RESEARCH ARTICLE

Exploring the role-based challenges of providing culturally inclusive health care for maternal and child health nurses: Qualitative findings

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Abstract

Aims: To explore how maternal and child health nurses (MCHNs) working in a specific regionally located service perceive and experience delivering health care to a diverse population.

Design: Qualitative exploratory study.

Methods: Qualitative interviews were conducted with MCHNs (*N* = 6) working in a particular regionally located service. Data were selectively coded, categorized and interpreted through a process of argument writing influenced by poststructuralist thought and Foucauldian conceptualizations of power.

Results: The data analysed were interpreted into the following categories: (a) system-level expectations of the maternal and child health role; (b) what these system-level expectations mean for the role and practice of MCHNs; and (c) what MCHNs themselves report prioritizing in their work. The analysis suggests that a substantial hindrance to the development and support of culturally safe, inclusive and quality maternal and child health care lies in the very ways contemporary health institutions seek to discipline the routine practices of MCHNs.

KEYWORDS

cultural issues, family care, health services research, inequalities in health, maternity nursing, multicultural issues, nurse roles, qualitative approaches, sociology

1 | INTRODUCTION

Despite some social science disciplines' (for example, sociology and anthropology) focus on the processes of culture in health, the knowledge, understandings and perspectives generated in these disciplines about what culture is and how it influences health experiences and outcomes have failed to penetrate substantially, into the health sectors of Western industrialized countries (Kagawa Singer et al., 2016; Malatzky, Mitchell, & Bourke, 2018). In fact, Kagawa

Singer et al. (2016), in their comprehensive analysis of how "culture" has been approached in health research, have argued that no other concept is as poorly understood and examined. For Kagawa Singer et al. (2016) and others (Malatzky & Bourke, 2017; Malatzky, Mitchell, et al., 2018), the "missing link" of culture needs to be fundamentally and substantially engaged with to reduce health disparities within diverse populations.

There is recognition, particularly in nursing literature, that the privileging of White, Western-centric models of health care is one

of the most significant challenges for healthcare systems in the delivery of quality, effective health care to socioculturally diverse populations (Akhavan, 2012; Alshawish, 2013; Gordon, McCarter, & Myers, 2016). This is reflected in increasing evidence that marginalized groups or those occupying non-normative identities within diverse populations continue to receive lower quality health care and experience poorer health than those with normalized identities (Bearskin, 2011; Desouza, 2013; Duffy, 2001; Gordon et al., 2016; Grant & Guerin, 2018; Whittal & Rosenberg, 2015; Woods, 2010). It is here that the concept of culture and what it means for health care is centred. Being responsive to health service users' needs must be informed by, include and require respect for the users' cultural location, their ways of seeing, living in, adapting to, experiencing and extracting meaning from the world (Kagawa Singer et al., 2016). This is a fundamental and essential part of providing safe, inclusive, quality and ultimately, effective health care (Coast, Jones, Lattof, & Portela, 2016; Desouza, 2013; Facente, 2010; Reiger & Keleher, 2004; Ruddock & Turner, 2007; Wilson, Kelly, Magarey, Jones, & Mackean, 2016). This is only possible to achieve when there is widespread recognition and deep reflection on the cultural location and practices of mainstream healthcare systems to which maternal and child health services belong.

The authors understand the concept of cultural safety to be the creation of an environment where all people feel socially, emotionally and physically safe and enabled to be themselves and to ask for what they need without fear (Williams, 1999). Relatedly, in culturally inclusive healthcare contexts, institutional cultures support and facilitate service providers to "relate across cultures" (Dwyer, O'Donnell, Willis, & Kelly, 2016), a process that involves critical self-reflection and introspection at a service level (Malatzky, Nixon, Mitchell, & Bourke, 2018). In this paper, these concepts are employed to diversity in its broadest sense, that is, not solely diversity in terms of differently racialized subjects, but also diversity across other culturally specific formations of human identity, including genders, sexualities, social classes and national identities.

1.1 | Background

During pregnancy and the postnatal period, most women (and their children) living in Western industrialized countries will be in contact with the healthcare system, specifically with maternal and child or family health services (Alshawish, 2013). For some women and/or families, particularly those belonging to marginalized groups or with non-normative identities, this may be the first and only point of substantial engagement with the healthcare system (Akhavan, 2012). Thus, these experiences are likely to affect future use of and/or access to health care. In this context, it is important to recognize that the processes of and practices related to human reproduction and childrearing are culturally informed and embedded. As Abel, Park, Tipene-Leach, Finau, and Lennan (2001, p. 1135) describe, "the way we humans look after our babies is invested with moral value and cultural and personal meaning [and]

infant care practices can differ in significant ways between cultures or social groups...." Thus, respect and accommodation for both cultural and social context have important effects in maternal, child and/or family health.

Yet the healthcare systems of the institutional and clinical practices in many Western industrialized countries have their antecedents in previous eras (Boi, 2000) when attending to the cultural and social contexts and needs of health service users was not considered or engaged with in the routine delivery of health care. Nor is there systemic acceptance of and reflection on the ways that healthcare systems and institutions are themselves cultural systems (Malatzky & Bourke, 2017). Training and working in these structures, contemporary health care providers continue to struggle with the provision of culturally safe and inclusive health care (Malatzky, Nixon, et al., 2018; Reiger & Keleher, 2004; Ruddock & Turner, 2007). In their research of culturally safe family nursing practice, Doane and Varcoe (2006, p. 7) articulate that:

> It is not too difficult to care for families who meet our expectations, who behave in ways we consider to be safe and appropriate, who treat each other the way we think they ought to and who align their actions with our nursing goals.

The "our" and "we" in this context refer to White, heteronormative and upper middleclass subjects, a reality that one particular participant in the study reported on here also acknowledged in describing the service where they worked as a "middleclass service...a lot of services are middleclass, White middleclass...they're run and developed by White middleclass and most of our team, if not all, are White middleclass," which for this participant underscored the "values and the way we [the service] operate." However, nurses "provide care to people and/or families whose values we do not share and who we may see making choices different than those we would make" (Doane & Varcoe, 2006, pp. 7–8). It is the provision of care under these circumstances that are the "hard spots" of family nursing (Doane & Varcoe, 2006). This conceptualization recognizes that because, as a discipline and practice, family nursing is culturally located and culturally informed, as are individual nurses, it is a challenge to provide care to families who do not share similar cultural locations or identities.

In Victoria, Australia, support for child development is provided to families with children under 6 years of age through public maternal and child health services (MCHSs). While funded by state and local governments, MCHSs are also subject to standards set by the federal government. The healthcare providers in MCHSs are "maternal and child health nurses" (MCHNs) (Kruske & Grant, 2012). MCHNs are qualified registered nurses and midwives (tertiary degree qualifications) and have completed further postgraduate qualifications in child, family and community health nursing (Willey, Cant, Williams, & McIntyre, 2018). Currently in the state of Victoria, MCHSs can be accessed by any mother and/or family living in the state with one or more children under the age of 6 years—Australian citizenship or permanent residency is not required (Willey et al., 2018). However,

MCHSs are not compulsory; families can disengage with these services for a variety of reasons, including if their cultural (and other) needs are not being met. However, families are strongly encouraged to use these services and the contact details of families with newborns in local catchment areas are disseminated to MCHSs by hospitals with birthing facilities. MCHNs provide a schedule of 10 key age and stage consultations with children under 6 years of age (Sanders, 2014). These consultations include assessments of children's health and development and surveillance of various childrearing-related practices, which are guided by state derived and mandated "checklists" (Sanders, 2014; State Government of Victoria, 2018). In this sense, the role of MCHNs involves applying, comparing and assessing the population as a whole against a single state sanctioned and, in many ways, sanitized version of culturally situated standards pertaining to childrearing. In this paper, we explore the fundamental practice challenges this creates for MCHNs in providing culturally safe and inclusive health care.

2 | THE STUDY

2.1 | Aim/s

The aim of this study was to explore how MCHNs working in a specific regionally located service perceive and experience delivering health care to a diverse population. Specifically, the research sought to identify the challenges MCHNs encounter in providing culturally inclusive health care. This research represents the first stage in a larger, multi-site project that is seeking to produce new knowledge about how mainstream regional and/or rural health services, of different kinds, can increase their cultural and social inclusivity for a broad range of local community members (Malatzky, Mitchell, et al., 2018). This work is being done in recognition that residents in rural and regional communities have less access to and fewer choices of services than residents of metropolitan communities (Malatzky & Bourke, 2017). The particular regional community where this research was conducted is highly diverse, both culturally and socially; it has the highest population of First Nation Australians outside of metropolitan zones in the state and its residents speak over 60 non-First Nation languages, the top five other than English being Italian, Arabic, Punjabi, Mandarin and Hazaraghi (Australian Bureau of Statistics, 2016). It also has one of the most active regional pride groups in the state and, according to the latest census data, its residents have a higher than national average rate of reporting assistance to family members due to a disability (Australian Bureau of Statistics, 2016). This community could be perceived as unusually diverse for a regional community. However, the dominant understanding of rural communities as homogenous has been heavily critiqued and rural researchers have highlighted the many ways rural communities are and have always been, home to diverse populations (Carter & Hollinsworth, 2009; Malatzky & Bourke, 2016). Despite the historical and contemporary realities of heterogeneous rural Australian populations, perceptions of rural homogeneity remain dominant in the broader populace and influence how rural practice can be perceived by practitioners as providing health care to a homogenous, mostly White, Anglo-Saxon community (Malatzky & Bourke, 2016).

This research was guided by the following research questions:

- How do participants (MCHNs) perceive and currently experience providing health care to a diverse population?
- What are the in-practice challenges of providing culturally inclusive health care?

It should be noted that the larger project where this research is situated focuses on mainstream services in regional and rural communities. However, the specific service involved in the research reported on here is a regionally located health service.

2.2 | Design

An exploratory qualitative approach was taken in this research (Gibson, 2009). The MCHS from which participants were recruited had been identified by the researchers as a possible case study site for the larger project given that MCHSs are a universal point of access to the healthcare system and provide health care to women and/or families from across local communities (Sanders, 2014). The manager of the MCHS (also a MCHN) was approached by the researchers and following an initial discussion to ascertain the level of interest in the project was presented with a proposed research plan for discussion and modification. Once a tentative plan for the research had been agreed between the researchers and the service's manager, along with another senior MCHN from the service, the researchers presented the proposed research plan during an all-staff meeting to elicit interest in, as well as advice and guidance about, conducting the research with the service. During this meeting, the specific aims of the research, including the aims and research questions of the initial phase reported on in this article, were discussed and agreed in consultation with staff.

2.3 | Sample/Participants

To begin the study, all MCHNs employed by the service (N = 16) were invited to participate in a face-to-face, one-on-one, semi-structured interview with a member of the research team. A copy of the Plain Language Statement (PLS) and Consent Form (CF) was emailed to all MCHNs, which included the contact details of the researchers. Staff interested in participating in an interview were asked to contact a researcher, either via telephone or email. Once contact had been made, the researcher liaised with each potential participant to find a suitable time to meet in person, to discuss the information disseminated in the PLS and CF (hardcopies also brought by the researcher for the participant) and if consent was given, conduct the interview. Six MCHNs contacted a researcher and subsequently took part in an interview. Two participants had been MCHNs for five or less years;

the remaining participants had been MCHNs for over five years, two for close to a decade.

Data saturation, as a particular epistemological position and theoretical practice originating in grounded theory (O'Reilly & Parker, 2013), was not a concept ascribed to in the design of this research. This decision is consistent with current understandings amongst qualitative researchers that data saturation is not always an appropriate or theoretically consistent practice to adopt (Barbour, 2001; Caelli, Ray, & Mill, 2003; O'Reilly & Parker, 2013). Other traditions within the qualitative paradigm emphasize how, given the uniqueness of each individual's life context, new ideas and meanings can always be generated from qualitative data, complicating the idea of data saturation, as it is commonly used in non-grounded theory-based qualitative research (O'Reilly & Parker, 2013; Wray, Markovic, & Manderson, 2007). Given the explorative nature of the study, the participant sample was considered adequate to engage with the aims of the research (Morse, 1995; O'Reilly & Parker, 2013).

2.4 | Data collection

Interviews were conducted between March 20 and April 20, 2018. At the preference of participants, interviews took place in participants' consulting rooms and ranged in length from 30–56 min, with an average duration of 42 min. Two different, experienced academic qualitative researchers conducted the interviews (half each), which were, with the permission of each participant, audio recorded. A flexible interview guide was used to focus the conversation on key questions (Denzin & Lincoln, 2011) pertaining to: the work of MCHNs; what is most valued in interactions with clients; perceptions of cultural, social and structural barriers to access; the idea of cultural and/or social inclusion in health and its practice; engagement; the identification of particular groups of women who are challenging to engage/there is a concern about in terms of access and engagement; and how the goal of the larger project (increasing cultural and social inclusivity) could be progressed within the service. Written consent was given by each participant. Handwritten notes were also taken by the researchers during the interviews, with the permission of participants, to enable recall of particularly pertinent sections of the discussions for later consideration (Miles & Huberman, 1994).

2.5 | Ethical considerations

Researchers requested that the senior MCHN who was involved in preliminary discussions with researchers about the project disseminate the email inviting participation to staff so that if staff did not wish researchers to have their individual email addresses, that could be respected (at a later point in the research, staff elected to give a researcher their email address to enable direct communication). However, once the researcher was contacted, communication was direct and confidential; neither the manager of the service, nor any other staff were informed by researchers who did or did not participate in an interview. Ethics approval was granted from a Victorian (State of Australia) university prior to the commencement of data collection.

2.6 | Data analysis

The audio-recordings of the interviews were transcribed verbatim into separate word documents, assigned a number (later replaced by a pseudonym) and checked for accuracy against the original recordings (Nikander, 2008; Richards, 2015). The transcribed data were then selectively coded and categorized in relation to the principal research questions (Braun & Clarke, 2013) by the first author. The resulting codebook, along with the transcribed interview data, was then disseminated to other members of the research team for cross-checking and refinement (Denzin & Lincoln, 2011). Through the process of argument writing (Connell, 2015), categorized data, specifically those categories pertaining to the challenges of providing culturally inclusive health care were further interpreted. In this process, data were treated analytically and connected with existing literature to develop and deepen the exploration and interpretation of data (Braun & Clarke, 2013).

The authors draw on a form of poststructuralist thinking labelled "feminist poststructuralism" to facilitate insight and interrogate meaning in the data. This form of poststructuralist thought focuses on understanding both how power is exercised and how social relations can be transformed (Weedon, 1997). Weedon (1997, p. 40) describes how a feminist poststructuralist lens "decentres the rational, self-present subject of humanism, seeing subjectivity and consciousness as socially produced in language, as sites of struggle and potential change." From this perspective:

> Meanings do not exist prior to their articulation in language and language is not an abstract system, but is always socially and historically located in discourses. Discourses represent political interests and in consequence are constantly vying for status and power. The site of this battle for power is the subjectivity of the individual and it is a battle in which the individual is an active but not sovereign protagonist.
>
> (Weedon, 1997, p. 40)

The theoretical work of Michel Foucault, most specifically his theorizations on discourse and power as "tools" for the critical analysis of the workings of power, is considered foundational to feminist poststructuralist frameworks. From a Foucauldian perspective, power is a relation exercised through discourses, which in turn constitute knowledge, social practices and human subjectivities (Foucault, 1988; Sawicki, 1991; Weedon, 1997). Thus, discourses are central to the way human perception, experiences and actions are governed. Foucault argued that institutional

discourses are particularly dominant and influential in society and in directing organizational practices, but that institutions are also key sites of contestation and power struggles (Foucault, 1988; Weedon, 1997).

2.7 | Rigour

The way qualitative research should be assessed is a contested topic (Finlay, 2006), with various different models and criteria for the evaluation of qualitative research proposed (Bochner, 2000; Finlay, 2006; Henwood & Pidgeon, 1992; Lincoln, 1985; Madill, Jordan, & Shirley, 2000; Polkinghorne, 1983; Richardson, 2000). There is agreement, however, that it is important to use criteria that are sensitive to the epistemological, theoretical and methodological traditions and practices used in a particular piece of qualitative research. In acknowledgment of these complexities, effort has been made to clearly describe the research and to provide participant extracts that evidence how the interpretations presented below were formed (Finlay, 2006). Care has also been taken to demonstrate respect and sensitivity to the perspectives and positions of participants (Finlay, 2006). The practice of member checking with verbatim interview transcripts is currently being critiqued and re-evaluated by feminist researchers (Birt, Scott, Cavers, Campbell, & Walter, 2016). However, a succinct report, which included the findings discussed in this article, was hand-delivered to participants and discussed in an informal all-staff meeting to check the analysis with participants and other staff, all of whom expressed that the interpretations of the interview data were relatable.

3 | FINDINGS

3.1 | System-level expectations

Dominant societal institutions, including health and education systems and local governments, expect MCHNs to monitor, survey and discipline the childrearing practices of families against a set of governmentally sanctioned standards (Sanders, 2014). This expectation is established and enforced through the creation of a series of checklists, monitoring procedures and directed interventions that MCHNs are mandated to perform (State Government of Victoria, 2018). This means that considerable attention and focus are directed to undertaking this work. This is illustrated in Lara's description of the MCHN role:

> ...it's quite a prescriptive job in many ways, there are lots of boxes to tick...there is a pressure sometimes, I think, to get all the tasks that are; so we have our guidelines that we follow and all the things that we need to achieve or get done...there is an element of pressure there to get that done.

The standards that MCHNs are given to measure childrearing practices against—the tick boxes—are culturally contingent standards. That is, what are considered "good" childrearing practices are not universal assessments; decisions about how children should be reared and how families should function are culturally informed and different cultures have different standards against which practices are measured and assessed (Scheper-Hughes, 1992). By judging the childrearing practices of all families against a single standard, the culturally contingent nature of these assessments is ignored and made invisible.

3.2 | What these system-level expectations mean for the role

The way the health system disciplines MCHNs by regulating the activities and practices that define the role to ensure that monitoring, surveillance and intervention are prioritized creates an important conflict for these practitioners. It means that the goals of MCHNs include changing specific childrearing practices that deviate from an unspoken and highly privileged, cultural norm—that of dominant Western, predominantly White, middleclass and heterosexual approaches to childrearing (Gerlach, Browne, & Greenwood, 2017). This is despite calls from within the nursing profession to move away from a focus on changing individual behaviours towards providing "options" within the "cultural contexts" of clients (Basnyat, 2011). Thus, while Rose expressed that "...we're not invasive...[we have] their best interests at heart...," in describing how a client had objected to her making a "cold call", she also explained how:

> ...she [the client/mother] was worried that I was coming to question her parenting perhaps and I might have been. Yeah, she was worried about what I might find in her house perhaps, or she thought I might tell her that she's doing everything wrong. I guess that's part of our role as well, is that we try and encourage, you know, give them recommendations of how to parent. No one wants to be told that they're not doing a great job parenting [emphasis added].

In this sense, the role and work of MCHNs are highly invasive because it involves making assessments and judgements, which are unacknowledged as culturally contingent, about the way children are raised, a highly meaningful, culturally based practice. This centres one of the underlying challenges for MCHNs to provide culturally and socially inclusive health care to families—as several participants expressed, the role is not just about weighing babies—and therein lies the struggle. The role involves making cross-cultural judgements about how children should be raised in an institutional environment that does not support the systemic recognition and understanding of cultural difference and culturally contingent childrearing practices as a critical component to

providing quality health care to diverse populations (Abel et al., 2001; Boi, 2000).

By instituting a monitoring, surveillance and intervention in the case of deviancy from the norm dimension to role of MCHNs, the health system reinforces and encourages the proliferation of othering processes in maternal and child health nursing. For example, several participants in this study, however implicitly and unintentionally, used talk that portrayed the knowledge held by "us" (the nurse; the subject observing and assessing the family's childrearing from a particular cultural location and discipline, something that is largely left unexamined, as a requirement of the role) as superior to the knowledge held by "them" (the family, often in reference to families from non-normative locations or positions) about rearing children and implying that "we" are in a position to educate "them" about childrearing. This kind of talk was often drawn on as participants simultaneously expressed an understanding, developed through practice and experience in the role, that there are different (to the White, middleclass, heterosexual norm), equally valid, ways of raising children, as articulated here by Maria:

> ...this is what their family has done for generations and here's this little white chick comes in telling me what to do about how I raise my children...[you have to be] very, very sensitive to a family's understandings, expectations, prior knowledge and thinking about that before you open your big mouth...I think that's probably where some nurses don't do so well and miss out on engagement because they're so focussed on I've got to get through this, this, this and this and it has to be done this way, this way, this way. Being a bit flexible to what you're getting back off the family and adapting what you're presenting, sort of heading towards a like common goal, maybe not exactly what we were looking for, but it fits with the family better and trying to make it safe for the family and children as well.

3.3 | What these system-level expectations mean for practice

In practice, the requirement for MCHNs to enact the monitoring, surveillance and intervention dimensions in the role compromises the ability to engage and connect with families, which affects practitioners' capacity to provide quality health care to families. This was articulated by Jane when she was describing:

> [when we do a home visit] ...there's a tick sheet that we have to do to run through all the SIDS talk, the talk that we give at the home visit and it does, it feels a bit like the police and that's something I've always struggled with...I just really struggle with it...[from observations] I just saw it, I could see it in her [a mother's] face, I thought oh there

> goes that one and it did – the rest of the visit was really hard work...

Here, Jane's account illustrates the disengaging effect that having to make culturally contingent judgements about childrearing practices can have on families—Jane could "see" her client disengaging and withdrawing from the consultation as a result of having her maternal practices assessed and measured against a selected and de-contextualized norm. According to Bearskin (2011), nursing care is unsafe if a client feels humiliated or alienated, which, based on Jane's description, was most likely the case in the above-mentioned scenario and in others described by participants in this study. Jane and other participants were aware of the precarious situation current "guidelines" around monitoring and surveying families in these kinds of ways put MCHNs—the risk that, potentially, the care provided can be culturally unsafe as a consequence—and in practice, participants described a kind of negotiation or "an internal professional conflict" and for some, an awareness of both the imperfection in official guidelines (for example, that there is evidence both in support of and against, which is the official position, the practice of co-sleeping) and an understanding, gained through practice, that performing the role of surveyor compromises the ability of MCHNs to engage and therefore work with families; an effect that research with mothering women has also highlighted (Malatzky, 2013).

3.4 | What is important to MCHNs in their work?

In contrast, participants' articulations of the mandated priorities in their roles, in response to what participants themselves most valued in their work and interactions with clients, the concepts of relational engagement and client trust featured in all participant narratives. Participants often described that to engage with clients, focus needs to be placed on the mother (participant language) and the "agenda" needs to be put aside:

> ...my aim is to make the woman leave feeling like her concerns have been heard, so that's usually the opening question, is there anything you wanted to talk about today or to discuss because we have our agenda that we're supposed to follow and tick boxes and you know get our stats in order. But occasionally that doesn't even get done in a visit if she's got other concerns. So, it could be anything she might have had a fight with her husband, she might have a crying baby so the whole visit is kind of focussed on dealing with immediate concern...

> Focussing on what the family wants from the situation rather than working from our agenda because if you do it from the other way around it just doesn't work...

Here, participants assigned priority to the mother feeling "heard" and feeling as though her concerns have been addressed. This was viewed as essential to establishing trust with a client, which in turn

was described as necessary for the client to feel comfortable telling them the "true picture" or their "true story." For Chloe, it is an honour to be entrusted with "the truth" and she described a need to respect the position of the client and to offer relevant advice or guidance from their position, sensitively and carefully:

> ...I listen to what the families have to say and co-sleep, well you know you've gone through the safe practices of sleeping and I suppose I'm flattered that they might say well I do co-sleep...I'm happy they can tell their true story...and then I can maybe guide...

In describing a similar context, Maria explained how important it is for her relationship with clients to "keep it [the consultation] as an open conversation, rather than telling them what they need to do." Maria described her work as "a relationship between the two of us [with the mother], where we're working together."

4 | DISCUSSION

This research aimed to understand how MCHNs in a particular regionally located service perceive and currently experience providing care to a diverse population. Further, it aimed to identify some of the in-practice challenges MCHNs in this service experience in providing culturally inclusive health care. The findings suggest that a substantial hindrance to the development and support of culturally safe, inclusive and quality maternal and child health care lies in the very ways contemporary health institutions seek to discipline the routine practices of MCHNs. The requirement of the state for Victorian MCHNs to use a range of checklists and other standardized measures to: assess a diverse range of culturally situated and meaningful mothering and/or family practices; compare to a prescribed age-specific norm; and "intervene" when there is a malalignment is a clear demonstration of what Foucault (1988) described as biopower. Manifest in two forms, disciplinary and regulatory (Sawicki, 1991), Foucault (1988) describes biopower as the technologies of power used by institutions to control, manage and regulate populations. In this context, through the mandating of checklist procedures, the healthcare system seeks to discipline the practices of MCHNs; to control their conduct, the very work they do, with the specific aim of regulating the childrearing practices of a population. The foci of this site of regulation, intimate family life, are consistent with the state's long-term preoccupation with reproduction, maternal bodies, birthing and predominately, mothering practices (Butler, 1993, 1997; Connell & Walton-Roberts, 2016; Feder, 2007; Foucault, 1988; Sawicki, 1991; Smith, 2007).

Yet as the narratives of participants in this study elucidate, the particular positionalities of MCHNs within the healthcare system and the complexities produced for practice can work to agitate both the disciplinary and regulating intentions of the state. Similar to Aston (2008), who writes about nurses as "social mediators," the findings of this research suggest that MCHNs are simultaneously

disciplined, predominately through their midwifery training, to highly value and prioritize their relationship with the patient/mother (sometimes family), which often challenges the ways they are encouraged to regulate childrearing practices by the health system. In the role of MCHNs, a site of struggle is created between medicalized and midwifery discourses, as well as broader cultural discourses (Newnham, 2014; Zerwekh, 1992) through which MCHN practice is guided. May (1992) describes a similar context in their analysis of nursing work. In an exploration of nursing practice as part of the social, May (1992) articulates how the work of "knowing patients as individuals," prioritized in more holistic models of health care, subverts the mandate of the clinical gaze. Thus, while the technologies of biopower work to suppress other modes of interaction, there are micro-relations of power at every level of the social body (O'Farrell, 2005); meaning that MCHNs can draw on alternative disciplinary discourses that govern their practice in different ways to inform how they work with clients.

There is increasing recognition that "culture" and socio-cultural diversity within a population has critical implications for nursing practice, which is itself located within a White, Western-centric cultural context. There have been sustained calls, under various terminology umbrellas, for broader conceptualizations of culture and cultural processes to be embedded into nursing education and on-going learning development (Browne, 2005; Crawford, Stein-Parbury, & Dignam, 2017; Desouza, 2013; Gerlach et al., 2017; Grant & Guerin, 2018; Grant & Luxford, 2008; Janevic, Sripad, Bradley, & Dimitrievska, 2011; Lynam, Loock, Scott, & Basu Khan, 2008; Renzaho & Oldroyd, 2014). The analysis presented here suggests that while these strategies are important, there remains a lack of firm, institutional commitment to supporting the comprehensive implementation of these initiatives. Thus, substantial critique needs to be levelled at the biopolitics involved in regulating the conduct of MCHNs. It is suggested that currently, power relations at this level are shaping how MCHNs can understand and negotiate between different cultural norms and practices. From the findings presented here, MCHNs can be aware of both the need to work with respect to the cultural context of their clients and how the current requirements in their role compromise that objective. We need to address what is restricting broad engagement with the complexities of culture and cross-cultural practice—how the (re)production of institutional practices are restricting the development of culturally inclusive health care.

4.1 | Limitations

Qualitative research can sometimes hold relevance for more generalized understandings (Braun & Clarke, 2013). However, it is grounded in the aim to capture, understand and interpret localized meanings embedded in social life through the collection of complex but narrow data and consequently, does not require large participant numbers (Braun & Clarke, 2013; Goodson & Vassar, 2011). Having considered this, the authors acknowledge that the participant sample reported on in this article is a small one and

contextualized within a single MCHS. Thus, suitable qualifications, specifically in relation to evidential claims, have been used (Finlay, 2006).

5 | CONCLUSION

The findings from this study highlight some of the systemic ways the healthcare system seeks to regulate the practices of MCHNs, which, when considered in the relational context of MCHN praxis, contribute to the perpetuation of culturally unsafe health care. The analysis presented in this article adds to current debates and knowledge about the challenges of providing culturally safe, inclusive and ultimately, quality maternal and child health care under current constraints. It has been suggested that to support change initiatives, critical attention must be focused on the forms of bio-power that are restricting flexibility in practice and circumventing the comprehensive uptake of culture-centred (in its broadest sense) curricula in educational and learning environments; curricula that could lead to radical changes in how health care is provided to diverse populations.

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