

**Nursing Praxis, Racialization, and ‘Othering’: An
Ethnography of Breastfeeding Promotion in
Urban, Western Canada**

by

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Abstract

This thesis examines how public health nurses (PHNs) racialize and 'other' mothers during the postpartum period. This study was conducted over seven months in urban, western Canada. Ethnographic methods included participant-observation, semi-structured interviews, and gray literature analyses. They helped to uncover the multifaceted ways public health nursing praxis reproduces and reifies racialized notions of 'Chinese' mothers in breastfeeding promotion contexts. I find that the historical professionalization of nursing, the medicalization of breastfeeding, and health promotion protocols shape how PHNs ascribe 'race' to women in relation to infant feeding. Further, racialized stereotypes and acts of 'othering' are concretized in nursing praxes. Even as nurses sometimes actively resist and regret these stereotypes, they nevertheless create contexts of exclusion that reinforce boundaries of citizenship and belonging for postpartum mothers and their infants. Most significantly, clinical practices pervasively mired in raced ideas of 'others' lead to differential care for mothers and their infants.

Keywords: racialization; othering; nursing praxis; breastfeeding; Canada; public health nursing

Dedication

I dedicate my thesis to the participants in this study and to all nurses who strive to reduce inequities. During my research, one nurse told me, “Please let us know if you find something that can improve our practices, especially if it is something that impedes care.” I know that this thesis may be difficult at times for public health nurses to read, but for those who do, I thank you for your willingness to listen and to consider how nursing praxes impact mothers and babies.

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List of Acronyms

BC	British Columbia
DHA	District Health Authority
MSc	Master of Science
PHCR	Public Health Critical Race
PHN	Public Health Nurse
SES	Socioeconomic Status
SFU	Simon Fraser University
TCN	Transcultural Nursing
WHO	World Health Organization

Glossary

Breast engorgement	This occurs in the postpartum period when breast tissues expand owing to pressure from the making and storing of breast milk (Walker 2006)
Cisgender	Individuals' experiences of their own gender agree with the sex they were assigned at birth (Wikipedia 2015).
Colostrum	Colostrum is breastmilk that is produced by the mammary glands of mammals (e.g., humans) during the early postpartum period and in late pregnancy. Colostrum has many health benefits, including antibodies that protect the newborn against disease.
Disparity	Marked differences in health outcomes that are deemed unequal, but the inequality is not based on normative judgements (Community Health Nurses of Canada 2013).
Essentialism	The belief that things (e.g., an animal or a person) have a natural 'essence' which identifies its function (Fuss 1989).
Exclusive breastfeeding	This infant feeding style means that a baby will only receive breastmilk and required medications. A baby will not receive other fluids (i.e., formula and water) or other foods This is the WHO's recommended infant feeding style for the first six months of life (2011).
Inequity	Whitehead (1992) defines health-based inequity as "differences in health which are unnecessary and avoidable but, in addition, are also considered unfair and unjust." For example, unequal health outcomes that occur due to unfair, socially produced systems (e.g., racist systems and policies) can contribute to inequitable health outcomes.
Lactogenesis	A biomedical term referring to the fact that changes in the breast occur prenatally and in the postpartum period, such that the breast is able to make and secrete milk (Neville et al, 2001).
Latch	This is a common term in public health nursing settings where the nurse and the mother discuss whether the baby is able to actively grasp onto, and feed from, the breast.
Mix Feed	This feeding style is when the mother or family occasionally provide formula supplementation at structured or unstructured feeding times. Mixed feedings can occur after breastfeeding (by bottle or breast) in order to 'top-up' the baby if the family believes the baby is still hungry. Formula might be given without offering the breast at certain times, and the mother may want to breastfeed at other times.

Othering	The process whereby a person who has power evaluates her/his own ideological norms and creates an 'other' based on the other person's perceived divergence from the norm (Said 1978).
Postpartum	The time period from the birth of a baby to about six weeks after its delivery.
Praxis/Praxes	The interweaving of nursing practice, theory, policies, protocols, as well as the socio-historical environment and the experiences of the nurse which create a particular kind of clinical encounter.
Race	This is a socially constructed concept that is often backed by science and medicine. However, scientific evidence has determined that race is neither biologically nor genetically valid. Nonetheless, race can impact the body through racism (e.g., health providers could provide sub-optimal treatment and care owing to their acceptance of racist ideology) (Krieger 2000; Gravlee 2009; Chapman and Berggren 2005).
Racialize, Racialized	To racialize someone is to give them an identity that they may or may not identify with. Identity attribution is based on local and contemporary racial and social hierarchies and is perpetrated by people in positions of power (e.g., dominant racial groups) (Fanon 1952; Fassin 2011).
Racism	This concept is based on false beliefs about people's inherent qualities and their social value in relation to racial hierarchies built on ideas of superiority and inferiority (Reading and de Leeuw 2014). Racism is demonstrated in various ways including interpersonal relationships, internalized ideas, structural systems, and epistemologies (Reading 2013; Jones 2000).
Top-Up	An activity where someone supplements breastfeeding or breast milk by giving the baby formula after a feeding.

Chapter 1. Introduction

How I Became Interested in ‘Race’ and Breastfeeding

During the early stages of my Masters of Science degree, I worked part-time as a public health nurse (PHN) with postpartum mothers and young families. Even though I had previously worked as a PHN with mothers and babies in the Yukon and Haiti for three years, I still had many questions about my own practice; this was especially true because I was working in a new location (British Columbia) and was providing a lot more breastfeeding support due to the relatively higher number of births in this densely populated urban area.

After a particularly difficult week, I asked a colleague to debrief with me. Two of my clients with newborns had ceased breastfeeding and were now exclusively formula feeding. I was concerned that I was not providing adequate care or the right kind of support. The nursing assessments I conducted did not indicate that the mothers were having problems regarding lactogenesis and the ‘latch.’¹ More importantly, both mothers had originally expressed a desire to exclusively breastfeed.

My colleague, a woman who self-identifies as Asian-Canadian,² looked at me sympathetically and said, “I have a question. Are they Chinese? I know that sounds racist, but it’s not.” Nurses are trained to assess their client’s ‘culture’ using Leininger’s Transcultural nursing (TCN) theories, and I felt that my colleague’s judgements regarding ‘Chinese’ mothers most likely stemmed from that perspective. (Leininger’s work and its contribution to the conflation of race

¹ Lactogenesis refers to changes in the breast that occur during pregnancy and in the early postpartum period, so that the breast is able to make milk (Neville et al., 2001). The ‘latch’ refers to the baby’s ability to actively grasp onto, and feed from, the breast.

² I deconstruct this term and its problematic usages in Chapter 4.

and culture is discussed at length in Chapter 3). I had always strived to provide culturally appropriate care, yet I felt that this kind of ‘culturally competent’ care conflated ‘race’ and culture, which could lead to racial stereotypes. At the same time, it simplified breastfeeding challenges. As a result, I set out to study ‘race’ and culture in nursing praxes.

As in the incident described above, nurses are regularly encouraged to consider the patient category of ‘Chinese’ mothers³ when considering care options. As categories of ‘race’ and culture became conflated, I wanted to learn more about nurses’ use of those two concepts. I began to wonder if I had been too quick to gloss over that potentially racist comment because I had also been trained in nursing school in theories of ‘culture.’ Did nursing education and theories render us more complicit with racist categorizations? Does nursing theory and practice reify notions of ‘race’?

My thesis delves into these questions, asking how nursing praxis can simultaneously encourage raced assessments and protocols even as it purportedly promotes equitable nursing care.⁴

When I discuss *nursing praxis*, I mean the everyday work of a nurse during clinical encounters. Nursing praxis is the dynamic relationship between nursing theory and everyday work practices, as well as how a nurse’s own lived work experience is impacted by her or his own specific historical location. I focus on both nursing activities (assessments, protocols, care) and on nurses’ personal historical contexts, the latter because biomedical providers often pay more attention to their clients’ culture rather than acknowledge their own routines as cultural practices (Chapman and Berggren 2005). Taylor (2003) and Traweek (1988) refer to this aspect of biomedical clinical culture as “the culture of no culture.”

My findings contribute to the anthropology of nursing by informing what is known about the nursing professions’ knowledge practices. Because nursing differs so substantially from how other biomedical professions provide care, it is important to analyze nursing praxis separately.

³ From here on, I put the words ‘Chinese’ in quotations to signify that ‘Chinese’ people have historically been deemed an essentialized, homogenous group in Canada (Ward 2002). Additionally, the label ‘Chinese’ not only signifies a country or an ethnic categorization, it also conveys a socially constructed, raced connotation.

⁴ ‘Race’ is also in quotations to remind the reader of its socially constructed nature.

Studying public health nursing as a unique biomedical profession also contributes to our understanding of ‘multiple biomedicines,’ thereby avoiding the common tendency to essentialize and totalize biomedicine (Hahn and Kleinman 1983). Attending to actual nursing praxis facilitates a reassessment of nursing education and praxes, a theme I aim to pursue in future work.

Background

Why Should We Look at Breastfeeding and ‘Race’?

Once I became interested in finding out whether breastfeeding outcomes in nursing contexts were being overdetermined through racial descriptors, I researched biomedical breastfeeding studies of why mothers stop breastfeeding. What I learned propelled me to explore breastfeeding inequities and disparities research. As my colleague’s comment suggests, the majority of biomedical research focuses on mothering practices rather than on nursing praxes. I found very few investigations of how nursing praxis could contribute to breastfeeding disparities and inequities. I also noted that biomedical research tended to ‘victim-blame’ mothers by ignoring important socio-historical reasons for breastfeeding inequities.

In Canada, breastfeeding initiation and duration rates are considered health indicators, which attempt to understand health status and health system performances for broadly defined population groups (Health Canada 2012). Breastfeeding inequities and disparities are measured by looking at the length and exclusivity of breastfeeding in relation to demographic categories. Biomedical research relies heavily on the demographic category of ‘race’ as the reason for breastfeeding disparities (Dodgson 2012). However, even when ‘race’ is correlated to breastfeeding initiation and duration rates, there appears to be a lack of interest in discerning why and how this category affects inequities (Dodgson 2012).

Biomedical research typically presents ‘race’ as a variable, a finding, or “an explanation rather than as data in need of analysis” (Chapman and Berggren 2005:147). As such, I am interested in how deployments of the ‘race’ concept are used in health care contexts, particularly in relation to how nurses understand breastfeeding inequities and disparities. Throughout my research, I

am cognizant of the problematic historical and contemporary usages of 'race,' such as grouping disparate and unique individuals based on perceived innate biological, genetic, physical and, therefore, social qualities (Marks 2011). I am also aware that scientific evidence has disproved that 'race' is biologically and genetically determined—that it is, in fact, a social construct. Yet, 'race,' as experienced through racism and discrimination, can have biological consequences through such mechanisms as differential care and treatment (Krieger 2000; Gravlee 2009; Chapman and Berggren 2005). Therefore, I am interested in how 'race' as a concept is efficaciously used in relation to breastfeeding and nursing praxis. Studying connections between 'race' and infant feeding within health care contexts is particularly revealing because reproduction and child rearing are intimate places where societal norms and expectations are enforced, in addition to being targeted sites of reformation for racialized groups (Jolly, 1998; Berry, 2010). I discuss how racialized mothers' infant feeding styles are monitored by the state in Chapter 2.

Currently, breastfeeding is promoted based on scientific facts regarding breastmilk's superior immunological and nutritional qualities. This knowledge is the basis of standardized recommendations that breastfeeding be promoted by health care professionals and institutions. The World Health Organization (WHO), the United Nations Children's Fund, the Public Health Agency of Canada, Health Canada, the Canadian Pediatric Society, the Canadian Nurses Association, the Canadian Association of Midwives, and the Dieticians of Canada all promote exclusive breastfeeding as the best way to feed a child for its first six months of life. Exclusive breastfeeding means giving no food or drink to the baby except breastmilk and required medications; it means that babies will not receive other fluids such as formula and water (WHO 2011). Once the infant is six months old, the recommendation is to continue breastfeeding while introducing nutritious solid foods until the child is two years of age or older (WHO 2011). These are the current, global breastfeeding recommendations, and they are used and endorsed in Canada.

During my public health nursing orientation, I took a 20-hour breastfeeding course through Perinatal Services B.C. called *Breastfeeding: Making a Difference* that outlined its benefits.⁵ I was given information that explained that breastfeeding provides perfect nutrition, reduces the chance of infections, and promotes optimal brain development for infants. For the mother, breastfeeding can reduce the risk of ovarian and breast cancers as well as decrease the risk of osteoporosis and type 2 diabetes. Breastfeeding also promotes infant and maternal attachment and bonding. Moreover, exclusive breastfeeding primes the mucosal lining of the digestive system, and even one bottle of formula can negatively change an infant's delicate digestive system (Dai and Walker 1999). The course highlighted that exclusive breastfeeding can improve many aspects of an infant's and mother's life, but especially their health status.

British Columbia has one of the highest breastfeeding initiation rates in Canada (Ministry of Health 2012). My research focused on biomedical care providers who provide infant feeding support following breastfeeding initiation in the hospital as B.C. exhibits relatively low duration rates (Ministry of Health 2012). The breastfeeding initiation rates in B.C. are approximately 95%, whereas exclusive breastfeeding upon being discharged from the hospital are 72%, and exclusive breastfeeding at six months is only 33% (Ministry of Health 2012). As the statistics show, many mothers in B.C. initiate breastfeeding, but they typically do not continue for six months, as per the WHO recommendations. Thus, my research focused on PHNs who provide services to postpartum mothers, their infants, and their families in postpartum community settings.

Aims of Thesis

While biomedical research has primarily focused on mother's infant feeding practices, I instead examine biomedical care providers themselves and how they understand breastfeeding inequities and disparities. Since I am interested in PHNs' own beliefs regarding the reasons for breastfeeding disparities and inequities, my research looks at how professional nursing praxis

⁵ Most of the participants took this same course.

'works on' and 'creates narratives about' postpartum, lactating, and non-lactating bodies. I theorize that nursing practices reinforce and reproduce 'facts' of 'otherness,' which have the potential to limit health care opportunities and outcomes for particular mothers and infants. The aim of this study is to explore whether and how professional knowledge, discourse, power, and notions of reality intersect to create and maintain ideologies of 'race' and 'otherness' in public health nursing contexts in B.C., Canada.

As my research process was iterative-inductive (a concept detailed in the Methodology section), new hypotheses emerged during fieldwork. My study originally looked exclusively at racialization; however, I soon realized that racialization alone did not fully account for what I was observing and hearing in the field. Thus, I needed to delineate the complex folding and unfolding of racialization as well as 'othering' in B.C.

Theoretical Orientation & Frameworks

As the central focus of my thesis is on the construction of 'race' and 'otherness,' I am drawn to history and social structures, particularly the dialectic making of embodied race through racialization. Racialization here refers to identity attribution based on perceived racial characteristics in relation to the prevailing social hierarchy. As Didier Fassin explains, "ascribing someone racially is therefore not only imposing an identity upon [her]: it is also depriving [her] of possible alternative identifications, including the mere possibility of multiple belongings" (2011:423). Thus, racialization is a way to exert power over another and assert the superiority of one's own 'racial' knowing over the lived experiences of the racialized person. Racialization can be employed for many reasons: to label, to appraise, or to validate oppressive practices (Fassin 2011).

Additionally, I am interested in "how races become embodied" (Fassin 2011:421). Fassin notes that the body is the place where racialization is employed, felt, and enacted. He further argues that:

The world is not exterior to me; it is what I perceive of it and this perception is embedded in history but also constitutes history. What makes the world exist is

therefore the body, which is the site through which the world comes into being within its spatial and temporal frame. (2011:428)

My thesis connects how historical configurations of maternal practices, professional nursing praxes, and racial ideologies continue into the present day. Although my research does not record first-hand accounts of postpartum mothers' realities, experiences, and reports related to racialization, the framework used is appropriate because it acknowledges the interconnections between historical and contemporary forms of racialized bodily processes. Thus, it is important to examine racialization and 'othering' when observing social interactions, especially when the terms of contact are related to bodily processes and professional obligations.

Furthermore, these social interactions are maintained within normative biomedical frameworks. If an interaction is seen to diverge from the norm, 'othering' can result. 'Othering' refers to the process by which the hegemonic subject evaluates her own ideological norms and creates the 'other' based on the perceived divergence from the hegemonic norm (Said 1978).⁶ In brief, 'othering' is a process of locating a person in relation to oneself, while racialization firmly situates the person in an understandable, fixed place. Racialization and 'othering' intertwine because both processes are predicated on perceptions of difference that are evaluated and assessed from a privileged place of power. Within the health care system domain, my participant PHNs hold positions of power vis-a-vis clients; they are thus able to ascribe 'race' and 'otherness' in particular ways. The processes of racialization and 'othering' are discussed in the next section.

⁶ The hegemonic subject in my study is the PHN because of her professional knowledge surrounding infant feeding and lactation. However, it must be stated that, contemporarily, the 'hegemonic' Canadian would most likely be read as 'White' and middle-class; it is important to note that not all of the PHNs interviewed would be socially constructed as 'White' in Canada. For example, a few participants bring up their "Chineseness," while other participants mention additional social locations and positions during interviews that signalled their 'non-White' or differently located statuses.

Research Design and Methods

Critical ethnographic research is an excellent way to explore whether and how professional knowledge, discourse, power, and notions of reality interact to create and maintain ideologies of 'race' in health care contexts. Ethnographic methods, including participant observation and semi-structured interviews, illuminate how professional practices contribute to processes of racialization and 'othering.' The following section outlines my setting and methodology (participant observation, semi-structured interviews, and gray literature) and touches on demographics and the participant recruitment strategy used. I then describe the data analysis process used.

Methodology

I employ Nader's (1974) process of studying "up, down, and sideways" as I examine the production and practices of people in positions of power. I "up the stethoscope" (Chapman and Berggren 2005:157) by focusing on nurses themselves and their professional practices, because biomedical research on breastfeeding primarily assumes that only mothers' practices should be analyzed, not health care practitioners' assumptions and practices regarding particular mothers. This discursive reallocation moves us away from attending only to racialized mothers' practices, which has been the norm in biomedical research and practice both historically and contemporarily. Shifting the gaze to the culture of PHNs in B.C. allows me to provide contextual accounts of how practitioners 'other' and racialize mothers.

The iterative-inductive approach I employ utilizes an "ongoing simultaneous process of deduction and induction, of theory building, testing, and rebuilding" (O'Reilly 2005:27). This scientific method more closely resembles a spiral assessment than a linear process, meaning that the literature review, question making, data collection, analysis, and writing up are continually evaluated, contrasted, and reworked. Such an approach facilitates a flexible research design while also supporting reflexivity throughout each stage of the research process. Through immersion at my field sites and by building on previous insights and understandings, I continuously learned more about my participants' meanings and concerns. This, in turn, impacted the research process as I explored themes and ideas not previously hypothesized.

Ford and Airhihenbuwa (2010) also recommend an iterative-inductive, reflexive approach when using Public Health Critical Race (PHCR) praxis in order to scrutinize and acknowledge the contingent nature of findings based on one's social location and positionality. With the issue of racialization at its core, PHCR praxis uses critical race theory tenets. In each stage of my MSc program, I considered myself a "research instrument" (Piantanida and Garmen 1999). Thus, PHCR praxis encourages me to continually critique my research questions and findings in relation to my own positionality and social location as a female, middle-class, 'White,' able-bodied, cisgender, heterosexual, public health nurse who was raised on Coast Salish territory in B.C.⁷ Additionally, PHCR praxis reinforced the importance of evaluating and monitoring my positionality as a clinically trained PHN, as well as to the institutional, disciplinary, and biomedical discourses in which I was first trained.

Moreover, as a nurse who has not experienced being (negatively) racialized, PHCR praxis facilitates increased 'race consciousness' by sensitizing me to the salience and everyday occurrences of a racialized life (Ford and Airhihenbuwa 2010). As such, I continually attempted to de-colonize myself throughout the research process by interrogating and reflecting on my history, assumptions, beliefs, theories, and practices. Despite this conscious intention, I may have missed nuanced ways that bodies are racialized because of my lack of lived experience as a 'non-White' person in Canada. I attempted to reduce this limitation by reading widely; listening to stories; critiquing media; watching critical films; going to conferences; participating in anti-oppressive, de-colonizing workshops; and being open to multitudes of opinions. Nonetheless, being a privileged, 'White' settler Canadian (the following segment explains why I intentionally refer to 'White' Canadians as *settlers* throughout my thesis) who grew up on Coast Salish territory and worked in breastfeeding promotion contexts may have limited my ability to perceive how 'raced' categories operate in B.C.'s clinical domains. That said, being classified as 'White' potentially allowed participants to talk openly about racialized 'others.' Essentially, my positionality and social location impacted my research process by opening up some possibilities for discovery while shutting out others.

⁷ 'White' is in quotation marks to signal its socially constructed nature.

Ethnographic Setting

Nurses, like many Canadians, are proud that Canada is reputed to be a tolerant, multicultural nation that has a 'universal' health care system. Yet Canada's settler colony origins generated a lamentable past of racist and discriminatory policies and practices. Nurses view themselves as administrators of equitable health care and do not acknowledge (and possibly, do not even realize) that they might be contributing to discriminatory and racist systems (Barbee 1993). However, nurses follow 'best practice' recommendations, protocols, and procedures produced within institutions that sometimes harbour institutionalized racism.

Discrimination in Canada was based on socially constructed ideas of 'race' through scientific racism (Ward 2002). Racism and discrimination were not only targeted toward the 'Indigenous' people of Canada, but also various immigrant groups who were not ascribed 'White' settler status.⁸ Beenash Jafri (2012) argues that racialized people within Canada may be *complicit* in settler colonialism without necessarily receiving the benefits and privileges associated with it. This is especially true in the province of B.C., where discrimination toward 'non-White' groups is particularly evident (Ward 2002). Thus, Jafri posits we should consider "settlerhood not as an object that we possess, but as a field of operations into which we become socially positioned and implicated" (2012). My decision not to refer to racialized Canadians and non-residents as 'settlers' is meant to draw attention to the social and institutional relationships, hierarchies, and structures of 'White' privilege and how those interactions impact people's bodies differently.

My ethnographic study was conducted in the province of B.C., and for purposes of confidentiality I will call the city by a pseudonym: Coast Salish City.⁹ British Columbia, encompassing 230 million acres of unceded Aboriginal territory (Roy and Thompson 2005),

⁸ Constructions of 'Whiteness' continually change throughout history, place, and time, and they are continually renegotiated and reimagined; for example, past 'non-White' immigrants were from countries such as Ireland (Ignatiev 1995), whereas (most) North Americans of 'Irish' descent are now classified as 'White.'

⁹ I chose this pseudonym intentionally as a way to draw attention to the fact that my ethnographic field sites are situated on stolen Indigenous land; I felt that this was important because of Canada's colonial history and its continued colonial attitude toward Aboriginal people in Canada.

became a province of Canada in 1858. The health authority in which I completed my research was located on unceded Coast Salish Territory. In order to preserve the confidentiality of my participants, I gave the health authority the pseudonym District Health Authority (DHA). Within the DHA, six public health units, which were located in an urban, metropolitan area known for its diversity, comprised my field site.

I chose the DHA because it is attempting to become the first regional health area in Canada to be labelled and accredited by the WHO as 'Baby Friendly.' Being baby friendly means that all hospital and community based health services adhere to the "ten evidenced-based steps to optimally support maternal-child health for all mothers and babies" (Breastfeeding Committee for Canada 2012:2).¹⁰ To achieve this goal, the DHA devised an infant feeding policy that targets not only health practitioners, but all staff members. This does not mean that all staff members provide lactation services, but it means that all staff members are required to provide a safe and inclusive space where all mothers can feed their infants by breast or by bottle. The policy also emphasizes that the DHA provides staff training to their clinical staff, distributes information about the benefits of breastfeeding and the risks of formula feeding, and supports clinicians so that they can provide adequate breastfeeding care. Additionally, the DHA and its staff will not provide formula advertisements or formula samples to breastfeeding mothers. Thus, the policy's principal purpose is to increase the number of safe places available to mothers and babies and to encourage mothers to breastfeed.¹¹

Furthermore, public health field sites were chosen because health care contexts have been shown to be excellent places to examine racialization and 'othering,' as they distill national values and discourses (Anderson and Reimer Kirkham 1998; Sargent and Erikson 2014). Social analysts such as Berry (2010) and Sargent and Erikson (2014) have studied biomedical practices and demonstrated that clinical praxis is a rich field for the reinscription of social stereotypes. Their accounts also indicate that raced ideologies often go unchallenged in clinical

¹⁰ Please see <http://www.unicef.org/newsline/tensteps.htm> for more on the ten steps.

¹¹ For purposes of confidentiality, I do not provide a reference for the policy, as it names the health authority. Please contact the author for information regarding this policy.

domains, and that health care contexts can engender processes of inclusion and exclusion. Therefore, public health units within Coast Salish City seemed an appropriate setting in which to understand whether 'raced' stereotypes might go unremarked and provide a basis for 'othering.'

Data Collection: Ethnographic Methods

My qualitative ethnographic inquiry was conducted over seven months, from May through November of 2014. Through immersion at six public health field sites, I completed participant-observation with 30 public health nurses in diverse settings such as home visits, infant-parent groups, childhood immunization clinics, breastfeeding clinics, public health offices, and committee meetings. I also completed 20 semi-structured interviews that averaged 45 minutes in length.

The research project includes two forms of informed consent appropriate to the methodologies used. For the purposes of conversational participant-observation, I employed oral consent (See Appendix A). Written consent forms (See Appendix B) were used during semi-structured interviews, and all participants were informed that permission from the DHA had been obtained prior to the study being conducted.

Participant-Observation

Participant-observation entails immersion into a particular culture and context. The researcher observes, asks questions, takes notes, collects other forms of data, and participates to the level appropriate and permitted by participants and acceptable to the researcher (O'Reilly 2005). Participant-observation is an informal, open-ended relationship that is driven by the participants. Prior to participation, PHNs were advised that they could discontinue involvement at any time and could choose not to answer any question for any reason. Continued consent was implied by their willingness to engage with the researcher over a period of time. I reminded participants of my research objectives using verbal reminders as well as non-verbal cues such as visible note-taking. My study had a 100% retention rate.

I attempted to complete the participant-observation portion with each participant before conducting the semi-structured interview because it helped build rapport and encouraged participants to be reflexive as well as to express contradictions. During participant-observation,

conversational techniques allowed the researcher to learn about participants' perspectives and knowledge without imposing the researcher's questions and biases on the participants (O'Reilly 2005). This also resonated with my inquiry's iterative-inductive nature, as it gave the participants the opportunity to influence both the questions I would pose and the theoretical perspectives needed to ground my work.

My level of participation was negotiated and re-negotiated throughout the research process with each individual participant and each health unit, and also in relation to the clinical setting (e.g., breastfeeding clinic versus immunization clinic). Explicit attention was paid to interpersonal dynamics within each unique public health context, particularly to the power hierarchies between PHNs and their clients.¹² Specifically, and as recommended by PHCR praxis, I sought to uncover contemporary patterns of social relations within health care contexts.

During participant-observation, I jotted down initial impressions such as the setting's physical details, noise, colours, smells, equipment, movement, and which individuals were involved (Emerson et al. 2011). Jottings are reminders that help create textured, detailed descriptions of ethnographic written texts, or what Geertz referred to in 1973 as "thick description." As 'raced' categories shift and change based on place, context, time, and population-of-people present (Ford and Airhihenbuwa 2010), these initial impressions added accuracy and detail to my written field notes.

Field notes were chronologically written up immediately after leaving the field site to ensure rich, detailed descriptions of the day's events. I also included asides and commentaries related to any emotional responses. Asides consist of brief and reflexive responses that pose questions, clarify, or attempt to interpret, and they ameliorate the potential for hasty and unsubstantiated conclusions, allowing the researcher to think through observations analytically (Emerson et al.

¹² The participants' clients were aware that I was not recording their personal information and, as such, did not need written consent for their participation. The participants and their clients were also aware that my purpose was not to provide nursing related services, nor to advise clients or other nurses while conducting research.

2011). Ford and Airhihenbuwa (2010) also recommend this method for PHCR as it enables critical self-reflection and helps prevent researcher bias.

Semi-Structured Interviews

In consideration of participants' time, I used an interview guide during all semi-structured interviews (See Appendix C). This method is more efficient as it utilizes both a list of research questions and provides for an in-depth interview (Bernard 2006). Prior to the interviews which began during my first week in the field, participants were given written informed consent forms as well as time to discuss any concerns or questions. All 20 participants consented to audio-recording. Even after consenting to be interviewed, participants were reminded that they could refuse to answer any question or interrupt the interview at any point.

Collection of Gray Literature

To augment first-hand accounts and to uncover and deconstruct professional knowledge concerning racialized women's infant feeding practices, I collected organizational gray literature related to public health nursing praxis and breastfeeding throughout my field work. This form of data collection does not need ethics approval or consent forms. Much of the gray literature was gathered from e-mails forwarded by public health nursing staff, educators, and management. I also collected information by searching the DHA's internal website.

Recruitment

I employed purposeful and opportunistic recruitment at six public health units within Coast Salish City. Participants consisted of PHNs who work part-time or full-time within the area of infant, child, and maternal public health. Recruitment posters were posted in non-public areas and in consultation with the PHNs themselves.¹³ Most of the recruitment posters were placed near triage areas where nurses typically met each morning to plan the day's activities. Study-

¹³ For purposes of confidentiality, I do not include the poster as an appendix because it provides confidential information such as the job title of the nurses and the name of the health authority. Please contact the author for more information regarding this poster.

detail information sheets and my business cards were also left close to the recruitment posters, so that potential participants could look at the information on their own time.

Additionally, a key informant PHN recommended an appropriate pathway to send recruitment e-mails. I provided recruitment information to nurse educators at each health unit who then forwarded my recruitment e-mail, on multiple occasions, to all of their respective public health nurses. Nearing the end of my field research, one unit requested that I provide a brief presentation about my study due to perceived low recruitment at this particular site. I gave a 10-minute presentation during one of their regular team meetings and offered to provide a similar presentation at other units, but did not receive any interest.

Interviews and participant-observation experiences were arranged based on the participants' preferences and time constraints. Some participants let me know of their interest in my study and either followed-up with an e-mail themselves or asked that I e-mail them at a later date. Nurses' confidentiality or comfort level concerns were addressed by offering to hold interviews away from the public health office, but only one interview was conducted offsite.

Participant Demographics

Although I did not include 'race' and 'ethnicity' data on my intake form, many participants disclosed identifiers through such terms as "White" (2), "Caucasian" (1), "European" (3), "Chinese" (2), and "Filipino" (2). Their ages ranged from the mid-twenties to the late-fifties. All of my participants identified as female. Some were childless, while others were mothers with children ranging in age from infants to adults. They were married or lived common-law, divorced, single, or had never married. Their native tongue was not always English, and some spoke more than two languages. During the interviews, some participants mentioned that they had an accent or openly discussed their immigration status. Some nurses dressed casually, while others wore designer outfits. Although my PHN participants did not fully reflect the global demographic profile of Coast Salish City, they were far from a homogenous group.

Below are three demographic pie charts constructed from intake forms completed by the 20 participants interviewed (See Appendix D for the intake form). I did not complete intake forms for participant-observation experiences as this would be antithetical to the rapport-building

process involved. However, 17 of the 20 participants interviewed also consented to the participant-observation process.

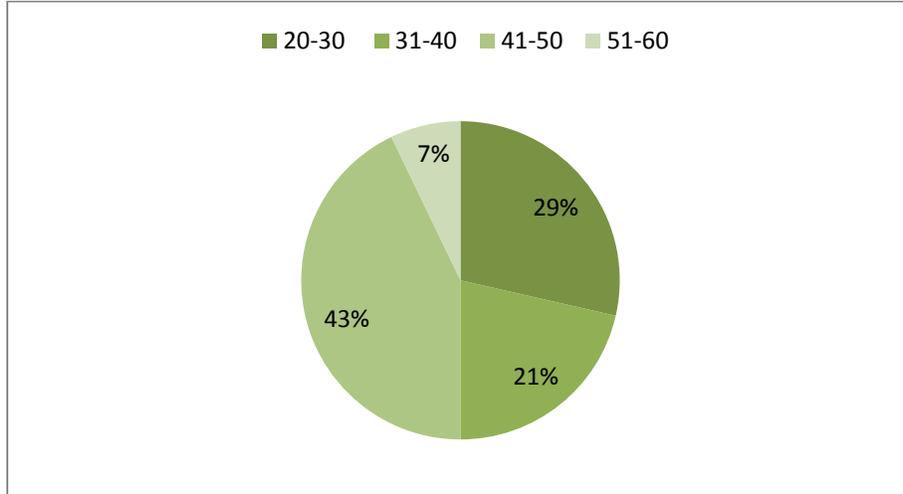


Figure 1. Age Distribution of Research Participants
Note. This figure shows that there was a fairly proportionate age distribution of participants. Half of the participants were between ages 20–40 and 41–60.

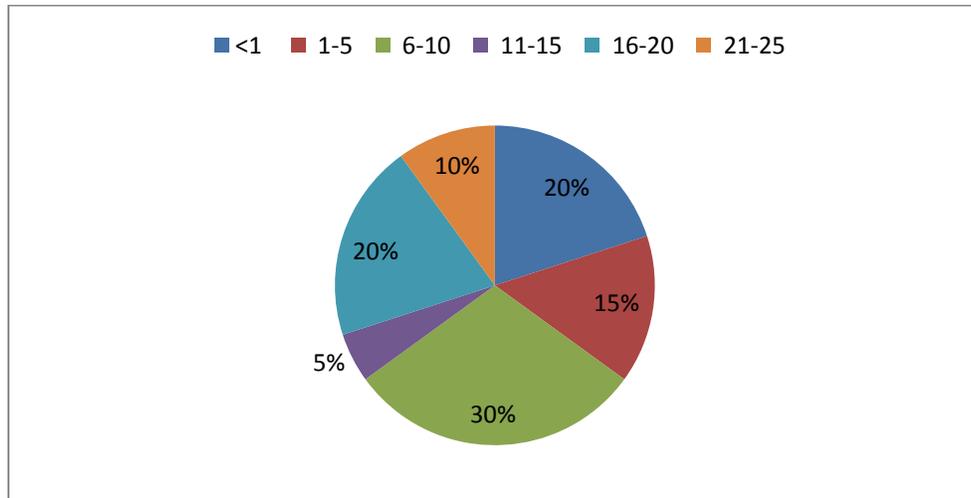


Figure 2. Years Participants Worked as a Maternal, Child, & Infant PHN
Note. This figure indicates that the participants had a variety of maternal, child, and infant PHN work experience. In nursing terms, the participants would be considered ‘novice’ or ‘experienced’ nurses. I use the terminology of ‘experienced’ nurses throughout my thesis.

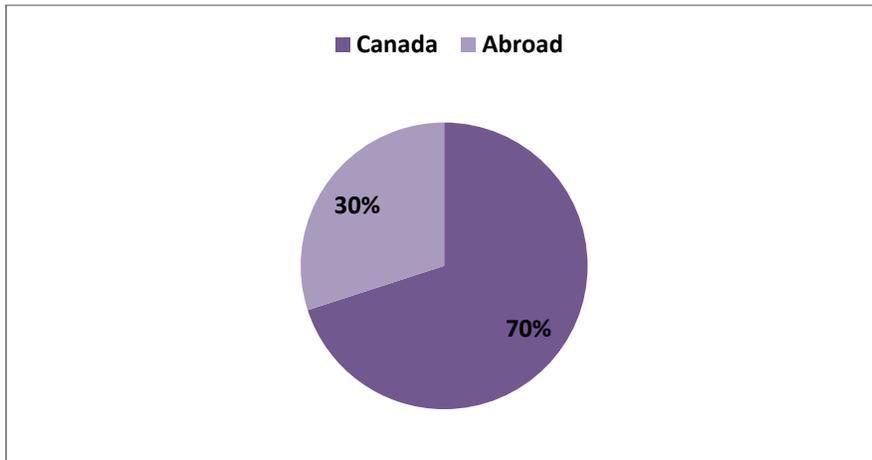


Figure 3. Distribution of Research Participants Born in Canada and Abroad

Note. This figure shows that not all of the participants are Canadian born.

The participant demographics graph indicates that, although my participants worked in the same setting, their experiences are quite diverse in terms of their years of experience as a nurse, their generation and age, their experience as mothers, as well as their place of birth. I share this to show that hegemonic notions surrounding ‘race’ in Coast Salish City transform many social locations and positions, which is why my research focuses on professional nursing praxis and processes writ large and not on the demographic categories of the nurses themselves. I discuss this issue in more detail in Chapter 3.

Data Analysis

I personally transcribed each interview one or two days following the interview. This aided the iterative-inductive nature of my inquiry by increasing my interaction with the data from the earliest stages. Field note accounts were systematically organized and analytically coded. The analysis process was used for the participant-observation field notes, semi-structured interview transcripts, and the gray literature. I used a standard word-processing program to sort data by creating files, using the copy-paste function, highlighting, and entering code categories. Emerson et al. (2011) recommend a standard word-processing program as the most appropriate approach for student researchers based on their belief that it ensures active

interaction with the data and facilitates the creation of new analytic codes and categories instead of relying on generic and redundant computer-generated codes.

Initially, I completed line-by-line coding using verbatim descriptions of my entire field notes and transcribed interviews. Codes were written next to the text from which they were gleaned and were then counted using a Microsoft Word keyword search. The codes and the respective number of times they were cited were then placed in an Excel document. The initial 500 verbatim codes were condensed to 42 categories by taking verbatim words and finding similar terms (e.g., wealthy, affluence, high income) and contrasting ones (e.g., low-income, poverty). I completed this by manually cutting each code and arranging them into similar categories on the floor. I then bound each pile together with a paperclip so I could go back and rearrange and edit categories as needed. I did this until I felt that no further editing and condensing was needed.

Despite Emerson et al.'s (2011) recommendation to do the analysis without using a computer program, I used NVivo to 'cut and sort' exemplars, a process which further refined my categories into thematic codes. Key themes were "sorted" and "piled" and then arranged into the chapters that formed my thesis (Bernard and Ryan 2010). Emerson et al. (2011) explain that the end point is not to create categories and sort data, but to be able to identify and contrast conceptually significant observations; I found NVivo helpful in that endeavor because I was able to put specific segments of the data into multiple categories.

Thesis Blueprint

Public Health Nurses are the 'front line' workers providing support and care related to infant feeding for postpartum mothers in the community. Unlike biomedical research that is interested in mothers' demographics in relation to breastfeeding disparities and inequities, my ethnographic research focuses upon PHN praxis as a potential perpetuating force of differential infant feeding support. Specifically, I am interested in the role of racialization and 'othering' in public health breastfeeding promotional contexts.

In Chapter 2, *Clinical Encounters*, I introduce the issue of 'race' and infant feeding in clinical settings because health care practitioners and mothers are inexplicably intertwined in the

postpartum period, when maternal bodies are assessed, surveilled, codified, and made into populations. I provide historical accounts of how nurses gained authority over infant feeding and the ability to ascribe 'race,' but I also connect it to present-day breastfeeding promotion contexts. I discuss the professionalization of nursing and its relationship to the medicalization of infant feeding and explore how statistics have been instrumental in biomedical providers' ascendancy as authoritative infant feeding 'experts.' I also discuss how biomedical practitioners became the intermediaries between government interests and mothers, which increases health care providers' "biopower." Later, I discuss how contemporary PHNs are contesting biomedical ideas surrounding statistics, standards, and norms. I describe how PHNs attempt to rectify and ameliorate the effects of medicalization and professionalization even as they reify notions of 'culture,' 'population,' and 'race.' The reinscription of racialized stereotypes occurs despite PHNs' wariness that biomedical apparatuses such as statistics often create generalizations.

In Chapter 3, *Racialization of Culture, Bodies, and Praxis*, I note that racialized terms such as "Chinese mother" are used regularly, even though PHNs are cognizant of the problematic uses of generalized labels. I demonstrate that historical, raced practices continue within institutional settings and are evident in nursing practice and theory today, illustrating how history and nursing theory collide and help to racialize mothers' names, breastfeeding practices, and bodies through nursing praxis.

The next chapter, *Affinities of 'Othering': Continuums of Citizenship and Belonging*, illustrates how racialized mothers are 'othered,' which consequently situates them along a referential continuum of belonging in Canada. My ethnographic accounts indicate that the practice of 'othering' creates arenas of inclusion and exclusion while reinforcing notions of citizenship and belonging for mothers and their infants in breastfeeding promotion contexts. I examine how nurses are inextricably caught up in larger structures that 'other' racialized mothers and infants.

Chapter 5 summarizes my material and introduces additional insights regarding my MSc thesis and its conclusions.

Chapter 2. Clinical Encounters

I arrived at a public health unit in an urban centre. The nurses were already gathered around in a “triage” area where liaison records are dispersed. These liaison records contain information regarding postpartum mothers and their newborns who have been recently discharged from a large, tertiary hospital. Joan, an experienced nurse I am observing and interviewing today, tells the triage nurse that she is able to do a follow-up home visit. When Joan receives the liaison hospital record, she reads both of the parents’ last names aloud and then adds: “Grandparents are coming from Nigeria and Japan.”¹⁴ Most of the PHNs look at Joan when they hear this.

“Japanese and Nigerian, that’s an interesting mix!” Crystal, a PHN, states. Another PHN comments, “Mixed kids are so beautiful, especially if the baby is a girl.”

After all of the liaison files are dispersed, we go back to Joan’s desk, where Joan quickly looks over the file and calls the mother. She sets up a home visit within the hour and tells me the mother complained of breast pain and would like a home visit, but that “it was hard to understand the Mom because she sounded like she had been crying.”

Stella, another experienced nurse, pipes up from a cubicle close by, “Japanese people are perfect breast-feeders. They are so gentle.” I look at Joan’s face, but she does not seem to want to engage. She neither agrees nor disagrees. Rather, she simply seems disinterested, as indicated by not nodding her head agreeably or making eye contact with me or Stella.

I think back to my earlier interview with Stella, and how she stated that ‘Japanese’ mothers all “have perfect breasts with perfect nipples that are perfectly pointed, and the baby latches perfectly” for breastfeeding. I wonder if Joan shares these beliefs about ‘Japanese’ mothers and whether such beliefs impact the type of care ‘Japanese’ mothers receive.

¹⁴ I changed the country to Nigeria to preserve the family’s confidentiality.

Joan gathers her nursing bag and baby scale, and we leave the unit to take a short drive to a new condominium in urban Coast Salish City. We ride a very fast, clean elevator to one of the top floors of the building. When we get to the clients' suite, the new mother opens the door before we even have a chance to knock.

The mother explains that she wants breastfeeding assistance because her breasts are very sore. During the conversation, the mother appears tired and teary. Joan sits close to her on the sofa, providing lots of eye contact. Joan asks if she can touch the mother's breasts. The mother consents verbally and Joan touches and assesses the top, side, and bottom of her breasts. After the assessment, Joan explains to the mother that she is experiencing "engorgement."¹⁵ Joan touches her own breast as a way to show how to do breast compressions during feedings to reduce breast pain from the engorgement. Throughout the conversation, the mother constantly massages her breasts. The mother is obviously very uncomfortable with her breasts' recent changes.

After the mother has asked all of her questions, she brings out the 'feeding chart' that shows when her baby was last fed and its bowel movements and voids over the past 24 hours. After she examines it, Joan tells her that it is a good time to wake the baby up for another feeding, as frequent nursing eases engorgement, and then asks if she would like the baby to be weighed at the same time. The mother agrees. After the baby is weighed, the mother begins to breastfeed. Joan encourages her, noting that she can see the baby's jaw moving with coordination and hears swallowing, which indicates the baby is getting lots of milk. The mother nods her head "yes," appearing to already know this. The mother continues to massage her breasts throughout the feeding, still appearing to be experiencing discomfort.

During the feeding, Joan off-handedly tells the mother, "You have really nice nipples and breasts for breastfeeding." The mother does not reply to this statement; she just smiles warily and continues to massage the painful lumps and harder areas of her breasts. I wonder if Joan's

¹⁵ Breast engorgement is a medical term meaning that the breast tissues are expanding and under pressure from making and storing breast milk (Walker 2006).

statement has anything to do with the belief Stella articulated earlier, that ‘Japanese’ mothers have perfect breasts and nipples for breastfeeding. I also wonder if that statement has anything to do with assessments of ‘race.’ After all, ‘race’ is popularly understood to be biologically and genetically determined, and Stella’s comment seemed to essentialize and racialize all ‘Japanese’ mothers as having the exact same ‘perfect breasts and nipples.’ My ponderings bring to mind Hoberman’s study of racism in medicine. He found that biomedical practitioners have a “silent curriculum” a phenomenon he defined as “medical gossip” which thrives on the perpetuation of racial folklore (Hoberman 2012:12). Was this an example of public health nurses’ racial folklore and the workings of the silent curriculum in Coast Salish City? More importantly, did this racial folklore change the type of care the mother received? And would differential care based on racial folklore contribute to breastfeeding inequities?

Ian Hacking explains that when people are classified into certain categories (e.g., Japanese), it creates new subjectivities, thus changing the way people exist, a process he refers to as “making up people” (2006).¹⁶ This making up of people simultaneously ascribes individuals into populations. Hacking’s (2006) theory of “dynamic nominalism” offers nuance by describing how categories used to describe diverse people (e.g., Japanese) can influence possibilities and experiences, but emphasizes that placing people into categories is a *dynamic*, as opposed to a static, process that is contingent upon history, place, space, and time. Racially naming a client (which was done in the exemplar above) does not necessarily cut off alternative possibilities for the mother, but it may bind the nurse to certain conceptions of who the client could be. This is particularly problematic when categories of ‘race’ and population are deemed innate, natural, and unchangeable. As I did not conduct interviews with postpartum mothers themselves, I cannot presume these racialized names are deterministic in relation to infant feeding. I can, however, assume that these categories influence nurses’ thoughts, actions, theories, and interventions—essentially, their praxis—which can subsequently constrain or enhance mothers’ opportunities due to differential nursing care. My ethnographic account of Joan’s interactions with the ‘Japanese’ mother opens up the possibility of how nursing beliefs, experiences, and

¹⁶ Henceforth, whenever I reference ‘making up’ people, I am referring to Hacking (2006).

practices can potentially create a racialized nursing praxis. (I discuss nursing praxis in more detail in Chapter 3).

This example also illustrates the everyday working experiences of public health nurses in Coast Salish City as they go about assessing bodies and providing ‘expert’ information to new mothers. Yet, there is a history behind how Joan gained this knowledge and authority surrounding infant feeding in the postpartum period; this chapter outlines how “bio-power” (Foucault 1973:140),¹⁷ statistical analyses, and norms gave medical practitioners authority over mothers’ infant-feeding decisions and the ability to ascribe racial typologies. My ethnographic accounts illustrate how PHNs try to negate this authority by contesting norms and statistics, yet even as they are actively trying to de-medicalize infant feeding and explaining how statistical categorizations can create stereotypes, they are also invoking new types of norms by focusing on cultural and population differences. Such differences are often euphemisms for racial categorizations. These ethnographic accounts clearly illustrate how statistics, norms, and clinical encounters become enmeshed and create a racialized praxis for PHNs. By studying today’s nursing praxis, I am able to delineate biomedical patterns of racialization in relation to historical trajectories. A brief description of how biomedical practitioners gained authority in ascribing racial characteristics and how they became ‘experts’ in the domain of infant feeding supplies the background for that discussion.

Biomedical Histories

Biopower and ‘Making up People’: Medical Classification, Objectification, and Standardization

Foucault argues that governments, or people in positions of power, create biopower—the ability to systematically group people into populations based on ideas of biological attributes. He asserts that biopower entails the surveillance, control, and objectification of bodies, and that its

¹⁷ Further mentions of ‘biopower’ are attributable to Foucault (1973), though I will not reference him each time.

purpose is to manage bodies to ensure healthy communities or (more sinisterly) to contribute to eugenics (Foucault 1973).

Bridges explains that biopower ‘makes-up’ populations because it dissolves individuals’ unique characteristics. Ultimately, the state and those in authority can define populations in whichever way they choose, thus using biopower to diminish the unique characteristics of the people who actually comprise the population (Bridges 2011).

But how do biomedical providers use biopower to ‘make up’ people and populations?

Biomedical practitioners are inextricably embedded in the production of biopower because they are authorized to “qualify, measure, appraise, and hierarchize” bodies (Foucault 1973:144).

Porter (1993; 1997) and Starr (1982) researched how, in the 18th and 19th centuries, regulation, policy, and specialization were used to professionalize western medicine. Professionalization increased when medical doctors gained scientific skills by assessing and categorizing people through experimentation, dissection, collection, classification, and objectification. These skills helped create ‘normal’ and ‘abnormal’ bodies (Lock and Nguyen 2012; Porter 1997).

Biomedical knowledge could not have emerged without data collection and statistical measurements. Statistical analyses were then used to create norms and track deviations from those norm, thus allowing taxonomies of things, including people, along a continuum of normality (Lock and Nguyen 2012; Marks 2011). These norms also encouraged the standardization of processes and assessments.

Natural and biomedical science principles have long been used to organize diverse groups of humans (Gilman 1985; Lock and Nguyen 2012; Marks 2011). The expanded authority of biomedical practitioners enhanced their legitimacy to ascribe norms, including ‘racial’ norms (Porter 1997). Assigning normative and non-normative behaviours and attributes to patients on the basis of scientific claims—coupled with the expert knowledge and status of biomedical professionals—solidified the categorization of people into races (Gilman 1985). For example, Gilman (1985:212) states that, early in the 1800s, “acceptable medical discourse” held that the anatomy, physiognomy, sexual nature, and lasciviousness of ‘African’ women were interrelated; the bodies and nature of ‘African’ women were also juxtaposed and seen as being antithetical to

'White' women's bodies and essences.¹⁸ European male physicians made scientific claims about these normative or non-normative classifications, which was corroborated by their professional medical training (including observation, assessments, and dissection) (Gilman 1985). Thus, taxonomies of people and bodies were created based on medico-scientific 'facts.' In essence, women's bodies were given normative or non-normative status in relation to the social location of the medical ascriber and the social hierarchy in which they were ascribed. Moreover, all 'African' women's bodies were perceived as being similar, which solidified racialized classifications into populations.

The following section illustrates how biopower is used to support breastfeeding promotion campaigns. As biomedical practitioners (i.e., medical doctors and nurses) are employed by the state and have considerable power, I first describe how biopower was historically deployed by biomedical providers in breastfeeding promotion contexts.

Infant Feeding in Canada

Child rearing and infant feeding provide excellent examples of how biopower—the surveillance and objectification of bodies—functions. Traditionally, child rearing and infant feeding were largely women's domain, but through the professionalization and prestige of science and biomedicine, women and mothers' power and authority shifted to biomedical 'experts' within governmental health authorities (Apple 1995). In early 20th century Canada, statistical measurements indicated that infant morbidity and mortality rates were very high and increasing as cow's milk replaced exclusive breastfeeding (Nathoo and Ostry 2009; Wolf 2003). The specialty of pediatrics and public health home visitation nursing developed as a way to promote and monitor infant feeding in an attempt to reduce deaths and illnesses (Nathoo and Ostry 2009; Porter 1997; Starr 1982; Wolf 2003). Even though many other factors contributed to infant morbidity and mortality rates (e.g., poverty), mothering practices became the primary targets of government and biomedical interventions (Arnup 2002). Thus, pediatrics and home

¹⁸ Again, 'African' and 'White' are in quotations to emphasize that these categories are socially constructed.

visitation established places in which mothers and their infants could be surveilled and, thus, infant feeding practices could be modified through state intervention.

Around the same time in the early 20th century, “scientific mothering” materialized as another way to ensure mothers continued to follow biomedical advice even while beyond the reach of the clinic or home visit (Arnup 2002). Mothers were given pamphlets by health professionals in order to receive ‘scientific,’ and therefore ‘accurate’ and standardized, information about child rearing and infant feeding (Apple 1995; Arnup 2002; Nathoo and Ostry 2009). Thus, mothers began to defer to biomedical practitioners to receive the most ‘up-to-date’ information on infant feeding and child rearing from ‘authoritative’ sources like government-sanctioned materials (Arnup 2002; Nathoo and Ostry 2009). In this way, health care providers became the liaisons between the state and its mothers. Furthermore, mothers were discouraged from seeking advice from family, friends, and neighbours and were instead encouraged to rely exclusively on government pamphlets and biomedical practitioners’ recommendations. Biopower began to infuse all relationships even when health care providers were not around, thus increasing the hegemony of biomedical opinions on infant feeding by devaluing and delegitimizing other forms of knowledge (Arnup 2002).

The professionalization of pediatrics and public health nursing and the pervasive ideology of scientific mothering allowed health practitioners to survey mothers in order to ensure they followed ‘authoritative’ advice (Apple 1995).¹⁹ Health care practitioners were thus able to identify ‘ideal’ or ‘good’ mothers based on who adhered to scientific and medical opinion on

¹⁹ In exploring the concept of “authoritative knowledge,” Jordan posits that biomedical forms of knowledge are often more influential than other forms of embodied knowledges, owing to its professional standing (1993 [1978]). In the 1920s and 1930s, Canadian public health nurses emphasized that mothers appreciated their ‘expert’ advice; however, other written documents indicate that mothers negotiated and contested PHNs’ suggestions and that they sometimes declined their services altogether (Arnup 2002). Even so, on a large scale, scientific mothering and the medicalization of infant feeding impacted mothers’ confidence regarding their own bodily processes and child rearing knowledge base (Apple 1995; Arnup 2002; Nathoo and Ostry 2009). Thus, biopower galvanized, managed, and shaped Canadians’ understanding of infant feeding and women’s bodies.

infant feeding (Apple 1995). However, not all mothers were treated (i.e., managed and surveilled) in the same way.

Creating Canadian Mothers

Even though home visitation was predicated on epidemiological indicators showing high infant morbidity and mortality rates, epidemiological figures did more than just explain the health of Canada's youngest citizens; it made up people into populations and facilitated breastfeeding promotion campaigns based on racialized classifications.

Breastfeeding promotion campaigns were contingent on local ideological concerns. After World War I, 'White' settlers became fearful of impending 'race deterioration' due to the high death rates of 'White' Canadian soldiers and the increasing immigration rates of 'non-Whites.' Ideas of 'race deterioration' were largely based on theories of eugenics and scientific racism. The Canadian government felt it necessary to promote breastfeeding as a way to ensure a healthy and productive nation-state as well as a functioning army in the future (Nathoo and Ostry 2009). Many young Canadian men had been killed in the war and many were deemed too unhealthy to enlist. Biomedical providers' interventions would, therefore, help produce the 'right population' through disseminating 'appropriate' infant feeding information.

Moreover, medical historians note that Canadian infant feeding reform and public health home visitation nursing initiatives were targeted at immigrant populations, even though all subsets of the population experienced high infant morbidity and mortality rates. Indeed, in some instances, 'White' settler populations had higher rates of infant morbidity and mortality than did 'non-Whites,' but they were not subject to home visitation services. The underlying belief was that breastfeeding would better curb morbidity and mortality rates for 'inferior and weak' immigrants. 'White' settlers were believed to be healthy and strong and, therefore, not in need of state surveillance and intervention (Nathoo and Ostry 2009).

Racialized immigrant mothers were believed to need additional support to produce the 'right population' owing to their 'faulty, weak' genetics as well as their 'un-Canadian' ways. Home visitation and well-baby clinics offered health care practitioners a way to introduce immigrant mothers to the most 'up-to-date,' scientific 'Canadian' ways (Arnup 2002). These services

ensured that ‘unassimilable’ families would become acculturated into mainstream, ‘White’ Canadian society. Thus, biopower was utilized for breastfeeding promotion because ‘non-White’ immigrant mothers were perceived as ‘other,’ thereby needing extra support to produce healthy offspring.

The next section describes how the past influences the future, showing how clinical encounters are still framed by biopower and racialized processes of making up people and populations. I elucidate how assessments, norms, and standards are contemporarily understood and how ramifications of scientific mothering and the medicalization of infant feeding are still felt, despite being contested by PHNs in breastfeeding promotion contexts. Additionally, the collusion of ‘race,’ ‘culture,’ and ‘population’ are explored in relation to how norms and statistics are understood in public health nursing contexts. I highlight new ways that PHNs create racialized norms about mothers throughout.

Contemporary Breastfeeding Promotion

In Western Canada, the economic downturn in the 1980s and 1990s precipitated health-care restructuring; one change was the switch to community-based settings instead of costly hospitals for postpartum nursing care (Spitzer 2004). Consequently, postpartum mothers’ hospital stays decreased from three days to 24–36 hours (Spitzer 2004). This community-based strategy continues today in Coast Salish City where all mothers enrolled in B.C.’s health care insurance plan are eligible to have home visitation services within 24–48 hours following hospital discharge.²⁰

The hospital-to-community transition of postpartum and newborn services begins when a hospital or liaison nurse transcribes the mother and infants’ chart information onto a liaison form. This form is then faxed from the hospital to public health units to ensure ‘continuity of care’ for the postpartum and newborn client. Liaison records inform the PHNs about discharged

²⁰ Chapter 4 outlines the eligibility criteria for B.C.’s insurance plan and how home visitation services are NOT universally available to all mothers and infants in Coast Salish City.

clients' contact information, age, health, birth history, and feeding plan. The public health postpartum program aims to provide continuity of care from the hospital to the community through continuing assessments of whether the mother and newborn are physiologically stable and aware of community supports and resources, and whether they might need breastfeeding support services.

Assessment, Norms, and Standards

The PHN is mandated to complete an initial telephone assessment within 24 hours after receipt of the liaison form. As per the Client Contact Guidelines, if the PHN identifies a “variance” (as per the Maternal and Newborn B.C. Perinatal Guidelines), a home visit or referral to another biomedical provider is warranted; if the client does not exhibit any variances, a PHN will either discharge the client or plan a telephone contact at a later date to reassess. Wikipedia’s definition of *variance* states, “In probability theory and statistics, variance measures how far a set of numbers are spread out” or, put another way, “the state, quality, or fact of being variable, divergent, different, or anomalous” (Wikipedia n.d.).

In public health settings, variances are deviations from norms that can be understood in two different ways; they can be either physiological or moral in nature. Physiological variances are determined according to statistical norms (e.g., assessments and measurements of newborn weight loss) and moral norms (e.g., ‘healthy’ social support networks). Sometimes, however, morals and statistics are imperceptibly infused.

During telephone calls, PHNs ‘triage’ mothers by asking specific questions to determine whether there are variances and if the nurse needs to do a “hands-on” assessment (meaning in-person; touching is not necessarily involved). As client loads are high, PHNs have to find out whether a home visit is warranted and whether the family wants a nurse to come to the home. At a home visit, the nurse may palpate the mother’s breasts, look at the colour and consistency of the mother’s and baby’s bodily secretions (including breastmilk and lochia from the mother, and stools and urine from the baby), and weigh the baby if the family agrees.

All PHNs emphasized that weighing the baby is an extremely important way to determine the baby’s overall hydration and feeding status. In fact, the PHNs have a flow chart called

“Breastfeeding, Weight, and Hydration in the First 14 Days: Assessment and Intervention” that helps each PHN determine which assessments and interventions might be needed.²¹ For example, the “standard assessment” encourages the PHN to observe the position of the baby relative to the mother while breastfeeding, how well the baby latches to the mother’s breast, how much milk the breast is producing, if the baby is receiving any milk, the amount of baby’s dirty and wet diapers, how often and how long the baby is feeding, the baby’s behaviours when feeding, the mother’s comfort with breastfeeding, and the baby’s weight by age. The standards that PHNs base their assessments and interventions on are based on statistical norms created by the classification and objectification of maternal and infant bodies.

However, not all of the nurses follow the recommended standard guidelines or use the flow chart. Elyse, a novice PHN with less than one year of experience with breastfeeding mothers, explains how breastfeeding courses, the breastfeeding flow chart, and the health authority’s orientation/mentorship program initially produced conflicting feelings and information regarding how she could best provide breastfeeding support. Ultimately her colleagues’ guidance and her own work experience helped her deconstruct norms, assessments, and standards of breastfeeding, as the following experience demonstrates:

I took two courses about breastfeeding and then I had a very hard time because I remember, with, um, I went on a home visit with [my mentor] and... [the] baby lost 10 percent [of its weight], and I was, like, “Oh my gosh, like, [the] 10 number!” And in my mind as a new nurse, I was, like, 10 is, like, a bad number, like 10 percent! We need to start giving formula. And [my mentor], I sort of looked to her to do the plan because I was still doing it with people, and I still hadn’t really had experience. And she said, ‘Well, there is lots of milk, so just wait. You want to be protecting breastfeeding. The mum wants to breastfeed, there is really good gulps there, so just wait for 24 hours and then just sort of wait and see.’ And then I went on-line to the intranet and there, um, I don’t know how, what it looks like, but it’s got the green, orange, and red [referring to the flow chart], and it really gives you a good understanding of what the intervention should be based on the different things.

This example explains how textbooks, guidelines, a nurse’s own experience, and guidance from other nurses may or may not be congruent in terms of understanding breastfeeding ‘norms.’ In

²¹ Please contact the author if interested in viewing this document.

fact, the 'textbook knowledge' seemed to confuse the novice nurse and cause anxiety. Such knowledge fixes norms, making the 10 percent weight loss seem like a scary variance that unequivocally warrants formula supplementation. However, her work orientation and her mentor's guidance prompted her to realize that breastfeeding 'norms' do not fit everyone. Elyse's experience illustrates how textbook knowledge surrounding breastfeeding 'norms' are contested by PHNs through their own working knowledge and experiences.

And while Elyse's vignette demonstrates the divergence between PHNs' ideal representations (i.e., textbooks) of medicalized bodily norms and everyday practice realities, Chapters 3 and 4 illustrate how PHNs' working knowledge and experiences, derived from specific contexts and historical antecedents, still ascribe mothers' bodies as normative and non-normative based on biomedical guidelines, cultural ideals, and the silent curriculum. These ideas of norms can racialize and 'other' particular clients by placing them along a continuum of belonging within Canada.

No 'Normal'

While statistical analyses and the development of norms created medical practitioners' authority to govern breastfeeding, contemporary PHNs in Coast Salish City contest static medicalized norms, explaining that textbook norms fail to adequately take into account the whole of their experiences. As a result, they make decisions based on their own experience and judgement. The majority of PHNs interviewed stated that observing and assessing the mother and baby's bodily functions are only part of the assessment. They emphasized that they are also looking at the emotional status of the mother, interactions within the mother-baby dyad, family dynamics, and many other factors, all of which help them determine whether the mother needs further support. The support PHNs offer includes information, education, encouragement, referral, and reinforcement.

When asked how a nurse knows whether a mother needs more breastfeeding support, PHN participants gave varied answers regarding the tension between norms, standards, and guidelines. While a few nurses seemed to follow the standard maternal/postpartum and

newborn guidelines, others claim that ‘norms’ do not exist within the embodied realm of breastfeeding. Isabelle voices this perspective effectively:

I almost want to say there is no abnormal because what normal is, because mum is mum, right? She comes with all of these, with all her unique factors. And that is where the ingredient she has for breastfeeding. And same thing with babies... But yeah, you know, mum comes with equipment (laughing, referring to her breasts)... Baby comes with equipment (laughing, referring to the mouth). Normal and abnormal? I am not sure (laughing).

Isabelle’s description of norms seems antithetical to the historical trajectory of biomedical knowledge, given that she does not believe norms exist. In fact, she seems to agree with Canguilhem’s position, that believing in norms may actually impede treatment and care and, in this case, adequate breastfeeding support. Canguilhem argues in his 1989 work, *The Normal and Pathological*, that norms can actually undermine a practitioner’s ability to diagnose, treat, and understand how society impacts patients’ lived experiences. Similarly, Isabelle later notes that the lactation and breastfeeding relationship is always in flux, fluid, and based on interpretation, and that norms are contextual and temporal. Stephanie, a novice PHN, stated that ‘normal’ in relation to breastfeeding is a “plastic term.” Put simply, there is no normal.

Again, while PHNs are able to articulate that there may be ‘no normal’ in terms of lactation processes and experiences, many PHNs still describe ‘norms’ based on hegemonic ideas of Canadian bodies and breastfeeding practices. Chapters 3 and 4 address the issue of how some women are considered less ‘normal’ based on perceptions of difference.

Internalized Norms

As noted previously, many nurses assert that although they understand and believe in the “science” surrounding breastfeeding and lactation, they rely mainly on their own experience and intuition to provide breastfeeding support for mothers. Crystal, a PHN with over 10 years of experience explains it in this way:

We have our mat[ernal]/newborn guidelines, so right from the beginning of [our PHN worksite] orientation, so [the information is] described very clearly [day] by day what is a normal and expected behaviour for breastfeeding, so that would be, like, you could look on there [printed guideline] to actually see what a true variance

is [by day in relation to baby's birth date]. But now, through my experience, I don't go to those [guidelines] anymore. It is basically, that, um, the mum describes something that is bothering her or that is painful to her, or she has a lot of questions about. That is basically how I go with her needs. And then it is knowing within my knowledge base what is normal and expected, and what is outside of that, and then I can just go and can tell by that.

Even though Crystal acknowledges that the standardized guidelines initially provided her with knowledge regarding what was "normal and expected" in terms of breastfeeding, she feels she has moved beyond using those guidelines and is now quite comfortable deviating from bounded, standardized categories.

However, standards and norms are often unconsciously internalized and may continue to guide PHNs without their awareness even as they deviate from certain recommendations, as Crystal's story illustrates. The next two chapters detail how PHNs tend to internalize other societal norms in the same way.

Cultural Norms

Abigale, a PHN with less than five years of experience, approaches the issue of norms differently. She believes that "normal infant feeding behaviours" exist, but she understands them in 'cultural' terms, rather than in complete medicalized terms. Even though biomedicine has its own cultures, Abigale is referring to culture in terms of the postpartum mother. She asserts that a significant aspect of her job is to normalize 'normal' infant behaviours and the breastfeeding process. Abigale hopes to normalize infant feeding cues and behaviours that may seem abnormal to the mother, but that contemporary PHNs now consider to be 'normal.' When describing how 'cultural norms' affect infant feeding, she states:

Yeah... There is pockets of culture across [Coast Salish City]. Umm... and it is not necessarily just ethnic, I think it is socioeconomic, maybe, like... People probably navigate or, what's the word?...migrate to areas that kind of fit who they are. Where on the West Side, it is often pretty professional, career families, and then the baby has to fit into that picture. Whereas... maybe, I don't know... These are all generalizations, and not everybody fits into them. But in more of the Aboriginal families, babies are a blessing and the world centres around the baby, and it is very normal that the baby would be around and involved in everything instead of being an addition... or, I don't know. Those things shape how you think about feeding, as well, because if it is normal for the baby to just be on you and feeding then... there is no concern there. That wouldn't be a variance. That

wouldn't be an abnormal thing, whereas with some of the families who are used to having control over everything, a baby who is at the breast all the time or who is wanting to feed, it's like a 'needy baby' or a... "there is something wrong with the baby," instead of it just being... normal. Or in cultures where babies shouldn't really cry, well then... A baby kind of fussing at the breast is... "there is something wrong with the milk," or "there is something wrong with feeding so give formula." I was at one home visit, and the grandma was trying to stuff the bottle into the baby's mouth while the mother was trying to breastfeed with a nipple shield. I had sweat dripping down, and I had an interpreter behind me (laughing), and I am, like (laughing), just wait... (Abigale gets slightly out of her chair and puts her arms out) "this baby can feed!" Literally, I am like overtop (Abigale uses her body to explain how she was pushing the grandmother away and trying to protect the mother/baby). That I haven't seen for a long time. (Laughing). And that is a very typical picture... in that... certain geographic area.

Previous anthropological work on clinical encounters focused on how health care practitioners and clients understand health and illness differently and on how biomedical providers often ignore the lived experiences of their patients (Kleinman 1980). Abigale's understanding is that 'culture' is the litmus test with respect to how her clients understand norms, a perspective that falls within Kleinman's (1980) theory of "explanatory models" and helps her negotiate care with her clients. On one hand, Abigale aims to de-medicalize infant feeding, but on the other hand, she is 'medically socializing' her clients so that they understand how and why their bodies are changing and can therefore follow her recommendations (Browner 1996) on such things as 'cluster feeding.' Like Isabelle, Abigale also seems to agree with Canguilhem that norms cannot be understood outside of their context and that diversity does not necessarily equate to pathology.

But what does context mean for Abigale? As she wades through the confusing arena of 'culture' and place related to infant feeding, she more or less comes up with nursing lay theories on why certain mothers feed their infants in certain ways, creating new normal parameters based on 'culture.' (Chapter 3 delineates how these lay theories are actually created and endorsed by nursing theory). Even though Abigale is trying to de-medicalize and empower her clients, she is still putting them into categories, despite her awareness that this can create generalizations. Like the explanatory model, Abigale's focus on culture may negate critiquing other sociopolitical, historical, economic, and structural factors that influence the clinical encounter (Lazarus 1988) and breastfeeding practices.

How Nurses Make Up People

Abigale's description of the grandmother forcing a bottle into the grandchild's mouth while the mother was breastfeeding was described as a "very typical picture... in that... certain geographic area." When I asked her to tell me more about the geographic area, it turned out that this area has a well-defined population. At first Abigale was very hesitant to describe this population. Initially, she claims that the population is "Asian." She then gets flustered, looks at me uncomfortably, and mouths, "Can I say that?" so that it is not heard on the voice recorder, and then proceeds to describe them as "Chinese." In fact, throughout all of my interviews and participant-observation experiences, the PHNs' clients were continually referred to as populations in place of other descriptors. Bridges' ethnographic research of pregnancy as a site of racialization describes similar findings: "Population is mimetic of 'race' insofar as both concepts share a logic of differentiation" (2011:179). She explains that both 'race' and population are perceived as natural categories, so that the social, political, and economic contexts in which they are ascribed are not examined. Therefore, the term population, like 'race,' is continually reinscribed as natural by its mere reference, even as it is simultaneously made apolitical.

But in contemporary times, what is the point of talking about people in terms such as populations? Perhaps Abigale's hesitancy to use the correct 'raced' word is due to Canada's concern with using politically correct terminology (Das Gupta 2009). Terms like population are deemed apolitical and neutral; they are therefore appropriate and readily used by PHNs in everyday nursing speech. Bridges' study also found that population was used as a means to "deracializ[e] racialist discourse" (2011:180). By not having to reference 'race,' biomedical providers can invoke raced particularities without being held accountable or having to reflect on why the term is invoked (Bridges 2011). Moreover, they do not need to be concerned that they will be called racist if 'raced' notions are not explicitly mentioned. Therefore, breastfeeding promotion and nursing praxis can continue as it always has through making up populations because their speech is politically correct.

Moreover, 'population' can be invoked as a way to stereotype and caricature diverse individuals based on socially constructed racial attributes. Bridges states that health care practitioners

would “caricature” population-of-people by not describing their internal diversity; she “began to wonder the extent to which the concept of population was responsible for that caricature” (2011:146). Thus, population is a new racialized term that can stereotype and caricature diverse individuals.

Trends, Populations, and Statistics: Formulations of Generalizations and Stereotypes

PHNs’ biomedical authority facilitates their ability to ascribe mothers into raced ‘populations.’ In this way, ‘race’ and population both function as a means to separate disparate people into ranked groups. Throughout my research, most of my participants identified infant feeding ‘trends’ in terms of populations. Further probing and discussions revealed that the population most PHNs were actually referring to were ‘Asian’ and/or ‘Chinese’ mothers. As noted in Chapter 1, the category of ‘Asian’ is in quotations to signify that ‘Asian’ people have been essentialized as a homogenous group in Canada (Ward 2002). ‘Asian’ and ‘Chinese’ categories were often conflated and used interchangeably by most PHNs. The next chapter outlines how the made-up population of ‘Chinese’ mothers are essentialized through the caricature of the “mixed feeder” (meaning the breast and formula feeder).

Even though public health nursing is intimately connected with statistical measurements, biostatistics, and epidemiology (as I discussed in the *Biomedical Histories* segment), the PHNs in my study did not come to know ‘population trends’ through statistics and epidemiological figures; they base infant feeding ‘trends’ on experiential knowledge. One PHN noted that, as PHNs are ‘on the ground’ anyway, they recognize ‘trends’ and thus do not need mathematics to label what they see and experience. This PHN was hesitant to believe that statistics could provide any new information about the lived reality of her postpartum clients and their infants.

Furthermore, more than half of my participants were hesitant to use statistics based on demographic categories to inform their practices. These participants felt that demographic categories such as age, income, race/ethnicity, and immigration status are only one way to categorize people, but that categorization could also hide more pertinent reasons for breastfeeding disparities/inequities. All of the PHNs interviewed emphasized that many factors in women and infants’ social and environmental milieus, as well as their medical histories and

current state of health, can impact breastfeeding initiation and duration rates. They also felt that statistics can be “skewed,” are “open to interpretation,” and are “funky.” Additionally, most acknowledged that statistical knowledge could lead to generalizations and stereotypes. As such, there was no consensus related to how statistics inform public health nursing practice; the reasons for breastfeeding or not breastfeeding were seen to be multifaceted.

And yet, the PHNs avoidance of using quantifications and statistics did not qualitatively reduce their use of stereotypes and generalizations. In fact, disguising racialized indicators with euphemisms such as population may similarly dissolve people’s multifaceted and unique characteristics, the very thing PHNs are concerned about doing if they rely upon statistics. However, it is quite evident that racialized categories such as ‘Asian,’ ‘Chinese,’ and ‘Japanese’ continue to operate in breastfeeding promotional contexts and that they are often disguised by using the population euphemism. I proceed now to deconstruct how racialized public health nursing assessments and surveillance are practiced among ‘Chinese populations’ in B.C.

Chapter 3. Racialization of Culture, Bodies, and Praxis

Nursing praxis racializes and ‘others’ particular mothers in Coast Salish City. When I refer to praxis, I am describing the relationship between nursing theory, practice, and a nurse’s own thoughts, beliefs, assumptions, histories, and experiential knowledge that is situated in specific contexts and histories. The latter factor requires me to critique the past in order to evaluate the present. I find Jolly’s (1998:19) concept of “past-in-present”²² a useful tool for understanding how the past and the present are continuous, related, and divergent, as they are in this instance, where colonial-settlers’ historical ideas of ‘race’ in B.C. continue to influence the everyday praxis of PHNs in Coast Salish City. I particularly explore the connections and disconnections between the ‘past-in-present’ because ‘Chinese’ mothers were disproportionately singled out by PHNs in my study. Specifically, I investigate whether and how Canada’s colonial past—replete with discrimination against ‘Chinese’ people—might affect how ‘Chinese’ women were perceived in contemporary Coast Salish City.

To that end, I study and critique how and why my participants overwhelmingly use ‘Chinese’ mothers as exemplars for discussing breastfeeding disparities and how those aspects impact nursing praxis.²³ My ethnographic accounts illuminate how racialization and ‘othering’ are enacted in public health nursing domains by examining PHNs’ beliefs, attitudes, theory, and practices and the relationship between their interior thoughts and exterior practices, all of which culminates in their praxis.

²² Hereafter, I attribute the concept and term “past-in-present” to Jolly (1998).

²³ *Disparity* refers to differences in health outcomes without normative judgement (Community Health Nurses of Canada 2013); whereas health inequity refers to health outcomes that are impacted by patterned, unfair systems that are socially produced and are not random occurrences (Canadian Public Health Association n.d.). ‘Chinese’ mothers’ infant feeding practices were not believed to be related to any inequitable circumstances. Rather, the ‘differences’ were attributed to the mother and her ‘culture.’

Unpacking Categories and Terms: Essentialism, Racialization, and Racism

Ward, a Canadian historian, in 2002 documented how the most powerful racial group in B.C.—‘White’ men—used raced-based popular thought to mold B.C.’s public policy to discriminate against ‘Chinese’ residents in the 19th and early-20th centuries. The politically and economically powerful ‘White’ settlers were able to enforce widespread discrimination by categorizing diverse people into the classification of ‘Chinese.’ Ward (2002) asserts that ‘Chinese’ people have thus been essentialized and homogenized in Canada despite being distinctly heterogeneous. This racial essentialism allows for systemic and personal discrimination that typically takes the form of racism.

Essentialism, racialization, and racism are deeply enmeshed. By essentialism, I am referring to the belief “in the real, true essence of things, the invariable and fixed properties which define the ‘Whatness’ of a given entity” (Fuss 1989:xi). Essentialism prevents a diversity of being by naturalizing and cementing socially constructed ideas of ‘others.’ I build on Ward’s 2002 work by looking at how racialization follows from essentializing praxes that view ‘Chinese’ mothers’ ‘Whatness’ in static and immutable ways. But racialization is more than just a belief in someone’s racial ‘Whatness.’ With racialization, the ‘Whatness’ is imposed and ascribed to people and their bodies because of differentials in power,²⁴ and it can be used in multiple and simultaneous ways. Racialization is the foundation from which social hierarchies are created and oppression can flourish (de Leeuw, Kobayashi, and Cameron 2011). The most benign form of racialization is labelling, but there will often be elements of evaluating and, in its most destructive form, validating oppression (Fassin 2011). Racism is the social consequence of racialization, but it does not necessarily occur each time someone is racialized (Reading 2014). Racism is based on false beliefs about people’s inherent qualities and their social value, usually involving a hierarchy of superiority and inferiority (Reading and de Leeuw 2014). Racism can

²⁴ ‘White’ people are racialized into the ‘White’ category, but the effects of racialization differ because institutional structures and historical and contemporary power dynamics do not instantiate continued, systemic racial discrimination involving ‘White’ people (Das Gupta 2009).

be found in interpersonal relationships, internalized ideas, structural systems, and epistemologies (Reading 2013; Jones 2000).

Racialization is identity attribution from someone in a position of power. As I noted in Chapter 2, the 'Chinese' identity assignation is in quotations to remind the reader of how people and 'populations' are 'made up' and to signify that these categorizations are contested, political concepts. The 'Chinese' label represents not only a country or an 'ethnic,' categorization, but also a 'raced' typology with regard to Canada's colonial history. The quotations symbolize the hegemonic usages of 'Chinese' identity, emphasizing that popular opinions neglect its internal diversity; social positions and identity categories that are glossed over for 'Chinese' people include, but are not limited to, socioeconomic statuses, geographic origins, language(s) spoken, citizenship status(es), religious background, and so on.

I am not setting up a false dichotomy of 'Chinese' versus 'White' as I unpack the 'Chinese' category in contemporary B.C. Rather, I am illustrating a significant finding in my research, namely that 'Chinese' mothers are continually assessed in relation to the hegemonic 'White' settler. Through these 'Chinese' exemplars, I identify how mothers' names, infant feeding practices, and bodies are racialized with reference to nursing theory and Canadian colonial history. While the views of some of the PHNs in my study diverged, my thesis focuses on the predominant themes expressed by the majority of my participants. Firstly, however, I revisit the past to reveal how history reproduces itself in new forms to demonstrate that, far from being dead, history continues to impact people's lives in Coast Salish City. Once I have addressed the past, I delineate how these ideas affect present realities and then close the chapter by explaining how racialization has been built into nursing praxis.

Canadian Historical Context

Contemporary notions of 'Chinese' mothers are remarkably similar to those historically held of 'Chinese' people generally. Ward's analysis of historic documents, including legislature and newspaper articles, highlighted the overt contempt and discrimination faced by 'Chinese' people on Canada's west coast. The prevailing belief amongst settlers was that the 'White' race was superior. Inherent in this view were the distinctions drawn between 'us versus them,' 'West

versus East,' and 'insider versus outsider.' There was the perception that 'Chinese' people could never fully assimilate into 'White' settler Canada because of their rigid qualities (Ward 2002).

The prospect of more unassimilable 'Chinese' aliens moving to Canada concerned 'White' settlers, who feared that mass immigration would result in the extinction of the dominant 'White race' (Ward 2002). At the end of the 19th century, immigration restrictions motivated by racial prejudices ensued. The Chinese Head Tax was created in order to prevent further 'Chinese' migrants from coming to B.C. This tactic not only prevented male 'Chinese' workers from immigrating, but also ended the immigration of 'Chinese' females as a way to limit 'Chinese' reproduction on B.C. soil.²⁵ Discriminatory immigration laws specifically targeted 'Chinese' women because the prevailing 'White' ideology purported that 'Chinese' women's 'essence' was antithetical to Canada's 'White' nationalist project (Ward 2000). 'Chinese' mothers' reproductive capabilities and their offspring were seen as a threat to the reign of the 'White race' in Canada. These examples illustrate and historically contextualize how 'Chinese' people, specifically women and mothers, were discriminated against. Racist policies were enforced because 'Chinese' people were understood to be an immutable, essentialized group amongst 'White' settler Canadians.²⁶

Moreover, essentialized notions of 'Chinese' people helped to concretize the social hierarchy and power of 'White' settlers in the province. 'White' political dominance was perpetuated through the regulation of immigration and by classifying 'Chinese' people as a racialized 'other' in Canada. These hierarchies of power and patterns of exclusion reinforced the hegemony of B.C.'s 'White' Canadians.

Yet, members of the "Chinese diaspora" in Canada, and B.C. in particular, have rejected, negotiated, and affirmed their "Chineseness" and the 'Chinese' category (Ng 1999:8–9). While I

²⁵ Of course 'Chinese' reproduction did occur, but it was substantially decreased because of immigration laws (Ward 2002).

²⁶ Even though racial prejudice was not unanimously articulated in B.C., racist notions were widespread, and dissenters of racist rhetoric kept their opinions to themselves (Ward 2002).

do not wish to portray B.C.'s 'Chinese' people as lacking agency related to their own identity constructions, I do think it important to emphasize the salience of the 'Chinese' category in relation to hegemonic 'White' settler assumptions and how new deployments of the 'Chinese' category are used today in B.C., especially in health care contexts. The ways in which 'Chinese' people were not accepted as Canadian and were perceived to be the racialized 'other' reverberate through time. Keeping these ideas in mind clarifies how similar notions of racialized 'others' impact clinical relationships between PHNs and their 'Chinese' clients today.

Contemporary Ethnographic Accounts of Racialization

Against this historical backdrop of institutional and socially mediated discrimination, I locate my ethnographic study within B.C.'s public health care settings in order to understand local, contemporary forms and constructions of racialization. As discussed in Chapter 1, my research participants' inhabit various social locations and positions, and not all of them are attributed 'White' settler statuses. I acknowledge that privileges are fluid; my participants have intersecting identities and consequently hold and yield power in different circumstances, times, and places. Importantly, as approximately one-third of my participants were former immigrants, they may have been educated and grown up with different ideas about 'race.'²⁷ Thus, my emphasis is not only on Canadian-born PHNs, but on how racialization and 'othering' are generated by local knowledges, biomedical ideas, specific sites, and historical junctures.

Moreover, racialized and non-racialized PHNs may take up (or resist) hegemonic ideas about racialized mothers' bodies because of their social locations, positions, and biomedical training. Perhaps counterintuitively, a PHN who has experienced racism may yet perpetuate it through various means such as internalized racism (Bridges 2011; Das Gupta 2009). The PHN may internalize racialized (and racist) beliefs regarding herself as well as her clients. As such, I

²⁷ John Hartigan's (2013) ethnographic research in Mexico shows how Mexican genomic researchers understand 'race' very differently than their American counterparts. Hartigan (2013) emphasizes that critical race theory is culturally based and therefore may not translate as well onto other settings as might be expected for the purposes of critiquing processes of racialization.

focus on contemporary nursing praxis as a way to move beyond binaries of the ‘non-White’ oppressed and the ‘White’ oppressor in order to account for the fluidity and contextualization of processes of racialization.²⁸

By focusing on context and nursing praxis, I examine the ways in which professional nurses have power, influence, and authority in infant feeding contexts. Focusing on nursing praxis in clinical settings allows me to study how biomedicine’s ‘hidden curriculum’ inculcates public health nurses. By acknowledging that public health nursing has its own set of values, practices, and histories, I demonstrate that it is one of ‘many biomedicines’ (Hahn and Kleinman 1983) and that it impacts PHNs and their clients in unique ways.

However, as racial ideologies and taxonomies stem from the ‘dominant’ group, I would be remiss to dismiss how ‘White’ settler privilege operates and continues to constrain opportunities for ‘non-White’ people in Canada, given that ‘White’ settlers have been “exalted” as the ‘adequate heirs’ of Canada (Thobani 2007:9). For those reasons, I emphasize and historically contextualize ‘White’ settler ideology and its continued influence in contemporary times by examining how the clinical domain in health care institutions distils local values and discourses (Anderson and Reimer Kirkham 1998; Sargent and Erikson 2014). I now offer concrete clinical examples that illustrate how historical racialized discourse continues in everyday institutional contexts in B.C.

Racialization of a Name

The triage area has nine liaison records waiting on a large desk to be assigned. Seven nurses are working today, and most are busy with follow-up appointments, immunization clinics, and parent-infant groups at community centres. The triage nurse asks who can take a new client as she attempts to distribute the files evenly amongst the nurses. Stella, the nurse I am currently observing and interviewing, asks for a new “primip” (first-time mother).

²⁸ For that reason, I do not dwell on my participants’ identity categories, unless they explicitly bring it up during participant observation or the interview.

She and I go back to her desk. Stella briefly looks over the liaison record and states, “I am not sure if this client speaks English.” She then proceeds to state the client’s last name: ‘Wong.’ I ask if the liaison record notes whether the client needs interpretation services, and she replies, “No, it doesn’t say anything about the language.”

My study participants are aware that I am studying nursing praxis and how it might contribute to breastfeeding disparities and inequities. Therefore, during my observation and interview experiences, I watch and ask questions about the PHN’s own breastfeeding promotion practices. While it might not seem significant that Stella equates the last name Wong with the assumption that the client does not speak English, Stella’s next interview excerpt provides more insight into why this is problematic.

Stella: I think the only culture that I see this particular problem [early cessation of breastfeeding and/or mixed feeding] with are Chinese mums... It’s so common because, like, every single time I pick up a liaison that says... It’s obvious that the mum is Chinese; it almost always says they are giving formula and I pretty much know how it is going to go from then on.

AM: How does it say on the liaison that they are Chinese?

Stella: It doesn’t. Just their name.

The PHN does not need to see the mother at all, as the liaison record ‘sees’ the mother. This example indicates that a racialized assessment does not require the observation of physical qualities such as skin colour or bodily features. Stella was not unique in equating last names with clients’ backgrounds; in fact, eight PHNs stated outright that they know a client’s ‘culture,’ ‘racial,’ or ‘ethnic’ background from the last name on the liaison form. Thus, the liaison record helps to make up ‘Chinese’ mothers and ‘place them into’ particular categories by communicating and concretizing preconceived notions about infant feeding styles based solely on last names.

I argue that last names and infant feeding styles are new markers of ‘race’ which assign mothers to the ‘Chinese’ category and, in doing so, consign the mother as “the imposition of difference” (Fassin 2011:422). Stella’s use of labelling last names to particular groups should be analyzed in relation to her earlier comment regarding the client with the last name Wong. In that instance, Stella also made assumptions regarding the client’s facility with language.

Racialized assessments based on infant feeding styles and last names prompt many PHNs to hypothesize about language ability and, potentially, immigration status. Thus, Stella racializes and ‘others’ her client because she believes Wong is an ‘alien,’ non-Canadian, last name. Ergo, the client must not speak English. As Fassin notes, “Racial ascription is always also a social assignation” (2011:423). Racialized mothers are marked ‘other,’ thus generating perceptions that they may not be fully integrated into Canadian society. (This feature is addressed in Chapter 4).

Racialization of Infant Feeding Style

During interviews or after participant-observation experiences, more than half of the PHNs brought up the concern that ‘Chinese’ mothers typically “mix feed” their babies.²⁹ Most were not able to provide an explanation for this phenomenon without relying on essentialized cultural terms. In fact, a large body of biomedical research has studied the “Chinese’ breastfeeding problem.’ Chen’s doctoral thesis based on interviews conducted in B.C. begins by stating succinctly “breastfeeding choices among Chinese mothers are a major challenge for health professionals in the Western biomedical care system” (2002:ii). Chen is referring to the widespread belief amongst health care practitioners that ‘Chinese’ mothers formula feed their babies indiscriminately as compared to their ‘Western’ peers. Again, biomedical research focuses on the mothers’ practices, not on biomedical caregivers’ rationale for marking particular mothers as ‘deviant.’

Similarly, Bridges (2011) discusses how racialized mothers in the United States are deemed deviant through the naturalization of ‘cultural’ differences. Bridges argues that this stems from Franz Boas’ attempt to prove that ‘culture’ was more relevant in determining a person’s life chances than was ‘race.’ Even though Boas’ concept of culture was anti-essentialist—it was an attempt to render racist discourse immobile—culture was taken up in multiple ways and often as

²⁹ Mixed feeding means not exclusively breastfeeding the infant during its first six months of life. It entails providing formula supplementation at certain feeding times, whether after breastfeeding (by bottle or breast) in order to ‘top-up’ the baby, or formula might be given without offering the breast or breastmilk.

a static, rigid concept mimetic to, and a placeholder for, 'race' (Bridges 2011). Over time, as talking about 'race' became impolite, 'talking culture' was deployed to do the same work (Bridges 2011). Thus, similar to Bridges ethnographic findings, 'Chinese' mothers in Coast Salish City are racialized because they 'deviate' from the unstated, 'White' Canadian norm.

'White' infant feeding norms become the normative, natural standard against which 'Chinese' mothers' infant feeding practices are measured. In this context, 'Chinese' mothers' practices are considered inferior because they are (perceived) to defy the WHO's, DHA's, and health practitioners' breastfeeding recommendations. 'Chinese' mothers become the 'imposition of difference' in relation to 'White' Canadians' infant feeding styles. Moreover, this hegemonic comparison essentializes 'Chinese' and 'White' mothers' infant feeding styles by believing that both these socially constructed groups of women have a 'Whatness' that defines them.

PHNs' processes of locating infant feeding practices is one way to situate the racialized 'other' by stating—"I know you, and I know you won't change." These thoughts and beliefs are similar to earlier 'White' settlers' assumptions regarding the 'Chinese' people's rigid and immutable qualities; they would never change or be capable of adhering to 'Canadian ways.' The belief that mixed feeding is a breastfeeding style that 'has always been done' by 'Chinese' mothers is another way to reify and reinscribe 'culture' in an essentialized, raced manner.

Racialization of Bodies

I now illustrate how 'Chinese' mothers' bodies are racialized within society and during the clinical encounter. The section above, titled *Racialization of a Name*, notes that 'Chinese' mothers are not racialized based solely on physical attributes. In fact, PHNs did not mention the physical features of their 'Chinese' clients. Yet, the 'Chinese' category is still 'colour-coded' because it is premised on unstated physical attributes. For example, not everyone who formula or mix feeds their baby will be put into the 'Chinese' category. Therefore, physical characteristics such as skin colour, hair texture, and eye shape still signal to the PHN which category a mother belongs in.

Public health nurses obviously did not make up the 'Chinese' category and construction alone. Raced ideas about bodies operate in the larger society and infiltrate the clinical realm. Ideas of

'Asians,' 'Europeans,' and 'Africans' began as early as the late-1600s and were cemented during colonialism (Reading 2013). The scientific and medical classification systems and ideas that racialize women's bodies (discussed in Chapter 2) still permeate today's society.

However, as one nurse noted, even though she grew up on Coast Salish territory, she first learned about the 'Asian' and 'Chinese' infant feeding stereotypes when she entered nursing school in B.C. Stereotypes such as 'no milk syndrome' were later reiterated when she worked on maternity wards and in public health breastfeeding settings. While there may be racial stereotypes about 'Chinese' women's bodies in the greater public, clinical settings exhibit unique stereotypes that are created in-house.

Raced ideas are also being co-constructed by racialized mothers. A few PHNs noted that 'Chinese' mothers often express the belief that their breasts are inadequate milk producers in relation to 'big breasted women' (a term that refers to 'White' Canadian mothers). During one home visit, a first-time mother was breastfeeding her baby on one breast and the other breast was dripping and pooling breastmilk onto the baby's diaper. Elyse, the PHN at that home visit, explained to me that the mother was nevertheless concerned about her milk production because she believed that her breasts were too small.³⁰ Elyse later explained that "no milk syndrome" is a common occurrence with 'Asian' mothers. Although Elyse acknowledges that 'no milk syndrome' is an "Asian stereotype," she justified her belief in its veracity by arguing that this stereotype is not a distortion. Elyse says she hears 'Asian' mothers' complaining about their breast size and milk production capabilities almost every day during her home visits. 'No milk syndrome' stereotype is therefore not a distortion or a generalization because virtually ALL 'Asian' mothers adhere to it.

Even though Elyse does not believe that 'Asian' mothers breasts are biologically inadequate to feed babies, she argues that the 'no milk syndrome' stereotype stems from "cultural differences" and "different insecurities" unique to 'Asian' women. I, on the other hand, do not agree. I contend that 'no milk syndrome' impacts many women from all over the world because of

³⁰ This mother self-identified as Chinese.

historical, social, economic, and political incidents that help create and maintain certain ideas about bodily processes and reproduction. Formula marketing companies have played a particularly large historical and contemporary role in promoting formula and devaluing women's bodies in many places, including China, Canada, and beyond (Van Esterik 1989).

PHNs' structural analyses are blinded by overly deterministic beliefs about 'culture.' Reasons for 'no milk syndrome' are typically blamed on 'Chinese' or 'Asian culture' in general and, in particular, the promoters of 'Chinese' infant feeding styles, 'Chinese' grandmothers.' As such, the stereotype of the 'Chinese' mother who believes in the 'no milk syndrome' myth is perpetuated. The next section discusses how 'race' and 'culture' have come to work interchangeably in nursing contexts.

Raced Theory: The 'Boxification of Culture'

The PHNs' theories of 'race' were bolstered and encouraged by their many years of nursing and cultural competence education. Leininger's (1978; 1988; 1991) Transcultural Nursing (TCN) theories aim to support nurses in assessing their clients' culture so that they can plan and implement proper care. The hope was that nurses would increase their 'cultural competence' by learning about other peoples' cultures. However, nurses would oftentimes simply read 'recipe style' guides, both about how to provide care for racialized people as well as the reasons given for their 'divergent' beliefs and practices (e.g., all 'Asian' mothers mix feed their infants because they do not understand the importance of colostrum).

As TCN theories and models developed in response to increased immigration and subsequent demographic changes in North America, they generally targeted American—read 'White'—nurses, so that they could adequately care for immigrant 'others.' Thus, Leininger's TCN theories were always built "within a framework of race and ethnicity" (Seaton 2010:8).³¹ While there have been additions and changes to Leininger's theory, it continues to be the preeminent

³¹ I discuss the conflation of 'race' and immigration in detail in Chapter 4.

'cultural care' model in nursing, where 'culture' is assessed by comparing difference in relation to the 'White' centre (Seaton 2010).

Similarly, Penny Van Esterik argues that the biomedical enterprise within breastfeeding promotion contexts has reinscribed race through the "boxification of culture" (2012:56). She argues that health professionals' main breastfeeding textbook, *Breastfeeding and Human Lactation*, encourages this boxification of culture by providing rationales about cultural differences in a 'recipe-like style' as a way to increase 'cultural competency.' Reducing breastfeeding styles to 'cultural tick boxes' only epitomizes differences and creates stereotypes; instead of promoting quality care, the focus on 'cultural knowing' creates essentialized, static groups by not recognizing the diversity amongst people.

These cultural stereotypes concomitantly 'racially box' particular mothers' infant feeding practices because, as mentioned earlier, culture is commonly conflated with categories of race and ethnicity in health care contexts. As Hannah noted in 2011, culture has come to be known as a proxy for 'race.' My aim is not to throw out the 'culture concept' altogether, but I do want to highlight when it is used and for whom. The problem of 'culture' was suggested as a reason for breastfeeding disparities during all but one of my interviews. Only rarely was a cultural critique of "Western" and 'Caucasian' infant feeding practices included, and those occasions centered upon the sexualization of women's bodies and formula-marketing campaigns, two issues which might impact 'Chinese' mothers as well (and may explain why some 'Chinese' mothers are concerned about their breast size and lactation capabilities). In this way, 'culture' helps PHNs make sense of potential 'disparities' without having to be critical of structural constraints.

Due to the focus on 'culture' and cultural difference evident in TCN theory, PHNs may not consider other potential reasons for 'deviant' breastfeeding practices by racialized groups. Alongside other anthropologists, I argue that cultural competence models have failed health practitioners. In fact,

anthropological critiques assert that cultural competence models tend to present culture as static, treat culture as a variable, conflate culture with race/ethnicity, do not acknowledge diversity within groups, may inadvertently place blame on a patient's culture, often emphasize cultural difference, thereby obscuring structural power imbalances, and finally, fail to recognize biomedicine as a cultural system itself (Carpenter-Song 2011:178).

Additionally, 'Western' and 'Caucasian' categorizations were typically invoked to juxtapose 'Chinese' or 'non-White' groups' infant feeding practices to 'normative' Canadian practices. As such, the majority of discussions surrounding 'culture' had to do with racialized groups—mainly 'Chinese' mothers—who live in Coast Salish City. Reimer Kirkham, who also completed ethnographic research in B.C.'s maternal/infant health care settings, states that the nurses she interviewed also viewed racialized clients as those who "carried culture, suggesting that culture has to do predominantly with difference from the dominant White culture" (2003:774). Therefore, 'culture' is deployed as a way to differentiate 'other' 'non-White' groups, including those categorized as 'Chinese.'

Other nursing theories focus on a nurse's culture instead of the clients, but they have not been widely taken up in practice (Seaton 2010; Browne et al. 2009). One example is Ramsden's 1996 "Cultural Safety" framework, which encourages the nurse to scrutinize her own culture, attitudes, prejudices, and power. Cultural Safety is not about the clients' culture or ethnic background; it is about the nurses' social location and positionality in relation to social structures and power. However, practitioners and scholars alike have argued that this theory is hard to implement in practice (Browne et al. 2009). Others have shown that nurses prefer the TCN tick-box approach to understanding 'facts' about their clients' 'culture' (Culley 2006). I argue that the most prevalent aspect of the Cultural Safety model that has been taken up in nursing practice is the reiteration of the totalizing concept of 'culture.' Like Browne et al., I agree that the conceptualization of culture needs to be improved in nursing theorizing, but I would also emphasize that this cannot be done in isolation. It must be done in conjunction with conceptualizations of 'race,' racialization, and 'othering,' among others.

Racialized Praxis

The question remaining to be dealt with in this segment is this: When nursing theory, practices, attitudes, and experiential knowledge collide and are imbedded in specific socio-historical and political contexts, what does a racialized praxis look like?

During each interview with my 20 participants, I asked if they would ever change their breastfeeding promotion practices. While most resisted the idea that they provide differential

treatment to their clients—which they understood to mean providing sub-optimal care—some participants reflected that, indeed, their practices do change when they provide services to ‘Chinese’ mothers. For example, a few explained that they would bring language interpreters to a home visit. Others noted that they would attempt to use laminated pictures, be more “hands-on,” and spend a little more time explaining and teaching “how we do things here.”

Despite the fact that all public health nurses interviewed explicitly stated that they would not be less likely to promote, support, or protect breastfeeding for any particular mother, at one public health unit, the postpartum package for “Chinese” speaking mothers was markedly different from those labelled “English.” The English postpartum package had information on breastfeeding and immunizations, as well as on community resources. The Chinese package contained the same materials, but with additional information on formula feeding. When I asked why the postpartum packages differed, I received only a half-hearted response. I was told that some PHNs decided at a team meeting long ago that adding information on formula to the Chinese postpartum package was simply an effective use of a PHN’s time. They felt that they would inevitably end up providing information on formula feeding anyway.

The postpartum package is a striking example of how beliefs about institutional practices can be reproduced in a way that does not stand up to careful reflection. It provides an explicit example of how PHNs’ beliefs, attitudes, practices and theory impact their clinical praxis toward ‘Chinese’ mothers. While I cannot say this is a *racist* praxis, per se, it can be deduced that ‘Chinese’ mothers are viewed as an essentialized group who receive differential treatment based on their perceived difference.³² Thus, through the systematic dissemination of formula materials, ‘Chinese’ mothers are denied by PHNs the recognition of other infant feeding realities and, it could be argued, other potential identities as well. Nevertheless, not all ‘Chinese’ mothers will receive the Chinese language package, as the decision regarding which version to leave depends on the nurse’s assessment.

³² The promotion of formula feeding is widely seen to deter breastfeeding. The information provided by PHNs was not as a promotional tool; it only gave instructions regarding how to prepare formula safely.

Stephanie, a nurse with less than a year's experience, provides an excellent example of how a nurse assesses when to offer a Chinese package during a home visit. On our way to the home visit, Stephanie explained to me that during the triage phone call with her client she had overheard the mother speaking Cantonese, so she brought both the English and Chinese postpartum packages. She explained that even though the mother spoke "perfect English," she was not sure if other members of the household did. Therefore, she brought both the Chinese and English packages and planned to ask the family which package they preferred.

During the home visit the mother explained her plans to exclusively breastfeed. Stephanie and the mother had excellent rapport throughout the home visit: their body language was relaxed, they both smiled and laughed often, and the mother was engaged in their conversation. Stephanie was able to help the mother with the baby's positioning and latch, so that breastfeeding was more comfortable for her. The mother and father of the baby seemed very grateful and content with Stephanie's breastfeeding support. At the end of the visit, Stephanie asked them which package they preferred: Would they like the Chinese, the English, or both packages? The baby's parents decided to keep the Chinese package, so that the baby's grandparents could read the information too.

Even though the mother indicated that she wanted to exclusively breastfeed her baby, Stephanie did not remove the information on formula supplementation. In fact, there is a good chance that Stephanie did not even know that formula information was in the package. She had not looked inside the Chinese package as she went through the English version with the parents. Moreover, the meeting held to decide what to include in the postpartum packages was made before Stephanie had finished her nursing degree or started her nursing career. Yet, knowingly or unwittingly, Stephanie provided the family with information on formula despite their expressed desire to exclusively breastfeed their baby. Thus, even when PHNs attempt to provide individualized, quality care, institutional practices have already inscribed and concretized pre-existing assumptions and biases through materials like the postpartum package.

Is History Repeating Itself?

Given Canada's historical discrimination toward 'Chinese' people, as well as the historical raced contingencies of public health breastfeeding promotion campaigns in Canada (as outlined in Chapter 2), my ethnographic study explores the continuation of racialization by PHNs in B.C. Examining contemporary forms of racialization help to explain how historical ideas of 'race' continue to impact the present. My decision to organize historically documented facts and my contemporary ethnographic accounts as juxtapositions, and alternate between them, contextualizes the interplay and reproductions of racialization and 'othering' for 'Chinese' mothers in B.C.'s public health nursing contexts.

As racialization and 'othering' are both relational and contextual, my research examines the unique ways in which 'Chinese' mothers are essentialized in Coast Salish City. Specifically, I look at how nursing practice, theory, and a nurse's own experiential knowledge contribute to making up 'Chinese' mothers. My ethnographic accounts confirm that, although racial terminology is not invoked by PHNs, it is nevertheless an underlying classificatory element. Moreover, new essences, attributes, and characteristics of 'Chinese' mothers, such as their last names and infant feeding styles, are deployed in order to show their immutable qualities. I demonstrate how nursing theory has concretized essentialist notions of race-cum-culture and how 'culture' is now the polite and pervasive term used to essentialize diverse individuals.

Finally, I reveal how processes of racialization are built into nursing praxis through the example of the postpartum package, one that highlights the fact that PHNs perceive 'Chinese' mothers' infant feeding practices as static and thus institutionally provide differential care that is structural in nature. Even though PHNs like Stephanie do not intend to participate in structural racism, they play a part by institutionalizing and reproducing racial stereotypes and, inevitably, providing differential care. Stephanie did not personally racialize her clients, but she still takes part in the racialization of 'Chinese' mothers and babies by following the 'rules' (i.e., what is distributed to 'Chinese' mothers in the Chinese postpartum package), and then providing differential care in the form of resources based on previous raced infant feeding assessments. In this way, racialization and racist practices are sometimes built directly into practice.

Additionally, by focusing on 'culture' and 'race,' PHNs do not have to identify and work through other factors that impact their clients' infant feeding realities. Similar to the 20th century public health home visiting programs described in Chapter 2, reifying and blaming 'culture' diverts attention from structural issues surrounding disparities and inequities while making the mother the object of reformation. Aiming to reform racialized mothers' infant feeding practices is a much easier prospect than analyzing their clients' structural conditions. Focusing on 'Chinese culture' depoliticizes and ahistoricizes mothers' lived realities.

The use of the 'Chinese' category is not apolitical; it is deployed for particular reasons which PHNs are inextricably caught up in. The 'Chinese' category and its multiple deployments are discussed at length in Chapter 4.

Chapter 4. Affinities of ‘Othering’: Continuums of Citizenship and Belonging

For ‘Chinese’ mothers and their infants in Coast Salish City, socially significant markers of citizenship and belonging in breastfeeding promotion programs create raced affinities of ‘otherness.’ PHNs are put in the position of enforcing a schema that, in effect, racializes and facilitates notions of ‘otherness,’ belonging, and exclusion. Using family dynamics, language, and immigration status(es) as indicators that differentiate ‘Chineseness’ from ‘Whiteness,’ PHNs are encouraged by the health authority and the government to position ‘Chinese’ mothers on a continuum of ‘otherness’ juxtaposed against ‘White,’ Canadians. ‘Chinese’ non-resident/non-citizens are ineligible for home visitation services, and PHNs act as gatekeepers to public health services. Although it may be an unconscious and unintended consequence, Canadian citizenship and belonging are policed vis-à-vis breastfeeding promotion programming.

‘Thou Shall Always Say You Breastfeed’

Family dynamics, language, and immigration status are indicators that PHNs use to differentiate ‘Chinese-ness’ from ‘Whiteness.’ Continuums of ‘otherness’ are not merely a PHN social construction; they are co-produced with the DHA and the Canadian government. The next sections discuss how ‘Chinese’ mothers are assessed and positioned on a continuum of ‘otherness’ in opposition to perceptions of ‘White Canadian-ness.’

At different points during the interviews, over a quarter of my participants stated that the ‘Chinese’ family was problematic in relation to mothers being able to exclusively breastfeed their babies. For example, Abigale, the PHN introduced in Chapter 2, described what it was like to provide breastfeeding support even as “the [‘Chinese’] grandma was trying to stuff the bottle into the baby’s mouth while the mother was trying to breastfeed with a nipple shield.” Abigale told me later that she attributed the ‘Chinese’ mixed feeding and formula feeding ‘trend’ on aspects that were “deeply rooted in the ‘Chinese’ community.” When I asked Abigale what being “deeply rooted” meant, she was unable to explain the term, implying that it was an innate quality that had to be intuited. Moreover, Abigale explained that this ‘deep-rootedness’ made her feel

uncomfortable initiating conversations with 'Chinese' families about feeding practices that diverge from the Canadian 'norm.' She expressed a belief that those entrenched, deeply-rooted differences created barriers in the nurse-client relationship.

Other nurses identified nurse-client-family disconnects and sentiments using terms such as "cultural battles," un-crossable "boundaries," and cultural "fights." For example, Stella explained that 'Chinese' grandmothers take their grandchildren away from the mother (in order for the mother to rest) and feed them formula. Stella states she finds the 'Chinese' family dynamics and consequent cultural influences to be "extremely hard to deal with, really hard to deal with. I just, you know, I often feel like there is just nothing that can break that cultural barrier there." Frustrations with infant feeding practices considered outside the Canadian norm were commonplace. PHNs locate the 'problem' within the family realm, where childrearing practices are considered the domain of the elder maternal women. Chinese grandmothers are believed not to value breast feeding, and PHNs tended to view the 'Chinese' family unit and their 'culture' as barriers to breastfeeding 'success.' As such, PHNs felt that 'Chinese' infant feeding practices were fixed and that they conflict with Canadian practices. Further, they felt that these differences were difficult, if not impossible, to overcome.

PHNs draw on TCN theories to help them navigate these interpersonal and 'cultural' barriers. Transcultural Nursing theories understand 'Whiteness' as a politically neutral concept from which one can interpret difference (Gustafson 2005). They also encourage nurses to catalogue 'facts' about racialized people in order to understand their clients (Gustafson 2005). These racialized 'facts' of difference simplify infant feeding realities and provide overly deterministic explanations of breastfeeding differences. However, TCN theories and other explanatory models are supposed to help nurses assess the meaning of health and illness for an individual, family, and community to enable them to provide enhanced care based on the mother and her family's needs.

But PHNs face a paradox. Although they want to promote breastfeeding in accordance with the WHO's and DHA's recommendations, they also want to be 'culturally competent' and sensitive, in accord with TCN theories. The WHO promotes homogenous breastfeeding recommendations, apparently assuming all people can and should feed their infants exactly the same way, whereas TCN theories recognize that people have different ideas about health and

wellness. The PHNs are torn between their desire to recognize and be sensitive to difference, on one hand, and pushing a medically approved agenda of universal sameness on the other. Public health nurses do not want to impose or enforce breastfeeding practices that may seem 'foreign' to the 'Chinese' mother and her family.

There is no doubt PHNs are trying to provide good care, even though they are simultaneously and subconsciously reinforcing 'cultural' differences. The terms used by PHNs—"barriers," "battles," "boundaries," and "fights"—emphasize the 'cultural' incongruence between the two groups and their axiological divides. It is possible that PHNs focus on these narrow categories of 'race,' 'ethnicity,' and 'culture' because they feel that global health recommendations do not accommodate diverse infant feeding styles. However, in doing so, they perpetuate disconnects based on racialized ideas.

Isabelle, a self-identified Chinese nurse, stated that half of her job is trying to decipher what mothers *really* want to do in terms of infant feeding. She, like other PHNs, said that some mothers simply do not want to breastfeed, but the mothers nevertheless feel obligated to adhere to socially sanctioned, biomedical recommendations. The PHNs contend that mothers may already feel undermined by 'good mothering' discourses that promote breastfeeding and thus may feel the need to 'lie' to PHNs:

And a lot of, all of them ['Chinese' mothers], it is almost, like, "thou shall always say you breastfeed." [She adopts an exaggerated Chinese accent as she voices the next sentence]. "Oh, yes. I come home and breastfeed." Like I said to you, is mum lying? Do they tell me the truth (laughing)? It is almost like you are not a good mum if you don't breastfeed.

There are tensions between PHNs' belief in the benefits of breastmilk and their assessments that a mother is ambivalent about, or downright averse to, breastfeeding. As the nurse plays an intermediary role between the mother and the DHA's mandated breastfeeding policies, mothers may feel that they are being judged and therefore play the 'good mother' role. Yet, interestingly, PHNs believe that the performance occurs predominately within the 'Chinese' community. While being a "pusher of the breastfeeding agenda" and being perceived as a "breastfeeding Nazi" concerned all PHNs no matter what population they worked with, it seemed to be most disconcerting for PHNs working with the 'Chinese' community.

As subjective as these accounts of performance are, they collectively add up and create 'facts' of 'otherness' about 'Chinese' mothers, thereby changing the relationship between the mother and the PHN. Public health nurses may find it difficult or uncomfortable to assess mothers who are perceived as innately different, a situation which is compounded by the belief that the mother may 'lie' anyway. These tensions, purposely or inadvertently, create complications in the provision of breastfeeding support for 'Chinese' mothers. In addition, the tension between the 'ideal' breastfeeding mother and the breastfeeding Nazi create a rift between 'Chinese' mothers and PHNs, reinforcing the 'them versus us' distinction and positioning 'Chinese' mothers as not fully Canadian, despite their citizenship status. These boundaries based on ideas of the 'other' challenge the rapport-building process. The mother may lose out on needed breastfeeding support and, as a consequence, become a 'less-than-ideal' Canadian mother because of her infant-feeding 'choice.' This consequently reproduces preconceived ideas about 'Chinese' mothers' infant feeding practices.

Beth, a self-identified 'White' nurse with over 20 years of experience working with breastfeeding mothers, explains that in certain geographic communities in Coast Salish City, the 'Chinese' family and the greater 'Chinese' community infringe on a mother's ability to breastfeed in public. She explains that 'Chinese' mothers have told her that when they go to Chinese restaurants in certain areas of the city, they have been told to breastfeed their babies in the washroom. Beth states that:

[Breastfeeding] is not an accepted practice culturally, and it might not be an accepted practice within the [Chinese] restaurant. So, yeah. But why, in a sense, why should we be imposing our own ideas as to whether that should be changed? You know, maybe it is not our place, right? Maybe we should be saying, that is the way it is, and it is their place, and it is nothing to do with us, so why should we try to change it. Right? So it is sort of a balance of things. Right? So maybe we don't have any right to be saying what they should be doing. Right? (Laughing). Because we are not Chinese. Right? So, yeah. Trying to put our values on another cultural group is bad news. Right? So, see? It might be absolutely fine.

In this instance, Beth indicates her awareness of unfortunate past(-in-present) histories of paternalism and colonialism (i.e., we know best, do as we say). At the same time, she is also reinforcing the divide between 'Chinese' and 'White' folks. Beth does not want to push 'Canadian' ways onto 'Chinese' mothers and their families and communities. Instead, she

wants them to feel enfranchised to have their own practices. In many ways, Beth's thoughts and ideas are laudable, but they also reinforce the distinction between 'us and them,' 'Canadian' and 'Chinese.' Moreover, discriminatory incidents faced by breastfeeding mothers in restaurants are not isolated to Chinese establishments in Coast Salish territories (CBC 2015; Ip 2015), but when it happens to 'Chinese' mothers, it is perceived to be a cultural thing. Beth's example shows that cultural relativism might decrease PHNs' level of breastfeeding support for mothers they consider 'Chinese'—or 'other'—because they do not want to be perceived as ethnocentric state minions who are 'pushers' of breastfeeding and biomedical values.

'Chinese' by Degrees

Through their assessments, PHNs instantiate raced affinities of 'otherness,' and, consequently, parameters of citizenship and belonging. Assessing where 'Chinese' mothers belong on the referential continuum of 'Canadian-ness' helps PHNs evaluate degrees of 'Chineseness' based upon a mother's perceived 'cultural influences.' Stella's tentative remark highlights this process:

Just because the mum is Chinese doesn't mean that that's the way it goes. So, culture really comes into play based on how traditional they are. So I often ask Chinese mums if they are going to do the 40-day, you know, "staying-in-the-home" thing. And that gives me a really good indication of, sort of, how traditionally, culturally they believe in following, sort of, old traditions. Other Chinese mums that I see who don't have their mother or mother-in-law present and are quite westernized, typically married to a Caucasian man, um, I don't see as much trouble around the breastfeeding. Or as much pressure on the mum to not breastfeed.

When 'Chinese' mothers live a more "traditional" lifestyle, it indicates their divergence from 'Western' practices. More traditional mothers' 'cultural' practices and influences are perceived as 'barriers' that make it more difficult to provide breastfeeding support and care. However, when 'Chinese' mothers are 'Westernized,' perhaps from marrying 'White' men, they are merely racialized as 'Chinese' and are not 'othered' because they now espouse 'White' Canadian practices. In some ways, then, racialized mothers' 'otherness' becomes less pronounced, but they are still situated as potential outliers. Thus, earlier 'White' settler assumptions of 'cultural' permanence seem to be somewhat alleviated, but they still reflect raced binaries.

Public health nurses openly acknowledge that they cannot assume how 'Chinese' their clients will be. Beth noted that less traditional "Chinese-Canadian" mothers seem to be outliers in their own 'Chinese' communities; she supplemented her earlier comments regarding 'Chinese' mothers' experience of breastfeeding in Chinese restaurants with the following story:

But it is hard for the mums who have grown up here, who see their friends going into restaurants with their families and other settings and they breastfeed with their families around and then they go to a more traditional place and they are not able to take that piece that they want to do [breastfeed in public] and transfer to a place that their families meet [e.g., Chinese restaurant]. So it is this clash of generations and cultures, and age, and stuff. So...

Beth is attempting to understand how a "Chinese-Canadian" mother's identity categories and her wider social and familial networks intersect to cause friction and tension. Beth explains that place of birth, cultures, family and community traditions, and generational understanding all impact a mother's ability to breastfeed and generate tension between Canadian and 'Chinese' cultures. Again, Beth demonstrates her understanding that 'Chinese' cultures are not homogenous. Her empathy for "Chinese-Canadian" mothers was evidenced by her hesitancy to say it was not acceptable for Canadian-born 'Chinese' mothers not to be able to breastfeed in public spaces with their families. Yet she also seemed to be saying that the situation only merited intervention if it affected non-immigrant 'Chinese' mothers. Again, Beth may be attempting to be 'culturally competent and relative,' or it may demonstrate Beth's close affiliations with Chinese-Canadian mothers, whether conscious or not. Whichever is the case, this provides an example of continuations of connectedness regarding ideas of citizenship status, racialization, and belonging for 'Chinese' mothers.

Erasure of the 'Chinese' Category: Socio-economic and Immigration Status(es)

It is important to note that the Chinese-Canadian category is a fairly new identifier in Canadian history. In the 1970s, due to the looming separation between French and English Canada, the federal government proposed Multiculturalism as Canada's official state policy and ideology. The move was designed to celebrate all racial, ethnic, religious, and cultural groups in Canada, while also encouraging 'immigrant,' 'non-White,' 'others' to profess their allegiance and

identification with Canada (Ng 1999). The category of Chinese-Canadian developed as a result of multicultural ideology situated within the Canadian hierarchy of ‘cultures,’ ‘races,’ and ‘ethnicities.’³³ Similar to the TCN theories discussed in Chapter 3, the ‘White’ Anglo-Saxon centre was again so hegemonic that it did not need to be named, but ‘new’ ‘immigrant’ groups such as the ‘Chinese’ community did; for example, multi-generational ‘English’ settler Canadians are labelled Canadian, whereas multi-generational ‘Chinese’ Canadians are categorized as Chinese-Canadian.³⁴ As Jafri described it in 2012, settlerhood in Canada is a socially situated position impacted by institutions, hierarchies, and structures.

Moreover, the Chinese-Canadian categorization also acknowledges that something of ‘Chinese’ ‘culture’ continues to be seen or assessed. As such, even though Canada is a ‘multicultural’ nation, the country continues to focus awareness on its “visible minorities” (Statistics Canada 2012).³⁵ And while the term *visible minority* is problematic and should be contested,³⁶ the collapsing of multiculturalism and visible minority notions and terms is relevant to my contention in Chapter 3 regarding the conflation of ‘race’ and culture. It also resonates with the current chapter’s discussion of how one knows who *truly* belongs and who does not. As Bannerji (1993:182) states, the term *visible minority* comes from the belief that *they* are “‘different,’ ‘not normal,’ ‘not like us,’ ‘does not belong.’” Bannerji then adds that creating a category based on visibility overlooks socio-cultural-historical differences amongst people, and instead assigns superiority and emphasis to a socially-constructed Canadian identity. Thus, ‘Chinese’ or “‘Asian’ appearance[s] plays a large role in how others read identities and shape inter-cultural encounters” in Canada (Ty 2004:8). ‘Whiteness’ is mainly reinscribed as the authentic and trustworthy Canadian identity that signifies belonging (Thobani 2009); Chinese-Canadians must

³³ ‘Chinese’ communities challenged, supported, and negotiated the Chinese-Canadian category in multiple ways (Ng 1999).

³⁴ For some, the Chinese-Canadian categorization was seen as an improvement, because they were not previously seen as Canadian at all by their ‘White’ peers. Nor were they considered ‘Chinese’ by their ‘Chinese’ peers (Ng 1999).

³⁵ The visible minority “category includes persons who are non-Caucasian in race or non-white in colour and who do not report being Aboriginal” (Statistics Canada 2012).

³⁶ The United Nations has asked Canada to “reflect further” on their use of the term *visible minority* because its language is racially discriminatory (CBC 2007).

still be labelled 'Chinese' to indicate their 'othered' citizenship status. Again we see that visible minority status is both a social assignation and a political statement.

However, the 'Chinese' category morphs, unfolds, and is erased in many ways. Kim, another experienced PHN, discussed the Chinese-Canadian label in a different way. She explains that Canadian-born and foreign-born 'Chinese' mothers do not belong in the same category at all because Chinese-Canadian mothers have more "knowledge and education" and are "more confident" than their immigrated 'Chinese' peers. The markers of belonging for Kim are interrelated and enmeshed: immigration status, birth place, knowledge, and education. She therefore believes Chinese-Canadian mothers experience the same level of breastfeeding difficulties as 'White' Canadian mothers because they grew up in Canada with 'adequate' access to 'education' and 'knowledge.'

Kim further breaks down the markers of belonging by noting that those who live in the wealthier neighborhoods will also be more likely to breastfeed because of increased 'knowledge' and 'education' regarding breastfeeding. Thus, Kim also brings in the issue of socio-economic status (SES) and education, and how they differentially impact 'Chinese' mothers. Moreover, PHNs explain that the less knowledgeable, less educated, and less wealthy areas of the city are predominantly inhabited by immigrant 'Chinese' mothers. A quote from Tania Das Gupta, an equity studies professor who researched nurse-on-nurse racism, elucidates this comment:

The term 'immigrant' in Canada is a code for 'non-White.' Whiteness is commonsensically associated with being 'Canadian,' and anyone who is not White risks the chance of being labelled as an outsider or 'immigrant.' Thus such identity labels are highly racialized. In addition, racialization is affected by one's class background and ethnic attributes (2009:100).

'Chinese' mothers are increasingly racialized as 'Chinese' when they are poor and live in poorer neighborhoods. Their SES and community also render them less knowledgeable because of their perceived immigration and raced statuses.

While Kim is obviously aware that 'Chinese' mothers have multiple and intersecting identities which impact infant feeding styles, she is not taking an 'intersectional' (Crenshaw 1989) approach. She is not examining or acknowledging that structural systems of oppression may impact women (and mothers) in various and multiple ways. Again, by not looking at 'Chinese'

mothers' intersecting identities, Kim erases potential complex and interactional constraints and freedoms that affect a mother's ability to breastfeed.

Interestingly, as 'Chinese' mothers' SES increases, they are also perceived to become less 'Chinese.' In fact, almost all of the PHNs interviewed who referenced the wealthiest area of Coast Salish City did not talk about the mothers who lived in this area in racialized terms. Rather, they used geographic descriptors focusing on the mothers' SES. In fact, many PHNs stated they simply did not know which population group lived there and preferred to use terms such as 'anxious' or 'wealthy.' These response distinctions were not due to differences within public health nursing unit cultures or the particular PHN's responses to questions, as PHNs from different health units conveyed similar ideas: The category of 'Chinese' was almost universally erased when a mother's SES increased. To understand this phenomenon, I questioned Jenny, an experienced mother-baby nurse who worked in the 'wealthiest' geographic area of Coast Salish City, seeking more information about the wealthy areas' "specific cultural group."³⁷

Jenny: We definitely, I would say, highest percentage around ethnicity/race would be um, would be of the Asian descent and, ahh... I can't give you the exact stats, but the census would tell us such, but I would believe at that it is close to 50 percent. The majority would be Mandarin speaking as opposed to Cantonese speaking. Um. But that being said, we have so many cultures, it is hard to pinpoint which one is which.

Jenny's commentary indicates that racial, ethnic, and cultural categories are conflated. Secondly, even when PHNs are aware of a mother's "Asian descent," the mothers' class position renders her 'cultural' background invisible. A mother's SES becomes the preeminent identification marker, and her affluence places her closer to the hegemonic 'White' settler within the Canadian state. In a sense, the PHNs make up such 'Chinese' mothers as more 'White' because their 'race' or 'cultural' group is now deemed inconsequential, just as the hegemonic 'White' settler is not mentioned in Jenny's explanation. It is simply understood that 'White' folk live in the wealthiest area of Coast Salish City. Where else would the 'exalted' and natural

³⁷ I used the same term the PHNs being interviewed used. For example, if the nurse used population, I used population.

'heirs' of Canadian lands live? Even though Jenny had to think about the 'cultural groups' that live in the area and reflexively stated that they are not easy to identify, she still mentions only the 50 percent 'Asian' category (instead of the approximately 50 percent 'White' category), and she then explains that English is probably not their first language (potentially also alluding to their immigration status).

Language as a Racialized Marker of Belonging: Who Belongs to Canada?

Language is another identifier of belonging in Coast Salish City. Fanon argues that

to speak means being able to use a certain syntax and possessing the morphology of such and such a language, but it means above all assuming a culture and bearing the weight of a civilization (1952:1–2).

The Canadian government has constructed Canada as a bilingual nation (English and French) despite its history of being multilingual (including numerous Indigenous languages). As B.C. was a former colony of England, the English language is considered a "marker of assimilation and allegiance to the Canadian project," particularly in that province (Reimer Kirkham 2003:768). Being able to speak English in B.C. enshrines clients as 'truly' Canadian, while not being a fluent English speaker renders them 'not fully' Canadian (Reimer Kirkham 2003). Thus, the simple request for interpretation services may 'other' a client and distance them from being perceived as belonging to the nation of Canada.

The use of language services in biomedical settings can offer other benefits. Sargent's ethnographic work in France's maternity hospitals indicates that biomedical providers use racial folklore to inform when and for what reason they should use language interpretation services (Sargent and Erikson 2014). Many biomedical practitioners withheld interpretation services because not relaying specific information to their clients increased compliance rates and simultaneously fortified "French republican values" (Sargent and Erikson 2014:32). Biomedical workers thus became enforcers of state policies and ideologies through parsing out services (Sargent and Erikson 2014). Assessments of language, therefore, can be conducted in order to determine a mother's identity and consequently justify the allocation of differential services.

These assessments are not solely based on biomedical providers' prejudices as they are reinforced and encouraged through state ideology and mechanisms.

In the case of B.C., who is perceived as needing language services and who is perceived as having a language 'barrier' is also problematized. Spitzer's ethnographic research in maternity units in western Canada found that nurses made "rapid assessments" by viewing racialized mothers as "problematic or time consuming" based on their *visible minority* status (2004:494). This included health care encounters with "[racialized] women who may not speak English or who are thought not to" (Spitzer 2004:502). Thus, who seems to speak English and who actually does speak English may be predicated on who looks—and is assessed to be—Canadian, meaning who is socially constructed as 'White.' During my participant-observation experiences, PHNs would often hypothesize on a mother's language ability based on her last name and the way she looked. They were often wrong.

While most of my participants did not explicitly include time-work factors in the equation of not utilizing interpretation services, they did describe institutional factors that impact access. Joan, an experienced nurse, notes:

There is a barrier in the lack of interpretative services, like, there is none on the weekends... Or you can't take an interpreter on a weekend visit. Well, I've never worked anywhere where you couldn't [bring an interpreter on the weekend]... It is the stupidest thing I have ever heard of. And so, then you are really limiting your, so then it is a real pain for the nurses to try and arrange visits.

Joan explains that institutional barriers and DHA policies prevent her from being able to access interpretation services for her clients. Similar to other anthropological research, I found that PHNs preferred to use family members as stand-ins for professional interpreters (Sargent and Erikson 2014). This preference was articulated even on weekdays when the Provincial Language Service contact line was readily available to schedule telephone or in-person interpretation services.

This is confounding because PHNs understand that language barriers can decrease their clients' access to appropriate services. Some PHNs, like Joan, recognize that not having language services is actually "stupid" because it negatively impacts care and creates barriers

within the nurse-client relationship, yet most PHNs were reluctant to advocate for changes in institutional or personal professional practices.

Cindy, an experienced PHN who identifies as Chinese and who speaks Chinese,³⁸ understands and deals with institutional and structural constraints in a different way. Cindy does not think 'Chinese' culture is an impediment for mothers who want to breastfeed; the problem is that the province and the DHA do not have adequate resources to support mothers who speak Chinese. She circumvents that deficiency by going on public health websites in China, Hong Kong, and Taiwan to find appropriate resources. Cindy purposefully explained that she always first provides DHA-approved translated materials. If the client needs additional information on a topic, she then finds it on public health websites that feature Chinese written information or videos. However, Cindy explicitly cautioned that she would not let her client go through the materials on her own. She explained that she highlights recommendations that are in alignment with provincial guidelines. Even though Cindy did not explicitly voice her concern that she could get into professional trouble by using non-authorized infant feeding information, her response seemed calculated and precise. Cindy clearly wanted me to know that she was not promoting information that contradicted B.C.'s nursing guidelines. In this way, Cindy's actions are still constrained by structural forces even when she actively attempts to provide quality care.

Cindy also mentioned that most nurses would not be able to provide this kind of service to 'Chinese' mothers because they do not have Chinese-language capabilities, noting that the lack of Chinese-speaking nurses may impact Chinese-speaking mothers negatively. Two other participants (Tiffany and Sarah) both expressed doubts that interpretation services significantly improve quality of care for Chinese-speaking postpartum mothers and their infants. Tiffany explained that "I have often felt that I can't provide the same level of support if I don't speak the same language." And while Tiffany utilizes interpreters to help deal with language differences, she contends that "it just never feels like quite the same, like quite the same connection." Sarah, an experienced PHN, describes her experiences with clients who have language barriers

³⁸ I do recognize that there are many Chinese languages and dialects but choose not to divulge Cindy's specific language ability for reasons of confidentiality.

in a similar fashion. She also stated that using interpretation services does not help “build a connection” with the client. Sarah admitted that “you really don’t develop a relationship” with clients when you use language interpretation services. And while Sarah states explicitly that you cannot tell someone’s ‘race’ from their first language, she raised the issue of language in relation to categories of ‘race’ and ‘ethnicity’ and the topic of ‘population trends.’ Such statements again raise the issue of whether ‘raced’ and ‘ethnic’ mothers’ perceived differences have anything to do with the ‘connection’ difficulty?

For example, a home visit with Tiffany demonstrates that assessing language barriers is a subjective phenomenon. Tiffany provided breastfeeding support for a self-identified French-Canadian mother and her young infant; the mother complained of on-going discomfort when the baby latched onto her breast. The mother stated that she struggled to find the appropriate English term, and eventually described the way she was feeling in her first language, French, by using the term “bête noire.”

After the home visit, I asked Tiffany to debrief with me. Tiffany explained that she felt she had provided really good care and was able to connect with the client because there was no language barrier. Though I wholeheartedly agree that Tiffany and the mother had excellent rapport and that Tiffany provided excellent care, there may well have been a language barrier. For instance, *bête noire* means the “bane of one’s existence” (Wiktionary 2015). The connotations surrounding ‘discomfort’ and ‘the bane of one’s existence’ invoke different meanings but, for whatever reason, Tiffany did not comprehend the nuances of the latter’s meaning. As English and French are Canada’s official languages and because (most) French Canadian mothers are also racialized as ‘White’ (and therefore considered authentic and trustworthy Canadians), Tiffany may have felt comfortable and familiar with this mother and thus not been aware of the potential cultural differences and language barriers between them. Despite the slight language barrier, Tiffany still asserted that they had excellent rapport.

Not speaking English or French may mark mothers as outsiders. The weekend interpreter policy institutionalizes and perpetuates ideas of who belongs and who does not within Coast Salish City health care contexts. Notions of ‘otherness’ are then concretized through purposeful structural constraints. In this way, PHNs may be inadvertently enforcing false boundaries of belonging and ideas of citizenship, for example, because they must comply with the interpreter

weekend policy. Moreover, not only are ideas of citizenship and belonging being defined and governed, but nurses are providing sub-optimal care because they are physically and institutionally unable to communicate with their clients. I argue that without effective language interpretation services, mothers receive differential care.

Governing Difference: PHNs as Enforcers

I now describe how PHNs inadvertently become enforcers of state policy that racializes and facilitates notions of 'otherness' and boundaries of citizenship. In Canada, all citizens and permanent residents are eligible for health insurance coverage through their province (Government of B.C. n.d.). The federal government allocates funding to the provinces through the Canada Health Act to ensure that health care is universal, portable, accessible, comprehensive, and publically administered (Spitzer 2004). All provinces provide additional funding and then supply health care resources from the total funding allocated from both levels of government. Residents (Canadian citizens and permanent residents) from each province are then enrolled into their province's health care insurance plan. (British Columbia's provincial health insurance is called the Medical Services Plan [MSP]).

Most provinces, including B.C., have a three-month waiting period between the time of enrollment and the time medical coverage begins. In other words, if you are not a Canadian citizen or a permanent resident, or even if you are and have not resided in B.C. for three continuous months, then you are not covered through MSP and have to pay for your own health care. Not having MSP coverage may be the only indicator of a mother's non-citizenship status. Thus, bureaucratic technologies like billing information is another way for PHNs to assess who belongs and who does not in Coast Salish City.

The following section draws on fieldnotes from one public health unit I refer to as the Garry Oak Community Health Centre (GOCHC). Although all health units received the same information and policy from their managers regarding "Eligibility Criteria for PHN Maternal/Newborn Services," the GOCHC seemed to have more clients that this policy generally targeted. As a result, the PHNs at this unit seemed to be more aware of its implications and talked about it

openly during interviews and participant-observation sessions. Below is an excerpt from fieldnotes generated from a session with Patricia.

By the time Patricia and I got to the triage area at GOCHC, seven PHNs were in a heated discussion about the issue of clients who lacked MSP coverage. Tiffany, a nurse with less than a year's experience, was asking if PHNs can provide a home visit for clients without MSP coverage. All of the other nurses in the room said "no" without hesitation. One nurse with over 20 years of experience explained that a home visit cannot be provided if the mother does not have MSP coverage; she explained that because the mother is "paying out of pocket," the "physician will follow-up" instead of a public health nurse. All of the nurses agreed with this statement, but also seemed to want to voice their opinion and began interrupting one another. One nurse began her sentence by stating if a client "parachute[s] in" to Canada, but she was unable to finish her sentence before another nurse interrupted her by stating these particular clients are "not part of the community." Some of the nurses glanced at Tiffany empathetically, but overall, the nurses were resolute and adamant that clients without MSP coverage would not be seen.

These bureaucratic technologies impact women differently as the absence of an MSP number identifies mothers as undocumented resident/non-citizens, which could, in turn, initiate a cascade of state surveillance (Sargent and Erikson 2014). As such, this system also differentiates and positions the 'ideal,' Canadian client/mother from undocumented clients/mothers within the larger social context and in relation to institutional structures and bureaucratic technologies (Sargent and Erikson 2014). The 'ideal' British Columbian would be Canadian and would have an MSP number. A problematic mother is someone who does not have an MSP number, is 'not part of the community,' and therefore does not belong.

PHNs Policing for the State

To understand more about bureaucratic technologies, later on in the day at GOCHC, I asked Patricia to explain to me more about MSP. Patricia contextualized what the nurses were talking about in the triage area regarding the provision of home visitation for new mothers and their babies:

So, what happened was, there was someone who had been identified by the, um, liaison nurse at the hospital as being here only to have the baby, so we do see that fairly commonly. Um, people from, a, quite often from Saudi Arabia, and also people from China seem to come here specifically to have a baby who will then have Canadian status. And then it is not their intention to remain or to become part of the community here, but they return to their country of origin. And it is sort of like they have the baby's status in a just-in-case basis.

When I asked Patricia how the liaison nurse would know if the family intends to “become part of the community,” she explained that it was most likely indicated because they were “self-pay” and “did not have an MSP number” and “[she] would presume [the liaison nurse] would ask if [the mother] is intending to live here.” During this conversation, Patricia was guessing at how the liaison nurse at the hospital navigates around bureaucratic technologies such as MSP; the reality is that Patricia does not for sure know how the liaison nurses ‘knows,’ but she has to trust the liaison nurse’s judgement regarding who ‘belongs’ and who does not.

In fact, there may be many reasons why a mother may not have MSP coverage including living in the province for less than three months (whether that resulted from a recent move from another province or being a recent newcomer to Canada), having a foreign-student visa, being a temporary foreign worker or diplomat, as well as being a homeless or transient Canadian who does not have the documentation needed to prove MSP eligibility such as a birth certificate (Cheung and Macklin 2014). Thus, many people in Canada may have various reasons for not having provincial health care coverage. However, in the instance of ‘Chinese’ mothers, the issue is not simply about MSP coverage, it is also about embodying the ‘other’—the ‘birth tourist’ and ‘anchor baby’—as indicated by one PHN’s description of mothers “parachuting in” and unfairly receiving the lifelong perks of Canadian citizenship while “not being part of the community.”

While it might seem like the nurses were just coaching Tiffany in work regulations, a closer look reveals that they were imparting ‘hidden curricula’ related to the ‘anchor baby and birth tourist’ discourse. As I noted previously, nurses do not just rely on textbooks and guidelines; much of nursing praxis is experiential, temporal, and contextual. It is also shaped and guided by mentoring experiences. It seems that the nurses in the triage vignette were mentoring Tiffany on appropriate behaviour regarding how to distribute scarce resources: their time and energy. These experienced PHNs did not provide Tiffany inaccurate information regarding how to

provide care to the mother and baby without MSP coverage. However, they did not discuss or refer Tiffany to the DHA's eligibility policy that could help Tiffany navigate through this nuanced conundrum. For instance, one part of the policy states nurses can use their "professional nursing judgement" when families have "pending statuses and plan to reside in Canada".³⁹ This means that nurses could contact the client, even if the liaison record indicates that they are 'not part of the community,' in order to assess the family's desires and plans. But the PHNs' discussion made it seem as if they would not 'triage' the mothers because they 'do not belong to the community.' Issues such as visa delay and other potential reasons for not having MSP coverage were also not discussed during Tiffany's informal mentoring session.

Continuities of Belonging

Yet Tiffany did not seem to be influenced by the 'hidden curriculum' and her more experienced nursing peers. When I asked her to tell me more about the MSP issue and eligibility criteria, she instead brought up nursing attitudes surrounding ineligible mothers:

Tiffany: It is sort of that venting, that you just sort of hear, sort of with a snide or sarcastic tone, that of, "Well, they are not going to be here in a year," and nobody ever comes out and says, "Well then, I won't provide them with the same level of care because they are not going to be here," but to me, it is sort of implied...

AM: What do you think it means if they are only going to be here for a year? What does that mean to the nurses?

Tiffany: I think it has to do with where our resources go... A lot have been complaining about how overworked we are when we are short-staffed... And so, I feel that people think that there is less time, more time should be devoted to people who are keeping the... I don't know if it is 'keeping the knowledge here,' or, you know, "If people can sort of just buy their way into a country really easily, is that fair and equitable?" Um, it is hard because I don't really know how to answer this question because I am not, like, it is comments that I have heard other people make, so I can't really speak to, you know, what they are thinking when they make that comment. I just know that I have heard it around here enough times that you notice it.

³⁹ Please contact the author if you are interested in viewing this policy. The policy was omitted due to issues of confidentiality.

The above excerpt provides two insights. One is that even though the policy encourages PHNs to use their ‘judgment’ regarding assessing postpartum mother’s particular circumstances, nurses may not provide “the same level of care” because ‘Chinese’ mothers are deemed outsiders, non-citizens. Secondly, PHNs may be positioned to provide inadequate care when they are feeling pressured for time and overworked. Again, Spitzer’s (2004:494) ethnographic accounts found that nurses ‘rapidly’ racialize mothers and simultaneously make them up to be burdensome clients based on their ‘raced’ status. Thus, ‘ineligible’ mothers in my study were marked by PHNs as time consuming owing to their lack of an MSP number and racialized status and were placed on a continuum of (not) belonging. As I explained in Chapter 3, a racialized assessment does not require the PHN to actually see the mother; the PHN already ‘knows’ mothers ‘just like her’ based on such attributes as last names. In this instance, MSP coverage is another marker signifying who she is, or is not.

Jus Soli – Citizenship by Birth on Canadian Soil

Around the same time of the triage meeting at GOCHC, an article was published on the B.C. Civil Liberties Association website discussing current debates surrounding birth place and citizenship.⁴⁰ Specifically, the two most recent ministers of immigration articulated the Canadian government’s desire to get rid of *jus soli* citizenship—meaning that they no longer support the premise that birth on Canadian soil should confer Canadian citizenship. *Jus soli*, or “law of the soil,” was now being presented by the federal government as a way for non-Canadian, non-resident mothers to take advantage of Canada’s scarce resources (Cheung and Macklin 2014). The federal government was concerned that non-Canadian/non-resident mothers were coming to Canada to give birth in order to receive citizenship status and Canadian benefits for their offspring. Therefore, the federal government argued that they needed to do something about these ‘birth tourists’ and ‘anchor babies’ who threatened Canada’s publically funded health care institutions and the generosity of Canada (Cheung and Macklin 2014).

⁴⁰ This article was written by Carmen Cheung and Audrey Macklin in 2014.

The issue of ‘birth tourists’ and ‘anchor babies’ cannot be understood in isolation from racializing discourses about ‘Chinese’ people in Canada. Various Canadian media outlets (including the *CBC*, the *National Post*, and the *Vancouver Sun*) featured articles about ‘birth tourism’ and ‘anchor babies,’ highlighting that it is primarily a ‘Chinese’ phenomenon (See Mercier 2013; Brean 2012; Ellis and Lee-Young 2015; O’Neil 2014).⁴¹ A new version of ‘raced’ immigration-restriction rhetoric is evolving, and once again, it targets ‘Chinese’ mothers and their Canadian babies (Ellis and Lee-Young 2015).

The issue of *jus soli* and citizenship rights relates to my earlier vignette with Tiffany. The nurses were subtly invoking the ‘anchor baby’ and ‘birth tourist’ discourse as they discussed MSP coverage as a marker of citizenship status and belonging. Just as the federal ministers of immigration claimed that ‘birth tourists’ were illegitimately accessing Canadian’s scarce resources, PHNs stated that the mothers were “parachuting in” and accessing services they were not entitled to because they do not belong. This is believed to be true even though ‘anchor babies’ are Canadian citizens according to *jus soli*, and they should receive the same services that other Canadian babies are offered.⁴² While MSP is one indicator marking belonging and citizenship status, it leaves the ‘anchor baby,’ Canadian newborn in limbo as one with—and without—status.

However, when actually looking at how many non-Canadian/non-resident mothers give birth to babies in Canada, the numbers paint a different picture: less than one-tenth-of-one-percent of all births in Canada are born to women who are non-residents/non-Canadians (Cheung and Macklin 2014). This is a very small percentage, and yet ‘birth tourists’ and ‘anchor babies’ were being discussed everywhere for a time, from the House of Commons in Ottawa to public health units in Coast Salish City. In fact, as indicated earlier, the DHA’s management drafted a policy

⁴¹ PHNs in my study did not exclusively state that ‘Chinese’ mothers are ‘birth tourists.’ However, the media encourages the public to believe that it is primarily ‘Chinese’ mothers.

⁴² Even though some ‘birth tourist’ mothers can easily pay for obstetrical services, PHNs in my study implied that not all physicians within Coast Salish City are able to provide adequate postpartum breastfeeding support. Even though nurses are seen as patient advocates, institutional policies like the ‘Eligibility Criteria for Home Visits’ may limit nurses’ ability to provide the kind of care that they consider appropriate.

emphasizing that mothers without MSP coverage are not eligible for postpartum public health services.⁴³ The issue of ‘anchor babies’ and ‘birth tourists’ highlights how raced ideological and governmental concerns infiltrate breastfeeding promotion contexts and impact PHN praxis. Obviously, PHNs can be agentive and navigate these structural constraints, just as Tiffany opted to do. However, despite PHNs’ autonomy, they are still low on the medical hierarchy and need to follow orders from management and directors of the DHA. In many ways, PHNs are constrained and shaped by systems just as much as the mothers are.

Making Up True Canadians

PHNs participate in both clinical and bureaucratic activities that make up ‘Chinese’ mothers. These activities show that racialization has many qualities: it shifts, changes, is complex, fluid, relational, productive, and contextual (Weheliye 2014). Racialization and ‘othering’ are contingent on social policies, institutions, and ideologies. PHNs are particularly implicated in processes of racialization and ‘othering’ because they are mandated to do the work of the state. Even though it may be unconscious and unintended, Canadian citizenship and belonging are monitored and controlled, at least partially, through breastfeeding promotion in public health contexts. In this way, PHNs contribute to making up the ‘right and true’ Canadian populace. Public health nurses contribute to nation building by assessing matters of belonging and ‘otherness,’ and they tailor their breastfeeding support activities to further those affinities and boundaries. Furthermore, institutional policies and structures may hinder PHNs ability to transcend culturally prescribed categories and systems that promote differential care.

⁴³ The “Eligibility Criteria for PHN Maternal/Newborn Services” highlights that “women/families are eligible for services when they reside in Canada and have: Canadian citizenship, permanent resident status, or a Minister’s permit to remain in the country (i.e., refugee status). Please contact the author if interested in viewing this policy.

Chapter 5. Making Race: Complexities and Complicities of Nursing Praxes

From the inception of breastfeeding promotion campaigns, ideas of 'race,' belonging, and citizenship provided rationales for differential infant feeding support. 'Chinese' mothers were not included in the historical targets of breastfeeding promotion campaigns in Canada because at that time 'Chinese' women were excluded from immigrating to Canada. Today the federal government has acknowledged its historical racist and discriminatory policies against 'Chinese' people. However, my thesis shows that historical racial prejudices are not dead for 'Chinese' mothers and infants, and live on through new formations of differential infant feeding support based on ideas of 'race,' belonging, and citizenship.

By focusing on how professional nursing praxis 'works on' and 'creates narratives about' postpartum mothers, I show how racialized 'facts' of 'otherness' are reproduced and reified within Coast Salish City, and through public health promotion practices. As such, I provide tangible, contextualized examples of how professional praxis creates and maintains ideas of racialized 'others' in breastfeeding promotion and public health nursing contexts.

Nurses are in a position of having to police citizenship and national belonging within breastfeeding promotion contexts. For example, even when an 'anchor baby' has Canadian citizenship status because s/he was born on Canadian soil, the baby is less likely to receive the same nursing care that other Canadian babies receive because it is perceived as 'other.' Similarly, the family of the baby is not offered the same home visitation services. If the mother is having difficulties with breastfeeding, the family will have to figure it out on their own. For 'anchor babies,' socially constructed parameters of citizenship and belonging occur within its first few days of life. 'Anchor baby' and 'birth tourist' rhetoric are extreme examples of 'othering' that find their way into breastfeeding promotion contexts. PHNs are implicated in this process as they are asked from the health authority to police 'deservedness' for the state. As such, PHNs determine who is worthy of breastfeeding support.

Breastfeeding promotion in Coast Salish City, BC, Canada creates and maintains a 'right and true' Canadian populace. Those who are not 'right and true' are 'othered', which leads to

differential care and, in turn, can have detrimental effects on health and wellbeing. PHNs want to deliver equitable, quality care, but the reality is that larger Canadian socio-political processes constrain the type of care PHN's can give.

The “racializing assemblages” (Weheliye 2014) covered in this thesis bring forth complex articulations and intersections of power and identity, and as such, notions of ‘race’ and ‘others’ are ‘made’ everyday through nursing assessment, norms, and surveillance. Sciences of the state (Foucault 1991:96) embed and reinforce racialized structures and public health systems that situate mothers and infants *in relation* to Canada, solidifying the affects of both belonging and othering, often simultaneously.

By focusing on the multitude of raced articulations, my thesis is able to explicate the complex ways and junctures that form ideas of who ‘Chinese’ mothers are for public health nurses. The ‘othering’ and the making up of racialized bodies is always inherently flawed, and context specific, but there is great hope that these practices are also temporal and ever changing.

Looking at ‘race’ in breastfeeding contexts encourages us to understand, think, and theorize about differential care, citizenship, belonging, and nation building. My study shows that differential care is ‘raced’ in breastfeeding promotion contexts; whether or not these differences will lead to wide scale differences in health outcomes is unknown. That would require a longer study. It is my hope that my thesis opens up new ideas for future research on how bodies are culturally mapped as ‘insiders or outsiders’ within health care contexts and how professional praxes contribute directly to health inequities.

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Appendix A.

Oral Consent

Purpose and Background: You are being asked for an interview along with other public health nurses who are knowledgeable about breastfeeding as well as nursing practices within the DHA.⁴⁴ This research is about how nurses promote, protect, and support breastfeeding during a time when breastfeeding disparities exist among population groups. A lot of research has been conducted on population groups and their diverse breastfeeding practices, but little attention has been paid toward nurses and their understanding of breastfeeding disparities. Alysha McFadden, a Master of Science student at Simon Fraser University, will be talking to public health nurses within the DHA about their work in breastfeeding promotional contexts. The Office of Research Ethics of Simon Fraser University and DHA has approved the research procedures detailed in this information sheet. If you decide to participate, your answers and comments will be kept confidential.

Procedures: You will be given the Study Information Sheet prior to giving consent. If you agree to be in this study, the following will occur: Alysha McFadden will shadow you during your everyday nursing routines and will ask questions and have conversations with you when appropriate. With your permission, Alysha will audio-record the interview for later transcription. You may refuse to answer any question and you may end the interview at any time. There is no penalty for deciding that you do not want to be interviewed; no one will be informed either way. Your employer is aware that Alysha is conducting research and has given permission for your participation in the study being conducted.

Benefits: This study may not benefit you directly, but you may enjoy sharing your expertise and experiences with the researcher. You will act as a guide to help explain breastfeeding promotion within the DHA and breastfeeding disparities within Coast Salish City.

Risks/Discomforts: The research questions are not of a personal nature. If any question is uncomfortable for you to answer, you do not have to answer it. You may refuse to have the interview audio-recorded or may stop the audio-recording at any time.

Statement of Confidentiality: If you decide to participate, your research records will be handled as confidentially as possible. Your answers will be recorded without your name attached to them. All research files will have a special identifying number rather than a name on them. All electronic files will be stored in a password protected computer and paper copies of your answers will be stored in a locked filing cabinet. When results of this study are reported, no names will be used. All answers you give me will be grouped and summarized along with those of other participants without any personal identifying information.

⁴⁴ Health authority name has been changed to ensure confidentiality.

Future Uses of Data: Beyond the conclusion of this project, the research may be used for educational purposes, conference presentations, and scholarly publications, as well as for further studies of Alysha McFadden such as a PhD thesis.

Costs: There are no costs to you as a result of taking part in this study.

Questions/Contact Information: With your signature below, you agree that you have talked to Alysha McFadden about this study and have had your questions answered. If you have any questions during the study, or at any future time, or if you want to read the final report, you may call Alysha McFadden at [...] or by writing to [...]@sfu.ca. If you have any concerns/complaints about this study or your treatment as a participant you can contact Jeff Toward, the Director of the SFU Office of Research Ethics at [...] or by email [...]@sfu.ca.

Statement of Voluntary Participation: Participation in this research is voluntary. You have received the Study Information Sheet. You have read the above consent form and understand the purpose of the study and what is required of you in participating. You can decide to participate or not and you can end the interview or withdraw from the study at any time. You voluntarily agree to participate in this study.

If you agree to participate you should sign below. You will be given a copy of this form to keep.

Signature of Participant

Date

Appendix B.

Written Consent

Consent for Participation in an Interview

You volunteer to participate in an interview conducted by Alysha McFadden from Simon Fraser University who is a Master of Science candidate from the Faculty of Health Sciences. I understand that the project is designed to gather information about breastfeeding disparities and public health nursing practices within the DHA.⁴⁵ This research project has been approved by Simon Fraser University and DHA's ethics review boards. Your employer, DHA, has provided approval for your participation in this study.

Participation

1. Your participation in this project is voluntary. You understand that you will not be paid for your participation. You may withdraw and discontinue participation at any time without penalty. Alysha McFadden may also ask for further contact to which you may decline.
2. You understand that the interview is related to your knowledge, experience, and nursing practice related to infant feeding. If, however, you feel uncomfortable in any way during the interview session, you have the right to decline to answer any question or to end the interview.
3. Participation involves being interviewed by Alysha McFadden from Simon Fraser University. The interview will last approximately 30 minutes to two hours per your desire. An audio tape of the interview and subsequent dialogue will be transcribed. The transcribed (written) information will be shared with Alysha McFadden's supervisor Dr. Erikson and committee members Dr. Nicole Berry and Dr. Stacy Pigg.

Confidentiality and Anonymity

4. You understand that the researcher will not identify you by name in any reports using information obtained from this interview, and that confidentiality and anonymity as a participant in this study will remain secure.
5. You will be interviewed in a location that is acceptable and maintains confidentiality. Alysha McFadden will use code numbers to track and label interview audio-records and transcripts.
6. I understand that code-number keys, signed consent forms, interview audio-records, transcripts, and field notes will be stored and locked in filing cabinets. Electronic

⁴⁵ The health authority's real name has been changed to ensure confidentiality.

versions of these documents are held in password-protected computer files. Post research, the paper-based and USB documents will be retained at Simon Fraser University in the Faculty of Health Sciences within a locked cabinet for ten years prior to their destruction.

Risks and Benefits

7. The benefits of the research include the opportunity to share my views, experiences, and knowledge. The study asks questions about nursing practices that impact nurses and clients.

8. There are minimal risks associated with my participation in this study. The risk of harm is no greater than those encountered in everyday life.

Future Uses of Data

9. Beyond the conclusion of this project, the research may be used for educational purposes, conference presentations, and scholarly publications, as well as for Alysha McFadden's PhD thesis.

Questions/Contact Information

10. I have read and understood the explanation provided to me. I have had all my questions answered to my satisfaction, and I voluntarily agree to participate in this study.

11. I have been given a copy of this consent form.

12. I can obtain results from the study from the principal investigator, Alysha McFadden, through the contact email provided on the Study Information Sheet.

My Signature	Date
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Signature of the Investigator	Date
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For complaints, please contact:
Jeff Toward, Director
Office of Research Ethics
Simon Fraser University

Appendix C.

Interview Guide

I am interested in learning about your everyday nursing practices. I am particularly interested in the ways in which you support, protect, and promote breastfeeding.

- Can you describe your day to day activities of supporting breastfeeding mothers?
- Can you explain to me a typical day of going out and doing home visits?
- What are some rules, procedures, guidelines that help guide your practice with breastfeeding mothers?
- Do your practices ever differ?
- How do you identify appropriate care plans for your clients?
- What are some challenges with promoting, protecting, and supporting breastfeeding?
- Can you explain a common problem that you encounter while trying to promote, protect, and support breastfeeding?
- Do you think there are disparities in breastfeeding?
- Why do you think disparities in breastfeeding exist?
- Why do you think breastfeeding disparities are primarily described by race/ethnicity?
 - How does this relate to your experiences working with mothers?
- Is there anything more public health nurses could do to promote breastfeeding?

Appendix D.

Intake Form

1. Are you male / female / other?
2. Were you born in Canada? yes / no
3. If no, where were you born?_____
4. If no, are you a Canadian citizen?_____
5. How old are you? Please circle: 20-25 / 26-30 / 31-35 / 36-40 / 41-45 / 46-50 /
51-55 / 56-60 / 61-65 / 66-70
6. How would you describe yourself?

7. What is your job title?_____
8. For how long have you had this job?
9. For how long have you worked with breastfeeding mothers?
10. Have you had education or training related to breastfeeding over and above what
is provided from VCH? yes / no
11. If yes, what kind of training was it?

12. If yes, who sponsored the training?

13. If yes, for how long was the training?

14. Is there anything else I should know about you?