From one perspective, re-interpreting the discourse of childbirth, the midwife supported Chinese women to make a choice which fit in with their Chinese cultural values and circumstances. From the other perspective, the expression of the midwife's identities can be seen as a resistance to the discourse of natural childbirth which ignores diversity among mothers and their subjective values.

Although the findings show that some maternity-care and health providers empower mothers to have the ability to make choices when they want, the findings also reveal that many Chinese mothers (as well as a few maternity care providers) do not see choice as an approach of liberation. In turn, they interpret, react to, and resist the discourse of choice in the light of their hybrid identities and cultural values.

As discussed earlier, identity, knowledge, value and experience are portrayed as socio-culturally constructed notions (Allen, 2005; Burr, 2003). Identity, in particular, is believed as hybrid, and can be developed, and challenged (Shome & Hegde, 2002) in social interactions with others and in different contexts (Beech & McInns, 2005; Meisenback, 2008). In this sense, many Chinese mothers resist constructing a rational and independent consumer identity in decision making because that consumer identity is against their cultural identity and Chinese values of childbirth and communication. The Chinese value of childbirth as a medical and risky event (Cheung, 2009) makes the mothers believe that the safety of childbirth can be guaranteed by medical and health professionals.

The Chinese knowledge of a cooperative doctor-patient communication (Jiang & Zhao, 2002) defines different identities of patients and doctors and their power relations. So, those maternity care providers who identify themselves as medical and authoritative care providers, based on their values and subjective experiences, are more likely to be trusted.

From a postcolonial perspective, the reactions of the Chinese mothers can be understood in the context of their hybrid identities as women from a traditional culture, that is fast embracing modernity who are now living in a developed country where natural forms of childbirth are privileged. In this sense, they are trapped in the in-between space of their traditional respect for the authority of those higher in a social hierarchy and their modernist aspirations of being in league with medicalised forms of obstetric care. They are part of a quintessential Third World which seems to fall in the gap between the influence of the West and the burden of its own tradition (Xie, 1997). From the other angle, the maternity care providers are also trapped in the discursive tensions between natural, and more traditional, forms of childbirth and unreflexive, neo-liberal demands for choice. Indeed, postcolonial scholars regard consumer choice as a part of the neo-colonial framework (DeLoughrey & Handley, 2011). Third World feminist scholars argue that choice does not necessarily mean liberation (Narayan, 1998). On their part, women sometimes voluntarily 'choose' to adopt practices that are perceived to be oppressive in western locations. Examples include the choice of women to wear the veil as an expression of their identity in several countries (Macdonald, 2006) or to adopt female genital mutilation in Africa (Njambi, 2004). Clearly, therefore, a lot of people either do not want to be liberated through choice or they have other cultural expressions of liberation.

In theory, the Western discourse of consumer culture directs institutions and practices including health institutions to satisfy the preference and needs of individual customers (Keat, 1990). A customer is encouraged to make a choice in full awareness of the situation explained, and that matches the customer's best interest (McLaughlin, 2009). But in practice, not all maternity-care and health providers were like the midwife who empathised with the feelings of Chinese mothers in empowering them to make an informed choice, which in fact conflicts with the discourses of choice and consumer culture and their derived expectations of workers' identities. The mothers had no choice of pain relief, no choice to call a midwife at hospital, or no choice of a caesarean section. The power advantage enjoyed by their maternity-care and health providers was linguistically managed by directive devices which included explicit language practices that carried social meanings of power (Fowler, 1985). Constitutive structures in producing and reproducing ideologies that legitimate the institutions/groups of power (Fowler, 1985) also worked in these contexts to create a power disparity between the mothers and their maternity-care and health providers. The New Zealand maternity and health systems and the hospital structures produced and reproduced the structures of knowledge and regulated certain boundaries and control in decision making.

The maternity-care and health providers' expressions of their knowledge of having pain relief, contractions, or a caesarean section revealed a practice of power in trying to promote the idea that the childbirth problems could be overcome in a more natural way. These communication practices were used by the maternity-care and health providers to position themselves in the dominant discourse of natural childbirth and resisted competing discourses of childbirth.

Certainly, whether having a natural birth or a caesarean section is safer, or whether having Gas or an epidural is appropriate, are not issues for this thesis. But it is important to be aware that in the New Zealand maternity and health context, mothers as customers do have a choice but it is under certain boundaries and controls. Such boundaries and controls are set by dominant discourses which define discursive practices in the health care environment, including communication practices and knowledge produced and expressed by mainstream groups. The mothers' hybrid identities expressed by their cultural differences and subjective experiences are also marginalised when the mothers are being socialised into mainstream discourses.

The matrix directs me to address the issue of agency in relation to Chinese mothers' vulnerability in making a free choice, and to challenge taken-for-granted knowledge stemming from Western neo-colonial ideologies and discourses. Western ways of thinking and imposing their thinking on others are problematised in ignoring subjective and multiple voices (Bhabha, 1994; Mohanty, 1996; Quayson, 2000; Spivak, 1988). In my research, all Chinese mothers were allocated to the same ethnic Chinese Plunket nurse. The fact is that "the people from a particular culture are not identical, and any culture has many intercultural struggles" (Martin & Nakayama, 2008, p. 33). Migrant ethnic Chinese mothers came from different locations of China. They formed different identities based on their life experiences. Some were more Westernised and others kept stronger cultural identities. The mothers might have different expectations and beliefs in childbirth, culture, communication, as well as health issues. However, these differences were not recognised by some of the Plunket staff and other maternity-care and health providers.

More significantly, postcolonial and Third World feminist readings of my findings help pose penetrating questions: Who empowers whom? Who liberates whom? And who represents whom? Colonial formations in earlier times divided West and East, and empowered the West to represent other parts of the world (Said, 1978). The issue of representing the colonised as incapable of speech still exists (Shome & Hegde, 2002) but in more subtle ways in contemporary times. For example, international business and management studies are critiqued for its institutional ethnocentrism in misrepresenting other forms of knowledge (Jack, et al., 2011; Westwood, 2006). Indeed, by locating others, dominant groups confirm their identities and define their boundaries (Littlewood & Lipsedge, 1997; Walsh, 1997). “The [people] above” in Plunket and some other New Zealand maternity-care and health providers confirmed their identities as belonging to a mainstream group which was different to Chinese and other Asian mothers. They enjoyed the power of speaking for the subaltern mothers, whilst hampering the mothers’ freedom to speak, especially given their own struggles with hybrid identities and competing discourses. The Chinese mothers can speak for themselves and are capable of self-empowerment but they need the discursive space to articulate themselves on their own terms.

The power enjoyed by maternity-care and health providers to represent other groups was also derived from their ability to access information and produce knowledge. As van Dijk (1985) says power can be invisible such as the ability to access, express, and manage knowledge. Both DeSouza (2006b) and Liem (1999) have identified the changes and challenges faced by migrant women in the transition to motherhood in an adopted land. DeSouza (2006b) says that migrant women can find it hard to get access to “social and institutional knowledge” (p.

196) of childbirth and care practices. They adapt to relying on self instead of family and friends and they also encounter problems of access to maternity-care and health providers due to language barriers. Chinese mothers, in particular first-time mothers, had little knowledge and information about the Plunket Society, roles, and responsibilities of Plunket nurses, and how to access Plunket nurses. They naturally became the powerless customers. Maternity-care and health providers then exercised power over the Chinese mothers in control of information. They had preferential access to information and they produced and managed this in a way that positioned themselves in advantageous roles in the intercultural communication processes.

The control of information is also uncovered in the ways that the mothers were unable to or found it difficult to make choices as they were denied adequate information about blood tests, birth plans, appointments, breastfeeding services, and contraception. Maternity-care and health providers paid perfunctory attention to Chinese mothers' demand for information of conditions and options. By controlling the information when communicating with the mothers, particularly new migrants and the first-time mothers, the maternity-care and health providers exercised their power by creating hierarchical relationships with the mothers. I use a specific example of a mother receiving little information about the Lac Latch consultant service to further explore the reasons why maternity-care and health providers regarded this mother's demand for breastfeeding information as not important.

From the perspective of maternity-care and health providers, every mother who gave birth had breast milk naturally. Assuming that the mother would receive support from her midwife and the Plunket nurse regarding breastfeeding

knowledge, they deemed that it was not urgent or necessary to contact another breastfeeding specialist. However to the maternity-care and health providers, their constructed knowledge of breastfeeding was based on the Western/white women's understandings of breastfeeding and they failed to recognise different contexts and identities of women in influencing their breastfeeding and childbirth knowledge. This view of portraying every woman as the same has already been critiqued by many Third World feminist scholars (Garry & Pearsall, 1996; Hesse-Biber & Yaiser, 2004; Mohanty, 1996).

Women's ethnicity, race, class, and other differences define the oppressive situations they experience as women (Sen & Grown, 1987). As one's knowledge and experience are historically and socio-culturally based (Allen, 2005; Burr, 2003; Hackley, 1998a), the different contexts women belong to also influence their expectations and needs of childbirth. This Chinese mother was not familiar with breastfeeding information because breastfeeding was not highly encouraged in China. The mother was away from her extended family while the role of extended family members in China was crucial in providing childbirth knowledge and support to the women after they gave birth to their babies (Kartchner & Callister, 2003). Also as an older, second-time mother with a pre-mature baby who had failed to breastfeed her first child, she was understandably eager to gain breastfeeding knowledge this time. But her contexts and differences were ignored by those maternity-care and health providers. Her expectations for more breastfeeding knowledge and access to the relevant information were denied by the maternity-care and health providers. In the end, her choice was not granted.

The roles and knowledge of the maternity-care and health providers towards childbirth set the rules of communication and how much information they



want to give. My analysis points to the fact that many Chinese mothers experience and interpret childbirth, culture, and communication differently to the expectation of systems in New Zealand. It is the systems which set rules and deny some mothers' access to certain information and their right to make an informed choice. As a result, the mothers experience confusion, dissatisfaction, and distrust towards their maternity-care and health providers and the childbirth practices in New Zealand.

### **Conclusion**

The roles and knowledge of the maternity-care and health providers towards childbirth set the rules of communication and how much information they want to give. My analysis points to the fact that many Chinese mothers experience and interpret childbirth, culture, and communication differently to the expectation of systems in New Zealand. It is the systems which set rules and deny some mothers' access to certain information and their right to make an informed choice. As a result, the mothers experience confusion, dissatisfaction, and distrust towards their maternity-care and health providers and the childbirth practices in New Zealand.

The concept of agency in my matrix leads me to question the discourse of choice as liberating. Choice in the New Zealand's maternity and health care services is seen as a way socialise consumers into the discourses of consumer culture and partnership communication. However, this homogenising approach shackles people who choose other different expressions of liberation. My findings reveal that not every maternity care provider complied with the notion of choice in practice. Some maternity-care and health providers exercised power

over Chinese mothers by assimilating them into the discourse of natural childbirth, controlling information, and resisting other knowledge and identities. The Chinese mothers were deemed to be customers but they remained hidden in a marginalised sphere. Their hybrid identities derived from cultural and subjective experiences were ignored, so they struggled to make the customer choices they really wanted. Accordingly, the trust between mothers and maternity-care and health providers was harder to be established and maintained in communication processes. In the next chapter, I examine the notion of trust which is central to creating understanding and improving relationships between mothers and their maternity-care and health providers

## CHAPTER 10: TRUST

Good communication between maternity-care and health providers and patients not only includes cooperation in information sharing and decision making, but also needs understanding, respect, and importantly trust with each other (Xie et al., 2006). Sincere attitudes and good abilities are regarded as the key attributions to trust (Berry, 2007). In health care settings, trust between patients and health professionals is established over time through supportive communicative behaviours (Berry, 2007; Hargie & Dickson, 2004). With trust established, patients are more likely to rely on the communicative behaviours of health care providers (Berry, 2007). With trust maintained with supportive people, patients can feel more comfortable and confident in getting through health care processes. In the following section, I discuss the concept of trust in relation to identities and cultures in the maternity and health care environment. Who are the ones that Chinese mothers trust? What are the attributions of their trust? In particular, what are the roles of identity and identification in building a trusting relationship? And how important is trust in communication between mothers and maternity-care and health providers, and between mothers and their support people?

### **Trust in Maternity-Care and Health Providers**

In this section, I focus on the establishment and maintenance of trust between Chinese mothers and their maternity-care and health providers. More specifically, I examine and analyse mothers' trust towards doctors, and other health providers who they regard as *insiders*. In turn, I examine Chinese mothers' expectations towards their maternity-care and health providers during

health communication.

### **Trust in Doctors**

The findings show that mothers' attitudes towards doctors were closely related to their cultural values and beliefs. Such attitudes made the mothers believe that some maternity-care and health providers in New Zealand were trustworthy, while other maternity-care and health providers were less reliable. For instance, two mothers shared their views towards maternity-care and health providers. Drawing on her knowledge about giving birth in Taiwan, one of the mothers felt the New Zealand maternity and health care systems were "outdated" because:

我们在台湾每次都是和医生做检查。我们台湾没有 midwives，只有产科医生。我们几乎每次产检都会做 scans。。。他们[产科医生][比产婆]更专业一些。

We, in Taiwan, do every antenatal check-up with a doctor. We have no midwives in Taiwan, just obstetricians. We do scans in almost every antenatal visit...They [obstetricians] are more professional [than midwives].

The other mother from the mainland of China compared her first childbirth experience in China to the second experience in New Zealand:

因为在妇产科里有很多人，产科医生，护士等等。在这里就不一样了，只有一个 midwife。我就在想她能够一个人处理我这个 case 吗要是万一有什么事有问题了。

The gynaecology division there had lots of people, obstetricians, and nurses, and so on. It is different here, only one midwife. I am wondering whether she can handle my case by herself if anything goes wrong.

The Chinese discourse of medical childbirth was reflected in mothers' attitudes towards doctors. Almost all the mothers interviewed thought experience in helping with delivering of a baby was the main reason for choosing a midwife. The mothers were not familiar with the idea of an independent midwife as in China pregnant women usually go to hospital for check-ups and delivery, and they have the most contact with medical professionals such as obstetricians (Qian et al., 2001). The mothers rely on medical professionals to take control of the childbirth process to avoid any accidents (Gao & Xia, 2006; Lazarus, 1994). According to the mothers in these cases, the maternity care procedures and practices in Taiwan shared similarities with the ones in Mainland China. For example, women in Taiwan "do every antenatal check-up with a doctor" and "do scans in almost every antenatal visit". In Mainland China, the mother was asked to contact "the gynaecology division" at the hospital. She was surrounded by "lots of people" including obstetricians, nurses, and other health professionals. Evidently, technical interventions are part of a doctor's service which is prevalent in both Taiwan and Mainland China. Also both mothers differentiated the maternity care services in their hometown from the ones in New Zealand. The first mother used "we", and "no midwives in Taiwan, just obstetricians" to make this distinction, while the second mother stressed "lots of

people” versus “only one midwife” to enlarge the difference.

The first mother used the term “more professional” to point out that doctors were preferred over midwives because of their better medical expertise and the technical interventions they applied in their services. Likewise, the second mother questioned the medical knowledge and skills of an independent midwife in handling all childbirth processes including the complicated ones. In ancient China, the identity of a doctor was compared to the Buddha with power to cure a patient’s disease (Jiang & Zhao, 2002). Even now, that sacred and adored identity of the doctor is still embedded in the Chinese mind. The power and status of the doctor are also defined by Chinese Confucianism, so the patient is required to always respect the doctor’s status and knowledge because the doctor holds a superior position to the patient (Gao & Ting-Toomey, 1998). Thereby, the mothers in these contexts trusted doctors over independent midwives not only because they were unfamiliar with the roles and responsibilities of the midwife, but also because the mothers maintained Chinese traditional knowledge and attitudes towards the position of doctors and the services they provided.

So what were the specific features of a doctor that gained Chinese mothers’ trust? Or what were the specific attributes of Chinese mothers’ trust in a doctor? One mother’s narrative below may answer these questions:

我当时就感到很害怕，因为我感到我的血流的已经让我有点迷糊了，我已经控制不住自己了，后来就有个 surgery[surgeon]来了一个高高大大的 surgery[surgeon]来了，讲话很好听就让人感到很放心，男的高高大又一脸的胡子，就是很 gentle 很 professional 的那种，也很轻松，他说哈我来了，我们进去吧，就说我是谁，没关系。。。他一来了我就

马上清醒，他说不要害怕，我们现在就去 emergency[手术室]了，你的丈夫不能进去，因为这个是 complicated，不是一般的 caesarean，我说好好，他跟我说什么我都很相信。

I was freaking out as the bleeding had made me feel a little bit dizzy. I could not control myself. Then a surgery [surgeon] came in, a tall big surgery [surgeon] whose voice was very nice that made people feel relieved. A tall big man with full beard, very gentle, very professional, and very relaxed. He said, “Ha I’m coming. Let’s go in there [the theatre]”. He introduced who he was, “doesn’t matter” ...I was awake at once when he came in. He said, “Don’t be afraid. We’re now going to the emergency [the theatre]. Your husband cannot go in there because this is complicated, not a normal caesarean.” I said “fine”. No matter what he said, I trusted him.

At this time, the mother was in a dangerous situation. She was bleeding a lot because of placenta previa. Her due date was one month later, but now she had to go through a caesarean delivery to ensure safety for both her baby and herself. Even though her husband was there keeping her company, the mother was still “freaking out”, felt “dizzy”, and “could not control” herself. Her fright, dizziness, and anxiety were erased as soon as a surgeon stepped into the room. The first impression the surgeon left on her, through his image and conversation, made the mother trust him. As the mother said, “I was awake at once when he came in”, and in the end she also commented, “No matter what he said, I trust him”. It is interesting to find out what attributes consolidated her trust in this

surgeon in such a short time.

Power relations between patients and doctors are dominated by Chinese people's attitudes and respect towards the image of a doctor (Jiang & Zhao, 2002). Especially when Chinese women are having caesarean sections, they heavily rely on medical professionals at hospitals to ensure their deliveries are safe and babies are healthy (Lazarus, 1994). It cannot be denied that the mother in this context already held trust towards the doctor because of her Chinese values of medicalised childbirth and tacit acknowledgement of stratified relations between a doctor and a patient.

What's more, the mother described her impression of the surgeon as "a tall big surgery [surgeon]", his "voice was very nice", and he was "a tall big man with full beard, very gentle, very professional and very relaxed". The mother in particular repeated "tall" and "big" to describe this surgeon. Her description reflects the key characteristics of a male figure. This male figure is still portrayed as being superior to a female figure in our society, which privileges men to dominate the structures of knowledge production (MacCallum, 2002). Believing the male surgeon's medical knowledge and expertise were superior, professional, and reliable, the Chinese mother felt "relieved".

To this mother, her different cultural background and other contexts further attributed to her subordinate position as a woman in a maternity and health context. Differences other than gender difference contribute to oppressive situations that the Third World women experience as women (Sen & Grown, 1987). This mother was not familiar with caesarean procedures in New Zealand hospitals. She was separated from her Chinese extended family members in that dangerous situation. Her husband was a local New Zealander who had little



communication with her in that situation and failed to sympathise with her feelings as a migrant Chinese woman. As a result, the mother shifted her trust to the surgeon who gave her more comfort and support. The openness of the initial contact between the doctor and the patient is very critical to the following diagnosis and treatments (Eisenthal et al., 1990, as cited in Dutta-Bergman, 2005, p. 293). The surgeon successfully created an open and relaxed atmosphere when he had the initial interaction with the mother. He started with “Ha I’m coming. Let’s go in there [the theatre]” to first make the mother feel relaxed. It was as if he knew the mother already. The surgeon then introduced himself to be open with the mother and to make their relationship closer. He also comforted the mother by saying “doesn’t matter”, “don’t be afraid”, and explained why her husband could not go into the theatre. By using very simple language and a persuasive tone, along with his professional identity and masculine characteristics, the surgeon easily received the mother’s trust. Having that trust indeed was important in the subsequent treatments and relationship maintenance.

Sometimes trust can be easily and quickly established in the initial contact with a doctor, but at other times trust in doctors needs to be built up through consistent contacts and experiences:

我相信 Doctor \*\* [家庭医生的名字], 不是所有医生, 我带过我姑娘看过很多医生, 我曾经做过这个[测试], 我带她去见 Doctor \*\*, 然后同时我会带她去见 emergency 的 doctor, 我测试过, 结果是我比较相信 Doctor \*\* 的。。。。。

其他的医生很被动, Doctor \*\* 水平也很高但是很主动。。。Doctor \*\* 会很耐心。。。 Doctor \*\* 下的药比较温和, 更适合中国人的。就像中国人相信中药对吧, 中药是慢的温和的。

I trust Doctor \*\* [name of the Chinese GP], not all doctors. I have taken my daughter to visit many doctors. I used to [test doctors]. I took her to see Doctor \*\* and at the same time I would take her to see an emergency doctor. I have tested before, and it came out a result to make me trust Doctor \*\* more...

Other doctors are very passive. Doctor \*\* is also high standard but very active...Doctor \*\* is very patient...the medicine Doctor \*\* gave is less intense, more suitable for Chinese. Like Chinese trust Chinese herbal medicine right? Chinese herbal medicine is slow and moderate.

The standpoint that Chinese tend to trust the doctor is still valid in this context; however, “not all doctors” deserve to be trusted. This mother’s trust in Doctor \*\* was based on her careful selection. She took her daughter to visit different doctors including Doctor \*\*, as she said “I have tested before, and it came out a result to make me trust Doctor \*\* more”. Given that postpartum is seen as a risky stage of childbirth which needs serious care (Xie et al., 2006), the mother contacted different doctors to check which doctor cared about her situation, and which one would provide appropriate care for her baby.

In the end, she chose to trust Doctor \*\* over other doctors in New Zealand, and provided a very detailed explanation of the reasons why she trusted that ethnic Chinese doctor. In the eyes of the mother, Doctor \*\* had as good abilities as other doctors. More importantly, his way of communicating with patients and sensitivity to the patients’ cultural backgrounds were portrayed as better than those of other New Zealand doctors. As the mother commented,

“Other doctors are very passive”, Doctor \*\* was “very active”, “very patient”, and “the medicine he gave is less intense, more suitable for Chinese”. Considering subjective contexts and circumstances of patients and understanding the patients’ narratives before taking further actions are perceived as ethical health communication practices (Guttman & Thompson, 2001). This doctor took ethical responsibility in communicating with the mother by considering her Chinese cultural background and expectations before treating her.

The mother’s trust towards this doctor also stemmed from her identification of similarities between the doctor and herself. In saying so, the mother chose to trust the diagnosis and treatment provided by the doctor. According to Kreuter and McClure (2004), health communication receivers develop more trust and respect towards sources which share similar attitudes, values, and beliefs. This particular doctor shared the mother’s Chinese identity, culture and communication style and was also familiar with Chinese patients’ expectations towards doctors, communication, health procedures, and treatments.

The Western health discourses of consumer culture and the partnership-based communication model define identities and responsibilities of patients and health care providers. In some aspects, they help explain why other Western doctors in New Zealand seemed to be very passive. Apparently, the mother felt uncomfortable with partnership communication between doctors and patients. Her values towards the Chinese cooperative communication prototype defined different identities and responsibilities of doctors and patients.

To conclude, Chinese trust in doctors stems from Chinese traditional values towards the image and power of doctors. With the demise of midwives and the rise of hospital doctors in the Chinese maternity and health care systems,

Chinese mothers believe that doctors are more professional and medicalised in helping mothers give birth to their babies and care for the babies safely. But just as the mother in the last example indicated, not every doctor was trusted, but only those who had characteristics which matched Chinese expectations. A key attribute of such trust is that of maternity-care and health providers being considered as *insiders*. I examine this attribute in the next section.

### **Trust in Insiders**

Chinese identify insiders as family, relatives, friends, and others with a special and close relationship. Chinese are more likely to participate in close and intimate interactions with insiders. They are reluctant to disclose themselves and involve in communication with those they consider outsiders (Gao & Ting-Toomey, 1998). In this section, I talk about insiders who are not merely close family, relatives, and friends of Chinese mothers but also their maternity-care and health providers who have dedicated themselves to creating close and harmonious mother-maternity care provider relationships.

As previously presented, an ethnic Chinese doctor won the trust of a Chinese mother because of his/her communication style and sensitivity to the mother's culture. My research findings show that ethnic Chinese maternity-care and health providers had more migrant customers, in particular Chinese, compared to their Western colleagues. They devoted more time in giving and receiving information in interactions with their migrant customers. For example, an ethnic Chinese GP explained his communication with Chinese mothers and families:

I am ethnically Chinese so they might think I understand their problems

better. A lot of other things like Chinese they also mix with Chinese symptoms, in terms of Chinese terminology, and you know these *ying* and *yang*, those things essentially. If you ask a Western trained doctor they are not familiar with those things. Some Chinese for example if you say my stomach is a lot of heat, so I probably understand what they mean, so I can probably ask more appropriate questions...If it is Cantonese it is very straightforward, very dialect, and if they are Mandarin just if they not quite understand well then I probably will have to write down in Chinese. I just look in their face, sometimes it is nonverbal communication will tell you something, so I just check it, you will probably see me next time double checking that you understand and if you want the next question, and also if not I write down.

Migrant mothers may struggle with their cultural identities as a result of being separated from their familiar languages, practices, norms, and other discourses of insiders (Collier, 1998). Trust and closeness are, therefore, easily established between ethnic Chinese migrants and maternity-care and health providers who share the same ethnic identity, language, and culture. This GP found Chinese trusted him because he could “understand their problems better”. Taking advantage of being trained in both Chinese and Western health systems, the GP understood Chinese “*ying* and *yang*” and “Chinese terminology” such as stomach heat, so he was able to “ask more appropriate questions” to the clients. As an ethnic Chinese, the GP was more aware of the language barriers, culture, and communication style of Chinese clients. He chose to speak Cantonese to those who spoke this dialect. To those who spoke Mandarin, he would write in

Chinese to ensure their understanding. The GP even relied on nonverbal communication such as “look in their face” to check their understanding, and he would also double check their understanding at the next appointment. Guttman and Thompson (2001) identify this kind of practice as being ethical health communication practice as health care providers are obliged to fulfil ethical responsibilities in terms of trying to understand patients’ situations and problems first before applying diagnosis and treatment.

Ethical responsibilities of health care providers also include acknowledging different ethical standards in different cultures (Guttman & Thompson, 2001). Ethical standards in Chinese health communication require patients to cooperate with doctors and respect their decisions because doctors hold higher positions. Complying with a cooperative communication model, Chinese patients feel more comfortable at taking a passive and listening role in communicating with health care providers (Gao & Ting-Toomey, 1998). Being familiar with Chinese ethical standards and taking Chinese communication style into consideration, the GP delivered culturally safe and ethical services to his clients.

Western-trained health providers, as noted by the GP, were not familiar with Chinese symptoms and culture, and hence might find it harder to understand Chinese clients’ problems. This point is justified in one midwife’s narrative regarding her challenge in building understanding with some Chinese mothers:

As I said at the end of the day, unless I am told [I don’t know]. I am not a psychic. I am not a mind reader.

This midwife’s reaction to Chinese passiveness and dependence in health

communication is in stark contrast to the Chinese GP's. The midwife regarded herself as different to a "psychic" or a "mind reader". Instead, she expected Chinese mothers to honestly tell her their concerns, ask direct questions, and disclose themselves. Her reaction is understandable since a partnership communication model expects "good" customers to take individual responsibility for health and physician-patient communication (Cegala, 2006; Dutta-Bergman, 2005; Johnson et al., 2004; Martin & Nakayama, 2008). Ethical health communication also obligates patients to share responsibilities in terms of revealing their expectations to health care providers, and honestly providing information which is required for diagnosis and treatment (Guttman & Thompson, 2001). However, trust was hard to create when the midwife and her Chinese clients held different and competing understandings of ethical responsibilities involved in health communication.

Some mothers expressed their trust in their independent midwives, and their trust was built on a special and close bonding relationship between the mothers and the midwives. Two mothers, in particular, saw their midwives as the most trustworthy persons in the childbirth process:

我第一会去找产婆。。。还有就是 trust，我觉得现在就像是亲密的朋友吧，如果当初是朋友的关系的话。有时候还有点像我是她女儿，她也这么说的，我是小孩子脾气，她说这种性格很好，自己不会憋在心里难过。她说我就是这种，我不开心，我就说，我不会憋着自己难过的。我觉得我们两个还是蛮相近的。

The midwife would be the first one I looked for...And it's about trust. I think the current relationship is like close friendship while the prior one

was just friendship. Sometimes it's also like I was her daughter. She said so, too. I was childish. She said, "this kind of personality was good as one wouldn't lock up sadness inside." She said, "I am like this. When I am not happy, I will say it out. I won't keep it inside." I think we two are quite close to each other.

我永远都 trust 她，在整个生产过程中 trust 她胜过我的丈夫，当她做出决定的时候，关于整个怀孕生产当中我 trust 她胜过任何人。。。我的内心很 strong，我想这是我跟她的共同点。就好像感觉我很了解她，她性格骨子里有些东西是和我一样的。

I always trust her. I trusted her more than I trusted my husband in the whole labour process. When she is making a decision in the whole pregnancy and labour process, I trust her more than anyone ...My heart is very strong. I think this is what I have in common with her. It's like I know her well. Something in her personality and heart is the same as the one in mine.

These two mothers shared commonalities of how and why they trusted their midwives. Both of them indicated that they trusted their midwives a lot. For example, the first mother thought that she would first look for her midwife if she had any childbirth questions. Her relationship with the midwife after the birth of the baby improved from being "friendship" to "close friendship". The mother further explained that their closeness was also derived from their mother-daughter relationship. The second mother stressed the extent of her trust



in the midwife by saying words like “always” and “more than”. She especially pointed out how she trusted her midwife in making decisions “in the whole pregnancy and labour process”.

The mothers’ trust towards their midwives was built on relationships and similarities through their ongoing interactions. Chinese tend to be more likely to involve in communication with insiders such as family and friends (Gao & Ting-Toomey, 1998). Both mothers treated the midwives as insiders whose services were relationship based, therefore, the first mother did not hesitate to behave “childishly” in front of her midwife, and the second mother “trust[ed] her [the midwife] more than anyone” including her husband in the childbirth process. The midwives, meanwhile, also treated the mothers as insiders and showed sensitivity to their needs. The midwife in the first quotation appreciated and embraced the mother’s “childish” personality, and sometimes treated the mother as her daughter. Although the second quotation does not explicitly show how the midwife saw the mother as an insider, we can feel that close ingroup relationship through the narrative of the mother regarding their shared personalities. According to the mother, she and her midwife both had the same personalities and they both were strong in heart. In the Chinese health context, health care providers are encouraged to treat patients as insiders or family members by offering information and showing support and emotional care (Jiang, 2005; Jiang & Zhao, 2002). In the New Zealand maternity and health context, the knowledge production of insider and outsider communication has not been acknowledged. However, the midwives in the examples above adopted insider communication techniques in contacting the mothers. The midwives were sensitive to the mothers’ Chinese culture, expectations, and personalities. They

showed the mothers care, support, and respect, which in return won back respect, preference, and trust from the mothers.

To summarise, I have outlined the reasons for and importance of trust in mother-maternity care provider communication. Chinese mothers tended to trust doctors more, in particular, male doctors and/or doctors who could show professional skills, knowledge, and understandings of different cultural expectations. Being considered as insiders of Chinese mothers and their families, ethnic Chinese health care providers were more likely to be trusted due to their similar identities, attitudes and values regarding communication and culture. Some midwives were also trusted and considered as insiders to Chinese mothers. Such trust was derived from their employment of a Chinese way of treating the mothers as insiders and providing extra care to the mothers. Drawing on these findings, I next examine the mothers' expectations towards maternity-care and health providers in order to see whether those expectations match those of the New Zealand maternity and health discourses on local maternity-care and health providers.

### **Expectations towards Maternity-Carer and Health Providers**

The Chinese perception of trust in a doctor and insider had a big impact on Chinese mothers' expectations towards maternity-care and health providers in New Zealand. The mothers in my study liked to compare and contrast the maternity procedures and services they received in New Zealand and China. First-time mothers were more likely to expect their maternity carers to have the same medical expertise as that of doctors in China and to care for them as insiders:

有一次我问她[产婆]: “我可以喝可乐吗?” “你不能喝因为它会伤害宝宝的大脑”, 她回答说。。。她说的我什么都照做。自从她说过后, 我就总是喝水几乎不喝可乐。

Once I asked her [midwife], “Can I drink coke?” “You should not drink it as it damages baby’s brain,” she answered...I do whatever I have been told to do. After the midwife said so, I always take water and seldom have soft drink.

As discussed in the last chapter, a midwife’s role of being authoritative and caring was expected by many Chinese mothers in my study. The quotation above is a typical example showing the mothers’ expectations towards medical and caring professionals. With the influence of Chinese expectations towards doctors, the mothers accepted the power distance between themselves and the midwives who were treated as having higher and dominant positions. By claiming “I do whatever I have been told to do”, the mother as a first-time mother chose to take a passive and compliant role of a patient. She was satisfied with following the doctor’s directions and complying with decisions given by the doctor.

Most mothers expected New Zealand health providers to have medical expertise even before their interactions with Plunket nurses. Below are some mothers’ comments about their expectations of the Plunket nurses before contacting them:

但我之前一直以为他们[Plunket 护士们]也是很专业的一种护士, 因为是 nurse 护士我想应该也是经过专业培训的那种, 懂得一些基本的孩

子护理的知识，所以我会期待她[她的 Plunket 护士]会提供一些[建议]比如说小孩应该怎么样去养育阿，怎样去喂养，还有孩子护理各方面的知识，另外还有一些疾病像是皮肤的问题不适他们会给你一些措施和建议。

But before, I always thought they [Plunket nurses] were also very professional nurses. Because they are nurses, I thought they should have been through professional trainings, and should have had some basic knowledge of baby care. So I expected her [her Plunket nurse] to provide some [advices] such as how to raise a baby, how to feed her, and different information about baby care. They would also give you some measures and advices for some diseases such as skin problems.

我以为就像 midwife 一样每个星期来上门探访，就像是一个义务医生，除了孩子生大病需要去医院找医生，剩下的就可以找她，因为她是 Plunket 的一个 ‘nurse’ 嘛所以我就心想这个是免费的医生，有小病就找她。

I thought [she] would be like a midwife who would come to visit every week. Like a voluntary doctor. Apart from serious diseases of baby that you have to see a doctor at hospital, you can see her for curing the rest of diseases. Because she is a ‘nurse’ at Plunket, so I thought she was a free doctor. Go and see her for minor diseases.

我当时期待想他们是不是应该和 midwife 做的事情是差不多的，像给小孩检查呀，妈妈有什么事情可以去问她呀，就是像一种 nurse。

At that time, I expected them to do things as a midwife would do, like checking on babies. A mother can ask her any questions. It's just like a nurse.

The ideological construction of these mothers' sense of childbirth strongly influenced their expectations towards the Plunket nurses. As childbirth in China is regarded as a medical event controlled by health professionals, Chinese mothers and their families believe that the processes of pregnancy, birth, and postpartum need careful and professional check-ups by health care providers (Xie et al., 2006). Also, a Chinese mother's postnatal check-ups are usually done by an obstetrician and hospital nurses (Ministry of Health of the People's Republic of China, 2001). So, these Chinese mothers in the quotations above assumed that the Plunket nurse was like a "professional nurse", a "midwife", or a "free/voluntary doctor". The Plunket nurse, from their perspective, had taken "professional training", would provide "different information about baby care" and specific "measures and advices" "for minor diseases", and would answer "any questions" a mother asked. The doctor-patient discourse and the discourse of medical childbirth controlled the mothers' expectations towards the Plunket nurses, their communication, and relationship. The comments of mothers showed that they were disappointed after learning their expectations were not reached.

In exploring trust in maternity-care and health providers, it is apparent that

Chinese mothers' trust towards maternity-care and health providers is based on their ideological understandings of childbirth as a medical event and their cultural perspectives of doctor-patient communication. Insomuch, doctors and midwives who show their professional and medical knowledge, and are culturally sensitive to the mothers' cultural backgrounds, are more likely to be trusted. The attributes to this trust explain that many Chinese mothers expect their maternity-care and health providers including midwives and Plunket nurses to take a more authoritative, professional, medical, and caring role in communication. However, their expectations are in conflict with the prescribed roles and responsibilities of maternity-care and health providers in New Zealand. In the last section which follows, I identify the extent of trust in family and relationships during Chinese mothers' childbirth processes in New Zealand, with a particular interest in changes and challenges to such trust in the mothers' childbirth processes in their adopted land.

### **Trust in Family and Relationship**

Trust in family and community relationships is unshakeable in Chinese society. Valuing a 'we' and in-group oriented culture, China emphasises the important position of family and relationship in society (Chen & Starosta, 1998; Gao & Ting-Toomey, 1998). Relationships also have a significant impact on Chinese women's childbirth processes. In this section, I explore these unshakable trusting relationships between Chinese mothers and their family and community in New Zealand. I examine three perspectives to explain how important the roles of these relationships are in the mothers' childbirth and care, and also their communication with health providers. Following the discussion

about the role of one's partner as an interpreter in the chapter on Language, I first discuss the benefits but mainly the challenges of relying on one's partner in the communication with a maternity care provider. Secondly, I analyse the change of a trusting relationship between the mothers and their extended family members in the childbirth processes in New Zealand. The relationships and tensions of old parents with a young couple in the family, and with the New Zealand maternity-care and health providers are also discussed. Finally, I examine the roles of one's cultural networks in assisting the woman to get through the childbirth processes in New Zealand.

### **Trust in Partner**

The roles of family and friends in China are critical in childbirth support and knowledge, as well as in physician-patient communication (Jiang, 2005; Kartchner & Callister, 2003; Martin & Nakayama, 2008; Mazurkewich, 2004; Wong & Pang, 2000; Xie et al., 2006). However, after Chinese mothers' migration to New Zealand, these roles undergo a change. DeSouza's (2005; 2006a) finding that migrant mothers shift to depend on their partners for childbirth support is also supported in my research.

As discussed in chapter seven, 'Language', some Chinese mothers heavily depended on their partners to avoid language problems in health communication. Considering their partners to be their only family member in New Zealand and believing their English and science knowledge levels were superior contributed to the mothers' trust in their partners to communicate with New Zealand maternity-care and health providers. In this sense, the presence of *the third party* facilitates communication between the mothers and their health care providers, but

it may challenge communication if *the third party* acts in a negative way.

I observed a challenging situation when a husband tried to dominate the conversation with the midwife while his wife kept quiet during an antenatal visit:

Father: How are you?

Midwife: I'm good. I'm really good. And how are you?

Father: Oh okay. Cold.

...

Midwife: Did they break your water last time, \*\* [name of the woman]?

Mother: Yes.

Midwife: And how do you feel about that?

Father: As long as it's done at the right time. I think the other midwife, she wasn't her actual midwife. Her midwife was on leave . . . (talked about his wife's last labour experience)

...

Midwife: What's the best way to contact you, \*\* [name of the woman]?

Father: Oh my cellphone is...

The husband tried to dominate the conversation and enjoyed power as a male figure. In contemporary male-dominated societies, men's knowledge is still privileged and this creates oppression and injustice explicitly or implicitly (Garry & Pearsall, 1996). Women's knowledge is devalued, and hence they find it hard to voice and act in certain ways that accurately reflect their true feelings and experiences (Harding, 1991). This is reflected in the way the husband opened the conversation with the midwife, interrupted the conversation between his wife and the midwife, talked about his feeling about the process of breaking water, and offered his phone number to the midwife. Though the midwife tried



to communicate with the mother by eye contact, calling her name, and asking her questions, she found it hard to encourage the mother to express her opinions.

The mother kept quiet during the visit although I knew her English to be perfect and she had no problems of understanding the midwife's questions.

As a mother who migrated from a developing country and now lives in a developed country, her oppressed situation as a woman in this maternity care environment cannot be separated from her hybrid identities and experiences as a migrant ethnic Chinese mother. Third World women are subordinated because of their different race, class, nationality and more, but they are also subordinated because of gender issues (Sen & Grown, 1987). Studies have indicated that many migrant mothers with non-Western backgrounds are more likely to value and emphasise traditional gender roles as wives and mothers in the Western adopted land (DeSouza, 2006a; Ho, 2006). The Chinese mother in this case also experienced this identity change. She used to be an undergraduate student when she was in Taiwan. After coming to this new land, the mother emphasised her role as a wife and then as a mother in the family. Although she worked as a nursery teacher, she defined her job as being convenient to look after her own kids when she was working in the centre. The identity change and context of this mother help explain why she heavily depended on her husband to make decisions and dominate the conversation with the midwife.

The important roles of family and friends are considered in doctor-patient communication in the Chinese maternity and health environment (Jiang, 2005). Chinese doctors are encouraged to pay attention to *the third party* including a patient's parents, partner, friends, etc., in decision making and communicating with the patient (Jiang, 2005). Being separated from her extended family

members such as parents and parents-in-law in her pregnancy, the mother in this case trusted her husband in communicating with the midwife. However, neither the midwife nor the mother realised that the presence of *the third party* challenged their communication and might affect the mother's treatments in terms of breaking water and other decisions made for the labour. This type of doctor-family communication is often ignored in the Western health care system (Martin & Nakayama, 2008), but it needs much emphasis in investigating the roles of Western management structures and practices in facilitating the childbirth processes for Chinese mothers and their families.

Chinese mothers' trust in partners was an inevitable result of being separated from the extended family members and familiar social networks in China. The partners took a major role in helping women in communicating with New Zealand maternity-care and health providers as their English and medical knowledge were assumed to be superior to those of the women. However, there were inherent challenges in this relationship of trust because of the partner's domination of the communication with maternity care providers and the exploitation of the mother's right to make independent decisions. In what follows, I explore the trusting relationship between Chinese mothers and their extended family members in New Zealand. I also investigate power relations between and among young parents, their extended family members, and local maternity-care and health providers with the involvement of family, friends, and other networks in the childbirth processes.

### **Trust in the Extended Family Members**

Not only are the roles of family and friends considered in Chinese

physician-patient communication, they are also taken into account in Chinese childbirth values, support, and care (Mazurkewich, 2004). In my research, only one woman did not receive support from her extended family members; the rest of the women received postpartum care from their mothers or mothers-in-law who came to New Zealand from China. One mother, in particular, lived with her parents-in-law and grandparents-in-law who helped her during her pregnancy and postpartum. Therefore, my argument goes beyond one of DeSouza's (2005) that migrant women shift to depend on their partners and themselves in the childbirth process as they receive little support from their extended family members. I argue that such a statement fits only in the periods when women are pregnant and in labour, but does not apply to the postpartum period and cannot be generalised for all migrant women. However, I acknowledge that the roles of the extended family members in the mothers' childbirth process are slightly different and their contributions are limited in certain ways.

During a particular antenatal visit, a midwife discussed the birth plan with a couple. One of the questions was about who would be present at the labour to support the mother:

Midwife: Who's going to be with you?

Father: Me and probably her mother.

Mother: No, my mother can't go. She'll be at home. My mother can't help [with] anything.

Father: Oh yes. She can't speak English and she can't drive.

Midwife: Okay. She will be supporting you at home.

The role of family is very important for Chinese women's childbirth and

postpartum (Mazurkewich, 2004) because childbirth is regarded as the process to carry on the family line (Lu, 2006). However, in the transition to motherhood after migration, such a trusting and dependent relationship between a Chinese mother and her family members is weakened because of language barriers and difficulties of the family members in fitting into Western societies. Like most of the women in the study, the woman in this case also asked her mother to come to New Zealand and help with her confinement. But when she and her husband were explaining why her mother would not be in hospital when she was in labour, they described her mother as the one who “can’t go”, “can’t help”, “can’t speak English”, and “can’t drive”. With little support from the health management structures and practices, the families of many migrant women were isolated and marginalised “at home” in supporting the women.

What I found out later in the interview with the same woman after her delivery was that her mother was waiting in the hospital when the woman was having a caesarean section in the theatre. According to this woman:

她[母亲]就很着急呀就在那个走廊来回走啊，紧张的要命，但是那时候是半夜差两分钟就 12 点了所有的人都睡觉了，就只有值班的医生护士在那里，也顾不上她了。后来还是有个护士给她搬了个椅子告诉她在哪里等着我就行了，开始让她到楼上病房里去等我，但是她着急就跑下来了，后来麻醉师做完了就[从手术室]出去，她就猜是我妈妈就告诉她没什么问题，她[母亲]说看到麻醉师给她竖个大拇指头，她就知道没什么问题她就比较放心了。

She [her mother] was very worried and was wandering in the corridor.

She was extremely nervous. But at that time it was two minutes to

midnight. Everybody went to sleep apart from doctors and nurses who were on duty there, so they didn't pay any attention to her. Later there was a nurse who brought a chair and told her where to wait for me. At first she was directed to wait for me at the ward upstairs, but she was worried so she ran down. After a while, the anaesthetist who had finished his duty [at the theatre] walked out. She guessed that was my mum, so she told her there were no problems. She [her mother] said that she knew there were no problems and was relieved when she saw the anaesthetist giving a thumbs up sign.

Traditionally, women from the extended family, usually mothers or mothers-in-law, attend the birth and take the main responsibility to support and care for mother and child in and after labour (Chu, 1996; Kartchner & Callister, 2003). This active role of the extended family has shifted to become more passive, in particular, during the labour process in a Western health setting. For example, this woman's mother could do nothing but just wait outside the hospital. She was "very worried", "wandering in the corridor", "extremely nervous", "ran down" from upstairs, and was finally "relieved" after knowing her daughter was fine.

From one perspective, it is immediately clear how powerless she was as an extended family member who could not speak English, had difficulties in communicating with any New Zealand health providers, and was unfamiliar with the New Zealand health systems and practices. From the other perspective, we can see that health management structures and practices in New Zealand have given little emphasis to facilitating the childbirth processes for migrant women's

families. At first, no doctors or nurses paid attention to the woman's mother because it was midnight. Nothing happened until a nurse noticed her and brought her a chair and asked her to wait at the ward upstairs. It ended up with an anaesthetist noticing her presence and explaining to her that everything was fine with a thumbs up sign. Unlike the Chinese health systems which encourage physicians to care about the feelings and feedback from *the third party* of patients (Chan & Xiong, 2008; Jiang, 2005; Xie et al., 2006), the New Zealand health care systems do not make a particular acknowledgment of this type of communication. As Martin and Nakayama (2008) claim physician-family communication is often ignored in Western health care. It is important to recognise the role of *the third party* in facilitating the communication between women and their maternity-care and health providers, and its contribution to patient satisfaction in the Western maternity and health environment.

After labour, the role of the extended family members becomes more important in helping the woman get through *zuo yue zi*, "doing the month" (Hao & Moore, 2003, p. 47) or "sitting the month" (Chu, 1996, p. 191). My findings show that most Chinese women had their mothers or mothers-in-law living with them temporarily for the first month or more after delivery. Their mothers or mothers-in-law took the responsibilities of cooking special food for the women, helped them with housework, and looked after babies while the women could take some rest after labour. However, the degree to which the women followed *zuo yue zi* varied due to the influence of the New Zealand values around childbirth, their different educational and working backgrounds, and locations in China they had migrated from. As a result, there were struggles and conflicts between some Chinese women (and their partners) and the extended family members, and

between maternity-care and health providers and the extended family members.

Two examples below are drawn from a mother's interview and an observation with another mother and her midwife after they gave birth to their babies:

生完之后产婆叫我去冲凉，我婆婆说啊不要冲不要冲，你知道中国人这方面都不一样的，我表面上是答应了她但肯定是不舒服啦，出了一身的汗我还是去冲了个凉，坐月子我觉得只要不是着凉了就没关系。

After delivery, my midwife asked me to take a shower. My mother-in-law said, "don't take a shower, don't take a shower." You know Chinese are different in such matters. I seemed to promise her but of course I didn't feel comfortable with it. I still went to take a shower after sweating all over the body. Regarding *zuo yue zi*, I think it doesn't matter if you don't get cold.

Midwife: So yesterday when \*\* [assistant of the midwife] went with your mum for a walk. \*\* [name of the assistant] told you? [They] got down the road and she [baby] started crying, and she [grandma]'s like, "Got to go back! Got to go back!"

Mother: Yeah, my mum said, what's so funny, they haven't seen each other [didn't look at each other]. \*\* [name of the assistant] came back and said, "Is your Chinese baby allowed to cry?" I said, "yup". "Oh your mum was running back." I said, "Maybe it's the first time [the] baby goes outside. My mum may be worried. My mum said the cars are always passing her. She feels scared." I can't understand my mum and \*\* [name of the assistant] said, "I'm sorry." I said, "no, no, no, not your

fault.” Sometimes [the] baby is crying and she [grandma] is scared.

Childbirth in China is aligned with certain cultural patterns, beliefs, and practices. In the first postpartum month after delivery, Chinese women have to comply with many confinement taboos such as not being allowed to go outside (Chu, 1996; Hao & Moore, 2003; Kartchner & Callister, 2003). The extended family members such as mothers or mothers-in-law then take over the main responsibilities of looking after women and their babies (Chu, 1996).

In both of the examples above, the women’s mother and mother-in-law had strong Chinese understandings of childbirth and expected the women to strictly carry out the rules of *zuo yue zi*, even though they were living in New Zealand. The first woman’s mother-in-law did not allow the woman to take a shower after delivery because she worried her daughter-in-law might catch a cold. The second woman had to stay indoors in the first month after delivery, so the responsibility of taking the infant out for a walk rested upon the woman’s mother. The walk ended up with her running back to protect the infant from crying.

Different cultural beliefs and practices around childbirth between the extended family members and New Zealand maternity-care and health providers caused conflicts and communication breakdown. As the first quotation shows the mother-in-law quickly responded, “don’t take a shower, don’t take a shower” after hearing the midwife said it was okay to take one. As indicated in the second quotation, the woman’s mother ran back with the crying baby, without communicating with the maternity care provider, which caused confusion and the assumption of the maternity care provider, “Is your Chinese baby allowed to cry?” A language barrier was surely one of the major issues in this situation, but cultural



shock on the part of the woman's mother in a new environment, and different perceptions around safety issues of the infant were the other reasons causing conflicts. The consequences were that the maternity care provider said, "I'm sorry" to the woman, and her mother felt "scared" and "worried" about what had happened.

Trust is enhanced between the women and their extended family members in China as family is the main source for childbirth support and information. However, such a trusting relationship gets weakened in the context of the New Zealand health care systems and discourses. In the first quotation, the Chinese woman pretended to promise to her mother-in-law that she would not take a shower, but she still went for a shower later because she believed that "it doesn't matter if you don't get cold". In the eyes of the second woman, as she explained to her midwife, her mum's behaviour and worries seemed to be "funny", and "I can't understand my mum". Conflicts and struggles not only occurred between the family members and the New Zealand health providers, but also occurred between the women and their family members. In the New Zealand context and under the influence of New Zealand's childbirth and health values, the extended family members seemed to have less power in communicating with Chinese women and health professionals. Further findings uncover that the first woman had a nursing background in China, and the second woman had a good educational background, was from an urban city of China, and had migrated to New Zealand a long time ago. These factors influenced their traditional beliefs and practices around childbirth, confinement, and mothering. This finding is similar to what has been found by Kartchner and Callister (2003) in terms of Chinese women carrying out the confinement rules differently because of where

they are from and what educational backgrounds they have.

Most maternity-care and health providers in this research did not pay much attention to their communication and relationships with the extended family members of Chinese women, except one midwife who was culturally sensitive to the role of family and relationship and was proactive to the potential challenges that might affect her client in raising babies and making decisions. During her visit to the woman at home after labour, she asked the woman and her partner how her mother would help them in getting through the postpartum period. After hearing that they worried her mother would tell them what to do all the time in raising babies and other issues, the midwife suggested:

I can actually sit here with you guys and babies and your mum and dad and you can translate for me. And sometimes when I have you translate for me they kind of like get to understand a bit more about how things are for you here. Okay?

This midwife surely took ethical responsibility in communicating with the woman and her family. The most effective health care providers acknowledge ethical standards of different cultures during health communication (Guttman & Thompson, 2001). This effective midwife took Chinese ethical standards of the involvement of *the third party* into account. To overcome the potential intercultural communication challenges between herself and the client's extended family members, and to avoid family struggles between older family members and the younger parents, the midwife recommended that the young parents translate what she would say when their mum and dad were around. By doing so, language barriers would be resolved. Their mum and dad would have

a chance to recognise the values and practices of the New Zealand maternity and health care services. More importantly, the extended family members would be respected and involved in discussions rather than be excluded from the communication between the midwife and the young parents. Indeed, acknowledging the role of family and friends in physician-patient communication is difficult but important (Jiang, 2005). Maternity-care and health providers need to be aware of different cultural values and practices, so they can deliver better health care services to the clients and their families in a culturally sensitive manner (Brislin, 1993; Kline, 2007; Ulrey & Amason, 2001).

To conclude, the assumed trusting relationship between Chinese mothers (and partners) and their extended family members became vulnerable during the childbirth processes in New Zealand. It was partly because the extended family members were unable to speak English and unfamiliar with the New Zealand maternity and health care services. It was also because the New Zealand maternity and health structures and practices paid perfunctory attention to physician-patient's family relationship. Besides relying on partners and/or extended family members to get through and cope with the childbirth processes, many Chinese mothers trusted their cultural networks in New Zealand to retrieve childbirth knowledge and information. Next, I move on to explore what kind of cultural networks the mothers depend on, how much the mothers rely on their cultural networks, and how their cultural networks influence the mothers' understandings of childbirth and communication with maternity-care and health providers.

### **Trust in Cultural Networks**

Language barriers of migrant women can cause the problem of access (DeSouza, 2006a). DeSouza also finds that Chinese mothers rely on their cultural networks to introduce a LMC. My study corroborated this in that most mothers depended on their experienced and trusted Chinese friends, who lived in New Zealand, to access midwives. Not only was it because the information about midwives and how to access them was not available in their language (DeSouza, 2006a), it was also because the mothers were away from their family and friends who were usually their childbirth information sources (Mazurkewich, 2004), particularly in pregnancy. One mother said:

我朋友帮我安排了第一次和产婆见面。是同一个朋友把她上次生产的产婆介绍给我的，她说那个产婆非常有经验而且头一次生产的时候挺帮她的。

My friend helped me book the first appointment with this midwife. The same friend introduced me to the midwife she had for her last labour. She said that midwife was very experienced, and helped her much with the first delivery.

Migrant mothers usually experience three big changes: from traditional societies to modern societies, from social responsibility to individual responsibility, and from medical childbirth to natural childbirth (DeSouza, 2005; 2006a; 2006b). This Chinese mother experienced these three big changes, especially because she was a new migrant in New Zealand, her English was not good, she was unfamiliar with the New Zealand maternity and health procedures,

and also she was separated from her own parents who were supposed to be her childbirth information sources in pregnancy. So, the mother tended to rely on her Chinese friend in New Zealand to introduce a midwife and book the first appointment for her. She also trusted her friend regarding the midwife's experience and practice.

For this Chinese mother, language barriers caused the problem of access. The information about midwives and how to access them was not available in the Chinese language. Thus, an experienced and trusted Chinese friend of hers became the main support for her in the early stage of pregnancy. However, it is believed that for experienced mothers, it is easy to get knowledge and support from cultural networks. But for the first-time mothers, it is difficult to find such support. The role of maternity-care and health providers then becomes very important in mother-maternity care provider communication to address the mothers' stress and uncertainty about the new health environment.

In this research, the mothers were also found to rely on their Chinese friends to shape knowledge about the New Zealand maternity and health systems and procedures:

我在这里的华人朋友都建议我吃 Elevit。我就问一个朋友，她也是怀孕在同时吃铁片和 Elevit，我问她每天应该吃多少铁片。我的第一感觉是去问产婆因为她比较专业，但是她不在所以我就只能问我的朋友。文化上不同，我不可能问我妈的吧。

My Chinese friends here all suggested me take Elevit (vitamins & minerals). I asked a friend who was also pregnant and was taking iron tablets as well as Elevit at the same time, how many iron tablets I should

take every day. My first instinct was to ask my midwife as they were professional, but she was not available. So I had to ask my friend. Culture is different. I couldn't ask my Mum.

In New Zealand, mothers are encouraged to take more personal responsibilities in childbirth, but Chinese mothers tend to seek support, and maternity and health information from more experienced family members and trusted people such as mothers and mothers-in-law (Kartchner & Callister, 2003; Mazurkewich, 2004; Wong & Pang, 2000). Because this mother was separated from her family members in her pregnancy and also due to differences in culture, she thought it was useless to ask her Mum about having Elevit and iron tablets. Her first instinct was to ask her midwife, but when she could not get that information from the midwife, she shifted to relying on her experienced and trusted Chinese friends in New Zealand to get the information which she needed. Being involved in Chinese cultural networks in New Zealand, Chinese mothers were able to communicate in their own language, and share similar cultural values around childbirth and other issues. More importantly, the mothers had the opportunities to learn new information and cultural patterns, and to renegotiate and reconstruct their knowledge about childbirth and communication.

Chinese online communities in New Zealand have become a different platform for some mothers to share ideas and perspectives. Three mothers in this research mentioned their use of Chinese online communities in the childbirth processes:

我觉的网络有用因为上面都是不同的妈妈的 ideas 讨论, 就会看大家是怎么样做。 像这边说可以放 cabbage[叶子], 网上也有说可以放

cabbage 叶子，每两个小时放一次。

I think the Internet is useful because different mothers share ideas on it, so I get to see how everyone does. For example, here they say it's okay to put on cabbage [leaves], there are some comments about having cabbage leaves on the Internet. Put on cabbage leaves for every two hours.

我老公经常上网他在网上看一些妈妈的讨论，看到好像华人的就有这个[Plunbet]nurse 来。[他]就只是在网上看别人聊华人妈妈的一个聚会，就是这个 nurse，[她们]怎么怎么讨论她。

My husband always gets on the Internet, and he took a look at some mothers' discussions on the Internet. It seems like this [Plunket] nurse looks after ethnic Chinese. [He] just took a look at others' discussions about a Chinese mothers' gathering on the Internet. It was this nurse, and [they] talked about her.

Mother: I see her [a friend of the mother, who was also a client of the midwife] on the Internet. She put our pictures on Internet.

Midwife: did she?

Mother: and the baby. Your picture. You are standing there and another nursing [nurse] or somebody there.

Midwife: my picture. Cool. How can't I get to see that.

Mother: Hehe...very nice.

Midwife: It's so weird that I got my name on the Internet and I don't ever

see. I don't know how to access it. That's tragic really.

Online Chinese communities in New Zealand became another source of information and support for some Chinese mothers in their childbirth processes. DeSouza (2006a) has identified the important role of migrant women's cultural networks in offering childbirth support and information such as getting access to a LMC, but she does not recognise the important role of the Internet as a communication platform for migrant mothers in the same cultural networks to share their childbirth understandings. For example, one Chinese mother in the first quotation described her online Chinese community as a stage that "different mothers share ideas on" and the mothers "get to see how everyone does". Mothers' understandings of childbirth in New Zealand could be influenced by their interactions with other ethnic Chinese mothers. Their different cultural understandings and approaches to childbirth would facilitate or challenge their communication with maternity-care and health providers.

Chinese online communities were also used as a venue open to all ethnic Chinese mothers in New Zealand to introduce, discuss or even criticise their maternity-care and health providers. According to the mother in the second quotation, her husband "took a look at some mothers' discussions on the Internet", and passed her information about a Plunket nurse who seemed to look after ethnic Chinese. The mother also tactfully added, "It was this nurse, and [they] talked about her." The information about maternity-care and health providers, and local maternity and health care agencies, was deficient for migrant women and their families. As discussed in chapter nine, 'Choice', it was partly because information was controlled by some maternity-care and health providers,



or partly because barriers to information occurred in miscommunication or communication breakdowns between maternity-care and health providers and non-Western migrant mothers and their families. In this way, the mother's own ethnic Chinese group became a valuable source of information to access knowledge about particular maternity-care and health providers, agencies, and health practices. However, the factuality of information in online communities was not validated, creating challenges in communication between the mothers and maternity-care and health providers. For instance, a mother might form a stereotype of a particular maternity care provider based on what she learnt from the judgements of other experienced mothers. As the midwife in the last quotation joked about her picture and name being posted in a Chinese online community, "It's so weird that I got my name on the Internet and I don't ever see. I don't know how to access it. That's tragic really." For some maternity-care and health providers, the emergence of online communities for migrant ethnic Chinese mothers can be a 'tragedy' because rumours spread quickly online and may even destroy their reputation as health providers. But significantly, Chinese mothers are able to make sense of New Zealand's values and practices around childbirth and reconcile them with their own ethnic Chinese group to facilitate communication with maternity-care and health providers.

I conclude this section by reviewing the three perspectives of the roles of family and relationship that I have discussed. The first perspective is about the trust and dependence on the women's partners in receiving childbirth support and information, but I find that one's partner exerts his power as a man and husband in appropriating his wife's voice in communication with her midwife. The second perspective is about the changes of roles and responsibilities of the

extended family members such as mothers or mothers-in-law in the New Zealand maternity and health care environment. In this new land, the women's extended family members become powerless in communication with maternity-care and health providers. Power struggles also occur between younger and older generations in ethnic Chinese families. And the last perspective is around the important role of women's cultural networks in getting access to maternity-care and health providers and receiving childbirth information. Chinese online communities in New Zealand are also found to be useful for ethnic Chinese mothers to self-identify and represent themselves, share different ideas, and influence each other's perspectives. So far, I have explored Chinese mothers' trust towards maternity-care and health providers as well as family and relationship. In the last section, I re-interpret the concept of trust with a thorough discussion about the attributes of trust, different expectations, and power and influence involved in the trusting relationships.

### **Revisiting Trust**

Trust involves accepting and believing in others' competence, integrity, and surety. It leads to a reliance on the communicative behaviours of others (Berry, 2007). In the childbirth processes of Chinese mothers, trust is particularly important as the mothers are more vulnerable in accessing childbirth knowledge and support in the new land. In the discussion below, I attempt to revisit the notions of trust in relation to identity, values, knowledge, power, and ethics. I emphasise the relationships between Chinese mothers and maternity-care and health providers, the mothers and *the third party*, and also between maternity-care and health providers and *the third party*.

Unlike Hargie and Dickson's (2004) argument that trust is not automatically created as a result of health professionals' status, my research findings indicate that trust can be formed automatically due to the status of health professionals and can be built in the initial health contact. With a constructed sacred image of 'doctor', many Chinese mothers in my study automatically trusted obstetricians, GPs, and other doctors. The mothers believed that doctors had competent medical knowledge, skills, and power to handle the childbirth processes and ensure the safety of both mothers and their babies. Independent midwives, however, were judged as less competent and less professional than doctors. The matrix directs me to reinterpret trust in maternity care providers in relation to Chinese mothers' historical, social, and cultural contexts.

Historically, doctors such as obstetricians have always been regarded as better trained and safer health professionals, whereas midwives have been portrayed as second-class health providers in Chinese society (Cheung, 2009). Although the titles of midwives shifted from *chan po* or *jie sheng po* to later *zhu chan shi*, and their responsibilities moved from conducting community-based maternity practices to offering hospital-based maternity care, the status and power of midwives have not improved. Chinese midwifery has been gradually moving into its demise. A major political, economic, and social change in the 1980s accelerated the demise of Chinese midwifery, as total hospitalisation, and medicalised and obstetrician-led childbirth were promoted nationwide (Cheung, 2009; Gu et al., 2011; Harris et al., 2007). As a result of the Chinese historical, social, and political impacts, the title "midwife" is vanishing from many Chinese mothers' memories. Unlike New Zealand, which has empowered midwives as being independent in taking the main responsibility for mothers (Kedgley, 1996),

China has no independent midwives but a few hospital-based midwives who manage normal deliveries and assist obstetricians with complex labours (Harris et al., 2007). When mothers migrate to New Zealand, many of them are not familiar with the roles and responsibilities of independent midwives. Trust in midwives is, therefore, hindered by Chinese values and knowledge of the position of midwife.

According to my research findings, some mothers' trust in doctors was automatically formed prior to the health contact or quickly established in the initial health contact. One of the mothers expressed her trust in a male surgeon before being taken into the theatre of the hospital for a caesarean section. Her example not only reflects her values of childbirth as being dangerous and perceptions of doctors as being professional, it also signifies gendered roles, expectations, and inequality regarding the identity and image of a doctor. This gender-stratified society raises gendered social practices and relations that construct women's knowledge, experience, and identities (Harding, 1991; Kirsch, 1999). The structures of knowledge production in the health industry are gendered too. The identity of a doctor is always associated with male characteristics which relate to mind, whereas a woman's characteristics often relate to body (MacCallum, 2002). The dualism of mind and body defines an unequal relationship between men and women. For example, in China, the power of a doctor used to be compared to the power of the Buddha in curing every disease (Jiang & Zhao, 2002). The Buddha is male, so it is understandable that the image of a doctor closely relates to male characteristics. Evidently, Chinese mothers are more likely to trust doctors because doctors are masculine, their services which involve frequent medical interventions are masculine as well, and

they are believed to be more professional and authoritative.

Sometimes trust is created at first sight, but at other times trust needs to be built and enhanced over time by supportive communicative behaviours (Berry, 2007). Chinese people do not easily trust people who are identified as outsiders such as strangers (Gao & Ting-Toomey, 1998). The Chinese communication character, “*zi ji ren* (自己人) or a focus on insiders” (Gao & Ting-Toomey, p. 37), explains that trust is built among insiders such as family, relatives, friends, and others with a special relationship. Maternity-care and health providers in New Zealand were more likely to be seen as outsiders who held different cultural values towards health care practices. Chinese mothers then tended to be less likely to participate in interactions with those outsiders. My research findings show that ethnic Chinese maternity-care and health providers found it easier to gain trust from their Chinese clients. Speaking the same language, sharing the same ethnic identity, and understanding similar cultural values contributed to such trust. But more importantly, trust was enhanced by Chinese maternity-care and health providers’ use of supportive and ethical communicative behaviours. With the same medical competence as their Western colleagues, ethnic Chinese maternity-care and health providers were more sensitive to Chinese clients’ culture, were more active in providing and retrieving information, and more caring about the needs and expectations of Chinese clients.

It needs to be pointed out at this stage that there are some inherent contradictions in a tall white male surgeon winning trust from Chinese mothers and an ethnic Chinese GP gaining the same trust from his/her Chinese clients. Hybrid identities and cultures of Chinese mothers and health care providers can be used to explain these situations. In social constructionism, identity is seen as

being constantly shaped, negotiated, and changed in interactions within different social and cultural groups (Beech & McInns, 2005; Meisenback, 2008). The traditional Chinese identities of the mothers were renegotiated through their social interactions with New Zealand health care providers and other Western people. Under the influence of both New Zealand and Chinese knowledge regarding health, childbirth and communication, the mothers are trapped in the in-between space where they expect medical interventions and a cooperative doctor-patient relationship but also feel at ease in support and care they receive from culturally sensitive health providers. This in-between space creates hybrid identities and cultures (Bhabha, 1990) that embrace different and new possibilities (Frenkel & Shenhav, 2006). The image of a tall white male surgeon not only expresses Chinese mothers' respect for a doctor's masculine and status authority but also reflects the mothers' expectation of Western advanced health services. A trusting relationship between ethnic Chinese health providers and their Chinese clients is not only in result of the ease of language and a similar ethnic identity and culture but also the health providers' support to the mothers and their sensitivity to the mothers' needs. In this sense, ethnic Chinese health providers are also trapped in the in-between space of identifying themselves as Western-trained health providers but also feeling a special connection to migrant ethnic Chinese clients.

Some Western maternity-care and health providers also successfully established and maintained trusting relationships with Chinese mothers by the use of similar supportive and ethical communicative behaviours. They actively offered information to the mothers, provided them with extra care, and treated the mothers as friends or family members. In the Chinese context, trust can be established between patients with those doctors who offer patients information,

respect, care, and treat patients as insiders (Chan & Xiong, 2008; Jiang, 2005; Jiang & Zhao, 2002). To the mothers, these Western maternity-care and health providers took the first step towards treating them as insiders by being sensitive to their Chinese cultural backgrounds, showing them care, but also adopting a cooperative communication prototype of sometimes dominating decisions in treatments. In return, the mothers trusted their maternity-care and health providers as insiders as well and committed to sustain their harmonious doctor-patient relationships.

However, the findings unveil the clash of Chinese mothers' expectations of maternity-care and health providers in relation to gendered roles and health communication. As previously discussed, Chinese mothers are more likely to trust doctors because doctors and their services are masculine. The identity of doctors as being professional and authoritative also attributes to the mothers' trust. Meanwhile, some midwives and other health providers are treated as the *insiders* of the mothers because of their feminine features, relationship-based services, and the roles of 'mothers and friends' they choose to take. The mothers submit with ease to a doctor's authority, and seek similar authority from the midwives and Plunket nurses as well, yet at the same time they expect their cultural needs to be cared and supported. Paradoxes exist in the mothers' different relationships of trust with doctors, midwives, Plunket nurses, and other health care providers.

Another issue needs to be discussed here which is that distrust and dissatisfaction sometimes are caused by a lack of access to adequate information. Some mothers' narratives of their expectations towards the Plunket nurses reflect a lack of information about the Plunket Society, and the role and responsibilities of the Plunket nurses for migrant mothers before the mothers go and contact

Plunket. Liem (1999) points out that migrant women often suffer from a “vacuum of knowledge”. Because migrant women such as Chinese mothers heavily rely on their families and relationships for childbirth and postpartum knowledge and support in their home countries (Mazurkewich, 2004), the women may find it hard to access social and institutional knowledge including health practices and beliefs after migration to Western societies (DeSouza, 2006b). The access of knowledge as well as the expression and management of knowledge are seen as an exercise of power (van Dijk, 1985). The New Zealand maternity and health care discourses produced certain knowledge of New Zealand health beliefs, and maternity procedures and practices. The Plunket Society and other local maternity and health agencies/communities were empowered to manage such knowledge to fit in with the existing discourses. Maternity-care and health providers and mainstream groups in New Zealand society had preferential access to such knowledge (e.g., the information about the Plunket Society and nurses), whereas migrant women and their families were marginalised in the processes of knowledge production and management.

Treating some maternity-care and health providers as insiders, Chinese mothers contributed to building and maintaining trusting relationships. Such trust was supposed to be applicable to the mothers’ communication and relationships with their real insiders – partners, family, and friends. Chinese Confucianism defines the important position of family in Chinese society (Gao, 1996; Gao & Ting-Toomey, 1998; Zhu & Herbert, 2002). Specifically, in Chinese women’s childbirth processes, family plays a significant role (Mazurkewich, 2004). This can be traced back to ancient China when birth was regarded as a domestic affair so only female family members, neighbours, and



midwives were allowed to be present (Harris et al., 2009). However, the findings reveal that although most Chinese women still received postpartum support from their extended family members, either their mothers or mothers-in-law, the women's trusting relationships with their extended family members became vulnerable. Distrust, confusion, and conflicts sometimes occurred between Chinese women and their extended family members and also between the family members and New Zealand maternity-care and health providers due to different understandings of and reactions to postpartum care, confinement taboos, and other maternity practices.

Indeed, lack of English fluency and lack of knowledge of the New Zealand maternity and health care procedures were two obvious weaknesses of the extended family members in supporting women in New Zealand. Seen through the theoretical lenses of postcolonialism, Western hegemonic knowledge structures of communication can be resisted by bringing in subjugated knowledge sources of communication such as the communication with *the third party* into the mainstream. Communication with *the third party* of patients is often ignored in Western health care (Martin & Nakayama, 2008) because it is in conflict with the Western discourses of consumer culture and partnership communication. The individual consumer and product/service provider are identified as the two critical contributors to the market. The Western partnership-based communication model in health communication also merely defines the partnership identities of patients and health care providers without acknowledging the involvement of patients' family and other special people. This is why there was a lack of communication between New Zealand maternity-care and health providers and the mothers' extended family members, and a lack of support for *the third party*

provided by the New Zealand maternity and health management structures and practices.

The women's trust in partners was not as much affected as trust in the extended family members. Particularly during women's pregnancy and labour stages, the partners took an important role in supporting the women in communicating with the maternity-care and health providers. However, the challenge of addressing power and gender inequality between the women and their partners remains. Another emerging trend shown in my research findings is that Chinese women tended to trust more in their cultural networks in New Zealand. These networks include their experienced and trusted Chinese friends helping the women access maternity-care and health providers and knowledge of maternity practices. They also include virtual friends sharing information and feedback in Chinese online communities. The women's cultural networks provided them with new communication platforms to (re)negotiate and (re)construct their identities and knowledge in these same cultural groups. Chinese women then had opportunities to express their identities and subjective experiences, which is supported by the matrix in reflecting alternative ways of thinking and doing from the subaltern women themselves.

### **Conclusion**

Rereading this chapter, which focuses on trust, I delved into identities and cultures in discursive practices of intercultural communication contexts between maternity-care and health providers, mothers, their families, and cultural networks. I was sensitive to the influence of power and knowledge production in the relationships and communication processes. The inherent contradictions exist in

mothers' relationships of trust with different groups. The doctor is trusted due to his professional identity and medical interventions as part of his services; the midwife is trusted because of her relationship-based support; the ethnic Chinese health provider is trusted because of cultural sensitivity and shared ethnic identities; and the family/friend/cultural network is trusted as a result of prior relationship and reinforcement of cultural identities. The experiences and expectations of Chinese mothers and health care providers are in light of hybrid identities and cultures that emerge from the dialectical tensions between East and West. Yet the notion of hybridity does not deny the unequal power relations between the two cultures (Frenkel & Shenhav, 2006). Power struggles not only occur in communication between mothers and their maternity-care and health providers, they also occur in the mothers' interactions with their family members, and between maternity-care and health providers and *the third party*. Overall, using Berry's (2007) words to end this chapter, trust is important in health communication for desired effects, but one needs to remember that trust sometimes needs a long time to build but it may be lost in a second.

## CHAPTER 11: CONCLUSION

This last chapter draws on the main conclusions from the previous chapters. The research explores Chinese mothers' intercultural communication experiences with their maternity-care and health providers from four perspectives – language, values, choice, and trust. Here, I conclude with the major findings and their significance. More importantly, I identify and discuss the contradictions and dialectical tensions that emerge from the findings with reference to implications for theory, practice, reflexivity, and future research. I finish the chapter with some of my closing thoughts on the thesis.

The core commitment of this research is to value Chinese mothers' subjective knowledge and experiences in relation to childbirth, culture, and communication, and at the same time to rethink and reorient the New Zealand mainstream structures of knowledge production in maternity care to be more inclusive. A matrix of difference, grounded in social constructionism, postcolonialism, and Third World feminism, is developed to provide a theoretical platform for exploring the notions of language, values, agency, and identity. This theoretical anchor helps analyse the discourses of language, values, choice, and trust in the communication between the Chinese mothers and their maternity care providers. Interviews, observations, and a reflexive researcher's journal are used to record and critically analyse participants' stories, experiences, and contexts. Now I draw attention to the key findings and their significance through the lens of the matrix.

### Language

The rise in the population of migrant ethnic Chinese mothers in New

Zealand has had an impact on the services of New Zealand maternity and health care providers to these mothers. Language differences have an obvious impact on interactions between English-speaking maternity-care and health providers and non-English-speaking Chinese mothers. Although different languages which construct different and subjective realities of cultural groups must be appreciated, my research found that the use of English creates the power to control and marginalise other languages. A group of people speaking a language other than English is easily visible and is marked out as an ‘other’. In New Zealand, understanding and speaking English is seen as the norm of “our culture” or “Kiwi culture”. Having difficulties in understanding and speaking English is, therefore, perceived as one of the biggest challenges in intercultural communication. Certainly, language barriers can cause misunderstanding, communication breakdowns, and even conflicts in relationships within maternity-care and intercultural communication contexts, yet language barriers often disguise other communication barriers such as different cultural understandings, gendered expectations, control of information, lack of trust, stereotyping and prejudices, or system barriers. This masking of other challenges with the use of language barriers is done by both health professionals and other participants.

Power tensions are not only exposed in the process of experiencing language barriers, they are also unveiled in the process of coping with language barriers. Many Chinese mothers self-empowered themselves through checking dictionaries, preparing questions, etc. to establish self-confidence in intercultural communication with New Zealand maternity care and health providers.

Likewise, some midwives and health providers attempted to empower the mothers by applying simplified verbal and nonverbal language techniques in communication and making the rigid health communication environment more

flexible and comfortable. It is also interesting to see that although the use of interpreters for overcoming language problems was highly valued by the mothers and their maternity care providers, they had different reactions. The mothers tended to depend on their partners or family members living in New Zealand to be their interpreters due to their prior trust and gendered expectations. However, some maternity care and health providers were concerned that the presence of the mothers' partners in health communication might place the mothers in a more passive and disempowered position. Accordingly, they attempted to empower the mothers by discouraging partners to be interpreters, favouring on-site bilingual health care providers instead. In this sense, I argue that language is not merely a system of sounds and written symbols to express meanings, but rather it is used by different social and cultural groups to construct their subjective identities and experiences, and is also used as a way of empowerment or disempowerment to define different power relationships in communication.

### **Values**

The processes of othering are also exposed in discursive practices of cultural and institutional values associated with childbirth and communication. Othering is used to differentiate *us* from *them*, and by identifying who we are not, we start to understand who we are (Kitzinger & Wilkinson, 1996). Different constructions of values of childbirth and communication are used by maternity-care and health providers and Chinese mothers to identify who they are and who they are not. The discourse of natural childbirth is valued in the New Zealand maternity and health care systems, so local maternity and health care providers are educated and socialised to espouse this value. They employ natural standards to educate Chinese women and regulate their behaviours such as saying

everything is normal or encouraging longer durations of breastfeeding. Such essentialising of women's childbirth experiences leaves very little room for a diverse understanding of different contexts of different women. In essence, assimilating Chinese women into the New Zealand discourse of natural childbirth overlooks different values and interpretations of childbirth.

On the other hand, Chinese mothers who are socialised into the discourse of medicalised and safe childbirth, believe that every aspect of childbirth has a potential for complications, and hence needs medical care and consistent support. In their interactions with the New Zealand maternity and health care services, these mothers realise that their values of childbirth are in conflict with the values of childbirth in New Zealand. Some of them suffer from an experience of being 'othered' because their different knowledge of childbirth is suppressed as unnatural and deviant. As a result, the mothers either force themselves to comply with dominant rules and expectations, or silently work against the discourses they do not believe in. The fact is that many maternity-care and health providers recognise that the Chinese values of childbirth are different to theirs, but only a few of them are willing to accept and work with these differences.

Two critical events of breastfeeding lead to a further debate about the processes of othering. The story of a midwife who lent a Western breastfeeding book to a mother can be understood as a way of supporting the mother's breastfeeding with extra information. The story of the midwife who brokered communication between the mother and the system in fulfilling the mother's wishes of feeding her baby can also be interpreted as a way of protection. However at the same time, both events expose the processes of 'othering' in the light of my matrix of difference. In interrogating the 'normality' of

breastfeeding within the New Zealand maternity-care and health context, I argue that mothers should have more opportunities to voice their values and circumstances of feeding their babies.

Meanwhile, some Chinese mothers suffer from being ‘othered’ due to their different health communication styles and expectations. A cooperative communication style is valued in Chinese physician-patient communication. It is derived from Chinese Confucianism, sociocultural backgrounds, and Chinese traditional communication expectations. Mothers then are expected to achieve an interdependent self in a way that respects doctors’ superior positions and that prioritises a harmonious health relationship. Yet, the Western dominant discourse marginalises other knowledges of communication. Although the partnership communication model is supposed to support and empower all women in their communication with maternity-care and health providers, in practice, this taken-for-granted knowledge of health communication ignores different values of communication in different cultural groups. Holding an alternative value of health communication, many Chinese mothers react adversely to the construction of an entrepreneurial self in interacting with New Zealand maternity-care and health providers.

Paradoxically, many Chinese mothers expected a cooperative doctor-patient relationship and worked against an entrepreneurial self in health communication, yet they tended to welcome partnership that addressed feminine characteristics. My argument then is that the mothers’ values and expectations of health communication and relationship are not pure and fixed. Rather, they are developed and changed according to the gendered and socio-cultural contexts the mothers are involved in. Chinese mothers value a masculine cooperative health relationship as they are willing to receive doctors’ clear directions and information,



while at the same time, they favour a feminine partnership communication as they desire for respect and care as women.

### **Choice**

The question: “Who has the ability to make a choice and when?” is recurrently asked in this study. The ability to make a choice reflects the management of knowledge, the (re)construction of identities, and the exercise of power. In Western society, choice is seen as a vehicle for liberation. In other words, if you have a choice, you have the ability to manage your own knowledge, frame an entrepreneurial identity, and use your power to speak for yourself. To achieve individual liberation, the New Zealand maternity-care and health systems are committed to the discourse of consumer choice. Such choice demands that maternity and health care providers empower every consumer to make an informed and independent decision, whilst it regulates their desired identities when involved in health communication.

Nevertheless, my research reveals the complexities and contradictions in the discourse of choice. Having the ability to make a choice does not always equate liberation. Some Chinese mothers do not want to be liberated through choice because their cultural identities of being passive and compliant in a doctor-patient relationship conflict with the required consumer identities of being proactive and independent in Western health communication. The mothers confront hybrid identities and cultures that interweave the values and practices of the West and the East. For cultural reasons, some mothers have different expressions of liberation, which is ignored and regarded as being oppressive in the eyes of many Western people.

The discourse of choice is also analysed as a medium of power and

influence. Some mothers are constrained to make an authentic choice because their hybrid identities and knowledge drawn from cultural and subjective contexts are seen as being subordinate to mainstream identities and knowledge that promote natural childbirth and partnership communication. Some mothers, in particular new migrant or first-time mothers, are unable to activate their choices because they find it hard to access information on the range and nature of options. Maternity-care and health providers have the power to decide how much information to give to the clients and when to give it. The control of information and privileging of certain kinds of knowledge, is, as I demonstrate, a form of health ethnocentrism.

### **Trust**

Furthermore, my research reveals the significance of trusting relationships in facilitating women's childbirth processes. Obstetricians, GPs, and other doctors are more likely to obtain trust prior to or in the initial contacts with Chinese mothers because doctors are historically prioritised over midwives to ensure the safety of childbirth in China. Associated with masculine identity and medical expertise, the doctor is portrayed as more professional and trustworthy. Ethnic Chinese maternity-care and health providers are found to be more likely to gain Chinese mothers' trust not only because of their shared ethnicity, culture, and medical beliefs, but also due to their relationship-based services. Trust in maternity-care and health providers can be enhanced over time with supportive and ethical communicative behaviours from New Zealand maternity-care and health providers. Offering clear directions and information, and supporting with extra care are attributes of such a trusting relationship. Conversely, distrust can be created as a result of a lack of support and care, as well as a lack of access to

information regarding the roles and responsibilities of New Zealand maternity and health care providers.

Dialectical tensions exist in the mothers' trust towards health providers. The Chinese mothers expect the midwives and some other health care providers to take a more authoritative role in communication as that unequal relationship is what they see as normal in doctor-patient communication. The Chinese values of a cooperative health communication shape the identities of the mothers. However at the same time, the mothers feel comfortable with the maintenance of relationship in health communication if feminine identities and needs are particularly addressed in this relationship. After migration to New Zealand, the Chinese mothers have struggled with their hybrid identities as the influence of the West sometimes counters Chinese traditions. The struggles with identities and cultures help explain why the mothers have conflicting expectations towards doctors and midwives. Distrust sometimes occurs between Chinese women and their extended family members, and between the family members and New Zealand maternity-care and health providers. Having language barriers and being unfamiliar with the New Zealand childbirth procedures are the most evident causes for the extended family members to get involved in communication with maternity-care and health providers. But more importantly, the New Zealand maternity and health care practices provide little support to *the third party*, be they extended family members, partners or friends, who are acknowledged as critical in patient's decision making and physician-patient communication in China (Jiang, 2005). The high involvement with *the third party* runs counter to the Western discourses of consumer culture, choice, and partnership communication, and hence avoided. Rather than heavily relying on the extended family members, Chinese mothers shift to depending on their partners to overcome language

barriers and get support in pregnancy, and the mothers choose to trust their cultural networks to reassure themselves of their identities, and (re)negotiate and (re)construct their childbirth values and knowledge.

### **Theoretical Implications**

The thesis makes several major theoretical contributions. Firstly, the research provides a framework for giving voice to a variety of stakeholders in the healthcare sector in general and the maternity-care sector in particular. Secondly, it shows how a narrow conceptualisation of culture can actually embed stereotyped understandings of people from ethnic minority groups. The thesis also unearths the colonising potential of mainstream knowledge in health and maternity-care which leads to a power imbalance in health communication. Indeed, it analyses the interplay between the colonial past and the neocolonial present in contemporary health care practices, and challenges the discourse of consumer choice and freedom that is taken for granted in healthcare.

More explicitly in this research, I have constructed a theoretical framework – a matrix of difference – drawn from social constructionist, postcolonial, and Third World feminist theories – to explore intercultural communication between Chinese mothers and New Zealand maternity-care and health providers. Rather than simply weaving in intercultural communication theories to examine mothers' values, behaviours, and challenges, I use the matrix to stress my ontological sense of the world which is made up of differences, that is, different languages, values, knowledge, identities, as well as different discourses and contexts. The matrix provides me with an epistemological foundation to theorise and discover the core issues of difference, and could be productively used in future research.

Future researchers could not only give voice to marginalised stakeholders and bring in alternative knowledge, contexts, and discourses from these people to challenge established hegemonic structures and discourses, but also delve into hybrid identities, subjective experience, knowledge, context, and power relations which emerged from their research data. The matrix is not merely an approach for assisting researchers to discover differences, but instead, it urges the researchers to relate contemporary communication practices to historical, political, and sociocultural backgrounds, and more significantly, to redo and rewrite the historical structure of knowledge production, in order to show different perspectives and achieve greater balance of power.

Methodological reflexivity has been integral to my work. I acknowledge the impossibility of maintaining pure rationality in conducting qualitative research. Reflexivity offers a d critical perspective for researchers to study their topics and review their own responsibilities in the research processes. Speaking from both the participants' and researchers' perspectives, the researchers are able to position themselves in more equal and collaborative relationships with their participants.

### **Practical Implications**

My thesis opens up several practical solutions for Chinese mothers and other migrant mothers who are not familiar with the New Zealand maternity and health care services. I suggest that these mothers first contact local maternity and health groups or visit their official websites (e.g., the Ministry of Health, the maternity services consumer council, the Ministry of Health's Mum 2 Be Helpline, Parent Centre, La Leche League). For mothers with difficulties in understanding and speaking English, I would refer them to their local migrant centres which provide interpreting services and pamphlets in additional language(s). Rather

than relying too much on their partners or family members living in New Zealand to help with the interpretation, migrant mothers should ideally take their English-speaking family members or friends to visit maternity care providers in the first interaction in order to address language issues. The necessity of calling for a formal interpreter, the costs involved, questions on who pays for the interpretation, and other related issues need to be discussed in the first interaction. Mothers are also encouraged to participate in more social and cultural gatherings such as a Chinese mothers' group organised by the Plunket Society, and join Chinese online communities such as Skykiwi, the most popular Chinese online community in New Zealand. Further, mothers need to be aware of their consumer rights in making an informed choice, accessing information, and controlling their own childbirth processes. Mothers have the power to make changes if they are not satisfied with the current health situation, make a complaint if they are not happy with their experience of any aspect of healthcare, ask questions if they do not understand, and say "no" to any requests from maternity care providers if the requests go against their cultural beliefs.

For maternity- care and health providers who may encounter language barriers in intercultural communication, they are encouraged to keep using a mix of verbal and nonverbal techniques such as Pidgin English, slow speaking tone, synonyms, visual aids, body language, etc., to facilitate mothers' understandings. It is also useful for care providers to make sure that the mothers do not ignore messages or pretend to understand them. If a maternity care provider is concerned about a mother with language difficulties which may affect diagnosis and treatment, he or she must employ a formal interpreter. But in an emergency, asking an on-site bilingual health provider to help with the interpretation is realistic. Meanwhile, decorating the office with warm lights, pictures of babies

and mothers, toys, and flowers is a way to distract the mothers from the nerve-racking experience of language barriers. Visiting mothers, who find offices intimidating, at their homes in the first few contacts can encourage the mothers to speak more in an environment that they are familiar with.

Openness in initial contacts is critical in building a trusting relationship between mothers and their maternity care providers. Rather than getting to the point directly in the first visit, maternity care providers such as midwives and Plunket nurses should ideally spend some time with the mothers to get to know their backgrounds, circumstances, concerns, and cultural expectations. Explaining the childbirth procedures, introducing local maternity and health agencies, and handing over fliers with contact details of health agencies and communities are also necessary in the initial interactions. In the overall communication processes, maternity care providers are encouraged to tap into different sources of knowledge and incorporate cultural and spiritual practices into the mothers' childbirth processes. With the spirit of cultural safety in mind, they are recommended to allow time for the mothers to discuss the options with their support people such as partners, extended family members or trusted friends, and let the mothers have a final say regarding their decisions. Indeed, not only are maternity-care and health providers responsible for providing culturally safe services, local maternity and health care agencies also share the responsibilities to improve their management structures and practices in facilitating childbirth processes for the mothers and their families.

Language issues within maternity-care and health contexts have implications for health management and services. The policies of recruiting interpreters for normal health visits and emergent health events need to be revisited. Maternity-care and health agencies need to upgrade their translation

services in written forms and the training of intercultural communication for their health care providers. My research has also indicated the significant impact of *the third party* of mothers in the childbirth processes; therefore, paying attention to this group when providing services to the mothers is necessary. That includes offering more support services to a mother's partner and extended family members and explaining childbirth services to the mother's support people by involving them in health communication.

For maternity-care and health care management, socialising different ethnic mothers into the same and totalising discourses of childbirth and communication ignores historical, socio-cultural, gendered, and political backgrounds of the mothers. Such essentialism leads to a resistance to mainstream discourses and exacerbates intercultural communication challenges between the mothers and their maternity care providers. The New Zealand College of Midwives (the NZCOM), hospitals, the Plunket Society, and other maternity and health agencies should have annual reviews on their health providers' performances. Educating maternity and medical students with a variety of cultural knowledges of childbirth and communication would encourage the students to think about how they are going to provide ethical care services to meet different needs and expectations of migrant mothers in their future clinical practices. In this sense, culturally safe training within the health systems would help consolidate New Zealand's identity as a growing multicultural society.

### **Reflexive Implications**

Exploring Chinese mothers' childbirth experiences and their communication with maternity-care and health providers is an emotionally charged project. The mothers disclose their birth stories, struggles to make a



choice, difficulties in understanding medical jargon, and their relationships with their maternity-care and health providers and support people. To record the mothers' experiences and my own stories, I have kept a reflexive journal since I started this project. Drawing from the journal, I describe my first birth experience in detail in the first chapter of Reflexive Introduction. I disclose my emotional struggles as being a new migrant mother which became the main motives for carrying out this project. I borrow two particular stories from the journal – one of a mother withdrawing herself from the project due to a miscarriage and the other of a couple struggling with language barriers in their interactions with maternity care providers – and incorporate them into the research process. More importantly, I recall the changes in my own identities, emotions, and relationships with participants after the end of the research.

When I was talking to some of the mothers after the end of the project, I found that they realised their consumer rights in making an informed choice, accessing information, and controlling their own childbirth processes, which many of them were unaware of during the research. I was happy to hear that the mothers and some maternity-care and health providers would like to make changes in the future to improve their intercultural communication and relationships. Another consequence of this project is the long-term relationships between many of my participants and me. I am still in contact with most of the Chinese mothers either face to face or via social media. Sharing the experiences of raising and educating our kids are often the major topic in our conversations. Three mothers, in particular, sent their kids to the same daycare where my kids were because the mothers said that they trusted my choice. Trust from the mothers is a valuable reward that I have received from my research journey. I won the trust not only because I am a researcher but also because I am an

experienced mother, a Chinese migrant, and a woman who cares for their feelings and needs.

I have also had opportunities to stay in touch with some of the maternity care providers. For example, one midwife called me and referred me to one of her Chinese clients who was struggling with the decision on starting a midwifery course. I remember the midwife telling me on the phone: “I told the mother that you are the right person to talk it through. You can be trusted.” I was proud of myself at that moment and I called that mother on the day. I met another midwife on the driveway of my home where she was passing by after finishing a postnatal visit to my neighbour. She treated me as a friend and complained about the visit to this Chinese family. Language barriers were still what she was concerned with, but moreover, the midwife was not comfortable with the highly involvement of the woman’s mother and mother-in-law in making decisions on breastfeeding. I told the midwife that I could have a conversation with my neighbour about feeding the baby and I was willing to help with interpretation in subsequent visits if they all agreed. This experience reminded me of the challenges of choice and communication with *the third party* that I found in my research. Although my research has ended, the intercultural communication challenges still exist, so it requires efforts from the mothers, the maternity care providers, and the entire health systems to avoid and overcome such challenges. On another occasion, a midwife and I were both invited to give speeches to a group of midwifery students in an educational institution. Our prior relationship in the research journey contributed to a harmonious collaboration during the speeches. More significantly, I noticed that she addressed many issues (e.g., medicalised childbirth, China’s One Child Policy, different cultural practices in childbirth) that we had discussed in the research interview. I was hoping that our

speeches would help those students to think about their future interactions with mothers who come from different social and cultural backgrounds.

Having this valuable research experience, I expect to delve further into future research in the disciplines of health communication and intercultural communication. I have discussed interactions between Chinese mothers and their cultural networks on the Internet which is an interesting topic that can be further explored in terms of the use of language, hybrid identities, (re)negotiation of childbirth and communication values, and advantages and challenges of using this channel. I also expect to further explore ethnic Chinese maternity and health providers' communication with their Western colleagues and Chinese clients. Research questions, such as how Chinese health providers construct and negotiate their identities and values in the interactions with their colleagues and clients; what hybrid identities and cultures do Chinese health providers struggle with; and as ethnic Chinese health providers, what challenges do they encounter at work, will be the focus. In addition, my future research could also reach to migrant ethnic Chinese fathers, the extended family members, and other migrant ethnic groups.

### **My Closing Thoughts**

This research uses the matrix of difference to help analyse the issues of difference in Chinese mothers' intercultural communication experiences with New Zealand maternity-care and health providers. The research findings reveal that local maternity-care and health providers who are familiar with the New Zealand's health discourses of consumer culture, partnership communication, and natural childbirth try to impose these discourses on *other* migrant ethnic Chinese. Accordingly, many mothers have experienced being othered due to their language

barriers, medicalised childbirth values, and cooperative communication style. The mothers find it hard to access information and make choices which they really want. Also maternity and health care agencies pay little attention to the impact of *the third party* of the mothers, and the importance of trust in health communication.

The research findings lead to theoretical, practical, and reflexive implications. In a theoretical sense, this research contributes to build on existing knowledge of intercultural communication and health communication in relation to the childbirth context. It encourages subjective and multiple voices to challenge hegemonic knowledge structures in much of the existing research. The matrix and methodological approaches provide a framework for future qualitative researchers to use in their research.

In a practical sense, upgrading the quality of services by addressing the mothers' cultural concerns, needs and expectations is important for creating an inclusive health communication environment for the mothers. The agencies also need to improve their management structures and practices to provide more support services for migrant ethnic mothers and their families. Indeed, good care and support can transcend intercultural communication issues. The research outcomes can also help the health industry provide beneficial information and strategies for people and agencies that need to cope with intercultural communication challenges in other industries such as finance and education.

In a reflexive sense, this research journey has had a significant impact on me, my participants, and our long-term relationships. The research has motivated me to explore wider areas about the communication experiences of ethnic migrant mothers, fathers, their family members, ethnic health carers, and their communication through new technologies. More research is encouraged to

give voice to stories from marginalised and vulnerable groups. As long as there are unequal power relations in society, such a research journey will never end.

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*Appendix A***DEMOGRAPHIC QUESTIONS**

1. How old are you?

< 20     20 – 24     25 – 29     30 – 34     35 – 40     > 40

2. What is your highest educational qualification?

High school     Diploma or trade qualification     Undergraduate degree

Postgraduate degree     Other

3. To what degree is your confidence when you are speaking English?

Very confident     Somewhat confident     Somewhat unconfident

Very unconfident

4. When did you move to New Zealand? \_\_\_\_\_

5. Where did you come from? \_\_\_\_\_

6. Do you have extended family living with you?

No

Yes \_\_\_\_\_ (Who are they?)

7. What was your job in your home country? \_\_\_\_\_

8. Do you have a job now in New Zealand?

Yes \_\_\_\_\_ (What is your current job?)

No \_\_\_\_\_ (What was your last job in New Zealand?)

9. How many months is your pregnancy? \_\_\_\_\_

10. What is the due date of your baby? \_\_\_\_\_

11. Is this your first child?

Yes

No \_\_\_\_\_ (How many other children do you have? \_\_\_\_\_)

*Appendix B***Table 2****DEMOGRAPHICS OF CHINESE MOTHERS**

<b>Characteristics</b>	<b>Number</b>	<b>Characteristics</b>	<b>Number</b>
<b>Age, y</b>		<b>Education</b>	
25-29	3	Diploma/trade qualification	2
30-34	4	Undergraduate degree	6
35-40	2	Postgraduate degree	2
>40	1		
<b>Speaking English</b>		<b>Migration, y</b>	
Very confident	4	Y 1995	1
Somewhat confident	3	2000-2005	8
Somewhat unconfident	3	Y 2009	1
<b>Coming from</b>		<b>Living with extended family</b>	
Northern China	6	Yes	
Southern China	3	No	4
Taiwan	1		6
<b>Job in China</b>		<b>Job in NZ</b>	
Education	4	Education	2
Government	1	Customer service	1
Finance	1	Accounting	1
Health	1	Management	1
Study	2	None	5
None	1		
<b>Gestation</b>		<b>Due date</b>	
3 or 4 months	3	June, 2009	1
6 or 7 months	6	August-October, 2009	5
9 months	1	November-December, 2009	2
		January, 2010	2
<b>Gravidity</b>			
First child	5		
Second child	5		

*Note:* The mothers migrated from Chinese cities which include Harbin, Dalian, Guangzhou, Wuhan, Qingdao, Tianjin, and other cities in the provinces of Hebei, Hubei, Heilongjiang, and Taiwan.

*Appendix C***INTERVIEW PROTOCOLS FOR MOTHERS****(For Mothers in Pregnancy)****Introduction**

- Who I am
- Purpose of the study
- Why I am interviewing you
- Show information sheet
- Confidentiality, tape recording, and note-taking
- Sign consent form
- Thanks for opportunity!

**Demographic Questions**

- At first, I would like to know some of your background information. Could you please complete this form which will take you only about 2 minutes?
- Declare again the rights of you as a participant
- Collect the form

**Interview Questions****A. Background (prompt questions based on the form)**

A1. So you came from... [Question 5]

- Which city did you come from?
- Why did you migrate to New Zealand?

A2. Here you answered that you also had ...other children. [Question 11]

- In what country did you deliver them?
- How old are they now?



[Prompt for other issues]

## **B. When you found you were pregnant**

B1. Please tell me what happened when you found you were pregnant.

- What did you expect at that time?
- What did you concern at that time?

B2. How did you find your LMC? (e.g., obstetrician, midwife, GP)

- What were your main reasons/criteria of choosing LMC?
- What challenges did you encounter when choosing LMC? How did you cope with them?

## **C. Communication with LMC**

C1. What did you expect the first-time visit with your LMC?

- What actually happened in your first-time visit?
- What stood out for you during the visit? Most memorable things did you experience? Can you please give me an example?
- Anything surprised you? Please give me an example.
- What challenges did you experience in the first-time interaction?

C2. What did your LMC tell you about pregnancy?

- Do you trust what s/he said? If not, why and what do you think about pregnancy? Y/n question – leading question suggest alternative: How did this fit with your existing knowledge/views of pregnancy?
- What things did you tell your LMC about pregnancy? What did s/he say?
- What things you couldn't talk about? What stopped you? [why can be a really hard question to address] Why?

C3. Can you please tell me how did you and your LMC make decisions? (e.g., making the next appointment, finalising your birth plan)

- Can you please give me an example? Describe what happened – how you

and you LMC talked about small and/or big decisions.

- Any other people participated in decision making? Who were they? What did they say/do?
- What good things did you experience in decision making?
- What challenges did you experience in decision making? How did you resolve them?

C4. Were there any other people present in your interactions with LMC? (e.g., interpreter, student doctor, nurse, your partner, family members, friend)

- What did they do?
- What did you feel when they were present?

C5. What kind of pamphlets regarding pregnancy have you received from your LMC or his/her health agency?

- In what ways do you find them useful?
- Any pamphlets are not that useful? Why? How can they be improved?

C6. Describe your current relationship with your LMC?

- If you could use a metaphor to describe this relationship, what would it be?
- If you have a physical problem regarding pregnancy, is your LMC the first person you turn to? If not, who is that first person?
- If you have an emotional/personal type problem regarding pregnancy, is your LMC the first person you turn to? If not, who is that first person?
- In your opinion, what are the challenges that affect your relationship with LMC? How can your relationship be improved?

#### **D. Communication with other health care providers**

D1. Are there any other health care providers you contact during your pregnancy? (e.g., GP, hospital doctor, nurse, obstetrician, midwife, community support

workers)

- How did you find them? In what situations do you contact them?
- Please give me some examples of good things happened in your communication with other health care providers?
- Any problems have you experienced? Please give some examples.

D2. What kind of pamphlets have you received from other health care providers or their health agencies?

- In what ways do you find them useful?
- Any pamphlets are not that useful? Why? How can they be improved?

### **E. Current impressions**

E1. What's going well at the moment?

E2. What concerns you at the moment?

### **F. Closing questions**

F1. We are at the end of the interview now. Do you have any comments to make?

F2. If possible, I'd like to accompany you to visit your LMC, so I can observe your communication process. When will you think be appropriate?

F3. I would like to interview you about 1 to 3 months after the birth of your baby. How do you feel about that? May I contact you closer to the time to see if this is possible?

**Thanks for Your Cooperation!**

**(For Mothers about One to Three Months after the Birth of Baby)**

**Introduction**

- Why I am interviewing you for the second time
- Explain the purpose of study
- Thanks for opportunity!

**Interview Questions**

**A. Thinking about the last interview**

A1. Last time you said..., is it still the same now?

- If no, what have changed you?

[Prompt for other issues]

**B. In the labour and delivery**

B1. What did you expect of your labour and delivery? What concerned you?

- Please tell me what actually happened in your labour and delivery?
- What good things happened?
- What challenges did you experience?
- What special things did you do? What were the reactions of your LMC?
- What things you couldn't do? Why?

B2. Were there any other health care providers helped with your labour and delivery? (e.g., obstetrician, nurse, midwife, student doctor)

- What did they do in your labour and delivery?
- What did you feel when they were present?
- How was their communication with your LMC if you noticed?

B3. Were there any other people present in your labour and delivery to support you? (e.g., your partner, parents, parents-in-law, other family members, friends)

- What did they do?
- What did you feel when they were present?

**C. After your baby was born**

C1. What did you expect of the postnatal period? What concerned you?

- Can you please tell me what actually happened this month?
- Any good things you experienced this month?
- What challenges did you experience this month? How did you and your LMC cope with them?

C2. What did your LMC tell you about the postnatal period? (e.g., breast feeding, wound care)

- Did you do as what s/he told you? What things you didn't do?
- What special things did you do? What were the reactions of your LMC?
- What things you couldn't do? Why?

C3. What kind of pamphlets have you received from your LMC or his/her health agency regarding the postnatal period?

- In what ways do you find them useful?
- Any pamphlets are not that useful? Why? How can they be improved?

C4. What are the other sources have you got information from regarding the postnatal period? (e.g., other health providers, family members, friends, cultural networks, internet, books)

- What kind of information have you retrieved from those sources? Please give me some examples.
- In what ways do you find those sources useful?

C5. Has your relationship with your LMC improved?

- a) In your opinion, what factors made this relationship improved?
- b) If your relationship with your LMC has worsened, what made it happen?

- c) If you could use a metaphor to describe your current relationship with your LMC, what would it be?

**D. Current impressions**

D1. What's going well at the moment?

D2. What concerns you at the moment?

**E. Closing questions**

E1. We are at the end of the interview now. Do you have any comments to make?

E2. As what I did last time, I would like to accompany you to visit your LMC or any other health provider once? When will you think be appropriate?

E3. I will do the last interview with you about 4 to 6 months after your delivery. Do you have any problems of that?

**Thanks for Your Cooperation and Take Care!**

**(For Mothers about Four to Six Months after the Birth of Baby)**

**Introduction**

- Why I am interviewing you for the third time
- Explain the purpose of study
- Thanks for opportunity!

**Interview Questions**

**A. Thinking about the last interview**

A1. Last time you said..., is it still the same now?

- If no, what have changed you?

[Prompt for other issues]

**B. Communication with the Plunket nurse**

B1. How did you find your Plunket nurse?

- What did you expect of the Plunket nurse?
- What did she actually do?

B2. Can you please tell me your first visit with your Plunket nurse?

- What surprised you?
- What interesting things did you experience?
- What challenges did you experience in the first time interaction?

B3. What did your Plunket nurse tell you about the postpartum and childrearing?

- Did you do as what she told you? What things you didn't do?
- What special things did you do? What did your Plunket nurse say?
- What things you couldn't do? Why?

B4. Were there any other people present in your interactions with the Plunket nurse?

- What did they do?

- What did you feel when they were present?

B5. What kind of pamphlets have you received from your Plunket nurse or the Plunket Society regarding the postpartum and childrearing?

- In what ways do you find them useful?
- Any pamphlets are not that useful? Why? How can they be improved?

B6. How is your relationship with your Plunket nurse?

- If you could use a metaphor to describe this relationship, what would it be?
- If you have a problem regarding the postpartum and childrearing, is your Plunket nurse the first person you turn to? If not, who is that first person?
- If you have an emotional/personal type problem, is your Plunket nurse the first person you turn to? If not, who is that first person?
- In your opinion, what are the challenges affect your relationship with the Plunket nurse? How can your relationship be improved?

### **C. Communication with other health care providers**

C1. Are there any other health care providers you contact during your postnatal period? (e.g., GP, hospital doctor, nurse, community support workers)

- In what situations do you contact them?
- Please give me some examples of good things happened in your communication with other health care providers?
- Any problems have you experienced? Please give some examples.

C2. What kind of pamphlets have you received from other health care providers or their health agencies?

- In what ways do you find them useful?
- Any pamphlets are not that useful? Why? How can they be improved?

### **D. Thinking about childbirth in New Zealand**



D1. Please tell me your best experience of communicating with a health provider?

- What made you think it is the best experience?

D2. Please tell me your worst experience of communicating with a health provider?

- What made you think it is the worst experience?

D3. What do you think about the childbirth you have experienced in New Zealand?

- Compared to the childbirth in your home country, what are the similarities? And what are the differences?
- What good things about having a baby in New Zealand?
- What things can be improved?

#### **E. Closing questions**

E1. We are at the end of the interview now. Do you have any comments to make?

E2. Is there anything you would like to ask me?

E3. Can I please accompany you to visit your Plunket nurse or any other health care provider? This will be the last observation I will need to conduct. When will you think be appropriate?

**Thanks So Much for Your Cooperation and Good Luck!**

*Appendix D***Table 3****DESCRIPTION OF DATA COLLECTION FROM MOTHERS**

<b>Mothers</b>	<i>1st interview</i>	<i>1<sup>st</sup> observation</i>	<i>2<sup>nd</sup> interview</i>	<i>2<sup>nd</sup> observation</i>	<i>3<sup>rd</sup> interview</i>	<i>3<sup>rd</sup> observation</i>	<i>Other activities</i>
<b>Mother 1</b>	When 6 months pregnant; 1 hour	When 7 months pregnant; during a visit to her midwife; 25 minutes	2 months after the birth of the baby; 1 hour	1 month after the birth of the baby; during a visit by her midwife; 20 minutes	5 months after the birth of the baby; 50 minutes	5 months after the birth of the baby; during a visit by her Plunket nurse; 30 minutes	A follow-up phone interview after the 3 <sup>rd</sup> interview
<b>Mother 2</b>	When 4 months pregnant; 1 hour	When 5 months pregnant; during a visit to her midwife; 30 minutes	3 months after the birth of the baby; 1 hour	1 month after the birth of the baby; during a visit by her midwife; 75 minutes	5 months after the birth of the baby; 45 minutes	6 months after the birth of the baby; during a visit to a Plunket nurse (other than her own nurse); 30 minutes	As a postnatal consultant; as a supportive person for her stress
<b>Mother 3</b>	When 6 months pregnant; 1 hour	When 7 months pregnant; during a visit to her midwife; 30 minutes	3 months after the birth of the baby; 1 hour	1 month after the birth of the baby; during a visit by her midwife; 40 minutes	6 months after the birth of the baby; 45 minutes	6 months after the birth of the baby; during a visit to her Plunket nurse; 20 minutes	

<b>Mother 4</b>	When 4 months pregnant; 45 minutes	When 6 months pregnant; during a visit to her midwife; 15 minutes	2 months after the birth of the baby; 50 minutes	1 month after the birth of the baby; during a visit by her midwife; 13 minutes	4 months after the birth of the baby; 40 minutes	6 weeks after the birth of the baby; during a visit to a GP and a nurse; 45 minutes	As an interpreter after the 1 <sup>st</sup> observation; as a maternity consultant
<b>Mother 5</b>	When 3 months pregnant; 70 minutes	When 4 months pregnant; during a visit to a radiologist; 30 minutes	1 month after the birth of the baby; 75 minutes	1 month after the birth of the baby; during a visit to Public Health nurses; 30 minutes	4 months after the birth of the baby; 1 hour	2 months after the birth of the baby; during a visit to her GP; 30 minutes	Supporting her with childbirth information and my empathy
<b>Mother 6</b>	When 7 months pregnant; 1 hour	When 8 months pregnant; during a visit to her midwife; 20 minutes	3 months after the birth of the baby; 1 hour	3 months after the birth of the baby; during a visit by her Plunket nurse; 1 hour	5 months after the birth of the baby; 75 minutes	5 months after the birth of the baby; during a visit to clinical nurses; 40 minutes	A follow-up phone interview after the 3 <sup>rd</sup> interview As a maternity consultant
<b>Mother 7</b>	When 7 months pregnant; 70 minutes	When 8 months pregnant; during a visit by her midwife; 35 minutes	2 months after the birth of the baby; 1 hour	1 month after the birth of the baby; during a visit by her midwife; 35 minutes	5 months after the birth of the baby; 1 hour	6 months after the birth of the baby; during a visit by her Plunket nurse; 30 minutes	Supporting her with childbirth information and my empathy

<b>Mother 8</b>	When 9 months pregnant; 50 minutes	When 9 months pregnant; during a visit to her midwife; 30 minutes	1 month after the birth of the baby; 50 minutes	1 month after the birth of the baby; during a visit by her midwife; 25 minutes	4 months after the birth of the baby; 50 minutes	4 months after the birth of the baby; during a visit to her Plunket nurse; 35 minutes	
<b>Mother 9</b>	When 3 months pregnant; 75 minutes	When 4 months pregnant; during a visit to a hospital obstetrician and an anaesthetist; 105 minutes	2 months after the birth of the baby; 75 minutes	1 month after the birth of the baby; during a visit to her midwife; 30 minutes	5 months after the birth of the baby; 45 minutes	6 months after the birth of the baby; during a visit to her Plunket nurse; 30 minutes	Introducing her to the midwives; emotionally supporting her especially after the birth of the baby
<b>Mother 10</b>	When 6 months pregnant; 1 hour	When 4 months pregnant; during a visit to a radiologist; 35 minutes	2 months after the babies' born; 50 minutes	1 month after the babies' born; during a visit by her midwife; 55 minutes	6 months after the babies' born; 45 minutes	6 months after the babies' born; during a visit to her Plunket nurse; 45 minutes	Supporting with information for improving her life situation

*Appendix E***INTERVIEW PROTOCOL FOR  
MATERNITY-CARER AND HEALTH PROVIDERS****Introduction**

- Who I am
- Purpose of the study
- Why I am interviewing you
- Show information sheet
- Confidentiality, tape recording, and note-taking
- Sign consent form
- Thanks for opportunity!

**Interview Questions****A. Background**

A1. To start out, I'd like you to briefly describe your current job, roles and responsibilities?

- How long have you been working as a midwife/obstetrician/nurse/etc in New Zealand?

A3. Most of your clients are Pakeha or any other ethnic group?

- How many ethnic Chinese mothers do you have contact now?

**B. Health support**

B1. How did you help ethnic Chinese mothers go through the childbirth process?

- What did you usually tell them? What were their reactions?
- Did you do or tell any special things that you wouldn't do or tell to other groups? What were they? Why did you do this?

B2. How did you help ethnic Chinese mothers make decisions? (e.g., finalising a

birth plan) Can you please give me an example?

- Any other people participated decision making? What did you feel?
- Have you experienced conflicts with ethnic Chinese mothers in making decisions? Please tell me what happened?

B3. What kind of pamphlets did you provide to ethnic Chinese mothers in their pregnancy, birth and postpartum?

- What are the purposes of providing those pamphlets?
- Did you give out any pamphlets in Chinese versions? What do you think about those Chinese pamphlets?

B4. What are the other maternity and health care providers who you cooperate with in facilitating the childbirth process for ethnic Chinese mothers and fathers?

- How do you cooperate with each other?
- What challenges have you experienced? How do you cope with them?

### **C. Experiences**

C1. What concerned you before communicating with ethnic Chinese mothers?

- What actually happened when you are communicating with them?
- What's going well?
- What still concerns you now?

C2. Have you found anything interesting or surprised when you are communicating with ethnic Chinese mothers? Please give me some examples.

- Why did you find them interesting or surprised?
- What were your reactions?

C3. Please give me an example of a good experience that you have when communicating with an ethnic Chinese mother?

- What aspects caused you to think it is a good experience?

C4. Please give me an example of a bad experience you have when communicating with an ethnic Chinese mother?

- What aspects caused you to think it is a bad experience?
- What would you do next time?

**D. Closing questions**

D1. We are at the end of the interview now. Is there anything else you would like to add? Do you have any comments to make?

D2. Is there anything you would like to ask me?

**Thanks for Your Cooperation!**

*Appendix F***Table 4****DESCRIPTION OF HEALTH PROVIDERS AND INTERVIEWS**

<b>Maternity-care and health providers</b>	<b>Ethnicity</b>	<b>Gender</b>	<b>Interviews</b>
Independent midwife 1	Pakeha	Female	1 hour length
Independent midwife 2	Pakeha	Female	1 hour length
Independent midwife 3	Pakeha	Female	1 hour length
Independent midwife 4	Pakeha	Female	36 minutes length
Plunket nurse 1	Chinese	Female	104 minutes length
Plunket nurse 2	Pakeha	Female	35 minutes length
Plunket nurse 3	Pakeha	Female	27 minutes length
Hospital midwife	Chinese	Female	50 minutes length
Hospital anaesthetist	Pakeha	Female	36 minutes length
GP	Chinese	male	25 minutes length



*Appendix G***INFORMATION SHEETS AND CONSENT FORM****(Information Sheet for Mothers – in English)****Research Project: Migrant Ethnic Chinese Mothers' Intercultural Communication Experiences with Their Maternity Carers and Health Providers in New Zealand**

Are you a migrant ethnic Chinese woman expecting a baby? If so, please read on.

We would like to hear from ethnic Chinese women who are immigrants to New Zealand and currently using maternity services. If this is you, we would like to hear from you and get to know about your experiences of communicating with your maternity-care and health providers. We are interested in finding out how cultural practices in childbirth affect communication between you and your maternity and health care providers in New Zealand. This would be a great chance to let health providers and their agencies know the challenges you face and improve the services they provide. You will also receive recommendations regarding your communication with your maternity and health providers, and understand what to expect, where and how to seek assistance when needed for your pregnancy, delivery and care afterwards in New Zealand.

*Thank you* for your initial interest in this research and we hope this following answers your questions, but if not feel free to contact us.

What's the project about?

This research project is for a Doctoral of Philosophy (PhD) degree at the Waikato Management School. The topic of the project is *migrant ethnic Chinese mothers' intercultural communication experiences with their maternity-care and health providers in New Zealand*, and the project requires Shujie Guo (Phoebe) to conduct research with you through using interviews and observation. Shujie Guo (Phoebe) can give you more details regarding her project.

Who's responsible?

Shujie Guo (Phoebe) is conducting a research project which Dr Prue Holmes is supervising. You can contact Dr Holmes by phone at 8384141; by fax at 8384358; by email at pholmes@waikato.ac.nz or at the address at Department of Management Communication, Waikato Management School, the University of Waikato, PB 3105, Hamilton.

What will you have to do and how long will it take?

Shujie Guo (Phoebe) will want to interview you three times (i.e., when you are pregnant, about one to three months after birth of the baby and then about four to six months later). Each interview should take approximately 30-60 minutes in most cases (and considerably less in some). The interview can be organised to take place at a time and venue when you feel comfortable talking. You will also be asked for your permission to record the interview.

Shujie Guo (Phoebe) would also like to accompany you while you visit your

midwife, general practitioner (GP), or Plunket nurse and to observe your communication with your health professionals three times (i.e., the first when you are pregnant, the second, about one to three months after birth of the baby, and the third, about four to six months later). The observation would be carried out at a place and time which convenient for both you and your health care provider. If at any stage or part of the visit you did not want her present, she would leave immediately you requested it. It is perfectly acceptable to participate in the interviews only without the observations.

What will happen to your information collected?

The interview responses and the observation notes will be used by Shujie Guo (Phoebe) to write her PhD paper. Only she, Dr Prue Holmes, and two other supervisors, Dr Cheryl Cockburn-Wooten and Dr Mary Simpson, will be privy to the notes, audio-recordings and the paper written. Afterwards, notes and recordings will be kept in a locked filing cabinet and all identifying information (e.g., your name) will be deleted. All electronic data will be saved in Shujie Guo (Phoebe)'s computer at university and another computer in her home, and they will all be passworded. No participants will be named in the research report unless explicit consent has been given by you, and every effort will be made to disguise your identity.

Our declaration to you, the participants

If you take part in the study, you have the right to:

- Refuse to answer any particular question, and to withdraw from the study at any time up until July 1<sup>st</sup> 2010.
- Ask any further questions about the study that occur to you during your participation.
- Be given access to a summary of the findings from the study when it is concluded.

**If you would like to be involved in this study**

Please contact Shujie Guo (Phoebe) in the first instance.

You can directly contact Shujie Guo (Phoebe)

by phone at 021 2312377

by email at spg5@waikato.ac.nz.

For further information you can also contact Dr Prue Holmes

by phone at 8384141

by fax at 8384358

by email at pholmes@waikato.ac.nz,

and at the address below:

Department of Management Communication

Waikato Management School

The University of Waikato

Private Bag 3105

Hamilton, New Zealand

Thank you for your time and interest in this study

**(Information Sheet for Mothers – in Chinese)****研究课题：在新西兰的华人妈妈与他们的助产士及其他医护人员之间不同文化的交流**

您是一位在新西兰第一次怀孕的华人妈妈吗？如果是的话，请您继续读下去。

我们非常希望得到您的反馈并倾听您与您的助产医护人员之间沟通的经历。我们有兴趣了解在生育方面文化习惯是怎样影响您在新西兰与您的助产医护人员之间沟通的。这会是一次让医护人员同其机构了解您所面临的挑战，并以此改善服务的很好机会。您也将从中得到关于如何改善与您的助产医护人员之间沟通的建议，并了解在新西兰从怀孕、生产、到产后都需要哪些帮助，从哪里和如何寻求帮助。

**感谢您**对此次研究所给予的兴趣。我们希望以下的答案能够很好的解答您的问题，如果没有您可以随时联系我们。

这是关于什么的项目？

这份研究项目是在怀卡多管理学院所属下的一份博士论文。这个项目的课题是*在新西兰的华人妈妈与他们的助产士及其他医护人员之间不同文化的交流*，这个项目需要 Shujie Guo (Phoebe)通过采访和观察来完成。Shujie Guo (Phoebe)会提供您更多关于她研究项目的详细信息。

由谁负责？

Shujie Guo (Phoebe)的这个研究项目是由 Dr Prue Holmes 来指导的。您可以致电 Dr Holmes 于 8384141,发传真至 8384358,发电邮至 pholmes@waikato.ac.nz 或是通过以下的地址联系她：Department of Management Communication, Waikato Management School, the University of Waikato, PB 3105, Hamilton.

需要您做些什么？要占用您多少时间？

Shujie Guo (Phoebe)将会一共采访您三次（在您怀孕期间，您生产后一到三个月左右，然后是差不多四到六个月之后）。每次采访会基本上占用大约半小时到一小时的时间（有时会更短）。具体采访的时间和地点会根据您的方便来予以安排，您也将会被问及是否允许录下您被采访的内容。同时 Shujie Guo (Phoebe)希望能够有三次碰同您去见您的产婆，家庭医生，或是 Plunket 护士的机会（在您怀孕期间，您生产后一到三个月左右，然后是差不多四到六个月之后），从而可以观察您与您的助产医护人员之间沟通的情况。进行观察的地点将由您同您的医护人员来决定。如果在一些见面场合您不希望 Shujie Guo (Phoebe)在场，她会根据您的要求马上离开。您只想参与采访而不想被观察也是绝对可以的。

怎样对待您所提供的信息？

采访的反馈内容将被 Shujie Guo (Phoebe)用来撰写她的博士论文。只有她，Dr Prue Holmes，和另外两位导师 Dr Cheryl Cockburn-Wootten 同 Dr Mary Simpson 才能接触所有的记录，磁带和文章。研究结束后，所有的记录和磁带会被保存在带锁的文档柜中，所有有关身份的信息（比如您的姓名）也会

被销毁。所以的电脑数据都会被加密并保存在 Shujie Guo (Phoebe)学校和家里的两台电脑上。除非是在明确表示同意下不然参与者不会在此研究报告中被提及姓名，而且我们会尽最大的努力来掩饰您的身份。

我们对作为参与者您的申明：

如果您参与此次的调查，您有权力做以下的事：

- \* 拒绝回答任何特别的问题，并且可以在 2010 年 6 月 1 日之前随时决定取消参与此次项目。
- \* 在您参与研究的过程中提出您所质疑的关于此次项目的任何问题。
- \* 在研究内容被总结后你可以获得一份研究结果的小结。

如果您愿意参与其中并表达您的意见

请首先联系 Shujie Guo (Phoebe)

您可以直接致电 Shujie Guo (Phoebe)于 021 2312377，或发电邮至 spg5@waikato.ac.nz

若您想了解更多的信息您也可以联系 Dr Prue Holmes 致电于 8384141，发电邮至 pholmes@waikato.ac.nz，或通过信笺上方的地址来联系她。

感谢您对这个研究项目所给予的时间和兴趣

**(Information Sheet for Maternity-Carer and Health Providers)**

**Research Project: Migrant Ethnic Chinese Mothers' Intercultural  
Communication Experiences with Their Maternity Carers  
and Health Providers in New Zealand**

Are you a maternity carer/health provider who has direct contact with migrant ethnic Chinese mothers? If so, please read on.

We would like to hear from maternity-care and health providers who are providing maternity care and support to ethnic Chinese women who are immigrants to New Zealand. If this is you, we are interested in finding out how cultural practices in childbirth affect communication between you and migrant ethnic Chinese mothers in New Zealand. Therefore, we would like to talk with you about your experiences of communicating with migrant ethnic Chinese mothers. In particular, we would like to understand the challenges you and migrant ethnic Chinese mothers face when communicating with each other and in health situations, and receive recommendations regarding your communication.

**Thank you** for your initial interest in this research and we hope this following answers your questions, but if not feel free to contact us.

What's the project about?

This research project is for a Doctoral of Philosophy (PhD) degree at the Waikato Management School. The topic of the project is *migrant ethnic Chinese mothers' intercultural communication experiences with their maternity-care and health providers in New Zealand*, and the project requires Shujie Guo (Phoebe) to conduct research with you through using interviews. Shujie Guo (Phoebe) can give you more details regarding her project.

Who's responsible?

Shujie Guo (Phoebe) is conducting a research project which Dr Prue Holmes is supervising. You can contact Dr Holmes by phone at 8384141; by fax at 8384358; by email at pholmes@waikato.ac.nz or at the address at Department of Management Communication, Waikato Management School, the University of Waikato, PB 3105, Hamilton.

What will you have to do and how long will it take?

Shujie Guo (Phoebe) will want to interview you. This should take approximately 30-60 minutes in most cases (and considerably less in some). The interview can be organised to take place at a time and venue when you feel comfortable talking. You will also be asked for your permission to record the interview.

What will happen to your information collected?

The interview responses and the observation notes will be used by Shujie Guo (Phoebe) to write her PhD paper. Only she, Dr Prue Holmes, and two other supervisors, Dr Cheryl Cockburn-Wooten and Dr Mary Simpson, will be privy to the notes, audio-recordings and the paper written. Afterwards, notes and recordings will be kept in a locked filing cabinet and all identifying information (e.g., your name) will be deleted. All electronic data will be saved in Shujie Guo (Phoebe)'s computer at university and another computer in her home, and they will be all

passworded. No participants will be named in the research report unless explicit consent has been given by you, and every effort will be made to disguise your identity

Our declaration to you, the participants

If you take part in the study, you have the right to:

- \* Refuse to answer any particular question, and to withdraw from the study at any time up until June 1<sup>st</sup> 2010.
- \* Ask any further questions about the study that occur to you during your participation.
- \* Be given access to a summary of the findings from the study when it is concluded.

**If you would like to be involved in this study**

Please contact Shujie Guo (Phoebe) in the first instance.

You can directly contact Shujie Guo (Phoebe)

by phone at 021 2312377

by email at [spg5@waikato.ac.nz](mailto:spg5@waikato.ac.nz).

For further information you can also contact Prue Holmes

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and at the address below:

Department of Management Communication

Waikato Management School

The University of Waikato

Private Bag 3105

Hamilton, New Zealand

Thank you for your time and interest in this study

**Waikato Management School**

Te Raupapa



THE UNIVERSITY OF

**WAIKATO**

Te Whare Wānanga o Waikato

Research Title: Migrant ethnic Chinese mothers' intercultural communication experiences with their maternity-care and health providers in New Zealand

**Consent Form for Participants**

I have read the **Information Sheet for Participants** for this study and have had the details of the study explained to me. My questions about the study have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I also understand that I am free to withdraw from the study at any time up until July 1<sup>st</sup> 2010 or to decline to answer any particular questions in the study. I agree to provide information to the researchers under the conditions of confidentiality set out on the **Information Sheet**.

I agree to participate in this study under the conditions set out in the **Information Sheet** form.

Signed: \_\_\_\_\_

Name: \_\_\_\_\_ Date: \_\_\_\_\_

I agree to the interviews and observation with the research being audio-recorded

Signed: \_\_\_\_\_

Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Researcher's Name and contact information:**

Shujie Guo (Phoebe)

Email: spg5@waikato.ac.nz

Management Communication (MCOM)

Mobile: 021 2312377

Waikato Management School

University of Waikato

PB 3105, HAMILTON

**Supervisors' Names and contact information:**

Dr Prue Holmes

Email: pholmes@waikato.ac.nz

Senior Lecturer

Ph: 07 8384141

Management Communication

Fax: 07 8384358

Waikato University

PB 3105, HAMILTON