

**Contesting Representations of Refugee-  
Background Women (and Men) as 'Needy' and  
'Problematic' in Healthcare Literature in  
Aotearoa New Zealand: Advancing the Case for a  
Capability-Driven Model**

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## Abstract

This research analyses how power operates discursively within the western biomedical model as it pertains to the representations and treatment of refugee-background women (and men) in Aotearoa New Zealand. It carefully investigates the tendency of current biomedical discourse to typecast women (and men) with refugee backgrounds as having considerable health needs, which predicates the (over-) representation of them as exclusively 'problematic' and 'needy' throughout refugee and healthcare related literature. It also considers other ways in which the western biomedical model may be inappropriate and inadequate for refugee-background communities.

This thesis takes its starting position from some of the concerns regarding health outcomes raised in a meeting with three representatives of various refugee-background communities in Wellington in 2011, and by the recent ChangeMakers Refugee Forum (CRF) (2011) report, *"barriers to achieving good health outcomes in refugee-background communities"*. In light of these concerns (and subsequent recommendations), this research aims to introduce alternative narratives in the effort to improve health outcomes, as well as constitute a more fair and just discourse.

The mentation of the thesis is heavily inspired by postdevelopment theory and its potential for more enabling and effective ways of 'doing'

development. I draw on this theoretical frame to explore how an asset-based approach to maternal healthcare services in Aotearoa New Zealand for refugee-background women may be a vehicle to help us negotiate the politics of representation and generate better health outcomes for refugee-background communities.

**Key words:** Refugee, women, representation, discourse analysis, postdevelopment, asset-based development, western biomedical model.

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## List of Abbreviations

1951 Convention	1951 Convention relating to the Status of Refugees
1967 Protocol	1967 Protocol relating to the Status of Refugees
ALAC	Alcohol Advisory Council of New Zealand
CBPR	Community Based Participatory Research
CDA	Critical Discourse Analysis
CRF	ChangeMakers Refugee Forum
CVD	Cardiovascular Disease
FGC	Female Genital Cutting
FGM	Female Genital Mutilation
GP	General Practitioner
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
IDP	Internally Displaced Person
INGO	International Non-Governmental Organisation
IRD	Inland Revenue Department
LMC	Lead Maternity Carer
MDG	Millennium Development Goal
MELAA	Middle Eastern, Latin American and African
MoH	Ministry of Health
MRRC	Mangere Refugee Resettlement Centre
NGO	Non-Governmental Organisation

NZIS	New Zealand Immigration Service
OECD	Organisation for Economic Co-operation and Development
STI	Sexually Transmitted Infection
TB	Tuberculosis
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
WHO	World Health Organisation

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# CHAPTER 1

## Introduction

*By definition refugees are survivors. They have survived because they have the courage, ingenuity and creativity to have done so (Refugee Council of Australia, 2006, para.14).*

Women with refugee backgrounds<sup>1</sup> are (over-) represented as ‘needy’, ‘problematic’, ‘diseased’, ‘burdens’ and as ‘victims’ in Aotearoa New Zealand and overseas. This representation occurs via persistent newspaper articles, television and radio programmes, academic research, refugee and development organisations, as well as health-related research and educational resources. Intertextually, these images/texts accumulate meaning precisely because similar representational practices and figures are being repeated, sometimes with variations, from one text or site of representation to another (Hall, 1997). Sara Mills (1997) has pointed out that

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<sup>1</sup> While the many contentions and complexities surrounding the term, ‘refugee’ are summarised in the following chapter, in this thesis I understand the term ‘refugee’ as a person who has been forced to flee their habitual residence because of persecution, violence or disaster. I recognise that while the causes and experiences of displacement are incredibly diverse, the limited choice and subsequent pressure that refugees endure as they attempt to ensure their own (and their family’s) safety are comparable (Grove & Zwi, 2006). A person with a refugee background or a former refugee (used interchangeably throughout this thesis) is someone who has survived a refugee experience, and is now resettling in a new country. The use of the terms, ‘refugee background’ and ‘former refugee’ is in acknowledgement of how a refugee experience influences that individual’s current realities (Kamri-McGurk, 2012).

these enunciations cannot be “attributed simply to the author’s beliefs, but are rather due to larger-scale belief systems structured by discursive frameworks, and are given credibility and force by the power relations found in imperialism” (p.106). This thesis examines the specific details of how western biomedical discursive frameworks<sup>2</sup> constitute as ‘truth’ the idea that refugee-background women (and men) have considerable health needs and problems, and (implicitly) very little in the way of health assets. A construction that is further circulated and maintained throughout health-related literature in New Zealand. The implications of this representation and positioning of women (and men) with refugee backgrounds will be discussed in the efforts to constitute a more fair and just discourse.

## **Impetus of my Research**

The impetus for this research came from both an interest in postdevelopment theory and its potential as a means for ‘doing’ development differently, and reflections on my professional experience as an independent midwife in Aotearoa New Zealand.

This thesis takes its starting position from some of the concerns raised in a meeting with three representatives of various refugee-background communities in Wellington, and by the recent ChangeMakers Refugee Forum (CRF)<sup>3</sup> (2011, see Appendix A) report, *“barriers to achieving good health*

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<sup>2</sup> Put simply, a western biomedical discursive framework is understood as a way of thinking, perceiving and talking about health that has been conceived by western-trained medical professionals and institutions. This framework has been circulated around the globe and become dominant in New Zealand. The western biomedical model is understood as the dominant healthcare system in western industrialised nations and is increasingly so in ‘developing’ nations. While complex, these ideas are further explored in the following chapters.

<sup>3</sup> ChangeMakers Refugee Forum is a rights-based advocacy NGO representing 14 different refugee-background communities in Wellington New Zealand (CRF, n.d.).

*outcomes in refugee-background communities*". The CRF (2011) report gathered information from focus groups held with 24 people from 11 refugee-background communities in Wellington. The participants elucidate the main barriers faced in maintaining their health in New Zealand and their recommendations to reduce these barriers. Three areas of concern were identified in the report that have spurred this thesis topic. Specifically the concerns related to: a) maternal healthcare provision and outcomes; b) discrimination in care; and c) delivery of culturally insensitive care. This thesis takes the position that the inadequacies inherent to the western biomedical model both produce and agitate these concerns.

In my attempt to address these concerns I analysed the health-related, New Zealand-based<sup>4</sup> literature regarding women with refugee backgrounds. Explored throughout this thesis is the tendency of this literature to (over-) represent refugee-background women (and their reproductive experiences) in terms of their (apparent) deficiencies and needs. The literature concerning refugee-background women (and men)<sup>5</sup> tends to be informed by the western biomedical model. Additionally, medical screening and healthcare services to former refugees in New Zealand are predominately guided by the western biomedical model. In this thesis, I suggest that women and men with refugee backgrounds are over-managed by the model, given that they are required to undergo medical screening and the associated medical surveillance in the community.

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<sup>4</sup> While this research has primarily analysed the New Zealand-based literature for relevance and coherency purposes, similar representational practices were seen in the international literature (refer to Chapter 5).

<sup>5</sup> Initially my intention was to analyse the literature exclusively focused on refugee-background women in New Zealand and their maternal healthcare provision and outcomes. Yet, after extensive searching it soon became apparent that there was only limited information available specific to women and maternal healthcare services. While I have attempted to privilege the experiences of women, both women and men with refugee backgrounds are represented as having high health needs and problems through biomedical discourse (predominately through medical screening), thus they are both included in my analysis.

Due to my experience as a midwife, my research is also concerned with exploring the experiences of refugee-background women with the maternal healthcare services in Aotearoa New Zealand. In this thesis I examine how the once non-medicalised processes of pregnancy and childbirth have become medicalised events firmly under medical control. Therefore, refugee-background women who are pregnant are likely to encounter the biomedical model of childbirth. This thesis is concerned that the limitations of the biomedical model may be accentuated for refugee-background women when negotiating their maternal healthcare because they are over-exposed to the model.

While biomedicine makes essential contributions to refugee healthcare, this thesis stresses its limitations. The biomedical model is focused upon disease, diagnosis, epidemiology research and the treatment of symptoms (Ryan, Dooley & Benson, 2008). Marjorie Muecke (1992) asserts that because pathology and problems are fundamental to the existence of the biomedical model, we are only sensitised to an individual's needs and deficiencies. Therefore it is a model which typecasts women with refugee backgrounds as only having considerable health needs, as the model does not recognise or account for strengths, assets and resources. This thesis also suggests that the western biomedical model tends to disregard and overlook non-western knowledges and ways of practicing health.

An understanding of health needs is certainly a key aspect of the general well-being of former refugee populations, it is however only part of the picture. Absent throughout the literature is any mention of the health resources, strengths or assets that refugee-background women (and men) possess. Of central concern to me are the implications of this for the health outcomes of people with refugee backgrounds. I suggest that a way we

could improve outcomes is to realise the limitations with the western biomedical model, and attempt to shift the needs-based focus to allow not only recognition of, but respect for the strengths and assets of refugee-background women (and men). This thesis explores these aspects with the aim of achieving improved maternal health outcomes for women with refugee backgrounds. This work may also inform and improve other healthcare services and outcomes for former refugees more generally, i.e. men and children.

The impetus of my concerns for this thesis topic came from Michel Foucault's (2000) finding that individuals who have suffered marginalisation and hardship, such as former refugees, tend to define and internalise themselves in the hegemonic discourse's construction of them. Thinking about this proclivity within the specific context of biomedical discourse and the representation of people with refugee backgrounds, it is worrying that this discourse exclusively focuses on their weaknesses, needs and problems. Undervaluing and not acknowledging that people with refugee backgrounds are people with an incredible amount of assets, resilience and capabilities.

Demonstrating the discursive (and therefore, socially constituted) nature of the biomedical model's constructions, fosters the sense that they are able to be questioned and challenged. It is hoped that, with time, this study may bring about real change and openings for more 'positive' ways of representing, speaking and thinking about refugee-background women (and men) regarding their health. This, in turn, may inform the other discourses circulating about former refugees, which may support more effective resettlement. At the very least, this work provides the groundwork necessary for further exploratory research into the area.

## Research Aims

Some of the recommendations to reduce the barriers to achieving good health outcomes made by the participants in the CRF (2011, see Appendix A) research include:

1. Health practitioners are trained to be more culturally responsive.
2. Health practitioners recognise the important role of communities.
3. Health practitioners take a more holistic approach when treating people with refugee backgrounds.
4. Recognition, among health practitioners, of the skills and experience that refugee-background people bring.
5. More acceptance and welcoming of diversity among the wider community.

In light of the concerns (previously outlined on p.3) and subsequent recommendations, this research aims to identify alternatives to current biomedical and community healthcare representations of refugee-background communities as 'problematic' and 'needy' as a means to support more effective resettlement and holistic development. Specifically, it seeks to:

1. Analyse and explore, via discourse analysis, the implications of how women (and men) with refugee backgrounds are represented and positioned within health literature in Aotearoa New Zealand.
2. Examine how the processes of pregnancy and childbirth have become firmly located within the western biomedical model and explore the implications of this for women with refugee backgrounds.
3. With reference to the CRF (2011) report's recommendations (outlined above), identify the characteristics of an asset-based approach to

maternal healthcare for women with refugee backgrounds, which may also be relevant to development work in international contexts.

4. Discuss how an asset-based approach to maternal healthcare for women with refugee backgrounds offers insights for postdevelopment practice: as a potential vehicle for applying the principles and ideals espoused within postdevelopment theory.

## Conceptual Frames

This research is grounded in postdevelopment theory. Escobar (2007) identified how postdevelopment theory is related to and heavily influenced by poststructuralism, postmodernism, feminism and postcolonialism. These theories provide an important set of conceptual and theoretical perspectives on power, representation and identity which have informed my work in its attempt to pave a way for a less-colonising healthcare system in Aotearoa New Zealand. In particular, I use postdevelopment theoretical insights to deconstruct the dynamics of power, language, and knowledge that are present in the health literature and healthcare practice concerning refugee-background women in New Zealand (Sidaway, 2008). Postcolonialism, like postdevelopment, is a powerful critique of the ethnocentric assumptions of 'development' and both rely on poststructuralism's linguistic and cultural analyses to critique development's power to name, represent and theorise about non-western cultures (McEwan, 2008). Postcolonialism analyses the relations between power and knowledge; relations which determine *who* creates knowledge, *what* counts as valid knowledge, and the consequences of this knowledge (McEwan, 2009).

The western biomedical model is adopted as the universal solution to many, if not all, of the current health-related development 'issues' facing New Zealand society. This thesis carefully considers whether the Eurocentric bias and inadequacies inherent within the biomedical framework means it lacks cultural relevance within our increasingly multicultural population. This examination is important to address issues of accessibility, appropriateness and effectiveness of development strategies aiming to improve health outcomes.

Additionally, postdevelopment theorists critique the idea that development happens over 'there' and call for development (or perhaps more appropriately, 'underdevelopment') of the minority world<sup>6</sup> (Habermann & Ziai, 2007). Applying this critique, this research takes place 'here' and the focus is on challenging the Eurocentrism and hegemony, that this thesis argues, is indicative of mainstream development and biomedical approaches. In the sage words of J.K. Gibson-Graham<sup>7</sup> (2005), "the challenge is to imagine and practice development differently" (p.6).

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<sup>6</sup> 'Minority world', 'developed', 'global north', 'first world', 'west', and correspondingly, 'majority world', 'developing', 'underdeveloped', 'global south', 'third world', 'east', are all terms commonly used to "distinguish between affluent, privileged nations and communities and economically and politically marginalized nations and communities", that is, the "haves" and the "have nots" (Mohanty, 2003, p.505). I prefer to use the terms 'majority world' and 'minority world' to refer to the countries of the south and north, respectively. Metaphorically the terms highlight how the Eurocentric ideas (originating from the minority and seen to have greater validity) have underpinned the common terms used to describe the majority of the world's population (McEwan, 2009). Where relevant, to keep the flow consistent with quoted and supporting texts however, I use the term 'western', and at times 'developed' and 'developing'. See n.25, p.49 for more details.

<sup>7</sup> J.K Gibson-Graham is the pen-name shared by feminist political economic geographers; Katherine Gibson and the late Julie Graham (Community Economies, 2009).



## Positionality

*Let us become vigilant about our own practice and use it as much as we can rather than make the totally counter-productive gesture of repudiating it* (Spivak, 1990, p.11).

My professional experience as a midwife in New Zealand has given me many insights that I draw on throughout this thesis. I specialised as a homebirth midwife and through my training, work experience and my own pregnancies and births, I developed a deep-rooted belief in the normalcy of childbirth and the potential for women to enact their power during normal birth (at home or birthing units). For me, the most meaningful part of this role was to work alongside women as they realised their strengths, power and potential through, what I consider to be, one of nature's most life-changing experiences. I particularly loved working with first-time mothers because often the experience was more pronounced and powerful. The transformation that can occur in first-time mothers and others around them as they realise how great they are is humbling. This is the stuff that stays with people throughout their lives. I truly believe that if health practitioners work with this transforming potential of pregnancy and childbirth more effectively, then women and their families will be more 'empowered', which may suffuse to other areas of their lives.

I have witnessed first-hand how the western biomedical model of childbirth<sup>8</sup> can 'disempower' women through interactions with healthcare providers, the objectification of women and the technology-focused environment. I

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<sup>8</sup> The western biomedical model of childbirth identifies the processes of pregnancy and birth as a pathological process requiring medical control to guarantee safety (Johanson, Newburn & Macfarlane, 2002; Wagner, 1993).

have also seen, on numerous occasions, maternal healthcare providers working within the biomedical model assert dominance, violence and control over women. As I elucidate through this thesis, I too have been complicit in the workings of this model, most probably because I was unable to see or fully understand the implications of my actions (or rather, inactions). Because of these factors, I orient towards a social model of childbirth, where pregnancy and birth are inherently understood as normal, physiological processes. And where care that is given is centred on the woman – her desires, preferences and experiences are all valued.

Additionally, in my experience as a midwife I have observed first-hand how many medical and health practitioners treat and view mothers with refugee backgrounds. I have also seen how midwives are treated by many doctors (and other midwives), and how undervalued they are by society at large and the media. I think it is fair to say there are considerable instances of violence and contention occurring in and between staff (as well as with ‘patients’<sup>9</sup>) in healthcare situations, and yet it is an environment that seems resistant to change. Perplexingly though the very people affected by unfair and unequal power relations (most often midwives) seem to perpetuate the same relations. There is probably a fair amount of what Kapoor (2005) labels ‘narcissistic samaritanism’ involved here, which no doubt stems from many midwives’ feelings of being undervalued and underappreciated within the maternal healthcare system.

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<sup>9</sup> While I recognise the limitations of the term ‘patients’, I have used it here to make clear that I mean the people that health practitioners are working for. ‘Partner’ or ‘client’ would be my preferred terminology as it suggests a more level-playing field in healthcare interactions. Though, from my experience healthcare interactions are anything but fair, and moreover, as Ilan Kapoor (2004) argues, changing the unequal power dichotomies of ‘us’ and ‘them’ (inherent in hegemonic biomedical and development discourses), takes a great deal more than mere semantics.

While this study emphasises the limitations with the biomedical preoccupation of pregnancy and childbirth, it is important to note that I am not anti-biomedical care. In the situations when it is *needed* – it is life-saving. I am however opposed to its unnecessary application in normal physiological childbirth. Drawing on Kapoor's (2004) engagement with Gayatri Chakravorty Spivak's (1988; 1990) work, I recognise that even as I critique western biomedicine I am familiar with the model and have been to an extent 'seduced' by it: I acknowledge I am complicit<sup>10</sup> in it. However, my experiences of working as a midwife have also given me insights into and ideas for the changes that could occur within the model. Thus, instead of my professional experiences limiting my study (which I originally perceived), I now consider them to be an asset, which may invoke a more ethical and considered exploration.

When I started writing this thesis I also questioned the extent I could contribute to this topic and, moreover, what right I had to carry out this research. I would catch myself thinking: "I'm 'just' a Pākehā solo mother, I don't personally know many people with refugee backgrounds, I have no idea what a refugee experience would be like – what do I know?" I struggled with my motivations for being so passionate about this topic. Was I just trying to 'help' others so I could feel better about my own circumstances? So I can take attention away from my own life and help someone who was, apparently, more 'needy' than me in some attempt to prove myself, or perhaps even to show there is someone more 'needy' than me. Another form of narcissistic samaritanism or transference of my political ideology onto less structurally powerful others (Kapoor, 2005).

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<sup>10</sup> Kapoor's (2004) ideas of acknowledging complicity are explored further in Chapter 3, p.69.

Why did the fact that most literature framed people with refugee backgrounds as needy invoke such a strong emotional response in me?

With time (and gentle prompting from my supervisor), it occurred to me that what I do know, what I have a deep visceral understanding of, is how it feels to be undervalued and disparaged. I am a solo-mother of two beautiful children. I live in a small flat in Wellington and every week I struggle to pay the bills and buy food. I go to work on my thesis every day and although I can see how the added stress affects my children and me, I do it so that we can make a better life for ourselves. I am desperate to enter the formal workforce so that I can 'prove' to everyone that I am worth it, I do count and I have something to offer.

When looking at my situation statistically, I am probably defined as someone who is in need, rather than as someone who has strengths and potential. I am very aware of the negative constructions attached to solo-mothers and this affects my decision-making on a daily basis. Many consider that solo-parents are an aberration and not the norm: we are seen as deviant. Or they position blame on us: it is 'my fault' that I am a solo mother and my family is 'lacking' and not complete because there isn't a mum and dad under the same roof. Yet, I consider myself a survivor; I am extremely resourceful, resilient, capable, determined and strong. So I wish to be known as someone that others could be inspired by, rather than someone that others aspire not to be. I try and prove to people that I am not one of the stereotypes: *'easy'*, *'slutty'*, *'selfish'*, *'on welfare'* or that my kids are troubled and un-cared for.

At times when writing this thesis there was an apparent tension between simply letting my interpretation emerge from the evidence and using the

evidence to assert or argue my points. This tension is undoubtedly due to my experiences of not feeling valued as a mother or midwife, and the ensuing desire to have my voice heard and understood.

Judith Butler (1992) has argued that to have a 'culturally intelligible' life, one must be recognised as having value and legitimacy. For those of us who deviate from the norms that constitute 'viable' subjectivities, our lives are deemed as being illegitimate or as not counting. Being truly valued by society involves shifting the focus to people's *strengths*, rather than their *weaknesses*, and what people can do, instead of what they can't do. Focusing on *opportunities*, rather than *problems*, can enable people to see themselves as the engines of their success, instead of seeing the solution and causes of their predicaments as being solely in the external environment (Mathie & Cunningham, 2002). Perhaps one of my most significant motivations for studying the representations of former refugees has been to try and avoid the risk of their children growing up unvalued or being seen as illegitimate by mainstream society.

People *with* refugee backgrounds (and notice here that I am not saying *from* refugee backgrounds because having a refugee experience should be regarded as an asset and a strength) have gone through an incredible journey that is difficult for others to conceive of or understand. Yet when they arrive in their host country, former refugees are not generally known as people with huge resources, capabilities and resilience or as people able to teach members of the host society. I hold refugee-background people in high regard, and I know that I am not the only one, so I have hope for change.

## Caveats

*Words can kill, words can heal, precisely because they have a powerful effect on how we understand ourselves in the physical and metaphysical worlds* (Watson-Gegeo & Gegeo, 2011, p.213).

This thesis is often critical of the biomedical model and practice, and specifically, male domination of medical practice. It is important to note that it is not my intention to criticise the health practitioners and services working towards improving the health outcomes of refugee-background communities. I acknowledge that medicine has important expertise to offer. My purpose is to encourage critical reflection on the *language* and *practices* that are currently being used within health services. It is language that is productive of particular outcomes rather than the individuals using the language (Doty, 1993). I realise that the discourses of which I am critical do not necessarily represent the thoughts and understandings of those using them. Yet, as a previous health practitioner, I know that I have used the very language that I am critiquing here. I hope that this thesis will alert those who use the words, phrases and descriptions detailed in Chapter 5 to ‘stop and reflect’. Such reflection is crucial to effecting the change needed to afford women with refugee backgrounds the respect and space they deserve to be able to exert their knowledges, practices and assets.

Additionally it is important to note that in my critique of the needs-based representations of people with refugee backgrounds in western biomedical discourse, I am not suggesting that there are particular health needs that are perhaps different from the host populations. Rather, I do this to highlight the possible negative implications for the health and wellbeing of refugee-

background people (as well as that of society as a whole) of exclusively referring to them as 'needy'.

There are two models of Māori<sup>11</sup> health that could be relevant here, these are; Te Whare Tapa Wha (developed by Dr Mason Durie) and Te Wheke (by Dr Rose Pere) (cf. Ministry of Health, n.d.). These models are grounded in the Māori world-view, which is holistic, relational and recognises the interconnectedness of every living thing (Ka'ai & Higgins, 2004). As locally-endorsed and locally-generated health and wellness models, they have been adopted widely for working with Māori clients in Aotearoa. I am interested in whether a similar process could happen for refugee-background communities and their health and wellness models. Further exploration of these ideas and the relevance of these Māori health models is beyond the scope of this thesis, but will be revisited at a later date in my doctoral project.

The voices of refugee-background women themselves are not represented in this thesis, due to the comprehensive, literature-focused groundwork necessary for this project. Indeed, the predominance of western biomedical terminology and perspectives throughout this thesis is notable. In my attempt to challenge the dominance and inadequacies of western biomedicine, I have chosen to analyse its history and trajectory to become the 'powerful', 'authoritative' and 'successful' profession it is today. Through this historical analysis, I am mindful that I may be reinforcing the hegemonic position of the model. As Barbara Heron (2007) notes this is a "hazard of deconstructing dominance: at the moment it is challenged, it reclaims centre stage and makes its issues the ones that count"

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<sup>11</sup> Māori are the Tangata Whenua (Indigenous people) of New Zealand.

(p.20). Though as Spivak (1990) adds, this deconstruction is vital as it may lead to improved practice.

Similarly, throughout this research I have been mindful of the tension between identifying the 'needy' and 'problematic' typecast of refugee-background women, and further perpetuating these stereotypes and labels. Additionally, in the process of identifying the 'Othering' that occurs in many healthcare interactions (refer to Chapter 5), I realise I may be (unintentionally) reproducing essentialised ideas of how refugee-background women are treated and want to be treated by health practitioners. However, this work has not been done before and represents the necessary first step towards destabilising the dominant discourse from within.

## **Outline of my Thesis**

This thesis is composed of seven chapters. The following is a brief summary of what the reader can expect from each.

### **Chapter 2 Terminology and Background: Former Refugees and Models of Healthcare**

The purpose of this chapter is to define the key terms and concepts used throughout the thesis. It provides the background context necessary for the following chapters.

### **Chapter 3 Approach**

Here, I outline the particular conceptual and theoretical frames guiding this study. This research is located within critical postdevelopment and postcolonial theories, which offer a useful lens through which to analyse the



power/knowledge nexus within biomedical discourse. In this chapter I also discuss how I have conducted discourse analysis – informed by Foucault's work.

#### **Chapter 4 Discourse Analysis: Part One – Disrupting Biomedical Hegemony**

Roxanne Doty (1993) states that in international relations, "hierarchy has been more of a background condition from which analyses proceed rather than something which is itself in need of examination" (p.303). The same can be said for western biomedicine. Throughout most of the literature I examined regarding former refugees' health, the authority and control accorded biomedicine was taken as *fait accompli* and as unproblematic. Accordingly the first stage of my analysis begins by providing contextual detail regarding medicalisation and medical social control, and by examining the historical trajectory of the western biomedical model, in an attempt to "denaturalize hierarchy" (Doty, 1993, p.304). Exploring how the processes of pregnancy and childbirth became medicalised events, demonstrates the specificities of the historical and sociopolitical factors involved in the establishment of biomedical hegemony.

#### **Chapter 5 Discourse Analysis: Part Two – Interrogating the Figuration of the 'Needy' and 'Problematic' Refugee-Background Woman**

This chapter examines the specific mechanisms identified in the circulating healthcare literature which work to maintain the enunciation of the 'needy' and 'problematic' refugee-background woman (and man). This analysis demonstrates how the authoritative and regulatory position of the biomedical model is essential to normalise the typecast. The chapter reveals the discursive formations that are present throughout the New Zealand-based literature, and also, due to the instructive nature of the analysed

literature, by implication, within healthcare services. The considerable discursive work invested into the constitution of the needy and problematic former refugee is exposed, which allows an understanding of the volatile nature of the figuration.

## **Chapter 6    The Case for Asset-Based Approaches to Maternal Healthcare for Refugee-Background Women**

In this chapter, I consider a conceptual framework that may balance the excesses and limitations of the dominant, needs-based maternal healthcare model to enable improved outcomes for women with refugee backgrounds. At the heart of the framework lies the concept of assets. An asset-based approach to maternity care may be a vehicle in which to espouse the insights from the critical postdevelopment and postcolonial theories. It is postulated in this chapter that an asset focus may enable the delivery of culturally-competent care as refugee-background women are able to collaborate more effectively and meaningfully with health services.

## **Chapter 7    Concluding Discussion**

This final chapter begins by reflecting on how my research findings intersect with each of the four aims of this thesis. I highlight recommendations for practice and future research instantiated through this research. I also note the contributions to development theory that this thesis has made. This chapter identifies the critical role that health practitioners have in challenging unfair discourses so that more enabling and just ways of talking and thinking about former refugees are engendered.

## **CHAPTER 2**

### **Terminology and Background: Former Refugees and Models of Healthcare**

#### **Introduction**

In this chapter I define the key terminology used throughout this thesis. First I provide an outline of the complexities surrounding the 'refugee' category. I then present a brief overview of the New Zealand refugee resettlement process. For refugee-background women, the experience of becoming and being a refugee is gendered. This chapter will briefly summarise the intricacies of this understanding. Next, the western biomedical model will be contextualised as underpinning the dominant healthcare approach offered to refugees resettling in New Zealand, and the inadequacies of the model will be introduced. I also provide a brief description of how the biomedical model of childbirth is understood and the effects of the model. Finally, I discuss the current understandings of asset-based development approaches and how they may engender culturally sensitive care provision.

## Forming the Label of 'Refugee'

*From the first procedures of status determination – who is a refugee? – to the structural determinants of life chances which this identity then engenders, labels infuse the world of refugees (Zetter, 1991, p.39).*

A 'refugee' is not a simple, fixed or timeless category. Rather, determining who is a refugee is an increasingly complex discursive exercise (Malkki, 1995; Scherschel, 2011; Zetter, 2007). As Lucia McSpadden and Helene Moussa (1993) explain, the label, 'refugee' is a legal construct reflecting the circumstances which caused an individual's flight from danger, and as such does not capture the essence and qualities of an individual's identity. The policies and regimes involved in forced migration<sup>12</sup> create hierarchical classifications of rights, which prompted Stephen Castles' (2003) call for a "sociology of exile, displacement and belonging" (p.14). Others suggest that the original definition of a refugee does not reflect the current geo-political context and the increasingly higher number of refugees unable to claim protection (Baines, 2004; Zetter, 2007).

Here, rather than try and present the currently understood definitions of the label 'refugee', I aim to discuss how the label is socially, politically and historically contingent. The scope of this thesis does not enable comprehensive exploration of the current critical debates surrounding the contentious categorisation, though I have attempted to provide a brief overview of the complexities.

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<sup>12</sup> Roger Zetter (2007) writes, the label, 'forced migrant' is increasingly replacing 'refugee' in the literature as it more accurately contextualises the complexity of the causes of dislocation while also capturing how refugees are part of wider migration movements. Zetter does note though that the term may reduce the focus on the rights of refugees to protection under the 1951 UN Convention Relating to the Status of Refugees (refer n.13, p.21).

After the Second World War, the protection of refugees was institutionalised and globalised under the 1951 United Nations Convention Relating to the Status of Refugees<sup>13</sup>. While throughout history displaced people who sought sanctuary have existed in great numbers, this Convention provided the first standardised definition of them (Malkki, 1995; Castles, 2003). Karin Scherschel (2011) observes that the 1951 UN Convention's notion of a refugee was originally highly selective, as it was only applicable to those refugees arriving in western countries from a Soviet bloc country where they were denied political and civil rights (also see Freedman, 2010). No mention was made of economic and social rights, or of the many other large groups of displaced people fleeing from conflict around the world (Freedman, 2010).

The Convention largely reflected the politics of the Cold War era; the concern lay with refugees suffering totalitarian regimes, "with the implication that the guilty parties were to be found east of the Iron Curtain" (Marfleet, 2006, cited in Scherschel, 2011, p.69). While the 1967 protocol expanded to include displacement across the world, it falls short of including internally displaced people, environmental refugees, people-trafficked for exploitative purposes, and people displaced by development projects such as dams, airports and roads (Castles, 2003; Scherschel, 2011). In the early 21<sup>st</sup> Century, UNHCR (2001-12a) expanded its role to include 'persons of concern to UNHCR', which include refugees, asylum seekers,

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<sup>13</sup> The 1951 United Nations Convention Relating to the Status of Refugees and its 1967 Protocol (1951 Convention) are the key legal documents that define who is a refugee, and the legal and social rights they should receive from the states that have ratified the Convention (United Nations High Commissioner for Refugees (UNHCR), 2007). The Convention also spells out a refugee's responsibilities to the host country and defines which people do not qualify for refugee status, such as war criminals (UNHCR, 2007). The first Article of the Convention defines a refugee as:

"[a] person who is outside his or her country of nationality or habitual residence; has a well-founded fear of persecution because of his or her race, religion, nationality, membership of a particular social group or political opinion; and is unable or unwilling to avail himself or herself of the protection of that country, or to return there, for fear of persecution" (UNHCR, 2007, p.6).

returnees, internally displaced and stateless persons. UNHCR's (2001-12b) primary purpose is to protect refugees, with particular attention to the safety of women and children.

Zetter (2007) observes that in the 1970s and 1980s, large-scale refugee movements were typically 'south-to-south', despite the conflicts being due to wider global geo-political and postcolonial causes. At this time refugee crises were 'managed' by humanitarian agencies and aid delivered through northern-based NGOs, where a refugee label was shaped according to a convenient (altruistic) humanitarian image (Zetter, 2007). Zetter (1991) explains that the labelling process inherently involves stereotyping people into prescribed groups, which simultaneously defines a client group and their assumed needs – food, shelter and protection. This process of disaggregating an individual's needs from their context, he argues, serves to form and legitimise the institutional identity (Zetter, 1991). Malkki (1995) writes that this standardised way of categorising displaced people located the cause of "the problem" within the bodies and minds of people categorised as refugees and not with the political or social oppression or violence that produced massive displacements of people (p.8). These factors contribute to Zetter's (1991) claim that refugees are "fully labelled in people's minds" (p.40).

Since the 1990s, determining who might be a 'refugee' has become more complex as there has been an unprecedented rise in refugees, asylum seekers and economic migrants entering western countries. This rise in numbers has challenged how the labels 'refugee' and 'migrant' are formed and managed (Zetter, 2007). Castles (2003) asserts that the division between forced and economic migration is becoming unclear because of the inequalities exacerbated through globalisation. As more economies are

failing, states and democracy are weakened and human rights abuses increase. Separating reasons for migration into strictly 'economic' or 'human rights' categories is challenging bureaucracies. He writes, "[u]nderstanding that forced migration is not the result of unconnected emergencies but rather an integral part of North-South relationships makes it necessary to theorize forced migration and link it to economic migration" (Castles, 2003, p.17). Zetter (2007) discusses how in some cases ethnic minorities who are persecuted through socio-economic exclusion, rather than explicit violence, may not strictly reflect the 'refugee' label. Another complexity involved in the label, is while fleeing persecution is central to the protective status, there exists contestation over what constitutes 'persecution' (Russell, 2002). These increasingly complex migratory and applicability processes create difficulty in determining refugee definitions (Zetter, 2007).

At the beginning of 2011, the number of refugees of concern to UNHCR was 10.5 million (UNHCR, 2001-11a), and the total number of 'people of concern' to UNHCR was 36.5 million (UNHCR, 2011a). Of the 10.5 million refugees, only about 1 percent have been resettled in a third country<sup>14</sup> (UNHCR, 2001-12c); the vast majority of forced migration occurs within borders (Grove & Zwi, 2006). These figures fall considerably short of the global number of forced migrants – somewhere between 100 and 200 million, dependent on the assumptions and definitions (Castles, 2003). Management of migration and the formation (and politicisation) of the label, 'refugee' has now become the responsibility of northern governments and not just humanitarian agencies, as in the past (Zetter, 2007).

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<sup>14</sup> There are three options for refugees offered by the UNHCR: voluntary repatriation, where refugees are supported to return home when conditions are safer; local integration, where refugees are integrated into the first host country, usually a neighbouring country; or resettlement to a third country, which is reserved for those refugees most in need of protection (UNHCR, 2001-12d).

In response to the “threatening rise in migration”, states across the ‘developed’ world have fractured the ‘refugee’ label and as a result, decreasing numbers of people are accorded the legal and physical protection of formal refugee status (Zetter, 2007, p.181). Conversely, as Natalie Grove and Anthony Zwi (2006) note, ‘developing’ nations (that have accommodated substantially larger numbers of refugees), generally adopt broader definitions surrounding assessment and response to refugees. The ever-increasing restrictions placed on the ‘refugee’ label has meant it is no longer a basic protective right under the convention, and thus reputed claimants are forced to assert their rights illegally. While anyone has the right to claim refugee status, Zetter (2007) argues that:

“claims to the refugee label are controlled by the draconian mix of deterrent measures and in-country policies and regulations. These new, and often pejorative labels, are created and embedded in political discourse, policy and practice” (p.184).

The definitions which determine who is a ‘refugee’ requires urgent revision to reflect the diversity and complexities that have been touched on here.

### **Former Refugees in New Zealand: The Resettlement Process**

New Zealand is one of the few countries that have a long-standing UNHCR resettlement programme. New Zealand's first involvement in refugee resettlement began after the Second World War. Since 1987, New Zealand resettles an average of 750 quota refugees per year (plus or minus 10



percent), and between 200 to 500 Convention refugees<sup>15</sup> (New Zealand Immigration Service (NZIS), 2004).

Over the 1999–2008 period, a total of 7,843 people from 56 countries were approved for New Zealand residence through the Refugee Quota Programme. The largest groups of quota refugees came from Afghanistan (1,319), Myanmar (1,278) and Iraq (991) (Quazi, 2009). Sixty percent of this total population was aged under 25. Overall, 53 percent of the quota refugee population was male over this period (Quazi, 2009). Across all nationalities of refugees entering New Zealand through the quota refugee programme over 1999-2008, males outnumbered females (except for Ethiopians, where 55 percent of the population were female). The overall female-to-male ratio for quota refugees was 0.9, which means that for every 100 males entering New Zealand there were 90 females (Quazi, 2009).

Of the annual quota of 750 refugees that come to New Zealand, the places are targeted under the three main subcategories are as follows: up to 75 places for the Women-at-Risk subcategory; up to 75 places for the Medical/Disabled subcategory; 600 places for the UNHCR Priority Protection subcategory, including up to 300 places for family reunification and up to 35 places for emergency referrals. Those who do not fall under any one of the three main subcategories is referred to as simply, quota refugee (Quazi, 2009).

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<sup>15</sup> New Zealand is one of only 16 countries to operate an annual refugee quota programme. Quota refugees are people that the UNHCR has mandated as refugees overseas. The people selected for resettlement in New Zealand under the annual Refugee Quota Programme are from three main subcategories: UNHCR priority protection cases (which includes Family and Emergency subcategories); women-at-risk; and people with disabilities or needing medical attention. Additionally people with refugee-like situations who are sponsored to come to New Zealand under family reunification policies account for an unknown number of resettlement cases. Convention refugees are former asylum seekers whose refugee status has been recognised in New Zealand by domestic authorities (Quazi, 2009; Immigration New Zealand, 2011a; Refugee Services Aotearoa New Zealand (Refugee Services), 2009).

In Table 2.1 below, the approvals granted for New Zealand residence for refugees by their subcategory over 1999–2008 are listed. Under the UNHCR Priority Protection subcategory, 42 percent of quota refugees were approved and under the Women-at-Risk subcategory, only 6 percent were approved (Quazi, 2009).

**Table 2.1: Application Category of Refugees who Entered New Zealand, 1999-2008**

<b>Application Category</b>	<b>Total Number</b>	<b>Percentage (%)</b>
<b>UNHCR Emergency</b>	101	1
<b>UNHCR Family</b>	1,778	23
<b>Medical/Disabled</b>	234	3
<b>Protection</b>	3,275	42
<b>Women-at-Risk</b>	506	6
<b>Quota Refugee</b>	1,949	25
<b>TOTAL</b>	7,843	100

Source: Quazi, 2009.

Each year, there are up to six intakes of around 125 quota refugees into New Zealand. On arrival in New Zealand, quota refugees are given permanent residence and spend a six-week orientation period at the Department of Labour's Mangere Refugee Resettlement Centre (MRRC) in Auckland (Immigration New Zealand, 2011a). MRRC consists of several agencies

offering “health, education, welfare and housing support” (Ministry of Health (MoH), 2001, p.24), which “prepare the refugees for their life in New Zealand. Among the agencies is a medical clinic, which provides health screening, and management of any medical problems found” (McLeod & Reeve, 2005, p.1). In Chapter 4, I argue that this screening programme *produces* the typecast of the ‘needy’ and ‘problematic’ former refugee.

On completion of the MRRC orientation programme, Refugee Services are responsible for selecting where quota refugees will be resettled. The refugees are mostly resettled in urban areas where the offices are located, these include: Auckland, Hamilton, Palmerston North, Wellington, Hutt Valley, Porirua, Nelson and Christchurch. Much consultation is involved in the resettlement decision and includes factors such as whether family or friends are already living in an area and what services and support are available for people from a particular community (Refugee Services, 2009). Refugee Services are contracted to provide support and services to former refugees for their first 12 months in New Zealand (Immigration New Zealand, 2011b). Staff ensure that resettling refugees have access to community services including work opportunities, unemployment benefits (if necessary), English classes, schools, health services, and appropriate spiritual and ethnic community support. Volunteers from Refugee Services work with former refugees for six months to assist in setting up homes, opening bank accounts, receiving IRD numbers, and social visits. Volunteers also help with orientating former refugees to the local community and facilities, such as public transport, hospital appointments, mail, and Work and Income appointments (Refugee Services, 2009; Immigration New Zealand, 2011b).

## Refugee-Background Women

*And where a campaign focuses on the vulnerability of one group, and is launched by a seemingly invulnerable “other”, the necessity of stopping to critically investigate the constructions, assumptions and ideas on refugee women, is all the more urgent (Baines, 2004, p.10).*

Since the early 1990s, ‘refugee women’ have been identified as a policy priority for the UNHCR (Baines, 2004; Freedman, 2010; UNHCR, 2001-12e). Yet there has been debate as to whether this prioritisation has led to much progress in effective policy and practice concerning refugee women (Freedman, 2010). Jane Freedman (2010) contends that the way in which gender mainstreaming has manifested in refugee protection activities has been purely focused on their ‘vulnerability’, and consequently “a gendered understanding of the global processes that produce refugees and of the protection needs of asylum seekers and refugees” has been largely neglected (p.590). The gendered nature of becoming, and experience of being, a refugee is incredibly complex and beyond this thesis’s scope, though I present a brief overview of some of the current debates.

Many argue that gender<sup>16</sup> issues have been largely absent from refugee discourse until fairly recently (Baines, 2004; Freedman, 2010; Kamri-McGurk, 2012; McSpadden & Moussa, 1993). Freedman (2010) explains that this is largely due to the limitations on the definitions and legal applicability of the

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<sup>16</sup> I understand gender as the socially constructed ideas and knowledge about what it means to be a woman or man, produced through the relations of actors and institutions. Gender relations shift and mutate across time, place and space (Baines, 2004; McSpadden & Moussa, 1993). Following Butler (1992), I understand gender as performative – gender is actively produced and expressed, but these performances have the capacity to produce these very “expressions” being performed. Understanding though that in these performative acts there is possibility to alter them (Butler, 1992, p.10). I consider gender, therefore, as discursive; there is no one “true” essential gender.

definition of 'refugee'. The 1951 Convention Relating to the Status of Refugees was written from a male perspective and was Eurocentric, as such the concerns of women tended to be overlooked (Freedman, 2010). Erin Baines (2004) writes that the UNHCR claimed its policies were gender-neutral; men and women were both protected equally. The limited UNHCR definition of 'refugee', as previously discussed, still has implications for the difficulties in mainstreaming gender into refugee and asylum policies and practices (Freedman, 2010). For instance, she notes that persecutions particular to women are often overlooked as valid reasons for seeking refugee status (ibid.). Additionally there has been a lack of scholarly research exploring gendered experiences of refugees, which has also contributed to the neglect of gender issues in refugee policy (Freedman, 2010; McSpadden & Moussa, 1993).

The lack of accurate gender-disaggregated data of some refugee populations and the diversity of experiences that cause men and women to become refugees (as well as the distinctions in their experience of being a refugee) have made mainstreaming gender difficult (Freedman, 2010; McSpadden & Moussa, 1993). Additionally, Freedman (2010) notes that the lack of data has led to many overstating the proportion of women refugees. For example, the Women's Refugee Commission (2012) claims 80 percent of the 42 million refugees and IDPs are women and children, whereas UNHCR (2001-2012e) states that approximately 50 percent of any refugee population are women and girls.

The problem with overemphasising statistics, writes Freedman (2010), is that they can essentialise 'women and children' into one category of 'vulnerable' groups, "thus obscuring even further the real nature of the statistical differences between men and women" (p.594). As Prem Rajaram (2002) and

Liisa Malkki (1995) have both argued, women and children are over-prevalent in humanitarian and media representations of refugees which has 'commodified'<sup>17</sup> women and children (cf. Chapter 5). This essentialisation has reduced understanding of the specificities of their experiences and how other factors such as class, ethnicity and age can affect their experience (Freedman, 2010). Women refugees are also largely absent from decision-making and participating in the policies, planning operations and practices of UNHCR, which has undoubtedly also affected gender mainstreaming (Baines, 2004; Freedman, 2010).

About half of the world's refugees are women and girls, yet men make up the majority of those who seek or succeed in resettling in western-based countries (Ascoly, Halsema, & Keysers, 2001; Freedman, 2010). Women constitute the vast majority in many refugee camps following civil wars or other conflict situations. While it is often assumed this is because men are involved in combat and the women and children flee, Freedman (2010) notes that this is not always the case as in many contemporary wars women are engaged in fighting, while men may be civilians. It is also widely understood that men make up the majority of those seeking asylum in western countries (Ascoly et al., 2001; Freedman, 2011). In New Zealand during 2008-2009, men made up 59.7 percent of the successful asylum applications, whereas women made up 40.3 percent (New Zealand Refugee Law (RefNZ), 2010).

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<sup>17</sup> Rajaram (2002) uses the term commodification to refer to the process of consigning refugees to their body by (over-) representing them as 'helpless', 'mute victims'. This he argues (re-) enforces stereotypes and predictability – refugees are "guaranteed to think, speak and act exactly as you would expect", this in turn, has led to the female refugee has a 'thing to be utilized': a commodity (p.253). Just as refugees are consigned to their body, Baines (2004) argues that refugee women are confined to a "gendered body", in order to promote gender equality to the global humanitarian network.

In light of the points discussed above regarding the limitations of determining 'persecution' and who might be a 'refugee', Freedman (2010) discusses cases where women seeking asylum on the basis of Female Genital Cutting (FGC – refer to Chapter 6) or forced marriage have been refused on the grounds that this is a normal cultural practice in their home countries. The gendered variation of situations surrounding forced migration, as well as the inexact figures of the gendered nature of the populations has made mainstreaming gender into refugee policy and practice difficult (Freedman, 2010). Freedman (2010) writes:

“in seeking to understand the obstacles to the achievement of gender equality in refugee protection it is also necessary to examine critically the global norms that have been created, and the frames that are used to represent women refugees and asylum seekers” (p.603).

Mindful of these complexities surrounding the essentialisation of gender and identity of refugees, some of the issues identified in the literature particular to refugee women include the following. According to Nina Ascoly and colleagues (2001), many women flee due to being sexually tortured and/or raped. In their research, the most common reason women gave for seeking asylum in the Netherlands in 1999 was a war situation (47 percent) or of belonging to an ethnic or religious group. In 16 percent of asylum requests reference was made to sexual violence, but only in combination with other reasons. They also found that most women come with children, whereas only 10 percent of men arriving independently come with children. Thus the experiences and needs of refugee men and women are different.

McSpadden and Moussa (1993) state that the refugee experience can challenge and shift sociocultural gender roles and behaviours, therefore

there is a “likely consequence of a shift in the previously experienced and expected power hierarchy and power differentials” (p.205). They discuss how women’s flight motives are largely due to sexual reasons, such as rape and the associated risk of ostracism from their family and community, whereas for men the persecution is essentially due to physical danger. They also found how the particular social situations of women affected their refugee or asylum experience, for instance whether they were married, single, living with relatives and/or friends. Additionally, McSpadden and Moussa (1993) highlight the increasing amount of domestic violence experienced by African refugee women in Canada and the USA. They state that the experience of resettlement for men can often be disempowering due to un- (or under-) employment or racism. Consequently some men feel they have lost their social status and authoritative position in their family. Additionally, men perceive women as having more rights socially and in the home, as well as increased access to employment (although at a lower income), which further compounds their anger and frustration (McSpadden & Moussa, 1993).

Freedman (2010) notes the importance of acknowledging that gender violence occurs in all countries; it is not particular to ‘refugee-producing’ countries. Implicit is the idea that human rights are not respected the same way as the ‘refugee-accepting’ countries, perpetuating the dichotomy between ‘us’ and ‘them’. As a result, she writes;

“the persecutions that take place in those other countries are attributed to immutable social and cultural characteristics, and the real dynamics of gender inequality underlying all types of gender-related violence, whether ‘here’ or ‘there’, are not analysed” (2010, p.602).



While the experience of being a refugee is distinct for women and men, Jennifer Hyndman (2010) contends that little is known about the gendered nature of being dependent on aid. She contends that masculine cultural norms can make the dependency situation for some refugee men humiliating. Hyndman (2010) cites a study by Alice Szczepanikova (2005) which found that the representations of the category, refugee, serve to feminise and infantilise refugees in relation to the host society. Drawing on Judith Butler's work on performativity and Michel Foucault's work on power, Szczepanikova argues that humanitarian settlement staff construct and maintain refugee identities as they perform particular regulatory roles. Some refugees can disassociate from the label "while others can make strategic use of it and/or find themselves trapped in performing the script of 'refugee'" (Hyndman, 2010, p.456).

### **Refugee-Background Women in New Zealand**

In recognition that women refugees are under-represented in processes for resettlement selection, in the early 1990s, UNHCR developed the 'Women-at-Risk' subcategory. New Zealand is one of the very few countries to have adopted the subcategory (Newland, 2004). The UNHCR (1991) states the aim of the subcategory is to enhance the resettlement eligibility for refugee women who may be otherwise ineligible under the general selection criteria. The Women-at-Risk programmes take different forms in different countries<sup>18</sup>, in the USA, New Zealand and Australia there is prioritisation of Women-at-Risk applications (Newland, 2004).

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<sup>18</sup> In New Zealand, the category ensures that places are reserved for "refugee women who are without the support of their traditional family protectors or community and are at risk in their country of refuge. These women would usually be outside the normal criteria for acceptance by resettlement countries and are in need of protection from gender-related persecution such as abduction, sexual abuse and exploitation. This subcategory generally includes the nuclear and dependent family members of the principal applicant" (UNHCR, 2011b, p.5).

There is a lack of research literature in New Zealand specifically pertaining to the experiences of refugee-background women (Kamri-McGurk, 2012). In my literature analysis, the predominant research concerning refugee-background women was collapsed to reproductive health issues. For instance, the *Handbook for Health Professionals* (MoH, 2001) and the *Refugee Health Needs Assessment* (Ali & Wilson, 2005) both have sections dedicated to refugee-background women, but essentially they concern the reproductive health *needs* of women.

## **Western Biomedicine**

*As the practice of modern medicine becomes increasingly a technical enterprise, it is more incumbent [sic] upon us than ever to recognize that the human body is not a machine, that health and illness are not merely biological states, but rather they are conditions which are intimately related to and constituted by the social nature of human life (Lock, 1988, p.8).*

The biomedical paradigm is based on a western body-mind dichotomous framework;

“a Cartesian division of man [sic] into a soulless mortal machine capable of mechanistic explanation and manipulation, and a bodyless soul, immortal, immaterial, and properly subject to religious authority, but largely unnecessary to account for physical disease and healing” (Kirmayer, 1988, p.59).

Cartesian dualism is attributed to the philosopher, Rene Descartes, who argued that the body represents one functioning system and the mind represents another, each of which science and religion had carved out as its separate domain (Cahill, 2001; White, 1996). Though, Laurence Kirmayer

(1988) details how as religious authority diminished, all parts of an individual's functions came to be understood and rationalised with a scientific lens. Cartesian philosophy propelled the mechanistic element of the medical model; an individual is understood as made up of independent parts, of which the mind and body are separate (White, 1996). As will be discussed in Chapters 3 and 5, the influence of Cartesian dualism on current western thinking has been significant, where most concepts (and consequently language) reflect this dichotomy (McEwan, 2009; Scheper-Hughes & Lock, 1998).

Cartesian philosophy revolutionised medicine as it lifted the limited orthodox Christian doctrines that had held that the body and soul were one (Cahill, 2001). Consequently a greater understanding of human anatomy and physiology was enabled (Cahill, 2001; Conrad & Schneider, 1980). It would be fair to assume that the increased knowledge of human anatomy and physiology over the last three centuries has been instrumental in the significant improvements in health. Yet, evidence suggests that the contribution of biomedical and scientific knowledge to improvements in health have been overstated by the medical fraternity (Cahill, 2001; Dubos; 1960; Conrad & Schneider, 1980).

The last three decades of the nineteenth century saw the rise of scientific medicine (medical practice supported with "scientific" evidence), which unified medical practice and formed the essence of the "biomedical model". As will be explored in Chapter 4, the enlightenment period of the west lay the foundations for this rise of scientific knowledge, and subsequently biomedicine. Kelman (1977) contends the scientific conceptualisation of the body is based primarily on Robert Koch and Louis Pasteur's "germ theory of

disease” developed in the 1860-70s (each disease is caused by a particular germ or agent, such as bacteria, parasites and viruses) (cited in Conrad and Schneider, 1980, p.14). This reductionist, disease-focus inherent in biomedicine enabled an understanding of the biochemical causation of disease at a cellular level. Medicine, consequently, became focused on the scientific *treatment* of the internal and biophysiological causes of disease, of which the external and social environment were seen as independent (Conrad & Schneider, 1980; White, 1996).

Medical intervention for illness therefore became validated, since the source of deviant behaviour is viewed as being within the individual and nothing to do with wider society (Dubos, 1960; Muecke, 1992; White, 1996). Thus, as Cecilia Van Hollen (2003) points out, medicalisation inevitably involves a “mystification of social inequities”, as the social structure that causes or gives rise to the problem or that constrains individuals is ignored (p.11). To elucidate further, because the biomedical model is grounded in the primacy of the individual and the necessity of treating the ‘needy’ and ‘diseased’, wider systemic issues and inequalities are often decontextualised and overlooked. This model of health concerned with identifying specific diseases and treating them is largely the basis for current medical practice globally (Cahill, 2001; Dubos, 1960). As will be explored in Chapter 4, while the western biomedical model has a relatively recent history, as it has evolved its ability to align with societal hierarchies has meant it is now dominant and hegemonic (Brown, 1998; Papps & Olssen, 1997).

Western biomedical care privileges western concepts and knowledges regarding health and illness, for instance it favours individualistic models of care that do not recognise collectivism. This thesis argues, as much research also does, that the conventional biomedical model lacks cross-cultural

relevance for non-western refugees (cf. Hollifield et al., 2002; Mortensen, 2008; Muecke, 1992; Singer, 2008; Schott & Henley, 1996). Judy Singer (2008) observes that because many refugees come from non-western cultures, it is crucial to provide meaningful cross-cultural care that acknowledges how their concepts and understandings of health and illness may be framed quite differently to the biomedical model.

Medical anthropologists refer to all societal medical systems<sup>19</sup> as *ethnomedicine* to acknowledge their culturally constructed nature (Brown, 1998). The western biomedical model is based on cultural assumptions around the causes of health and illness, and as such it is considered an *ethnomedicine*<sup>20</sup>. Deborah Gordon (1988) notes, the apparent rationality and neutrality of biomedicine is fervently accentuated by practitioners and protagonists as a way to refute its socially constituted nature. The epistemological and cultural assumptions of biomedicine, as well as the variations in its practice across societies has been extensively studied by anthropologists. Accordingly, it is widely understood that western biomedicine is not culture-free and that it cannot be removed from its historical, sociopolitical and cultural context (Brown, 1998; Gordon, 1988; Schott & Henley, 1996; Singer, 2008).

While the practice of biomedicine has originated in western nations, as it has become globalised it has undergone a process referred to as 'indigenisation' (Kleinman, 1995). This refers to the process of incorporation and coalescence

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<sup>19</sup> A medical system refers to a cohesive collection of ideas and concepts of particular healing approaches, such as Ayurveda, homeopathy, naturopathy and biomedicine (Brown, 1998).

<sup>20</sup> Describing western biomedicine as an *ethnomedicine* acknowledges that it is one therapeutic practice among many. As Peter Brown (1998) notes all medical systems rely on the manipulation of somatic and psychological processes in 'patients' to enhance the powerful effects that *belief* in the healer and the medicine has (often referred to as the placebo effect). Because western biomedicine is the dominant and hegemonic system in most societies, this effect is often more successful.

of the cultural nuances of the society into which it is introduced and practised (Kleinman, 1995; Singer, 2008). As many researchers note, people can be active agents in the medicalisation process and resist or invite certain aspects according to their needs and desires (Jolly, 1998; Ong, 1995; Van Hollen, 2003). Another aspect which emphasises the complexities around the categorising of biomedicine is that often in societies, people use multiple medical systems simultaneously – referred to as medical pluralism (Brown, 1998). Therefore western biomedicine is malleable and there are variations in its manifestation across and within diverse cultures (Gordon, 1988; White, 1996). For instance, in the United States, surgical procedures are performed twice as often per capita than in Britain (White, 1996). Brown (1998) suggests that this is because biomedical practice in the USA is based on an metaphorical understanding of the body in techno-mechanistic terms, which has led to more aggressive approaches.

My intention in demonstrating the pluralistic nature of western biomedicine is to emphasise how there is no essential ‘truth’ to be discovered; it is merely another socially-constituted structure which operates discursively, and thus able to be challenged. Though what separates western biomedicine from other forms of healing is the fundamental worldview which privileges science, technocratic values, the primacy of the individual and reductionism, as well as its assumed exclusive and hegemonic position (Jolly, 2002; Kleinman, 1995; Singer, 2008).

In many societies health and illness is predominately understood in terms of the western biomedical model (White, 1996; Singer, 2008). Throughout this thesis, I use the term, *‘the western biomedical model’* to contextualise the historical and socio-political processes that embody its form (and its effects). I also use the terminologies, *‘western biomedicine’* and *‘western biomedical*

*practice*' interchangeably to refer to the practices which manifest the ideals and values espoused within the model, the latter, I realise, has more specific application.

To expand on my definition from Chapter 1 (p.2), '*western biomedical discourse*' refers to the (well-delineated) cluster of ideas, thoughts, attitudes and practices which provide a recognisable and 'legitimate' language (or way of representing knowledge about) issues of health and illness<sup>21</sup>.

'Western' is used to refer to the shared "background of understandings" in which biomedical discourse and practice operate within (Gordon, 1988, p.23). Medicine, contends Kevin White (1996), "is not independent of the society which produces it" (p.39), and as such western culture has pervaded the conceptualisation of the model. The term 'bio' captures the integral 'scientific', and 'biological' approaches to disease causation and cure of the model, and 'medicine' signifies the therapeutic claims of the model. There does exist wide variation of terms used to describe the model and correspondingly diverse justifications. As Arthur Kleinman (1995) writes,

"if you ask biomedical professionals what word they would use to describe their field, most will say, in a powerfully succinct usage that does capture a sense of the hegemonic self-perception that has become almost a caricature worldwide, "Why not just call it medicine!"' (p.25).

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<sup>21</sup> As will be explored in Chapter 3, following Michel Foucault (1980; 1994), I understand discourse as inextricably connected to practice – discourse shapes practice, which, in turn, (re-) informs (and re-affirms) discourse, and so on. It is impossible to escape discourse; there will always be discourse.

## Biomedical Maternal Healthcare

*There is no doubt that before, during, and after birth biomedicine often favors untoward intervention, using sophisticated technologies to inspect, secure, and schedule the processes. The massive investment in such technologies is patent from the novel processes of fertilization and conception, through ultrasounds, amniocentesis, fetal heart monitoring, anesthesia, induction, episiotomies, forceps deliveries, and cesarean sections (Jolly, 2002, p.10).*

In Chapter 4, I provide an historical account of the medicalisation of pregnancy and childbirth, which traces how the meaning of childbirth transformed from a human experience to a medical-technical problem (Reissman, 1983; Williams, 1997). The biomedical model of childbirth has prevailed in most countries; one where birth can only be defined normal as retrospect, the site of care changed from home to hospital, the carers changed from home to hospital, and techniques changed from non-interventionist to ones highly reliant on technology and drugs (Reissman, 1983; Wagner, 2001). Consequently, obstetrics has become the mainstream ('malestream') form of knowledge, and natural childbirth is largely considered 'alternative' (Oakley, 1984). As Sara Mills (1997) has pointed out, a great deal of effort and discursive work was invested into ensuring that medical science is regarded as the authority of the 'true' and 'scientific' and anything alternative is considered inferior and amateurish.

The care that is predominately given to pregnant and labouring women is prescribed and scrutinised by medical professionals, acting on a definition of childbirth as hazardous and requiring surveillance. It is based on western notions of time, place and scientific calculations (Henley-Einion, 2003), which for many women has proved culturally inappropriate (refer to



Chapter 6). In modern obstetrics, the normal physiological process of birth is not well understood and consequently interventions, such as labour induction, electronic foetal monitoring, episiotomy and caesarean section, are often misused and excessively applied. Which as Robbie Davis-Floyd and colleagues (2009) argue has caused unnecessary morbidity, and increasingly mortality, to the baby and/or mother<sup>22</sup>.

Additionally, research has associated the model with: women's alienation, increased anxiety and guilt, loss of confidence and identity, and their increased dependency and ignorance (Davis-Floyd, 2001; Davis-Floyd, Barclay, Daviss, & Tritten 2009; Guilliland & Pairman, 1995; Wagner, 1993; Walsh, 2003). The biomedical model of childbirth also mitigates against women's choice and can result in a loss of women's power and their being dispossessed of their 'motherhood knowledge'<sup>23</sup> (ibid.). For refugee-background women who are pregnant and are likely to encounter the biomedical model of childbirth, these effects may be heightened.

While the use of drugs, interventions and technologies is increasing, there is substantial scientific evidence which does not support the routine use of these procedures (Davis-Floyd et al., 2009; Schott & Henley, 1996; Wagner, 2001). Furthermore, the scientific evidence which demonstrates improved

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<sup>22</sup> Robbie Davis-Floyd and colleagues (2009) site the extant research exploring the specificities of morbidity and mortality associated with technological birth interventions. These include: infections as a result of over-performance of vaginal examinations; dysfunctional and/or premature labour and birth resultant from syntocinon inductions of labour, which also interferes with the mother's own production of oxytocin and her ability to breastfeed; and the increased use of antibiotics in birth is increasing resistant strains of bacteria in infants (p.9).

<sup>23</sup> Here I use the term 'motherhood knowledge' to refer to a mother's understanding, resources, practices and expertise relating to pregnancy, birth and infant care. As Robyn Longhurst (2008) writes, these initial trajectories into motherhood can be life-changing and profound. As such (and based on my experiences as a midwife and mother), I realise that the support given to a mother to have confidence in her own 'motherhood knowledge' at this time can impact on her future maternal work. In Chapter 6, I identify how maternity is discursive to illustrate the multiplicity of experiences and practices which constitute 'motherhood'.

outcomes from humanistic and birth techniques supporting the physiological process (such as upright positioning for birth and companionship during labour), is often disregarded (Davis-Floyd et al., 2009; Wagner, 2001). The rules and hierarchies often found in hospitals, they write, “stifle creative thinking and acceptance of the scientific evidence supporting noninterventionist approaches” (Davis-Floyd et al., 2009, p.3). Davis-Floyd and colleagues (2009) also note how the focus of the biomedical birth models is on the economic and status gain of the practitioners and the institutions rather than the mother and baby.

Though, it is important to reiterate that just as western biomedicine is not practised homogenously, there is no singular mode of western biomedical birthing knowledges and practices. Primarily because, and as will be pointed to in Chapter 4, women are not just passive recipients of the medicalisation process, they can selectively reject or invite medicalisation according to their own needs and desires (Jolly, 1998; Ong, 1995). However as Margaret Jolly (1998) warns such “exercises of agency” are complex and are inextricable from issues of power, gender and class; it is not “as if choosing between modes of mothering is a kin to wheeling a supermarket trolley” (p.1). Van Hollen (2003) explains how childbirth is medicalised in diverse and uneven ways throughout the world. Due to under-resourcing in some majority world countries, the manifestation of medicalisation appears quite different to many countries in the minority world (Jolly, 2002; Van Hollen, 2003).

## Asset-Based Community Development

*[E]very living person has some gift or capacity of value to others. A strong community is a place that recognizes those gifts and ensures that they are given (Kretzmann & McKnight, 1993, p.27).*

There has been growing interest in asset and strength-based approaches to development in recent decades, which has arisen out of dissatisfaction with needs-based approaches to development (Kretzmann & McKnight, 1993; Mathie & Cunningham, 2005). Alison Mathie and Gordon Cunningham (2005) discuss how the needs and problem-based focus of various well-intentioned institutions, such as universities, donor agencies, NGOs, governments, and the mass media has meant a number of programmes have emerged with a “problem-solving mission” (p.177). As will be explained in Chapter 3, this proclivity of needing to solve the ‘problems’ of/with others is revealing in itself. In development, the consequences of an exclusive focus on problems and deficiencies can be devastating. As Mathie and Cunningham (2005) observe, “leadership that denigrates the community by emphasising the severity of problems in order to attract resources, and people in these communities internalizing a view of themselves as incapable of initiating positive change” will undoubtedly lead to “a pervasive feeling of hopelessness” (p.177).

In Chapter 5, I discuss how the (over-) representation of refugee-background communities as needy and problematic tends to initiate ‘needs’ maps or approaches, which convey only part of the truth of their actual situation. The concern, John Kretzmann and John McKnight (1993) observe, is that these maps are considered the whole reality of these communities and are not generally regarded as only a fragment of the picture. Thus approaches

are developed solely focused on problems and deficiencies “that teach people the nature and extent of their problems, and the value of services as the answer to their problems” (Kretzmann & McKnight, 1993, p.2). Mathie and Cunningham (2005) note that the communities may become further weakened as they develop dependence on these services and institutions. Yet, somewhat perversely, and as will be pointed to in Chapters 3 and 4, these institutions “develop a vested interest in maintaining this dependency” (p.177). Another critical argument regarding needs-based initiatives are that fragmented approaches are often developed which deny people’s depth and breadth of knowledge regarding their own development and needs. They also ignore people’s own problem-solving capabilities and what they are already doing for themselves.

Because refugee-background men and women are often marginalised in their healthcare, advocating an asset-based approach is vital as it positions people as the principle *agent* in their health and development (Mathie & Cunningham, 2005). Working with an asset focus creates spaces that will mobilise strengths as much as possible – engendering better health outcomes. It also ensures that people are viewed holistically – their experiences, skills, preferences, and knowledges are all privileged (Rotegard et al., 2010).

## **Summary**

This Chapter defined key terms to help develop a foundational understanding for this thesis. The following chapter outlines the theoretical and conceptual frameworks that have informed my approach to this study. I also elucidate the specificities of the processes taken in my use of discourse analysis.

## CHAPTER 3

### Approach

#### Introduction

*There can, of course, be no apolitical scholarship (Mohanty, 1988, p.66).*

I begin this chapter with an exposition of the conceptual frames of my research. As stated in Chapter 1, the impetus of this research has come from the premise espoused within postdevelopment theory that development, if managed and practised differently, can be a more enabling and meaningful process. Using insights from postdevelopment and postcolonial theories, this chapter describes how I have developed a 'way' of analysing western biomedical discourses. Heavily inspired by Michel Foucault, the discourse analysis that I employ is suffused with poststructural sensibilities enabling me to get at how certain subjects and modes of subjectivities are constituted.

#### Conceptual Framework

##### Postdevelopment

*It can mean 'anti-development': a rejection of the development project and the binaries of Third World/First World, developed/underdeveloped that are*

*thus invoked. It can refer to an analysis of the unfair dynamics of power that present themselves through any such language of development and representations of 'the poor' or 'the needy' [...] It can also be used to direct thought towards how development might yet be a conduit for achieving social justice (McKinnon, 2008, p.281).*

As previously discussed, conceptually and theoretically, this research is heavily inspired by the potential of postdevelopment theory to consider and practise development differently. The work of postdevelopment protagonists, J.K. Gibson-Graham (2005) has stirred in me a sense of conviction that there are alternative, and innovative, ways of broaching maternal healthcare for refugee-background women that may engender more enabling processes and outcomes. In their efforts to conceptualise a practical postdevelopment approach, they write that the theory offers “a mode of thinking and practice that is generative, experimental, uncertain, hopeful, and yet fully grounded in an understanding of the material and discursive violences and promises of the long history of development interventions” (p.6). Following Gibson-Graham (2005), in this thesis I use postdevelopment insights to deconstruct the unfair power dynamics in health literature and practice to highlight the possibilities within maternal healthcare services to be more inclusive and meaningful for refugee-background women.

Postdevelopment theory was conceived in the early 1990s due to the so-called impasse of development studies of the mid-1980s (Nederveen Pieterse, 2000; Sidaway, 2008). Prominent postdevelopment theorists, such as Arturo Escobar (1995), Gustavo Esteva (1992) and Wolfgang Sachs (1992) write extensively about development's fallacies and failures. They take an 'anti-development' position; they were extremely critical of the assumptions,

intentions and worldview of mainstream development thinking – and as such, outright rejected it as a concept (cf. McEwan, 2009; Sidaway, 2008). Perhaps the largest inspiration on postdevelopment theory is French historian and philosopher, Foucault who stressed how the interpretation of reality is shaped by culture and language (Connelly, Li, MacDonald & Parpart, 2000). Following Foucault, postdevelopment theorists see development as a discourse that orders and constructs the object it seeks to ‘help’ (Nustad, 2007). Development has, according to Escobar (1995), “created a space in which only certain things could be said or even imagined” (p.39). Seeing development as a discourse allows the relationship between power, language and knowledge to be deconstructed so that these ‘spaces’ can be challenged.

Escobar (1995) challenges us to decolonise our minds from the ideas of development and to question what a world would look like without development. To do so, he asserts, would require us to “imagine moving away from conventional Western modes of knowing in general in order to make room for other types of knowledge and experience” (Escobar, 1995, p.216). In this thesis, I build upon these critiques of the westernising and homogenising tendencies of development to locate a postdevelopment inspired way of broaching development<sup>24</sup>.

Postdevelopment theorists argue that by defining the ‘Other’ by what is not yet attained or in the process of becoming, but what the west is willing to offer, only serves to legitimise the development industry (Ziai, 2007). Further, the question must be asked, what exactly is the ‘Other’ catching up to? And in the area of maternal health, what does a ‘developed’ model of

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<sup>24</sup> In this thesis, this way of “broaching development” refers specifically to maternal healthcare services for refugee-background women.



care look like and who defines it? In many western (and non-western) countries, the biomedical model of childbirth tends to be privileged in maternal healthcare. Yet as alluded to, and which will be explored in Chapters 4–6, as a model it may not be appropriate in all contexts. Indeed the many negative effects of the model are well-documented, and include increased mortality and morbidity for the baby and mother.

Jane Parpart (1995) asserts that development, through its belief in the superiority of western values, discredits and subordinates the livelihoods, techniques, knowledges and practices of ‘developing’ communities. Therefore as Cecilia Van Hollen (2003) argues, non-western and non-biomedical models are constructed as “under-developed” or “backward”. Furthermore the use of these dichotomies has led to a demeaning view of the ‘developing’ world<sup>25</sup> (Parpart, 1995). The consequences of this construction remain under-researched, particularly in the area of maternal health (cf. Jolly, 1998; Jolly, 2002; Kempe, Noor-Aldin Alwazer & Theorall, 2010; Van Hollen, 2003).

Sydney Spangler and Shelah Bloom (2010) argue that development’s “postcolonial construction of the third world woman” implies that women in these parts of the world are dependent on “Northern expertise for survival” and are thus discouraged from using their own agency (p.761). Alison Mathie and Gordon Cunningham (2008) explain,

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<sup>25</sup> I am mindful of the inadequacies and imprecision of using terms, such as ‘developing’ and ‘developed’, to distinguish between different nations and communities. As Chandra Mohanty (1988) observes, this language does not acknowledge the socio-political implications of these divisions, such as how the terms serve to (implicitly) reinforce economic and cultural hegemony. She writes, “only from the vantage point of the West is it possible to define the third world as underdeveloped and economically dependent. Without the overdetermined discourse that creates the *third* world, there would be no (singular and privileged) first world” (Mohanty, 1988, p.83, emphasis author’s own).

“[a] responsibility to enable the less privileged to live with dignity and opportunity has often been translated into the language of ‘victims’ and ‘saviours’ in an arrangement that is at best condescending, but is ultimately self-serving on the part of organisations offering development assistance” (p.2).

Though care is needed here, as while this may indeed be a possible effect of development’s interventions, these assertions discursively represent a singular monolithic ‘third world woman’, which Mohanty (1988) writes tends to (re-) produce and homogenise ‘third world difference’ (read; veiled, religious, illiterate, poor and traditional). Additionally this assumption of third world women as a homogenous oppressed group can be colonising (in a discursive sense). To explain, the construction of difference, a ‘third world woman’ enables and preserves a particular self-presentation of a western woman as being liberated, secular, and as having control over her own life (Mohanty, 1988).

## **Postcolonial Theory**

*Postcolonial theories assert that discursive power (which also translates into material power) still lies with the West (McEwan, 2009, p.73).*

Cheryl McEwan (2009) writes that postcolonialism is a complex and widely-applied term, for instance, it can refer to the time period after colonisation<sup>26</sup>, and it can also be used as a critique of the legacies of colonialism. Space precludes a thorough analysis of its contested meanings (refer to McEwan, 2008; 2009), though here I use the term to refer to an *anti-colonial* critical approach to analyse issues of power, knowledge and representation. Postcolonial approaches highlight how the language of colonialism still

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<sup>26</sup> Often written as post-colonialism to denote the concept of time. Additionally, it is important to note that I am not suggesting that colonisation is a thing of the past (McEwan, 2009).

exists and continues to shape western ideas and practices (McEwan, 2009). This thesis uses postcolonial theory to question whether this proclivity lingers in New Zealand maternal healthcare services.

Postcolonial theory is useful in providing a framework and space from which to bring to the fore the voices and interests of those who may be excluded or undervalued due to the dominance of the western world view (Young, 2003). It asserts not only the *rights* of non-western people, Young (2003) argues, “but also the dynamic power of their cultures, cultures that are now intervening in and transforming the societies of the West” (p.4). Postcolonial theory aims to ensure spaces for the agency of non-western people. Postcolonial feminisms are concerned with ensuring these spaces “allow for competing and disparate voices among women”, rather than simply representing the white, middle-class western feminists (McEwan, 2008, p.127).

Edward Said (1978, cited in McEwan, 2009), understood to be one of the greatest influences in postcolonial theory, argued that colonialism operates as a discourse of domination. To elaborate, knowledge is regarded as a form of power as authority and control is given to the possessors of knowledge. Though knowledge was, and to an extent still is<sup>27</sup>, produced and controlled by those in the west (McEwan, 2009). Said was primarily concerned with western representation of non-western cultures, which “were ideological representations with no corresponding reality; they said more about the West than they did about the real world they purported to represent” (McEwan, 2009, p.63). The processes of representation, as this quote suggests, is implicitly discursive and as Said argues involve ‘Othering’ –

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<sup>27</sup> I am not suggesting that knowledge *is* produced by the west; rather the west has orchestrated the *perception* that knowledge is a product of the west.

oppositional binaries between the 'Other' and 'self'. As McEwan (2009) argues, these "binaries are not innocent, but are bound up in logics of domination" of all those constituted as 'Other' (p.122). Othering serves to not only set apart those deemed different, but also to produce a sense of superiority in 'self', which worked as justification for colonialism of those deemed 'subordinate' and 'inferior' (McEwan, 2009). In Chapter 5, I identify specific instances of Othering discourse in healthcare services for former refugees.

Central to western scientific thought are binary oppositions, which have been shaped by Descarte's mind/body separation (refer to Chapter 2, p.34). There are a whole series of hierarchically valued binaries, including active/passive, developed/underdeveloped, man/woman, centre/margin, straight/gay, masculine/feminine, able/needy, and self/other (McEwan, 2009; Waitt, 2010). The left pole of these binaries is usually the dominant one and associated with greater advantages, and those on the right are more likely to be rendered threatening and requiring control (McEwan, 2009). Foucault (1984) states, "the government of the self allies itself with the practices for the government of others" (p.19). To elucidate, while the poles of binary oppositions are reductionist and essentialising, they are necessary; "we need 'difference', because we can only construct meaning through a dialogue with the 'Other'" (Hall, 1997, p.235).

Dualistic thinking is still evident today and functions to draw out the 'normal' self, from those who are in any way significantly different – the 'abnormal' Other (Hall, 1997; McEwan, 2009; Waitt, 2010). Jan Nederveen Pieterse (1992) asserts that the media age in which we live escalates and perpetuates Othering, in part because the images received in the minority world come without historical analysis. They appear as "manifestations of

culture”, produced through discourse which perpetuate the dichotomy between the ‘Other’ and the ‘norm’, and in doing so (re-) establishes opposition, hierarchy and exclusion (Heron, 2007, p.2).

McEwan (2009) writes, “the relationship between (white) western and ‘other’ feminisms has often been adversarial, partly because of the failure of white women to recognise where they stand” in relations of power (p.58). Within the context of this thesis work, I am aware what the colour of my skin represents; “that whiteness exerts a force that is both global and colonizing in its effects” (Heron, 2007, p.9). I am also well aware of the paradox of carrying out this research using postcolonial theory, a theory which critiques the assumption many white women make that they must rescue the ‘Other’ woman – whether or not it is wanted (Syed & Ali, 2011). Barbara Heron’s (2007) work exploring the experiences of white Canadian women as development workers in Africa offers insight here. She makes a connection between whiteness and development, “and the ways in which they rely on the construction of a racialized Other”, a construction which enables a way of knowing oneself (Heron, 2007, p.6). The ‘helping imperative’, implicit to development work, is linked to the discursive formation of a ‘moral and good bourgeois’ identity, a relationship that she terms, “colonial continuities” (2007, p.6). This term refers to the colonial-like practices which continue in neo-colonial modes, which I understand to be practices which marginalise, subjugate and oppress others, while simultaneously enabling these practices to be justified and validated (Othering). My stake here in my particular ‘helping imperative’ has been discussed in my positionality statement in Chapter 1.

## Criticisms of Postdevelopment and Postcolonial Theories

Postdevelopment theory has produced a strong critique of development, however critics have argued it is just that, a critique, and not a functional paradigm<sup>28</sup> (Ziai, 2007). Similarly, many scholars have critiqued postcolonial theory as being too theoretical and not able to address material concerns (cf. McEwan, 2009, p.71). However, this research demonstrates that it is this very critique that offers the opportunity for reflexive practice: the time to reflect — to stop and think about what has happened, is happening, and should happen next — is essential to effective development practice and research.

Both postdevelopment and postcolonialism are, in essence, concerned with representation and discursive power. As Maria Baaz (2005) observes there are fears that the focus on development discourse(s), may result in the 'urgent' and 'real' problems in the world, such as poverty not being addressed. This fear is largely due to the belief that discourse analysis is seen as incapable of dealing with these urgent problems. However, as McEwan (2009) asserts, because discourses create the very contours of our 'reality' (our knowledge, practices and attitudes are constructed through discourses), studying discourses is a vital component to effective development.

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<sup>28</sup> Postdevelopment theory has been widely critiqued for several reasons, including its proclivity to conceal difference within development and to collapse development with narrow meanings of modernisation, westernisation and homogenisation (McEwan, 2009; Nederveen Pieterse, 1998; 2000). It has also been critiqued for its tendency to romanticise grassroots and local development (ibid.). Additionally the position taken by some postdevelopment theorists to reject all development has been contested, "as though there were something necessarily problematic and destructive about deliberate attempts to increase social wellbeing" (Gibson-Graham, 2005, p.6). Recent postdevelopment strands have moved beyond this harsh critical position into more constructive reflection that recognise the potential for change *within* development discourses (Gibson-Graham, 2005; Kapoor, 2004; McEwan, 2009; Sidaway, 2008).

At any rate, Baaz (2005) maintains that “discourse analysis that is ‘ambushed by relativism’, ‘immobilized by nihilism’ or ‘denies development needs’ should rather be seen as poor (or apolitical) discourse analysis rather than as the necessary consequence of asserting the discursive nature of knowledge and practice” (p.10). Locating interventions of development within the discursive, she explains, acknowledges the socially constructed nature of reality. Economic inequalities are discursive, as they entail social practices through which meaning is constituted (Baaz, 2005).

Examining discourse in this study does not ignore the fact that refugee-background women may have particular health needs, rather it highlights how all the associated identities of the ‘needy’ and ‘problematic’ construction are produced discursively, and how these identities connect to power relations and practices.

### **Why Not Feminist or GAD Theories?**

This thesis is primarily concerned with altering and destabilising the dominant needs-based discourse of the western biomedical model, as well as examining its material effects on refugee-background women. Given that this thesis is concerned with women’s bodies and exploring the lived experiences of refugee-background women; and given that I am interested in investigating the relations of power within these services and, in particular, challenging the dominant masculine ideologies, it may seem both fitting and appropriate for me to employ a feminist lens. There are many reasons why I have chosen not to use the feminist lens, in the following paragraph I outline the most pertinent.

Early analysis revealed that issues of gender, class and race all interconnect to form a ‘web of power’ to produce and sustain the hegemonic position of

western biomedicine. Additionally, the associated subject identities and positioning that the discourses construct, required a lens able to consider how gender, race and class intercept and affect each other. Feminist theory has been criticised for being insufficient to address the interrelationships between race, gender and class, as well as the tendency to privilege white women's experiences (Amos & Parmar, 2006; Spelman, 2006) – aspects which are untenable given the aims of this study. This said, aspects of this thesis are at times also suffused with insights from feminism.

Furthermore, I recognise that the framework of Gender and Development (GAD) may have had potential to inform this thesis. However my primary focus on the workings of discourse meant that postdevelopment theory offered a more suitable framework. GAD may become a more applicable framing for my proposed future empirical research.

## **Postdevelopment Theoretical Frame – The Analysis of Discourse**

Discourse analysis is the theoretical framework of postdevelopment to problematise the “grand narratives about development” (Sidaway, 2008, p.17). In this thesis, I utilise a Foucauldian-inspired poststructural discourse analysis (Graham, 2005) approach to analyse the assumptions and relations of power operating discursively within New Zealand's health services.

### **Poststructural Discourse Analysis – Informed by Foucault's Work**

Discourse analysis is an interpretive methodological approach. It is interdisciplinary so its form can vary greatly depending on the social domain being investigated and one's analytical perspectives (Fairclough,



1992; Graham, 2005; Phillips & Jørgensen, 2002; Waite, 2010). Given this, Louise Phillips and Marianne Jørgensen (2002) attest that, no clear consensus exists “as to what discourses are or how to analyse them” (p.1). In a basic sense though, discourse refers to a way of talking about or representing knowledge about a particular topic or aspect of the world (Hall, 1997; Phillips & Jørgensen, 2002). Interestingly, Ian Parker (1999) surmises that the more interdisciplinary the discourse analysis, the broader the understanding, as texts (and differing forms of, such as speech) can be incorporated that are not usually encountered within the particular discipline. While discourse analysis can be used in all disciplines or areas of research, it is important to note that the philosophical underpinnings (regarding the role of language and knowledge in the construction of reality) must be accepted by the researcher (Phillips & Jørgensen, 2002).

Foucauldian discourse analysis does not delineate methodological rules or templates and thus some writers have argued that it is a difficult or vague ‘methodology’ that lacks the rigour of linguistically-based methodologies, such as Critical Discourse Analysis (CDA) (cf. Graham, 2005; Waite, 2010). It is thought that developing a methodological model may be too reductionist and mechanical – dampening the potential of discourse analysis (for explanation refer to Waite, 2010, p.219). While liberating in one way, in another I found the task of devising how I was going to go about my discourse analysis challenging and puzzling in the initial planning stages. However as I became immersed in the literature I analysed, the work that needed to be done became apparent: the ubiquitous representation and positioning of women with refugee backgrounds as exclusively needy and problematic, combined with the limited research examining this phenomenon, needed examination.

Discourse analysis is well-positioned to work out how it is possible that these representations of refugee-background women have come to be exclusively couched within the needs-based discourse of biomedicine, a discourse that tends not to recognise or value assets or strengths. My challenge then became about how best to present the work so that the statements ‘carried’ themselves (with minimal or no narrative), rather than about how to conduct discourse analysis. As this chapter will show, the approach I took was far from prescribed, it did however enable me to pinpoint how language has worked to produce the conception of the ‘needy’ refugee-background woman, and the associated objects, subjects and practices.

Many writers perceive Foucauldian discourse analysis as inaccessible and shy away from its use for the fear of “one’s work being dismissed as *unFoucauldian* – *if one doesn’t get it right*” (Graham, 2005, p.2, emphasis author’s own). To counter this apprehension, Linda Graham (2005) suggests naming an approach that engages Foucauldian theory, ‘poststructural discourse analysis informed by Foucault’ – as I have done here. Common among Foucauldian approaches, she observes, is that they have a poststructural sensibility<sup>29</sup>, suffused with a “theorising that rests upon complexity, uncertainty and doubt and upon a reflexivity about its own production and its claims to knowledge about the social” (Ball, 1995, cited in Graham, 2005, p.3).

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<sup>29</sup> Foucault’s work on discourse has been associated with poststructuralism, which is an episteme that identifies language as a key medium for constructing meaning (Parker, 1999; McHoul & Grace, 1993; Phillips & Jørgensen, 2002). The key principles of social constructivism have foundations within poststructuralist theory, which recognise that the process of analysis is always interpretive and contingent on the theoretical, epistemological or ethical perspectives of the researcher. In poststructuralism the fluidity and transitory nature of meaning is recognised and, unlike the earlier structuralist theories that assumes there exists one fixed meaning, poststructuralists acknowledge that there are a series of discourses, “whereby meanings change from discourse to discourse” (Phillips & Jørgensen, 2002, p.12).

## **Social Constructivism**

Consistent with my philosophical assumptions associated with postdevelopment theory and its antecedents, the discourse analysis approach used in this research is underpinned by social constructivism. Social constructivism recognises that knowledge is not a mere reflection of reality; rather it plays an active role in constituting and constructing the world (McHoul & Grace, 1993). Underpinning social constructionism is the premise that all research is subjective and interpretive, as a researcher's own personal, cultural and historical background will shape their perspectives and understandings (Brockington & Sullivan, 2003; Creswell, 2003). Thus claims of objectivity, coherence and truth are avoided, as the attention is given to the social practices involved in the construction of all knowledge, including scientific knowledge (Waite, 2010).

## **What is Discourse?**

*Discourses define what is and is not appropriate in our formulation of, and our practices in relation to, a particular subject or site of social activity; what knowledge is considered useful, relevant and 'true' in that context; and what sorts of persons or 'subjects' embody its characteristics (Hall, 1997, p.6).*

For the purposes of this thesis, discourse<sup>30</sup> is defined as a relatively well-bounded cluster (or formation) of ideas, images and practices, which provide a language for talking about – a way of representing what is deemed to constitute legitimate knowledge about – a particular topic at a

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<sup>30</sup> There are many variations in the definition of discourse, including what formulates discourse and how it is used. Thus I consider it necessary to be clear in the interpretation of discourse that this research sits in.

given historical period<sup>31</sup>. These particular knowledge systems or discourses set the parameters about what exists in the world (meanings), and governs the way that topics can be talked about and reasoned about (attitudes), as well as its associated conduct (practices) (McHoul & Grace, 1993; Hall, 1997; Shapiro, 1981; Waitt, 2010).

According to Foucault (1972), nothing has any meaning outside of discourse. It is important to emphasise that this does not denote nothing exists outside discourse, which as Baaz (2005) warns is a common misreading. Rather, physical objects do exist, but only assume meaning and become 'objects of knowledge' within discourse (Hall, 1997). Laclau and Mouffe (1990) elaborate; "objects are never given to us as mere existential entities; they are always given to us within discursive articulations" (cited in Baaz, 2005, p.11).

Discourse defines what is 'normal', who belongs, and who is excluded (Hall, 1997). Subjects' actions take place within discourse, and subjects are active in acquiring their identities through discourse by a conscience or self-knowledge (Foucault, 1982; Kendal & Wickham, 1999). Additionally, as Kalpana Wilson (2011) points out, discourses do not only construct the 'subjects' and 'objects', but also the intended audiences. Audiences are never passive recipients, as interpretation of texts is always a "socially, spatially, and temporally contingent process" (Waitt, 2010, p.230).

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<sup>31</sup> Discourse does not prioritise language – as other forms of analysis do (such as textualism, linked with writers like Derrida) (Papps & Olssen, 1997). Traditionally though there has been little interest in language in the social sciences, and as such it remained in the domain of formal linguistics. In the last few decades, a 'linguistic turn' occurred and as a result language was recognised as something that does not just speak about reality (Fairclough, 1992; Shapiro, 1981). Accordingly the concept of language has become increasingly significant in social sciences and since the 1990s analysis of discourse has become central to development studies, particularly in the field of postdevelopment (Nederveen Pieterse, 2011).

Also discourses can delimit the range of objects that can be constituted and they demarcate what can be legitimately regarded as knowledge (Shapiro, 1981). Thereby, as Shapiro (1981) rightly points out, norms are established “for developing conceptualisations that are used to understand the phenomena which emerge as a result of the discursive delimitation” (p.130). In this sense discourses work to (re-) produce and (re-) establish their authority and validity. Subject-positions are also constituted through discourse; these are specific positions of agency and identity which are produced in “relation to particular forms of knowledge and practice” (Hall, 1997, p.303). To further explain, discourses produce who has the right to speak and they portray particular kinds of people as having authority and as being agents of knowledge (Waitt, 2010).

As Phillips and Jørgensen (2002) note, the concept of discourse *producing* subjects is very different from western ideas of the subject being an “autonomous and sovereign entity” (p.14). While people can make sense of representations and messages in many different ways, we are all limited by discourses in what we can meaningfully say, think and do<sup>32</sup>. Richard Dyer (2002) sums up this philosophical quandary succinctly,

“[w]e are all restricted by both the viewing and reading codes to which we have access (by virtue of where we are situated in the world and the social order) and by what representations there are for us to view and read. Power relations of representation put the weight of control over representation on the side of the rich, the white, the male, the heterosexual...”(p.2).

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<sup>32</sup> As previously stipulated, I am mindful of the tension between how dominant discourses shape us as subjects, and how, as agents, we have the capacity to alter these discourses. It is an incredibly complex, and contentious, dialectic that will be explored further in Chapter 4.

## Power/Knowledge

*Power is a strategy, a strategy that maintains a relation between the sayable and the visible. The visible is always in danger of exhaustion because it is completely determined by the sayable* (Kendall & Wickham, 1999, p.49, emphasis author's own).

The power/knowledge nexus, as Stuart Hall (1997) points out, enables not only the assumption of authority of the truth, but knowledge also has the power to make itself true. Power, he argues, “is implicated in the questions of whether and in what circumstances knowledge is to be applied or not” (Hall, 1997, p.48). Particular systems of knowledge work as instruments of ‘normalisation’, determining what counts as true and false, and it is in this sense that power and knowledge are mutually interdependent (Foucault, 1980; Phillips & Jørgensen, 2002; Waitt, 2010). Accordingly, knowledge is not just a system of thoughts, rather it can be socially legitimised and controlled, also it can be used to regulate, constrain and to discipline the conduct of society. Discourses, then, can operate as a subtle (or not) form of social control and disciplinary power that work through knowledge to establish and sustain the ‘regime of truth’ (Hall, 1997; Phillips & Jørgensen, 2002; Waitt, 2010).

For Foucault, the ‘truth’ is unattainable – there is no single, unchanging, universal ‘truth’ as statements shift their meanings as per the historical rules of a particular discourse (Hall, 1997; Waitt, 2010). Truth instead can be understood “as a system of ordered procedures for the production, regulation, distribution, circulation and operation of statements” (Foucault, 1980, p.133). Foucault was interested in exploring how certain knowledge is sustained as ‘truth’ through **discursive structures**, rather than the

questioning of its truth (Hall, 1997; Kendall & Wickham, 1999; Phillips & Jørgensen, 2002).

An example of a discursive structure is the western biomedical model, which as Gordon Waitt (2010) argues, “has become the most appropriate way of thinking about what exists in the world” (p.233). The disciplines of biomedicine and science have been, and still are, instrumental in constructing and regulating the subject and what it means to be ‘normal’ (Papps & Olssen, 1997; Ong, 1995). Foucault refers to these structures as ‘biopower’, and asserts they are coherent and powerful vehicles that manage and regulate all realms of society. Rather than relying on force, modern states use knowledge to organise and regulate populations by describing, demarcating, and delivering the prescriptions of normality and truth (Foucault, 1980; Papps & Olssen, 1997).

With these aspects in mind, this study is concerned with how the connection of discourse and power (knowledge/power) has produced the conception of refugee-background women as being ‘needy’ and ‘problematic’, which has had certain real effects for both health practitioners and the refugee-background ‘clients’. This research also examines how these effects have been set into practice within certain historically-specific medical and health regimes (Hall, 1997).

### **Discourse Analysis**

*Discourse analysis is the study of a ‘mysterious force’ (Georgakapoulou & Dionysis, 1997, p.23).*

Discourse analysis seeks to uncover “the social mechanisms that maintain structures and rules of validity over statements about particular people,

animals, plants, things, events, and places” (Waite, 2010, p.218). It examines the specific methods, practices and techniques used to ‘normalise’ particular knowledges, while simultaneously excluding (and undervaluing) alternative forms of knowledge (Hook, 2001). Discourse analysis is concerned with the social consequences of discursive representations, thus it inevitably involves issues of power and knowledge. As McHoul and Grace (1993) put it, discourse analysis can show the “historically specific relations between disciplines (defined as bodies of knowledge) and disciplinary practices (forms of social control and social possibility)” (p.26).

Another crucial aspect of discourse analysis is to highlight the ambiguities and inconsistencies within the analysed texts. While discursive structures appear fixed and natural, they are socially constituted processes and accordingly they are inherently fragile. Thus highlighting inconsistencies within discursive structures provides possible opportunities for other meanings, attitudes and practices (Waite, 2010).

It is virtually impossible to think, act and speak outside of particular discourses and attain the ‘truth’, hence the purpose of discourse analysis is not to assess if what is said is ‘true’ or ‘false’, neither is it to discover a ‘reality’ outside of the discourse (Phillips & Jørgensen, 2002). While in principle there may be an infinite number of ways to formulate statements, in practice the statements produced within particular discourses are to a large extent similar and repetitive. Thus the starting point is to analyse the discourse itself, to work with what is said or written and explore the patterns and repetitions in and across the statements (McHoul & Grace, 1993).



In this analysis, I am not seeking to determine whether or not women with refugee backgrounds have high health needs, but to examine what is said about them and what is not, and how this representation has become normal and dominant. My purpose is also to identify what some of the effects and implications are for women, their families, and for those that work with refugee-background communities. To borrow from Graham (2005), the aim of my analysis is to “try and grasp subjection in its material instance as a constitution of subjects through the interrogation of discursive practices that objectify and subjugate the individual” (p.10).

## **My Research ‘Methods’<sup>33</sup>**

### **The Trajectory of my Methods**

On 11 March 2011, I consulted with four representatives and advocates of various refugee-background communities in Wellington New Zealand: Koos Ali, Jamie Barack, Annie Coates and Maureen Zaya. The purpose of the meeting was primarily to make connections, to explore the possibility of conducting research with former refugees about their maternal health experiences, and to establish which areas the representatives thought warranted research. The representatives all agreed that identifying the characteristics of an Asset-Based Community Development approach to maternal healthcare for women with refugee backgrounds in Aotearoa New Zealand could support more effective resettlement.

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<sup>33</sup> I have used the quotation marks here as the term, ‘methods’ can denote a reductionist and formulaic approach. Thus it does not adequately reflect or capture the philosophical assumptions of my epistemology.

In addition to conducting discourse analysis, my initial intention in this thesis was to carry out Feminist Participatory Action Research (FPAR) with a group of pregnant Burmese women with refugee backgrounds to explore their experiences with maternal healthcare services. Specifically, I proposed to document the strengths, assets and capabilities (specific cultural knowledge and practices) that they draw on through their pregnancy and childbirth experiences, using in-depth interviews and focus groups. Though as I began my review and analysis of the literature, it became apparent that the discursive work needed to set the groundwork for this empirical research was more comprehensive than intended. Accordingly my sole focus became amalgamating the current understandings regarding medicalisation, western biomedical discourse(s), the history of maternal healthcare, and representations of refugee-background women (and men) to create a foundation that would enable a more informed and focused empirical project to be carried out at a later date as my doctoral project.

### **Working Reflexively**

Before I began my analysis I scoured through research databases for New Zealand (and overseas) articles using keywords such as, 'refugee', 'health', 'representation', 'maternal', 'biomedical', 'assets' and 'medicalisation'. As I studied the research, I tried to shelf any preconceptions I had and read, listen, and look at the texts with "fresh" eyes and ears in order to "disclose the created 'naturalness' of constructed categories, subjectivities, particularities, accountability, and responsibility" (Waitt, 2010, p.224). As a way to accomplish this Phillips and Jørgensen (2010) suggest pretending to be an anthropologist exploring a foreign universe, and accordingly the 'normal' may appear strange – and vice versa. Although if one accepts that all knowledge and 'truths' are discursively produced, then endeavouring to work from an independent platform is complex. It may be difficult (or even

impossible) to treat or recognise discourses as a discourse (especially when working within them), thus one cannot with any certainty avoid any pre-existing categories (Foucault, 1972; Hall, 1997; Phillips & Jørgensen, 2002; Waitt, 2010).

Instead, and in keeping with social constructionist ideals, researchers need to “become self-critically aware of the ideas that inform their understandings of a particular topic” (Waitt, 2010, p.225). In carrying out this research, I have tried to be transparent by disclosing my assumptions and interpretations that have shaped my research. Specifically, I have been self-reflexive about my subjectivities, provided a positionality statement (see Chapter 1, p.9), and have been cognisant of changes to my ideas as the research project unfolds (Waitt, 2010). Gillian Rose (1997) observes that, like discourses, research provides partial, situated knowledges – “the sort of knowledge made depends on who its makers are” (p.306). I have written in first person throughout to locate my positioned voice, which may help demonstrate to the reader how my position (as a Pākehā, former midwife, mother and development studies post-graduate student) has informed my understanding of my research.

In my analysis, I have attempted to present how and what biomedical discursive practices ‘do’ by allowing the work to “emerge in its own complexity” (Foucault, 1972, p.47; McHoul & Grace, 1993; Waitt, 2010). To achieve this I provided as many historical examples and cited statements from the texts as possible, while trying to avoid making loaded interpretive comments. There is no quantitative data, such as content analysis<sup>34</sup> as this

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<sup>34</sup> Content analysis involves the counting or grouping together of words or phrases (Parker, 1999).

would counter my assumptions regarding the nature of meaning. As Parker (1999) explains:

“words and phrases do not come ready packaged with specific delimited meaning that a researcher can be sure to know as if they were fixed and self-contained. Rather it is the interweaving of words and phrases in different contexts that gives them their sense, and when we attempt to grasp patterns in a text we always have to carry out that exercise against a cultural backdrop” (p.2).

To reflect (and respect) the ‘complexity and multiplicity’ of meaning, I have not followed a prescribed method in my analysis; rather I have presented a variety of ways to read the statements from a range of texts. Like Parker (1999), I consider discourse analysis as a way to encapsulate my sensitivity to language and to help me highlight the nuances of meanings that can seemingly go by unnoticed. There is an implicit coherence between my sensitivities and my perspectives and interpretations, and thus I recognise that there will undoubtedly be other ways to interpret and make sense of the material (Graham, 2005).

As I wrote my analysis however it was difficult to stop attempting to convince the reader about the meanings and implications of certain statements, as I wanted to be sure they ‘saw’ it as I did. Thus although I tried to present how the discourses I’ve analysed reflect the author’s understanding of the world, I cannot say without doubt that in some instances, they may reflect mine (and my imposed ‘taken-for-granted’ discourses from elsewhere) (Phillips & Jørgensen, 2002; Waite, 2010).

In Ilan Kapoor's (2004) exploration of Gayatri Chakravorty Spivak's (1988; 1990) writings on self-reflexivity, he identifies a four-step systematic approach to how to represent the subaltern<sup>35</sup> ethically. These steps include:

- *Negotiate the discourse from within* – realise that one can never escape discourse; thus altering and negotiating hegemonic discourses must be attempted from within them.
- *Acknowledge one's complicity* – to achieve the former step, Kapoor observes that we must openly declare our desires and complicities with the discourses we are imbued in. This, writes Kapoor (2004), "helps temper and contextualise one's claims" (p.641).
- *Transform one's privilege into a loss* – in an attempt to challenge hegemonic knowledge systems and representation, one must carefully deconstruct where privilege is. This involves looking at how one's own behaviours, attitudes and habits may reproduce and perpetuate dominance.
- *Learn to learn from below* – learning to learn means refraining from thinking that one has all the answers and that what one knows is inherently 'better' (Kapoor, 2004, p.643).

In my attempts to ensure this work is ethical and that it does not counter the decolonising aims of my research, I have tried to follow the aforementioned four steps of self-reflexivity. Specifically, in this thesis I am working within the dominant biomedical discourse to identify more enabling discourses as a

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<sup>35</sup> Subaltern originates from Italian theorist, Antonio Gramsci, who used it to refer to persons socially, politically and geographically outside of the Western hegemonic power structure (Kapoor, 2004). McEwan (2009) discusses how the term has been misappropriated by many writers who use it to signify any oppressed or marginalised people, and not specifically the subaltern. Using Spivak's critiques, McEwan asserts that in postcolonial theory it is used to refer to people who are outside the privileged hegemonic discourses. Postcolonialism is concerned with creating spaces "to allow the subaltern to speak, rather than always being spoken for by either elites or colonizing Northern representatives" (McEwan, 2009, p.16). Here I use 'subaltern' to refer to former refugees whose 'voices' may not be heard within the dominant biomedical discourse.

way to balance the excesses of the model. Second, in my positionality statement (p.8) I have declared my complicity in the discourse. Third, throughout the writing of this thesis I have challenged the assumptions (including aspects of my own) that westernised biomedical care is somehow superior to other medical systems.

Last, this thesis argues that an asset-based approach to maternal healthcare for refugee-background women (fundamentally) involves learning to learn from the 'subaltern', as well as providing the spaces for this to occur. The challenge though, writes Kapoor (2004), is to ensure that these spaces allow the women to be 'heard'. I acknowledge that the voices of refugee-background women are not presented here, though I hope that this work provides a step towards the creation of spaces in which those working within hegemonic discourses are ready to 'listen'.

### **My use of Discourse Analysis**

*We must show that they [discourses] do not come about of themselves, but are always the result of a construction the rules of which must be known, and the justifications of which must be scrutinized; we must define in what conditions and in view of which analyses certain of them are legitimate; and we must indicate which of them can never be accepted in any circumstances* (Foucault, 1972, p.25).

The western biomedical model is socially constructed and could be different. Using discourse analysis, this thesis investigates the taken-for-granted, commonsense understandings about former refugees inherent within this model's application in New Zealand to demonstrate how some statements are accepted as true or 'naturalised', while others are not.

My approach has been specifically inspired by Roxanne Doty's (1993) work exploring foreign policy discourse and demonstrating how a hierarchy of subjects is produced. The approach Doty (1993) takes poses '*how-possible*' (how is it possible) questions, rather than the more conventional *why* questions commonly taken to analyse foreign policy. She argues that *why* questions are incomplete as they "take as unproblematic the possibility that a particular decision or course of action could happen" (Doty, 1993, p.298). They fail to examine how meanings are produced and attached to certain subject-positions, and they also neglect to explore the way in which power works to construct particular subject identities, subject relations and a range of possible conduct. As Doty (1993) explains, in using *how-possible* questions "what is explained is not why a particular outcome obtained [sic], but rather how the subjects, objects, and interpretive dispositions were socially constructed such that certain practices were made possible" (p.298). *How-possible* questions still enable asking why, but they induce a more thorough critique and understanding, as central to these modes of questions is the view that power is productive of particular outcomes.

Following Doty (1993), I ask – how is it possible that refugee-background women are only known as having health needs and problems, and not seen as having assets and strengths? How were certain subjects and subjectivities constituted so as to make possible the western biomedical model's authority to manage, judge and organise certain groups, as well as all issues of health and illness in society? How did the practices involved in this hierarchical construction of subjects enable refugee-background women to be constituted as only having considerable needs and not (valued) assets and knowledges? These modes of questions facilitate a deeper engagement and analysis of the various conditions that had to be in place to allow these things to be possible (Doty, 1993).

To date, research examining the health of former refugees has, in general, focused on ascertaining *why* refugee-background women and men have high health needs (cf. Ali & Wilson, 2005; Carolan, 2010; Carolan & Cassar, 2010; CRF, 2011; McLeod & Reeve, 2005; Ministry of Health (MoH), 2001; 2011; Mortensen, 2008). Depending on the approach, explanations focus on the barriers refugee-background people face in achieving good health, such as their 'lack' of understanding (these cultural explanations are explored in Chapter 5); or particular problems with healthcare practices, for example a shortage of interpreters; or they may identify issues with healthcare practitioner perceptions, such as lack of cultural awareness. It is common in all these lines of enquiry to take as unproblematic the possibility that former refugees are exclusively needy – failing to analyse the power operations that constitute the subject identities, subjectivities and positioning that enable this construction.

The aims of my analysis have been threefold; first, I defined and contextualised western biomedicine and biomedical discourse, the medicalisation process and medical social control to provide some background and critical awareness to my field and scope of investigation. Second, I carried out an historical analysis of how the processes of pregnancy and childbirth came to be medicalised events firmly subjected to medical control. This examination presented tangible examples of how it is possible that the western biomedical model is (evidently) regarded as having authority and control over all issues health and illness. It also demonstrated the propensity of the model to exclusively focus on pathology and problems. The insights from the first two phases of my research formed the basis of the third part of analysis involving a thorough critique of the health-related texts in New Zealand concerning people with refugee backgrounds. Furthermore, I was interested in identifying the possible



implications of the 'needy' and 'problematic' representation of former refugees that these texts produce, circulate and maintain.

## **Part One and Two: Challenging Biomedical Hegemony**

*We have to know the historical conditions which motivate our conceptualisation. We need a historical awareness of our present circumstance (Foucault, 1982, p.209).*

The contextual phase of my analysis combines the current thinking around what the western biomedical model and biomedical discourse are, as well as medicalisation and medical social control. In my initial stages of analysis I assumed that 'the' western biomedical model was an uniform homogenous enterprise and accordingly used this understanding to explore the trajectory of the model into a (major) site of social control. Analysing literature from the critical fields of sociology, anthropology, health sciences and midwifery, I began to understand the plurality of its forms, and thus my appreciation of the inextricable coherence between discourse and practice developed. Foucauldian insights further cradled this awareness of the contingent relationship between the western biomedical model, the practice of biomedicine and western biomedical discourse – one can't exist without the other (refer to Chapter 2, p.38). From this position, my analysis was careful to record the social factors that made it possible for biomedicine to have the broad reach and dominion that it enjoys; I did not set out to discover any 'true', essential western biomedical structure<sup>36</sup>.

In Chapter 4, using the classifications of medical social control, I then analysed how the medical screening process that former refugees are

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<sup>36</sup> Which, if I had, may have worked to reify and cement the dominance of the model.

required to undergo at Mangere Refugee Resettlement Centre (MRRC) is constitutive of medical control. The screening process, I found, in large part renders it possible for former refugees to be understood and consequently represented as having considerable health needs. The statements that materialised from the medical research of the screening were found in most of the circulating health-related literature that I analysed. This process helped me address my first *how-possible* question: how is it that refugee-background women are only known as having considerable health needs?

The second part of my analysis involved exploration of the historical-social circumstances that facilitated the processes of pregnancy and childbirth to become medicalised. I looked at literature from midwifery, health sciences and sociology (which was often dated). In my analysis, the specific strategies employed to help secure the conceptualisation of pregnancy and birth as a medical “problem” (requiring medical control) emerged. This galvanised my second *how-possible* question: how is the hierarchy of the western biomedical project made possible? My historical analysis also demonstrated the circumstances which rendered it possible for particular kinds of knowledge (western, biomedical and scientific) to become understood as valid, legitimate, trustworthy or authoritative, while other knowledges are marginalised.

### **Part Three: Interrogating the Figuration of the ‘Needy’ Refugee-Background Woman**

*All texts are the outcome of a power-laden process, fashioned within a particular social context (Waite, 2010, p.226).*

Drawing on the two first parts of my analysis, I examined the texts circulating in New Zealand, which specifically related to the health of

former refugees. Within them I sought to identify particular instances of western biomedical discourse, and to highlight its associated effects and practices (refer to Chapter 5). This textual analysis made it possible to get at my third question – what are the specific mechanisms at work which construct the ‘needy’, ‘diseased’ and ‘problematic’ refugee? And which position do particular subjects take to another? I chose to analyse the following texts:

- *“Refugee Health Care – A Handbook for Health Professionals”*. Published in 2001 by Ministry of Health (MoH), New Zealand. Statements drawn from this text are identified with the superscript (1).  
I also analysed the 2011 revised<sup>37</sup> *“Refugee with Special Health Needs – Women from Refugee Backgrounds”* chapter of this Handbook.  
Analysed statements from this chapter are distinguished as (1<sup>a</sup>).
- *“Refugee Health Needs Assessment”*. Published in 2005 by Regional Public Health, Wellington, New Zealand, and written by Koos Ali & Joy Wilson. Statements from this text are characterised as (2).
- *“Maternal Health”*. A presentation given by midwife, Irene Chain at the Refugee Health Collaborative Women’s Forum on 24 March, 2011. Excerpts from this presentation can be distinguished as (3<sup>a</sup>).

### **Rationale of Text Choice**

These texts were chosen primarily because of their relevance to my research focus (i.e. former refugee maternal and general health) and because they were generated in New Zealand. Various people, presumed to be authorised speakers, subjects and actors within refugee health and/or biomedicine, such as health practitioners, healthcare services, health board

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<sup>37</sup> It was advised that this chapter will replace the 2001 chapter of the same name in the revised edit of handbook due to be published late 2011 (A. Mortensen – primary project coordinator, personal communication, 22 June 2011)

experts, refugee service providers, New Zealand immigration staff, and people with refugee backgrounds have written (or have been consulted with in the writing of) these texts. This broad range of authorship and contribution to the texts indicates that the particular ideas and statements throughout the texts (regarding the high health needs and problems of refugee-background people) are, as Waitt (2010) notes, about the effects of discursive structures, “accepted and repeated by most people as ‘commonsense’, unproblematic, unquestionable, and apparently ‘natural’” (p.234). The extensive range of input into the texts also suggests that many (variously ‘positioned’) people think, speak, write and act within western biomedical and scientific discourses. Foucault (1972) observes that, it is the continual use of the discourses by people who are discursively positioned within them that govern their dispersion (Foucault, 1972). The repetition serves to (re-) establish and (re-) produce the dominance of the biomedical model, and the particular ideas, subjects, practices and attitudes it nurtures.

The intended audiences for all the texts were similar: healthcare practitioners or service providers to people with refugee backgrounds. The texts are anticipated as instructional and/or directional for the practitioner’s healthcare provision to former refugees. As such, it would be fair to assume that the statements made would reflect, to a certain extent, the current practices, attitudes and ideas of healthcare practitioners working with refugee-background communities. In most cases, the audience is positioned as belonging to the same group as the author, seen by the use of personal pronouns such as, ‘we’, ‘our’, ‘my’, ‘I’ and ‘you’. This is in contrast to how the refugee-background ‘subjects’ are positioned as ‘them’, ‘they’ and ‘these people’. These Othering binaries (refer Chapter 5, p.132) set apart refugee-background women and men as different and not belonging to the audience of healthcare practitioners. Waitt (2010) asserts that “audiences can be

conceptualized as co-authors of a text” because authors will use certain discourses to heed to “the needs, demands, and fantasies of the intended audience” (p.228).

The MoH Handbook was chosen as it is the document that is most cited when referencing the high health needs of refugee-background communities in New Zealand (cf. Ali & Wilson, 2005; Cheuk Chan, Peters, Reeve, & Saunders, 2009; New Zealand Immigration Service, 2004; Mortensen, 2008; 2011; Perumal, 2010). Additionally, the MoH is the government organisation that provides leadership and policy for the health and disability sectors in New Zealand (MoH, 2010), and as such the ideas represented in this handbook are likely to be institutionalised throughout the sectors. The Health Needs Assessment was chosen because Koos Ali (the author and one of the refugee-background representatives consulted with) alerted me to the findings of the research. Specifically, she expressed concerns regarding the dissatisfaction of refugee-background women with maternal healthcare services and outcomes. Ali reported that the Assessment was widely used in public health services and other refugee service provider organisations (K. Ali, personal communication, 3 March 2011). Also, given my research is based in Wellington, Aotearoa New Zealand, the Assessment carried cogent place-based relevance.

The presentation on Maternal Health by Irene Chain was analysed for several reasons. In it Chain discussed her experiences and practice working with refugee-background women, and that of her colleagues at the Swan Midwives clinic in Mt Roskill, Auckland. The presentation was the only document I found that was solely focused on the maternal healthcare given to refugee-background women in New Zealand. Through the visual medium and relaxed setting of the presentation, I was able to pick up on the

more casual and 'everyday' discourses used in reference to refugee-background women. This is important because as Milliken (1999) explains, discourses are not just official texts, they're "background capabilities that are used socially" (p.233).

### **Textual Mechanisms**

When making the statement that former refugees have high health needs, most of the literature I looked at (post-2005) cited the paper by Alison McLeod and Martin Reeve (2005), '*The Health status of quota refugees screened by New Zealand's Auckland Public Health Service between 1995 and 2000*' (see Ali & Wilson, 2005 [note: the paper was unpublished at this time, but the authors quote it]; Cheuk Chan et al., 2009; MoH, 2011; Mortensen, 2008; 2011). The paper reports the main findings of the medical screening of refugees (between 1995 and 2000) at Mangere Refugee Resettlement Centre (MRRC). It was published in the *New Zealand Medical Journal* (NZMJ); the official journal of the New Zealand Medical Association and regarded as the principal scientific journal for the profession in the country (NZMJ, n.d. (a)). One could postulate that due to the high regard for the journal (and biomedicine), the paper is regarded as reputable, and subsequently widely read and quoted.

In McLeod and Reeve's (2005) paper the following assertion is made: "*The results demonstrate a well-known fact: Refugees and asylum seekers resettled in countries of second asylum have high health needs*" (p.10). Using Doty's (1993) textual mechanisms: *presupposition*, *predication* and *subject positioning*, I was able to identify how the 'needy' and 'problematic' former refugee is constituted, and how subjects have been positioned vis-à-vis one another (refer to Chapter 5). While all three mechanisms work together and simultaneously, I discuss each separately to draw out specific ways in which

the discursive practices of biomedicine work. First the textual mechanism, *presupposition* works to create the background knowledge necessary for the statement to make sense. Implicit in any language use, is the existence of certain subjects and objects, and their positioning in relation to each other. Thus presuppositions constitute “a particular kind of world in which certain things are recognized as true” (Doty, 1993, p.306). Second, *predication* involves the attaching of various attributes and qualities, via the use of adverbs and adjectives, to construct the identities of subjects.

Third, *subject positioning* works by linking together certain subjects and objects using relationships such as opposition, identity, similarity and complementarity. As Doty (1993) reasons, the way in which a subject is positioned relative to other subjects, determines the very nature of that subject. Deconstructing the texts helps to identify,

“the oppositional structuring in a text which results in the hierarchization of one term in relation to another. The dominant term is highlighted by the subordinate term which is deemed the “other,” the deviant, or the inferior, to the first term” (p.306).

These textual mechanisms are rather transparent in the McLeod and Reeve statement, and yet despite this overtness, the constructions have become widely used and circulated in a variety of texts. The construction of refugees and former refugees as needy and problematic does not just exist in one or two texts, “[d]ifferent texts within the same arena (i.e. site) and texts from different arenas may share the same logic according to which meaning is created and subjects constructed” (Doty, 1993, p.308). Hall (1997) refers to this occurrence as *intertextuality*, where meanings can be understood and ‘fixed’ in particular ways, depending on its regularity and relation to a number of other, similar messages. As Doty (1993) points out because

former refugees are constructed according to the same logic in a variety of texts, it is fair to assume a controlling or dominant discourse at work.

Though, as will be shown in Chapter 5, while these ideas appear 'fixed' and natural, there are cracks and there is resistance, which may mean there can be opportunities and openings for them to be changed.

### **Organisation of Themes**

As I read through the texts, recurring words and images began to emerge and I was able to sort them into four interpretative themes. I titled these: *Questioning Current Stereotypes*; *Privileging Western Biomedicine*; *Othering in Health*; and *Talking about Assets?* Within these themes were various subthemes, which instantiated or encapsulated different forms of the main themes. For instance, under the theme, *Questioning Current Stereotypes*, there was a section titled, *Medical Screening Literature*. This included the textual mechanism analysis of the aforementioned statement in the McLeod and Reeve (2005) paper. The second theme, *Privileging Western Biomedicine*, included subthemes such as: *Discounting the Health Concepts of Former Refugees* and *Unreliable Voices*. I identified three forms of *Othering* present throughout the texts, these were: *Essentialising Explanations*; *Culturalist Explanations*; and *The Diseased and Contagious "Other"*. The last theme, *Talking about Assets?*, identifies the occurrences throughout the texts where the known assets of former refugees are mentioned or remain unacknowledged or contradicted.

### **Why Discourse Analysis?**

McHoul and Grace (1993) argue that changes in public ideas about particular things precede changes in private individuals' perceptions, and not vice versa. While I am cognisant of the implications this has for agency (refer to p.90 & 180), it is a compelling reason for my implementation of



discourse analysis here. Identifying some implications of particular instances of biomedical discourse may increase awareness and bring about change in current social practices and attitudes.

In the process of conducting my discourse analysis I've come to realise asset-based development as a practical application to enable the ideals ensconced within postdevelopment theory. Hall (1997) asserts that discourse analysis brings with it an "acknowledgement that a different discourse or *episteme* will arise at a later historical moment, supplanting the existing one" (p.46). This realisation may produce a new and more just discursive formation and in turn, more 'positive' societal conceptions of refugee-background women. While still confined to the boundaries of a discourse, the shifting (more enabling) subjectivities that are engendered, may result in refugee-background women (and men) more 'empowered' to exercise forms of agency and productive power<sup>38</sup>.

My analysis seeks to question and confront the biomedical discursive practices that objectify and marginalise former refugees – thereby limiting their opportunities for meaningful engagement within health services. As such, it can be said that this thesis aims to challenge unfair power relationships and social injustice.

## **Summary**

This chapter has explored how postdevelopment and postcolonial lenses offer the extensive frameworks necessary for this investigation into how

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<sup>38</sup> Refer to Chapter 4, p.90, for my poststructuralist-informed analysis of power and empowerment.

power operates discursively within the western biomedical model, and its associated effects. Heavily inspired by postdevelopment visionaries, Gibson-Graham (2005), I have used the ‘tools’ of the theory; discourse analysis, to elucidate an alternative (and more enabling) way of ‘doing’ development<sup>39</sup>. I have also discussed the specificities of how, and the reasons why, I’ve used a Foucauldian-informed, poststructural discourse analysis in this thesis.

The next chapter examines how it is possible that representations of refugee-background women are exclusively couched within the needs-based discourse of western biomedicine. This examination is pivotal to understanding the transition from birth as a natural life event controlled by women to becoming a process that is treated as a medical condition.

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<sup>39</sup> This way of “doing development” is using an asset-based development approach to maternal healthcare services for refugee-background women. Explored further in Chapter 6.

## **CHAPTER 4**

### **Discourse Analysis: Part One – Disrupting Biomedical Hegemony**

#### **Introduction**

*To tackle the ideological functioning of a science in order to reveal and modify it [...] is to question it as a discursive formation; it is to tackle not the formal contradictions of its propositions, but the systems of formation of its objects, its types of enunciation, its concepts, its theoretical choices. It is to treat it as one practice among others (Foucault, 1972, p.186).*

In this chapter, I critically examine the specific details of the western biomedical discursive frameworks that create, circulate and sustain as ‘truth’ the idea that refugee-background women have high health needs and problems, while simultaneously silencing other possible imaginings. I aim to uncover the particular regimes of power and knowledge that have produced certain categories, subjectivities and social relations, while hierarchically positioning people in them. It is my intention here to decentre the biomedical model’s hegemonic position; to borrow from Linda Graham (2005), I intend “to dissect, disrupt and render the familiar strange by interrogating” (p.7).

To document the historical ‘discovery’ of women with refugee backgrounds constituting a medical problem, attention must first be given to how and when western biomedicine became a dominant force of society and the consequences of this dominance. In this chapter I argue that the jurisdiction and authority accorded the biomedical model occurred from the ability of medical practitioners and institutions to professionalise and extend control over the healing enterprise, despite the inability of biomedicine to illustrate absolute efficacy in improving health. This chapter highlights the historical and sociopolitical features that made possible biomedicine’s current expansive (and complex) jurisdiction. As the number of human events now subject to medical control expands, not only is the experience of these events transformed, but also they are increasingly constructed via the biomedical model (Foucault, 1973; Reissman, 1983). This following analysis will demonstrate how medicine is a social enterprise, which, through the process of human action, constructs illness (Clarke, 1983; White, 1996): “illness is not inherent in any behaviour or condition, but conferred by others” (Reissman, 1983, p.5).

First, I briefly define what is meant by medicalisation and medical social control. I discuss how the medical screening programme for former refugees at the Mangere Refugee Resettlement Centre (MRRC) is constitutive of medical social control. Then to historically ground this analysis, I examine how the once non-medicalised processes of pregnancy and childbirth have become medicalised events firmly under medical control. This examination allows understanding of how and why it is that western biomedicine is dependent on the necessity of pathology and problems. It also demonstrates the model’s tendency to disregard non-western and ‘unscientific’ knowledges. Exploring the historical events that preceded medicine’s trajectory to power provides the opportunity to ask

Roxanne Doty's (1993, refer to Chapter 3, p.71) how-possible questions: how have representations of women with refugee backgrounds become exclusively couched in the needs-based discourse of western biomedicine? And, how is it possible that this apparent authority and hegemony is (seemingly) never questioned?

Of concern is how the dominant biomedical discourse is able to produce and "make intelligible" the subjects authorised to speak about refugee-background women, while also defining the practices by these subjects towards the 'needy' and 'problematic' refugee-background woman – as defined by the discourse (Milliken, 1999, p.229). These discourses also produce the audiences for these 'authorised actors', which serves to normalise and legitimate the medical practices and interventions towards former refugees. In this process a particular 'commonsense' is validated, while other ways of seeing and talking about former refugees are (apparently) meaningless and unfeasible (Milliken, 1999; Waitt, 2010). Yet while these dominant discourses appear fixed for large numbers of people, it will be illustrated here that a large amount of work and commitment is required to "'articulate' and 'rearticulate' their knowledges and identities (to fix the 'regime of truth')" (Milliken, 1999, p.230). Consequently, making these discourses inherently unstable and thus open to alternative possibilities.

## **Medicalisation**

The term medicalisation literally means to make medical. However, in the 1970s the term was used increasingly to critique (over-) medicalisation. Irving Zola (1983) provides a straightforward definition; medicalisation is a

“process whereby more and more of everyday life has come under medical dominion, influence and supervision” (cited in Conrad, 1992, p.295). For example, in the past various conditions, such as alcoholism, homosexuality and drug addiction were classified as ‘bad’, now they come under medical scrutiny and are consequently categorised as ‘sick’ (Conrad & Schneider, 1980).

Peter Conrad (1992) sees medicalisation as a definitional issue, involving both the use of a medical framework and terms to understand and define certain behaviours or conditions, and the use of medical intervention to ‘treat’ or ‘control’ these experiences being described as deviant. The medicalisation of childbirth, which is at the heart of this thesis, therefore, can be defined as a:

“process whereby the medical establishment, as an institution with standardized professional guidelines, incorporates birth in the category of disease and requires that a medical professional oversee the birth process and determine treatment” (Van Hollen, 2003, p.11).

There is disagreement about what motivates medicalisation. Scholars have cited causes ranging from intentional occupational expansion by the medical profession, ‘medical imperialism’, and increased societal reliance on technology and scientific experts (cf. Conrad & Schneider, 1980; Dubos, 1960; Reissman, 1983). In Aihwa Ong’s (1995) paper she problematises biomedicine as a “mix of good intentions, desire to control ‘diseased’ and ‘deviant’ populations, and the exigencies of limited resources which often compel medicalization” (p.1244). Conrad (1992) provides a summary of the social factors that have provided the context and subsequently perpetuated or assisted medicalisation, these include: the attenuation of religion; the unshakable faith in science; rationality and progress; the well-established

prestige and authority of the medical profession; and a general humanitarian trend in western societies (p.213). The factors highlighted by both Conrad and Ong are of particular interest in the context of international development where western-based biomedical strategies and technology are being exported to 'developing' nations as a means to enable the Millennium Development Goals (refer to Chapter 6, p.170).

## **Medical Social Control and Medical Screening**

*Among the schemes of knowledge/power regulating individual and social bodies, modern medicine is the prime-mover, defining and promoting concepts, categories and authoritative pronouncements on hygiene, health, sexuality, life and death (Ong, 1995, p.1244).*

According to Conrad (1992), without medicalisation medical social control is more difficult to achieve as it loses its legitimacy (in a definitional sense). Thus, more often than not, medicalisation precedes medical social control. Medical social control can be understood as the use of medical means or authority (intentional or not) to fix certain behaviours according to social 'norms' (Conrad, 1979).

Zola (1977, cited in Cahill, 2001) observes how modern medicine is now a major site of social control, which is sanctioned by the institutions of state, religion and law. He discusses how biomedicine has become 'the new repository for truth', where supposedly neutral and objective medical 'experts' and technology are regarded as authoritative and legitimate knowledge. Medicalisation, and the labels it endorses, are increasingly relevant to most areas of human existence. This process, Zola (1977) argues,

has been insidious and, for the most part, un-dramatic (cited in Cahill, 2001). In this way, modern medicine works as a disciplining mechanism that establishes and regulates people to social 'norms'; more specifically, deviant behaviour is understood, minimised, eliminated and normalised using medical means – which consequently renders citizens 'governable' (Cahill, 2001; Conrad & Schneider, 1980; Foucault, 1991; Ong, 1995; Reissman, 1983). As Ong (1995) asserts, "the control of the terms and practices that produce various 'subjectivities' in the target population is itself a source of social power" (p.1246), thus while biomedicine is attending to the health of citizens, it also shapes the social needs, rights and norms deemed appropriate for members of the modern welfare state.

Conrad (1979) classifies three general forms of medical social control: *medical ideology*, *medical collaboration* and *medical technology*. Although they're not entirely discrete, he separates them to "'unpack' the elements of medical social control and catalogue the range of possible controls" (1979, p.3). In his 1992 paper, Conrad adds a fourth, based on Foucault's work – *medical surveillance*. This fourth element is particularly relevant here because it plays a central role in the medical screening process for refugees entering Aotearoa New Zealand.

Before quota refugees arrive in New Zealand they are required to undergo pre-screening for active tuberculosis and HIV infection. Any "tuberculosis must be treated before travel to New Zealand, and the number of quota refugees with HIV infection accepted for resettlement is limited to 20 per year" (McLeod & Reeve, 2005, p.12). Then when quota refugees first arrive they spend six-weeks at MRRC (Ministry of Health (MoH), 2001). Among the agencies offering support and preparation for former refugees at MRRC



is a Medical Clinic, “which provides health screening, and management of any medical problems found” (McLeod & Reeve, 2005, p.1).

The oft-cited paper by Alison McLeod and Martin Reeve (2005), states that while the reasons for screening are diverse, the aims are “generally set up to minimise public health risk” (p.12). The MoH (2001) *Handbook for Health Professionals* (providing services to refugees) cites the aim of screening is to: “identify those who have health problems, and treat or refer to specialist agencies, as appropriate; and prevent the spread of infectious diseases such as tuberculosis (TB) and human immunodeficiency virus (HIV) infection” (p.27). At the end of the six weeks “all refugees aged 17 years and over are given a copy of their medical records. Adults are advised to give their records to their family doctor [...] Each record has a ‘problem list’ [...] which lists ongoing problems and the person responsible for follow-up” (MoH, 2001, p.28). The GP notifies the MRRC when the refugee registers to ensure all refugees are accounted for and a copy of each refugee’s record is also sent to MoH in each district of resettlement (Refugee Health, 2009).

The processes adopted during this medical screening process closely reflect Conrad’s (1979; 1992) categories of medical social control. The first, *medical ideology*, imposes a medical model for accrued social and ideological benefits (screening refugees will minimise public health risk). The second, *medical collaboration*, doctors assist (usually in an organisational context) as information providers, gatekeepers, institutional agents, and technicians (the Medical Clinic at MRRC and its associated medical organisations in the community). The third, *medical technology*, suggests the use of technology as a means for social control, such as drugs, surgery and screening (refugees undergo comprehensive health screening and associated treatments). And last, *medical surveillance*, is felt by refugees as they experience the medical

gaze as physicians lay claim to all knowledge and activities concerning their “conditions”, both at MRRC and later when they have resettled.

## **Power and Agency**

While it is clear that, using Conrad’s (1992) categories, former refugees are subject to medicalised social control, it is less clear how they feel and interpret this. Similarly, the possible implications for former refugees subjected to biomedicine’s discursive framework are not well understood. Medicalisation, writes Cecilia Van Hollen (2003), cannot proceed without a population of patients who cooperate (or resist). Conrad (1992) himself cites a number of examples where ‘patients’ and medical practitioners themselves are actively involved in medicalisation, concluding that medicalisation is an “interactive process and not simply the result of “medical imperialism”” (p.219). In a similar vein, Ong (1995) critiques Foucault’s tendency to ignore the agency of the “subjects of regulation” (p.1244). Her account of how Cambodian refugees “themselves draw the medical gaze, [and] how their resistances to biomedical interventions both invite and deflect control” (p.1243) compels the need for more research in this area.

When exploring how refugee-background women negotiate reproductive healthcare services, it is important to consider Sarah Brubaker’s (2007) claim that the majority of feminist literature critiquing medicalisation tends to ignore issues of race and class. She states that because of this, the focus of research is largely on:

“the ways in which they [privileged women] are denied choice and control over their reproductive experiences, rather than examining the various ways in which medicalization provides and denies

reproductive choices differentially to women at different social locations" (p.532).

Plainly the issue is more complex than much literature implies.

It is crucial that research is conducted to explore how particular groups themselves interpret, participate and experience modern medicine to ensure that people are not cast in a passive, 'voiceless' role (perpetuating the very occurrence being critiqued). Reissman (1983) and Ong (1995) both argue that the reasons behind participation and the free-will exerted in the medicalisation process will involve many historical, social, political and economic influencing factors, which are too complex to detail here.

Fundamentally though the process involves power, where the seemingly powerful medical model is able to categorise, manage and govern particular groups in society and have these categorisations realised both in spirit and practice (Conrad, 1992).

In any situation that attempts to confront unfair power relations, it is critical to reflect on definitions of power. Poststructuralists view power not as "a commodity that can be held or redistributed but as an effect: an action, behaviour or imagination brought into being in a specific context as the result of the interplay of various communicative and material resources" (Kesby, Kindon & Pain, 2007, p.20). Further, poststructuralists see power relations as fluid and constantly shifting, which allows for the recognition that the effects of power are not stable (Cahill, 2008; Flyvberg, 1998).

Likewise 'empowerment' is relative and reversible and needing constant cultivation. It is not static and something that can be gained at a particular time (ibid). Accordingly, empowerment can never be bestowed; rather approaches can only facilitate the marginalised to be the agents of their own process (Kesby, 2005; Smyth 2007).

The discourses and practices that maintain power relations need constant maintenance and reproduction, achieved through both the dominating and dominated actors playing out their socially defined roles. As such, the focus of my work on increasing awareness of how power operates discursively within the biomedical model may alert all groups to the socially constructed nature of these roles. From this new awareness they may then be able to assert alternative and more enabling roles, relationships and behaviours.

Poststructuralism allows understanding of the complexity of power relations and how there are multiple ways to enact power, which can have both 'negative' and 'positive' effects. This research draws on John Allen's (2003) power modalities, such as: domination, resistance, seduction, persuasion, manipulation, coercion, authority and co-option to demonstrate this complexity. Understanding these multiple ways to exert power fosters the sense that people have many avenues to initiate meaningful change and accordingly emphasis can be placed in creating or enabling spaces for people to enact their power in different ways (Cahill, 2008).

In Ong's (1995) research exploring medical clinicians' and Khmer refugees' interpretations of their encounters she found that Khmer refugees use a range of complex subversive strategies and manipulations to elude and circumvent medical discipline and control, while seeking specific desired medical resources and attention. Khmers exercised power using tactics such as silences, polite smiles, faking illness, poses of passive obedience, and being resistant and non-compliant with their medication regimes when engaging with medical practitioners. These strategies provide helpful illustration of how those with seemingly limited power can exercise their power in 'positive' ways, inviting and deflecting medicalisation according to their own needs and desires. Ong (1995) suggests that these "cultural

performances as patients” constitute biopolitical lessons in citizenship through which the Khmer refugees pursue their desire for resources controlled by the medical profession (p.1251). Recognising these complex webs of power may help open up new spaces in the health sector for creative engagement that emphasise ‘positive’ forms of power.

While refugee-background communities in New Zealand may recognise the potential ‘negative’ effects of being positioned as needy, they themselves may utilise this identity to secure funding and resources for their communities (Kamri-McGurk, 2012; Westoby & Ingamells, 2010). Indeed the needs-based model is utilised by many agencies and researchers working to improve outcomes for refugee-background communities (cf. Chapter 5, p.125). In Chapter 6, I make a case for asset-based approaches to maternal healthcare models for refugee-background women, which may be a way to balance the critical need to access resources and funds with more enabling and culturally appropriate discourses. First though it is important to historicise in order to understand how biomedicine has become the dominant discourse able to label, categorise and supervise many different populations and groups.

## **Medicalisation of Childbirth**

*In the process of medicalisation, men, by virtue of their location in the public sphere and their control over science, came to colonise the birthroom (Papps & Olssen, 1997, p.8).*

Examination of how the processes of pregnancy and childbirth came to be medicalised shows that western biomedicine’s trajectory to the “powerful,

prestigious, successful, lucrative, and dominant profession we know today” (Conrad & Schneider, 1980, p.9) stems from its success in extending control, rather than as a direct consequence of biomedical knowledge and expertise (Cahill, 2001; Conrad & Schneider, 1980; Dubos, 1960; Reissman, 1983; Van Hollen, 2003). The history of the medicalisation of childbirth also illustrates the mechanics of how western biomedicine has been produced as the dominant discourse having the apparent authority and control over all issues of health and illness. Additionally, this examination will enable awareness and understanding of implications of how biomedical discourse is able to produce various subjectivities.

Childbirth is an area where struggle over professional dominance has been (and still is) prominent (Davis-Floyd et al., 2009; Henley-Einion, 2003; Reissman, 1983). As Alyson Henley-Einion (2003) argues, nowhere is the “expansion of medical jurisdiction into the realms of previously non-medically defined problems” been more apparent than in the sphere of childbirth (p.174). Following is a brief overview of what appears to be a rather complex history (for a detailed account see: Donnison, 1977; Ehrenreich & English, 1978; King, 2007; Oakley, 1984; Papps & Olssen, 1997; Rothman, 1991). This short analysis examines the medicalisation of childbirth in England and the USA as these were the practices and beliefs transposed to the colonies, including New Zealand. It is important to note the sources differ somewhat in their recordings and timing of events, though I have endeavoured to present the most accurate analysis. Additionally, while it might seem that the following only presents the history of midwifery, it is difficult, as Barbara Rothman (1991) asserts, to examine the medicalisation of pregnancy and childbirth without due attention to midwifery; “the history of maternity care is the history of midwifery. The rise of obstetrics was the fall of midwifery” (p.50).

Prior to the eighteenth century, antenatal care as a concept did not exist and childbirth was considered a 'social' event firmly located within the domestic sphere and predominately handled by female attendants and midwives (not considered as part of the medical establishment) (Cahill, 2001; Donnison, 1977; Henley-Einion, 2003; Oakley, 1984; Papps & Olssen, 1997; Rothman, 1991). Birth was understood as essentially a female experience of which a man – even a skilled physician – could not understand (Michaelson, 1988). Midwives used their knowledge and experience, passed down from centuries of women to attend and support the birthing woman (Lichtman, 1988). Maturity was thus considered an advantage given that an older woman may have themselves been through, and supported, many births (Donnison, 1977). In Europe, by the middle of the fifteenth century midwives began to be regulated by municipal authorities<sup>40</sup>; they were required to show they were of 'good' character, would not perform abortions, and that they had technical competence (Donnison, 1977). There was a general belief that childbirth was controlled by fate at the time and death in childbirth was relatively common<sup>41</sup> (Michaelson, 1988).

Over the period of more than a century (between the late eighteenth and twentieth centuries) the 'social' model of childbirth changed from being controlled by women to being "based on the motivations and philosophies of masculine science and medical intervention" (Papps & Olssen, 1997, p.8; Reissman, 1983). The research differs slightly in the details and explanations

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<sup>40</sup> Prior to this, in medieval and post-Renaissance Europe, the Church was considered the regulatory authority of midwives (as well as many other aspects of human affairs). The Christian doctrine infiltrated the whole process of birth, and consequently certain ancient superstitious beliefs, such as 'purification' of a new mother being needed before she could re-enter the church, played an important role in maternity care (Donnison, 1977).

<sup>41</sup> There is limited data available of rates of mortality and morbidity, but it is generally agreed that the rates were high in comparison to today's standards. Remembering though that there were no aseptic techniques, antiseptics or analgesics at this time. Additionally, there was no 'formal' training for midwives, as well as there being a wide range of competence – in and between women and men (Donnison, 1977; Michaelson, 1988).

of this transformation, it is clear however that the many strategies employed were largely due to the 'regular'<sup>42</sup> doctor groups' efforts and ability to: professionalise, reconceptualise childbirth as a 'normal' life event to an 'abnormal' and 'managed' one; erode public confidence in the healing abilities of midwives; and assume 'superior' intellectual and moral knowledge over pregnancy and childbirth (Cahill, 2001; Ehrenreich & English, 1978; Oakley, 1984; Papps & Olssen, 1997; Reissman, 1983). This following analysis will detail each of these strategies.

### **The Professionalisation Process**

Before the 1858 Medical Registration Act in England the practice of medicine was unregulated. There was an oversupply of healers with varying levels of training and expertise (Conrad & Schneider, 1980; Papps & Olssen, 1997; Reissman, 1983). At the beginning of the nineteenth century, the 'regular' physicians began a "sustained and determined" campaign to "smear and discredit" the 'irregular' practitioners (predominately women) (Cahill, 2001, p.336; Papps & Olssen, 1997; Reissman, 1983). The aims of which were fundamentally to limit the practice of medicine to a certain class, gender and education level, and to subsequently gain legal monopoly over healing practice (Cahill, 2001; Clarke, 1983; Papps & Olssen, 1997). Heather Cahill (2001) asserts that the ability of the 'regulars' to professionalise was one of the most significant factors in securing medicine's monopoly over healing. The 'regulars' managed to group together physicians, surgeons (split from barber-surgeons<sup>43</sup>) and apothecaries (including the emerging general practitioners) to form one occupational group called 'doctors', which was enshrined by the 1858 Act (Conrad & Schneider, 1980; Reissman, 1983).

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<sup>42</sup> Formally educated and predominately white, upper-class men.

<sup>43</sup> Barber-surgeons were common medical practitioners in medieval Europe when surgery was predominantly conducted by barbers and not medical physicians (Donnison, 1977).



The professionalisation process was accompanied by increases in both status and income for all its members (Blane, 1997, cited in Cahill, 2001). To clarify, prior to the Act there was considerable public opposition and resistance to 'regular' physicians because they practised a highly interventionist "heroic medicine" (Conrad & Schneider, 1980, p.10). This form of medicine involved treatments such as bloodletting, vomiting, blistering and purging, which rarely worked and often made patients worse (Conrad & Schneider, 1980; Oakley, 1984; Reissman, 1983). It was in this context that the many competing unlicensed and 'irregular' medical factions developed their own medical schools and professional societies, and attracted public support probably due to their treatments being less invasive and dangerous (Clarke, 1983; Conrad & Schneider, 1980). The 'regulars', though, perceived themselves as being superior and referred to themselves as 'professional', despite them being no different than the unlicensed in terms of effectiveness (Cahill, 2001; Witz, 1994). Also they continued to charge more, which, as Cahill (2001) notes, undoubtedly assisted them to gain support from the influential wealthy classes.

Interestingly, the apothecaries (who were of lower class) were the most active in their plight to unify with the higher class surgeons and physicians, largely because they had the most to gain and they were most at risk from the unlicensed, 'irregular' competition (Cahill, 2001). However, all members of the group benefited from the professionalisation process as it allowed them to have ultimate control over healing; over their own work and that of others (Papps & Olssen, 1997). It also enabled them to have control over hospital admissions which facilitated their monopoly as they could select patients from influential and wealthy groups in society; thereby using their healing knowledge as an exclusive commodity (Cahill, 2001).

Professionalisation, Barbara Ehrenreich and Dierdre English (1978) assert, is:

“defined by its *exclusiveness* [...] the male professional hoarded up his knowledge as a kind of property, to be dispensed to wealthy patrons or sold on the market as a commodity. His goal was not to spread the skills of healing, but to concentrate them within the elite interest group which the profession came to represent” (p.34, emphasis author’s own).

Analysis of the strategies used by the ‘regulars’ to professionalise reveals how pivotal class, race and gender were to the process. During these centuries men, predominantly upper-class men, dominated life within the public sphere, which undeniably assisted the ‘regular’ medical group (who class, gender and race were closely matched) in achieving healing monopoly (Armstrong, 2002; Cahill, 2001; Papps & Olssen, 1997; Reissman, 1983). As Kalpana Wilson (2011) expounds, “the class which is the ruling *material* force of society, is at the same time its ruling *intellectual* force, it has to give its ideas the form of universality, and represent them as the only rational, universally valid ones” (p.320, emphasis author’s own). As such, it can be argued that biomedicine’s constructions of reality are intricately related to the structure of power in society at any given historical period (Reissman, 1983). White, middle-class men’s knowledge was privileged and the subsequent power and dominance accorded to the ‘regular’ group enabled them to exert exclusionary and demarcatory (refer to p.109) methods over the subordinate ‘irregular’ groups, including midwives. For example, the passing of the 1858 Medical Registration Act required formalised training for entry into the medical profession, yet medicine excluded midwifery from the medical register (Witz, 1994). Further, although the Act used the word *persons* to describe those who were fit to practice (and not specifically men or women), the institutions that provided the required instruction excluded

women, thus effectively prohibiting them from the medical profession (Cahill, 2001).

Important to the success of the professionalisation process was for doctors to set themselves apart from the lower classes of society. Having ultimate control over admissions to hospitals also enabled medical doctors to select patients from certain 'poor' groups in society that provided 'interesting' educational and learning material. Thus the gender- and class-divided society of the time proved essential for the ability of the regulars to obtain medical monopoly, as women and the poor could essentially contribute to the training and expansion of knowledge of the doctors (Cahill, 2001; Foucault, 1973). Foucault (1973) explains this 'reciprocal' nature of the clinician-patient relationship:

“there emerges for the rich man the utility of offering help to the hospitalized poor: by paying for them to be treated, he is, by the same token, making possible a greater knowledge of the illness which he himself may be affected; what is benevolence towards the poor is transformed into knowledge that is applicable to the rich” (p.84).

### **Reconceptualisation of Childbirth**

Ann Oakley (1984) suggests the medicalisation of childbirth involved two main stages. The first stage in the seventeenth and eighteenth centuries involved its incorporation into 'normal' medical discourse and the second stage involved the gradual redefinition of pregnancy and childbirth as a pathological phenomenon “akin to illness” (Oakley, 1984, p.12). To further explain, initially the 'regular' doctors claimed their territory in childbirth as attending difficult or 'abnormal' births and then over time gradually

redefined birth as inherently pathological and abnormal, only able to be defined as normal in retrospect.

This first stage was possible because prior to the eighteenth century, the right to use surgical instruments was solely with male surgeons. Thus men were only involved in childbirth when live birth was considered absolutely impossible and barber-surgeons were called in to perform embryotomy (crushing the fetus in utero and removing it piecemeal) or removing the baby by caesarean section after the death of the mother (King, 2007; Rothman, 1991).

Around 1720 saw the rise of the male-midwife who was involved in live birth (King, 2007). Rothman (1991) explains that this involvement was due to the development of obstetrical forceps which enabled the removal of the baby without necessarily destroying it, making surgical intervention the speciality of male-midwives. As obstetric technology, such as forceps and anaesthesia, advanced so too did the number of men involved in birth<sup>44</sup>. The growing prestige of male-midwives at this time was largely due to a class-battle, where elite women employed them to set themselves apart from the lower classes (King, 2007; Wilson, 1995). Many researchers note this not because of their superior skill, as maternal and infant morbidity and mortality were increasing at this time, but because of the ability of the male-midwives to convince women of the dangers of childbirth and the incompetence of midwives (Cahill, 2001; Donnison, 1977; Reissman, 1983; Rothman, 1991). The control of birth technology by medical men at this time

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<sup>44</sup> It is important to note that these technological advancements were not associated with less morbidity or mortality. Karen Michaelson (1988) and Jean Donnison (1977) give examples of how the overuse and misuse of forceps led to many women suffering severe perineal lacerations, as well as increased infant morbidity and mortality.

set the precedent that midwives deal with 'normal' births and obstetricians with 'abnormal' and complicated ones (Williams, 1997).

In, what Oakley (1984) refers to as, the second stage of medicalisation of pregnancy and childbirth, medicine had to highlight and exploit the pathological potential of birth and challenge midwives' conception of 'normal', as "technology alone (primarily the forceps) was not enough to affect the necessary cultural reform" (Arney, 1982, cited in Cahill, 2001, p.338). This reconceptualisation provided the basis for medical expansion into the childbirth arena because by defining birth as inherently pathological and abnormal, meant that the earlier precedent that obstetricians deal with 'abnormal and high-risk' pregnancies enabled them to successfully extend their power base (Donnison, 1977; Rothman, 1991). Further, as Cahill (2001) points out, the definitions of what constitutes 'abnormal' can be highly subjective, but the ability to "label individuals as such remains solely in the hands of this influential professional group", not surprisingly, the number of pregnancies deemed 'high-risk' continued to rise (p.335). To have this reconceptualisation of childbirth supported and realised by the public and physician colleagues, the regular doctors needed to erode public confidence in midwives and assert the "need for a science of obstetrical practice" (Reissman, 1983, p.6).

### **The Rise of Science**

*The medical practitioners who colonised childbirth in the eighteenth century characterised themselves as bringing rational knowledge to an area dominated by ignorance and tradition* (Moscucci, 1990, p.51).

Medical practitioners, in their efforts to differentiate themselves from the 'unorthodox', also asserted *intellectual* and *moral* superiority over pregnancy

and childbirth. In the eighteenth century, formal instruction for childbirth practitioners began under the surgeon William Smellie and although this teaching was for both genders, men and women were taught different things, which perpetuated their segregation (King, 2007; Williams, 1997). Men were taught predominately 'scientific' knowledge of biology, providing the basis for their systematic dispute and devaluing of women's and midwives', largely, traditional and experiential knowledge (Cahill, 2001; Papps & Olssen, 1997). This subordination of midwifery knowledge, enabled doctors to facilitate the exclusion of women from 'formal' knowledge and training. Another way medical practitioners were able to erode public confidence in midwives was through their public opposition to abortion. Using science to argue against abortion beyond the stage of 'quickening'<sup>45</sup>, medical practitioners were able to claim the intellectual and moral 'high' ground (Thomson, 1998).

According to Ehrenreich and English (1978), by the late nineteenth century science was "the transcendent force to which the doctors looked to lift medicine out of the mire of commercialism and gird it against its foes" (p.69). Science was fast becoming a sacred national value, and between 1880 and 1920 experts from all disciplines had to prove a scientific basis (ibid). As Elaine Papps and Mark Olssen (1997) put it, "discourses of enlightenment science underpinned enlightenment ideas of progress and linear continuous development", science was revered as not only the "road to truth", but as a "vehicle that would carry all on the road to a bigger, brighter and better future" (p.43). It was in this context that medicine, as it became more scientific, was able to garnish increasing support from the

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<sup>45</sup> In pregnancy, quickening refers to the first motion of the fetus in the uterus as it is perceived or felt by the pregnant woman. It usually occurs between the 15-20<sup>th</sup> weeks of pregnancy. In the 18<sup>th</sup> and 19<sup>th</sup> centuries, if a woman tried to procure an abortion if the fetus had quickened, it was considered homicide (Wilson, 1995).

middle to the upper classes. Midwifery, however, was often seen as an obstacle to scientific advance, unsurprisingly then, as Ehrenreich and English (1978) assert, the subordinate classes still used midwives.

Many writers equate the attributes of science with that of men, yet as Papps and Olssen (1997) affirm it is not 'masculine' per say. They outline the certain historical occurrences which nurtured structural positioning of men and women in different societal spheres, and consequently meant that "male knowledge came to represent an authoritative representation of the real" (1997, p.20). Additionally the historical trajectories of science and medicine are quite distinct and at times even antagonistic to each other with medicine being associated with healing and as such is much older than scientific disciplines. However, the ability of both medicine and science to claim "a special epistemological status" was significant and this is of relevance to this thesis (Papps & Olssen, 1997, p.22).

While scientific knowledge has traditionally been equated with 'truth', a concept that is positivist, neutral, detached, Papps and Olssen (1997) have argued it is a form of cultural hegemony and thus cannot be separated from issues of power and control. Knowledge is inseparable from power in both its production and effects and hence it is only with hindsight that "one can begin to cautiously assess how science contributed to life and with what other effects it had in the process" (ibid, p.21). Medical and scientific knowledge has been, and to a large extent still is, controlled and produced in the west, and the implications of this dominance are explored here. At this historical moment scientific biomedical knowledge equals the 'truth', biomedicine surpasses culture: it is fact, and accordingly knowledge about the apparent high-health needs of former refugees acquires authority and constitutes the 'truth of the matter' (Mills, 1997; Waitt, 2010). This thesis

aims to detach the power of truth from science's hegemony, in an attempt to highlight the effects of the discourses within which it operates.

### Devaluing Women

*Men began taking over obstetrics and they invented a tool [the vaginal speculum] that allowed them to look inside women. You could call this progress, except that when women tried to look inside themselves, this was called practising medicine without a license (Mead, 1974, cited in Oakley, 1984, p.255).*

The medicalisation and control of childbirth occurred via various male practitioners – male-midwives, surgeons and physicians, and according to some, this was grounded in the institutions of patriarchy<sup>46</sup> (Papps & Olssen, 1997). As Henley-Einion (2003) notes, this control of childbirth by men occurred mainly in oppressive ways. While patriarchy in the western world can be dated back to Christianity, physicians (white, upper-class, university-trained men) as early as the fourteenth century managed to assume authority from the church over the processes related to health, death and birth (Cahill, 2001; Papps & Olssen, 1997).

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<sup>46</sup> I understand patriarchy as a problematical and contested term. Space precludes a thorough analysis, though here I provide a brief insight into the debate. Historically it was used by feminists to provide a distinction between the forms of oppressions based on class and those rooted in a (considered) fundamental inequality between men and women in all societies (Rowbotham, 2006). This concept is limited because “it implies a universal and historical form of oppression which returns us to biology” – suggesting a single determinate cause of women’s oppression (Rowbotham, 2006, p.52). Thus, as a concept it is insufficient to provide an in-depth analysis of inequalities of gender relations, as well as between women. Additionally it denies the notion of agency to women, implying “a fatalistic submission which allows no space for the complexities of women’s defiance (ibid, p.52). Though, here I have used the term to provide an historical understanding of the distinctiveness of male control of formal power structures. Patriarchy, writes Sally Alexander and Barbara Taylor (2006), is a necessary systematic tool to “begin to reclaim for political change precisely those areas of life which are usually deemed biological or natural” (p.58).



Cahill (2001) argued that since this time, medicine and religion together have systematically devalued female roles and traits and excluded women from formal channels of power in society through the dissemination of a patriarchal ideology. The medical model epitomises patriarchy in that it positions women as fundamentally sick and abnormal, and assumes their bodies are dysfunctional (Cahill, 2001; Davis-Floyd et al., 2009). The medical model, as outlined earlier, also defines pregnancy and childbirth as essentially pathological, which, as Ehrenreich and English (1978) have argued, served two purposes; it helped to disqualify women as healers and yet made them highly qualified patients.

The medicalisation of childbirth has served the financial interests of doctors, where the majority of consultations with women are due to “women’s reproduction and its prevention” (Clarke, 1983, p.64; Davis-Floyd et al., 2009; Ehrenreich & English, 1978). Jan Williams (1997) noted how the medical gaze is a very useful tool to establish discipline and control over pregnant and delivering women, she argued that this “discipline was felt necessary if control over the situation was to be achieved and obstetrics was to fully become a science” (p.235). Interestingly the same level of medical surveillance does not exist for men (Cahill, 2001). It can be argued that the exclusion of women from healing practice (including attendance during childbirth) and the evolution of a medical field specifically to attend to women’s illnesses and their bodies constitutes (covert) social control over women (Cahill, 2001; Clarke, 1983; Oakley, 1984).

### **Cultural Hegemony**

Medicine has become associated with the succession of technological, scientific and social innovations over the last few centuries and this has subsequently increased the control of the medical profession. The scientific

achievements of the nineteenth and twentieth centuries, such as the discovery of antibiotics and anaesthesia made a significant reduction in maternal and infant mortality rates (Cahill, 2001; Conrad & Schneider, 1980; Papps & Olssen, 1997).

Though, Papps and Olssen (1997) have argued that while no one debated these scientific achievements, “it became increasingly disputed as to why a knowledge of some of the technical possibilities and capabilities relevant to childbirth should have automatically led to the *control* and *management* of the birthing process” (p.175, emphasis authors’ own). The development of each scientific intervention increased the authority and jurisdiction of the doctor, and also the intervention itself came to be understood as ‘normal’, which reinforced the role of medicine in having control over pregnancy and childbirth (Papps & Olssen, 1997). The increasing use of birth interventions also meant that the place of the midwife was reduced to be more closely aligned with that of a nurse – assisting (and subordinate to) the doctor (ibid.). Though interestingly, Rothman (1991) and Michaelson (1988) have observed that the medical control of birth occurred “*before* the development of any of what are now considered to be the contributions of modern obstetrics” (Rothman, 1991, p.41, emphasis author’s own), which emphasises that the authority and stature accorded to doctors stems more from their ability to extend their power and control.

Initially, the medicalisation of childbirth did not directly result in better outcomes for women and babies, as research shows that both maternal and infant mortality rates increased between 1915 and 1930 (the period that midwives’ attendance at births abruptly declined) (Donnison, 1977; Reissman, 1983; Rothman, 1991). In the long term though there has been a decline in death rates, although many have pointed to improved

environmental circumstances and nutrition for the justification (Cahill, 2001; Michaelson, 1988; Reissman, 1983; Rothman, 1991). In fact, Cahill (2001) cited a 1982 study discussed by Nicky Hart (1985), which found that the mortality rates fell most sharply during the First World War when 60% of medical practitioners were drafted. While she recognises that this may just be a correlation and not signal causation, fewer doctors and fewer infant and maternal deaths could be casual as there would have been a reduction in surgical intervention and the use of forceps, which were both associated with increased mortality and morbidity. It is thus quite possible that medicine's contribution to the reduced maternal and infant mortality rates may be less than popularly assumed (Cahill, 2001; Donnison, 1977).

Interestingly the credit accorded to obstetrics for improvements in the outcome of childbirth is a similar trajectory to the acquired status accorded to the 'regulars' (white, upper-class and formally educated men) in late nineteenth century. The regulars, in their effort to improve their public image at that time, claimed credit for the considerable reduction of certain diseases, such as the plague and cholera, despite the fact that this decline was almost entirely due to improvements in social conditions, such as better nutrition, housing and sanitation, rather than a result of new and improved medical knowledge or practice (Conrad & Schneider, 1980; Dubos, 1960; White, 1996). Indeed as Ray Fitzpatrick (1997, cited in Cahill, 2001) found, it was not until the end of the 1930s that the first medicines to have any significant bearing on mortality rates from infectious diseases began to emerge.

By the late nineteenth century the regulars had gained "cultural authority" (Reissman, 1983, p.6) over definitions of health and disease and provision of health services. That is, they managed to create a culture that accepted,

assumed and consequently legitimised biomedicine as being responsible for improvements to health and life expectancy (Cahill, 2001; Conrad & Schneider, 1980; Dubos, 1960; White, 1996). Other forms of healing, such as midwifery and homeopathy, were marginalised as non-biomedical and unscientific by comparison, the increased status of biomedicine therefore enabled hegemony in the healing market (Singer, 2008).

Thus the 'regulars' were able to gain, what Antonio Gramsci (1971) referred to as, "cultural hegemony" or "cultural leadership" through a process much like a 'battle' in which the dominance of the 'regulars' needed to be consistently "remade and rewon" (cited in Papps & Olssen, 1997, p.21). Western biomedicine established medical dominance and hegemony, whereby the associated scientifically-based values, norms and practices became instituted and understood as 'commonsense', and in this process alternative viewpoints and practices were subjugated and marginalised (Papps & Olssen, 1997).

The ascendancy of biomedicine enabled its own knowledge base to be validated and accepted as the standard model of healthcare. Stuart Hall (1997) has claimed that the biomedical model is able to assume such power through exploiting the naturalisation versus culture dichotomy; if the assertions are cultural then they are open to change, but if they are natural, then they are beyond history and are permanent and fixed. Thus naturalisation is a representational strategy employed by biomedicine to fix its hegemony and the effects have been to subsume and invalidate other forms of healthcare.

Though in western societies in recent years there has been a slight revival of other forms of healthcare, such as homeopathy or naturopathy, which are

often referred to as complementary or 'alternative' medicines (Schott & Henley, 1996; Singer, 2008). Yet, even though there is increasing support for these practices, they are still considered 'alternative' to the dominant biomedical model. A model, which as Sara Mills (1997) has argued, is:

“supported by institutional funding, by the provision of buildings and staff by the state, and by the respect of the population as a whole whereas the other [alternative medicine] is treated with suspicion and is housed both metaphorically and literally at the margins of society” (p.19).

### **The Current New Zealand Context**

While the above historical analysis is based on both American and English experiences, I have focused more on the English situation as when they settled in New Zealand in the early nineteenth century they introduced and incorporated their gendered culture, including the idea that birth was predominately a masculine domain (Papps & Olssen, 1997). The enactment of the 1902 Midwives Act in Britain which regulated midwifery education and practice had significant influence on New Zealand's passing of the very similar 1904 Midwives Act (Papps & Olssen, 1997).

Although this Act gave midwifery a legally defined status, it meant that midwives and midwifery came under the control and surveillance of the medical profession who “operated a successful demarcating strategy to define this ‘subordinate’ group’s sphere of practice and competence” (Cahill, 2001, p.338; Donnison, 1977; Papps & Olssen, 1997). To Papps and Olssen (1997), the issue is more complex than just definitional concerns – where the medical profession demarcated that midwives only deal with normal aspects of pregnancy and childbirth care. Rather, the issue is how biomedicine has utilised the knowledge and power nexus to establish

hegemony over all healthcare practice. From the passing of the 1904 Midwives Act to the time of enactment of the Nurses Amendment Act 1990, the regulation of midwifery was closely associated with the development of knowledge and power by the medical profession in relation to childbirth: “hospitalisation, technology and intervention facilitated a medical discourse of childbirth in New Zealand which altered the role of the midwife” (Papps & Olssen, 1997, p.174).

The hospital is now widely considered the safest place for babies to be born due to the continued and consistent persuasiveness of the obstetric establishment, leading to an estimated 96 percent of births in New Zealand hospitals in 2007 (MoH, 2011b). This move has resulted in an almost complete medicalisation of pregnancy and childbirth, which as many have argued, has led to the “dehumanisation” of birth (Davis-Floyd et al., 2009; Wagner, 2001) (refer to Chapter 2, p.40).

In New Zealand, the caesarean section rate during 2010 was 25 percent<sup>47</sup> (MoH, 2011b), well above the 15 percent mark that the World Health Organisation (WHO) recommended as the limit (Anderson, 2004; WHO, 1985; WHO, 2009). In their revised statement of 2009, WHO suggested countries either use the recommended range of 5-15 percent or set their own standards. In New Zealand there is no consensus regarding the optimal caesarean section rate, although there is agreement that the current rate is too high (MoH, 2011b). A 2007 study by WHO researchers found that caesarean section rates above 15 percent correlated with higher maternal mortality (cited in Davis-Floyd et al., 2009).

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<sup>47</sup> This statistic is provisional only and may be subject to change (MoH, 2011b).

Davis-Floyd and colleagues (2009) warn that because practitioners (and women) are increasingly conversant with the benefits of caesareans there is a proclivity to ignore the associated risks and implications. These include infection, chronic pain, difficulty bonding with breastfeeding and infant-bonding, maternal and infant injury and death, respiratory problems with the baby, and problems with future pregnancies and births. These are just some examples of the many implications of the increasing caesarean rates – which suggests that the dominant biomedical model of childbirth does not always deliver better outcomes for women and babies. In Chapter 6, I explore the implications of the biomedical model of childbirth for refugee-background women and its exportation to ‘developing’ countries.

## **Summary**

As this chapter has demonstrated, illness is constructed. It follows then that the idea that former refugees have considerable health needs is a social construction, which, through the (perceived) legitimacy of the medical model, has predicated the (over-) representation of former refugees as exclusively needy and problematic throughout the literature. A figuration which serves to cement and (re-) establish the dominance, authority and hegemony of the western biomedical model. Yet as this chapter has shown, the biomedical model is a social enterprise and as such it (and the labelling and representation it authorises and manages) is contingent and partial. Therefore western biomedical discourse can be ruptured and decentred to make spaces for alternative discourses.

The next chapter will analyse the circulating health-related texts regarding women with refugee backgrounds in New Zealand. This analysis

demonstrates the (great deal of) discursive work invested into ensuring that former refugees are only known as people with considerable health 'problems' and 'needs'.



## CHAPTER 5

### Discourse Analysis: Part Two – Interrogating the Figuration of the ‘Needy’ and ‘Problematic’ Refugee- Background Woman

#### Introduction

*How we are seen determines in part how we are treated; how we treat others is based on how we see them; such seeing comes from representation (Dyer, 2002, p.1).*

This chapter will examine three recent, health-related, New Zealand-based texts regarding women (and men) with refugee backgrounds, which I argue, circulate and maintain the idea that they only have considerable health needs and problems. It will be shown that a large amount of discursive work is employed to ‘fix’ this idea while simultaneously reifying the authority and dominance of the western biomedical model. The chosen texts are: the Ministry of Health *Handbook for Health Professionals* (2001, identified on the Tables below as <sup>(1)</sup>), which includes the revised Chapter 6 titled, *Refugees with Special Health Needs* (MoH, 2011)<sup>(1a)</sup>; the second is the *Refugee Health Needs Assessment*, by Ali and Wilson (2005)<sup>(2)</sup>; and the third is the *Refugee Health Collaborative Women’s Forum* presentation by Irene Chain<sup>(3)</sup>

(2011) and the associated Case Study<sup>(3a)</sup> (refer to Chapter 3, p.75 for rationale regarding text selection).

In this literature, the claims that people with refugee backgrounds have high health needs and problems are largely based on the research analysing the medical screening programme at the Mangere Refugee Resettlement Centre (MRRC). This chapter will demonstrate how medical screening fundamentally *produces* the typecast of refugee-background communities as diseased, needy and problematic to society.

Medical screening is based on the pervasive medical gaze that seeks out 'truths' as embedded in the human body (Foucault, 1973). Peter Conrad and Joseph Schneider (1980) have suggested that the medical gaze functions (wittingly or unwittingly) as a disciplining mechanism that "seeks to eliminate, modify, isolate, or regulate behavior" (p.242). Echoing Roxanne Doty's (1993) work this chapter will use the textual mechanisms; predicates, presuppositions and subject positioning (refer to Chapter 3, p.78), to analyse the widely-cited paper by Alison McLeod and Martin Reeve (2005)<sup>48</sup>. Here I provide examples of how medical screening discourse is able to naturalise as 'commonsense' the idea that people with refugee backgrounds are diseased, problematic and have only health needs (not health assets). It will also explore the associated attitudes, subjectivities and practices that are consequently constituted.

The verbs, adverbs and adjectives used throughout the texts construct the 'needy', 'problematic' and 'diseased' refugee-background woman (and

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<sup>48</sup> The paper by Alison McLeod and Martin Reeve (2005) reports the findings of the "mass medical-screening" of former refugees between 1995 and 2000 at MRRC (p.12) (for further details see Chapter 3, p.78).

man). Jennifer Milliken (1999) points out that texts never only produce one thing or subject. The following analysis demonstrates how various other subjects are constructed through implicit (and explicit) contrasts and parallels. These include, the healthy 'subject' of the host community differentiated from, but related to, the constructed needy and problematic former refugee. Also the health practitioner who is responsive to the needs of former refugees and who is able to determine what is appropriate health behaviour and what are considered health 'issues'. My purpose here is to name and mark the dominant self, and to highlight how this dominance is constructed. Exposing and deconstructing these relations of ascendancy may consequently allow opportunities for more inclusive and enabling healthcare services to be facilitated.

## Questioning Current Stereotypes

*Knowledge is a form of power, and by implication violence; it gives authority to the possessor of knowledge (McEwan, 2009, p.26).*

In Chapter 4, I demonstrated that at this specific historical moment western scientific biomedical knowledge equates with the 'truth'. The figure of the former refugee as needy and diseased has come to be known through the scientific evidence, the 'facts', courtesy of the hegemonic position and veracity of biomedicine (Malkki, 1996). Surita Jhangiani and Jennifer Vadeboncoeur (2010) explain that once an ideological position is naturalised it is assumed to reflect the "natural order of the world, 'what is' and the power obtained given 'what is' reflects the way it must be, rather than a social construction" (p.173). The previous historical analysis illustrated the methods used to naturalise the hegemony of western biomedicine. Box 5.1

below provides quoted examples of how the texts utilise the dominant, powerful and authoritative position of western biomedicine to ‘fix’ the assertions made about refugee-background women (and men) (while simultaneously reifying the dominance of the model).

#### Box 5.1: Statements Regarding Women with Refugee Backgrounds

- *The many complex needs of women from refugee backgrounds<sup>1</sup>*
- *Have a number of distinct health needs specifically related to their gender<sup>1</sup>*
- *Many of these women have distinct sexual and reproductive health needs<sup>1</sup>*
- *Refugees with special health needs<sup>1</sup>*
- *May have psychosexual and psychological health issues<sup>1</sup>*
- *Post arrival, women from refugee backgrounds have the lowest coverage for cervical screening, higher rates of pregnancies complicated by diabetes and lower rates of breastfeeding compared with other groups<sup>1</sup>*
- *Women from refugee backgrounds may have higher-risk pregnancies<sup>1</sup>*
- *These women may be a high risk group for post-natal depression<sup>1</sup>*
- *The more common mental health issues among refugee people<sup>1</sup>*
- *Women have special mental health needs<sup>2</sup>*
- *Affirmed that refugees have high health needs that need addressing with a range of different strategies<sup>2</sup>*
- *Refugees resettling in second countries have high health needs<sup>2</sup>*
- *The major health issues identified are: Physical Health, Oral Health, Mental Health, and Gender-based health needs<sup>2</sup>*
- *Refugees have high health needs. In particular physical and mental health issues<sup>2</sup>*
- *If we don't catch these ladies early, then 50% of them are actually all high risk, because we have already had diet deficiencies<sup>3</sup>*

Sources: MoH, 2001<sup>(1)</sup>; Ali & Wilson, 2005<sup>(2)</sup>; Chain, 2011<sup>(3)</sup>.

Box 5.1 above lists the statements in the texts, which assert the “many”, “complex”, “major”, “high”, “distinct”, “special” and “common” health needs of refugee-background women. Taken together, these statements work to (re-) produce the figuration of the ‘needy’ and ‘problematic’ refugee-background woman.

## Contesting the Medical Screening-Related Literature

The majority of the statements quoted in Box 5.1 (extracted from the examined post-2005 literature) are supported by McLeod and Reeve's (2005) research, which examined the screening programme at MRRC (refer to p.78). Doty's (1993) textual mechanisms (see p.78) have been useful to analyse the following potent statement made in McLeod and Reeve's (2005) paper: "*The results demonstrate a well-known fact: Refugees and asylum seekers resettled in countries of second asylum have high health needs*" (p.10).

According to Doty (1993), the statement "as part of a larger discourse, creates a 'world' in the sense that a particular 'reality' must be accepted in order for the statements to make sense" (p.308). Thus, McLeod and Reeve's statement presupposes that people called 'refugees' and 'asylum seekers' exist, that there is something called 'countries of second asylum', and that refugees and asylum seekers resettle there. It also creates the background knowledge that there exists something called 'health needs' and that the refugees and asylum seekers who resettle in countries of second asylum have high levels of these. The statement also presupposes that a thing named 'results' (that are based on medical science) are able to demonstrate 'fact' and moreover that the authors have the presumptive right to assert this statement as 'fact'. The superiority of medical knowledge is taken for granted and not open to question, it is quite plainly: 'fact'.

Another way that the above statement creates 'reality' is through the use of predications: the 'refugee' and/or 'asylum seeker' is endowed with having *high health needs* and by inference very little in the way of health assets and capabilities. Also, rather more implicitly, that representatives of the discourse of biomedical science have the ability to know, speak and write about the refugee 'Other' – the object of their knowledge. In this way,

western biomedicine is established as the authoritative subject; able to accurately describe the health situation of refugees and from this description various attitudes and practices deemed appropriate are derived. The text also constitutes particular kinds of subjects vis-à-vis one another; the apparent right of the (medically-trained) authors to be the speaking subject and the 'refugee' the subject/object of this discourse locates these subjects in opposition to one another. Consequently the 'refugee' is awarded a simpler degree of agency than the author who is able to assert "well-known fact[s]" (McLeod & Reeve, 2005, p.10). Furthermore, the use of the word 'high' positions refugees relative to other kinds of subjects, who by implication have 'low' or 'normal' health needs. Thus refugees are deemed problematic and subordinate because they deviate from these, apparently, 'un-needy' 'superior' subjects. The subject positioning here establishes opposing relationships where the refugee is constructed as deviant from normal, the 'Other' (refer to p.132 below). According to Doty (1993), the outcome of the above statement means that particular practices concerning refugee-background people are made possible and are justified.

While I have emphasised that my aim here is not to verify whether women with refugee backgrounds actually have what is known as 'high health needs', it is difficult not to note some flaws in the 'evidence' for McLeod and Reeve's (2005) claim. Highlighting these shortcomings draws out the apparent subsequent efforts that occur to stabilise and fix these meanings. Noting these contradictions is important because while biomedicine's discursive frames that naturalise and impose boundaries on ideas and perceptions of refugee-background communities appear stable, they are actually fragile and therefore able to be ruptured. Thus possibilities for meanings, attitudes and practices to be challenged or changed are revealed (Waite, 2010).

As their 'measure' of high health needs McLeod and Reeve (2005) use the number of referrals made to secondary services based on the screening that former refugees receive at MRRC. To support the use of this measure, they cite a paper that "compares the rates of referrals for refugees with those of a usual general practice population, and found that 16% of refugees were referred, compared to 5% of general practice population" (McLeod & Reeve, 2005, p.10). Though, alarmingly, the authors of that particular paper warn that the refugee referral rate "**cannot** be compared directly with the relevant Irish general practice referral" rate (Murphy, Lynch & Bury, 1994, p.175, emphasis added). This is because the refugee referral figure is based on *point prevalence*, whereas the general practice referral figure is derived from *period prevalence*<sup>49</sup> studies. It is extremely concerning therefore that Murphy, Lynch and Bury are misquoted and so grossly misrepresented by McLeod and Reeve. It is similarly perturbing that the same comparison rate and statement has been reiterated in the study by Koos Ali and Joy Wilson (2005, p.14).

Another reason why comparisons between former refugees and general practice populations are inappropriate is that the screening processes at MRRC are, without a doubt, 'comprehensive'. They include the following tests: urine test; 3 stool tests for intestinal parasites, as well as the salmonella and shigella bacterial species; Mantoux test (for tuberculosis exposure); full blood count; erythrocyte sedimentation rate (ESR); haemoglobinopathy screening; liver function tests; iron studies; serology for hepatitis B virus (HBV), hepatitis C virus (HCV), HIV, morbilli and rubella antibodies; measles IgG; treponemal infection; schistosomiasis; chest x-ray (if over 16

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<sup>49</sup> *Point prevalence* is a measure of the proportion of people in a population who have a disease or condition at a particular time; it is like a snapshot of the disease in time. This is in contrast to *period prevalence*, which is a measure of the proportion of people in a population who have a disease or condition over a specific period of time, such as a season or a year (Gerstman, 2003).

and not pregnant); clinical physical examination; psychosocial assessment; dental assessment; any other necessary screening tests such as lipid levels. All sexually active women are also offered cervical smears and gynaecological bacteriological screening (McLeod & Reeve, 2005; MoH, 2001; Refugee Health, 2009). Plainly, the screening that refugees endure is so exhaustive that to accurately determine whether refugees have high health needs (using secondary referrals as the index) comparison with a control group undergoing the same comprehensive testing would be required; that is, comparing like with like. Also, when we consider that screening looks for asymptomatic diseases, disease precursors and/or disease surrogates (McLeod & Reeve, 2005), the 'unscreened' general population may not necessarily know they have these conditions. Therefore the referral rate to secondary services will be skewed for this unscreened group.

It is important to note that one of the most common reasons for referral to secondary services from MRRC is counselling and psychological care for refugees requiring "alleviation of psychological upset" (McLeod & Reeve, 2005, p.12). This occurrence is problematic for a number of reasons. First, the tendency of the medical paradigm to pathologise refugee mental health has led to (over-) representation of them as being 'sick' and traumatised. This tendency, in large part, provides the basis for typecasting former refugees as having high health *needs* (Mortensen, 2008; Muecke, 1992). This reductionist interpretation of refugees is seen in the chapter dedicated to "*Mental Health Issues*" in the MoH Handbook (2001). The chapter provides detail of "the more common mental health issues among refugee people", and **does not have one single reference** to any resources or strengths that former refugees have (MoH, 2001, pp.67-80).



While understanding the traumatic experiences that refugees have gone through pre-arrival is a key aspect in assessing psychological well-being, it is, as Dermot Ryan, Barbara Dooley and Ciaran Benson (2008) assert, only part of the picture. They argue that the medical conceptualisation of refugee mental health has meant, “individuals who have demonstrated incredible resilience are seen in terms of perceived deficiencies – as bearers of psychiatric symptoms” (2008, p.2).

Ryan and colleagues (2008) present a conceptual model based on privileging resources; this model, rather than pathologising personal distress, conceptualises it as a normal response to major life changes. Similarly, psychiatrist Derek Summerfield (2001) has stated that the psychological ‘upset’ that is perceived to be present in refugee populations in fact falls in the range of normal cognitive responses to an adverse situation. Ryan and colleagues (2008) argue that to achieve a more holistic view of the life experiences of former refugees, the limitations and deficiencies within the attitudes and policies of host societies need attention. Additionally, a consequence of focusing on the traumatic events pre-arrival, has led to the suffering associated with the “stigma, isolation and rejection of being irretrievably out of phase with the host society and its values” being largely neglected (Muecke, 1992, p.520). Put another way, because the medical model is predicated upon the necessity of pathology or problems; the material, social, physical and cultural resources of refugees are ignored and constrained, which can lead to negative psychological outcomes when resettling (Ryan et al., 2008).

Second, to reiterate my previous points, the high-rate of referral to counselling and psychological care positions former refugees relative to the general population, who by implication have lower levels of psychological

‘upset’. This tendency continues to constitute and amplify the attitude of self-toward-Other, which makes particular practices possible (Doty, 1993). Yet, given that New Zealand has high rates of domestic violence, child abuse, teenage pregnancies, binge drinking, as well as the highest rate of youth suicide among OECD countries (Newton, 2011); a random pool of New Zealanders enduring the same psychosocial screening assessments as former refugees at MRRC may, arguably, result in nominal difference between secondary referral rates. Additionally, there is a tendency for western biomedical services to use a linear model of psychological conditions, which as Aihwa Ong (1995) has argued, assumes that all populations follow common patterns of grief and suffering. Underlying this tendency is the notion that westernised ‘mental health’ concepts can be universally applied.

The western biomedical model’s mental health categorisations, argues Ong (1995), have the tendency to “by-pass or invalidate the patients’ cultural understanding of their lives, as they are taken through a medical acculturation process that moves from the particular and the cultural to the ethnic and scientific” (p.1247). In this process, the stories and experiences of people from refugee-background communities are set and understood according to western context. A context, which, undoubtedly, has limitations in capturing the complex and diverse ways refugee-background people experience trauma and grief, and how they attempt to rebuild their lives in a new country (Mortensen, 2008).

McLeod and Reeve (2005) note that “refugee health needs may be less than those of certain at-risk groups of the resident population” (p.10). They cite a 14-year-old study by Neil Solomon (1997) that found the health costs of

former refugees lay between the health costs of Maori and Pacific Island people. This study was:

“undertaken to support the following notions – a) that refugees and asylum seekers do have special health care needs, b) that such needs are not recognised by the Ministry of Health’s present funding formula; and consequently, that this results in material disadvantage to the Northern region [in New Zealand]” (Solomon, 1999, p.16).

While my research is not aiming to decipher whether former refugees may have health needs that are different from and perhaps more comprehensive than the host population, it is disturbing to note that the construction of them as sick and needy relates explicitly to availing more funds for the Northern Regional Health Board.

The 1997 Solomon study is another that is widely cited in refugee health-related literature (cf. Ali & Wilson, 2005; McLeod & Reeve, 2005; Mortensen, 2008; 2011). It was commissioned by North Health, a division of the Transitional Health Authority (THA), that is “responsible for purchasing publically-funded personal health services for the vast majority of New Zealand’s ethnic minority peoples” (Solomon, 1997, paper A, p.1). The report comprises six interrelated papers, one of which is titled, ‘*The health status of New Zealand’s quota refugees – A comparative assessment*’. This particular paper “addresses the difficult problem of measuring the health status of refugees and asylum-seekers at population level” (1997, p.i). Solomon (1997) evaluated a “number of high profile, high cost health status indicators” to show “that the health status of refugees and asylum-seekers is probably best equated with that of Pacific Islands people” (p.i). This, Solomon (1997) argued, is important because refugees and asylum-seekers

are “included with Others<sup>50</sup> and therefore attract no additional secondary care funding to accommodate the demonstrated additional personal health care need” (p.i).

The comparative assessment makes some fairly sweeping assumptions and uses dated and often unreferenced data unable to be crosschecked, particularly in the diabetes and smoking sections. The data from the McLeod and Reeve’s 2005 report cites much lower rates of the diseases than the 1997 Solomon study uses, which may mean that Solomon’s report is no longer relevant. These lower reported rates of diseases may also be due to improvements in the health of former refugees. At any rate the author himself notes the difficulty of comparing health across populations and sub-populations: “Comparisons must usually be made with limited data and therefore with varying levels of certainty” (paper A, p.4). Yet despite this apparent uncertainty, the findings have been, and are still, widely referenced when comparing the health costs of former refugees with other population groups, and when typecasting former refugees as ‘needy’.

In a different context, Doty (1993) writes that the State is “constructed by the discursive practices of those who speak about, write about, and act on its behalf” (p.310). This same assertion can be said about the western biomedical model in this study. Biomedical practices such as screening, and labelling people as diseased and having high health needs are important elements in the production and reproduction of the power of the model. These practices serve to provide biomedicine with subjects to gaze at and learn from. In the name of ‘protecting’ the health of society, the model re-establishes biomedicine’s authority to access former refugees freely.

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<sup>50</sup> Presently refugee groups are identified as ‘other’ in the statistical classification systems used to monitor the health of New Zealanders (Mortensen, 2008).

It is important to note that “no studies appear to look at the effectiveness of refugee health screening”, and yet it continues to be carried out without any adaptations, and arguably, minimal legitimacy (McLeod & Reeve, 2005, p.12). While comprehensive pre-screening of refugees is only executed in USA, Canada and Australia, New Zealand does still carry out overseas screening for active tuberculosis and HIV infection. McLeod and Reeve (2005) note that “this screening is generally not done for the refugees’ benefits” (p.12).

Research to establish the effectiveness of the medical screening of former refugees is sorely needed and a fundamental component of this will be to examine the effects and implications of the screening (and associated medical labelling) on former refugees. Perhaps if this was carried out, the extensiveness of the screening may be somewhat reduced.

### **Encountering Other Deficit-Based Discourses**

This above analysis focused on the textual mechanisms; predication, presupposition and subject positioning at work in the key statement<sup>51</sup> in McLeod and Reeve’s (2005) paper. I have also detailed some inconsistencies with the statement to highlight how the biomedical model is socially constituted, and hence there are possibilities for its disruption and transformation.

While the statement analysed is widely circulated and (re-) establishes the idea that refugee-background people resettling in New Zealand have high health needs, it does not exist in a vacuum. The United Nations High Commissioner for Refugees (UNHCR) (2007), the agency charged with

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<sup>51</sup> “The results demonstrate a well-known fact: Refugees and asylum seekers resettled in countries of second asylum have high health needs” (McLeod & Reeve, 2005, p.10).

'looking after the interests of' refugees, refers to refugees as "burdens" and "problems" (p.6). For a large multilateral agency (that is mandated to protect refugees) to use this language, undoubtedly contributes to the presupposition, or background knowledge that leads to, and perpetuates, the mis-informed needs-based discourses regarding refugee-background people. As Natalie Grove and Anthony Zwi (2006) write:

"refugees and asylum seekers are rarely portrayed as individuals with agency, skill or resilience [...] Rather, as the language of 'burden sharing' suggests, they are perceived as needy, helpless and a drain on resources. This representation starts with the reporting of humanitarian crises and is reinforced on arrival" (p.1935).

Jane Freedman (2010) and Erin Baines (2010) note that often the way that aid is administered in refugee camps perpetuates unequal power relations. Many refugees have reported feeling they need to emphasise their 'powerlessness' and 'victim' status in their requests for protection from UNHCR officials (Freedman, 2010). This idea of the 'competent' aid workers distributing aid to 'helpless' refugees accentuates the dichotomies of 'disciplinary' and 'obedient', and 'helper' and 'victim' (Baines, 2010; Freedman, 2010).

The research literature regarding refugees, and former refugees, which privileges a needs-based focus is considerable<sup>52</sup>. Marjorie Muecke (1992)

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<sup>52</sup> See, for example: Ali & Wilson, 2005; Allotey, 1999; Briscoe & Lavender, 2009; Brown, Carroll, Fogarty & Holt, 2010; Carolan, 2010; Carolan & Cassar, 2008; Collins, Zimmerman & Howard, 2011; CRF, 2011; Correa-Velez & Ryan, 2011; NZIS, 2004; Furuta & Mori, 2008; Guerin, Allotey, Elmi & Baho, 2006; Hollifield et al., 2002; Kennedy & Murphy-Lawless, 2003; McLeod & Reeve, 2005; McKeary & Newbold, 2010; MoH, 2001; 2011; Mortensen, 2008; 2011; Perumal, 2011. Conversely, there is also significant research that critiques the overreliance on the deficit model, which is drawn on here (Butler, 2005; Clark-Kazak, 2009; Eastmond, 2011; Grigg-Saito, Och, Liang, Toof & Silka, 2007; Grove & Zwi, 2006; Malkki, 1995; 1996; Mortensen, 2008; 2011; Mortland, 1987; Muecke, 1992; Oo & Kusakabe, 2010; Ryan et al., 2008). Though it is important to note that in some of these cases the needs-based discourse is still prevalent.

discusses two paradigms that have shaped current understanding of refugee health: “the objectification of refugees as a political class of excess people, and the reduction of refugee health to disease or pathology” (p.515). The apparent ‘commonsense’ and normalisation of the needs-based representation of former refugees – throughout all sectors, is encapsulated with Liisa Malkki’s (1995) assertion that refugees, “by virtue of their ‘refugeeness’ occupy a problematic, liminal position” (p.1).

## **Privileging Western Biomedicine**

*Medicine like all our helping institutions tends to be riddled with the racist, sexist and classist values of larger society, and to the extent it is, contributes to the distancing of refugees as a class of people (Muecke, 1992, p.520).*

Gordon Waitt (2010) asserts that one social mechanism used to naturalise science as truth is the privileging of the relatively powerful group’s voices and technologies over others. As the previous chapter has shown, this mechanism was largely instrumental in how it was that the ‘regulars’ (largely white, middle-to-upper-class and formally educated men) were able to assume medical control over pregnancy and childbirth in the late eighteenth century. This thesis is not attempting to argue whether western or non-western medical discourses are more (or less) reminiscent of (or more ‘accurately’ able to assert) the ‘truth’. Rather it aims to highlight how the western biomedical model is, at this historical moment, produced as the dominant model of healthcare and how this is realised in both spirit and practice. Box 5.2 below lists some of the statements in the analysed texts which privilege the western biomedical model of healthcare, and in so doing work to (re-) establish the dominance and Eurocentric-nature of the model.

### Box 5.2: Privileging the Western Biomedical Model

- *Their [people with refugee backgrounds] initial contact with New Zealand nurses or doctors may be the first opportunity in their lives to receive client-focused, high quality health care<sup>1</sup>*
- *Mangere's 'on arrival' health screening is unique<sup>1</sup>*
- *Delivery of safe, effective and culturally appropriate care to refugee clients<sup>1</sup>*
- *Many people from refugee backgrounds will not have had access to comprehensive health care for years<sup>1</sup>*
- *Their successful resettlement depends on how we as a country, respond to their needs<sup>1</sup>*
- *Quota refugees receive an organised, comprehensive screening programme on arrival<sup>1</sup>*
- *As a midwife, if I don't fix the head, I don't get the babies<sup>3</sup>*

Sources: MoH, 2001<sup>(1)</sup>; Chain, 2011<sup>(3)</sup>.

In the above Box, New Zealand's healthcare services are endowed with the following attributes: *"high quality", "unique", "safe", "effective", "comprehensive" and "organised"*. The healthcare services are hierarchically positioned as the authoritative and knowledgeable assessor or agency that the former refugee clients *"depend"* on to *"fix"* their *"heads"*. This positioning permits those working within New Zealand's healthcare services to engage in particular practices to *"respond to their needs"*.

### Discounting the Health Concepts of Former Refugees

In the health sector, privileging western biomedical knowledges and concepts may lead to other, non-western knowledges and voices being subsumed and invalidated (Malkki, 1996; Ong, 1995; Waitt, 2010). Box 5.3 below contains statements from the analysed texts that work to discount the health concepts, knowledges and approaches of refugee-background people. Implicit (or explicit) in these statements is that former refugees' knowledge about health is incorrect and lacking.



### Box 5.3: Discounting Former Refugees' Health Concepts

- *Nutritionally inadequate diet<sup>1</sup>*
- *The client may lack a 'health' vocabulary<sup>1</sup>*
- *Lack of education about potentially harmful effects of food<sup>1</sup>*
- *Failure to thrive in children...factors could include insufficient breast milk or formula, inadequate introduction of solid foods<sup>1</sup>*
- *A decline in breastfeeding: bottle feeding may wrongly be seen as a modern, better alternative<sup>1</sup>*
- *They may not be aware of the consequences of incorrect, under- or over- dosing or not completing the course of medication<sup>1</sup>*
- *The health care available in their homelands also often differs greatly from that offered in New Zealand. A lack of familiarity with New Zealand systems of health care therefore needs to be considered when providing care for women from refugee backgrounds, and health professionals must be prepared for possible feelings of uncertainty, suspicion and fear amongst these clients<sup>1a</sup>*
- *Have had little or no previous health screening<sup>1a</sup>*
- *Have had limited access to and knowledge of sexual or reproductive health services<sup>1a</sup>*
- *May have health problems due to untreated gynaecological and obstetric conditions after years in refugee camps or homelands where there is a lack of medical facilities<sup>1a</sup>*
- *May have limited knowledge of their reproductive cycle<sup>1a</sup>*
- *Refugees often have difficulty understanding mental health disorders<sup>2</sup>*

Sources: MoH, 2001<sup>(1)</sup>; MoH, 2011<sup>(1a)</sup>; Ali & Wilson, 2005<sup>(2)</sup>.

In Box 5.3 above, the predicates linked to the health practices and understandings of former refugees include: *"inadequate", "lack", "failure", "insufficient", "wrongly", "incorrect", "problems", "limited access to and knowledge of", "untreated" and "difficulty understanding"*. Taken together these statements demonstrate the Eurocentric nature of health services – the western perspective is seen to have the greatest influence and validity, and *"is seen to be the only way of comprehending the world"* (McEwan, 2009, p.14).

## Unreliable Voices

Malkki (1996) has contended that the narrative, stories and voices of refugee-background women (and men) are presumed to be unreliable and unascertainable “set against an ostensibly knowable, visible medical history of injuries or illness” (p.385). Box 5.4 below includes the statements that illustrate how the knowledge and voices of former refugees are represented and positioned as untrustworthy and false. Predicates linked to former refugees’ health knowledges and practices include: “*unreliable*”, “*out of date*”, “*forged*”, “*incomplete*” and “*unsatisfactory*”. It could be argued that these statements work to give authority to health professionals to discount any documentation that refugees bring, and subsequently enable fresh surveillance of their bodies to produce ‘correct’ and ‘reliable’ records.

### Box 5.4: Unreliability of Former Refugees’ Voices

- *Many medicals completed for refugees in their country of origin are unreliable, out of date or forged<sup>1</sup>*
- *In some instances medicals can be ‘bought’ from complying doctors<sup>1</sup>*
- *Many refugee people may have incomplete immunisation or unsatisfactory records of vaccination<sup>1</sup>*
- *Consider the accuracy of the birthdate and, if doubtful, x-ray for bone age<sup>1</sup>*

Source: MoH, 2001.

## Dismissing Knowledges of Refugee-Background Women

Another way that the texts are working to (re-) assert the validity and authority of the western biomedical model is through the tendency to disregard and dismiss non-western health practices. Box 5.5 below includes

statements from the texts that work to dismiss refugee-background women's knowledge as 'traditional'<sup>53</sup>, 'alternative' and 'hearsay'.

#### Box 5.5: Dismissing Refugee-Background Women's Knowledge

- *May be reluctant to use family planning services due to religious beliefs, cultural attitudes, lack of education and erroneous beliefs surrounding the use of contraception<sup>1a</sup>*
- *Although New Zealand health care providers may often view the use of traditional medicine as a sign of ignorance, LMCs [Lead Maternity Carers] should always acknowledge and show respect for women's health beliefs, and work alongside women to discourage the use of potentially harmful traditional remedies while endorsing those which may be of physical or psychological benefit<sup>1a</sup>*
- *Where these practices clash with your own beliefs, remember that childbirth is a challenging time and unless the practice is actually harming the health of the mother or baby, it should be respected<sup>1a</sup>*
- *Many women from refugee backgrounds come from cultures with strong traditional health customs and beliefs. They may have very different views from their LMCs on how pregnancy should be managed; the causes of pregnancy complications; the need for medical interventions such as caesareans; and the midwife-client relationship<sup>1a</sup>*

Source: MoH, 2011.

In the above Box, the predicates attached to the knowledges of refugee-background women include: "lack", "erroneous", "cultural", "ignorance", "potentially harmful" and "traditional health customs and beliefs". Implicit is that western biomedically-based healthcare services are not cultural or socially constituted; rather they're rational, neutral and stable. While the MoH Handbook (2001) recommends that the health practitioner should show respect for the women's health beliefs, it is concerning that the (western-based) practitioner is positioned as having the authority and

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<sup>53</sup> I use this term with caution, as I recognise the tension between the, oft-used, 'tradition' versus 'modern' dichotomy. Margaret Jolly (2002) writes, "[t]his deep but problematic association between the traditional and the indigenous, the modern and the Western is an endemic problem for scholars analyzing transformations in birthing in comparative, cross-cultural contexts" (p.2). She calls for efforts to move beyond these binaries, which may enable recognition of the fluidity of birth and culture.

control to 'judge' which health practices are 'beneficial' and which are 'harmful'.

## **'Othering' in Health**

*Opposing Us, the Self, and Them, the Other, is to choose a criterion that allows humanity to be divided into two groups: one that embodies the norm and whose identity is valued and another that is defined by its faults, devalued and susceptible to discrimination (Staszak, 2008, p.1).*

Another mechanism seen throughout the analysed literature that works to 'fix' the dominance of the western biomedical model is *Othering*. The concept of Othering can be defined as a process that serves to distinguish those deemed different from oneself, and where one's own identity is constructed using others as the reference point (Johnson et al., 2004). As discussed in Chapter 3, this thesis draws on postcolonial theory, of which the concept of Othering is central. For postcolonial theorist, Cheryl McEwan (2009), Othering refers to "the systemized and hierarchical construction of difference between groups of people on the basis of such factors as 'race', ethnicity or culture" (p.122). Following Grove and Zwi (2006), one's own identity is determined (and fixed) through the positioning (and stigmatising) of an- (other). To explain, colonial discourse constructs, or more correctly co-constructs, the non-western 'Other' simultaneously with the production of the western 'self', and consequently one cannot be seen or understood without the other (Grove & Zwi, 2006; McEwan, 2009). Thus the 'Other' is conceptualised as different from the 'unmarked norm', and is produced through various discourses that create hierarchal relations of opposition and subordination (Heron, 2007).

Othering practices in the health sector (intentional or not) have been found to reinforce and reproduce the dominating and subordinating relations between particular actors. Consequently those treated as 'Other' often experience marginalisation, decreased opportunities and exclusion in their healthcare (Johnson et al., 2004). Research has established some of the health effects of Othering, such as shorter life expectancy, higher infant mortality, depression, stress responses and hypertension (ibid.). Also, it has been found that people who feel unwelcome or who have had negative experiences with health services are less likely to re-enter and seek appropriate care, thus Othering practices can also affect health by creating access barriers to healthcare (Bowes, 1993, cited in Johnson et al., 2004).

While these health effects of Othering are known, there is limited research exemplifying specific Othering practices in health services. As Joy Johnson and colleagues (2004) note, examples of these can help "raise awareness of how seemingly innocuous and everyday statements can distance providers from patients", and in light of this, highlight ways to improve and transform services (p.254). To improve access to healthcare for refugee-background women, it is thus crucial to examine how the process of Othering is manifested in healthcare services<sup>54</sup>.

The study by Johnson and colleagues (2004) explored interactions between healthcare providers and South Asian immigrant women in Canada to describe Othering practices and their effects. Their analysis revealed three forms of Othering: *essentialising*, *culturalist* and *racialising* explanations.

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<sup>54</sup> As discussed in Chapter 3, this thesis does not examine interactions between practitioners and consumers, though the literature analysed is written by or written for practitioners. Therefore the language used will undoubtedly reflect and shape healthcare practices and interactions.

Here, I apply this work to provide examples throughout the texts I've analysed that reflect essentialising and culturalist explanations.

In the texts analysed there was rarely any explicit reference to racial categories of refugee-background communities and so I have not incorporated this form of Othering in my analysis. However another form of Othering that was significant in the texts, was the tendency to typecast refugee-background people as 'diseased' and 'contagious'. In the texts there were many statements indicative of Othering discourses, such as using markers of difference: "these people" and "them", from "us" and "we". Whether this language is intentional or not, it can reinforce and reproduce relations of subordination and domination.

### **Essentialising Explanations**

Essentialising involves making overgeneralisations or stereotypical descriptions about people based on categories such as race, culture, social background, and healthcare beliefs and practices. As Johnson and colleagues note (2004), "these over-generalizations tend to be ahistorical and abstracted from the broader social, economic, and political issues influencing culture, health, health practices, and ways of life" (p.260). Stereotypical descriptions of the healthcare practices of different ethnocultural groups can reduce, naturalise and fix 'difference', while ignoring individuality and diversity within groups (Hall, 1997; Johnson et al., 2004). Box 5.6 below lists examples of essentialising used in the texts analysed, followed by a discussion of their implications.

### Box 5.6: Essentialising Explanations

- *Many refugees arriving on our shores are debilitated by trauma, loss and unresolved grief*<sup>1</sup>
- *Refugees are the human casualties*<sup>1</sup>
- *The refugee experience continues as they struggle to a new environment and rebuild their shattered lives*<sup>1</sup>
- *Family reunification refugees have the same health issues as quota refugees*<sup>1</sup>
- *Memory and concentration problems are common features of the refugee experience*<sup>1</sup>
- *Refugees have increased risk for TB, which is typically found in deprived, overcrowded living conditions*<sup>1</sup>
- *If young people's experience of the new culture has been hostile or indifferent...the chances of drifting into drugs, drinking, gambling or criminal activity are increased*<sup>1</sup>
- *For those that have some literacy*<sup>1</sup>
- *These women may be a high risk group for post-natal depression*<sup>1</sup>
- *Third world refugee women are in every sense refugees at the end of the charity line where they wait endlessly for food, water, medicines, and whatever basic needs have to be met*<sup>1</sup>
- *These women often have low English language proficiency and poor levels of literacy*<sup>1</sup>
- *Careful explanations may be needed due to memory and concentration problems*<sup>1</sup>
- *Their coping capacity may be limited*<sup>1</sup>
- *A woman who is unable to feed, shelter and clothe herself and her children is often forced into prostitution*<sup>1</sup>
- *Many women from refugee backgrounds may experience difficulties surrounding female genital mutilation*<sup>1a</sup>
- *Many women will have been sexually abused or raped*<sup>1a</sup>
- *Most [women with refugee backgrounds] will be experiencing financial hardship*<sup>1a</sup>
- *Women have special mental health needs*<sup>2</sup>
- *Refugees often have difficulty understanding mental health disorders*<sup>2</sup>
- *We do lots of counselling with these patients*<sup>3</sup>
- *So we work together quite closely with family start. I usually try and bring someone in for... [little giggle]...these ladies especially when there's language in the antenatal period so they get to meet them because I don't get to go around all the homes antenatally and that's the start to see what issues we've got before we're even having the baby*<sup>3</sup>
- *I can only see that counseling of refugees should occur very early when coming from war torn countries, and preconceptual education a must [sic]. I now counsel all my clients on the very first visit and build up a complete picture that develops a warm relationship of trust*<sup>3a</sup>

Sources: MoH, 2001<sup>(1)</sup>; MoH, 2011<sup>(1a)</sup>; Ali & Wilson, 2005<sup>(2)</sup>; Chain, 2011<sup>(3)(3a)</sup>.

The statements in Box 5.6 above provide examples of the binaries that get created between 'us' and 'these women', 'appropriate' and 'inappropriate',

and 'problematic' and 'unproblematic'. In this process women with refugee backgrounds are set apart as different. McEwan (2009) writes that these naming practices are not innocent, but rather "they are part of the process of 'worlding', or setting apart certain parts of the world from others" (p.26). Despite the current tendency in health to provide services "couched in a discourse of equal treatment and cultural appropriateness" (Johnson et al., 2004, p.58), the statements reveal that Othering discourse is indeed evident. Also, I recognise that because the resources are providing information about former refugees as a targeted group, it has encouraged the speaking of them as a homogeneous group, further perpetuating essentialist explanations of Othering. Yet there is no mention in any of the documents analysed of the diversity that exists within communities of former refugees, despite the knowledge that within ethnic groups there is more diversity than across them (Johnson et al., 2004).

Another aspect of essentialising or stereotyping is ethnocentrism, in that it divides the 'normal' from the 'abnormal' – "it facilitates the binding together of all of us who are 'normal' and sends into symbolic exile all of Them who are in someway different" (Hall, 1997, p.258). In this way, the Othering discourses in health can have assimilating messages, where certain groups' health practices are encouraged and shaped according to the dominant western biomedical model. These discursive efforts to establish 'normative' health behaviours are, according to Hall (1997), an:

"attempt to fashion the whole of society according to their own world view, value system, sensibility and ideology. So right is this world view for the ruling groups that they make it appear (as it does appear to them) as 'natural' and 'inevitable' – and for everyone – and, in so far as they succeed, they establish their hegemony" (p.259).



Colonisation, by its very definition, is assimilating; a conversion “by which non-Europeans were to be transformed into something European like”, and James Belich (1996) has asserted that this ethos has not left us (cited in Jaber, 1998, p.40). In the healthcare literature I analysed there are many assimilating messages. For example, statements related to diet are based on western frameworks of what constitutes appropriate healthy eating, and consequently the knowledges and practices that former refugees have are dismissed. Assertions in the literature such as: *“health problems among refugee groups may be related to diet and lifestyle”*, *“nutritionally inadequate diet”*, *“lack of education about potentially harmful effects of food”*, and *“diet’s a big one”* send the message that what former refugees eat and know about food is “inappropriate” and “incorrect”. This undervaluing and eradication of non-western health beliefs and practices is, as Ong (1995) has suggested, a strategy to gain general acceptance and achieve assimilation. In this way the healthcare services for refugee background communities in New Zealand become yet another site where “Western ways of knowing are reproduced” (Rajaram, 2002, p.247).

Malkki (1996) argues that after World War II, increasingly universalised discursive ways of representing refugees among governments, journalism, media, refugee agencies and other NGOs emerged (albeit sometimes unintentionally), which consequently silenced people classified as having refugee backgrounds. She adds, “their accounts are disqualified almost a priori, while the languages of refugee relief, policy science, and “development” claim the production of authoritative narratives about refugees” (1996, p.386). These western-based agencies apparently know former refugees better than they know themselves. Following Edward Said’s (1979) pioneering work on Orientalism and the construction of Other, this act of ‘knowing’ is viewed as inseparable, a necessary tool, to maintain

power and domination (cited in Jaber, 1998). The messages throughout the health and medical screening literature analysed here are that the health beliefs and practices of refugee-background communities are (constructed as) somehow subordinate to western-based biomedical knowledge. The resolute belief in western-based health and medical scientific knowledges acts as the legitimating force to particular statements and behaviours. By constructing former refugees' knowledge as the Other, the west then becomes constructed as the authority of all issues relating to health.

The decontextualised images used throughout literature concerning refugees and refugee-background communities has, as Prem Rajaram (2002) asserts, rendered them "speechless and without agency, a physical entity, or rather a physical mass within which individuality is subsumed" (p.251). An effect of this essentialism, as Malkki (1996) argues, is that refugees "stop being specific persons and become pure victims in general" (p.378). While she acknowledges that refugee populations usually consist of people in urgent need, the social processes involved in the delivery of assistance ignore the details of specific histories or contexts of former refugees, and the political causes of their circumstances. Therefore a situation is created where refugees are treated as mute victims or "voiceless bodies", rather than historical actors (Malkki, 1996, p.378).

The photographic images used throughout the texts I analysed (specifically, Ali & Wilson, 2005; MoH, 2001; 2011), perpetuate the 'needy' representation of refugee-background communities through overuse of decontextualised bodies without narration provided of their historical, political, social backgrounds or even, simply, their name (Rajaram, 2002). Quotes from refugee (and refugee-background) women and men are used in both texts, but no names or context are provided, in this way they become

universalised as a general refugee, an “anonymous corporeality” (Malkki, 1996, p.388). Children and women are overrepresented in the imagery, perhaps because, as Malkki (1995) argues, they “embody in the Western imagination a special kind of powerlessness” (p.11). Of the 62 photos of former refugees used in the MoH (2001) Handbook, all but 16 of the photos contain children, and 18 of them are of only children without adults. While it is true that women and children represent over half of the world’s refugees (Freedman, 2010; UNHCR, 2001-2012e), it is still worrying how predominant they are in the visual representation of displacement (Malkki, 1995).

The image on the cover of the *Refugee Health Needs Assessment* (Ali & Wilson, 2005) is a portrait headshot of an African girl who looks about ten. It is a large central photo, underneath which is a Somali proverb about hope, as if this is the entire context required. There is no information about the girl provided – no name, no relatives and no story. In this way she has become a generic refugee: a figure that ‘speaks’ to us “in a particular way: wordlessly” (Malkki, 1996, p.390). As Nandita Dogra (2007) notes many studies have critiqued these ‘negative’ visual images<sup>55</sup> used by development INGOs, which similarly have depicted people in the south as ‘helpless’ and ‘passive’. Women and children tend to be ubiquitous in fundraising appeals by INGOs, which many argue has the effect of ‘feminising’ and ‘infantilising’ the south (Clark-Kazak, 2009; Dogra, 2011). Also, use of these types of ‘negative’ imagery can reinforce dichotomous stereotypes of the southern ‘victims’ needing to be rescued by the western ‘saviours’ (Dogra, 2007). The appeals by INGOs have also encountered criticism for their failure to

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<sup>55</sup> Though, more recently there is an increasing use of ‘positive’ and ‘active’ imagery, which Kalpana Wilson (2011) argues demonstrates “continuities with representations of ‘productive and contented’ workers in colonial enterprises”. These images, she argues, work to obscure oppressive and exploitative relations, and ensures any resistance to the neoliberal framework is hidden (2011, p.316).

educate and create awareness of the political nature of so-called 'under-development'<sup>56</sup>.

The implication of the 'negative' figuration of refugee-background communities is that they can be perceived as being without agency and consequently dependent on the 'expertise' of the host community's healthcare providers. For Malkki (1996), "this vision of helplessness is vitally linked to the constitution of speechlessness among refugees: helpless victims need protection, need someone to speak for them" (p.388).

Altogether these images and messages have the effect of (re-) establishing the idea that former refugees are in 'need' of 'our' help. The construction of refugees as having high health needs and problems, and as a universal group lacking in health knowledge and expertise, is 'beneficial' as it allows us ("us" as health professionals and "us" in the host communities) to construct our identity according to their needs. This is problematic because, as Heron (2007) asserts, we fail to recognise "how we are implicated in global economic processes of globalization that underlie these needs", such as wealth and resource extraction (p.3). It also has the effect of obscuring what refugee-background communities are already doing for themselves.

### **Culturalist Explanations**

Box 5.7 below lists the cultural explanations that were identified throughout the texts. This refers to the process of using the cultural beliefs and practices of refugee-background women as explanations for problems with healthcare provision and utilisation.

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<sup>56</sup> As well as failing to examine how those in, so-called, 'developed' countries can look at how the levels of (over-) consumption directly (and indirectly) impact on people in the majority world.

### Box 5.7: Culturalist Explanations

- *Politeness may lead the client to indicate that they have understood when this is not so<sup>1</sup>*
- *Providing optimal care to refugees can be a challenge for health professionals. This is because refugee clients: may be ignorant or mistrustful of the health system, or feel isolated and misunderstood because of their lack of English; may be highly traumatised, or suffering from grief, depression or feelings of guilt for surviving when others did not...<sup>1</sup>*
- *Fatima spent all of this pregnancy complaining of minor ailments, headaches, urine infections and pains everywhere. She visited several doctors and turned up at hospital when it suited her. She was very rude to me, and very demanding<sup>3a</sup>*
- *Fatima was beyond counselling and would retaliate at any suggestion of it<sup>3a</sup>*
- *Many emotional issues came out in labour<sup>3a</sup>*
- *She [Sajida] often turned up at different GP surgeries complaining of urine like symptoms and pelvic pain<sup>3a</sup>*
- *Afsheen was expecting her 3<sup>rd</sup> baby I visited her at home she was very demanding and was always angry if my visits were late or not on time [sic]<sup>3a</sup>*
- *She [Fatima] went into labour and what I thought was going to be an easy birth was complicated<sup>3a</sup>*
- *Vaginal examinations were torture, and she turned very hysterical, thus needing an epidural and very long birth of 16 hours<sup>3a</sup>*
- *I said I would not look after Fatima again because she was far too demanding...She was demanding an epidural<sup>3a</sup>*
- *I visited her at home I was punished for not doing my job well, she complained of headaches which were not to do with the epidural...She went to Auckland Accident and emergency [sic] after my visit; they did a lumbar puncture and found nothing<sup>3a</sup>*

Source: MoH, 2001<sup>(1)</sup>; Chain, 2011<sup>(3a)</sup>.

Drawing upon 'culture' as an explanatory framework places the blame for access barriers on refugee-background women themselves. Consequently the underlying issues that fundamentally affect healthcare remain unnamed and unproblematised. To further explain, the literature exposes the tendency to attribute refugee-background communities' lack of language, their shyness or their beliefs to problems with healthcare access, and subsequently the focus is on changing these behaviours. In this way the discriminatory attitudes and practices of healthcare services, such as lack of female healthcare providers, lack of interpreters and limited clinic hours are

overlooked (Johnson et al., 2004). Very little, if anything, is said about how the host community's healthcare system can be adapted so that the strengths, knowledges and capabilities of women with refugee backgrounds can be encompassed and embraced.

While the MoH (2001; 2011) texts recommend that female practitioners and interpreters be used in certain situations, it remains to be seen whether this occurs in practice. For instance, the *Refugee Health Needs Assessment* found that there exists a lack of cultural understanding by service providers and a low use of and access to interpreting services in health (Ali & Wilson, 2005). Additionally, the ChangeMakers Refugee Forum (CRF) (2011) report found that people with refugee backgrounds experienced many barriers to accessing interpreters and faced discrimination by health practitioners. The report also found that health practitioners were not culturally sensitive and that they tended to rush appointments.

In the MoH Handbook (2001) there is just one statement that asserts the importance of acknowledging people's strengths: "*respect your client's knowledge and experience*" (p.35). This was one of very few statements throughout the analysed texts. Furthermore, the overarching impression of the Handbook lacked similar sentiments, which led me to surmise that this attempt was "done in a stereotypical, reassuring fashion that serves to comfort the Self in its feeling of superiority" (Staszak, 2008, p.1). Healthcare services require many improvements to the access, responsiveness and availability of services to former refugees (this is explored further in Chapter 6).

In the revised chapter of the MoH Handbook (2011), "*Refugees with Special Health Needs: Women from Refugee Backgrounds*", there are numerous

examples of culture being used as an explanatory model. One such example is that when describing the influences of the health-seeking behaviour of refugee-background women, the following explanation is given:

*"These factors include a woman's previous health care experiences, health knowledge, traditional health beliefs, and religious beliefs. In addition to this her behaviour will also be influenced by factors such as her level of education, length of time in a new country, socio-economic status and immigration status" (p.1).*

A little further on, the authors state, *"many women from refugee backgrounds have difficulty accessing health care services in New Zealand due to language barriers, cultural barriers..." (p.1).* However cultural values are organic, they are not static as these statements presuppose. Instead of seeing culture as a dynamic and 'lived experience', these statements suggest stereotypical and overgeneralised views of refugee-background women (Johnson et al., 2004).

Further examples of culturalist explanations in the MoH (2011) revised chapter are seen in the section on 'family violence'. To explain why *"[w]omen from refugee backgrounds may be particularly vulnerable to family violence" (p.5),* reasons given include:

*"they may lack family support; usually they have dependants; for some, an unsatisfactory relationship is better than no relationship<sup>57</sup>; cultural differences, inability to speak English, and lack of knowledge on how to access alternative housing, income, legal and support services make it difficult for them to leave..." (p.5).*

Another explanation given is; *"changing roles within traditional family structures following diasporas may result in men feeling disempowered in host countries which puts then [sic] under additional pressure and increases stress*

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<sup>57</sup> I consider this an atrocious statement; i.e. implicit is that the authors' assume the woman has made a decision to be abused.

*levels*" (p.5). While there is helpful advice for health practitioners given, such as using an impartial interpreter and providing telephone numbers for support services if she wishes to leave, it is, again, distressing to note that the social, cultural and political systems that may be affecting and disempowering the woman and her family are overlooked, and instead cultural explanations are given.

There were statements throughout the texts where issues of 'culture' were conflated with non-compliance or lack of responsibility and motivation (Johnson et al., 2004). When situations were difficult for health professionals, Othering language appeared to explain this behaviour, and as Johnson and colleagues (2004) argue "underlying this explanation is an unnamed "idealized other" who is compliant, realizes what is "important", and "listens" to the advice of experts" (p.260).

In particular, Box 5.7 above lists some of the statements from the maternal health educational CD and Case Study where the midwife makes repeated reference to the behavioural problems with her clients: Fatima, Sajida and Afsheen. Implicit in her statements are that there exist 'normal' clients who know how to behave, who do not demand, and who are calm and compliant. Using her clinical experience (and 'scientific' evidence), the midwife is able "to legitimize, rationalize, and convince others and [...herself...] of the veracity of these claims" (Johnson et al., 2004, p.261). The discourses present in all the texts analysed send the message to maternal healthcare providers that refugee-background women are (potentially) problematic clients, who need to be managed appropriately. These statements further perpetuate the dichotomy between self and Other and serve to reinforce the existing patronising and colonial discourses present in maternal healthcare services.



Throughout the texts, reference was made to improving service providers' cultural knowledge of refugee-background communities to enable more effective engagement. An important point, yet no tangible suggestions were made about how to achieve this (explored further in the following chapter). Indeed it would take time, reflection and commitment on behalf of the health professionals to learn more about their clients that come with refugee-backgrounds.

### **The Diseased and Contagious 'Other'**

*The social construction of boundaries of 'self' and 'other' and their relationship to boundaries of 'safety' and 'danger' are particularly relevant to understanding notions of health and disease (Flowers, 2001, cited in Grove & Zwi, 2006).*

An outcome of medically-based screening programmes, such as that at MRRC, is that former refugees become constructed as a "category both contagious to and dependent upon the civil society" – the contagious 'Other' (Ong, 1995, p.1244). The compulsory medical screening, many argue (see Eastmond, 2011; Malkki, 1995 & 1996; Ong, 1995), constructs former refugees as "carriers of exotic and mysterious diseases...as well as suffering from 'mental illness' [and thus they] must be treated and 'transformed'" (Ong, 1995, p.1245). The discourses substantiated in response to the medical screening process continue to circulate as former refugees are "treated and transformed" via New Zealand's public health services, which "continue to focus on the problematized (interior and exterior, political and social) body" (Ong, 1995, p.1245). As Grove and Zwi (2006) write, people with refugee backgrounds tend to be "portrayed as a threat to a robust and healthy society, a threat of disease itself. *They* must be screened and quarantined to avoid the spread of disease" (p.1937, emphasis author's own). This 'risk' of

disease undoubtedly conditions not only how former refugees perceive themselves but also how they are perceived, which ultimately affects health outcomes at both the individual and community levels.

### *Medical Surveillance*

The message that overwhelmingly came through the literature I analysed was that refugee-background communities are 'diseased' and 'risky', and thus they require medical 'surveillance' and 'help'. Through medical screening the symptoms of former refugees must be assessed, diagnosed, treated and the findings subsequently published (Muecke, 1992; Ryan et al., 2008). This management of former refugees is justified because of the 'risk' of public contamination, the 'veracity' of medical science, and the preoccupation of biomedicine with disease and the quest to 'know'.

Foucault (1973) describes the power of the medical gaze: "the eye that knows and decides, the eye that governs...a gaze that was not content to observe what was self-evident; it must make it possible to outline chances and risks; it was calculating" (p.89). As was shown in Chapter 4, an important element in the biomedical model's power to control was to have the power to 'know', but, as Elaine Papps and Mark Olssen (1997) write, "to do this was a requirement to have greater access to surveillance" (p.111). Box 5.8 lists the statements from the texts that reveal the importance (to biomedicine) of screening former refugees. The last two statements show how imperative programmes, such as health promotion and education with refugee-background communities, are being side-lined due to the commitment to medical screening.

### Box 5.8: Medical Surveillance Statements

- *It is therefore difficult for the available services to seek out these newcomers [asylum seekers and family reunification refugees] and offer health...and other support in an organised way<sup>1</sup>*
- *Since not all asylum seekers can be traced<sup>1</sup>*
- *Maintain a low threshold of suspicion for these conditions<sup>1</sup>*
- *While quota refugees will have been screened for a number of these diseases, many asylum seekers and family reunification refugees will have received little or no screening<sup>1</sup>*
- *After being caught out, my advice re back pain in a refugee client – think TB until proved otherwise<sup>1</sup>*
- *You need to get into the communities to identify issues. You need to be proactive in your approach and assertive in your follow up care<sup>1</sup>*
- *Refugees who remain unscreened pose a risk to themselves and to public health<sup>1</sup>*
- *The difficulties in tracing and locating [family reunification refugees] mean that many remain unscreened<sup>1</sup>*
- *Many asylum seekers will remain unscreened for long periods<sup>1</sup>*
- *Due to the many potentially complex needs of women from refugee backgrounds, it is worth actively inquiring about the possibility that they may be pregnant or planning pregnancy (or at least, not actively preventing pregnancy), in which case a comprehensive health assessment should be offered<sup>1a</sup>*
- *The services provided under the [Regional Public Health] contract are...follow-up of Mangere health screening of new arrivals to the region; TB screening and facilitating health screening as per Mangere screening protocol as required<sup>2</sup>*
- *The completeness of screening can vary from area to area however all refugees referred to Regional Public Health are screened for tuberculosis. Other health screening similar to the MRRC is facilitated through their primary health care provider<sup>2</sup>*
- *There is insufficient capacity after dealing with refugee screening for this position to initiate a true cross service response to refugee health needs<sup>2</sup>*
- *Unfortunately at present refugee screening needs dictate that intersectoral and health promotional initiatives are undertaken as time allows and are not as extensive as needed<sup>2</sup>*

Sources: MoH, 2001<sup>(1)</sup>; MoH, 2011<sup>(1a)</sup>; Ali & Wilson, 2005<sup>(2)</sup>.

### ***Diseased Typecasting***

Chapter 4 of the MoH Handbook (2001) has tables and lists of “common” health issues, and infectious and parasitic diseases, of which health professionals are warned to “maintain a low threshold or suspicion for...and refer appropriately” (p.49). There are tables listing “specific health issues for refugees from different regions” and an alphabetical list of the “more

common health issues among refugee groups” (2001, pp.40-8). Later in the chapter is a table that “sets out signs and symptoms of common infectious and parasitic diseases found in countries of origin” (2001, p.49). While all of these descriptions may be useful in providing guidance for health providers, they can also overgeneralise former refugees as a homogenous group at risk of disease. A health professional referring to these lists only has to run their fingers down a column and find where their “refugee client” has originated to be met with an extensive list of “*common*”, “*may occur*”, “*rare/less common*” infectious and parasitic diseases that they may be carrying (2001, p.51). It is extremely disturbing to see people being categorised this way and only serves to position former refugees as the ‘diseased and contagious Other’.

The final eight-page table in the MoH (2001) chapter is a comprehensive list of the “*unfamiliar infectious and parasitic diseases*” (pp.53-60). Although it is assumed that these unfamiliar diseases are referring to ones that their refugee clients may be carrying, this is not explicitly said, perhaps another example illustrating the tendency to overgeneralise and stigmatise former refugees. Box 5.9 below lists the statements made about former refugees that typecast them as the ‘diseased and contagious Other’.

### Box 5.9: Diseased Typecasting

- *Infectious and parasitic diseases are common in many of the countries from which refugee people originate<sup>1</sup>*
- *Many refugees and asylum seekers arrive in New Zealand with advanced or untreated dental disease<sup>1</sup>*
- *TB infection and disease should always be considered in refugee groups<sup>1</sup>*
- *HIV is increasingly common, along with other sexually transmitted infections (STIs)<sup>1</sup>*
- *Disease levels vary on arrival<sup>1</sup>*
- *May feel shame or rejection through having a communicable disease such as TB or HIV<sup>1</sup>*
- *Refugees have increased risk for TB, which is typically found in deprived, overcrowded living conditions<sup>1</sup>*
- *Higher rates of pregnancies complicated by diabetes<sup>1a</sup>*
- *Women from refugee backgrounds may have higher risk pregnancies for some of the following reasons:*
  - *Recurrent urinary tract infections;*
  - *Pelvic infections;*
  - *Sickle cell disease, thalassaemia, anaemia below 10g/dh;*
  - *Vitamin D deficiency;*
  - *Exposure to STIs or HIV;*
  - *Rheumatic heart disease;*
  - *Higher risk of TB;*
  - *FGM<sup>1a</sup>*
- *Untreated and advanced dental disease<sup>2</sup>*
- *We work with GPs, cause again, we have patients who have poor diet, thyroid issues and with poor diet you have patients with cardiac problems...and everything else<sup>3</sup>*

Sources: MoH, 2001<sup>(1)</sup>; MoH, 2011<sup>(1a)</sup>; Ali & Wilson, 2005<sup>(2)</sup>; Chain, 2011<sup>(3)</sup>.

While the authors of the MoH Handbook (2001) note that there are not large numbers of these “*infectious and parasitic*” diseases seen in New Zealand, they state it is “still important to be aware of these infections and to remain vigilant” (p.53). A vigilance that may actually be more harmful than beneficial because of the marginalisation and exclusion these Othering practices may effect. Further, it would be interesting, and no doubt insightful, to ascertain whether (and to what degree) former refugees have indeed become a threat to public health (cf. Ong, 1995).

## Talking About Assets?

*The data and conclusions about refugee health that we have in the literature are exclusively negative. Absent is the study of refugee health or of healthy refugees. Yet refugees present perhaps the maximum example of the human capacity to survive despite the greatest of losses and assaults on human identity and dignity (Muecke, 1992, p.520, emphasis author's own).*

After analysing the texts (and literature further afield) I was left with the impression that it is seemingly not possible for former refugees to be known as people who have skills, strengths and knowledges. A great deal of discursive work is done to ensure that what are, quite clearly, *assets* were distorted into *problems* or *needs*. An example of this is seen when considering the low alcohol use of men and women with refugee backgrounds. The alcohol consumption rate for refugee-background men is 7.3 percent and only 1.1 percent for women (McLeod & Reeve, 2005; Ali & Wilson, 2005). These prevalence rates have originated from the MRRC screening programme where all adult refugees were asked if they drink alcohol. By way of comparison, 85 percent of all New Zealanders aged 16–64 drank alcohol in the past year (MoH, 2009). Three in five (61.6 percent) past-year drinkers consumed more than ALAC's (the Alcohol Advisory Council of New Zealand) recommended maximum (six standard drinks for males and four for females on a drinking occasion) at least once during the last year (ibid.).

In the *Refugee Health Needs Assessment*, lifestyle factors, such as alcohol and smoking are identified as being “significant health issues” for refugee-background people (Ali & Wilson, 2005, p.22). Yet alcohol consumption is so low compared with the average New Zealand rate, and official

recommended intake amounts, that it should be described as a significant health '*asset*'. Three paragraphs later the authors note that the alcohol consumption rate is low, but however it is never acclaimed as an asset that host societies could learn from. Rather, it is shelved as being due to religious and cultural reasons, and because of this it is suggested that there "may be under reporting of alcohol consumption" (Ali & Wilson, 2005, p.22). Again, culturalist explanations are used to explain this difference, which, instead of celebrating the low alcohol consumption of refugee-background people, it is stigmatised. The McLeod and Reeve (2005) report only presented the consumption rates and, unfortunately, makes no acknowledgement of the low levels. Consequently, an asset that can be drawn on to assist with the health effects (and associated costs) of alcohol consumption in New Zealand is lost<sup>58</sup>.

There are further examples seen where the known assets of former refugees are dismissed or not acknowledged, such as their low rates of eczema, glue ear and asthma compared with the host population (McLeod & Reeve, 2005). There are also low rates of tobacco use among refugee-background women, especially in comparison to host populations (ibid.). Another known asset is a low prevalence of diabetes in communities coming from the Horn of Africa, largely attributed to their "traditional" diets (Ali & Wilson, 2005, p.40). Yet as illustrated previously (see p.137), the statements in the analysed texts indicate that the diets of former refugees were perceived as 'lacking' and 'inappropriate'. Another strength that is ignored is the low rate of sexually transmitted infections among women with refugee backgrounds (McLeod & Reeve, 2005). Perplexingly though, both the MoH

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<sup>58</sup> In New Zealand, the situation is alarming with between 600 and 1,000 people dying each year from alcohol-related causes. It is also estimated that alcohol consumption is an important risk factor for more than 60 different disorders (ALAC, 2009).

Handbook (2011) and the *Refugee Health Needs Assessment* (Ali & Wilson, 2005) state that refugee-background women have distinct sexual and reproductive health *needs*.

There is also a practice of 40 days of bed rest for the mother after giving birth for many women with refugee backgrounds (MoH, 2011). As a former midwife (and mother myself) I know intimately how much of an asset it is to have a mother who is well rested after giving birth. Nonetheless, as the following excerpt in Box 5.10 illustrates, the literature once more draws upon ‘culture’ to frame this difference into Otherness, and in the process the barriers inherent in the maternal healthcare system, such as lack of clinical hours and support, are overlooked.

Box 5.10: Postnatal ‘Assets’

*The experience of post-natal care for many women from refugee backgrounds in New Zealand is very different to that in their countries of origin. In many of the cultures women and their infants practice a period of confinement in the home after birth (commonly 40 days) where they are cared for by their families. In New Zealand, women from refugee backgrounds may not have family members here to provide this level of support. These women may be a high risk group for post-natal depression and health practitioners need to be alerted to their client’s expressions of isolation and depression.*

Source: MoH, 2011, p.12.

At other times in the literature, the assets of people with refugee backgrounds were instead attributed to their health professionals. When discussing her practice (which is made up of predominately refugee-background women), midwife Irene Chain (2011) reports, “*I actually have a*



92% vaginal birth rate and 4 % epidural<sup>59</sup> rate". These rates do indeed indicate success, however to report it like this results in the midwife becoming the 'successful star' of the story and the woman (the one that is doing the tremendous work delivering her baby) becomes the background; the object without a voice. The binary oppositions in this statement are palpable: Active-Passive, Success-Failure, and Progress-Backwardness. As McEwan (2009) notes, these binaries are not innocent as they are "bound up in the logics of domination", serving to cement the superiority of the western-trained health practitioner and the biomedical model (p.122).

Another way that the literature conveys that former refugees could never be known as asset-rich, is the lumping together of their 'needs' and 'problems', without any discussion and coherency. At times, the references for the statements were not given or were out of date. The following excerpt is the complete second paragraph from the revised chapter (2011) in the MoH Handbook<sup>60</sup>. The way it is written makes it difficult, or even impossible, to consider (or even imagine) refugee-background women as having skills, knowledge and strengths.

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<sup>59</sup> Epidural is a form of regional analgesia involving injection of drugs into the epidural space (the outermost part of the spinal canal). It is used to help with the pain during labour, and can cause both a loss of sensation (anaesthesia) and a loss of pain (analgesia), by blocking the transmission of signals through nerves in or near the spinal cord (Thorp & Breedlove, 1996).

<sup>60</sup> This chapter is titled '*Refugees with Special Health Needs - Women from Refugee Backgrounds*' (MoH, 2011).

### Box 5.11: “Refugees with Special Health Needs”

*Studies of the health of women from refugee backgrounds in New Zealand have indicated many of these women have distinct sexual and reproductive health needs<sup>11</sup>. <sup>iv</sup>Post arrival, women from refugee backgrounds have the lowest coverage for cervical screening, higher rates of pregnancies complicated by diabetes and lower rates of breastfeeding compared to other groups. <sup>v</sup>Additionally, these women often have low English language proficiency and poor levels of literacy. <sup>vi</sup>Mothers of young children and the elderly may experience significant social isolation. 50 percent of women did not use contraception and 78 percent of women of reproductive age had Vitamin D deficiency or insufficiency. In addition some communities have a very high incidence of harmful traditional practices such as FGM, and of infectious diseases such as HIV/AIDS*

Source: MoH, 2011, p.1.

## **Summary**

This chapter has illustrated the large amount of discursive work employed to naturalise and assert as ‘fact’ (based on western biomedical science) the idea that former refugees are diseased, needy and problematic. It has also highlighted some of the implications of the discursive practices of the western biomedical framework, which consequently make the delivery of culturally-appropriate care challenging.

The demonstration of how power works discursively within the western biomedical model, may alert all groups to the socially constructed nature of the associated roles, behaviours and relationships. Accordingly those involved in health, including providers, researchers and consumers, can work towards creating spaces so that more ‘positive’ forms of engagement can take place. In order to acknowledge and promote the assets, strengths and resources of former refugees, alternative paradigms are recommended

where refugees are construed as “prototypes of resilience despite major losses and stressors” (Muecke, 1992, p.515).

As the last section illustrated, women and men with refugee backgrounds do have assets and strengths that are known, but disregarded. They will also, undoubtedly, have many other skills, knowledges and resources that are not yet widely known; the current healthcare models make it extremely difficult to expose, exert or draw on these. The next chapter will conceptualise a possible way of working with refugee-background communities that will privilege their strengths and assets, while also addressing their health needs.

## CHAPTER 6

### The Case for Asset-Based Approaches to Maternal Healthcare for Refugee-Background Women

#### Introduction

*A fundamental limitation to our understanding of refugee health is that the positivist paradigm of medicine has shaped most of our research and therapeutics. Another paradigm that is primarily concerned with refugees as extraordinarily resilient human beings is also indicated (Muecke, 1992, p.521).*

The purpose of this chapter is to make a case for why the processes of pregnancy and childbirth need to (and easily can) incorporate an asset-based focus. In this chapter I cover seven areas. First I consider the notable potential of maternity, like development initiatives, to offer more meaningful and enabling participation in one's own development. For refugee-background women, working with this potential may enable spaces for empowerment and improve health outcomes. Second, drawing on the discursive formations identified in my earlier textual analysis, I outline the

material specificities of biomedical inadequacy, with reference to the participants' concerns from the ChangeMakers Refugee Forum (CRF) (2011) research.

I then consider the discursive elements of maternity, which helps to recognise how, like development, maternity is subject to the same interplay between power, language and knowledge. Fourth I identify the continuities of colonial projects to 'modernise' motherhood with development's predilection of the biomedical model as a means to reach the Millennium Development Goals (MDGs). Accordingly, I warn against its widespread exportation to 'developing' countries. Fifth, this chapter describes asset and strength-based approaches to development and outlines how they offer a way of broaching the practice of postdevelopment. I then outline a conceptual analysis of health assets, which advances a clearer understanding, as well as rousing implications for research and practice. Last, I identify some practical ways that health practitioners can engage an asset-based focus in their interactions with refugee-background clients. This chapter suggests that balancing the needs-based focus of the biomedical model with the diffusion of asset-based discourse may foster a sense of belonging and inclusiveness (necessary for culturally-appropriate care), as well as realise more effective and meaningful resettlement.

## The Potential of Maternities

*Even in the most patriarchal societies [...] pregnancy and birth are the primary arenas in which women have status and prestige* (Vincent Priya, cited in Schott & Henley, 1996, p.163).

There is expansive research literature identifying the critical importance of the childbearing experience to women and their families (cf. Carolan, 2008; Carolan & Cassar, 2010; Cheung, 2002; Davis-Floyd, 2001; Davis-Floyd, et al., 2009; Van Hollen, 2003; Wagner, 2001). For refugee-background women, research suggests that childbearing may be one of the most important roles in their life (Carolan & Cassar, 2010; Cheung, 2002; McLeish, 2002; Rice, 2000). It has also been noted that refugee-background women become pregnant when resettling as an attempt to start over and reaffirm their lives (James, 2003). When considering the potential for the processes of pregnancy, childbirth and motherhood to create spaces within which women can exert their power, agency and authority, this trend is logical (Davis-Floyd, 2001; Davis-Floyd et al., 2009; Kempe, Noor-Aldin Alwazer & Theorall, 2010; Van Hollen, 2003; Wagner, 2001).

To have cultural beliefs and practices recognised and accommodated during the childbearing process is important for all women, including those who have refugee backgrounds (Carolan & Cassar, 2010; Schott & Henley, 1996).

Annica Kempe and colleagues (2010) explain that:

“in all cultures over time, knowledge has grown from women’s childbirth experience, serving as a base for their understanding and interpretation of this event. Each birthing system can be thought of as a system of authoritative knowledge providing the basis on which decisions are made and actions taken in a given situation” (p.130).

Where women are routinely marginalised outside the reproductive sphere, conserving the opportunities for them to exert their authority within it is extremely important for their personal empowerment (Kempe et al., 2010; Schott & Henley, 1996; Wagner, 2001). For refugee-background women, exercising their authority and identity in their childbearing experiences could be one way they can balance the (seeming) lack of possibilities that they may have in other areas of life. This is not to say that this is necessarily the case, rather reproduction is just one sphere which holds potential for empowerment, but how refugee-background women are supported during this time can impact on their sense of self, and (arguably), in turn, their resettlement experience. *Valuing* and *mobilising* the skills, assets and knowledges of refugee-background women during childbearing is one way to create (and conserve) spaces for their authority and autonomy to be exercised.

Unfortunately, as I have shown previously, the tendency of the western biomedical model to (over-) represent refugee-background women as needy, and to disregard non-western knowledges and ways of doing, may mean these natural opportunities for exerting power, agency and authority are being removed or overlooked. Developing on my analyses in Chapters 4 and 5, the following section will identify the specificities of why biomedical maternal healthcare approaches are inappropriate, inadequate, and possibly even detrimental for refugee-background women.

## **The Inadequacy of the Biomedical Model**

Multiple barriers have been identified which mean that access to maternity care for refugee-background women and their experience of care is fraught

with challenges and difficulty (Ali & Wilson, 2005; Carolan, 2008; Carolan & Cassar, 2010; CRF, 2011; MoH, 2001; 2011). Explanations given for these barriers centre on services being culturally insensitive, unsympathetic and unaccommodating (ibid.). Yet research exploring tangible ways in which culturally-sensitive care can be promoted is scarce and tends to draw upon cultural explanations, such as the lack of English and understanding of refugee-background women<sup>61</sup> (refer to Chapter 5, p.140).

Chapter 5 analysed the many assumptions and stereotypes regarding refugee-background women (and men) revealed in the New Zealand-based literature. Here I examine some specific instances (and implications) of the ways in which these discursive formations have taken material form. The concerns generated from the CRF (2011) research<sup>62</sup> are drawn on to categorise these instances, and to keep the findings relevant to the aims of the thesis. These categories are not distinct; rather they intersect and coalesce, as each impact on the others in myriad ways. Where possible I have utilised examples from Aotearoa, but in some areas I've used international literature.

### **Discrimination in Care**

*Health services and the people that work within them inevitably reflect the attitudes and practices of wider society (Schott & Henley, 1996, p.43).*

In New Zealand and internationally, there is extant literature that refugee-

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<sup>61</sup> As stated in Chapter 5, in this way issues of power and control in healthcare services are masked and unproblematised (Johnson et al., 2004).

<sup>62</sup> As previously discussed, this research identified three areas of specific concern out of the many that were raised by the participants of the CRF (2011, see Appendix A) research that are applicable here. These are: a) discrimination in care; b) culturally insensitive care; and c) maternal health outcomes.



background women (and men) receive discriminatory healthcare<sup>63</sup> and more inequitable outcomes than those in the host community (Ali & Wilson, 2005; Hollifield et al., 2002; Mortensen, 2008, 2011; Schott & Henley, 1996). Judith Schott and Alix Henley (1996) state that the causes of this discrimination have three main themes which combine to create (and maintain) inequalities in access to care, these are: a) personal discrimination; b) the culture of the organisation; and c) the established organisational processes (p.43).

Participants in the CRF (2011) research reported feeling “unwelcome” when accessing health services (p.10). Some felt that medical practitioners and service staff were rude and judgemental, and stereotyped them. Participants reported feeling alienated by medical staff and many felt they were not given adequate explanation about their medical concerns or reasons for referral. Many women felt that the skills and knowledges they had were not appreciated because they could not speak English. One participant, a professional midwife in her home country, reported that while women in her community valued her skills and experience, health practitioners were often dismissive and impatient. When she supported women in the delivery suite, the ward staff disregarded her knowledge and skills, this, she said, *“was like a slap in the face”* (2011, p.11).

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<sup>63</sup> Annette Mortensen (2008) observes that refugee-background communities face institutional racism and discrimination in the health sector, as well as in other social and economic domains, which have direct impacts on their health. The Ministry of Health in New Zealand developed the *Reducing Inequalities in Health* strategy in 2002 to assist the health sector to improve the overall health of the population and reduce health inequalities (Mortensen, 2008). The *Reducing Inequalities in Health* model identifies four areas of intervention to reduce socioeconomic inequalities, which could assist in improving the health outcomes for former refugees. These areas look at the social, economic, cultural and historical factors, which fundamentally determine health and include strategies such as antidiscrimination legislation. Presently however, because refugee groups are overlooked in the statistical classification systems used to monitor the health of New Zealanders (as they are identified as ‘other’, see n.66, p.166), they are excluded from this strategy (Mortensen, 2008).

In the international literature, there is research reporting on the intrinsic racial discrimination that occurs within healthcare institutions (Correa-Velez & Ryan, 2011; McCourt & Pearce, 2000; McLeish, 2002). Health researchers, Christine McCourt and Alison Pearce (2000) observe that health practitioners tend to rely on inaccurate, and often contradictory, stereotypes when providing maternity services to “minority ethnic women”, including women with refugee backgrounds (p.146). Assumptions such as “they are too submissive or too demanding” or that “they are intolerant of pain or, conversely, able to tolerate pain easily”, have led to “minority ethnic women” facing structural disadvantage or discrimination in their maternity care (2000, p.146).

A study by Nina Ascoly, Ineke Van Halsema and Loes Keysers (2001), which explored the reproductive healthcare experiences of refugee-background women in the Netherlands, found that there are several major barriers within health services. The limited time for consultations, lack of information about available services and lack of interpreters are all factors which have resulted in many women arriving to the clinic “very late in their pregnancies” (p.384), or not at all (Correa-Velez & Ryan, 2011; Lalchandani & MacQuillan, 2001).

Refugee-background people accessing health services late or not at all is also a common occurrence in the New Zealand context. Often discrimination in healthcare services is cited as a common barrier for this (Ali & Wilson, 2005; CRF, 2011; H. Hayden, personal communication, 10 February 2012; Refugee Health and Well-being Action Plan Inter-sectoral Working Group, 2006). Although, it is difficult to accurately assess the level of maternal healthcare utilisation because of the lack of robust refugee demographic health data available.

## Culturally Insensitive Care

*Our beliefs about health and about what makes us ill, where to seek treatment for what, and how to prevent illness are as much influenced by our culture as our views on family patterns, acceptable dress and what constitutes normal behaviour (Schott & Henley, 1996, p.17).*

Throughout the literature, lack of culturally-sensitive care is often cited as a barrier for former refugees to access healthcare (Ali & Wilson, 2005; CRF, 2011; Lalchandani & MacQuillan, 2001; MacIntyre, 1994; McLeish, 2002). Though, definitions of what 'culturally-appropriate care' is and how health practitioners can provide it is not often given. Schott and Henley (1996) provide a useful definition: "care is provided in such a way that it is accessible and effective for people of different cultures" (p.22). Dorcas Grigg-Saito and colleagues (2008) add that health practitioners need to understand their client's perception of their situation and the things they think will improve it<sup>64</sup>.

There are numerous examples through the literature of instances where western-based biomedical practices have alienated or offended refugee-background women and men. In the CRF (2011) research, women, in particular, felt that health practitioners needed training in delivering culturally-sensitive care. Some participants described situations where health practitioners did not accept their cultural practices. For example, some Somali participants discussed how their cultural practice of providing community support and comfort for sick individuals, was disregarded by hospital staff. All participants discussed how providing community support

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<sup>64</sup> As previously discussed in Chapter 1, Māori health and wellness models could be of relevance. Given these models are grounded in Māori world-view and philosophy they offer critical insights into the development and delivery of culturally-appropriate care.

is a vital aspect of care that is not recognised by New Zealand healthcare practitioners.

In her study with 33 women seeking asylum who were pregnant or delivering their babies in England, Jenny McLeish (2002) argued that unsympathetic and culturally inappropriate maternity services in host countries accentuate feelings of powerlessness and vulnerability among newly arrived refugees. As one participant in her research reported, *“many things I feel I don’t have any control over, but also the situation I am in makes me to believe that I don’t have any value and I’m nothing for ever”* (McLeish, 2002, p.55).

A Community-Based Participatory Research (CBPR) project working with former refugees from Africa and the Middle East resettled in New Zealand and Australia, identified the complex negotiation to reproductive rights many former refugees face (Guerin, Allotey, Elmi & Baho, 2006). The authors observed that many women characterised their experiences in health services as *“inherently marginalizing”* (p.12). An incredibly devastating Australian cross-cultural encounter of a pregnant Eritrean woman with a refugee background whose baby had died at 25 weeks was discussed with the researchers (Guerin et al., 2006). The woman had a bicultural worker<sup>65</sup> with her in hospital when the death was discovered, and was surprised and distressed that despite this, she was sent home with a *“dead baby inside her”* because there were no beds available (2006, p.14). The next day the woman gave birth and was *“presented with the dead fetus and left alone with it; again this was then normal hospital procedure to enable a healthy grieving process”* (2006, p.14). The woman was left by the

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<sup>65</sup> In Australia, agencies are encouraged to employ bicultural workers. These are people from ethnic minority backgrounds to *“deal with issues that affect clients from those ethnic backgrounds”*. Generally their ‘skills’ are their ethnicity (loosely defined as country of birth) and their language abilities (Guerin et al., 2006, p.15).

bicultural worker who had to attend another birth, but was distraught that the worker had not explained to staff the inappropriateness of leaving her with a corpse. She described the experience as “one of the worst in her life, surpassing anything she had experienced as a displaced person” (2006, p.14).

Martha MacIntyre (1994) observes another example of differences in cross-cultural health concepts. In her examination of migrant women’s experiences with Australian hospital services, she discusses how one Vietnamese woman who had just given birth had described feeling ‘cold’. Within the cultural context of Vietnam, as MacIntyre (1994) explains, the term ‘cold’ refers to feelings of ‘debility’ and ‘weakness’, and these conceptions of temperature are central to the process of achieving balance in the body. However the biomedically-trained practitioner in this case understood ‘cold’ as only relating to the physical sensation of temperature. The doctor dismissed the Vietnamese woman’s concerns and told her that the hospital room was already very warm. These examples demonstrate some of the tensions that exist between western biomedical and non-western knowledges – elucidating the limitations of the biomedical model’s ability to provide culturally meaningful care.

### **Maternal Healthcare Outcomes**

For refugee-background women resettling in Aotearoa New Zealand there appears to be increasing concern with the rising rates of caesarean sections (K. Ali, personal communication, 11 March 2011; Ali & Wilson, 2005; A. Bloom, personal communication, 29 November 2011; CRF, 2011).

Specifically, in the CRF (2011) report, “women expressed concern about what they believed was an increase in caesarean rates among women in their communities and felt they were rushed into agreeing to have caesareans, which they considered to be unnecessary and culturally

inappropriate” (p.9). The *Refugee Health Needs Assessment* also found there was growing disquiet among refugee-background women with the use of caesarean section (Ali & Wilson, 2005). There are no reliable statistics regarding the caesarean section rates of refugee-background communities because information tends to be collected on ethnicity and not refugee status<sup>66</sup> (Ali & Wilson, 2005; L. Neilson (MoH), personal communication, 31 August 2011).

As previously reported, the total caesarean rate in New Zealand during 2010 was 25 percent. For the MELAA<sup>67</sup> population in New Zealand, the caesarean section rate for 2010 was 34.5 percent<sup>68</sup> (MoH, 2011b). This was the highest rate of caesarean section of all the ethnic groups in New Zealand<sup>69</sup>. These statistics are extremely concerning and presently there is a lack of research in New Zealand exploring the reasons for these particularly high rates of caesarean section amongst the MELAA groups (A. Bloom, personal communication, 29 November 2011). In international studies, increased caesarean section rates have been associated with particular health issues identified as being prevalent among refugee-background women (Carolan, 2010; Correa-Velez & Ryan, 2011). These include FGC (Female Genital Cutting)<sup>70</sup>, HIV/AIDS and STIs (Carolan, 2010; Correa-Velez & Ryan, 2011;

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<sup>66</sup> Mortensen (2008) explains that New Zealand’s health sector tends to group people with refugee backgrounds in the ‘other’ category. She argues that this means their health needs are not identified, nor given priority, which is inequitable. More recently, refugee-background communities are grouped in the Middle Eastern, Latin American and African (MELAA) group (L. Neilson (MoH), personal communication, August 31 2011).

<sup>67</sup> MELAA refers to groups from the Middle East, Latin America and Africa (Perumal, 2011).

<sup>68</sup> These statistics are provisional only and subject to change (Ministry of Health, 2011b).

<sup>69</sup> A recent report assessing the health needs of the MELAA population shows that in the Auckland region the rates of caesarean section between 2006-2009 for the MELAA populations were all higher than the current New Zealand rate. African women had 31 percent caesarean section rate, Latin American women had a rate of 32 percent and Middle Eastern women had a lower percentage of 27 percent (Perumal, 2011). Importantly, Perumal notes that these populations are made up of a diverse group with varying reasons for migration.

<sup>70</sup> FGC (female genital cutting), female circumcision or FGM (female genital mutilation) is the procedure involving “partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons” (WHO, 2012, para.1).

McLeish, 2002). Future research needs to be conducted to establish more accurate birth outcomes of women with refugee backgrounds in New Zealand, and to work with women, health practitioners and services to explore ways to improve outcomes.

This rise in caesarean sections in New Zealand appears to be a trend that has been observed in many developed countries (Anderson, 2004). For example, in some countries in Latin America regarded as 'developed', the caesarean birth rate was between 70-90 percent (Davis-Floyd et al., 2009). This trend is worrying considering the western model of childbirth is being exported to developing countries in the drive to achieve MDG Five (Conrad, 1992; Davis-Floyd et al., 2009; Van Hollen, 2003, refer to p.170). Also of concern is that no randomised trials comparing the risks and benefits of caesarean section with vaginal delivery exist (Anderson, 2004), although a recent policy brief from World Health Organisation (WHO) (2010a) found that all modes of delivery involving intervention are "associated with an increased risk of severe perinatal outcomes" (p.2). Robbie Davis-Floyd and colleagues (2009) discuss two studies conducted with WHO (2006; 2007, also outlined in Chapter 4), which both found that increases in caesarean rates were "associated with a significantly higher risk for severe maternal morbidity, mortality, and postnatal treatment with antibiotics" (p.10). Clearly, the dominance, and exportation, of the western biomedical model of childbirth needs critical review.

## Maternity as a Discourse

*In talking of maternities [...] we are insistent on how these seemingly natural processes of swelling, bearing and suckling, the flows of blood, semen and milk are constituted and fixed not just by the force of cultural conception but by coagulations of power (Jolly, 1998, p.2).*

As discussed in earlier chapters, this research considers development as a discourse. Like development, maternity<sup>71</sup> – the experiences of being a mother and how this is valued (and devalued) – is constituted through discourse (Jolly, 1998; Longhurst, 2008; Van Hollen, 2003). Maternal bodies, writes Robyn Longhurst (2008), “contrary to popular belief, are not entirely ‘natural’, rather they are an interface between nature and culture, biology and the social, materiality and discourse” (p.4). Seeing maternity as a discourse allows recognition and understanding that there are a multiplicity of experiences and practices, and across various sites, which constitute ‘motherhood’ – there is no one way to be a mother (Longhurst, 2008). Yet examining the colonial critiques of Indigenous mothering (cf. Jolly, 1998; Van Hollen, 2003), and identifying the continuities of these critiques inhabiting maternity services offered to refugee-background women (refer to Chapters 4 and 5), it is implicit that there is a ‘right’ and ‘good’ (‘universal’ and ‘Eurocentric’) way.

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<sup>71</sup> Borrowing from Longhurst (2008), my use of the word ‘maternity’ draws on numerous meanings, such as the processes of being pregnant and giving birth, the consequential relationship between the mother and offspring, and the nurturing of a child. Remembering that maternity is discursive, thus as Jolly (1998) points out there are many who may not necessarily go through pregnancy and become mothers, such as those who adopt.



## Biomedical Maternity Care and Development

*Birth is one of the most powerful of all human experiences, yet it can also be one of the most disempowering* (Davis-Floyd et al., 2009, p.1).

The links between development and colonial projects to ‘improve’ motherhood appear remarkably coherent (Van Hollen, 2003). As Margaret Jolly (1998) notes, the colonial endeavour to ‘improve’ or modernise maternity involved the medicalisation, rationalisation, as well as surveillance of pregnancy, childbirth and the postpartum periods. Contemporary development interventions espouse the western biomedical model (often referred to as “skilled attendance”) as the universal solution to reducing global maternal mortality (Clarke, 1983; Freedman et al., 2005; Jolly, 1998; Spangler & Bloom, 2010; Van Hollen, 2003; Wagner, 2001; WHO, 2010b). A model, which as I have shown in Chapter 4, is predicated on and reifies pathology and problems, and one which tends to privilege western-based knowledges and ideals.

This thesis takes the position that as a model, the western biomedical model of childbirth is inadequate as the universal solution for reducing maternal mortality and morbidity. As has been discussed here, the model has many worrying consequences associated with the rise in birth interventions. Additionally, the routine surveillance of mothers and babies (and the associated ‘norms’ this engenders) practised in the western biomedical model of childbirth is inappropriate in many cultural contexts. Indeed, many authors note that in numerous ‘developing’ countries, despite biomedical care being readily available and accessible, women are choosing to birth at home with traditional midwives or attendants (Davis-Floyd et al., 2009; Penwell, 2009; Papua New Guinea – National Department of Health,

2009). In light of these aspects, the former Director of Women's and Children's Health in WHO, Marsden Wagner (2001) warns:

“western, medicalized, high tech maternity care under obstetric control usually dehumanizes, often leads to unnecessary, costly, dangerous, invasive obstetric interventions and should never be exported to developing countries” (p.25).

### **Millennium Development Goals**

Two of the Millennium Development Goals (MDGs)<sup>72</sup> are pertinent to this thesis, these are: MDG three, *'Promote Gender Equality and Empower Women'*; and MDG five, *'Improve Maternal Health'*. My reasons for discussing these goals here are to problematise the, often unquestioned, and usually unaltered exportation of western biomedical strategies to 'developing' countries.

Importantly though, as Ascoly and colleagues (2001) warn, because international strategies to improve reproductive health for refugee-background women are largely considered “in the context of poor conditions in the so-called developing countries – the world's ‘economic South’”, they tend to focus on service supply and relief services (p.378). This tendency, they state, “reflects the built-in bias to focus on the South as the place where the problem is, and might explain the [...] *problematizing* of the reproductive health needs and coping mechanisms of ‘refugee-newcomers’” (2001, p.391, emphasis added). With this in mind, I carefully consider how insights from this thesis can inform MDGs three and five.

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<sup>72</sup> The Millennium Development Goals (MDGs) are eight internationally agreed development goals that all 193 United Nations member states in 2000 committed to achieve by the year 2015 (United Nations Development Programme (UNDP), 2012).

### ***MDG Three: Promote Gender Equality and Empower Women***

As discussed, the spheres of maternity have the potential to empower women. Empowerment is a term that I use with caution though (see p.90). I consider empowerment as a bottom-up process, rather than something that can be bestowed from the top-down (Oxaal & Baden, 1997; Rowlands, 1995). Thus development strategies cannot *empower* women – women must empower themselves. Empowerment, asserts Naila Kabeer (2005), “is rooted in how people see themselves – their sense of self-worth. This in turn is critically bound up with how they are seen by those around them and by their society” (p.15). This significant point resonates at the very heart of this thesis: how people are *seen* comes from representational practices. Thus the (over-) representation of refugee-background women (and men) as ‘needy’ and ‘problematic’ is disempowering. Programmes and policies aimed at empowering women need to be aware of this inextricable coherence between representation and empowerment.

As many researchers have identified (and as discussed in Chapter 2), women and men come in to and experience the refugee (and asylum-seeking) process differently because of their gender (Ascoly et al., 2001; Kamri-McGurk, 2012; McSpadden & Moussa, 1993). While women make up half of refugee populations, men constitute the vast majority of those who reach industrialised countries and claim refugee status. It is also understood that women become refugees because they are fleeing gender-based persecution or sexual violence (Ascoly et al., 2001). While the refugee condition is gendered, so too is the reproductive health experience, particularly pregnancy and childbirth<sup>73</sup> (Ascoly et al., 2001). Furthermore, as shown here,

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<sup>73</sup> Chapter 4 analysed the increased male dominance resultant from medicalisation of childbirth. This occurrence has implications for the broader gender relations in society (as well as agitating the relations between nature, culture and technology), of which need critical understanding as the biomedical model becomes more globalised and applied to non-western cultures (Jolly, 2002).

the experience of being a refugee shapes how women encounter their maternal healthcare during childbearing. Efforts to improve the provision of care and services to refugee-background women who are pregnant or mothers therefore requires gender sensitivity and could also promote a systematic approach to challenging gender inequalities.

### ***MDG Five: Improve Maternal Health***

Global efforts to reduce maternal mortality are currently at the highest and most concerted level so far to achieve MDG five — the furthest behind of all the MDGs. In efforts to address the issue, mainstream development research and strategies: tend to privilege the service supply-side of maternal health over the demand-side; are grounded in the biomedical model of childbirth; and assume universal ideals (Freedman et al., 2005; Women Deliver, n.d.; WHO, 2005; WHO, 2010b; WHO, 2010c). Sydney Spangler and Shelah Bloom (2010) argue that despite considerable efforts over the last 20 years to apply the biomedical model globally, childbirth-related complications still threaten many women's lives. Indicating that the biomedical model may not be appropriate in all contexts. Indeed, as outlined in Chapters 2 and 4, as well as here, there is a comprehensive body of research documenting the numerous negative effects of the biomedical model on women and babies.

The exclusive focus on service supply dangerously positions women as passive 'objects'— mere recipients or 'victims' of external factors (Oxaal & Baden, 1996). To elucidate, while improving access to emergency obstetric services and resources is essential for improving maternal health outcomes, it is not enough because "obstetric care must be *sought* in order to be received" (Spangler & Bloom, 2010, p.761, emphasis added). Many researchers argue that approaches taken to reach the MDGs need to think

beyond service provision and work with women to “understand their perceptions, practices and health-seeking behaviours” (Brunson, 2010; Furuta & Mori, 2008; Kempe et al., 2010, p.133; Oxaal & Baden, 1996; Spangler & Bloom, 2010).

The success of any strategy needs to acknowledge and facilitate the spaces for women to make and act on decisions to maintain their health and wellness in meaningful ways. According to Kabeer (2005), this active agency or behaviour can be understood as an empowering process. Though strategies and interventions that foster active participation of women command considerable commitment over longer periods. Additionally, as Marie Furuta and Rintaro Mori (2008) point out, these approaches tend:

“to be less valued in a refugee setting by experts who label refugees as powerless and entrenched with characteristics of dependency, as they are the object of aid and under the protection of states and international agencies. In this era of refugee donor fatigue, an exclusive strategy for professional service provision may increase inequalities in access to women’s health care and therefore in the outcome of maternal health” (p.885).

Accordingly this thesis argues that it is necessary to focus efforts on practical ways that health practitioners can engage and facilitate spaces for refugee-background clients to draw on their strengths and assets. Asset-based approaches to maternal healthcare may enable women to meaningfully engage in their health and thus reduce (the aforementioned) barriers to equitable health outcomes.

## **Strength and Asset-Based Approaches to Development**

At its starting point, asset-based development (defined in Chapter 2, p.43) assumes that all people have strengths and assets, and that recognising and valuing these can be a key motivator for people's ability to take action. It is important to note that asset-based approaches do not deny the existence of or ignore the needs or issues that people may have. Nor do they suggest that there is no need for additional resources from elsewhere. Rather, through the process of galvanising strengths and assets, individuals and their communities can define and drive the process of their development and therefore use any outside resources more effectively (Kretzmann & McKnight, 1993; Mathie & Cunningham, 2008). Recognising and combining the potential within themselves and their communities can enable communities to realise their goals. This potential includes one's personal attributes and skills, as well as relationships among people.

In their research using a strengths-based approach with a Cambodian refugee community in Massachusetts to improve health outcomes (specifically cardiovascular disease (CVD) and diabetes), Dorcas Grigg-Saito and colleagues (2008) found many benefits. In particular, taking an asset-based approach led to: a) improved engagement in services; b) enhanced health behaviours; c) increasing family empowerment; and d) improved ability of participants to forge relationships and social networks. While they had not yet been able to measure any change in CVD or diabetes, they demonstrated improvements in healthcare practitioners' knowledge of Cambodian health beliefs and the former refugees' access to healthcare had also improved (Grigg-Saito et al., 2008).

As discussed in Chapter 3, for postdevelopment proponents, J.K. Gibson-Graham (2005), the critiques of mainstream development's assumptions and thinking are precisely what guide creative and innovative ways of practical engagement. The challenge for postdevelopment protagonists is to not give up on development. Liisa Malkki (1996) explicates this important point; it is because development initiatives are incredibly important that there needs to be "better ways of conceptualising, designing, and challenging them" (p.379). In her anthropological field research with Hutu refugees in Tanzania, Malkki (1996) found that many refugees thought that "embracing instead of escaping hardships was wise as the knowledge of difficulties would teach and empower people, making them worthier", she notes that in this sense, "refugeeness was seen as a matter of *becoming*" (p.381, emphasis author's own). For Gibson-Graham (2005), it is this 'becoming' which offers meaning, and which embodies postdevelopment thinking and action – as it is grounded in possibilities and potential. Using the critiques of the western biomedical model, this thesis has developed what an asset-based approach to maternal healthcare might look like as a way to engender an alternative, and more enabling, way of 'doing' development.

### **What is an Asset?**

Assets do not merely denote economic capabilities – the means by which people make a living; but the social, spiritual and cultural capacities and abilities that people also have (or perceive they have), and which can be tangible or intangible (Bebbington, 1999; Mathie & Cunningham, 2005). Anthony Bebbington (1999) explains that assets are what give "*meaning to the person's world*" (p.2022, emphasis author's own). By this he means that assets are not simply things people use, but they also give people the capability and potential to "*engage more fruitfully and meaningfully with the world, and most importantly the capability to change the world*" (p.2022,

emphasis author's own). Mathie and Cunningham (2005) explain that, in this way, a person's sense of self is interconnected with the assets and capabilities that they have, or perceive they have.

Assets are inextricably connected to action and agency. People's ability to take action and challenge services and structures that govern resource control and allocation, is partly dependent on their assets and capacities. Though the extent to which people can draw on and use their assets is linked to their agency and ability to access assets (Bebbington, 1999; Mathie & Cunningham, 2008). Access to other assets can be increased by social capital; this can be defined as the relationships with other actors, which can generate goodwill, reciprocity and trust (ibid.). Robert Putnam (1995) writes that social capital has numerous benefits for communities as when people join together with common goals, they can effect social change.

Navjot Lamba and Harvey Krahn (2003) researched Canadian former refugees' utilisation of social capital and found that when faced with financial, health, employment or personal issues former refugees rely on their family and community networks. The authors concluded that social capital was considered a key resource for former refugees (Kamri-McGurk, 2012; Lamba & Krahn 2003). In the area of maternity, the concept of social capital is vital for care providers to understand so avenues for people to engage collaboratively with each other can be facilitated. For example, enabling refugee-background mothers to recognise and mobilise the assets and strengths within their community so that new mothers can be supported to 'lie-in' for 40-days after giving birth. Another way that the social capital concept can be utilised, is the creation of spaces where health practitioners and refugee-background women could discuss and share their



ways of doing and knowing about certain aspects of pregnancy, childbirth and/or mothering.

## **Assets in Health**

*Using one's health assets to mobilize and act empowers the patient to become an agent for health, producing power, strength, and health (Rotegard, Moore, Fagermoen & Ruland, 2010, p.519).*

The tendency of biomedical care to focus on the identification and treatment of problems or needs with patients does little to enhance or mobilise patients' strengths and capabilities (Rotegard et al., 2010). In healthcare, asset-based approaches are not widely known or used (Rotegard et al., 2010). However there are, as discussed in the previous chapter, recent moves to incorporate strength-based approaches in the psychology and mental health spheres (cf. Muecke, 1992; Jhangiani & Vadeboncoeur, 2010; Ryan, Dooley & Benson, 2008). Rozella Schlotfeldt's nursing model (developed in the 1970-80s) has been identified as the first to utilise the concept of health assets, though there has not yet been a comprehensive analysis of the concept. As such there lacks a clear understanding and definition of what health assets are and how to incorporate them into practice (Rotegard et al., 2010).

Ann Rotegard and colleagues (2010) set out to examine and define the concept of health assets and to develop a framework that may guide future clinical research and practice. They developed the following definition:

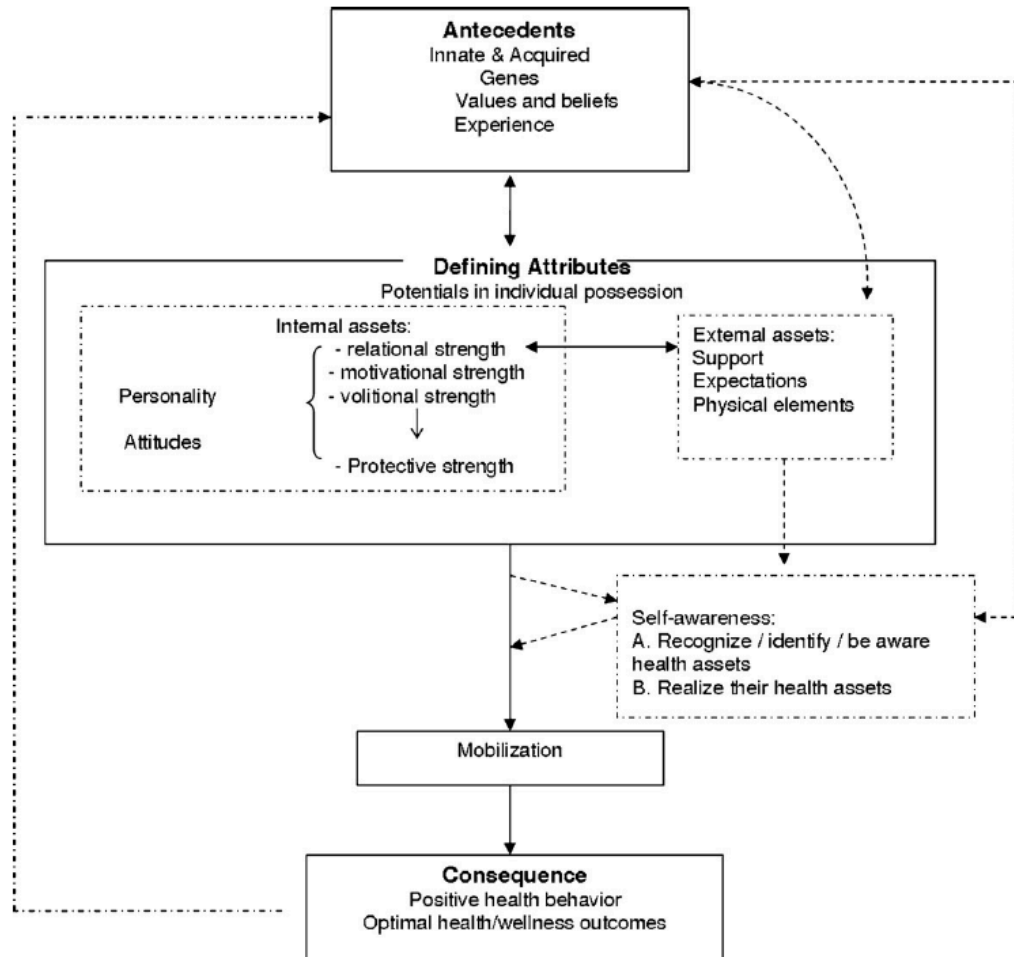
“health assets are the repertoire of potentials — internal and external strength qualities in the individual’s possession<sup>74</sup>, both innate and acquired — that mobilize positive health behaviors and optimal health/wellness outcomes” (2010, p.514).

Rotegard and colleagues (2010) examine literature in the health and psychosocial sciences published from 1966 to March 2007 to analyse, and subsequently develop, the concept of health assets in a nursing care context. They propose a definition and a conceptual model of health assets, which describe the *attributes*, *antecedents* and *consequences*, as well as its *associated concepts*. Figure 6.1 below depicts their proposed conceptual model of health assets. Here I use their extensive analytical work to develop and explore how an asset-based approach to maternal healthcare might look. First I briefly outline each of the elements of Rotegard and colleagues’ (2010) health asset model, as well as the elements relationships to each other.

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<sup>74</sup> This idea of ‘possession’ is problematic, given the poststructural orientation of this thesis. Though, this research by Rotegard and colleagues (2010) has discursively framed health assets in this way. Here I have tried to use language that reflects the complexity of situations influencing the ability to draw on and use one’s health assets.

**Figure 6.1: Conceptual Model of Health Assets**



Source: Rotegard et al., 2010, p.515.

## Attributes

Health assets can be latent or potent, they can be used with or without purpose, and they can include both internal and external components. As such, Rotegard and colleagues (2010) conclude that it depends on the individual person whether they use their health assets in particular situations and how they choose to use them. Yet, I postulate that the ability to utilise and draw upon one's assets is decidedly more complex than this.

The notion that action is dependent on the individual overlooks the structure/agency dialectic (Doty, 1997). Wider historical, social, economic and political influences, which undoubtedly impact a person's ability to assert their agency, are ignored (also discussed in Chapters 3 and 4). Suffice to say, it is not enough to only identify one's assets and strengths, rather, tangible opportunities must be created and made explicit to enable people to draw on them and to use them effectively. This is particularly true for individuals who have experienced marginalisation in healthcare situations, or for those who may be unfamiliar with the services.

In Rotegard and colleagues' (2010) analysis, internal health assets are defined as "positive strength characteristics inherent in a person and expressed through one's personality and attitudes", and they include four dimensions: *relational*, *motivational*, *volitional* and *protective* (p.518). Examples include, humour, positive thinking, hope, courage, will and optimism. To develop and strengthen one's internal assets is largely dependent upon one's external assets. External assets are described as the social and cultural support available to a person, as well as the physical and environmental elements that may influence them. An overview of the four dimensions of internal health assets as identified by Rotegard and colleagues (2010) follows.

The first, *relational* strength is "a type of social, cultural, and/or spiritual connectedness, of belonging and having bonds, and a sense of close, empathetic, supporting, and/or positive relationships" (Rotegard et al., 2010, p.518). Relational strengths can be developed and shaped through life experiences, values and beliefs (these aspects are conceptualised as *antecedents* of health assets – see p.181). Trusting in oneself, in significant others, and in healthcare providers is identified as being an important relational strength (ibid.).

Second, *motivational* strength in health reflects the drive or desire of an individual to invest in their own or their loved one's future. For example, the threat of developing gestational diabetes may motivate a woman to engage in healthy lifestyle choices. Other motivational strengths outlined by Rotegard and colleagues (2010) include optimism and hope.

The third dimension of internal health assets is *volitional* strength, described as one's determination or will to persist and take control despite challenges. It is a desire that "is essential for making decisions, choices, determining or using one's will, consciously or deliberately" (Rotegard et al., 2010, p.519). Volitional strengths include empowerment to reach one's potential, and commitment to reach wellness and health. In my experience as a former midwife, a woman's volitional strength was crucial and I often saw it emerge during long, first-time labours when the woman would continue to keep going despite not seeing or feeling any progress.

The last dimension, *protective* strength, is when individuals protect or buffer themselves or others against challenges or adverse health effects to keep them safe. Protective strength can help people to manage their emotional response to certain undesired situations and assist them to take control. Rotegard and colleagues (2010) note that the more health assets a person is able to draw on, the greater their protective strength and the more a person's health will flourish. Thus protective strength is determined by the amount of internal and external health assets a person has (and is able to utilise) (ibid.).

### **Antecedents**

In their concept analysis, Rotegard and colleagues (2010) identified antecedents of health assets, these can be innate or acquired and include:

*genes, values and beliefs, and life experiences*. They explain that differences in the presence and deployment of health assets may be due to individual variations in antecedents. The first, *genes*, “describes the biological mechanisms and heredity transmitted from one generation to another that controls particular characteristics, like physical appearance and behavior, and also plays a role in personality” (2010, p.520). Genetic traits are not fixed and can shift depending on life experiences and environmental influences.

Another antecedent, *values and beliefs*, can influence health assets and behaviours by enabling people to develop self-awareness, which consequently will assist them to use their assets. Examples of values and beliefs include self-esteem and spirituality.

Finally, integrating *life experiences*, such as: gaining new skills and knowledge; cultural experiences with family, peers, school, and community; and developing new relationships, can develop, strengthen and maximise one’s internal health assets. Antony Morgan and Erio Ziglio (2010) found that negative life experiences in adults, such as poverty, disasters and unemployment can impact people’s ability to utilise and develop their assets.

### **Consequences**

These four dimensions of health assets – relational, motivational, volitional and protective strength – can initiate *mobilisation*. Mobilisation refers to the process of taking action and engaging positively and meaningfully in one’s health. Rotegard and colleagues (2010) discuss how researchers have correlated the process of an individual’s mobilising their health assets with ‘empowerment’. Thus they conclude that approaches in health with an asset focus are more likely to enable the individual to exert their authority and

power in meaningful ways to mobilise positive health behaviours, than a needs-based focus is. As shown in Figure 6.1 above, self-awareness can strengthen mobilisation. Having the confidence to recognise and realise one's capabilities can lead to an ability to more readily draw on one's assets and be positioned to take action (Rotegard et al., 2010).

Mobilisation leads to two types of consequences: (a) positive health behaviours, and (b) optimal health/wellness outcomes (see Figure 6.1). When people are able to draw on their health assets, it can activate them to make decisions and engage in behaviours which promote positive health. This, in turn, can lead to *self-actualisation and attainment* – when a person has regained “the balance between problems and assets” and can carefully, skillfully and successfully negotiate challenges and change in life (Rotegard et al., 2010, p.521). As shown in Figure 6.1 (represented by the arrow running from consequences to antecedents), in this process of exposure to new experiences, an individual's repertoire of health assets are multiplied and strengthened. *Self-actualisation* or self-fulfilment is understood as fundamental to one's quality of life. Drawing upon personal health assets enables individuals to realise and release their potential, which results in fulfilment and satisfaction. The ultimate consequence of health assets is ‘maximised’ health, that is, *optimal health and wellness outcomes* (Kretzmann, 2000; Rotegard et al., 2010).

### **Salutogenesis**

The concept of *salutogenesis* is identified as being a foundational element of health assets (Morgan & Ziglio, 2010; Rotegard et al., 2010; Singer, 2008). Salutogenesis is a worldview orientated towards focusing on the origin or causes of health rather than the existing pathogenesis focus on diseases or illness of the biomedical model (Antonovsky, 1987; Morgan & Ziglio, 2010;

Singer, 2008). First coined by medical sociologist Aaron Antonovsky in the 1980s, salutogenesis has resurged in recent years through the empirical work of Bengt Lindstrom and Monica Eriksson (2010). Antonovsky (1987) was interested in what resources enable an individual to maintain good health when faced with significant life challenges (Singer, 2008). Central to salutogenesis is the question, “*what causes some people to prosper and others to fail or become ill in similar situations?*” (Morgan & Ziglio, 2010, p.6). A salutogenic orientation enables the factors (or the combination of health assets) that are most likely to cause health to be identified (Lindstrom & Eriksson, 2010; Morgan & Ziglio, 2010).

The fundamental components of salutogenesis are ‘sense of coherence’ and ‘general resistant resources’ (Antonovsky, 1987; Rotegard et al., 2010). Sense of coherence consists of the factors: comprehensibility, manageability and meaningfulness. In Antonovsky’s theory, for an individual to maintain health, they require: *comprehensibility* to understand what is happening to them and around them; *manageability* to draw on their resources or those in the community to manage their situation; and the ability to attach *meaning* to their situation (Singer, 2008). According to Rotegard and colleagues (2010), sense of coherence refers to “the capability to see that one can manage in any situation despite challenges in life” (p.520). General resistant resources can be understood as ‘health assets’, and for Antonovsky (1987) are not central to health as such, rather it is the ability to use general resistant resources intentionally that is. The focus of salutogenesis therefore is on categories of resilience and agency, not categories of disease and diagnosis.



## Refugee-Background Women and the Concept of Health Assets

*Thinking salutogenically not only opens up the way for, but compels us to devote our energies to, the formulation and advance of a theory of coping* (Antonovsky, 1987, p.13).

The strengths, integrity and resilience that many refugee-background women (and men) have drawn on as they face new situations and put their lives back together are health assets. Antonovsky was intrigued by what could be learnt from people who have endured trauma and challenging life experiences and yet able to maintain a healthy outlook and able to rebuild their lives (Singer, 2008). Within the psychological health-based literature that advocates an asset focus, “resilience” and “resourcefulness” are two terms that are often used to describe former refugees (cf. Butler, 2005; Eastmond, 2011; Grigg-Saito et al., 2008; Mortensen, 2008; Muecke, 1992; Ryan et al., 2008). Resilience involves:

“the evaluative awareness of a difficult reality combined with a commitment to struggle, to conquer the obstacle, and to achieve one’s goals despite the negative circumstances to which one has been exposed, which were and remain evocative of sadness” (Garmezy, 1991, cited in Muecke, 1992, p.520).

Resourcefulness can be described as the repertoire of behavioural actions that enable individuals to make decisions and act (Rotegard et al., 2010). Applying asset-based approaches to healthcare enables former refugees to draw on their own coping and health enhancement strategies, which were crucial to rebuilding their lives and re-establishing social connections. This facilitates and maintains good health. Approaches that have used the ‘sense of coherency’ and Health Asset concepts strongly correlate with improved

mental well-being and quality of life (Lindstrom & Eriksson, 2010). Furthermore, studies have shown that those “who are more able to re-build their lives have also been able to re-establish social connections” (Singer, 2008, p.57). These findings are significant; they illustrate the necessity of approaching healthcare for former refugees differently. A holistic approach to health is required that does not give one particular medical system hegemony over others.

As Margaret Jolly (1998) contends, because the mother is often marginalised in maternity debates it is important to insist on her centrality. Taking an asset-based focus to maternal healthcare for refugee-background women puts the woman squarely at the centre as the principle agent in her own health and development. By starting first with an appreciation of the health assets of a woman, that is, the skills, knowledges, attitudes and behaviours she uses to maintain and promote wellness, the focus of care changes. An asset-based approach to healthcare for refugee-background women, also ensures that women are looked at holistically; the care provided is grounded in what the women herself considers important and central.

## **Recommendations for Practice**

### **Mapping a Woman’s Assets**

*Investing in the assets of individuals, communities and organisations can help to reduce the health gap between those most disadvantaged in society and those who achieve best health (Morgan & Ziglio, 2010, p.6).*

In this section I suggest a systematic approach that practitioners can take to identify and elicit their clients’ health assets, thus building an ‘asset map’ or

asset inventory. Here I am interested in the specificities of practice; I want to provide tangible examples that could be easily grasped by health practitioners.

In most asset-based approaches to development, the construction of an asset map is the central methodology (Gibson-Graham, 2005; Underhill-Sem & Lewis, 2008). Yvonne Underhill-Sem and Nick Lewis (2008) define an asset map as “a project to identify social, cultural, governmental and economic assets to facilitate future, as yet undetermined community-imagined and led development projects” (p.313). Kretzmann and McKnight (1993) describe asset mapping as the process of constructing an inventory of the gifts, skills and capacities of individuals, associations and institutions within a community. While the examples I’ve seen in the literature are community asset maps, and thus identify such things as infrastructure, local institutions, and natural resources, the process is similar to the one I propose here. As this thesis has highlighted, for many women with refugee backgrounds, community-based assets may be as central to the maintenance and promotion of health as her individual assets.

Dudzile Radebe (2010), a member of the Eastern Cape NGO coalition in South Africa (proponents of Asset-Based Community Development-ABCD), reports it is the behavioural and attitudinal changes activated through an asset focus that are of critical importance, rather than the specific tools or methods used. To further explain, it is through the process of developing an asset map that important and meaningful change is inspired; in the significant shift to “talking about assets [...] a positive language of action, ownership and wealth” is invoked (Underhill-Sem & Lewis, 2008, p.313). Language, as Robert Chambers (1997) articulates, shapes how we think and what we do, as such it is through the process of choosing words, which

evoke meaningful, respectful and enabling interactions that will initiate positive change.

In the MoH Handbook (2001) I analysed, there is a three-page table, titled: *“Issues to consider in history taking and medical examination”*, which “may be helpful for an initial consultation, particularly when taking a medical history of the client or carrying out a medical examination” (p.37). The table lists in alphabetical order possible diseases and health issues that former refugees may have (it does not mention any strength or capability that a former refugee could have). This table is important to analyse as it is proposed as a guide for health practitioners when taking histories for “initial consultation” (2001, p.37). Initial consultations have the potential to set the precedent or tone of the client-practitioner relationship, and thus could be considered an opportunity to identify capabilities and assets to mobilise positive health behaviours. The overwhelming focus on sickness, illness and disease right from the outset is problematic because it may become difficult for the practitioner, and more importantly for the refugee-background client, to be known or seen as a person with assets and capabilities throughout the rest of the healthcare interactions.

Chapter 3 of the Handbook (2001) focuses on “communicating effectively with refugee clients” (p.31), it contains a list of questions (see Box 6.1 below) to enhance “communication and rapport” and “encourage the client’s perspective” (2001, p.35). Though again, these are specifically focused on their sickness and illness.

### Box 6.1: Questions to Enhance ‘Communication and Rapport’ Espoused by the Ministry of Health

- *What do you call your sickness or illness?*
- *What do you think has caused it?*
- *What do you fear most about your sickness?*
- *What problems has your sickness caused you personally, in your family, at work?*

Source: MoH, 2001, p.35.

While these questions are designed to enhance clients’ engagement in their healthcare, the unintended effects of exclusively focusing on sickness and illness are that opportunities to identify and mobilise strengths and assets are lost. To achieve more meaningful and enabling interaction, I suggest instead asking questions in which the assets and strengths of refugee-background women are privileged, see Box 6.2 below for my examples<sup>75</sup>.

### Box 6.2: Questions to Enhance Communication and Rapport using an Asset-Based Focus

- *What things do you do to help make yourself feel good?*
- *Have you been through this sickness before, if so what things did you do to make yourself feel better?*
- *Are there certain foods that help?*
- *Who do you ask for help to make yourself feel better?*
- *What advice have you received? How did it help?*

### **Taking a Herstory with an Asset-Based Orientation**

When taking a pregnant refugee-background woman’s herstory, I have created the following questions (Box 6.3), which a maternal healthcare

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<sup>75</sup> I am aware that English is not the native tongue of many former refugees, so these questions will need to be tailored for each unique client, with the help of interpreting services.

provider can use to create spaces in which the woman can draw on her assets.

Box 6.3: Taking a Pregnant Woman's Herstory with an Asset-Based Focus

- *How many weeks gestation are you?*
- *How are you feeling?*
- *Can you please tell me how this pregnancy is going for you so far?*
- *Is this your first pregnancy?*
- *What things do you like about being pregnant? What things don't you like about being pregnant?*
- *Tell me about a time that you felt powerful and overcame adversity?*
- *How did that make you feel?*
- *What things are helping you feel good during this pregnancy?*
- *How did you discover some of the things that help you feel good?*
- *What foods and drinks have you been eating during this pregnancy? Why have you been eating these particular foods and drinks?*
- *What exercise have you been doing this pregnancy? Why?*
- *Do you feel like you are getting enough rest? When do you rest?*
- *Have you had any nausea or vomiting during this pregnancy? What have you been doing to help with this?*
- *Have you had any back pain or any other pain in your body during this pregnancy? What have you been doing to help with this?*
- *Has anything happened during this pregnancy that you didn't expect? [If yes] What? And how did you manage it? How did you find out about that [how you managed it]?*
- *Who have you been getting support from with this pregnancy? How has that been for you?*
- *Have you asked for someone's advice on anything during this pregnancy? Who have you asked and what did you ask about? [If no] Why not?*
- *What things have your friends and family recommended that you do to make you feel good in pregnancy, labour or postnatally?*

The following questions in Box 6.4 could then be asked to identify the client's pregnancy and birth knowledge and experience:

Box 6.4: Ascertaining Knowledge and Experience

- *Have other people talked with you about their pregnancy, birth and postnatal experiences? Who? What relation were they to you? Where did they give birth? What did you learn?*
- *Have you supported other pregnant women? What things did you learn from that experience?*
- *Have you been at someone's birth before? Whose birth? What did you do at the birth? What things did you learn from that experience?*
- *Have you supported other women with looking after their baby or helping them after their birth? What things did you learn from that experience?*
- *Have you been to antenatal classes? [If yes] What did you enjoy about these classes? What have you learnt from these classes? [If not] Why not?*

Box 6.5 below lists questions that could be asked to identify health assets and experience the client has obtained from any previous pregnancies.

Box 6.5: Identifying Knowledge and Assets from Previous Pregnancies and Births

- *How does this pregnancy differ from that of your previous experience(s)? Where were you? Did anything unexpected happen? Did you manage anything differently from this current pregnancy? What? Why?*
- *Can you please tell me about your birth experience? Where were you? How do you feel about that experience? What aspects about this birth experience do you hope will be similar in this upcoming birth?*
- *Can you please tell me about your postnatal period? How do you feel about that experience? What aspects about this postnatal period do you hope will be similar in this upcoming postnatal experience?*

## Summary

To improve health outcomes, as well as more effective and meaningful resettlement, maternal healthcare services must foster a sense of belonging and inclusiveness, achievable through diffusion of an asset-based focus. While the needs-based focus is necessary to identify specific ways that services can develop to address barriers that some refugee-background women face, it is insufficient and inappropriate to exclusively apply a needs-based strategy. An asset-based focus places the woman at the centre of the care and, as such, enables culturally-appropriate and holistic care to be offered. It also reminds the woman of her strengths and abilities, and how resilient she can be.

The next chapter completes this thesis by revisiting the four research aims and reflecting on the insights generated. I also outline some recommendations for future research and practice to develop and improve health services for refugee-background women. Finally, I discuss the ways in which this exploration can contribute to development theory.



## CHAPTER 7

### Concluding Discussion

*Health practitioners have a critical role to play in reframing [...] health services and health policies for forced migrants, by promoting inclusion and by helping shape a narrative which integrates and values the experiences of this population (Grove & Zwi, 2006, p.1931).*

#### Introduction

Annette Mortensen (2008) explains that former refugees face institutional racism, marginalisation and discrimination in the health sector in New Zealand. Throughout this thesis, I have identified many statements and practices pertaining to refugee-background women and men that illustrate the inadequacies, cultural inappropriateness, and at times, harmfulness of the biomedical model. Additionally in Chapter 5, I isolated statements and practices in healthcare services that construct former refugees as the 'Other' – creating distance, opposition and conflict between 'us' and 'them'. These practices produce and reinforce the idea that former refugees are different and do not belong to the mainstream host community (Grove & Zwi, 2006). Furthermore, these marginalising and dehumanising statements and practices can create (and perpetuate) public discourses of intolerance. Governments could then use these negative discourses to avoid and neglect

their humanitarian responsibilities to protect persecuted and displaced people (ibid.).

I have argued that challenging the dominant exclusionary discourses in health (as well as other burden and needy discourses), may nurture a more inclusive and just narrative. Identification of these alternative representations could foster improved health outcomes for former refugees (as well as for society as a whole) and lead to more effective and meaningful resettlement.

In this concluding chapter I begin by reflecting on how my research findings relate to each of the four aims of this thesis<sup>76</sup>. Using the critiques of the biomedical model, this thesis has advocated for infusion of an asset-based approach to maternal healthcare for refugee-background women. In this chapter I outline some recommendations for future research and practice that this suggestion has engendered. Next, I note how this thesis has contributed to development theory and practice. Finally, I conclude by emphasising the possibilities within the medicalisation ‘project’ for alternative and more enabling discourses to arise.

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<sup>76</sup> The aims were to: 1. Analyse and explore, via discourse analysis, the implications of how women (and men) with refugee backgrounds are represented and positioned within health literature in Aotearoa New Zealand.

2. Examine how the processes of pregnancy and childbirth have become firmly located within the western biomedical model and explore the implications of this for women with refugee backgrounds.

3. With reference to the CRF (2011) report’s recommendations, identify the characteristics of an asset-based approach to maternal healthcare for women with refugee backgrounds, which may also be relevant to development work in international contexts.

4. Discuss how an asset-based approach to maternal healthcare for women with refugee backgrounds offers insights for postdevelopment practice: as a potential vehicle for applying the principles and ideals espoused within postdevelopment theory.

## **Aim One: Western Biomedical (Mis-) Representations**

This thesis analysed the operations of discursive power that constitute what counts as 'truth' about the health status of refugee-background women (and men). Drawing on western scientific knowledge, relatively powerful groups working within the biomedical paradigm have been able to fix subject identities, subjectivities, practices and attitudes towards refugee-background people constituted as needy, diseased and problematic. Central to my research was examination of the way in which the discourses of western biomedicine have developed, which fosters the understanding of how people with refugee backgrounds are constructed as 'needy' and 'problematic'. Throughout my analysis it was overwhelmingly apparent how instrumental the representational strategy of naturalisation was to produce and sustain the biomedical model's hegemony.

My analysis of biomedical discourse(s) accomplished two things: first, it revealed the statements and practices which claim and maintain that refugee-background people have considerable health needs and problems; and second, it explored how this creates and perpetuates various exclusionary practices, such as Othering and dismissal of non-western health knowledges (Doty, 1993). I have postulated that because pathology and problems are basic to the western biomedical model, the proclivity to position refugee-background people as having considerable needs is inevitable. A positioning which also serves to reify and cement the relevance and applicability of the biomedical model.

Additionally, in Chapters 4 and 5 I demonstrated that western concepts and languages are so entrenched in the health sector that other ways of approaching, practising and thinking about health (and illness) are

overlooked and disregarded. The dominance of the model is immense; its organisation, management and judgements have become widely accepted throughout the world. The development industry, in its drive to attain the Millennium Development Goals, has readily accepted and exported the concepts and practices of the biomedical model. While I have shown the plurality in manifestation of western biomedical practices, it is the ontological and epistemological underpinnings of the model, that is, its technocratic, reductionist, mechanistic, scientific, individualistic nature, and its exclusionary and dominating tendencies, which appear relatively fixed, and are thus of concern.

As I have demonstrated, the category, 'refugee' is a complex discursive process; by virtue of the label 'refugee', one has had to occupy a 'needy' and 'problematic' position. This position is perpetuated and maintained as former refugees encounter the biomedical frames imposed through compulsory medical screening in the resettlement process and further circulated through the health-related literature. In Chapter 5 I illustrated that while extensive and persistent discursive work is employed to maintain this construction, there are many inconsistencies and flaws with its logic.

This thesis has identified some of the assets and strengths that are known about refugee-background people, such as low rates of alcohol consumption and diabetes (courtesy of biomedicine), yet they are disregarded and overlooked. Undoubtedly there are many other resources and strengths that are not yet widely known, or able to be known and drawn on, due to the inherent nature and hegemony of the biomedical model.

## **Aim Two: Overlooking the Potentials of Pregnancy and Childbirth**

In Chapter 4 I examined how the processes of birth transitioned from a natural life event controlled by women to being a medical 'condition'. This demonstrated the trajectory of medicalisation and medical social control, that is, the legal and regulatory authority that western biomedicine now has in society. Western biomedicine achieved this degree of control through many sociopolitical factors and strategies employed by the 'elites' in society, rather than as a direct consequence of medical research, science and technology. In essence, I postulated that the power, prestige and dominance accorded the model are the outcome of social and cultural factors, rather than the workings of western biomedicine.

The biomedical model of childbirth is predominant in western societies, and increasingly so in non-western ones, due to development and globalisation. This thesis has shown the extant limitations of the model, these include: the increased and inappropriate use of intervention and technology, which has led to unnecessary morbidity and mortality risks to women and babies; the disempowerment and loss of confidence in women; and women's increased guilt and anxiety. The biomedical model of childbirth has dehumanised birth and transformed it into a medical-technical problem. The implications of these limitations are more pronounced for pregnant refugee-background women, who, as I have shown, are (over-) subjected to the western biomedical model. A model which incommensurably represents (and consequently understands) them as 'needy' and 'problematic'. Throughout this thesis I have warned that this positioning will undoubtedly (and worryingly) impact on how refugee-background women see themselves.

The concerns of various refugee-background communities regarding their “barriers to achieving good health outcomes”, has informed my thesis topic (CRF, 2011, see Appendix A). I have suggested that the inadequacies inherent to the biomedical model produce these ‘barriers’. Specifically, I argued that the discrimination and cultural insensitivity that refugee-background women experience in their care has led to the adverse maternal healthcare outcomes. Outcomes such as rising rates of caesarean sections, which has been associated with increased risk of severe perinatal outcomes. Additionally, the noted trend of refugee-background women not seeking or receiving equitable maternal healthcare may be attributed to the discriminatory characteristics and cultural inappropriateness of the western biomedical model of childbirth.

This thesis highlighted the potentials for the processes of pregnancy and childbirth to create and conserve spaces for refugee-background women to exert their authority, agency and power. In Chapter 6, I proposed tangible ways that practitioners could work with women to draw out, privilege and mobilise their skills, assets and knowledges regarding ways they maintain health in pregnancy and childbirth. In this process, not only could spaces be created for women to exercise their authority and autonomy in meaningful ways, but mutual learning about other ways of knowing and approaching maternity health could be engendered. This thesis has highlighted how the western biomedical model of childbirth precludes opportunities for women to exercise their power, agency and authority.

### **Aim Three: Meeting ChangeMakers' Recommendations**

As noted above, asset-based development approaches have the potential to address some of the limitations of the western biomedical model. Using maternal healthcare as an example, this thesis has identified the characteristics of an asset-based approach, which may be relevant and applicable to development work in other contexts. Here I suggest that five of the recommendations made by the participants in the CRF (2011) research (in light of their concerns regarding healthcare provision and outcomes) can be met through employing an asset-based approach. Below I briefly outline the specificities of how an asset-based approach can enable the CRF (2011) recommendations.

#### **Health Practitioners are Trained to be more Culturally Responsive**

Inherent to an asset-based approach to healthcare is the ability to provide care that is accessible and relevant to the client – positioned as the central agent in their own health and development. By first taking the position that privileges their concepts and understandings of health and illness, refugee-background women (and men) are able to define and drive the process of their healthcare engagements. As I have suggested, people attribute meaning to using their own skills, knowledges and experiences to address their health concerns, and as such culturally-appropriate care involves the creation of spaces in which to do this. Additionally, the healthcare practitioner is then positioned to learn from and understand their client's perceptions regarding the strengths and assets they can draw on to maintain their health. In Chapter 6, I proposed that the infusion of asset-based discourse into maternal health services may enable culturally-sensitive services to develop as a likely consequence. In turn, improvements to access

and utilisation of maternal healthcare services for refugee-background women may be engendered.

### **Health Practitioners Recognise the Important Role of Communities**

A legacy of Cartesian dichotomous thought, the individual/society distinction, has meant that sickness is seen to arise in an individual's body and has nothing to do with social relations. As I have shown in Chapters 2 and 4, treatment of illness within the western biomedical model is centred on the individual. It is therefore difficult for health practitioners working with the model to perceive how social relations can help (or hinder) one's health. Given that the concept of social capital is a foundational element of asset-based development, community networks are galvanised and fostered. Working within an asset-based approach could enable health practitioners to activate attitudinal changes towards recognition and facilitation of communities as a key health resource of refugee-background people.

### **Health Practitioners take a more Holistic Approach when Treating People with Refugee Backgrounds**

As I have shown in Chapters 2 and 4, the western biomedical model is reductionist by nature. Another heritage to Cartesian mind/body separation and germ theory is the view that illness is seen as occurring to parts or organs of a body, rather than affecting a whole human body. Biomedical knowledge tends to focus on symptoms and disease relief of the individual. Taking a holistic approach, conversely, involves treating a whole person and appreciating the values that they place on their experiences of health or illness. Incorporating an asset-based approach to healthcare for refugee-background women (and men) enables the health practitioner to begin by ascertaining which aspects are of importance to the client. The focus could change from being exclusively on the diagnosis of illness, to privileging the



knowledges, preferences, resources and experiences of former refugees. As a result, people with refugee backgrounds may be looked at holistically as the focus of care is with their lived experiences.

### **Recognition, among Health Practitioners, of the Skills and Experience that Refugee-Background People Bring**

In this thesis I highlighted the implications for refugee-background women of privileging western biomedical discourses in maternal healthcare services. One such implication is that it may impact on the abilities, desires and momentum of women with refugee-backgrounds to assert their ways of doing and knowing within currently offered maternal healthcare services in New Zealand. As I have shown in Chapter 6, at the very core of asset-based development approaches are methods to recognise, value and mobilise people's skills and experiences. A holistic acknowledgement and understanding of the assets, knowledges and experiences that refugee-background people draw on to maintain their health can prompt care delivery which builds on their asset base, rather than inadvertently depreciating their skills, assets and knowledges. I have suggested that building upon what people *have*, rather than what they *lack* opens up a new way to engage with clients. It facilitates an asset 'bank' to develop, and through continual asset-focused interactions, a person's confidence in their health assets may grow, and optimal health and wellness outcomes could be achieved.

### **More Acceptance and Welcoming of Diversity among the Wider Community**

*A weak community is a place where lots of people can't give their gifts and express their capacities [...] the most powerful communities are those that*

*can identify the gifts of those people at the margins and pull them into community life* (Kretzmann & McKnight, 1993, pp.27-8).

Healthcare services can play a major role in fostering a sense of belonging and inclusiveness. These aspects are not only critical to achieving improved health outcomes, but also to engendering effective and meaningful resettlement (Grove & Zwi, 2006). As discussed in this thesis, protagonists of asset-based development assert that being able to express and use one's assets and skills will lead to a person feeling valued and being more likely to contribute and connect to those around them. As communities realise the capabilities and contributions of various people, the community will prosper and become more powerful (Kretzmann & McKnight, 1993). In Chapter 6, I proposed that employing an asset-based approach to health might provide spaces for health practitioners to engage meaningfully with refugee-background clients to foster collaborative learning and appreciation. This engagement may help promote more enabling and fair narratives regarding former refugees, which in turn could inform other circulating burden and needs-based discourses, and work towards more inclusive and effective resettlement.

#### **Aim Four: Insights for Postdevelopment Practice**

As stated in Chapter 3, the conceptual framework for this thesis has been inspired by the work of J.K. Gibson-Graham (2005). In their work, they broached the practice of postdevelopment by representing diverse economies in societies as an alternative to mainstream development approaches which advocate "capitalist expansion" (p.5). Like Gibson-Graham, I do not consider postdevelopment as 'anti-development', rather I

see it as an opportunity to stimulate alternative and more meaningful ways to imagine and practice development. Hence, I have proposed an asset-based approach to maternal healthcare for refugee-background women as a vehicle for applying the principles and ideals espoused within postdevelopment critiques. As I have shown, the 'one-size-fits-all' model advocated as the way to improve maternal healthcare is inadequate, inappropriate and detrimental to women with refugee backgrounds. The drive to 'modernise' maternity healthcare serves to validate and reify the hegemony of the western biomedical model. A model which renders the assets, knowledges and skills of refugee-background women invisible and non-credible. As discussed in this thesis, implicit in New Zealand's healthcare services are assimilating messages, which suggest that the ways former refugees know and approach health are incorrect and inappropriate. An asset-based approach could give value to diverse and alternative ways of managing maternal health, in opposition to the exclusivity of the hegemonic practices characteristic of the biomedical model.

## **Recommendations for Future Research and Practice**

In this thesis, I have brought together a patchwork of complex ideas and theories to provide a thorough and comprehensive investigation of my research aims. As noted in Chapter 3, this work has formed some of the groundwork necessary for further empirical research. It is imperative that further research is carried out to establish more accurate birth outcomes of women with refugee backgrounds in New Zealand and to work with these women, health practitioners and services to explore ways to improve outcomes.

As discussed, in my future Doctorate I intend to conduct Feminist Participatory Action Research in collaboration with a group of refugee-background pregnant women and mothers to document the strengths, assets, knowledges and practices that they draw on through their maternity experiences to maintain their health. With this information I hope to work with the participants of the research to create a resource that participants could use to educate and inform health practitioners about the ways in which their assets can be worked with productively. I believe that this work will provide specific tangible examples that health practitioners can utilise to deliver culturally-competent care. This, in turn, could improve healthcare access and outcomes for refugee-background women. This proposed work might also contribute to the, fairly limited, knowledge base that exists regarding maternal healthcare access and outcomes of refugee-background women in New Zealand.

The conceptual model and definition of health assets developed by Ann Rotegard and colleagues (2010) provide a strong basis for further enquiry to develop theoretical and practical frameworks. Their promising and in-depth exploration into health assets draws upon commonalities of the concept across various health disciplines, and as such it is widely applicable. For many working in health though, the concept of health assets may seem fairly abstract due to the preoccupation of disease and pathology that pervades current practice (Muecke, 1992; Rotegard et al., 2010). Thus the extensive work by Rotegard and colleagues (2010) offers a concrete and clear foundation that can guide both practice and research. Based on their study and the research I have generated here, I have identified the following areas for further investigation.

### **Building the Capacity of Health Practitioners**

Implementing an approach to health with entirely different philosophical underpinnings will need a great deal of commitment, different types of engagement and (undoubtedly) innovative ways of measuring outcomes (Rotegard et al., 2010). An approach or tool will only be effective if there has been capacity building of those implementing it. In Chapter 6, I proposed ways that health practitioners can work with refugee-background women to elicit their assets. Though knowing what to do with the information and how to then use their assets, skills and knowledges productively will only occur if the capacity of the health practitioner and supporting services has been fostered. How such commitment and capacity can be built needs further exploration.

### **Examining the Risks of an Asset-Based Approach to Health Becoming Depoliticised and Semantically Diluted**

In critiques of development, there are many examples of various ‘new’ and ‘innovative’ approaches that have been widely adopted in domains as different as the worlds-they-make. This, combined with the tendency of the approaches’ political and historical contexts to be overlooked, has meant that they become “virtually robbed” of their once political and emancipating origin (Batliwala, 2007, p.557; Cornwall, 2007). For example, one of the most widely used, and as many argue, abused terms by development agencies and many other disciplines today is ‘*empowerment*’. The wide application of the word across a multitude of sectors and broad spectrum of society highlights the difficulties in pinpointing the actual meaning of ‘empowerment’ – lending itself both to miscommunication and semantic dilution.

Many argue that the widespread co-option of 'empowerment' is not about simple linguistics, but subversion of the politics that the term was created to symbolise (Batliwala, 2005; Moore, 2001). The absence of any real definition illustrates the 'politics of meaning', which enables differently positioned users to assert very different understandings and conceptualisations of the term (Rist, as cited in Cornwall, 2007). As Cornwall (2007) adds the clouded description of empowerment has a purpose as "policies depend on a measure of ambiguity to secure the endorsement of diverse potential actors and audiences" (p.474). The use of words and concepts that can be open to interpretation can hide multiple agendas, providing room for manoeuvre and space for contestation (ibid). Asset-based approaches may be vulnerable to the same appropriations. Further research needs to be conducted to ensure that asset-based interactions do not merely include 'buzz-words', but that they enable transformative and meaningful practice.

### **Ensuring an Asset-Based Focus in Health does not Replicate One-Size-Fits-All Development Models**

In Rotegard and colleagues' (2010) analysis, the concepts of *resilience* and *resourcefulness* were defined as being merely "related concepts" to health assets, as they "have some kind of relationship with the main concept studied, but did not contain all the defining attributes" (p.520). The rigidity of the study's method of analysis resulted in the exclusion of the concepts of *resilience* and *resourcefulness* from the defining attributes of health assets. Yet, the concept of health assets is defined as an individual's repertoire of potentials, "that mobilize positive health behaviors and optimal health/wellness outcomes" (Rotegard et al., 2010, p.514). For different individuals, the 'repertoire of potentials' will be different, that is, factors that mobilise positive health behaviours for one person will undoubtedly be

different from those of another person. Therefore the defining attributes of health assets should encompass and reflect that diversity.

As this thesis has found, many scholars consider former refugees as having relatively high resiliency and resourcefulness (refer to Chapter 6). However, if one is working within the health asset framework developed by Rotegard and colleagues (2010), these particular concepts would not strictly be considered health assets, and consequently may be disregarded or dismissed. The danger of being too prescriptive in conceptualising health assets is that a 'one-size-fits-all' model becomes developed – echoing the postdevelopment critique of mainstream development interventions.

It is important that any resources produced from my intended Doctorate research into asset-mapping avoid the propensities of biomedical discourse(s) that I have critiqued here. There will always be other ways to approach health and wellness during pregnancy and childbirth<sup>77</sup>, and it would be unfortunate if any readers or users of the resource felt that their experiences were being disregarded or unrecognised because they run counter to the particular discourse presented (Jhangiani & Vadeboncoeur, 2010). Stating out the outset that there are multiple ways of experiencing and expressing maternal health may help to avoid reproducing essentialised notions of culture. Future research needs to explore how an asset-based approach can reflect institutional and 'cultural-hybridity' (ibid.).

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<sup>77</sup> For instance, in Chapter 1 I briefly discussed the Māori health and wellness models, which are more holistic, relational and less individualistic than the mainstream western biomedical models.

## Contributions to Development

*The power of vocabulary to change how we think and what we do is easy to underestimate. It influences the course of development in many ways: through changing the agenda; through modifying mindsets; through legitimating new actions; and through stimulating and focusing research and learning (Chambers, 1997, p.1744).*

Much of the criticism directed at development studies concerns the construction of the development 'subject', and has called for more just and fair representations of the communities being worked with. In light of this apparent tension, here I have drawn on the critical insights offered by postdevelopment theory to explore the discursive constitution of former refugees as needy and problematic medical 'subjects'. As well, in the efforts to both practise and conceptualise development 'differently' (using the critiques and ideals espoused by postdevelopment theory), I have suggested infusing an asset-based development approach to maternal healthcare for women with refugee backgrounds. In this thesis, the important principles of postdevelopment theory have nurtured a more enabling and sustainable 'development' to be imagined. Katharine McKinnon (2008) notes that postdevelopment theory has not yet been utilised to address hegemony, though as shown here the postcolonial and poststructuralist foundations to the theory have been extremely useful in challenging the hegemony of the western biomedical model.

Yet as Cheryl McEwan (2009) notes, development has largely ignored these important insights offered by postdevelopment theory. In fact, there has been much critique that it is an unproductive body of knowledge which does not offer practical ways of 'doing' development (cf. Cahill, 2008;



Gibson-Graham, 2005; McKinnon, 2008; Ziai, 2007). The work I have presented here disturbs and nullifies these critiques. The insights offered by postdevelopment theory have, above all, fostered the opportunity for reflection – to ensure that any development intervention is meaningful, enabling, accessible and nurtures a space for ‘becoming’. And to make sure that the material and discursive mistakes of past development practices are learnt from. In this thesis, postdevelopment theory has offered the opportunities for these important reflections.

In Chapter 6, I also raised some important insights for the Millennium Development Goals (MDGs) three and five. Specifically, I discussed ways in which taking an asset-based approach to maternal healthcare can promote gender equality and women’s ‘empowerment’. I also suggested that the inadequacies inherent to the western biomedical model indicate that as a model it is not enough to reduce maternal mortality. Rather, approaches taken to reach the MDGs need to acknowledge and foster spaces for women to make and act on decisions in meaningful ways to maintain their health and wellness. Asset-based development may create and conserve these spaces.

## **Final Word**

It may be helpful to consider Peter Conrad’s (1992) assertion that the factors affecting the degrees of medicalisation are not yet fully understood. Put another way, while some conditions are fully medicalised, such as birth and death, others may be only partly or minimally medicalised, for example menopause and spouse abuse, and the reasons for this variance are not yet understood. Developing this understanding may furnish those groups

adversely affected by medicalisation with the premise to challenge its domination.

One factor Conrad (1992) cites as reducing the degree of medicalisation is the existence of competing definitions represented by “strong interest groups” (p.220), therefore championing new and fairer discourses concerning refugee-background communities may enable disruption of the medically controlled needs-based ones. The conceptualisation of refugee-background communities as needy and problematic has only become normal and dominant through discursive explanations. Acknowledgment that the biomedical model’s discursive frameworks are socio-historically produced makes it possible for alternative discourses or imaginings to arise and supplant them.

This thesis has argued that privileging refugee-background women’s assets, knowledges and ways of approaching their health could see “western (formal) science [lose] its universal position, and [become] one of a range of competing and contested knowledge systems” (Briggs & Sharp, 2004, p.662). I have suggested ways that maternal healthcare services can be less-colonising and more enabling for refugee-background women. I hope that this research has interrupted the ubiquitous image of the ‘needy’ and ‘problematic’ refugee-background woman (or man) – a positioning that is neither accurate or fair.

## Appendix A



*'To be healthy is almost out of reach for refugee families because of the conditions we live in.'*

# Barriers to achieving good health outcomes in refugee-background communities

A report prepared for Regional Public Health and the Department of Labour

## **Executive summary**

This report highlights the barriers facing people from refugee background communities in achieving and maintaining good health. Information in this report was gathered at four focus groups held in May 2011. Focus group participants came from 11 different refugee-background communities.

The main barriers identified by participants were limited English language skills and issues around the use of interpreters; living in damp, mouldy houses; being unemployed and having limited incomes; stress resulting from trauma and/or being separated from their families; a lack of awareness of how to keep healthy in New Zealand; discrimination and a lack of culturally sensitive health services.

Participants made a number of suggestions on how to reduce these barriers and improve their health. These included: more funding for English language classes, improved housing conditions, cultural awareness training for health practitioners, health promotion material for people who did not speak English, being re-united with family members in New Zealand and for health practitioners to take a more holistic approach when treating people from refugee backgrounds.

## **1.0 Introduction**

The aim of this report is to increase understanding of the health requirements of refugee-background communities. Like many communities whose members are predominantly from low socio-economic backgrounds, former refugees face many cross-cutting health issues that are barriers to achieving and maintaining good health. This report highlights these barriers and documents research participants' suggestions on how these issues could be addressed.

## **2.0 Methodology**

Information for this report was gathered from four focus groups held in May 2011. The research process was underpinned by ChangeMakers' Standards for Engagement (2008), which outlines the importance of working alongside communities and ensuring that participants are engaged in a meaningful way. As part of this process, and to ensure that participation was not limited to a select few, we assisted people to attend the focus groups by covering transport costs and by providing a koha. Where needed, interpreters were provided to ensure that the participants who had limited English language skills could express themselves freely.

A total of 24 people from 11 communities participated in the focus groups. Twelve participants were aged 30 years old and above and twelve participants were aged between 18-29 years. There were two male and two female focus groups in recognition that health issues can be sensitive and that we were likely to achieve more in-depth information if gender specific groups were run.

At the beginning of each focus group, we explained the format of the session, talked about confidentiality, and discussed speaking protocols (e.g. allowing equitable space for participant contribution and the right to 'pass' if participants do not wish to contribute). All participants signed an agreement form that gave their consent to participate, to be recorded and provided the option to withdraw from the process at any time (see Appendix A).

Each of the focus groups were recorded. ChangeMakers conducted a thematic analysis of the findings, identifying key issues and barriers to achieving and maintaining good health. Most of issues related to each theme were raised and discussed by all four focus groups. Where a specific group raised an issue that was not discussed at other focus groups, this has been noted within the report.

### 3.0 Research findings: factors influencing health

A range of interrelated issues were identified by participants as having a significant impact on their health.

#### 3.1 Housing

Participants identified the link between living in unhealthy houses and their health. They stated that many of their houses were damp and mouldy, lacked proper ventilation and that these living conditions resulted in poor health for them and their families. Women felt that their health and the health of their children had deteriorated since arrival in New Zealand with increased rates of colds, allergies, hay fever, asthma and other respiratory diseases.

*'Refugees who get a house in very bad places, that causes most of the sickness. The house is most important.'*

*'Housing [New Zealand] never change anything. They just came a few months ago, they paint the whole wall but the mould is still coming... whenever we wake up in the morning we just cough, cough really hard.'*

Participants also observed that overcrowding was a problem among refugee-background families due to small houses being allocated to large families.

*'Too many people live in one house, if one becomes sick, others become sick too'*

#### 3.2 Income and employment

Participants spoke of the connection between income, employment and health. Being unemployed and having limited income was seen as a major barrier to attaining good health. Participants said that if they had a steady income they would be able to afford decent accommodation, buy healthy food, and have ready access to family doctors.

*'If we can get a chance of employment, then that may change something'*

As many people from refugee backgrounds are beneficiaries, a key priority for participants was to ensure that they had enough money to feed their families.

Participants felt that the increasing cost of living in New Zealand made it difficult to live well and be healthy. Several stated that healthy food was expensive and for many refugee-background families on a limited budget they were unable to afford healthy food.

*'All these good things are out of our reach, even though you know their importance.'*

*'The cheapest things are those that can cause health problems. Because the refugees are not earning much, they have to go for the cheaper things.'*

*'The organic food is so expensive. Nobody will go to buy them. If you go to buy them, then tomorrow you will not get anything to buy. So I think healthy food is a problem.'*

Participants also highlighted the link between unemployment and the deterioration of their health. They spoke of the stress, depression and other mental health issues they experienced due to the financial pressures here and abroad. Several male participants spoke of expectations from family members back home that they would be supported by those who had been resettled here.

*'You are expected to support families back home, you cannot find a job here, so you get stressed.'*

*'If people see one of their people is outside [the country], they hope that they have got money, they will be asking for help. And if you cannot be able to help them... because of your conditions here then it can really create a big problem.'*

*'You look at yourself, I'm eating here but my brothers and sisters are not eating there... You cannot feel happy because you cannot support anyone who is there in need of help.'*

Many participants spoke about long hospital waiting lists. Some commented that the lack of income in refugee-background communities meant that most could not afford health insurance and were therefore forced to wait which created additional stress.

### **3.3 Language**

Participants stated that having limited English language skills was a major barrier to achieving good health. They identified several language-related issues that are covered in the following sub sections.

#### **3.3.1 Access to services**

Participants felt that the best way to facilitate access to services was for people to learn English and that the New Zealand Government needed to put more resourcing into this area. Female participants highlighted that not knowing English impeded not only their access to health services but also to other services, including those provided by Work and Income and Housing New Zealand. Participants stated that limited English language skills made it very difficult to communicate effectively or even explain their sickness.

*'It cripples us...we can't say what we want.'*

*'At the end of it language plays a very big role. ' [in keeping healthy]*

*'If you can't express yourself, everything is difficult for you.'*

Participants felt limited English language skills resulted in limited health service provision. They felt they were dismissed by health professionals who didn't have time to work out what they were trying to communicate.

#### **3.3.2 The use of interpreters**

Participants recognised the need for and the importance of interpreters when people could not speak English. However, some were unaware of their right to an interpreter and either went alone or brought their children with them to appointments. Others experienced situations where there was no interpreter provided, or when an attempt was

made to get one, a suitable interpreter was not available. This experience applied outside the health system as well (e.g. Work and Income and Housing New Zealand).

Participants felt that informal interpreters (i.e. family or community members) needed to be trained so that they were aware of issues such as confidentiality. Male participants stated that if the community was aware that the person had received training, then the community would have confidence that their health issues would remain confidential. They also stressed that the community would need to know the person who was interpreting.

*'Trust plays a big role here.'*

*'If you don't know someone then you can't trust them.'*

*'Health issues are sensitive. You need to be able to trust the person who is interpreting and that they will keep the information confidential. If this was done through training then people would have confidence that the interpreter would be educated about ethics and confidentiality.'*

*'... if the person is more connected to the people and then the moment the people start to know that person...this person seems to be a very good person within the community. They can see him, they can talk to him.'*

In reality, many people were faced with using someone to interpret who was not trained and they worried that the community would hear about their health issues.

*'They still take someone [to interpret] and that's the problem, some people are not training, there is some news that happen that come out of the room.'*

Participants agreed that interpreters needed an understanding of the health system and medical terminology so that interpreters could explain clearly to patients what the health practitioners were saying.

Some participants suggested that the health system provide interpreters but others, mainly the female participants, felt that they didn't want outsiders knowing about their personal issues and so preferred to have family members interpret. However, they also acknowledged that some children did not want to act as an interpreter.

Female participants were also very uncomfortable with having male interpreters and wanted more women interpreters to choose from.

*'I cannot say all my problems to male interpreter because of our culture... I'd rather lose the therapy/treatment than losing my privacy.'*

### **3.3.3 Participation in society**

A language-related issue that impacted on participants' health was the extent to which they were integrated into the wider community.



People who had limited English language were in danger of isolating themselves, which had a negative impact on their physical and mental health.

*'...because of language barrier we stay at home, we isolate ourselves, we stay at home, don't want to go out.'*

*'When people isolate themselves, they sit there, they think about what happens in your own country, they have friends, they have uncles, they have sisters...'*

Participants from the younger women's group highlighted that it was difficult for them to socialise with 'Kiwis' and that they were often excluded because of their limited English language skills.

*'It's hard to find some other Kiwi friends...to learn more about the culture.'*

Participants also noted that many refugee-background communities do not participate in physical activities like swimming due to language and cultural barriers. They felt that service providers needed to develop better ways for refugee communities to be involved in physical activities.

### **3.4 Mental health**

While participants spoke of specific health issues such as headaches, digestion, problems sleeping, arthritis, diabetes, and blood pressure problems, they acknowledged that many of these problems were stress related. Participants agreed that mental health issues were of great concern to them and their communities.

*'The main problem that refugees face is related to trauma, is related to stress.'*

*'When a person is not in a good condition mentally, he cannot do anything.'*

*'Stress is most important because if you are stressed you don't eat food and if you don't eat food your body is getting weaker and weaker, you don't sleep properly...'*

Participants felt that mental health issues were not given enough consideration when they went to the doctor and that health issues were not considered from a holistic perspective; there was tendency to treat the symptoms.

*'It shouldn't all stop at the lab. That's what happens; you get these three or four tests that are negative and that is the end of the story, they don't want to know anymore about you.'*

Participants suggested that doctors work closely with psychologists to ensure that mental health issues were being treated.

*'The doctor needs to give some space for psychological problems. He must understand that we are a community of refugees and that we have gone through a lot of problems.'*

*'A lot of the problems are actually psychological and obviously influence what happens on your body.'*

*'So it would be good for doctors to have a bit more information about us and for them to have the ability to move us to a psychologist or whatever for them to get a proper assessment of what is happening.'*

### **3.5 Separation from family**

Participants spoke about the stress of having left friends and family overseas, and about the negative impact that worrying about them had on their health.

*'We worry every time, every day.'*

*'It is worse when you are the only one in New Zealand, when you've got your wife and kids back home, you don't sleep, you don't eat, you don't do anything, you don't integrate...it's like you are living in a prison.'*

*'Having your whole family here will make you smile, seeing your kids.'*

*'When we are eating here we are thinking about our families back in Africa. ...what is happening with them? Are they having food?'*

*'We worry every day, every time, your mind is always divided, you don't know where to concentrate.'*

### **3.6 Access to information**

Participants felt that the dissemination of health messages to refugee-background communities was sometimes poor, and this was accentuated by people in communities not having adequate English language skills. They felt that service providers needed to give more consideration to how to communicate health messages to people who did not speak English.

Participants wanted more awareness among refugee-background communities about how to attain and maintain good health, what foods were good for you, and where you could go to get good advice.

Being aware of who to talk to when there was a health problem or being able to advocate on behalf of yourself or someone else was also seen as important. As one participant stated:

*'...my mother has an eye problem where the eye was weeping and they said it will be six months before she can have an operation to fix this. Because I complained it is now 1 month.'*

While the participant was grateful that his mother would receive the operation sooner than expected, he observed that many refugee-background people would not know who to complain to or have the language skills to do so.

*'There is no one to tell you about these things and if you don't know the language you cannot solve these problems.'*

Several participants spoke about differences between their home country and New Zealand and how these impacted on their health.

*'Our country is a warm country and this is a very cold country.'*

Another participant stated that people needed to be well briefed before arriving in New Zealand so that they had realistic expectations about life here.

*'You were expecting you know, milk and honey as you have been told and when you come you see things differently here...some people even ask themselves, why am I here? I am not getting what I expected.'*

Participants also noted that the differences between their culture and life in New Zealand presented many problems that could impact on their health. They noted that greater awareness of these differences would help them manage expectations and to address issues when they arose.

### **3.7 The cost of services**

Many participants spoke of the cost of going to the doctor and felt that this was a barrier to achieving good health.

*'.... is the price of those visits. The price is \$17. If you have two family members then that is going to be \$34 and if you have more than one thing that is wrong with you then that is going to be more.'*

*'I went to the doctor once about my head, it was hurting and the doctor asked me if there was something else. So I told him about my stomach and he said those are two visits, you have to pay for two visits.'*

*'Lowering the price would make things much easier.'*

Participants stated that access to free blood tests and ambulances was beneficial.

### **3.8 Culturally sensitive health services**

Participants recommended that doctors should have not only medical information about patients but also information on where the patient comes from, what was happening in that country (as this could result in stress and related health problems) and the sort of diet that patients were used to. Doctors should be trained to work with culturally diverse patients and to be culturally responsive.

*'Health professionals...cultural awareness training so they don't have preconceived ideas about you. They should be welcoming and not try and see you as quick they can.'*

Women in particular felt that health practitioners were not culturally sensitive. They identified the need for better communication between health practitioners and communities, and in particular better cultural understanding from health practitioners. Women expressed concern about what they believed was an increase in caesarean rates

among women in their communities and felt they were rushed into agreeing to have caesareans, which they considered to be unnecessary and culturally inappropriate.

*'We are hurried to have caesarean section... sometimes we feel like objects.'*

Another participant stated that she felt that health practitioners did not engage with female patients or allow the patient to give input.

*'I know what happens to my body.'*

Female participants also spoke of the need for the gender of the health practitioner to be matched to that of the patient. Women participants preferred to be treated by female doctors; a point that was reinforced by one male participant.

*'She would rather lose that treatment than lose her privacy' [in terms of having a male doctor]*

Participants stressed the need to provide social support to individuals who are sick and that this cultural practice should be accepted by hospital staff. Two female participants described the Somali tradition of how unwell people were accompanied from 'a to b', explaining that sick people in their communities are never left alone. They talked about the effect of Somali 'traffic increases' at hospitals; when a member of their community was in hospital, community members are expected to visit and provide comfort. These participants noted that doctors appeared to find this practice frustrating and would ask community members to provide space for the patient.

Participants noted a difference in beliefs between New Zealand healthcare and communities' cultural beliefs about what was important for a patient (Somali: touch, community support, comfort). Participants agreed that community support was an enormously important aspect of care.

### **3.9 Continuity and quality of care**

Participants spoke of the difficulty interacting with different health professionals when they were at hospital or at medical centres instead of one person who knew the participant well.

*'Continuous assessment over a long period, they would be able to know this person better and whether one sickness is creating all these others. They would know exactly what's wrong.'*

### **3.10 Discrimination**

Part of this was simply feeling unwelcome when accessing health services. As one participant noted:

*'[people should]...be appreciated because they are people who have a problem and they live in New Zealand. They should feel welcome.'*

Many women participants felt that doctors didn't take the time to ensure that the patient understood the problem and often they would be referred to the hospital without knowing why. Others felt alienated by doctors especially at hospitals.

Participants in the older women's focus groups agreed that the skills and knowledge they brought with them from their home country were not appreciated, because they could not speak English. One participant, a professional midwife back home, observed that women in her community trusted and valued her expertise, but that her skills were not recognised by health practitioners in New Zealand. She noted that when she accompanied women to the delivery suite, ward staff were dismissive of her knowledge and the support she provided to patients. This participant described a range of experiences from supporting family members, to receiving treatment herself, to trying to ask for a drink of water, where staff were dismissive and impatient.

*'It was like a slap in the face.'*

Other participants described doctors and staff as being rude, judgemental and automatically stereotyping patients.

In contrast, young male participants did not feel discriminated against.

*'They are not racist, by racist I mean they don't care about your...who you are, they just help you.'*

## 4.0 Key barriers

This report has highlighted focus group participants' perceptions of the barriers to achieving and maintaining good health for people from refugee background communities. These include:

- Living in damp, mouldy overcrowded houses.
- Having limited income to buy healthy food, and to support family and friends who are in their home country.
- Having limited English language skills.
- Not having access to trained interpreters who are trusted by communities or being offered an interpreter who was not the same gender as the patient.
- Feeling isolated and not welcomed by 'Kiwis'.
- Being separated from family members who were not in New Zealand.
- Mental health issues not being considered when they presented at a doctor for a physical complaint.
- Having to deal with different health professionals rather than someone who knew them well.
- A lack of awareness of how to keep healthy, particularly for people who don't speak English.
- Unrealistic expectations about life in New Zealand.
- A lack of culturally sensitive health service provision.
- Discrimination.

## 5.0 Recommendations

Participants made a number of suggestions on how to improve health outcomes for people from refugee background communities. These were:

- Prior to their arrival, refugees receive information so that they have realistic expectations of life in New Zealand.
- Houses are upgraded and maintained so that they are warm and dry.
- Families are allocated houses that are appropriate for their family size.
- Greater employment options are made available to people from refugee backgrounds.
- More funding is allocated for English language tuition.
- Health promotion activities include resources targeted at those who do not speak English.
- Greater access to trained interpreters is made available.
- Community members can access trained interpreters whose gender matches that of the patient.
- Family members are supported to resettle in New Zealand.
- Health practitioners are trained to work with culturally diverse patients and to be culturally responsive.
- Health practitioners recognise the important role communities play in supporting people who are hospitalised.
- Health practitioners are educated about refugees, where they have come from and the situation in their home countries.
- Health practitioners take a more holistic approach when treating people from a refugee background that incorporates the patient's mental health, their history and where they have come from.
- Recognition, among health practitioners, of the skills and experience that people from a refugee background bring to New Zealand.
- More acceptance of diversity among the wider community with people welcoming refugees into their community.
- Better coordination and cooperation between refugee service providers including health and other social service agencies to enable interrelated health issues to be addressed.

Participants recognised that the health system alone could not address the issues that they had raised or their suggestions on how these issues could be resolved:

*'They [the health system] have to get help from Housing, from MCLASS from ChangeMakers...anyone who is related to the communities. One hand can't make a sound, two hands makes a sound.'*

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