RIIKKA HOMANEN

Doing Pregnancy, the Unborn, and the Maternity Healthcare Institution

ACADEMIC DISSERTATION
To be presented, with the permission of the board of the School of Social Sciences and Humanities of the University of Tampere, for public discussion in the Väinö Linna-Auditorium K104, Kalevantie 5, Tampere, on February 8th, 2013, at 14 o’clock.
Acknowledgements

Doing research is a collaborative project and the end result of it draws on a diversity of voices. These voices include not just abstract institutional voices of scholarly theory or the voices of a given research field but also the voices of the particular and special people involved in the research process at all its different stages. Their perspectives and good intentions have greatly reframed my study again and again, allowing me to include new research-based and experience-based observations, commentaries, viewpoints and theories. I am forever grateful for having had such fantastic companions with whom to share my insights.

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I dedicate this book to my mum, Eva, who has known, nurtured and tended me in her subtle and delicate ways ever since I was nothing but a funny feeling in her belly and a blur on a screen.

On a snowy white day in Tampere, Jan 2, 2013

Riikka Homanen
Summary

This study is concerned with the relationship between pregnant women and the unborn in the context of maternity healthcare institution in Finland. Maternity healthcare in Finland is mainly a nursing practice that includes social support on the side of medical screenings and a long-lasting client–professional relationship which may be seen as supportive of pregnant women’s agency and reproductive freedom, unlike the technology-driven medical professional practice that tends to undermine pregnant women’s experience-based knowledge and represent the unborn as an autonomous, separate and conscious being.

To account for these kinds of practices and for the particular lives, activities and perspectives of pregnant women involved in them I have adopted an institutional ethnographic framework as theorised by Dorothy E. Smith. In institutional ethnography the social organisation of institutional work practices is by definition explored through the people who participate in them and from their perspective. Smith’s concept of standpoint has offered a way to orient research to the local particularities of pregnant women’s lives, working in this way as a methodological organiser for larger power relations manifest in particular ways in activities within maternity health care practices. In line with this orientation my study, first, inquires into women’s experience-based knowledge and viewpoints of pregnancy and the unborn to establish an outline of the interchanges with the institutional orders of maternity healthcare. Then, informed by these associations, my study asks how, at the practical level of care work, the unborn and its relationship to the pregnant woman is enacted both temporally and topically. Finally, having thus established that my research commitment is anchored in the engagement of pregnant women within institutional orders and out-of-orders, I will further attend to the question of how the agency of pregnant women is realised in relation to the unborn in these practices.

The research material was collected through ethnographic fieldwork at four different maternity healthcare clinics over approximately three months in the course of 2006–2008. The material was assembled through multiple methods of data production, including video recording, observation, interviews and documentary material. My analysis owes much to
feminist studies of technoscience in material-semiotic practices (especially Donna Haraway’s) and their acknowledgement of heterogeneity, instability and fluidity of subjects, objects, agency and logics of institutional power.

The analysis shows that in the pregnant women’s experiences the unborn are enacted in a bodily process from an ambivalent feeling into something more concrete: a human life, a baby and, finally, one’s own particular baby, to whom are attributed at least potential personal characteristics, gender, social identity and kin relations. By doing pregnancy in many ways women come to know their unborn as persons that need to be attended to by naming, by changing lifestyles, tolerating medical interventions, acquiring baby goods, and rearranging households, life cycles and social relations by engaging others, especially partners, to participate emotionally and practically. A lot of this preparation is done in the ‘best interest of the child’. The notion is used to display cultural maternal competence but as a vague and fluid concept it allows some variety of choice as to which kind of a maternal self one may become and what kind of a social world expressive of a particular kind of unborn–woman relationship one may (co)create in her individual family life.

The ‘best interest of the child’ is ultimately an institutional policy level term that is used in quite subtle ways in the everyday activities of the clinics. Characteristic of the work of public health nurses’ is the careful building of rapport and solidarity to manage affectively the anxieties of pregnant women and their partners about the unpredictabilities of pregnancy, and to encourage changes in lifestyle. The delicate negotiations involved in promoting transformations for parenthood include taking up a position as a mediator of scientific ‘facts’ about foetal damage and psychosocial risks, and not taking a strong stand on good parenting. Scientific ‘facts’ are geared to maternal response in order to change lifestyles and to encourage bonding with the unborn. In these ways multiple unborns are performed.

In these practices there is a temporal, yet somewhat incoherent, logic to enacting the unborn that accords with biological development as the technoscientifically known. The unborn are transformed from foetuses, human life and babies in general to particular
babies and children in a more distant future. The care work does not, however, rely totally on the omniscience of technoscientific confirmation: it works to complement less visible models of bodily ‘female instinct’ having more distant origins. The two subjects of medical practice, the foetal patient and the maternal patient, never fully emerge in the practice.

Emotional, psychosocial and socio-material transformations in unborn–woman relations are on the formal agenda of care in around the third trimester of pregnancy, when family counselling starts. There are more and less standardised ways of supporting these transformations and screening for problems in them. Counselling interaction takes the form of (family) therapy. The parents-to-be are encouraged to reflect and talk about their mental journeys toward becoming their parental selves with the professional objective of attuning them to family values and bonding them with a baby that has subjective characteristics. The nurses guide at a distance and approach parenthood abstractly in terms of psychosocial knowledge. Psychosocial knowledge appeals to the ‘social’ for support in parenthood from family members, peer groups, a variety of professionals, and even ‘the whole village’. Compared to the early stages of pregnancy, with their limited range of medical and nursing advisors, late-term care lifts the unborn up for the scrutiny and performance of a multitude of actors.

Multiple support groups are perceived as necessary according to the current ideology of maternal competence that claims that women need to be educated scientifically to know their unborn’s needs, ‘choices’ and demands. Professionals should work as equal partners with citizens in the name of more choice and autonomy. As public servants nurses do not have the authority to act as custodians to the unborn, but manage risks and establish securities through prevention methods that do not wholly determine the ways and forms of well-being. The problem with this approach is that, paradoxically, it allows control to be exercised over pregnant women despite the beautiful operating principles of empowerment and voluntary partnership. It may place the determination of maternal competence and the child’s well-being in antagonistic hands. Advancing freedom of choice and diversity among women may be subsumed into a rising wave of neoconservative values that invite
women ‘freely’ to choose conventional family lives in which they are reunited with the unborn at the expense of reproductive autonomy.

Under the ethos of not taking a stand the power to organise social relations is also redirected to work from below. Pregnant women are held accountable at clinics for the choices they make when these do not fit into a scale of normality in assessments of risk factors. As a result some women’s relationships with their unborn are enacted as poorly managed because they diverge from measurable scales that coincide with the characteristics of social class divisions. Mastering and attuning to the assessment encounter and its therapeutic code, however, seems to imply possibilities for establishing oneself as a respectable maternal self and a change to avoid unwanted intervention and moral judgment. These strategies of respectability, self-reflection and narration are required to follow the appointment interaction and to express preference for certain maternal competences, such as working relations with one’s partner and a willingness to try to change for the ‘better’. Although in principle today anyone who steps into a clinic is treated equally as ‘the same’, one can see how women in poor living circumstances may become objects of intervention and paternalism when they are more easily given the terms to talk about their hardship than more privileged women. The ideal, thus, remains a committed family with two heterosexual parents who are assigned gendered tasks and responsibility: women are assigned bodily nurture and a position as mediator between the unborn and the male partner who is the biological father and who takes care of the household and is an attentive father. State paternalism that makes attending and attuning to maternity healthcare activities a civil responsibility lives side by side with the emergent rationale of voluntary partnership, where self-reliance in parenthood is the operating principle.

In conclusion, I argue that maternity healthcare work is affective labour that critically reworks the medical-technical foetal person and insists on time, trusting professional relationships and the experiences of women. It provides for health and well-being and feeling of security and choice, and vague agency within the scope of institutionally tolerated parental relations that allow one to authorise oneself a space where it is also
permitted to lose control and be creative. Further, offering women more choice and autonomy in the form of therapeutic reflection may work in desirable ways for some women. It may, however, also be interpreted as a demand of consumer capitalism and a managerialist response of the welfare service system to that demand. Women are not really free to choose whatever they desire, as I have shown, and market models fit poorly to care relations. Overall, while the everyday practices at the clinics are messy and no form of power has the ability to impose a totalising hold on them, particular unborn and maternal selves and social ties before birth are produced in a style that facilitates changes and processes that are expected, to a large extent, to take place by themselves. As such the ability and inability to turn a relationship of a pregnant woman and an unborn into a mother–child relationship can be understood as a practice of biopolitics and biopower.

Keywords: the unborn, pregnancy, maternity healthcare, institutional ethnography, ruling relations, agency
Tiivistelmä

*Raskautta, syntymätöntä ja äitiysneuvolainstituutiota tekemässä*

Tutkimukseni käsittelee raskaana olevien ja syntymättömien välistä suhdetta suomalaisen äitiysneuvolan kontekstissa. Äitiysneuvolassa terveydenhoitajat seuraavat syntymättömän kehitystä, raskaana olevan naisen hyvinvointia ja näiden kahden keskinäistä suhdetta aina alkuraskaudesta synnytyksen kynnykselle. Lääketieteellisen seurannan ohella neuvola tarjoaa myös sosiaalista tukea. Näiden piirteiden on katsottu tukevan raskaana olevien naisten toimijuutta ja lisääntymiseen liittyvää vapautta. Äitiysneuvolakäytännöt eroavat teknologiakeskeisestä lääketieteellisestä ammattikäytännöstä, joka helposti ohittaa raskaana olevien naisten kokemusperäisen tiedon ja esittää syntymättömän autonomisena, erillisenä ja tietoisena olentona.

Sovellan tutkimuksessani Dorothy E. Smithin institutionaalisen etnografian ja tutkin neuvolan institutionaalisten käytäntöjen organisointumista käytäntöihin osallistuvien ihmisten ja heidän näkökulmiensa kautta. Smithin standpoint-lähestymistavan mukaisesti pohjustan tutkimukseni raskaana olevien naisten elämien paikallisiin todellisuksiin ja tutkin neuvolan käytäntöihin manif estoituvia valtasuhteita niiden pohjalta. Tutkimukseni tarkastelee ensin naisten kokemuksen perustuvaa tie toa ja näkökulmia raskaudesta sekä syntymättömästä. Tältä pohjalta kysyn tutkimuksessani, miten käytännön neuvolatyöössä syntymätön ja sen suhde raskaana olevaan naisen tuotetaan ajallisesti ja aihekohtaisesti. Lopulta pohdin vielä raskaana olevien naisten toimijuuden suhdetta syntymättömään niin kuin se realisoituu käytännöissä, koska tutkimuksellinen sitoumusen on siinä, miten naisia osallistetaan ja miten he osallistuvat institutionaalisiin järjestysteisiin ja epäjärjestysteisiin.

institutionaalisen vallan logiikit ymmärretään heterogeenisiksi, epävakaaksi ja muuntuviksi.


”Lapsen etu” on institutionaalisen politiikkatason termi, ja sitä käytetään melko hienovaraisesti neuvolan jokapäiväisessä arjen toiminnassa. Terveydenhoitajien työlle on ominaista luottamuksellisen ja solidaarisen asiakassuhteen rakentaminen, joka edesauttaa naisten ja heidän kumppaniensa raskauden epävarmuustekijöiden aiheuttaman ahdistuksen affektiviselle hallintaan sekä elämäntapamuutoksiin rohkaisemista. Hoitajat omaksuvat sikiovauroita ja psykososiaalisia riskejä käsittelevien tieteellisten ”faktojen” välittäjän position. Varovaiselle ja neuvottelevalle tavalle tukea vanhemmuuden muutoksia on tyyppillistä myös se, etteivät hoitajat ota vahvaa kantaa hyvästä vanhemmuudesta. Tieteellisillä ”faktoilla” tavoitellaan äidillistä vastakaikua, jonka ajatellaan aikaansaavan elämäntapamuutoksia ja ruokkivan kiintymissidettä syntymättö-mään. Nämä tavat tuottavat moninaisia syntymättömiä.
Neuvolan käytännöistä on eriteltävissä ajallinen epäyhtenäinen logiikka tehdä syntymätöntä, mikä kulkee raskauden teknotieteellisesti tiedetyn biologisen etenemisen mukaisesti. Syntymätömät muunnetaan sikiöistä, ihmiselämästä ja vauvoista yleensä tietyiksi vauvoiksi ja lapsiksi. Teknotieteeseen ohella käytetään vähemmän näkyviä malleja historiallisesta, ruumiillisesta "naisen vaistosta". Nämä lääketieteellisen käytännön subjektit, sikiöpotilas ja äitipotilas, eivät koskaan täydellisesti ilmene hoitokäytännöissä.


Vallitsevan äitiyden ideologian mukaan moninaiset tukiryhmät ovat tarpeen, koska naisia tulee tieteellisesti kouluttaa tunteamaan ja tietämään syntymättömänä, ”valinnat” ja vaatimukset. Ammattilaisten tulisi tehdä työtä kansalaisten kanssa tasavertaisina kumppaneina taatkaen näille enemmän valinnanvapautta ja autonomiaa. Julkisen palvelun edustajina hoitajilla ei ole toimivaltaa toimia syntymättömien vartijoina vaan hallita riskejä ja tuottaa turvaa ennaltaehkäisevien menetelmin, jotka eivät täysin määrittele hyvinvoinnin muotoja. Tämän lähestymistavan ongelma on paradoksaliseksi, että kauniista voimaanuttamisen ja vapaaehtoisuuden toimintaperiaatteistaan huolimatta se sallii raskaana olevien naisten kontrolloimisen. Äidillisen kompetenssin määritteleminen

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Johtopäätöksenä välttän, että äitiysneuvolatyö on affektiivista työtä, joka kriittisesti työstää lääketieteellisesti tuotettua ja teknisesti määritettyä sikiöhenkilöä. Työ vaatii aikaa,

Avainsanat: syntymätön, raskaus, äitiysneuvola, institutionaalinen etnografia, valtasuhteet, toimijuus
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1. Introduction

In many domains in contemporary European and U.S. cultures, the foetus functions as a kind of a metonym, seed crystal, or icon for configurations of person, family, nation, origin, choice, life, and future. As the German historian of the body Barbara Duden put it, the foetus functions as a modern ‘sacrum’, that is, as an object in which the transcendent appears (Duden 1993). The foetus as a sacrum is the repository of heterogeneous people’s stories, hopes, and imprecations.

(Haraway 1997, 175)

From the point of view of feminist science studies, freedom projects are what make technical projects make sense – with all the specificity, ambiguity, complexity, and contradiction inherent in technoscience. Science project are civic projects; they remake citizens. Technoscientific liberty is the goal. Keep your eyes on the prize.

(Haraway 1997, 175)

The above remarks by Donna Haraway on the foetus and on the feminist take on technoscientific projects such as the foetus sum up how technology, science, (national) politics, social class and economics hang together culturally in all their gender specific practices. I interpret Haraway, first, as reminding us that the technical clinical foetus observed via technological apparatuses and known through biosciences has been culturally fetishised into an abstract and transcendental child of the nation, a promise of and hope for the future and a reminder of the risk of no future for ‘life’, nation and person. These promises, hopes and fears are invested in the notion of family and its ‘free choices’. Haraway, thus, makes trouble for the reductionist understandings of reproductive technologies and science that claim to show the origins of what we are, and thus makes trouble for the ideological power invested in the practices of technology and science. The technologically and scientifically mediated figure of the foetus is not the same as the pregnant woman’s knowledge or experience of the new life within. Rather, it is the substitute child that is constituted in concert with political and cultural projects and then returned to private imaginaries to shape the private experience, social relations and knowledge in pregnancy and of reproduction.
Haraway does not, however, as is common to her utopian projects of and for the subject (think about the cyborg in 1991b), dismiss science or technology as merely subordinating material and semiotic practices – for women, children, the non-white, bodies and the unprivileged – but calls for feminist re-readings and ‘freedom projects’ within technoscience. Technoscientific practices also provide reproductive agency and are open to feminist interference that may shift the existing patterns of care-giving.

In this doctoral thesis, I will apply the Harawayan project to the context of Finnish social liberal culture and Nordic welfare services by making an analytical inquiry into the practices of maternity healthcare and pregnancy. The Finnish contexts and practices bear traces of the thinking on the foetus as a sacrum that arises from the combination of certain neoconservative values and liberal individualistic patrimony common to the Anglo-American settings (see also Berlant 1997) within which Haraway is writing. Her abstract theoretical notions of this foetal power, if you will, to make social relations and orders will be given situated content and specified.

The Finnish context is of scholarly interest for a project on the foetus and its social relations because, unlike in strictly liberal and conservative models of conceptualising the foetus, within the Finnish socio-political framework and reproductive policy the morality and individuality of the foetus are in principle separable. Thus an opposition between women’s choice and foetal subjectivity does not emerge as easily as it does in the Anglo-American world. The subject of historical social-democratic welfare in Finland, as well as other Nordic countries, is defined more in terms of citizen’s social rights to health (care) and social benefits and equality to safeguard life than in terms of the democratic rights and personal autonomy common to concepts of political citizenship (e.g. Helén & Jauho 2003).

This is apparent in the fact that debates on foetal rights and status, and reproductive politics in general, have never been as noisy, problematic or polarised in Finland as elsewhere, especially in Anglo-American countries (Burrell 2003; Leppo 2012; Tuomaala 2011, 196). Political debates have mainly taken place in the context of welfare services and welfare politics, and politics are implemented at the level of health education in the
services provided by the state and the civil societies. Healthcare services, including foetal screenings, health education and routine check-ups, as well as the politically accepted abortion provided by public healthcare, are made available to all in the name of social equality. They are also intended to protect mothers and their relations to the child within, at least historically (Nätkin 2003; 2006; Julkunen 2004, 22; O’Connor & Orlof & Shaver 1999, 160–185). Maternity healthcare, then, seems an obvious area of study for addressing the specificities of the Finnish foetus and the unborn child. That is where the public and the private, to the extent that such a division is applicable to the Finnish context, foetuses and pregnant women implode to form child-mother relationships, or a lack of them, prior to birth.

In Finland maternity healthcare has remained in the primary healthcare\(^1\) sector and is institutionalised in maternity healthcare clinics in which public health nurses and midwives provide the services (Benoit et al. 2005, 725–729). Clinics are often located in clients’ own neighbourhoods in cities, and in their own municipalities in rural areas. Pregnant women meet with their appointed nurse approximately 10–13 times, and meet with an obstetrician three times. The care involves providing support in the form of advice and information on, for example, healthy eating habits and preparing for birth, especially for the future mother, and control of the somatic changes experienced by the pregnant woman and the foetus, including one or two ultrasound screenings. Furthermore, attention is paid to the social and psychological environment of the child (-to-be) by encouraging both parents to reflect on and discuss issues of parenthood and family life, such as home arrangements and drug and alcohol abuse in the family. In addition to meeting pregnant women and their partners, the nurses’ work also includes teamwork with other professionals in the fields of early social care and child healthcare, including social work, family care work, child psychology and obstetrics, in order to assess and solve the problems of the families. These teams meet regularly to try to solve the problems of individual families. (Handbook of Maternity Healthcare 2007; Ministry of Social Affairs and Health 2004; see also Homanen 2012.)

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\(^1\) As opposed to the specialised healthcare that is provided by hospitals.
How, then, are we to explore care like this, that includes social support on the side of medical screenings and long-lasting client–professional relationships, and that replaces doctors with midwives and nurses. That is, care that corresponds with the suggestions made by feminists during 1980s and 1990s in their critique of maternity healthcare (see e.g Oakley 1984; 1992; also Kuronen 1994a, 130; 1999)? The second quotation by Haraway above holds the obvious answer for me. In it she elaborates the feminist commitment to inquire into practices of technoscience, such as those of healthcare. Such a commitment places one in a scholarly community starting from the 1970s and women’s health movements that have developed a toolkit for technoscience studies on reproductive practices. Essentially, applying such a toolkit commits the researcher not just to showing how the unborn² and its relation to the pregnant woman is multiple and contested for its own sake but also how ‘questions of power, resources, skills, suffering, hopes, meaning, and lives are always at stake’ (Haraway 1997, 188) in a situated and partial manner.

To account for the particular lives, activities and perspectives of pregnant women in the practices of healthcare that are coordinated by larger societal power relations I have adopted an institutional ethnographic (IE) framework (Smith 1987; 2005). In IE, the social organisation of institutional work practices are by definition explored as people participate in the practices and from their perspectives, such as the articulation of medical scientific (ethical) models. The starting point of IE is in the experiences of the people engaged in the institutional activities, and the experience and the experience-based knowledge of practices form the basis for the ethnographer’s analysis of wider institutional orders beyond the individual experience. Moreover, experience is seen to emerge through dialogue among the research participants in particular temporal and spatial contexts. Dialogue, in IE, refers to an ongoing interchange between participants³ that is cumulatively responsive to diversities of viewpoint. (ibid., see also Homanen 2012.)

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² By now it must be clear that the life within is not one but multiple and varies according to the context of constituting it. It is the technical-clinical foetus, an ambivalent feeling of new life within, a historical institutional policy object – the unborn child – and so on. Therefore I have decided to call it just ‘the unborn’ that can then be enacted as a foetus, child and so on. For a more elaborate discussion see pages 30–31.
³ Participants may include people in a face-to-face encounter and/or conceptual entities such as texts, discourses, ideology and so on.
Accordingly, I went into the clinics to follow pregnant women on their journeys through the services and through pregnancy for a relatively long time period, as is common for ethnographic fieldwork (see Harbers & Mol & Stollmayer 2002; Marcus 1995; Clifford & Marcus [eds.] 1986). By video recording and observing activities as they took place in the consulting rooms, coffee rooms, hallways and auditoriums of the clinics, as well as interviewing and having more informal chats with the pregnant women and the nurses, I came to grasp not only the multiplicity of associations linked to the unborn in care practices but also how the multiple unborn hang together in a temporal process of enacting it in formal and informal, and articulated and unarticulated ways. This method has also allowed me to see how the multiplicity of the unborn and its relations are coordinated by the ways women engage themselves in pregnancy, and how the styles and intensities of the engagement also manifest operations of power and are expressive of unborn–woman relations. Within the procedural practices the unborn do become constituted as special child members of society and even, at certain points in pregnancy, as individuals and social beings. Consequently on those occasions they do put pregnant women’s bodily integrity, reproductive agency and rights in danger (see also Bordo 1993; Martin 1987).

These are the points I have set on the agenda of this doctoral thesis. I am interested in exploring both the limits to and the possibilities for women’s agency in the constitution of prenatal social relations in maternity healthcare. Studying the possibilities for agency is just as important as studying the limits, as Haraway also noted for technoscience generally, because care practices by no means merely constrain but also provide reproductive freedom and well-being in pregnancy, a time that seems to be characterised by many physical and other uncertainties and insecurities.

My study will contribute to the existing social science and women’s studies research on pregnancy, reproduction and healthcare by offering a detailed account of the processes and practices of care. By now there is plenty of empirical research literature on these issues, but it seems to be concerned mainly with care for illness or with other problematic conditions during pregnancy, such as substance abuse, foetal surgery, foetal patienthood, \textit{in vitro} fertilisation, pregnancy loss, genetic counselling and embryology (e.g. Leppo 2012; 2008; Leppo & Perällä 2009; Casper 1994; 1996; Thompson 2005; Williams 2005;
Keane 2009; Meskus 2009; Parry 2009; Haraway 2004a). Research exploring care directed to all participants in pregnancy seems, instead, to focus on ‘isolated’ practices of screening, of assisted reproductive technologies (ART), of giving birth and of medical care (e.g. Kingdon 2007; Barad 1998: Rapp 2000; Etorre 2001; Palmer 2009; Sandell 2010; Malin 2003). It is important to acquire knowledge on the whole process of maternity care for all pregnant women, including women and unborn not yet diagnosed with specific problems, because otherwise it will remain unclear both how practices identified elsewhere as good and effective are actually implemented and also how to develop preventive care.

1.1 Pregnancy and social relations as research subjects

Before formulating my exact research questions, I will take a detour into prior academic discussion on pregnancy and the unborn as constitutive of social relations in order to find a space as well as conceptual framework for my own research. The unborn/foetus has been an explicit focus in (feminist) social and cultural studies at least since the 1980s. It first appeared in Anglo-American academic discussions that aimed to develop universal frameworks for conceptualising the unborn. However, research on it soon spread both in terms of empirical approaches and national contexts. Since the 1980s Rosalind Petchecky (1987), Barbara Katz Rothman (1989ab), Emily Martin (1987), Faye Ginsburg and Rayna Rapp (1995), Marilyn Strathern (1992), Ann Rubinow Saetnam (2005), Charis Thompson (2005) and many others have produced critical analysis on the multiple character and social relations of the unborn that are crucial to feminist work on the (politics of) foetal personhood, agency and subjectivity. They have shown how women can be granted full reproductive freedom without reducing the unborn to neutral biological matter.

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4 The fact that there is less social science and gender studies research on the (whole) process of care practices with other support on their agenda than just the medical (health promotion and psychological parental support) can be explained by differences in national healthcare and social welfare systems. In Anglo-America, where most of the research on pregnancy, the unborn and maternity healthcare is conducted, maternity healthcare is run by doctors (and to some extent midwives) in hospital environments and centred around a medical screening of health that in Finland falls beyond the scope of preventive healthcare. Further, additional services, such as health visitors’ home visits in the UK, are in most cases targeted at families already classified as ‘problem families’ (e.g. Kearney & York & Deatrick 2000).

5 Rather than just medical care for previously diagnosed illness that is provided by hospitals and doctors.
Notwithstanding this, feminists have been accused of a reluctance to engage in reflexive discussion on foetuses despite the increasing social and moral value granted to foetuses (Michaels & Morgan 1999; Morgan 1996, 48). To me this seems a somewhat harsh overstatement. It would be more correct to say that in the early eras of consciousness-raising in the 1970s and in 1980s feminists tended to ‘work around the foetus’ (see also Michaels & Morgan 1999; Addelson 1999). This is understandable to the extent that inherent in the early theories of patriarchy and pro-choice politics are concepts of human personhood and individual agency apparent in their emphasis on individual choice and rights (e.g. Hartouni 1999, 297). Within such conceptualisations refocusing attention from the unborn with rights as a (semi-)autonomous person to the woman as an individual with full reproductive freedom reduces the unborn to culturally neutral biological matter.

The unborn addressed in these scholarly formulations emerged along with the development and growing use of reproductive technologies. The unborn that once was somatically experienced and mediated became transformed into the pre-human form of human life that we now recognise as the ‘foetus’. Parallel to the technological development, in a variety of social practices the technologically constituted foetus is granted value as human life, personhood, autonomy and civil rights. For instance the foetal unborn has acquired the leading role in publicly defined problems concerning women’s reproductive rights, such as abortion. The modern technology-driven medical practice and science is commonly understood in theory and research on pregnancy and foetuses as enabling the separation of the unborn and its mother. This, then, serves the advocates of foetal personhood, such as pro-life activists, and provides a means to shift pregnancy, maternity, gender identity and childbirth into the hands of other actors, potentially stripping women of their reproductive agency in decisions concerning their unborn. (e.g. Oakley 1984; Rothman 1989ab; Leppo 2012, 62-63; cf. Firestone 1971.)

Conceptualising pregnancy in terms of individual agency and personhood, or lack thereof, has not proved very useful in solving the contradiction between the unborn and pregnant women: the debate is ultimately reduced to arguments for and against foetal autonomy. Nor do such concepts appear to be useful tools for making sense of the empirical world,
since for pregnant women themselves pregnancy is not just about conflicting interests between them and their unborn but also about collaborative interests that affect how bodies are lived and actions taken (see also Oaks 2000; Sevón 2009, 73). At some times women experience the unborn as separate from themselves, and at others as part of themselves (Markens & Browner & Press 1997, 386). The status of the unborn as its own person, an individual or legal subject, is, at best, partial. In other words, the individualist and dichotomous model, in which women’s lifestyle and right to choose are perceived as limits to the rights of the unborn, is quite ambivalent in regards to women’s experience and everyday lives. There have been a few interrelated theoretical-political/philosophical approaches and concepts that go beyond the individualistic dogma in exploring reproduction, including concepts such as relationality (e.g. Whitbeck 1984; Sherwin 1992; Shildrick 2004), collective action (e.g. Morgan 1996; Casper 1994; Addelson 1999), material semiotics (Haraway 1997; Barad 1998) and agential realism (Barad 1998).

In general, to be able to conceptualise pregnancy as a (set of) social relationship(s), adjustments to the ‘conventional’ understandings of the body, subject, personhood, agency and social relations are required – not just in relation to the unborn within but also in relation to the pregnant woman’s sense of self. This is because in a phenomenological as well as in a social sense the pregnant woman is herself and not quite herself simultaneously (e.g. Homanen 2007; Piensoho 2001; Young 1998; Rothman 1989ab; Kristeva 1982; 1993). While the pregnant body may be experienced as a stranger at times it cannot be identified with an ill body, because it rarely appears alienating in the same sense. Julia Kristeva⁶ (1993, 180) has suggested that pregnancy could be explored via subjectivity that is constitutive of another within. In a similar vein Barbara Katz Rothman (1989a) renders concepts of individuality and possession questionable in pregnancy by pointing out how the body of a pregnant woman in social practice seems not to be her own as it was before pregnancy. Her sense of self-determination is transformed when all kinds

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⁶ Kristeva as well as other French psychoanalytic theorists such as Hélène Cixous (e.g. 1976) and Luce Irigaray (e.g. 2001) have discussed pregnancy in wider terms than the common psychoanalytic concept of fulfillment of lack. Rather, they seem to conceptualise pregnancy as a condition of simultaneously having and not having a relationship with the Other, and bodily being simultaneously oneself and not oneself. My theoretical approach does not apply psychoanalysis or the work of writers in that tradition per se but obviously the conceptualisations of Kristeva, Cixous and Irigaray can also be authenticated in more sociological terms.
of actors, people and apparatuses are claiming ownership of and a custodian role towards the foetus and (thus) the woman’s body. Further, Rothman reminds us that pregnancy is not just a physical relationship between the pregnant woman and the unborn but a social relationship as well: pregnant women respond socially to the unborn and its ‘activities’ as do other people around her (ibid.).

The efforts to conceptualise pregnancy as social relations in a way that do not push aside either the personification and morality of the foetus or women-centred, pro-choice politics (e.g. Bordo 1993, 95) have involved the mobilisation of notions of relational agency. The logic of the relational modelling can be summarised thus: if persons are conceived not as autonomous but as relationally enacted and socially situated beings, then the relationship between the woman and the unborn is no longer modelled as a conflict between two persons or on the basis of making either participant disappear (Morgan 1996 on Whitbeck, Sherwin and Petchecky).

Lynn M. Morgan (1996) takes issue with such (mostly) theoretical and philosophical attempts written in the 1980s and early 1990s (e.g. Whitbeck 1984; Sherwin 1992; Petchecky 1987; Strathern 1992; Duden 1993). She concludes that, despite these theoretical efforts, by replacing ‘the individualistic’ with the feminist antidote of the day, ‘the relational’, the texts under her review fail to escape culturally specific Western biases. Morgan (ibid.) argues that the problem with the particular writers she takes up is not the concept of relationality per se, but the concepts of agency and inherent embodiment that imply that embodiment and embodied subjectivity somehow precede their cultural inscription (ibid.; see also Michaels 1999, 133 on Duden). According to her, this is apparent in the ‘early’ philosophical accounts, where relationality or sociability is located in the cognitive and corporeal attributes of the foetus/infant, in the pregnant woman’s sentience and/or in a larger social network. A person is, accordingly, someone who has come to possess certain biological attributes that enable relationship-making, her mother’s consciousness of an existing relationship and/or a social network’s realisation of the full self-awareness needed for social interaction. (Morgan 1996, 52-55.) What is assumed, then, is relationality of the personhood but not of the body or better yet the physical
(including the mind), although (and partly because) such assumptions are made in the name of granting women self-sovereignty.

What Morgan (1996) is implying is that if the embodied woman in these ways is retrieved as the site of pregnancy she will be essentialised in terms of biology and reproduction. How, then, to approach pregnancy and the foetus without assuming precursors to personhood or subjectivity, such as already existing biological embodiment? Building on earlier conceptions of relationality, Morgan⁷ (1996), Meredith W. Michaels (1999, 130), Laury Oaks (2000) and Monica Casper (1994) suggest that any effort to relocate the pregnant woman as the site of pregnancy will have to involve taking into account the contexts within which the embodiment is materially and symbolically constituted. These contexts refer to the specific historical, political, cultural and social sites and matters within which the foetus, its relations and agency are configured and enacted. Within each of these sites there is embedded a specific power matrix that coordinates to whom, or in what agency, it locates itself at any given moment. If there are no a priori presumptions taken for granted about the essence or ontology of anything or anyone, women’s reproductive rights and freedom should be formulated over and over again in response to what appears to matter at any given time and space. (Morgan 1996; Casper 1994; Michaels 1999.)

Basically, what is suggested is that feminist analyses should be sociologically informed and self-reflexive (see also Silius 2010; Porter 1994). At the level of political activity in certain Western local controversies over reproductive freedom, then, individualist argumentation on ‘choices’ and rights may achieve momentary success but in other situations – other nations, cultures, times and so on – such a logic of argumentation could better be replaced by a collective approach to the constitution of the unborn. What one has to be reflexive about is that the approach chosen does not advance dominance over people.

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⁷ Even though Morgan (1996) seems to be mapping theoretical and conceptual limitations of the past few decades of research in her article, what she finally ends up doing is building on the work she critiques. That, at least, is how I prefer to situate her in the history of feminist theory on the unborn/foetus. As Clare Hemmings (2011, 31-57) notes, reproducing (decade-by-decade) progress narratives that represent the past feminist work as essentialist, anachronist and unreflective cannot explore how new theory adds on to existing theory in a non-linear fashion (see also Anttonen 1997, 51).
For example, locating humanity in larger social networks of relations in a culture that emphasises biological sentience as constitutive of personhood may result in undermining women’s right to early abortion, mandatory HIV testing and medication for women and so on, as noted by Kathryn Pyne Addelson (1999, 33). (In fact this is happening right now in right wing neoconservative parts of the West).

On a more theoretical side, reflexivity and being sociologically informed, in my understanding, means that the unborn needs to be studied as enacted in different *practice* rather than assumed as some singular entity waiting to be discovered – by medicine, parents or scientific devices. The unborn or the foetus is thus viewed, in this study as well as others (e.g. Casper 1996; 1998; Oaks 2000), as a way of organising social relations. Thus different practices involving collective/shared activities concerning the unborn and conceptualisations of them are not (merely) different perspectives but multiple *enactments* of the unborn. (Mol 2002, 32–36, 44; cf. Ruppert 2011, 223–224; Law 2004, 54–57; 2008). I use the term enactment, that has widely been adopted by researchers in science and technology studies (STS), material-semiotics or post-ANT (Actor Network Theory), rather than terms like construction. This is because whereas ‘construction’ implies fixity and completeness, enactment emphasises how realities and representations are simultaneously performed in an endless process (Mol 2002, 44; Law 2008, 635). The unborn, as well as other entities such as bodies, things and people, then, are continually performed a new and maintained in a process of doing. They are empirical matters.

To account for this tentative, historical, emergent and multiple nature of the unborn child, baby and foetus and its relations, I have decided to name it just ‘the unborn’ when I am talking about a subject position that can then be occupied by the foetus, the baby, the child and so on, depending on the context of performing it. The term ‘unborn’ is certainly not a neutral term, but it is less politically charged and value-laden than a prenatal child or a baby. Instead, the term foetus would, in my view, imply that the unborn is always first and foremost the technologically mediated scientific figure. If that is the case, it has to be arrived at empirically and not assumed. Lastly, the term unborn suits the empirical field
under study because the work and the people involved in the activities at the clinic aim at birth.\(^8\)

1.2 Research task and questions

Evidently, in order to be able to discuss the ethical and social significance of both the unborn and women in pregnancy, we must rethink reproduction by recognising that the relationship between the pregnant woman, in her body, and the unborn is culturally, politically, historically and socially constituted and variable (Bordo 1993, 93; Morgan 1996; Michaels & Morgan 1999). Pregnancy and the figure of the unborn consist of a mixture of laboratory facts, ethics and morals invested in different practices (Addelson 1999, 25; Duden 1993, 15), and cannot be equated with, for instance, the figure of the woman ‘with child’, as was the case in the more distant past (Duden 1999). Hence the relations between women and the unborn cannot be reframed in isolation from changing social arrangements, practices and material relations. The objective of my study, then, is to show how the unborn is not a child per se, but must be constituted as such in a configuration of material and social relations that vary according to the site of that constitution. One such site is the pregnant women’s lives in and outside of the clinics as they are connected with and coordinated by the actions of others in institutional orders. My interest, then, lies in women’s own articulations as well, as starting points to my inquiry. Thus the study also contributes to the long tradition in drawing attention to women’s point of view in reproductive matters (e.g. Rich 1976; Carter 2010; Henwood 2001; Bondas 2000; Evans 1985; Piensoho 2001; Ruusuvuori 1991).

I follow the task set by Meredith Michaels and Lynn Morgan (1999, 4) when they state that as feminists we cannot risk leaving the study of pregnancy and the unborn (‘foetuses’ in the original) to our antagonists, because to do so would contribute to the persistent assault on women’s procreative integrity when the unborn increasingly merit a place on the social and political scale trans/nationally.

\(^8\) In other contexts of study, such as for instance pro-life activism or politics, the term may not be as suitable, given that not all the unborn/foetuses are granted attendance and care as valuable human life or persons-to-be on their journeys to birth.
My study, then, first, inquires into the experience-based knowledge of pregnant women about their activities and viewpoints to draft a picture of the interchanges and relations with institutional orders and actors. Informed by this dialogically produced experience I will move onto the clinics to ask how the unborn and its relationship to the pregnant woman are enacted in the practices of maternity healthcare both temporally and topically. How does the relationship between the pregnant woman and the unborn become institutionally coordinated as a relationship between a mother and child in pregnancy? Because my research commitment is anchored in the engagement of pregnant women in institutional orders and out-of-orders I will, further, attend to the question of how the agency of pregnant women is realised in care practices in relation to the unborn and its activities (as enacted).

1.3 Outline of the thesis

The thesis will be structured as follows. In Chapter 2 I will discuss my theoretical and methodological choices in more detail. My conceptual orientation combines institutional ethnography as theorised by Dorothy E. Smith with certain insights from particular science and technology studies (STS) that discuss how different entities, such as the unborn, are enacted in a material-semiotic (or socio-material) and procedural manner (Mol 2002; 2008a; Haraway 1991a; 1996; 1997). The concept material-semiotic refers to the way realities and representations are simultaneously performed, as discussed in the case of the analytical concept of enactment. In the rest of the chapter I will draft a preliminary picture of the ethnographic field I am about to enter. I will provide a brief description of the ways in which the history of the organisation and current guidelines and policies coordinate maternity healthcare work, and give contextual information on the field clinics that participated in this study, i.e. the ethnographic setting. I will also discuss my interference in that field, and my method of bringing together different research materials in a multisited and dialogical institutional ethnography of multiple pregnancies and the unborn.

Chapter 3, Pregnancy as an embodied experience, the first analytical section of the research, inquires into experience-based knowledge in pregnancy that is, pregnancy as it is
lived and experienced. The description of interviews I had with pregnant women and field observations form an outlining framework for the ethnographic analysis of institutional practices and orders that will follow in the subsequent chapters, both in the sense of controversy and complement. I will show that pregnancy is accounted for as a set of transformations within which selves are born and selves shift. Overall I will address the social relations that coordinate pregnant lives and selves in and outside the clinics but that are also constituted by the women themselves.

The second analytical section of the research, Chapter 4, *Pregnant selves and unborn relations in the paths of maternity healthcare*, begins the actual inquiry into the practical and specific realities of everyday work at the clinics. I ask how the logics of transformation and teamwork in making babies, children, mothers, kin relations and so on are actually realised in care work as documented in video recordings of the appointments, observational and documentary material, and interviews with the nurses. In the chapter, I will trace the temporal rationale of doing care and pregnancy in the institution i.e. go about my inquiry as pregnant women do and follow the paths from the first appointment onwards, in line with the progression of pregnancy. I will argue that the temporal movements in the processes of care for pregnancies follow a logic, albeit it is somewhat incoherent, whereby mental and socio-material transformations of family life are provoked to move from nurturing and caring for a foetus, a human life and a baby in itself, to attending to one’s own particular baby and a child with at least potential personality traits, gender and social identity, and kin ties. In the practices of evoking bonding in maternity healthcare, these ties and social relations to one’s unborn are enacted, above all, as emotional affection and preparation, early interaction and, possibly, over-attentiveness that coincide with psychosocial knowledge on and approach to the abstract issues of parenthood. The institutional stir to bonding, however, leaves scope for vague agency to make homes and maternal selves through social and material arrangements within one’s own social networks.

The final analytical chapter, Chapter 5, *Multiple ruling relations in making the unborn–woman relations*, attends to thematic logics of care that cannot be linked to any specific
phase or point in the temporal trajectory of care. The themes in making unborn relations that, in effect, set spaces and limits for women’s agency are technoscience-in-the-making, politics/citizens-in-the-making, divergence/class-in-the-making and consumers/product-fetishes-in-the-making. These logics of making relate to the temporality of care and have been touched upon earlier in the thesis: they make and break the temporal logic of transforming foetuses, human life and babies in general to particular babies and children with identities and social bonds. This chapter is more abstract and theoretical, because of my commitment to (institutional) ethnography: staying responsive to the dialogue between myself and the research participants and the knowledge produced in dialogue. At the point of writing up my thesis, this means that I must not succumb to the singular voice of scholarly theory that shares with other abstract institutional discourses a tendency to marginalise the intentions and perspectives of the original speakers and actors (Smith 1998, 67; see also Van Maanen 1988, 73–100). My structural response has been to offer first ethnographic description that remains at a more descriptive analytical level and is, thus, also accessible to a wider variety of readers. Finally, I will bring in theory and the more abstract power relations coordinating care. In this way, I attempt to maintain a multiplicity of voices and knowledges-in-the-making (which are open to the reader).

In Chapter 6, the concluding chapter, I will explicitly answer my research questions and reflect on my research as a whole. Further, I will discuss the potential implications for maternity healthcare, especially regarding care directed at the maternal–unborn relationship. This also involves thinking through what it means to grant or not to grant the unborn agency from a feminist perspective in the light of my research and its conceptual applications.
2. Theory and methodology

My theoretical and methodological orientation combines institutional ethnography (IE) as theorised by Dorothy E. Smith (1987; 1991; 1998; 2005) with certain insights from traditions of science and technology studies (STS) that are influenced by feminist research and (post-)actor-network theory (ANT). Most of these traditions focus in particular on differences, both within medicine and between medicine and other locations. They understand health, bodies and ‘conditions’ (or illness) as politically and discursively produced in medical practice. (e.g. Mol 2002; 2008a; Harbers, Mol & Stollmeyer 2002; Haraway 1991a; 1997; Berg & Mol 1998.)

2.1. Institutions as objects of inquiry

In short, the overall project of institutional ethnography is to explore the social relations organising institutions as people participate in them. Institutions, in Smith’s view, are vast complexes embedded in ‘ruling relations’ that are organised around a distinctive function, such as healthcare. Institutional ethnography aims to go beyond and behind the individual’s doings, knowledge or experience to discover how what they are doing is connected with the doings of others. The idea is to map the institutional aspects of ‘ruling relations’ that refer to distinctive authoritative forms of social organisation and social relations – mediated by texts of many different kinds. (Smith 2005, 225, 227; 1987, 160, 166–67.)

Dorothy E. Smith has a background in feminist sociology, and is probably best known for her work on methodology and her accounts of institutional ethnography (Smith 1987; 2005; 2006). She has also done empirical work on educational systems and psychiatric practices (e.g. Griffith & Smith 2004; Smith & David 1975). Her institutional ethnographic research material has varied from different kinds of documentary/text material to interviews and observational material. According to Smith, institutional ethnography should involve looking for sequences of action that implicate other people, other experiences, other work and texts in institutional processes, and courses of action.
That is, the ethnographer should search for indications of connections to social organisation and relations. To put this in simplified and more technical terms, this means exploring conceptualisations and sequencing as social relations in organisational action or work (linguistic or otherwise) (Smith 1987; 2005; 2006).

Social organisation is present in the language people use in their everyday lives. That is, they use terms and concepts that organise activities in which they participate. Furthermore, these terms coordinate activities in accordance with each term’s meaning in a given setting (Smith 2005, 132–135; 1987, 156–157). Emphasising the sequences of action directs our attention to the fact that terms, language, experiential accounts, work activities and so on are embedded in institutional process(es) that establish different positions in social relations enacted at the level of everyday work, for example, at maternity healthcare clinics (e.g. Smith 2005, 158).

The textuality or text-based organisation of (care) work is of extreme importance in Smith’s theory of institutions. According to her, it is the existence of technology that enables the replication of texts and gives contemporary institutions their particular character. Replication makes it possible for texts to be viewed in particular local and observable settings, and at the same time enables those texts to engage the individual’s consciousness in relations that are to a certain degree independent of the local setting. Furthermore, the replication of texts independent of time and place produces the stability and replicability of the organisation and hence the institution: texts have a standardising (‘generalising’ in the original) effect. This is crucial to the recognisability of institutional (inter)action as such, regardless of local context. This is something Smith calls ‘translocal’.⁹ (Smith 1991, 209–225; 2005, 165–198; 1987, 212, 136–41.) This is how both the nurses and the pregnant women are involved in text-based work – complementarily – to produce institutional subjectivity and agency inside and outside the clinics.

The notion of text is used in institutional ethnography to refer to ‘words, images, or sounds that are set into a material form of some kind from which they can be read, seen, heard,

⁹ ‘Extralocal’ in Smith 1987, 47.
watched, and so on’ (Smith 2006, 66). Smith notes that unlike some theories of ‘text’, her work uses the term ‘strictly to identify texts as material in a replicable form (paper, print, film etc.)’ (Smith 2005, 228). However, it should be noted that texts in action in everyday institutional work do not have to be materially present in forms, handouts or textbooks, for example, at a given moment. A peculiar ‘agency’ of texts in action, textual regulation – which may appear nowhere in the observed situation as such – may be identified from characteristic uses of argumentation or concepts, i.e. interpretive frames or discourses (Smith 2005, 118, 165–182; 1991, 120–159).

Finally, according to Smith, texts should be understood as occurrences embedded in what is going on. This suggests that they are not to be analysed separately from the ways in which they enter into and coordinate sequences of action (Smith 2005, 118, 165–182; 2006). For instance, Finnish maternity healthcare texts, such as case files or the casebook system, are a product of, and make accountable the coordination of the work of public health nurses in relation to clients or patients (pregnant women) and administrative standards. Public health nurses are made accountable to the municipal healthcare administration, and they are expected to follow the guidelines by reporting through a computerised casebook system during or after every individual appointment. This information implies that, even when not observable, these texts are still integral to the courses of action, and organise work at given moments.

**Socio-material practices in institutional activities**

I will start this section with a snapshot from my ethnographic data. In it I will contrast two ways of atributing qualities to the unborn as I have come to understand them during my fieldwork at three different maternity healthcare clinics ¹⁰ in one large city in Finland.

> Often before the screening the public health nurses choose to inform pregnant women and their partners about screenings in accordance with the brochures handed out at the clinics. This seems to be in accordance with the local policy linked up with the will of the individual: women need to make...

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¹⁰ Additionally, video-recordings of special ‘welfare assessment interviews’ were obtained from a fourth clinic.
a choice between attending or not attending the screenings. Furthermore, the nurses use rather clinical and medical terms when referring to the unborn, and try to keep to ‘the facts’. This is done on purpose: nurses tell me that they intentionally use the term ‘foetus’ and try not to personalise it in other ways before the screenings, so as to ease the anxieties some women might have concerning the screenings. However, nurses offer these ‘facts’ in various ways that are embedded in advice-giving on how to think positively, and in encouragement and affirmation. They may, for instance, tell stories of their own pregnancies and give the pregnant woman a warm hug. When discussing the screenings afterwards, mostly in the cases where there are no abnormalities, the nurses go back to talking about babies or ‘womblings’ (kohtulainen) that ‘do’ things and are new members of the family in many ways. These womblings may have a nose that looks like their father’s on the ultrasound screen, or they may show temperament if they kick a lot in the womb. It seems that these associations and positive feelings towards the baby-to-be are provoked by the nurses.

It is not really surprising that health workers hold back and stick to giving ‘neutral’ information like this about screening for somatic abnormalities when it comes to making decisions about diagnostic tools or treatment. The highly valued Western ideal of patient (informed) choice or autonomy in all its varieties obviously shapes daily care at the maternity healthcare clinics. It is even taken as a self-evident ‘good’ within a medical ethical repertoire of care that works in alliance with biomedical knowledge about the natural order of things. Most often care is also organized in terms of citizen’s/social rights of some kind. (e.g. Helen 1997; Pulkkinen 2003, 135–157; Mol 2008a, 29–41; Duden 1993.)

When patients (or clients) are put in this decision-making position, it is usually either by means of the market or by means of the civil society. In the former case, patients become customers who need to make value choices between different ‘goods’ of healthcare i.e. care acts and interventions. In the latter, on the other hand, interventions are chosen not as ‘goods’ but as policy measures. Patients act first and foremost as citizens who are granted jurisdiction and representation over interventions, but they must argue civically. (Mol 2002, 166–167; 2008a, 14–42; Harbers & Mol & Stollmeyer 2002, 217–219.)

Yet this is not the end of the story. For a few decades now, many feminist accounts of reproductive matters have been amending the way ‘will’ or ‘choice’ is understood in
Western theoretical, popular philosophical and socio-political thought (e.g. Whitbeck 1984; Petchecky 1985; Morgan 1996; Addelson 1999; Harouni 1999). Indeed, the critique of Kantian, utilitarian and liberal conceptions of the autonomous subject that makes rational choices was the starting point of the ethics of care (e.g. Held 2006, 3–4; Baier 1994), and such conceptions were even deemed absurd in relation to pregnancy in some feminist accounts (e.g. Duden 1993). This has meant a shift from the universal principle of doing ‘good’ to practical deliberations on the various available courses of action in specific situations, and a shift from autonomous (human) subjects to relational (human) subjects. With this shift scholars have tried to grasp the fact that power differences alter the possibilities of doing (good) care. (Harbers & Mol & Stollmeyer 2002, 218; Mol 2008a; Held 2006.)

However, so far the majority of studies on healthcare have been dominated by a humanist orientation to practices: human beings are the relevant actors in these conceptualisations (Harbers & Mol & Stollmeyer 2002, 218). It has been noted that, in order to understand clinical practice, it is not only the concept of will or choice that needs to be altered, but also our understandings of the workings of nature and technology, the materialities and technicalities of practices (ibid., Mol 2008a, 1–8). This has only recently been attended to, mostly by science and technology studies (STS) scholars such as Annemarie Mol (2002; 2008a), Hans Harbers and Alice Stollmeyer (in Harbers & Mol & Stollmeyer 2002).

In the specific case of screenings this means that the ‘natural course’ of foetal development or pregnancy is in some sense left unexamined. If natural fate is invoked, what is left unaddressed is the fact that people experience and deal with foetal abnormalities and uncertainty in different ways. Some women’s anxieties may be assuaged by offering support – advice, encouragement and affirmation – while others’ may not. It does make a difference how doubt – which is just as characteristic of healthcare practices as certainty – is lived with. For instance, shifting the repertoire from unborns with social relations and identities to unborns that are more like mere bodies in a biologically natural process (‘the foetuses’) can be understood as a way of accommodating the unpredictability of screening results. A mere concept of nature holds little explanatory power in relation to the question
of ‘how to give shape’ to the course of pregnancy (cf. Mol 2008a; Harbers & Mol & Stollmeyer 2002, 218).

How, then, can (good) shape be given to the course of pregnancy, if pregnancy matters and the unborn are not one but *multiple* in this way, and if healthcare practice attends to this multiplicity and uncertainty? Activities at the clinics do not depend on what is ‘real’ in any singular and straightforward way, and professionals orient themselves towards ideal standards, such as ‘patient autonomy’, ‘health’ and ‘the good life’, in many different ways; but this does not mean that we cannot seek positive interventions (Harbers & Mol & Stollmeyer 2002, 219). This is where ethnography as a methodology of inquiry comes to the fore.

Engaging in an ethnography of the practicalities and materialities of daily care allows us to attend to the ‘goodness’ of care differently than, for example, the medical professional or ethical approaches. It sets out to enquire into the modes and styles of setting standards in care work *practices*, and to study the giving of ‘good’ and avoidance of ‘bad’ care (Mol 2008a). Thus the focus is on knowledge practices – not so much on finding ‘the truth’ but on how objects such as pregnancy matters are handled in practices. Since they are not same from site to site or moment to moment, this ethnography also asks how the coordination between such objects proceeds (Mol 2002, 5–6). Answering these questions involves paying attention to the specific issues that are at stake in practices. Furthermore, since this approach claims that making a judgement in a single difficult moment of deciding about a course of action tells us little about the ‘goodness’ of care, it also calls for an ethnographic time frame. A long period of fieldwork is required to attend to the entire trajectory of care for patients/clients. Overall, because the issue is to explore the modes of care given at specific places such as clinics and the dynamics of a collective that insists on the socio-materiality of practices, ethnography offers a suitable toolkit. (Mol 2008a; Harbers & Mol & Stollmeyer 2002; see also Beaulieu & Scharnhorst & Wouters 2007; Hine 2007; Clifford & Marcus 1986.)
To address the materialities, technicalities, practicalities and ‘goods’ that organise institutional activities, then, my theoretical and methodological orientation draws on insights from writers associated with traditions of science and technology studies on material practices11 (e.g. Mol 2002; 2008a; Harbers, Mol & Stollmeyer 2002; Haraway 1991a; 1997; Berg & Mol 1998) and applies them to a Smithian project of institutional ethnography. These writers have also been characterised as engaging in (feminist) studies of technoscience (FT). Especially, my PhD project has been influenced by Annemarie Mol’s (e.g. 2002; 2008a) and Donna Haraway’s (e.g. 1991a; 1997) work.12

Combining elements of these two traditions of thought is not an easy task. It is not that ethnographic methods per se conflict with the FT approaches I aim to apply. Rather, it is a question of fitting together their respective ontological presumptions. Thus, combining elements from FT to IE involves altering my conceptual framework as such.

I want to emphasise here that I am not trying to formulate a theoretical fusion of any kind, because that would require a PhD study of its own, and in any case I remain sceptical that such a fusion would even be possible. There would always be traces of irreducible differences, and there would not be any smooth compromises: at best a hybrid text, in which both theoretical repertoires would coexist but ‘not [always] at once’, could be achieved (cf. Mol & Messman 1996, 437). I want to take the term ‘hybrid’ in this sense of not being ‘at once’, and to conceptualise IE and FT as two modes of ordering ‘in the form of theoretical repertoires’ (Mol & Messman 1996, 437) which relate to each other in many ways but cannot and need not be neatly reduced to or conflated with each other to apply them both. In my analyses there might remain simultaneous narratives from both orderings that ultimately will be coordinated: they will hang together, but not as one. Overall, I will only apply some insights from particular writers, namely on the enacted/performed character of (natural) objects/subjects, to widen my analytical IE perspective, particularly on agency.

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11 that often involves health and illness/disease.
12 Mol’s and Haraway’s work differ from each other is some respects, especially in relation to conceptualising power and normativity. This will be elaborated on later on in this chapter.
In what follows, I will elaborate on my working through of these (seeming) differences in ontological commitments. First, I will revisit Smith’s key methodological concepts by bringing in elements from socio-material (or as it is also called, material-semiotic) ways of thinking methodology. I will simultaneously consider the possibilities and benefits of doing such combining work. Then I will orient my key concepts of agency and subjectivity to both FT and IE lines of thinking.

**Institutional ethnography and feminist studies of technoscience**

Smith’s conceptual ‘design for ethnography’ works for me as a broad frame for conceptualising how institutions exist as objects of inquiry (Smith 1987; 2005). The overall project of institutional ethnography is to explore the social relations organising institutions as people participate in them, from the perspective of specific groups within such institutions. My particular focus is on pregnant women’s partial and shared agency and embodiment. In other words, the actualities of pregnant women’s lives and accounts of their experiences work as an entry point (standpoint) that organises my analysis. It is from this partial and particular perspective that the analysis proceeds to account for the ‘ruling relations’ coordinating the work and workings of all the actors involved at different levels (and sites) of institutional activities as they stand today.

As I understand it, Smith’s key methodological concepts in her studies of institutions include *standpoint*, *experience*, *ruling relations* and *work* (knowledges). Smith’s view of standpoint cannot be equated or identified with certain social standpoints which usually originate from subjugated experience (e.g. Rich 1976; Chodorow 1978; Harding 1986; Hartsock 1975). That is, it cannot be simply equated with what have been termed the ‘feminist standpoint theories’, usually associated with the 1970s and 1980s. Smith herself explicitly takes issue with the theoretical challenge to the notion of standpoint made in terms of its alleged essentialism (in regard to the category ‘woman’, especially Harding 1988). Smith (2005, 10) writes that

*The version of standpoint that I have worked with [...] does not identify a socially determined position or category of position in society [...] Rather, my notion of women’s*
(rather than feminist) standpoint is integral to the design of what I originally called ‘a sociology for women’ [1987, RH], which has necessarily been transformed into ‘a sociology for people’. It does not identify a position or category of position, gender, class, or race within the society, but it does establish as a subject position for institutional ethnography as a method of inquiry, a site for the knower that is open to anyone.

Standpoint, then, is a methodological starting point in the local particularities of bodily existence and people’s everyday lives. It is designed to be an alternative to the objectified subject of knowledge of social-scientific discourse in ways that do not return it to the universalised subject or empiricist truth claims on the basis of any unified experience as an authority to speak truly (Smith 2005, 7–25; 1987, 78–88). It is in this way that Smith’s (later) work on standpoint can be described as a model or method that attempts to answer the criticisms usually ascribed to postmodern feminism. Although Smith does not use the terms ‘partiality’ or ‘multiple’ (subjectivities) as, for example, Donna Haraway (1991a; 1997) and her contemporaries do, I see no reason to think that their views on subjectivity or knowing are incompatible. Rather, these conceptualisations offer material to build upon some of Smith’s notions.

The term ‘experience’ in Smith’s formulations refers to what people come to know (knowledge), and it originates in everyday bodily being and action and cannot be reduced to the givens of institutional discourse. It emerges for the ethnographer in dialogue with particular people at particular times and sites. Hence experience is not some a priori feeling between the body and the world, or something that is subsequently evoked in conversation (Smith 2005, 123–143). To refer to that kind of a priori being, Smith uses the term ‘lived experience’. This is probably the point where material-semiotic views at a first glance seem to be in greatest contradiction with the theoretical presumptions of institutional ethnography. Experience, perception and similar concepts are tangential to science and technology studies in general, and STS on health in particular, because such concepts imply a separation between the caregivers and the cared-for, and between interpretations and physicalities (e.g. Mol 2002, 10–13). The associations between the social and the physical/material are the main focus of STS/FT theory and research.
This is where Donna Haraway’s (1991a; 1997) unique approach proves useful. Her work on ‘situated knowledges’, which refers to the partiality of knowledge, addresses what Smith calls ‘the standpoint’ (achieved via dialogically produced experience-based knowledge). For Haraway, situated knowledges are a reflection of the ‘particular and specific embodiment’ (1991a, 191) of the knower, which in turn is telling of her position in social networks (1991, 190; Campbell 2004, 170). While Smith is a little vague, in my view, when defining experience as knowledge and research data, I would argue that her explication of the research process of IE effectively posits a version of ‘situated knowledges’.

Experience-based knowledge accounts produced in an IE inquiry are addressed as situated accounts of what is happening and done on an everyday basis, and how all these happenings and doings are linked to social relations beyond experiential accounts (Smith 2005, 41–43; see also Campbell 2006). Experience or experience-based knowledge serves the IE knowledge interest of pointing toward how social (power) relations institutionally rely on, and to some extent determine, people’s everyday lives. Thus, although Smith does on occasion speak of experience in such a way as to make it sound like an authentic feeling or perspective, in her insistence on describing experience as something that can only be spoken by the experiencer (e.g. 2005, 224), her analysis ultimately approaches experience as positions in institutional networks. IE use of experience-based knowledge accounts, then, resonate strongly with what Annemarie Mol (2008, 9) calls ‘extended ethnographic observation’. She writes how, in her research, the researchers asked people ‘about the events and activities they were involved in’ and ‘drew upon their skills as co-researchers’ (ibid., 9–10). There is no huge conflict of episteme, here, between the traditions of IE and (the particular) FT, in that the origins of research knowledge are conceptualised in quite the same way.

However, embodiment, bodies or, better yet, physicalities are not an explicit focus in any of Smith’s writings. She does address the issue of embodiment as a site of consciousness, mind, thought, subjectivity and agency as particular people’s local doings (e.g. Smith 2005, 24–25; 1987, 82–83), but she does not write extensively of embodiment,
corporeality or embodied subjectivity/agency. However, I do not see this as an insurmountable problem for my own adaptation of the key concepts. I perceive the material-semiotic worldview as a more sensitive or specified one for studying how ‘realities’ (Moser 2008, 99), be they concepts, facts, persons or natural objects, come to matter in the practices of everyday life.

This is not to say that Smith does not consider different kinds of entities as enacted in relations or networks. On the contrary, she explores how things are put together as organised relations in different (trans)local practices, as do some feminist technoscience scholars. Her notion of social relations (and text-mediated ruling relations) does imply the importance of viewing people’s activities as enacted again and again in a profoundly locational, relational and orderly way, as she indicates when she comments: ‘The term [social relation] […] orients the researcher to viewing people’s doings in particular local settings as articulated to sequences of action that hook them up to what others are or have been doing elsewhere and elsewhen’ (Smith 2005, 228). It is just that she grounds ethnography in (ruling) social relations that institutionally exist between people. Although non-human actors and objects as embedded in practices can produce subject positions for the people involved, personhood, subjectivity or mattering is not granted to all non-human, especially natural, actors or objects.

Smith’s notions of texts and textuality may, however, be seen to acknowledge the workings of materialities in (institutional) practices (for textuality of technology, see Vehviläinen 2004, 265; 1997). Her main interest, however, is in the standardising work the texts do or do not do. What is not fully attended is the heterogeneity and instability of the socio-material practices and performatives. Standardised and stable realities certainly exist, as STS also acknowledges, but focusing too exclusively on them represses the vague, diffuse and unspecific parts of the world from our studies (Law 2004, 2).

From STS/FT I have adopted the notion of subjectivity, personhood and agency that are not reduced to the notion of a subject position (with a discursive function) and one’s standing in relation to it that is ultimately how Smith conceptualises agency and
subjectivity (e.g. Smith 2005, 223; cf. Foucault 1991/1975; 1990/1976). These positions are unstable, in that they may change over time and look different depending on the place from which you look at them. Yet the concept does not really leave room for much agency outside a given institutional position. In other words, one has to learn the institutional practice, which is somewhat predetermined – for instance by institutional language – in order to gain subjectivity at a given institutional location. To address agency that is not merely the property of discourse(s) I need, as a starting point in my analysis, a less fixed and more multiple, performative and situated notion of subjectivity and agency that is crafted in the practice of a multitude of materialities.

Smith’s last key concept of and emphasis on *work* (knowledges) refers, in my view, to the unit of research. Smith adopts her notion of work from the Wages for Housework Group, who expanded the concept to refer not only to housework but to anything that people do that takes time, effort and intent. Work, then, refers to the actual ways in which people participate in institutional processes. (Smith 2005, 145–161; 1987, 165–167; see also 1977.) In other words, her focus is on the practices of the institutions: what is being done in the practices, in relation to power? Practice is to a large extent the interest and unit of research also in the kinds of studies of technoscience that I draw on.\(^\text{13}\)

Studies on science, technology and healthcare, such as Foucauldian approaches, which mobilise a notion of governance, governmentality or management have been criticised within the field of STS for focusing on how medicine or other disciplines do or do not structure practices and clash with individual agency, choice, experience and so forth (Latour 1988, 178; Mol 2002, 40–41, 62, 66–70; Law 2004, 35–36; Ruppert 2011, 219).\(^\text{14}\)

\(^{13}\) Haraway (1991; 1997) does not discuss practices much, but can be seen as studying them by exploring the textuality of language and lines of thought and so on.
\(^{14}\) During my research I confronted one question many times: if ethnographic methods and practice as a research unit per se are not in conflict with the FT approaches I meant to apply, why not abandon Smith’s theoretical and methodological formulations – or more precisely, her ontology of the social – altogether? At the time, it seemed a reasonable question, given that scholars such as Annemarie Mol, Donna Haraway, Duden and others have done extraordinary work on practices in different locations without the need for more theoretical or methodological formulations about institutional practices. I was also reminded, as I discussed earlier in this section, that fitting the ontological presumptions of Smithian IE to those of the FT texts that I intended to use is no easy task. Now, at the end of my research project, I think that a lot of the critiques made by different people, all of whom were engaged with material semiotics and theories that ontologically render different entities the ‘same’ in a political sense, resulted from relative ignorance about Smithian
These approaches are seen as assuming that disciplines are the glue that holds the social together in a singular order and hence organises (human) agency (e.g. Mol 2002, 62–71). Some of this criticism seems rather harsh, since many important and fine pieces of research have stemmed from these approaches (on Finnish (maternity) healthcare and social services e.g. Vuori 2001; Nätkin 1997; Kuronen 1994a; 1999). Furthermore, it is a question of different research interests or politics, and of research projects at different ranges.

STS, especially material semiotics and similar approaches, have claimed solution to the problem of singularity of power in their interest in entities (signs, humans or other things) that have been left out or ‘silenced’ as ‘others’” outside orders of different kinds. This way they claim to address both power/politics and the multiplicity of realities by attending to every entity as an interrelated/interactive part of various orders (discourses, networks, bodies of knowledge etc., which are themselves ‘entities’). An entity may be constituted as mere noise or ‘other’ in one order but as information in another. Material semiotics shows the efforts and routes it takes for something to count as information or as ‘out of order’. (e.g. Law 2004; Mol & Mesman 1996.) Although material semiotics does not attend to silenced people, it claims that it is not apolitical; nor does it side with the strong, as is sometimes alleged (e.g. Mol & Mesman 1996; Law 2004, 13–14). Semiotic analysis brings to light how compromises between different exigencies are made when objects/subjects are enacted in different practices. Thus it also shows what activities are needed for an object to become something different; it shows how hierarchies are made, and that that process is not ‘innocent’. However, in my view, such an analysis often stops at operations done on the level of mapping out relations and enactments of entities, thus providing no tools to tell (also) situated human stories in which people participate in larger power relations, which are also of great interest in my study.

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theory on issues of power and discourse. Chiefly, they resulted from an equation of Smithian theory with Foucault’s theory, which seems to be the ‘straw man’ against which theoretical controversy is often directed in STS (e.g. Ruppert 2011; Mol 2002; Law 2004). Further, I have been able to clarify to myself how and why it is important to hold on to a Smithian project of inquiring into institutional power. Interestingly, close to the end of my research project, I also encountered the opposite position, being asked whether the FT approach really does bring any additional value.
Particular writers in STS, then, provide my ethnography with more tools to address the fact that in lived reality things do not always go as they ‘should’, according to some systematic logic. It is here, at a less discursive or systematic range, at the level of practice that does not necessarily follow a discursive logic, that my ethnography can inquire into care work that insists on bodies, physical hands-on work and fine-tuned technologies. However, I rely on Smithian IE for an analysis of power relations and discursive orders. Her ‘ontology of the social’ cannot be equated with Foucauldian approaches, but it makes possible an account of political power hierarchies that impose (multiple) orders on the social world somewhat in line with FT analysis. This is because Smith addresses power and discourse not as external to subjectivities as singular orders that coerce them but, rather, as orders that are realised partially, fluidly and in a responsive manner to distinctive situations in practices (Smith 2005, 127).¹⁵

*Bodies, agency and subjectivity fine-tuned*

Specific writers (e.g. Mol 2002; 2008a; Harbers & Mol & Stollmeyer 2002; Haraway 1991a; 1997; Berg and Mol 1998) in the fields of STS or technoscience studies have, first, influenced my analysis of socio-material or material-semiotic ways of producing knowledge and different entities, such as the unborn and the body. As discussed in the Introduction, the analytical concept of enactment allows me to avoid essentialising the woman in the body, so to say. What I am escaping also is the pull of two grand theoretical or philosophical positions that have widely been applied to conceptualise the body, the phenomenological and the constructionist. Putting it roughly, the constructionist approach to bodies, especially in studies on health, illness and medical practice, is often associated with Foucault’s (1990/1976; 1991/1975) work on bodies as constructed in discursive and other institutional practices of power (see also Oinas 2001, 22–27). The phenomenological take on the body, by contrast, is more transcendental in its interests in the ‘lived’ body in

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¹⁵ In fact, Smith (2005, 127) explicitly expresses how her view on power and discourse differs from that of Foucault, writing that ‘too often taking up the concept of discourse following in Foucault’s footsteps accords discourse an overpowering role’. Instead she adopts Bakhtin’s conceptualization, according to which ‘each moment in action can be seen as both reproducing and remaking discourse’ (ibid.). Smith thus adopts Bakhtin’s concept of dialogue, to which I will be returning to in the Chapter 2.3 Fields of difficulty and dialogue.
its intersubjectivity and perceptional attributes (perhaps the most influential writer is Merleau-Ponty, e.g. 1995; see also Shilling 1993, 198–199).

Constructionist bodies have been criticised by both phenomenology and STS for having been reduced to textual and passive bodies subjected to power/knowledge (e.g. Heinämaa & Reuter & Saarikangas 1997, 8–9; Grosz 1994, 3, 9; Berg & Akrich 2004). Bodies that appear (biologically) constructed and maintained are not experiencing or sensuous bodies, nor specific bodies that need special attendance in everyday practices. By contrast, the phenomenological approach has been blamed for not taking sufficient account of the social and cultural origins or orders (the construction) of the body, thus, making it a ‘first-person’ experience and somehow ahistorically ‘pure’ (Shilling 2008, 2, 4; Turner 1994, 48-49; Berg & Akrich 2004, 3–8).

Although I think that the STS line of argument generates too much controversy between itself and, especially, constructionism (and post-structuralism), it does offer tools for exploring bodies and embodiment in everyday healthcare practice that phenomenology and constructionism do not offer. For example, the Foucauldian modern and medically constructed body may have been the reality in research and governance practices and discourse in the beginning of the twentieth century but it can be argued that it was not realised in the everyday medical wards and offices of the time, nor nowadays, as Marc Berg and Paul Harterink suggest (2004). Foucault operates at a more strategic (population) level of institutions and governance (especially the Lectures at the Collège de France 1977–1979//2007/2008) and his interests lie in principle in larger historical developments, and more specifically in one development in particular, the rise of the determining power of biomedicine in the constitution of bodies and subjects, and ‘life’ as the object of governance. Thus, in my view, it is obvious that when one looks at everyday concrete and material practices and activities more closely at an everyday level the whole picture looks messier and less unified than from the strategic distance. This by no means proves Foucault or a constructionist approach ‘wrong’. Nor does it suggest that Foucauldian theory does not allow active subjects that not only subject themselves to power but are also part of subjectifying themselves anew. However, by treating embodiment as a process
rather than a starting point, STS writers on material practices are able to point toward both the historical and social constitution of specific bodies and the having/being of this body, thus to some extent bridging the constructionist and the phenomenological body (Berg & Akrich 2004, 3; Latour 2004b).  

In drawing attention to material-semiotic enactments these STS writers also mobilise an enlarged conception of agency, extending and broadening it to include, especially, natural non-human actors and objects. This multiplicity of and in the ‘logic of care’ (Mol 2008a), and thus of agency, is best understood in terms of moment-to-moment practical, material and situated practices that produce different kinds of subjects, persons and objects which are enacted in a distributed and partial way in the different locations of maternity care. This is also how I will approach care practices, and these conceptualisations of care and care activities will allow me to investigate the multiple ways that different agencies, be they clients, professionals or babies(-to-be), are enacted in different ways at appointments, multi-professional team meetings, home visits and so on. This also allows me to address the question of ‘goodness’ in care: how are the situations of people coming to the clinics improved? What is ‘improved’ in each specific place and time? 

In other words, care work is working with differences, and agency is to be found first and foremost in relations or sets of relations that are enacted in a distributed manner in everyday organisational activities. Furthermore, the term ‘enacting’ leaves open who or what an actor is. Many non-solid entities are involved in enacting health, diseases and bodies. By leaving open who and what does the doing, we can study human and non-human participants as entities that are done in similar ways in practices, without getting tangled up in presumptions concerning the foundational differences between (human)  

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16 This, then, is where my study diverges from social science that locates its locus in the concept of the ‘body’ or ‘embodiment’, the approach often applied to studies of reproductive matters of health (e.g. Martin 1987; Oakley 1984; Bordo 1993; Akrich and Pasveer 2004; Homanen 2007; Carter 2010). By emphasising how objects and subjects are enacted, unstable, and tentative, the concept of ‘the body’ loses the ‘the’ and is made an empirical question, as are other concepts as well. In this way, my approach to pregnancy and the unborn cannot be characterised as sociology of the body or anything of that kind.
subjects and (non-human) objects incorporated in modernist ontologies of agency (e.g. Mol 2002; 2008a). Things and not-yet-humans can also work and do things.

The self that resides in relations, interactivity and situations, and insists on materialities and technicalities, is not an agent in even a remotely similar way to the subject of modernist ontologies. If the actorship of a subject is distributed, then her boundaries are semipermeable; ‘semi’ because to be situated is not to be free-floating. Situatedness means taking into account not just where you are, but where you come from and where you may go, and at what cost, in your wider social historical contexts. (Mol 2008b; Haraway 1991a.) If shared activity is everywhere, and the changing of scenes or situations transfers objects/subjects, then it is a question of pinpointing when and where, in all the flows, subjectivity and agency emerges.

How, then, can we know when and where to pinpoint the emergent agent and subject that is not merely performing its discursive or material power-formation’s function? Surely not everything that acts or does things should be granted the status of an agent – a status that not only escapes power constraints but also has objectives to take a hold on the world around, even if not at the level of grand society changes. Here is where the Smithian standpoint is mobilised in my study which is, as I have argued, a method to account for situatedness. Thus I analyse the enactment of entities and varieties of actors (not assumed agents), namely the unborn and its relations, as done through a standpoint that is the particular location whence comes knowledge of whatever is at issue. This for me serves as a navigator to where and when, in FT terms, the flows stop, and as a navigator pointing to

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17 The divide between object and subject is dissolved here, along with the idea of active (knowing) subjects and passive (known) objects (e.g. Mol 2002; 2008a).
18 Marja-Liisa Honkasalo’s (2008) concept of minimal agency comes close to what I mean by agency that is not grand but, nevertheless, not merely actorial. Minimal agency comprises minimal gestures which are socially unimpressive and yet have enormous objectives, such as keeping one’s own and one’s family’s hold on the world and remaking it on different terms (ibid., 206–208, 245–246). Minimal agency is also something that is done together: it is a form of change-making that is achieved in a team (ibid., 248–249) (community in the original), and in a team nobody is left to act or think things through alone. Enduring the unpredictability of screening results, establishing workable daily rhythms to soothe the unborn, and trying again and again, always trying something new, to find a way to ease nausea associated with the early stages of pregnancy are all examples of minimal agency, doings that are minimal, everyday and precarious. Furthermore, they are work that is done together with the unborn, partners, other family, friends, healthcare personnel and things.
the subject. Thus it will provide constraints as to how far agency can be extended in regard to non-humans, for example. In my case, as in many Smithian cases (e.g. de Montigny 1995; Diamond 1992; Griffith and Smith 2005; Griffith 1998; Campbell 2001), the standpoint ultimately will ground my ethnography and maintain the focus on the agency of actual people – the pregnant women – under definite material conditions.

In effect, the Smithian project of institutional ethnography allows me to stay focussed on the operations of large power relations in society while simultaneously looking in detail at the material-semiotic orderings of the clinics’ everyday care. Despite the rejection of the accusation that it is apolitical, the problem with much STS work in terms of analysing agency is ultimately the problem it has with analysing power. Namely, its epistemological tendency towards analytical symmetry.

Analytical symmetry is in general associated with Actor Network Theory and, in particular, with Bruno Latour’s early work and its applications (Latour 1987; Law 1987). The concept refers to an emphasis in which different knowledges, actors, objects and sites are rendered analytically symmetrical. While this epistemological (and ontological) move expands the analytical perspective, it fails, at the same time, to examine critically how and why some knowledges, actors, objects and sites are (historically) assigned more agency, value, importance and resources than others (e.g. Collins and Yearley 1992; Casper 1994, 845–847; Haraway 1997, 33–35; cf. Haraway 1991a). Simultaneously, making political claims becomes impossible: how to formulate a politics of reproduction if the status of pregnant women and the unborn are perceived as (politically) symmetrical from the start?

Of all the alleged solutions to the problem of analytical symmetry within STS (e.g. Mol and Messman 1996; Mol 2002; Law 2004; Haraway 1997; 1991b; Pels 1996; see also Harman 2009) I think Donna Haraway (1997; 1991a) manages to theorise grand subjugating knowledge-powers, the (techno-)biopower-in-the-making of (gendered) subjects, most convincingly.19 Her emphasis seems to be on the movements and relations

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19 Annemarie Mol, in my view, is more focused on orders that are established beyond, or despite, grand society level orders. She does, for instance, attend to market logic, citizen rights, and organisational and population management in care, but her analysis and theory seems to be directed to showing how such orders
between the material and the discursive, and not on each of these categories as discrete concepts. She calls for (ethnographic) studies that originate from situated temporal and local characteristics that organise and are organised by historical social relations i.e. ‘situated knowledges’. These changing relations between material, physical and symbolical entities and sites bear traces of (value) hierarchies aimed at sustaining the authority of certain relations at the expense of others.

The problem with the adoption of ‘situated knowledges’ is, I think, that it cannot be made by anybody else. It is too situated and vague to offer concrete methodological tools (see also Rabinow and Marcus 2008, 85). Smith, by contrast, does offer conceptual tools for studying power, especially in relation to institutions that she has been studying and theorising about for decades.

Taking into account the ‘noise’, the multiple and the heterogeneous in the orders of maternity healthcare work, however, means that (bio)power is considered to operate ‘from below’ (Michael Hardt’s term 1999). Forms-of-life, sociality and (collective/distributed) subjectivities are produced in the multiple logics of in-the-making, in practices (Haraway 1991a; 1997; Mol 2002). This indeed coincides with the Smithian view that no given (discursive) power relation can have an overpowering role in situations (Smith 2005, 127). Discourses or other power formations coordinate institutional situations, but they do not totally determine them or ‘structure’ them. Furthermore, they are themselves dialogically modified in the situations (ibid., 17–18; 127; 1987, 108).  

fail to account for less rational and practical orders of care (2002; 2008a). Thus, her work does not, nor does it aim to, show how grand power relations work but, rather, how they are multiple, fragile and, at least some of time, not working. She does, then, offer a novel framework for thinking through the workings of historical power relations and politics based on them, but not a means of studying their effects.

Even though I may have been able to work around grand ontological and epistemological differences in my hybrid methodological and theoretical formulation, the problem certainly will remain of addressing (historical) political and philosophical issues on the one hand and all the heterogeneity in the practices on the other. Furthermore, it is a problem not just in STS but also in other social science and feminist traditions of theoretical and methodological thought. Nor is this a novel problem. There has been a lot of general debate in both social sciences and feminist theory about the fundamental tension between an emphasis on power and the political (structures) as well as the cultural or textual, and an emphasis on (individual) agency – for instance, between STS and ethnomethodology, critical theory and post-structuralist (cultural studies) approaches, or postmodern theories and feminist politics (Harman 2009, 99-228; Butler 1995a; 1995b; 1997; Fraser 1995a; 1995b; 1997; Mol and Mesman 1996). For feminism the contradiction is not just theoretical but political, too, for we cannot simply abandon notions of progress and emancipation even though the
2.2 Maternity healthcare work in Finland as a field

In this section I will give a brief (historical) description of the organisation of Finnish maternity healthcare from the viewpoint of historical ‘regulatory frames’ and give a contextual description on the fieldwork clinics. Regulatory frames are the ‘wide variety of conceptualizations, theories, policies, laws, plans, guide-lines etc. that operate at a general level to structure the institutional action and reality coordinating people’s work [both nurses and pregnant women] at local level’ (Smith 2005, 191). This section should be read to some extent as an ideological narrative (Smith 1990), and it approaches the institutional commitments and so on that are placed upon care work as organising social relations in everyday work, rather than as abstract entities. The chapter will end in a brief review of the recent prior research on maternity and child healthcare practices.

Maternity healthcare organisation: Protecting mothers and saving children

Finnish maternity and child healthcare (MCH) clinics are organised within public health centres, and are intended to ensure a good standard of health for the mother, the unborn child, the infant and the family as a whole (e.g. Screening and Collaboration in Maternity Healthcare 1999). Its services are provided free of charge, and as such the provision of care indicates that health services for pregnant women have become a state responsibility – a part of the Finnish welfare society.

On many levels throughout the history of Finnish maternity healthcare women have played an active role in its provision. First of all, the maternity and child healthcare clinics are run by public health nurses (and, to some extent, by midwives), most of whom are women, rather than by doctors. In general, the role of doctors and hospitals has never become as prevalent in maternity healthcare in Finland as it has elsewhere (for example, in the United

notions presume humanity and universal rights (Ramazanoglu 2002, 34-35; Singleton 1996). The only real working solution presented so far has been to do both kinds of research, e.g. by Nancy Fraser (1995b, 166-168) in a commentary on her debate with Judith Butler.
Kingdom). Indeed, in Finland maternity healthcare has remained in primary healthcare, centred on maternity healthcare clinics, where public health nurses and midwives provide the services (Benoit et al. 2005, 727–729). Hence, while feminist researchers and activists in other national contexts (e.g. the USA, UK) have identified ‘the medical turn’ in, or medicalisation of, maternity healthcare as a key feature of the history of care for pregnant women (e.g. Martin 1987; Oakley 1984), this pattern of medicalisation is not fully applicable to the Finnish context (Kuronen 1994a; 1999, 73; Kuosmanen 2007, 169).

Other researchers have noted that Finnish maternity healthcare can best be characterised as a site of activity among women (Kuronen 1999; Mesiäislehto-Soukka 2005), a site for population politics/policy (Nätkin 1997), or an institution of public management (of women as citizens) (Wrede 2001; 2003).

The second key feature in the background to contemporary maternity healthcare provision in Finland is the influence of women’s movements. The women’s movements, involving both bourgeois and working-class women, greatly influenced the establishment and formation of the maternity welfare work that began in the early 20th century, and later of the nationalisation and institutionalisation of maternity healthcare initiated in the 1930s. The period after the Finnish civil war in 1918 was characterised by anxiety concerning population growth and the future of the nation. It may be said that during those times maternalism as a political movement and discourse became combined with progressive...
(or pro-natalist) population policy. Reproductive politics that emerged from the women’s movement in the period from 1918 to the end of 1960s pursued not only population growth (or quality improvement) but also welfare for and protection of mothers and, through them, children. (e.g. Nätkin 1997, 16–17; 2006, 27–30; Vuori 2003, 42–43; Anttonen 1997, 181; Wrede 2003.)

The early maternity and child health welfare work referred to above emerged as a way to resolve emerging social problems. These problems included population policy anxieties and worries over infant mortality, but also moral concerns pertaining to, especially working-class, women’s lives. Since the first decades of maternity welfare work at the beginning of 20th century, maternity healthcare in Finland (as in some other parts of the Western world) has become increasingly specialised, medically and to some extent psychologically, as part of a more general pattern of increasing professionalisation and institutionalisation. Consequently, the emphasis on social problems started to disappear (Kuronen 1999, 70; 1993; Benoit et al. 2005, 727–729; Wrede & Benoit & Sandall 2001, 36–40).

Traditionally, Finnish maternity healthcare provision has mainly operated as a preventive agency. In practice this has meant that it has involved providing support in the form of advice and information for future parents, especially the mother-to-be and monitoring of the somatic changes experienced by the pregnant woman and the foetus. The 1944 legislation on municipal maternity and child healthcare (Laki kunnallisista äitiys ja lastenneuvoloista 224/1944 and Laki kunnallisista terveyssarista 223/1944) highlighted education, advice, guidance and health promotion. The services were to be oriented towards modernisation in that it was used to hold people responsible for being ‘good citizens’ as required by the modern industrial world. The concept of maternalism in Anglo-American discussions and contexts is quite different in both content and style of argument. In Anglo-American discourse, motherhood did not include paid work outside the home, and the tone taken has tended towards the mystification of motherhood. (Nätkin 1997, 19; 2006, 28-29, 37; Anttonen 1997, 182.)

Only to be rediscovered during roughly the last three decades, at least rhetorically (e.g. Wrede & Benoit & Sandall 2001).

Preventive agency refers to care work aimed at promoting healthy lifestyles and screening for problems before they become severe in medical and psychological terms. In general, the task of primary care work is not to provide treatment for illness. In cases where serious problems are detected a referral is made, for instance to a hospital or a psychologist.
towards all pregnant women and young children (not only to poor families). At the end of the 1940s, maternity benefit payments were made conditional, as women were required to visit a midwife or doctor before the 16th week of pregnancy in order to be eligible. (Nätkin 2003, 23–24; Kuronen 1999, 63; Wrede & Benoit & Sandall 2001, 37.)

Up to the 1970s, maternity healthcare work could be characterised as an institution of protecting motherhood. Ritva Nätkin (2006) argues on the basis of her research on policy documents that reproductive politics from the first decades of the twentieth century protected the mother and her child (to-be) ‘in the inner chamber’ or ‘core’ of the family and nation. The protection of motherhood included both paternalistic and maternalistic control and glorification of motherhood, and implied a family type that is asymmetrical, as the mother of the family nurtures in the private of the home whereas the father protects and provides for the family. (ibid., 28–29.)

The Public Health Act of 1972 rearranged the whole primary healthcare system in Finland and revoked the 1944 MCH care legislation. This legislation offered only a brief instruction to each municipality ‘to organise education, including pregnancy counselling, and to arrange general health checks for its residents’ (Kansanterveyslaki 1972, 14§, transl. Kuronen 1999, 65). Nevertheless, maternity and child healthcare continued to be provided according to the model which had been crafted in the 1920s and consolidated in the 1944 legislation. (Kuronen 1999, 65–66; Wrede & Benoit & Sandall 2001, 38–39.)

Despite the organisational continuity in provision, the 1970s can be seen as a turning point for protection of motherhood. Welfare policy and reproductive politics started to lose pronatalist elements that promoted increasing birth rates and obligations, and gained a more gender neutral and individual emphasis in regards to parenthood. In the new model of the family that has emerged, both the mother and the father participate in care and in working life and procreate by choice, not out of obligation to the nation. (Nätkin 2006, 30, 35; Benoit et al. 2005, 728.) Despite the tone of gender neutrality and the symmetrical model of shared care and parenthood, in practice, as Jaana Vuori (2001) shows, care and tasks are not really shared ‘equally’. Mothers merely seem to gain the extra task of actively
incorporating the fathers as the new, caring and active fathers they are supposed to be according to protocol since 1970s and 1980s (see also Daniels 1999). Further, the break between the cultural figure of a distant breadwinner father of the past and the attentive father of the present has been questioned as a model that simplifies the historical multiplicity of fatherhood and policy on fatherhood (Aalto 2004).

National guidelines and recommendations and a universal patient casebook system regulated and coordinated maternity healthcare work fairly consistently from 1972 until the 1990s, when the operational environment of maternal care was changed (Viljamaa 2003, 36). In 1992 the national health administration (valtionosuusuudistus) was closed, and consequently municipalities were given far more responsibility to develop their own services. Abandoning the centralised model of maternity and child healthcare has also resulted in less centralised national regulation. As a result, municipalities have developed their own services which in diverse ways follow the recommendations, guidelines, health promotion policies and projects initiated nationally, municipally or by NGOs or other bodies. (Viljamaa 2003, 36; Julkunen 2010, 106.) In the city region in which I conducted my fieldwork, local guidelines for maternity healthcare were compiled in 2003–2004 and have been irregularly updated by maternity healthcare personnel both on the local intranet and in print. Understandably, all this inconsistency in the guidelines further complicates the textual coordination of everyday work done by nurses and pregnant women.

The most recent national guidelines for maternity healthcare, published in 1999 (and consistent with previous guidelines published in 1995), outlined the purpose of maternity healthcare as follows:

*In a broad sense, maternity healthcare strives to promote the health and well-being of future parents, and to help them to take a positive view of family life and the role of the family in society. The expectant mother, the father and the whole family should be able to perceive pregnancy, birth and care for the infant as a safe and enriching experience. Preparation for parenthood and child-rearing creates the basis for a lasting maturation process. In addition to medical and nursing care, the expectant parents want maternity healthcare to provide them with social, emotional and psychological support and assistance in their new life situation, especially when their first child is being planned, expected and born.*
There is a strong emphasis on the psychological aspects of parenthood in this document, exemplified in the employment of terms such as ‘positive views’, ‘experiences’ and ‘emotions’ as noted also by Marjo Kuronen (1999, 68) in her ethnography on maternity and child healthcare in the 1990s. Medical care is only briefly mentioned. Advice, psychological support, social support (which is nowadays called psychosocial support in development discussions) and family-orientation are also mentioned in the quotation above. These aspects of health provision have been much discussed and criticised at least since the 1980s. (Yesilova 2009, 97–102.)

Psychological and social support appears to have been discussed and offered in terms of ‘psychosocial knowledge’. The term derives from traditions of psychological theory and is widely used in approaches to healthcare and social work nowadays. In a nutshell, it is family-psychological in nature. That is, psychosocial concerns refer first and foremost to concerns within family relations (Nätkin and Vuori 2007, 1), and the support offered often takes the form of therapeutic counselling (Yesilova 2008, 105).

At the same time over recent decades the focus has increasingly shifted to ‘early preventive/intervention’ (varhainen puuttuminen) agency in welfare politics and service reforms (Harrikari 2008, 123). Together these two tendencies have resulted in a situation where it seems to be politically acceptable to intervene in family life as early as possible in order to attend to every risk possible, those risks often being linked somehow to an ability to function in immediate family relations. What is emphasised and used as the guiding logic for argument in the debate and reform of services is concern for the children and ‘the (best) interest of the child’.

The concept of ‘the (best) interest of the child’ has been interpreted as a culturally ambiguous and fluid concept (Nätkin 2003, 37–38; Kurki-suonio 1999, 1–2). Further, it is such a strong value object that arguing against it appears socially unacceptable in itself. The only way to argue is within the concept, showing that the interest of the child lies
somewhere other than what has been assumed (see Hurtig 2003, 33; Kurki-Suonio 1999). In the historical context of maternity health care today this slippery concept gains new content and subjectifies, in my opinion, a child even earlier than before – before birth.

**Recent organisational changes**

Since the beginning of the millennium, the overall field of the Finnish maternity and child healthcare (MCH) system has been undergoing a vast organisational change that stems from challenges to the prevailing policy guidelines. It has been recommended that instead of focusing on medical screening and children who have already been born, care work should direct attention to the social and psychological environment of the child(-to-be), in this case the social unit of ‘the family’, to prevent future problems (Rimpelä 2008, Viitala & Kekkonen & Paavola 2008). Furthermore, the family should be participating as equals with healthcare professionals in the enhancement of child health, development and family welfare. These developments in Finland can be associated with the idea of shared care, which is widely advocated in the health and social care systems of not just Finland but also many other Western countries. The concept is used to designate systems of health and social care in which laypeople are involved in taking responsibility and making decisions concerning their health and social circumstances, or where their health and social care is shared among various professionals (see e.g. Boyle et al. 2003; Winthereik 2008; Vuori 2001).

The emphasis on the MCH system and the argumentation for reform outlined above stem from two particular observations made by different national and municipal policy actors. First of all, many commentators have noted that mental health, social and developmental problems are increasing among young children and accumulating in disadvantaged families (National Research and Development Centre for Welfare and Health 2006; 2007; Rimpelä 2008). Second, early family relations are seen as crucial to child well-being, mental health and development (Kangaspunta et al. 2005; Goodman 2008; Swanson &

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27 This participation of families is often discussed in terms of ‘family-centered work’ (see also Kangaspunta et al. 2005).

28 Here, then, shared care does not refer just to sharing care for children between mothers and fathers.
Wadhwa 2008). This indicates that families need particular support at the critical stage of transition to parenthood. In Finland MCH clinics have played a major role in offering such support, as they reach almost 99 per cent of the population (Viitala et al. 2008).

Various interventions have been developed and implemented in an effort to bring about change in existing MCH work practices (Kangaspunta et al. 2005; Viitala et al. 2008). One such intervention is the so-called family-centered MCH clinic in the one large city in Finland where my field clinics are situated at. In this model the changes to MCH system include: 1) the integration of hitherto separate clinics for maternity and child healthcare, and 2) the utilisation of the expertise of multi-professional teams in solving the problems of families. This involves pooling experts from the fields of early health and social care for children, and 3) new working methods to enable public health nurses and midwives to focus on psychosocial support, such as interviewing with and without forms (‘welfare assessment forms’) and conducting home visits during late pregnancy.

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29 It is important to note that none of these worries or commitments are totally new; some of them date back to the 1960s (see e.g. Kuronen 1994a; 1999; Nätkin 2003, 19–20; Helén 1997, 11).

30 The intervention in question and its implementation were a result of two different projects. It was first piloted within the municipally funded project, which was part of a larger municipal mental health project in 2002–2004. The dissemination of this interventionist model was first carried out in a project which was a subproject of the nationally funded PERHE project (PERHE-hanke) in 2005–2007. The intervention model was to be applied to all child and maternity healthcare clinics by the end of 2011 as a municipal project.

31 In general nowadays, social and healthcare work is often described in terms of multi-professionalism. In a nutshell this refers to work which combines knowledge systems and expertise from more than one field. It aims for a more ‘holistic’ understanding of an individual family’s situation and to overcome administrative and organisational boundaries (Kangaspunta et al. 2005; Kangaspunta & Värrri 2007; Aims and scope of the Family-centered MCH clinic 2007; see also Nätkin & Vuori 2007, 7). In the case of the clinics where I did my fieldwork, the professionals included in the team were two public health nurses, two family workers (of which the other was preferably a social worker by profession), a social worker from child welfare services, an obstetrician or a pediatrician, and a maternity and child healthcare psychologist. Teamwork is carried out at the clinics in meetings that take place roughly every two weeks. The nurses bring cases to discuss to the meetings, and they also invite individual families in problematic situations to attend. At the meetings further action is negotiated.

32 Psychosocial support just described in general terms is seen in professional documents as addressing issues such as anxiety (Castaneda & McCandless, & Palermo 1956), self-esteem (Rosenberg 1979), family relationships, and social support (Punamäki 1996, 3). When this concept is employed with reference to maternity healthcare, new (sub)categories emerge. Factors which are seen as crucial in indicating the need for support are identified in families’ social relationships, including problems in the woman’s relationship with her partner, anxiety levels, use of intoxicants, the family’s financial situation, and mental images of the child-to-be (e.g. Kangaspunta et al. 2004; 2005; fieldnotes from the health nurses’ training in spring 2007; see also Nätkin & Vuori 2007).

33 The word ‘form’ could be substituted with ‘questionnaire’, because in the Finnish language and the institutional practice considered here they are the same.

34 In addition to home visits conducted immediately after birth.
Thus my study examines the various ways in which the idea of family-centered and multi-professional care is realised in MCH work practices by focusing on this one specific ‘intervention’, the family-oriented MCH clinic, and on the working methods it entails.\(^{35}\)

The purpose is to explore, from the standpoint of the pregnant ‘client’ and in reference to my research questions, how these new working methods are embedded in what is and has been going on in the maternity healthcare practices in four clinics in one large city in Finland.

However, what are scientifically the most interesting are those working methods that are not directly defined by protocol\(^{36}\) or structurally imposed. This does not mean that these methods, which derive from standards established for care work in practice, are not linked to the fulfilment of newly imposed working methods. Indeed, my ethnographic approach, which addresses the whole process of maternity care, will reveal the ways in which the new working methods become part of the old orders of the trajectory of care for pregnant women and their partners. For instance, if individualisation of family life and childhood in welfare and family politics has resulted in removing the unborn from the chambers of the protectionist model as suggested by Ritva Nätkin (2006), how is it manifested in the activities of maternity healthcare today? This is something that has been previously unexamined to some extent as I will show later in this section (Tiilikainen & Homanen & Lindfors & Ruusuvuori, forthcoming).

**The field clinics**

Altogether four clinics were included in the study. I myself did fieldwork at three. The fourth was asked to participate merely to acquire recordings from the new welfare assessment form interviews, because such recordings could not be obtained from the other clinics. The reason for this was that at the other three clinics interviewing with the form was not conducted consistently with all pregnant women and their partners, and it seemed

\(^{35}\) Because my focus is on maternity healthcare, I will not attend to the practice of combining maternity and child healthcare.

\(^{36}\) By protocol I refer to the vast institutional, local and national, code of conduct originating from texts of different kinds that are, on a formal level, imposed on the practices of everyday work.
that the nurses did not want me to record these particular appointments. I was, for example, told that they were not able to tell in advance when such appointments would take place because the parents had the freedom to choose when to discuss the forms. Later I learned that the interviewing appointments had to be reserved in advance (regardless of whether the parents then wanted to discuss the forms or not) because they last approximately 1.5 hours, that is, nearly an hour longer than a standard appointment. It is understandable, though, that the nurses at the three primary field clinics did not want me to video record the form-interviewing appointments: because they had just recently been introduced to the standard method they were insecure about their interactional skills and seemed to perceive our social science research project as an examination of those skills. In short, they were afraid of us taking a critical view of their professional skills.

All the clinics are situated in one large city in Finland with a population of approximately 200,000, and the three primary case clinics are within walking distance of the city centre. In the whole city there are over 20 maternity healthcare clinics. These are located in client’s own neighbourhoods, which is also common elsewhere in Finland. The three primary field clinics operate in separate buildings/facilities which is common in large inner-city clinics. In rural areas with low populations clinics are usually situated in connection with health centres. The clinics are assigned a client population in the surrounding area so that each public health nurse is responsible for the care of approximately 40 pregnancies and 200 children under school age per year (approximately 80 pregnancies per nurse working only in maternity healthcare).

The neighbourhoods within which the clinics are situated are quite similar, although there are some differences. One clinic is situated in a more suburban neighbourhood than the other two, which are closer to the city centre. Many people in the area live in houses and town houses, and more often than not own their housing. In the other two neighbourhoods the case is rather different: proportionally, renting is slightly more common and more people live in apartment buildings (City of [Name of the city] 2012ab; Statistics Finland 2010ab). The nurses themselves, however, describe their clientele in similar ways: all of them described variations in terms of age, socio-economic and marital status and education
of the pregnant women in their area (interviews with nurses 1–7). Considering that the city in question is one of the largest in the country and a university city, it is not surprising that the population in the central area with heterogeneous housing prospects is quite heterogeneous itself.

The three clinics were chosen mainly because of their availability, to put it bluntly. In fact, access was formally denied from the rest of the clinics in the city area. However, the decision to choose three clinics rather than just one or even two was made in advance. I aimed to capture the diversity within maternity healthcare practices that could, then, be explained through institutional elements. In other words three field settings, the clinics, provided me with not just more variety of practice than a single setting, but also ‘ethnographic evidence’, to use Van Maanen’s term (2006, 16), about the institutional character of those practices that cannot be explained away by, say, the personal style of the nurses of one particular clinic (Beaulieu, Scharnhorst and Wouters 2007). From this perspective it was also preferable that the clinics were situated in similar neighbourhoods, because it can be assumed that the nurses’ work is not organised in terms of totally different clienteles.

It was not intended to include more than three clinics in the study because that would have been totally impracticable both for me and for the potential research participants. Although other nurses from different clinics were not asked personally about participating, I am inclined to believe the administrative personnel’s opinion that the other clinics were too much involved with other research and reform to participate in ours.

From the point of view of IE, the selection of three clinics is quite enough. Through particular stories (told or observed) of particular people the ethnographer can identify similarities and differences across actors’ experiences or/and whether they organise various settings of sustaining power (inequalities) (Smith 1987; 2005; DeVault and McCoy 2006). This does not, however, mean that IE aims at making universalising claims about the prevalence of experience or organisation of activities. Rather than making generalising statements about commonalities in the accounts and activities of the
participants, it puts such abstractions to test. It seeks to find out how abstract concepts and terms deriving from either theory-based conceptualisations or institutional orders are made use of and realised in different fields of work (DeVault and McCoy 2006, 18).

**Studying activities in the practices and processes of maternity healthcare**

Prior research on the actual practices and processes of maternity (and child) healthcare in the form of preventive healthcare to support transformation to parenthood is amazingly scarce – amazingly, given the increasing attention paid to the need for support for parenthood by the healthcare policies and research of Western countries (Armstrong and Hill 2001; Jallinoja 2006; Rimpelä 2008; Department of Health 2004). During this research I collaborated with three other researchers in a research project on a review study of the available peer-reviewed journal articles published during 2000-2009 dealing with maternity and child healthcare research that address family support, as it is widely understood (Tiitinen et al. forthcoming). We undertook the review because the existing reviews of the subject have mostly concentrated on charting the relative effectiveness of different types of intervention (e.g. de Oliveira & Camacho & Tedstone 2001; Whittaker 2002; Kearney & York & Deatrick 2000).

We looked at 93 peer-reviewed journal articles on family support in MCH published between 2000 and 2009. Characteristically they mainly concerned specific risk target

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Eight electronic databases were searched: CSA Linguistic and Language Behavior Abstracts, Medline, Sociological Abstracts, Sociology: A SAGE Full-Text Collection, EbscoHost: Academic Search Premier, CINAHL, Science Direct (Elsevier), and Ovid: PsycINFO. The search phrases were: (“prenatal care” or “prenatal clinic” or “maternity clinic” or “antenatal clinic” or “welfare clinic” or “maternity and child healthcare” or “child health clinic” or “child healthcare” or “maternal healthcare” or “maternal health clinic” or “infant healthcare” or “infant health clinic” or “baby clinic” or “health visit”) and (support or “transition to parenthood” or “shared care” or “family-centered” or “family-centred”) and (parent or family or father or mother). After a preliminary review of the search results, the following exclusion criteria were applied: maternity and child healthcare clinics are mentioned only as a) a place for data collection, b) one aspect among other similar aspects (e.g. as one of different sources of support), and c) a possible target of the application of research results. As our focus was support for parenthood in preventive maternity and child healthcare we also excluded articles considering d) the utilisation rate, volume, history or financial cost of providing maternity and child health services, e) the epidemiology, aetiology, diagnosing or nursing of the specific health problems of individual clients or target groups (e.g. diabetes or HIV), or medical care of specific illnesses that fall beyond the scope of preventive healthcare, f) ethical questions considering foetal screening, and g) child welfare. Articles considering all other aspects of maternity and child healthcare were included. Finally, the few studies that concentrated on maternity and child healthcare in developing countries were also excluded on the grounds that there is a homogenous understanding about the basis of...
groups, such as women and children with special needs or risk factors e.g. teenage mothers, lesbian mothers, incarcerated mothers and disadvantaged mothers. Furthermore, the research was conducted mainly in Anglo-American countries and within the academic disciplines of nursing studies, medicine and public health. Accordingly, biases emerge.

First, we concluded that the articles are attuned to medical-epidemiological risk thinking and/or the interests and terms of healthcare organisations. Second, the studies were conducted within Anglo-American primary care organisations and culture and thus, as already noted, are not directly comparable with Finnish or other Nordic or European service system or contexts (Devries et al. 2001). Third, less attention seems to be paid to men’s accounts and efforts aimed at engaging them in MCH activities. As the theme of the articles under review was maternity and child healthcare, the bias towards studying mothers does, however, seem reasonable.

Methodologically, most of the articles examine the views and perceptions of mothers and healthcare professionals on family support (63) and the effectiveness of intervention (21). Among our material, only eight articles could be classified as studies with a principal focus on (the processes of) care practice activities using such methods as observation, video recording, tape recording and patient records (Plews & Bryar 2002; Appleton & Cowley 2004; 2008a; 2008b; Sydsjö & Wadsby 2003; Kouri et al. 2006; McCourt 2006; Kemp et al. 2006–7). There were more than eight articles in which such a scope was claimed, but it became evident on closer examination that this was not actually the case. The articles in question were based solely on analyses of interviews and/or survey answers, and thus were really reporting the perceptions of clients or healthcare personnel on the processes and practices of care. Participant accounts of services certainly enable one to grasp certain aspects of the procedural logics or practices of care. Such work has aimed at mapping out service provision and practices, not simply addressing the experiences, opinions or satisfaction of clients and healthcare personnel in MCH care. (Tiitinen et al. forthcoming.)

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38 Similar observations have been made previously (e.g. Pelkonen, Hakulinen and Perälä 2005; Vallimies-Patomäki, Gissler and Viisainen 2003).
Nevertheless, there is a considerable difference between research that looks directly at practice via such methods as observation, video recording, tape recordings, patient records and so on, and research that relies simply on participant accounts of the practice and process. Not everything in care practices is obvious or even verbally available to the people involved (Mol 2008a, 8), and research that is prestructured on the basis of categories deriving from formal guidelines and protocols may leave the unarticulated and informal dimensions of care intact. (Tiitinen et al. forthcoming.)

In the eight articles chosen to represent practice and process research\textsuperscript{39} multiple dimensions of care were usually explored by combining different types of research material (observational data often in combination with interviews and surveys, and patient history/records in combination with surveys/questionnaires). For example Christine McCourt (2006) combined interviews, observations and a survey to study antenatal booking visit communication practices and processes. C. M. C. Plews and R. M. Bryar (2002), instead, used the same kinds of research material to explore how health visitors give advice and bring up difficult issues. In our article we argue that these kinds of methodological choices make it possible for the studies to ‘tease out patterns of the processes or trajectories of MCH care (on the issue at stake) and not just regularities among individual treatment decisions, difficult moments of patient choice, or the quantity or quality of the information, advice, or support given. Thus they offer knowledge about the procedural modes of action that a lot of previous research and even policy and protocol do not specify and, in our view, rarely adequate acknowledge’. (Tiitinen et al. forthcoming.)

Overall there is little unmediated (social scientific) research-based knowledge on the processes and practices of maternity and child healthcare in the 2000s, either in volume or in content. Answering questions about processes and practices concerning support in parenthood and child health and welfare, be it giving advice, communicating screening

\textsuperscript{39} The practices and processes addressed in these articles include needs/risk assessment (4), peer support (1), antenatal booking (1), advising and giving information (3), caseload vs conventional practice (1), use of formal guidelines (1), bringing up issues at the appointments (2), psychosocial support (1), referral to other services (2) and discussing medical screening (1).
results or anything else, requires exploration of the modes of care given in specific and
particular MCH care settings (See Harbers & Mol & Stollmeyer 2002) and a description of
the actual organisation of interaction between clients and healthcare personnel (Heritage &
Maynard 2006 [eds.]). We argued, and I argue here, that such procedurally oriented
research and sampling is required to reveal the processes and logics of MCH care, because
if the procedural nature of care and care practices are not scrutinised as such it will remain
unclear how the practices identified as effective and perceived as good are actually
implemented and disseminated (Tiitinen et al. forthcoming).

2.3. Fields of difficulty and dialogue

Like many ethnographers before me (e.g. Hammerley & Atkinson 1995; Clifford &
Marcus 1986), at the writing-up stage I found it hard to pinpoint where and when my
fieldwork actually started or ended. Obviously, I remember and wrote down in my
fieldnotes the date and place of my first ‘actual’ fieldwork day. I arrived at the first
maternity healthcare clinic, where all the nurses had consented to participate in the
research, overcome with feelings of fear and anxiety. I had barely slept the night before, I
had my brand new notebook packed in my bag, and my hands were shaking when I set up
the cameras in the consulting rooms. Similarly, I clearly remember the last day I spent at
each clinic. I recall feeling relieved but at the same time sad as I sat in the coffee rooms
with the nurses, drinking farewell coffees and discussing my research and the future.

Yet as I look back on my research process, I realise that many activities, places and times
before and after the ‘actual’ fieldwork at the clinics also must be incorporated into it.
These include the first contacts with people in the maternity healthcare organisation,
applying for formal research permission and seeking consent from different levels of the
actual work organisation, discussions with the nurses about preliminary results and
research materials, and almost monthly meetings and hundreds of emails with informants
from the local municipal administration. After the actual fieldwork was carried out, we
researchers in a research project arranged workshops in each of the participating clinics for
the nurses who participated in the study. In the workshops, researchers and nurses together
watched and reflected on extracts of video recordings of each individual nurse’s own
appointments with clients. The initial purpose for the workshops was for the researchers to communicate their preliminary analyses to the participating nurses and to offer the nurses a space to reflect on their work practices, based on the activities seen on the videos and our preliminary analyses. All these places and spaces, or sites, are part of my fieldwork, not just in the sense of gaining access to the field and reporting back on the research, but also in the sense that those experiences, encounters and observations contributed to the knowledge produced in my study and reshaped its framework.

Thus my research field includes not only the multiple sites of the everyday, actual and textual, frontline setting of care work and the encounters taking place in it, but every site that has contributed to how I came to know and describe my field. Furthermore, the ways I know and describe my field involve my own presence or interference in it. I agree with writers such as Jessica Mesman (2007) and Donna Henriksen (2002) that in ethnography interfering (intervening in the original) is not really a choice, but an unavoidable condition. In this sense my study differs from classic descriptions according to which ethnographers go to the field, observe, but do not change anything. Just by being in the field the ethnographer makes a difference, and in my case I am not trying to deny it. I have not aimed to make interventions of any specific kinds during my fieldwork, but I acknowledge and reflect on the fact that neither I nor the participants in my study have full management of knowledge, resources or identities, which all fluctuate in the research process (see also Mesman 2007; Holmes & Marcus 2008).

Overall, I share the view that participation always characterises feminist research in general and ethnography in particular. This can be theorised as interfering, intervening,

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40 This brings me to the question of how to conceptualise all the public health nurses, the pregnant women, their partners, their children, the doctors, psychologists, social workers, family care workers, administrative staff, and the lecturers in the various training and counselling classes who participated in my research. Are they informants, the researched, co-researchers or participants, and do these positions vary over the phases of research (design, implementation and evaluation/reporting back)? After many headaches and with the help of earlier literature on the topic, I have decided to call them participants (and informants), but with quite strict meanings. Obviously, as a feminist scholar, I do not want to conceptualise them as the researched, because to do so would entail objectifying connotations and fixed power relations between the researcher and researched (see also Mesman 2007). I also dislike the terms co-researcher and co-ethnographer, because they blur the differences and conceal the different institutional positionings of the researcher and the participants (cf. Mol 2008a, 10). To render all the participants, including the researchers, ‘the same’ would ultimately
collaboration or feminist action research, to name but a few alternatives (see e.g. Haraway 1991a; 1997; Mesman 2007; Reinharz 1992). In fact, over the last twenty years or so, collaborative approaches to ethnographic practice, termed a reflective turn (Van Maanen 2006, 16), have become widespread. Ethnography and collaboration are viewed here as intertwined practices (e.g. Henriksen 2002; Messman 2007; Holmes & Marcus 2008). According to approaches that stress the collaborative dimensions of ethnography, ‘doing ethnography’ entails not just giving descriptions of practices of the given field but also changing them either deliberately (as in action research) or unintentionally (just by being in the field). It has even been claimed that the research participants in contemporary ethnographic research settings increasingly expect outside interlocutors, other professionals, researchers or wider public deliberation to be part of their everyday life. The settings where such people operate include contexts that require people to reflect on their own actions and engage in a communicative relationship with the outside world. (Holmes & Marcus 2008.) In my view, such settings are often to be found within contemporary institutional/organisational contexts, such as NGOs and state services, where communicative practices are increasingly constituted within a discourse of dialogue, participation and empowerment (Phillips 2011): that is, workers are encouraged to work in multiple and equal ‘partnerships’ with participants from various field of expertise and lay people who are constructed as ‘active’ informants or even co-researchers (Homanen 2012, 214–215). As I will show, the Finnish maternity healthcare organisation I analyse in my mean paralleling scientific interests with the health and social workers’ (often politically minded) interests, thereby neglecting the question of the positions of ‘insider’ and ‘outsider’ and conflating the multiple roles and responsibilities of all the participants (cf. Mesman 2007). All of the people from the fields of maternity healthcare that have taken part in my research have played a double role as participants and informants. Depending on the person, the emphasis on participation and information-giving has varied, and it may have changed over time. However, all the people who contributed to my research material have in some way or another given me relevant information concerning the social relations and orders that structure their everyday activities. This has been the case both in the discussions I have had inside and outside the clinics and in my recorded and transcribed (expert) interviews with pregnant women and public health nurses. All the informants are also participants to varying degrees. (the model adopted from Anna Rastas [2007].) By calling them participants I want to stress the dimensions of collaboration with people in the field. I have for the most part set the research agenda myself, and have kept my research project from becoming part of theirs (cf. Caswill & Shove 2000). Yet I recognise that the concerns and even politics I encountered in the field redirected my research interests and analysis..
study is a good example of one such institutional site (see e.g. Handbook of Maternity Healthcare 2007).

Of all the terms conceptualizing participation and collaboration I prefer Donna Haraway’s (1991a, 1997, 272-273) term *interference*, which refers to critical feminist studies (of science) that *diffract* rather than reflect. What Haraway means by this is that feminist studies, and scientific studies and knowledge in general, should diffract existing patterns of science: the concept contains the idea of interference patterns that can shift existing meanings (1997, 16). Thus, unlike the reflected image of ‘the same’, diffracted patterns of interference bear ‘the effort to make difference in the world’ (1997, 16; 2004a, 69–70).

I understand the model of diffraction as re-visioning reflection and participation through *situated knowledges*. Indeed, the model draws upon Haraway’s earlier writings on reflexive knowledge and connective politics in *Situated knowledges: the science question in feminism and the privilege of partial perspectives* (1991/original in 1988) and *Simians, cyborgs and women: the reinvention of nature* (1991b) (see also Campbell 2004). Responding to Sandra Harding’s (1986) concept of *feminist objectivity*, Haraway wrote of situated knowledges as feminist objectivity in relation to both feminist knowledges (of science) and scientific knowledge itself (1991b, 188/1988). The concept refers to the partiality of knowledge, all knowledge. It is a ‘location, partial embodiment and partial perspective’ (Haraway 1991a, 191; cf. Smith’s standpoint). The particularity and specificity of the embodiment of the one who knows is reflected in the concept, as is her position in social orders or ‘networks’ (Haraway 1991a, 190; Campbell 2004, 170).

I interpret interference, diffraction and situated knowledges as mapping positive interventions in a critical, reflective and *dialogic* manner. Dialogue is the key in Smithian methodology to achieve experience-based knowledge so essential to discovering how individual actions are connected with and coordinated by the actions of others in institutional orders. Experience, as mentioned before, is understood in IE as what people come to know through everyday bodily being and action and emerges for the ethnographer
in *dialogue* among particular people in particular times and in particular places. (Smith 2005, 123–141.)

These dialogically produced accounts of people’s experiences, then, work as entry-points that organize the further inquiry into the social relations coordinating the work of all the participants involved in institutional activities. In theorizing the social, social relations and the epistemological grounds for studying them, Smith draws on Bakhtin’s theorization of dialogue. For Bakhtin (1981; 1986), language is an ongoing and historically developing complex which is responsive to time and people’s intentional utterances. According to Bakhtin, language is inherently dialogic as meanings are produced through the interplay of multiple voices. In that interplay, a unity is formed but, as a result of the play of difference across voices, that unity is a multivocal one, full of contradictions (Bakhtin 1981; Clark & Holquist 1984). The rules and regulations of language (grammatical, cultural and other) are integrated into language. However, language is not determined by such regulations and each utterance reproduces and elaborates language (Bakhtin 1981; 1986; Smith 2005; Homanen 2012, 217).

In Smith’s application, the concept of dialogue is more inclusive than that of Bakhtin. Whereas Bakhtin’s (1981; 1986) concern is mainly language as dialogue, for Smith dialogue characterizes the social practice in general. Social complexes, such as institutions, are ongoing historical processes in which people’s actions are caught up in, and responsive to, what others are doing and responsive to, and shaped by, what has been going on. By adopting this kind of dialogic ontology of the social, IE aims to treat people as agents and subjects and take account of the particularities of their lives and actions. Thus it strives to avoid constructing abstractions that objectify people. Such abstractions, it is argued, are often in play both in institutional activities and in conventional research practices through representation in texts and face to face interaction. (Smith 2005, 50, 62, 66, 68, 123; Homanen 2012, 217.)

Smith claims that in institutional contexts, privileged, totalising interpretations and representations have a tendency to suppress diverging perspectives and experiences. Here,
she draws on Bakhtin’s critique of monologue as an attempt to force through a singular voice in the face of plural meaning-making (Smith 2005, 62, 66). Dialogue for her is not just a naturally occurring human encounter but can be realized potentially through methods and efforts to avoid monologue.41 (Homanen 2012, 217-218.)

Experience-based knowledge that IE seeks to acquire in dialogue is, however, never obtained fully and without difficulties. Some of them originated from problems inherent in IE theorizing of dialogue between participants42 and some from the design and implementation of the particular research at hand and from the situatedness of the ethnographer doing the fieldwork. IE recognizes that institutional workers accounts always remain to some extent subpressed by the abstract institutional terms and concepts. The original design of my study and the context of suspicion linked to my position in relation to nursing administration that, I will shortly elaborate on, was not productive in that sense. They resulted in a situation of power imbalance that could not be erased. (Homanen 2012, 232.)

Further, I myself as the embodied instrument of ethnographic knowledge – that seems to be the minimal definition of ethnography (Ortner 1995) – had an effect on the field and the ethnographic knowledge produced. Among other things, I am a childless and academically educated woman in my 30s, I am a PhD student in women’s studies, and I am situated in numerous ways, both similarly with and differently from my informants, in networks of various power relations in and out of the field (see also Fortier 1998). In fact, what is

41 This is not meant, however, to imply that Smith perceives that dialogue is something that can be achieved through a set of fixed methods. That would be in contradiction with her ontological commitments in which realities, discursive and non-discursive, are only realized in practice. Thus, methods for achieving dialogue are realized in each individual practice at certain times, and they may or may not be transformable to other practices or times.

42 Smith includes non-human participants in her concept of dialogue, especially conceptual entities (texts, discourses and so on). However, dialogue has been criticised for being a humanist concept that is unsuited to ANT-influenced STS research (e.g. Plesner 2012). For instance, Ursula Plesner (2012) has proposed a change in vocabulary, from ‘dialogue’ to ‘negotiation’, to include all the elements – not just people – in the formation of (research) knowledge and to enable a shift from the ‘knower to the known’. I see no need to change vocabulary, here, for two reasons. First, the IE concept of dialogue is already quite inclusive compared to the theories on dialogue with which Pelsner takes issue (e.g. Black 2008; Anderson & Baxter & Cissna 2004 [eds]). Second, I have already included ANT-influenced insight in my methodological framework (including the most recently introduced concept of diffraction) to account for ‘odd types of assemblages’ (Plesner’s 2012 term) that may escape critical theory focused on power inequalities and using concepts such as dialogue.
constituted here is an enormous material-semiotic web of relations that fluctuates over time, as does my position in it.

In the rest of this subchapter, I focus on the possibilities and limitations and problems for achieving diffraction and dialogue by concentrating on three possible sources of difficulty in my study: 1) conflicting interests the researcher and the participant nurses had; 2) the different (power) positions between researchers and participant nurses; 3) differences in the knowledges of the participant nurses and the researchers, and the meaningfulness and origins of those knowledges.

**Conflicting interests or complementary projects?**

In the beginning of my fieldwork, the nurses talked a lot about politics with me in relation to a new nursing intervention, the family-centered MCH, involving new and additional working methods implemented by the municipality. They seemed to view me and the other researchers of the project as representatives of the local administration responsible for the intervention, or at least someone(s) who could influence the decision makers. They voiced their resentment toward the new nursing intervention, pointing out that they felt that all their and their predecessors’ experience-based knowledge and work were being overlooked by the administration. At times, I was also an object of their resentment and was treated with hostility and suspicion. For example, I was told not to use some discussions that took place in the coffee room in my research because the nurses were afraid the administrative staff would make their lives hard, and sometimes I was denied access to the coffee room all together by the door slamming in front of my face. (Homanen 2012, 221-222.)

Regardless of my repeated assurances that neither I nor the other researchers in the project were advocates for the reform or representatives of the administration, I cannot blame the nurses for being suspicious of me. Acquiring their consent to participate in the first place had followed a top-down model where contact was first made with the people in charge of

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43 The new methods were aimed at ‘client-centeredness’, addressing ‘psychosocial concerns’ and ‘family-orientation’.
reforms in the administration, and the consent of the regional administrative personnel (regional head nurses and doctors) had been obtained before the nurses themselves were contacted.\textsuperscript{44} Furthermore, the administrative personnel selected the specific clinics that were to be contacted for individual consent. The nurses at the clinics were informed of all this and knew about other contacts we had with administrative personnel in charge of the reform, and I would not be surprised if they had felt obliged to give their consent given that the authorities had given theirs. (Homanen 2012, 222.)

The nurses’ interest in influencing the administration through us seemed to conflict with our research-based interest to gain knowledge of the actual work practices. Although I do believe that I eventually gained the nurses’ trust, the question of conflicting interests still haunted me through out my fieldwork. The nurses’ interest and the agenda to influence administration as well as our research interests were still the same despite the trust gained in the field. As Caswill and Shove (2000) point out, there is a danger that such conflicts of interest lead to the loss of a space for interaction among the research participants. (Homanen 2012, 222.)

How, then, could the nurses and I work together given our conflicting knowledge interests? At first, I feared that the nurses would merely speak within the abstract administrative discourse, albeit from a critical position. But in practice when administratively trendy abstract terms and care principles were brought up, the nurses sometimes, criticised how, in formulating new initiatives, the administration overlooked nurses’ practice-oriented knowledges and experiences. For example, the nurses told me that care standards and objectives, such as ‘client-centeredness’, addressing ‘psychosocial concerns’ and ‘family-orientation’, that were presented as ‘new’ by the administration had been realized in the nurses’ work practices for a long time prior to the intervention. When I asked the question ‘how’, this sometimes led to accounts of how such standards were met

\textsuperscript{44} In detail the process of acquiring consent went as follows: First, formal permission from the municipal Committee of Research Permissions for Welfare and Health Institute (21.8.2006) (SOTE:3827/403/2006). Then consent from administrative staff (regional head nurses and doctors for three different MCH regions in the city) had to be obtained before the clinic staff could be contacted. What happened at this point was that the administrative staff discussed possible clinics for fieldwork with each other and with the clinics’ own staff. In one region we were denied access altogether, and in another we were told to contact only one of the clinics. In the third region we were pointed towards more possible clinics to contact.
in everyday work. It could be argued that my and the nurses’ differing knowledge interests led to complementary projects: my research interviews and workshops arranged in my research project for the participant nurses after the fieldwork was conducted provided the nurses with a space for articulating their critical stance toward the administration and also provided me with experience-based knowledge on nurses’ work practices (concerning the actualities linked to administrative interests). (see also Homanen 2012, 222.)

Dialogue in a Smithian sense can be said to have taken place. Experience-based knowledge that cannot be reduced to the givens of the institutional discourse was articulated. These articulations were certainly constructed partly within the terms of, and therefore were constrained by, institutional discourse but the complex actualities of doing, for instance, ‘family-orientation’, and the administrative influences of organisation on such work were elaborated upon. Moreover, experiential elaborations were made for, and also by, us researchers in dialogue with the nurses. As Smith (2005, 127) points out, following Bakhtin, dialogue (also) happens when speakers create ‘utterances that have not been spoken before and are responsive to distinctive situations and storytelling motives’ [italic RH]. The motivation of the nurses to tell us about their ways of taking all the family members into account was political and shaped by an assumption that we might speak for them in reporting on our study to the local authorities.45 At the same time, our differences in knowledge interests also resulted in situations where nothing personal was shared and where we researchers did not respond to the nurses’ political appeals. (see also Homanen 2012, 223.)

**A childless postgraduate student in feminist social research: issues of positioning**

When the research participants got used to seeing me in the waiting room and talking to me when they had time, I believe the guards were let down. For instance with respect to conducting interviews on attitudes on the reform (not used in my sub-study) and organisation of the workshops, the nurses wanted me to be the interviewer and the contact

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45 A promise to report on the nurses’ perspective on the intervention was made to the nurses, and that promise has been kept in the research report written for and published by the municipality in a publication series on city welfare services (Ruusuvuori et al. 2008).
person and some of them specifically asked me to be present at the workshops. This indicates that the nurses and I had developed a relationship of trust – something that, in ethnographic research, takes time and effort to establish (Peacock 1993; Hammersley & Atkinson 1995). (Homanen 2012, 223.)

This does not mean that we researchers and the nurses ever established a relationship as equal partners. Rather, as we built up trust and familiarity, my role and position changed from that of a suspicious character with possible administrative interests and multiplied: sometimes, I was positioned as a poor little PhD student who was interested in learning about the nurses’ work, and not changing it, and also interested in learning about experiences of pregnancy. This positioning may have been reinforced by my repeated assurances to the nurses throughout my fieldwork that they were the experts on, and providers of knowledge about, the everyday realities of health. Moreover, I was a bit of an oddity because of my childless status. The fact that I am not a mother myself received confused looks and comments. It seemed hard to comprehend that someone would want to study maternity if she was childless. Both pregnant women and the nurses told me about their experiences of motherhood and family life. Having no children gave me the singular identity as ‘the student’ of pregnancy and maternity healthcare. This was fruitful for my research as participants assumed that I did not know anything and did not use professional terminology. (Homanen 2012, 223-224.)

On occasion, I was the expert. The nurses were eager to ask me about the research project, and on those occasions my position shifted to the expert position. I was careful about what to tell them so that my answers would not unduly influence their behaviour or what they told me. Our research project team had written an information sheet about the research that was distributed to the clinics. However, the sheet was written in a rather obscure and abstract style, and the nurses wanted to know more. I refrained from emphasising the feminist nature of my research, because I was worried about its possible associations with ‘radical’ movements and -isms. I talked instead about men and women in maternity healthcare, ‘participant interaction and social relations in care work’ and so on.
Finally, I had quite a peculiar position in the setting of the workshops arranged for the nurses. On the one hand, I was a relative insider in relation to the nursing staff because of my earlier involvement and compared to the other two researchers that for the most part remained ‘outsiders’. On the other hand, the workshop was a new landscape compared to the earlier encounters I had had with the nurses in their everyday working situations, and as such it had the potential of changing my position both in relation to the nurses and in relation to the outsider group of university researchers. But the nurses’ request that I served as the contact person and that I participated in the workshops hints at a position of mediator or facilitator in a social order that is not the institutional order of the university nor the maternity healthcare but a communicational order established between the two within the framework of my research project.66 (Homanen 2012, 224.)

Nevertheless, the design and setting of the workshops enforced the position of us researchers as experts. As I have already mentioned, the meetings were originally planned as forums for communicating preliminary findings in lay terms to the nurses and offering them a space to reflect on their working methods and to share experiences of care work by talking with us. The nurses were aware of this. In fact, it was not until the actual workshop encounters that I started to think that maybe we researchers too could get feedback from the nurses on our interpretations. For that reason I started to take notes at the meeting but not detailed ones.47 (Homanen 2012, 224.)

The position of us researchers as experts was reinforced through our choosing the topics and video clips for the workshops and determining the (same) structure for all the workshops: I was to give a 5 minute talk on the observations and interviews conducted and

66 I have written an article on the workshops, their research context, design and implementation, from the perspective of possibilities for dialogue and collaborative knowledge production in IE (Homanen 2012). The article was published shortly before my thesis, and it is referred to with (Homanen 2012) when the article is being cited.
47 For example, there are no extracts of the interaction or comments that took place at the meetings. I focused on the nurses’ comments to our interpretations and on novel ideas and notes they made about the video clips. Later, I did add notes about the overall course, setting and impressions of the meetings. However, the exploration that is based on those notes is unfortunately not very detailed and focuses on the nurses’ commentary on the video clips and their feedback on our interpretations. Had the original design been geared towards dialogic knowledge production, I would have had more detailed material.
then we would watch a video extract from the recordings of the meetings with clients of each of the participant nurses and then discuss our observations (nurses’ comments first, then the comments of us researchers and finally freely). (Homanen 2012, 224.)

In general terms, the original design of communicating to the nurses was not supportive of a setting for mutual engagement or dialogic encounters where ‘no one story overrides; no story is suppressed’ as Smith (2005, 143) puts it. The design and the structure gave the impression of a setting of a lecture or a seminar that positioned the nurses as the students and us researchers as the expert-teachers. I myself helped to reinforce these positions and relations by preparing and giving a talk that was quite general, descriptive and very abstract with no concrete real life examples. I told them that they had found their own ways of meeting the administrative demands, that the basic foundations for care appeared to be trust and rapport that are achieved over time and in equal partnership with the clients, and so on. (Homanen 2012, 225.)

By positioning ourselves this way as experts, we positioned ourselves also in an authoritative position of knowing in the situation of the workshop, and, thus reinforced asymmetrical power relations between us and the nurses. This may have undermined some of my earlier work in dissipating the nurses’ suspicions that I was an advocate for the local administration. (Homanen 2012, 225.)

However, when watching the video clips of each nurse’s meeting with a client, the nurses started to tell specific stories and giving concrete examples of their work. Often the accounts of their interactions with clients were related to the case in the video clip but the nurses also made comments on the extent to which it was possible to generalize on the basis of their experiences. Working with video-clips formed a platform for the articulation of experience-based knowledge on care work in terms of the specificities and actualities of everyday work at the clinics. This is of extreme importance in IE as the aim is to gain insight into how the institutional order shapes and is shaped by the actions of people in particular contexts (Smith 1987; 2005; DeVault & McCoy 2006). (Homanen 2012, 225.)
In practice, the viewing of video clips proceeded so that, after viewing the videos, the nurse whose session we had just watched had the first opportunity to comment on the session. Often the nurse started to criticize herself/himself for talking in a funny way, behaving awkwardly, spending too much time in front of the computer and not being in close contact with the family members or paying too little attention to somebody or something. We researchers responded to this self-criticism by reassuring the nurse by telling her/him that it is common for people to view their speech and gestures as funny and awkward on video. With respect to comments about a lack of attention to the clients or to a particular topic, we began by asking why she thought so. We also used questions to indirectly introduce our observations regarding the administrative-research driven themes of ‘building rapport’, ‘discussing difficult issues’ and ‘who’s the client at the clinics’, such as ‘Did you really take the pregnant woman’s worry into account here?’, ‘Could you have done something differently?’. Implicit in these kinds of question is a preference for particular actions that the nurses quickly picked up on. They would take the preference and implicit critique into account by starting with comments such as ‘it may be so but it is also that’ and move on to tell the story of the individual family and the care plan involved, sometimes with reference to similar cases. (Homanen 2012, 225-226.)

Moving to the main activity of watching and discussing the extracts appeared to change our positions once more. This time the nurses were no longer in the position of being merely informed about our research-based, partly administrative-driven observations but also in the position of communicating how our observations related to the specificities of their everyday working life. Their position, then, took a turn toward a more authoritative or equal position in terms of knowledge production. At this point I was certainly listening and learning. What I was hearing was experience-based knowledge on the articulations of administrative and other ruling relations in the everyday practicalities; I was hearing knowledge that is dialogic in a sense that it drew on a diversity of voices: nurses’ own intentions and perspectives, as well as social organisation and discourse of institutional origin (Smith 2005, 123–130). (Homanen 2012, 226.)
The showing of the video extracts, then, worked as a catalyst for moving the discussion beyond the institutional concepts and categories. Our provokative questions and observations did this too. Thus one of the voices heard in the accounts at the workshops was our research-based voice. The nurses did not just recall past activities in some random or ‘pure’ way but oriented their answers to our interest to talk about certain themes, video extracts and commentary that bore the traces of models of social organisation of care obtained from research literature and policy/administrative discussions. The nurses’ experience was, then, brought into being in the setting of the workshop as an interchange between what they remembered and our interests and attention – that is, it was a product of dialogue (cf. Smith 2005, 128). (Homanen 2012, 226.)

To conclude about the dynamics of positioning, as I moved from one research setting and one stage of my research project to another, my fluid and ambiguous position as an ethnographer was transformed from an ‘expert’ outsider with possible links to administration to a relative non-participatory insider whose knowledge interests ran parallel to those of the nurses and, in relation to the workshops, to, a mediator in research communication and one of the ‘experts’. The nurses too changed positions from being objects of study and of administrative measures (as perceived by them) to being experts on their own professional field, to being something closer to a equal partner in communicative interchange. The steps were closely linked to, and overlapping with, one another. For instance, had I never gained the position of relative insider I most likely would have never been able to ease the nurses’ anxieties about administrative interests, never been accredited the position of a mediator at the workshop and other research communication settings, and perhaps never obtained experience-based knowledge of the specificities of care work. (Homanen 2012, 226-227.)

**Collaborative knowledge production**

In this section, I will discuss my final point about the difficulties for collaboration in knowledge production that may, however, carry with them the possibility for dialogue: the

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48 This is a position within which the other researchers from my project were quite stably fixed on throughout the research process.
differing forms of knowledges of the nurses and researchers. I will do so by discussing the interchange between my observations (from the videos and the fieldnotes), our preliminary interpretations of them, the nurses’ accounts on their activities and comments on the extracts shown in the workshops in the light of our interpretation, and, finally, my subsequent interpretations of the activities that have transformed compared to the preliminary ones. Thus, in this section, the attention is not just oriented to the fieldwork at the clinics or their background but also to what happened after the fieldwork was over (for the day, conducted altogether), after I packed up my notes and cameras and everybody went home.

From the point of view of the IE research process, this is important in that IE is fundamentally an analytic project where every encounter with a participant in the field is meant not only to produce insight into a particular circumstance but also to point to the next step in an ongoing, cumulative inquiry into the institutional processes (Smith 1987, 2005: Grahame 1998). This cumulative inquiry and analytic process is also, according to Smith (2005, 1998), dialogic in nature. The institutional ethnographer must remain responsive to the dialogue between herself and the research participant and the knowledge produced in the dialogue. As elaborated, that knowledge is experience-based yet oriented to the focus of the research-based field encounter. Moving to the setting and the moment of analyzing field notes on the encounters bears the danger of once more succumbing to monologism, this time to the singular voice of scholarly theory that shares the same tendency as other abstract institutional discourses to marginalize the intentions and perspectives of the original speakers (Smith 1998, 67). (Homanen 2012, 227.)

How, then, to sustain dialogue, be responsive to the multiplicity of voices, including scholarly discourse, in analysing and writing ethnography? Smith (2005, 135) advises ethnographers to “find generalizations and standardizing processes in the ethnographic data, in people’s local practices, including language” (Smith 2005, 135). (Homanen 2012, 227.)
To take account of or to integrate multiple voices, obviously involves addressing the question of how to bring together different forms of knowledge (on the issue in general see also Watson-Verran & Turnbull 1995), in my case the nurses’ practice-oriented, experience-based ideas about maternity healthcare and our academically informed concepts and theory. I suggest that, as far as it is possible to ever produce such a heterogeneous analysis, the answer lies in an on-going reframing and re-evaluation of the analytical insights of all the participants in a cumulative process, and an attempt to avoid objectifying descriptions of peoples’ lives and to maintain a multiplicity of voices and knowledges in-the-making. (Homanen 2012, 227-228.)

Going back to my notes and transcriptions at the university office, the nurses’ and pregnant women’s comments often started to make me reflect on my interpretations on what is going on in the videos and activities observed. By re-framing my inquiry to include the commentary I analyzed the appointment encounters anew. Yet another voice, then, enters into the (dialogic) analysis process, that of social science theory. I should say re-entered, because the scholarly institution with its concepts and categories had obviously been present earlier and that presence was acknowledged by all the participants. (see also Homanen 2012, 230.)

As already mentioned, social science theory, according to Smith (1998; 2005), carries the danger of subordinating or marginalising other perspectives because of its insistence to jump to the level of generalization with its abstract concepts and terms. Have I, then, managed to do social theory on how medical ethical models coordinate everyday activities at the clinics without losing sight of, subordinating or marginalizing, the nurses’ perspectives? I think I have to some extent and I have done so by not stopping at choosing a theory-based way of conceptualizing that appears somehow expressive of what was found to be happening in the appointment videos or in the nurses’ accounts but by further finding out how the care activities and experience-based knowledge make use of and realize such concepts and terms (see also Smith 2005; 135). As I have tried to show, this direction of inquiry involves cumulatively orienting oneself to the other’s interests, positions (of power) and knowledges that are transformed, often unpredictably, in time and
place. It also involves (re)-evaluating and reflecting on, one’s way of coming to know the research field. Orienting oneself this way is not about becoming submerged into the field or the interests of the research participant but finding common ground through reflection. (Homanen 2012, 230.)

Finally, it is dialogue achieved in the analytical inquiry, in Smithian terms, that makes it possible to overcome potential difficulties in bringing together different knowledges and epistemic commitments embedded in them. My research-based, theory-driven conceptualizations of the nurses’ meetings with clients were sometimes confronted by the nurses’ own practical experience-based knowledge gained through encounters with clients over a long time period or pregnant women’s bodily experience-based knowledge. I was able to overcome the conflict of episteme, if you will, without silencing the other form of knowledge and disregarding the origins of it, by a kind of a hermeneutic process where generalizing theoretical interpretation was, at least to some extent, brought into encounters with the research participants and also, in the case of the workshops, linked to a specific case of care activities presented on video. Dialogue took place when the nurses and pregnant women oriented themselves to the theoretical interpretation (inherent in the interview questions and in the workshops) and reframed their activities on the basis of that interpretation and presented an account which included the voice of social scientific theory, institutional orders and her own perspective and experience on them. Further, the dialogue continued in another setting where the researcher committed herself to an inquiry that avoids producing nominalizations out of commonalities found in the accounts of the nurses and activities seen on the videos. (Homanen 2012, 230-232.)

2.4 Research materials, analysis and ethics

The collection of research material was conducted by three researchers including myself, each of whom had her own subproject.49 My project was based on ethnographic work at

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49 The research project had, in fact, two parent subprojects from different disciplines (social sciences and psychology) that were further divided into subprojects. The multidisciplinary research project (2006–08) on child healthcare clinics was called Ennaltaehkäisevä terveystöineuvolassa (responsible leaders: Docent J. Ruusuvuori and Professor R-L. Punamäki, University of Tampere). Near the end of the fieldwork period, a fourth researcher joined the social science project.
four different maternity and child healthcare clinics for approximately three months, and included multiple methods of data production such as video recording, observations of nursing work activities, interviews and documentary material from various sites of maternity healthcare practice, as is common in multi-sited ethnographic inquiry (see Hammersley & Atkinson 1995; Marcus 1995; Harbers & Mol & Stollmayer 2002; Huttunen 2010). After the fieldwork was carried out, we arranged workshops in each clinic for the nurses who had participated in the study in order to communicate preliminary findings in lay terms and to offer them a space to reflect on their working methods.

The empirical fieldwork was mainly conducted by me over a three month period in the course of 2006–2008. A relatively long period of fieldwork was conducted in order to explore the dynamics of a variety of care practices that could not be grasped through short visits to the field (e.g. Hammersley & Atkinson 1995; Harbers & Mol & Stollmayer 2002). The fieldwork was conducted in short periods of four to five days, so that I spent about one working week a month in each clinic. This was done so that the fieldwork would not be too exhausting to any of the participants. After approximately three months had been spent in the clinics I decided to finish the fieldwork, because it seemed that I had covered in my observations all the different activities, settings and temporal cycles related to doing pregnancy and maternity healthcare (see Diamond 2006, 58; Hammersley & Atkinson 1995, 23–54). Further, through video recordings, I had collected a huge amount of data-intensive material in a relatively short period of time. Also, it would seem that ethnography done in one’s own culture requires shorter fieldwork in that the researcher is familiar with the basic social conduct and language of the field (Eriksen 1995, 19–20).

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50 Only additional video recording from a fourth clinic was conducted to obtain welfare assessment form interview appointments.

51 The research material will be stored at the Department Social Research for 25 years, after which it will be destroyed. Negotiations about storing the data in some form at the Finnish Social Science Data Archive have been initiated to ensure further use.

52 Smith gives little attention to particular methods of collecting material, so I have had to explore other literature resources here. Interviewing is the only exception in Smith’s coverage. In Institutional Ethnography. A Sociology for People, for example, she makes reference to participatory observation on five separate pages. On one page it is referred to as a method in an illustrative research setting (30), on another it is mentioned in reference to comparisons made between IE and extended case study method (35), and in the remaining references it is discussed with regard to attaining experience-based knowledge as data through dialogue between the ethnographer and field observations (125, 150, 160).
In detail, the main body of data consists of partially transcribed videotapes and observations from maternity healthcare appointments (69), professional team planning meetings (11), training sessions for nurses (four during the spring of 2007), a training afternoon for the members of multi-professional teams, and family counselling classes (eight). Pregnant women's and public health nurses' interviews (seven of each), guides and handouts distributed to families, forms on pregnancies kept by public health nurses, and local and nationwide guideline material for care work were also collected. (For further details see Research materials).

The decision to use videotapes was originally made for quite practical reasons. As mentioned above, I collected my data as part of a larger research project, and the other researchers’ methodological orientation was towards conversation analysis. They therefore used videotapes as their main form of data. Since I saw no great problems in using videotapes as a source, it was decided that the appointments and team meetings would be video recorded without a researcher present in the room. Although the use of video has not always been really common in ethnographic fieldwork, I do not see it as a particularly problematic method. In fact, the videotapes worked as a sort of a memory aid for me: I could always go back to the detailed recordings of appointments in a way that mere memory and field notes did not allow. This is something that is described as an epistemological advantage of video recordings as ethnographic data: they allow the observation of details that are not visible or memorable to participants (including the researcher) in a given situation, and provide access for researchers who have not participated in the collection of the material (Peräkylä 1997; Knoblauch 2006, 73). Further, there is an intimate bond between video and ethnography: video is audio-visual observation automatised into video technology. Both video and observation allow the addressing of ‘natural situations’ and the conduct of people in those situations (Knoblauch 2006, 71; Knoblauch & Schnettler & Raab 2006).

However, there are certainly methodological consequences of having a camera present at an appointment or a team meeting rather than having an observer present. For instance a camera can capture a limited range of the environment in comparison to an observer, and
is a different kind of co-producer of knowledge than an observer in each given situation. There is a debate over the degree to which video is participatory and contributes to the actions compared to observation (Knoblauch 2006, 71). Certainly, video equipment can be obtrusive to action, but there are situations where the presence of an observer is even more so (Lehn & Heath 2006). In my own study, I made observations supporting both views. When I asked pregnant women and couples to participate in the study before they went in the appointment rooms, the use of video quite often aroused doubt and suspicion. People seemed to feel uncomfortable about their actions being recorded, and told me that they would not be able to act ‘naturally’. Quite soon I noticed that mentioning early on that I, myself, would not be present in the room and that the cameras were quite small and situated high up in the corners of the room seemed to ease their minds about giving consent. Often, after the appointments were over and I went in to turn off the cameras, they commented on how fast they forgot about the cameras and, contrary to their prior suspicions, did not think that the cameras distorted the situation at all. I suppose, the default opposition to camera use has to do with people not just being used to such a method of data collection and, possibly, to cultural imagery related to surveillance cameras. Despite this, people gave their consent in over 90 per cent of cases, which is an extremely high rate of consent.

In addition to partial transcriptions of the appointments (1420 pages) and team meetings (311 pages) that I have used, I have also written separate field notes on the video recordings (272 hand written pages on appointments and 63 pages on team meetings: for detailed data information of the recordings see Research materials). The reason for this was that transcriptions of all the recordings, in addition to the other material, would have been too vast to handle. A full transcription of a first time appointment lasting 1 hour 38 minutes, for example, covered 89 pages, and a 64 minutes team meeting took 106 pages. Because my research interests cover the whole range of maternity healthcare as a field of making unborn–maternal relations, I did not see it as necessary to get more transcribed material, which would have been the case for a study focused more on the particular and analysing structures and patterns in interaction of a kind typical for social science using video material, e.g. conversation analysis (Erickson 1988).
In the fourteen interviews I conducted, I applied different kinds of interview methods to try to go beyond articulations of abstract institutional discourse (Smith 1987; 2005), such as statements by nurses that they work in line with particular principles or recommendations set for maternity care work like ‘client-centredness’ or ‘family orientation’. (For the outlines of the interviews see Appendix I, and for data information see Research materials). Generally I tried to interview in an open-ended manner. I first asked the nurses and pregnant women to talk about their work and pregnancy in their own words, then asked them to elaborate on different issues such as what different principles meant for them in practice and to give concrete examples. (Smith 1987, 187–190; 2005, 135–142; see also DeVault & McCoy 2006.) Finally, if there was time, I introduced themes that were not touched upon earlier but were of interest to my research. Although the nurses and pregnant women responded to this line of interviewing, at some points it was still hard for me to gain an understanding of what they actually did when performing particular discursive principles, such as client-centredness, and what significance doing whatever they did had from their viewpoint. Thus, in spite of my efforts to apply ethnographic interviewing techniques, the nurses and pregnant women sometimes adhered to abstract descriptions and short examples within the terms of administrative and policy discourses on maternity and child healthcare. The interviews conducted took from 1 to 1.5 hours and they were transcribed in full (138 pages of nurses’ interviews and 132 pages of pregnant women’s interviews, single line spacing).

In contrast to the difficult moments in the interviews, the activities and discussion that took place in the workshops, particularly around video recordings of the nurses’ appointments, seemed to evoke specific stories and explanations of the nurses’ own experiences of doing maternity healthcare. The workshops, then, also became sites for collaborative knowledge production, as the nurses’ experiential knowledges were articulated alongside the scientific knowledge implicit in my comments and questions. I took notes of the workshops.

53 A few people employed by and/or working on their master’s thesis in the research project have transcribed video recordings and interviews collected and used by me: Sanni Tiitinen, Aku Kallio, Merja Viteli, Henna Kinnunen, Sanna Juurakko, Katri Keskinen, Sanna Tuominen and Niina Taimisto.
Observations and talks I had with nurses and pregnant women and their partners in the waiting rooms, hallways and coffee rooms of the clinics, family counselling classes (eight) and training events held for nurses on the nursing reform in Spring 2007 (four seminar days) were documented in field notes (500 hand written pages in total, including 48 pages of seminar handouts with my notes: see also Research materials). The documentary material consists, first, of the main guides for nursing in maternity healthcare identified by the nurses themselves: the latest national guide at the time, Screening and collaboration in maternity healthcare (1999), and a locally produced guide on the intranet, Handbook of Maternity Healthcare (2007) that was compiled precisely because at the time there were no up-to-date nursing guides for maternity healthcare. Further, I included everything the nurses introduced to me as material they use in their work: forms used in gathering information from pregnant women and their partners for assessment, guides and handouts about baby care and parenthood and Files for family counselling classes that introduced issues and materials for counselling classes. Finally, I familiarised myself with a few recent publications on maternity healthcare from the Finnish Ministry of Social Affairs and Health and the National Institute for Health and Welfare, as well as municipal publications on the new nursing reform and some literature on which the new working methods were based. (For a complete list of documentary material see Research materials). The documentary material is part of the social setting under investigation (Hammersley & Atkinson 1995, 158), and can be seen as textually coordinating everyday work at the clinics (Smith 2005, 170–179).

**Multiple sites and logics**

In addition to considering my position in the field of research as dialogic, my fieldwork method in this study can be characterized as multi-sited. I follow Bruno Latour’s (2004a) suggestion to turn matters of fact into matters of concern and look at the common world as constitutive of contestation and debate. With this he is suggesting a turn to the politics of

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54 The Institute is a result of merging the National Public Health Institute (KTL) and the National Research and Development Centre for Welfare and Health (STAKES) in 2009. Thus, publications from an earlier era are STAKES publications.
nature and science, and to the nature and science of politics. Ingnunn Moser (2008, 98) further develops Latour’s concern by saying that we do not understand the ‘working of power and dominance in the situations of multiplicity’. In the spirit of Michel Callon and Vololona Rabeharisoa (2003) she works ‘in the wild’ by showing how one matter of concern, namely Alzheimer’s disease, is being crafted in a range of locations and practices, from laboratory settings to clinical practices and civil movement networks. In a similar manner I worked with each location in maternity healthcare to show that they present different versions of what pregnancy concerns are and how they should be dealt with.

These locations include the site of doing policy and protocol, which in most cases is informed by statistical and quantitative research results. In other words, it is informed by a measurable change in a sufficiently large number of people, and is intended to alter the situations of individuals (cf. Mol 2002, 127–142). However, the relationship between individuals and populations, or care practice and policy practice, is not one of straightforward inclusion or causality. This has been noted in several prior studies, and it seems obvious in light of my own research as well (e.g. Berg 1998; Mol 2002; 2008a; Ruppert 2011). Indeed, the (work) object in focus in these practices is not the same. Rather, the sites of doing protocol and doing care work are complexly intertwined. This intertwining is also of interest to my research. It seems that there is much more involved in implementing protocol than adding the order embedded in protocol to the messiness in the clinical practice or replacing the former with the latter (see also Berg 1998, 228). In the following analysis, this is often realized in terms of the relations between the formal and informal aspects of work.

There are also the sites for enacting pregnancy in practising new and old working methods at the clinics: appointment work, home visits during pregnancy, multi-professional team meetings, and interviewing with the new ‘welfare assessment’ forms. The practice of working methods can be further divided empirically into more that one site of enacting pregnancy. Furthermore, there seems to be a (historically) relevant and quite specific division of labour between care work provided by the state and that provided by third-sector actors, and their coexistence in various forms of relation in turn shapes maternity
healthcare and thus concerns over pregnant women’s lives in Finland. These relations are such that both parties are able to rely on the division of labour and keep acting accordingly and are hence determined by their relations to each other. Exploring how different locations, matters and knowledges interfere with one another, in dialogue, then, is a method of bringing together different kinds of research material (see also Gordon & Lahelma & Holland 2004).

In line with my methodological orientation, I have teased out and listed the material and discursive enactments of pregnancy concerns that relate to the relationship between pregnant women and the unborn, as well as the sites of those enactments in my fieldwork material. That is, I have explored the multiple relations that are done differently in screening for diseases or problems, treatment and advice on nutrition, the mental transition to parenthood and so on – in interviews, documentary material and videos and fieldnotes on observations. This has also involved analysing who or what does the enacting in a given site. After differentiating between the enactments and their spatial specifications I will map the ways in which these multiple relations are related to each other, i.e. how are they coordinated. In other words, the aim is to show how, with all the different enactments, frictions and differences in practices, in the end each and every pregnant woman is supplied with, if not a single diagnosis or assessment, at least a single treatment or a decision not to treat. Objects and relations may be done multiply in a given institution, but they are not fragmented: ‘they hang together’ (Mol 2008a) according to some logic.

The logic of coordination or ‘hanging together’ refers to both temporal and thematic rationales of doing care and pregnancy. It comes close to what Foucault (2007; 2008/1977–1979) means by biopower and biopolitics as forms of power, governance and politics obsessed with life, health and well-being of modern individuals as they appear in biological and social scientific cohorts or populations of people. My study is, then, informed by Foucault’s discussion of how, in modern liberal thought and power/knowledge regimes, potentials of people as ‘species’ are managed, regulated and maximised by means of mechanisms or ‘apparatuses’ that deal with rates, patterns and probabilities about a population and its ‘nature’ (Foucault 1990/1976; 2007; 2008/1977–
1979). I will refer to Foucauldian conceptualisations of biopower/politics where relevant along the way (see also Haraway 1997, 11–14; Deleuze 1990).

I have, however, decided to stick with the analytic concepts of logic and rationale (and synonyms alike). Logic as an analytical tool is derived originally from philosophy, and it seeks to formulate rational rules of reasoning (Mol 2008a, 8). The way I use it in my thesis is quite different and has fortunately been made easier by writers who have, first, undermined the seemingly universal rationalist logic (e.g. Nye 1990; Mol 2008a) and, then, addressed practices with it (Mol 2008a). Thus the concept is ‘stretched’ here, for the purpose of applying it to practices that are by no means coherent.

I will also talk about discourses and modes and styles of ordering, but they will always come after the local, fragile and pertinent rationales that have been uncovered as they are realised in practice. This is in line with my Smithian and STS project that is interested in how discourses and orders do not simply ‘speak over our intentions’ but also how the dialogue between intentions and gives of a (Foucauldian) discourse is fluid (Smith 2005, 127). Smith (2005, 127) claims that applying a Foucauldian concept of discourse seems to result in according it an overpowering role. In my view, this is the same argument made by STS writers like Annemarie Mol (2002), when she says ‘[Foucault] has been abandoned [by some writers] in his suggestion that society mimics organisms and thus hangs together in a single epistême’. The solution Smith (2005, 127–143) offers is an adoption of Bakhtinian conceptualisation, where ‘each moment of discourse in action can be seen as both reproducing and remaking the discourse’. Mol (2002; 2008a), instead, abandons

I say ‘Foucauldian’ and not ‘Foucault’s’ conceptualisations, here, because it has been claimed that life and politics in the present are not precisely as Foucault conceptualised them. According to Deleuze (1990), for example, institutions and society as a whole are going through a change that situates them beyond Foucault’s society. Mainly this is due to technological changes and reforms (of control) that make people more mobile, more networked and, thus, make their associations with institutions and systems of domination dispersed and ‘weaker’. Donna Haraway (1997; 1991b) also extends Foucauldian biopower to include technoscience in her concept of techno-biopower.

I am not totally convinced by Mol or others (Law, Ruppert) that Foucault really is making this suggestion. I would, rather, argue that he is working at a different level of analysis than STS typically is. His interests lie in the historical strategic level of governing and politics of governing. Therefore, he may not be offering tools to explore agency that is not some grand form of political resistance, but he is certainly not saying that subjects are merely manipulated or involved in subjecting themselves to power and governance (disciplinary and biopower) the same everywhere and at all times.

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discourses, orderings and perspectives altogether and engages in an inquiry into multiple associations that do produce orders but make no claim to the ways in which socio-material orderings came into being and establish themselves. I refuse to leave my analysis to that and, thus, follow in Smith’s footsteps to see how local orders associate to larger cultural and social power relations.

Addressing this ‘hanging together’ or logic in practice, for me, means attending to the whole organisation of Finnish maternity healthcare as it is today; Whichever enactment wins the day is embedded in the ‘ruling relations’ articulated in everyday practices (cf. Smith 1987; 2005). So finally I will think through how all this coordination of work relates to the overall organisation of maternity healthcare. The four maternity healthcare clinics and other locations of maternity healthcare can be perceived as cases that are never just local (although they cannot be really generalised either) (see Mol 2008a, 32). The specificities of cases, be they clinics or diseases or something else, travel from one site to another. I am invoking here the problematic of ethnographic cases common to particular STS traditions that cannot be fully equated with more traditional ways of thinking about case studies (on STS case study Beaulieu & Scharnhorst & Wouters 2007), and this coincides with a Smithian approach to ethnographic research material. For Smith (2005), or for STS case studies, there is no separate ethnographic (participant observation) study of the micro level followed by a theoretical exploration of the macro level. Rather, in institutional ethnography, when inquiry moves beyond the lifeworlds of people or their grasp of the world that produces their experience, it means to find out ‘how people produce out of the particularities of their everyday living standardisations and generalisations characteristic of institutions’ (ibid., 36). Thus there are no prior commitments or taken-for-granted external determinants such as class, gender relations or other forms of order, but larger social relations (of class, gender and so on) coordinate and are articulated by, in my case, pregnant women’s work with the care work of nurses at the clinics.

Similarly in STS ethnographic case studies, cases are considered as ‘middle-range issues’ (Beaulieu & Scharnhorst & Wouters 2007, 672–673). What is meant by middle-range is
not a middle point between data and theory or a ground between the micro and macro level (such as doing policy and care work), but situations (Beaulieu & Scharnhorst & Wouters 2007) or sites (Mol 2002; 2008a) carefully explored ethnographically to offer pertinent questions that are not local in origin. Ethnographic case studies establish specificities that allow us to discover what remains the same and what changes from one situation to the next (ibid., 676; Mol 2008a, 9), i.e. how these specificities are made to travel (Mol 2008a, 32). Explanations for variations and differences between cases, then, can be sought in cultural, social or institutional elements. Ultimately, it is a question of longstanding and common commitment in ethnography to study ‘large issues in small places’ (Eriksen 1995). It is just expanded to include multiple sites of observation (broadly understood), and a broadened understanding of the relations between the local (lifeworld) and the global (system) in which the global is an emergent dimension of the connections among sites (Marcus 1995).

Let me elaborate on that with an example of (maternity) healthcare policy work, care work and research. First of all, the site(s) of doing policy and protocol are in most cases informed by statistical and quantitative research results. In fact, although policy and protocol documents obviously inform care practices around maternity healthcare in contemporary Finland, the work object of the two sites is not the same. The protocol and policy documents are concerned with public health, and they suggest that if the right information is given to the right people they will act on it. Nevertheless, the work object is not the individual who is supposed to act, but the population whose well-being is statistically measurable (see also Berg 1998; Mol 2002, 119–133). In Finland, concern over young children’s and families’ psychosocial well-being in public and policy discussions before the construction and implementation of the new maternity and child healthcare (MCH) protocol was shaped by administrative agencies counting admissions to hospitals and other special services. These calculations were also fed into government research institutes for the study of epidemiology and so on. Along with the prevailing agreement that healthcare should treat ‘patients’ or ‘clients’ as wholes that include a family (cf. Mol 2002, 119–120), all of this has resulted in recommendations for care work
that requires the participation of a broad array of medical, social and psychological workers and technologies, and of families themselves.

When assessing and working with individuals and individual families, healthcare professionals certainly take into account their own knowledge of the frequency of particular problems in the population, but this does not mean that statistics and (new) protocols informed by such numbers will straightforwardly redirect the efforts of each professional from detailed work with individual cases to working with a new ‘whole’ of a different kind (cf. Berg 1998; Mol 2002; 2008a). Different professionals in the care teams have different work objects and knowledges, and thus they have very different views of problems, client selection and the reasons and means for intervention. Physiological, social and psychological aspects of pregnancy may all be dealt with, and a workable solution and practice are reached for each case. Yet it seems that in practice there are frictions, tensions and power relations at play in the processes of realising such practices at the clinics.

Ethical considerations

In what I would call a classic key text in feminist ethnography, Can there be a feminist ethnography, Judith Stacey (1988) inquires into the ethical vulnerabilities of ethnography and asks if there can even be a feminist ethnography on those grounds. According to her, the ethnographic method may appear ideal for feminist research in that it is explicitly opposed to hierarchical and exploitative research relations and rejects the (positivist) separations of the object and subject and the knower and the known of research. However, she reminds us, ethnography is ethically far more dangerous than ‘conventional’ methods in that the greater the intimacy achieved with the participants the greater the risk of exploitation. She claims that contradictions between feminist principles and ethnographic method are inescapable in relation to the research process and the end product of research. In the ethnographic process, it is impossible to overcome totally the differences in interests and (power) positions. At the end of the day, regardless of how friendly and trusting the researcher–participant relationship has become, the researcher has a research-based

57 Neither I nor Stacey is claiming that there is, or even should be, some uniform canon of feminist principles in research, but it is still possible to outline some conceptions that are commonly shared.
interest and is free to leave the social (power) relations in the field and write up a product of fieldwork that, unlike fieldwork itself, can rarely be called a collaborative product.

Stacey wrote her article in 1988. A lot has happened since then in the methodological field of ethnography, some of which Stacey had anticipated. What Stacey termed ‘new’, ‘postmodern’, ‘postructuralist’ and ‘critical’ ethnography has to some extent lived up to its potential for a resolution to the feminist ethnographic paradox she described. This is realised in a move towards reflecting the partiality, the collaborative nature and the textuality of ethnographic knowledge that is often called ‘the self-reflective or reflective turn’ in ethnography (Stacey 1988; Van Maanen 2006; Clifford & Marcus 1986 [eds.]). Thus, the partially feminist ethnographies there can be (and indeed are) must be self-aware of the partiality of their constitution and description as well as their capacity to represent the self and other – i.e. the ethical pitfalls of the method – to be able to mitigate some dangers (Stacey 1988; see e.g. Ahmed 2000).

I and my study are certainly the product of the reflexive turn, to the point that sometimes I have felt that I suffer from what Clifford Geertz (1988) famously called ‘epistemological hypochondria’ in ethnography. That is, I have panicked over knowing and representing ‘the other’ (in relation to myself), the nurses, pregnant women and so on, in my study: ‘[H]ow one can know that anything one says about other life forms is as a matter of fact so’ (ibid., 71). The solution for me has been to acknowledge fully the intrusive and unequal character of my participation in the field and the collaborative, yet partial, character of the knowledge produced, as well as to try to make the research project in some ways more collaborative.

Further, during the almost 25 years after Stacey’s plea for reflections between feminist research and ethnography on the self, commitment and partiality in research, feminism and ethnography as fields of inquiry have finally engaged with each other in explicit terms (see also Strathern 1987). In fact, Paul Rabinow and George E. Marcus (2008) (with Tobias Rees and James D. Faubion) in their interchange with anthropology after Writing Culture (1986) – one of the central texts assigned to the reflective and postmodern turn – give feminist thinkers credit for a multitude of advances in ethnography (ibid., 26, 29-30, 39-40, 127), especially writers in reproductive technologies such as Sarah Franklin (e.g. Franklin & Ragoné 1998), Rayna Rapp (2000) and Charis Thompson (2005).
As key figures in the move to post-foundational, collaborative and participatory forms of ethnography, Douglas Holmes and George Marcus (2008; see also Clifford & Marcus [eds.] 1986) argue that traditional ethnography’s understanding of collaboration in terms of research participants’ responses to, cooperation with and toleration of the ethnographer’s agenda underestimates participants’ abilities reflexively to produce analytical insights about their life worlds. They suggest that these analytical insights should be integrated into research to define the issues to be explored and the means by which the issues are to be explored. Understanding research collaboration in this way avoids the classical distinction between phases of design, implementation (data collection, analysis and writing the research report) and evaluation of results. Instead of providing an outsider report for participants and other audiences to evaluate, the ethnographer seeks collaboration with the participants in different or all phases of the research process (Mesman 2007, 281; see also Homanen 2012, 215).

As I discussed in the subchapter on collaborative knowledges, in my research project we engaged some of the participants, the nurses, in one phase of the research, the analysis phase. Specifically, we engaged them in workshops where their own work practices as documented on video were reflected on jointly (Homanen 2012). The workshops were originally planned as a way to ‘give something back’, but they also became sites for collaborative knowledge production and dialogue of a specific kind. This can be viewed also as a more ethical kind of knowledge production, as dialogic knowledge production in general, in that representing ‘the Other’ is constituted to some extent with multiple voices built up on each other.

A collaborative effort was also made in the research report written for and published by the municipality, where the nurses’ perspective on the nursing intervention was reported (Ruusuvuori et al. 2008). In this way, the possibility that their knowledge interests could influence the administrative decision-making through the research project was taken into account, making the project more complementary, and the ethical dilemma concerning the nurses’ assumption that the project was an advocate for the research was thus also to some extent mitigated. However, this did not resolve the ethical problem about the hierarchical
power relations assumed because I was viewed as a representative of the administration. As discussed in the subchapter on research positions, however, it seemed that as the fieldwork proceeded I fortunately shifted from this position closer to being a relative insider.

The pregnant women and their partners were not made participants in the research in such a manner. A similar section on their perspectives on the care was included in the report but their motivation to tell me things or let me video record their activities was less likely than the nurses’ to have been shaped by political concerns about influencing local decision makers. No workshops were arranged for them either. The main reason for this was that there were too many of them for us to be able to get together and watch videos and reflect. Additionally, in my view, it would have been unethical for us as researchers to discuss nursing conduct in such a personal manner with these women and men given that the nurses were also participants in the study. In this written thesis and other publications on the project, our observations on nursing conduct are linked to wider tendencies in maternity care and similar cases, and thus do not give the impression that certain patterns of conduct are linked to the individual style of a particular nurse. Therefore I decided, and promised, to make copies of my thesis accessible to them by sending it to the participant clinics, circulating the Internet address for its online publication to the women interviewed and to the clinics most of them will still be visiting for child healthcare now that their children are born. The structural choices in this thesis, and the choice of a writing style in which I first offer an ethnographic description that stays at a more descriptive analysis level and is thus accessible to a wider variety of readers, can also be viewed as ethical choices in this regard.

Unfortunately, this does not resolve the ethical shortcoming common to a lot of research: not making the process of research valuable for the participants whilst emphasising the end product, the report/publication (Knott 1995; Stacey 1988). I can only hope that the pregnant women and their partners found some additional value in participating in our study beyond just being part of a study that aims in the long run to make care practices ‘better’ (something I usually said when asking for their consent). My mind was eased in
this respect a little when one of the seven women I interviewed told me after the interview was over and the tape recorder was turned off that she felt that the interview was therapeutic. She had had some unfortunate complications in her pregnancy and had felt that some healthcare personnel had downplayed her symptoms and not been responsive to her worries. I was proud to have been assigned the role of an attentive listener in this way.

There remains one outstanding ethical problem in relation to my particular research that still needs to be discussed. That is the problematic question, already briefly addressed, of consent and the top-down model of obtaining formal consent. After receiving formal permission from the municipal Committee of Research Permissions for Welfare and Health Institute (21.8.2006) (SOTE:3827/403/2006) consent was obtained from administrative personnel and specific clinics were appointed for participation by them. It seems likely, then, given the suspicious attitude towards me at the beginning of the fieldwork, that some nurses may have felt they were obliged to consent to participate. I remain hopeful that, as the research process progressed, their ‘choice’ to participate became worthwhile to them after all. At the workshops, at least, they told us that the research had not interfered as much with their work as they had feared, and they were quite eager to participate in the workshops and talk to me generally and in interviews. However, here, a certain feminist ethnographic dilemma remains. On the one hand, principles of respect for potential participants would suggest compliance to not to do fieldwork at all at such sites of resistance. On the other hand, such compliance would mean collusion with a quite anti-feminist mechanism of concealing the public (state service) care and management of women’s reproductive lives. Whatever decision I made, I would have violated a feminist principle.

All the participants, both nurses and pregnant women and their partners, were handed an information sheet about the research along with the written consent form. The information sheet was written in a generally accessible way explaining the objective of studying social interaction at many levels (see Appendix III). I often gave additional description and examples on issues of interest, and assured potential participants of the protection of their anonymity. Despite this I am afraid that some people might not always have known what
they had consented to in full detail. Once, for example, an immigrant couple, who refused participation, wanted to discuss the research further. After discussing the method of video recording for a bit, I realised that they had not understood the use of the tapes. The partner of the pregnant woman asked me ‘On which television channel will the videos be shown?’ This incident got me worried that other people who had consented might also have misunderstood something or felt uninformed in some respects and just not asked me for further information.

I also wondered whether the nurses realised what the observational material covered. Were they fully aware that casual conversations we had in the hallways and the discussions I heard in the coffee rooms could end up in my thesis? Finally I got my answer: on a few occasions, after an (often critical) account of a client family or administration in a coffee room, nurses told me not to include that particular account in my study. In these cases, I resolved the (also feminist) dilemma in favour of the nurses and kept these specific accounts out of the ethnographic description. The prospect of them reading through my thesis and spotting discussions they had explicitly asked me to exclude seemed to me to violate the ethical principle of protecting research participants from the risk of getting hurt (e.g. Murphy & Johansson 1990; Kuula 2006).
3. Pregnancy as an embodied experience

In this chapter I will draw on accounts of the experiences of the pregnant women I had the opportunity to talk to and interview during my fieldwork. The chapter will provide the reader with insights into the research questions on relations to the unborn as they are discussed and experienced by pregnant women in everyday life. At the heart of the analysis is the pregnant subject who experiences, knows and articulates pregnancy in an embodied manner. She cannot be reduced to the institutional subject(s) of maternity healthcare. Rather, the pregnant subject(s) drafted here reframes whatever positions women are institutionally appointed in within maternity healthcare.

Methodologically the (dialogically produced) accounts explored here point to the next steps in an ongoing inquiry into the social relations shaping local activities at my case clinics. In other words, the accounts offer points of entry into aspects of social organisation that go beyond what the women themselves know or acknowledge (Smith 1987; 2005). They are, therefore, not intended to be representative of any particular demographic sample.

The description and analysis of the interviews and talks presented in this chapter is intended to provide an outline for the subsequent analysis of institutional practices. In line with IE methodology, the aim of my analysis is not really to generalise about the people interviewed or look for commonalities in experience but, rather, to describe social processes and look for indications of social relations that may have generalising effects, like similarities of experience and so on (Smith 2005, 51, 135; DeVault & McCoy 2006, 18). The issues discussed in this chapter are treated as drafting the standpoint position that will accumulatively organise the analysis of the everyday practices of the clinics and wider power relations.

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59 I conducted seven recorded interviews, and talked to numerous women in the hallways of the clinics during my fieldwork period of roughly three months.
There is prior research on women’s experiences in pregnancy in Finland (e.g. Piensoho 2001; Homanen 2007; Leppo 2012) that also addresses women’s relations to healthcare services. I could have used such research knowledge to draw a picture of women’s experience-based knowledges of pregnancy, then used that to further my inquiry into the social relations that coordinate such experience in maternity healthcare practices. However, I wanted also to address the experiences of women who go to the field clinics where I did my fieldwork, because the particular experience they have opens up a particular partial view into specific local practices. Social (power or ‘ruling’) relations coordinating experience and practices not only have generalising effects on women’s experiences but also embody messiness that in its own specific and situated ways have the ability to keep (and not keep) their hold on women’s lives and activities.

The fact that I asked to interview women from the clinics where I did my fieldwork, and that I just went in one day and asked women as they came out of the consulting rooms, has an effect on the quality of my material. The interviewed women were aged between 24 and 39. They were expecting their first or their second child, and were either pursuing or had completed an occupational or a university level degree. All of them were also living in a heterosexual relationship with the biological father of their child(ren).

Further, there are no so-called unwanted pregnancies or teenage pregnancies in my interview data; nor do some questions that could be associated with social problems really emerge in my material. For example, mothers with substance abuse problems were channelled to a specialist clinic for maternity healthcare, and asylum seekers were directed to a specific nurse in the municipality during the period of my fieldwork. For interviews and obtaining other material from people in such specific circumstances it would have been more fruitful to contact those places directly. It can also be argued that it is not so easy to talk to a stranger from a socially problematic position. Luckily I was able to discuss some of these issues in the interviews and talks I had with the nurses. They also came up during the video recorded appointments and multi-professional team meetings discussed in the next chapter. Further, prior research serves as a reminder that pregnancy and attending healthcare and other welfare services in maternity are not always such
relatively happy experiences as my interview and talk accounts may suggest (e.g. Leppo 2012; Liljeroth 2009; Jokinen 1997; May 2001).

3.1 Transformations in pregnancy

[Pregnancy has changed my] self-image probably so that now I really need to grow up. I have to think that I am responsible for someone else and I can’t play around. I have to really think how to arrange the everyday and what to do and where the money comes from and how to act. I have been kind of an eternal adolescent before, but if now I would start being [an adult]. But it has come from the fact that I am going to be a mum.

(Pregnant woman 2, age 30, 20 weeks of gestation, first pregnancy)

The quote above from an interview with a pregnant woman suggests that becoming a mother implies the need to become an adult who is responsible for others and not just herself. Furthermore, part of growing up is devoting one’s time to thinking about the arrangements, financial and otherwise, of everyday life. Adulthood is evoked by the forthcoming motherhood in which one is responsible for more than oneself.

In all of my interviews and in many of the discussions I had with pregnant women, it became obvious that pregnancy is a process and period of many transformations. In pregnancy selves are transformed – or to use the term common to recent literature and healthcare work knowledge on parenthood, they are in a transition to something (parenthood, motherhood and so on) (e.g. Family counselling Files 2008) – and selves are born. Transformation is the common denominator that organises the themes and sequencing in my material. All of the transformations involve a lot of doings and work, among which are growing into adulthood, doing responsible deeds and so on.

60 The quotations from the interviews and talks with the pregnant women, as well as with the nurses and the ethnographic descriptions of interchanges between the pregnant women, their partners and the nurses at the appointments and other situations at the clinics have been translated by me. I have tried to translate all the accounts as plainly as possible and to find expressions that match the Finnish ones as closely as possible. However I am aware that non-native translations that omit any dialect or accent, as well as tidying up some of the awkwardnesses of spoken language, can potentially produce impressions of class positions not found in the original transcription.

61 I have decided not to use pseudonyms in this study but, instead, to identify research participants only by their location in the institutional process being discussed: e.g. public health nurse, pregnant woman, partner and so on. This is in line with IE attempts to avoid individualising the line of writing (and analysis) by maintaining a focus on the institutional processes (DeVault & McCoy 2006, 41).
Simultaneously, the selves enacted, selves that work, are repositioned in a network of social relations, big and small (kinship, various divisions of labour, the gender system, etc.).

**Transforming the woman in the body**

What happens to women in their bodies in the processes of (narrating) experience and work in pregnancy? I took the title of Emily Martin’s classic book *The Woman in the body: a cultural analysis of reproduction* (1987) and twisted it into the subtitle *Transforming the woman in the body*, because I think that, in a way, and some 20 years after that book, the answer is to be found in a project quite similar to Emily Martin’s. That is, in a project that aims to tease out ‘women’s alternative vision[s] of modern existence […]’, refractions of women’s many different places in the social order […] as women talk about major physical events they experience […], whether women are aware of scientific ideas as well as other ideas about gender in society’ (ibid., 22–23). Times have changed as have conceptualisations regarding knowledge production and the role of medical technoscience and healthcare institutions in women’s lives. Yet the task remains the same.

Pregnancy and giving birth are, without a doubt, major physical events in women’s lives. Better yet, pregnancy is a life-altering process within which the physical, the social and the cultural/institutional are procedurally rearticulated (into a multiple). It seems to me that pregnancy as a life-rendering process sometimes starts even before the positive pregnancy test or the onset of pregnancy symptoms. Women talked to me about changing their lifestyle according to the healthcare instructions available, and, most of all, they talked about the process of hoping and trying to get pregnant:

> It is like, something that I have, in a way, thought about since I was little that I am going to have a family and all that, although I couldn’t be sure whether it would happen for me. But this [pregnancy] has been a kind of a continuum for that which I have thought and hoped for [in life] since I was young. And particularly procreation [of kin], well, it does seem important to me.

*(Pregnant woman 5, age 33, 14+262 weeks of gestation, first pregnancy)*

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62 The phrase ‘number+number’ refers to weeks of gestation + additional days of gestation. The phrase is commonly used at the clinics.
Pregnancy and children may be something that has been planned for from one’s own childhood. In the quotation, the pregnant woman describes her life as an autobiographical project where procreation seems a natural and self-evident end in itself. It is as though a model of ‘ideal’ life course is being realised in the quotation. Simultaneously, the woman situates pregnancy within the whole trajectory of life. On other occasions, even ‘biological deadlines’ were discussed. For example, later in the same interview, when I asked the woman to tell me about the moment when she found out she was pregnant, she told me mostly about trying to get pregnant and the experiences involved:

*It was in that way anticipated that we knew that it [getting pregnant] might happen and hoped for it, of course. I only missed one period and then we took the test. It sounds a bit like a mundane thing, but, of course, when you wait for it to happen and know that it can happen, it is not really a surprise. Of course, it was a really positive thing, because it didn’t happen the first time, and we were already a bit alarmed. Even though we did know that at this age, when one starts to try and hope, one might not get lucky right away, but luckily we didn’t have to wait longer than this. So, really positive information but not as a surprise because we knew what to do. This is why I always wonder about surprise pregnancies. Of course if one is on the pill or something, so it really is a surprise but people know what they do, reasonable people.*

*(Pregnant woman 5, age 33, 14+2 weeks of gestation, first pregnancy)*

Here, as in many discussions and also in other interviews, the pregnant woman comments on her age, which according to her and to medical definitions puts her close to the biological category of an advanced maternal age. She does not, however, comment on the suitability of a woman ‘of advanced maternal age’ for childbearing or rearing. Rather, she and her partner were just worried about the possible fertility issues that are considered to become more prevalent as a woman gets older (see also Homanen 2007).

Women who are hoping and trying, of an advanced maternal age or not, are ‘reasonable people’ who at this time and age know what to do and what to expect. They also know when to get pregnant. It was not just age that was a matter of concern in the timing of pregnancy, but also the conditions of life. Sometimes pregnancy was planned well ahead, as for the informant just discussed, and sometimes ‘it just felt natural given the life
circumstances,’ which are usually linked to relationship status, financial situation and/or point in one’s career.

Although the (idea of) pregnancy seems to transform selves even before one gets pregnant, getting pregnant – or, more precisely, finding out by taking a pregnancy test, probably the most commonly used antenatal diagnostic technology today – is in my view a turning point in itself in transforming selves. This is because confirming pregnancy has immediate implications for women’s lifestyles and their experiences of embodiment, self and other.

I discussed the issues of lifestyle, taking care of oneself and the effects of pregnancy on one’s everyday activities both with women expecting their first child and with mothers expecting the second or the subsequent child(ren). In a nutshell, the difference between being pregnant for the first time and being pregnant for the second time or more seems to be linked to familiarity drawn from earlier pregnancy or pregnancies, and to practical everyday matters concerning caring for often quite young children while pregnant. Women talked about being more ‘relaxed’ and having more ‘realistic’ expectations concerning the pregnant body, family life and themselves as mothers. Being pregnant and giving birth for the first time was the life- and self-altering experience that is reflected upon when pregnant for the second time:

Q: I’d like to go back to the story now [earlier I handed the pregnant woman a piece of paper where I had written instructions to tell a story], and I would like you to tell me in your own words about your pregnancy. In your story you may connect it [your pregnancy] to your life as a whole. You may, for example, include all the feelings and experiences that you have found meaningful. You can start from wherever you like, go back to whatever topic you please whenever you please, and use as much time as you like. I will make a few notes to go back to later on.

A: [...] With the birth of the first child it felt like it drastically changed my life and whole way of thinking. It was quite clear that we wanted a friend for the first child and wanted this great experience for the second time. Now, if one compares this pregnancy to the first pregnancy one can easily notice that now one concentrates notably less probably because one already has the first child there on the side. So, one concentrates on the first child and the belly is just carried along. Of course, it doesn’t lessen the feelings I have for this baby[­to­be], but maybe it is born to a different
kind of family than the first child was born into. That is something that comes to my mind first off. It feels wonderful that the first child has swept us into this children’s world and into children’s way of thinking and all that. So, with this second one, one already looks at the world differently.

(Pregnant woman 6, age 33, second pregnancy, 31–32 weeks of gestation)

Even though I tried not to specify what in particular women could or should relate their pregnancies to in the whole trajectory of their life, this woman, as well as others, told her story with reference to her first pregnancy. It is implied in the quotation that while getting pregnant for the second time is a great experience, the (needed) transformations into parenthood are already for the most part done, and besides, there is not really time to concentrate on one’s own bodily condition and activities. ‘One concentrates on the first child and the belly is just carried along,’ as the pregnant woman puts it.

Nevertheless, pregnancy, and the first pregnancy in particular, launches a range of new and altered activities in the everyday lives of pregnant women. At first one may act ‘automatically’ for the quite obvious reason that there are no bodily sensations to match the two red lines or dots in the pregnancy test. Women told me about quitting or considerably reducing their smoking and drinking, choosing less intensive forms of exercise, paying attention to their diet, resting more and perhaps working a bit less. Yet it does not seem common for women to fully realise pregnancy in the early stages. Rather, giving up things sometimes feels bad, although no one ever fully questioned the importance of doing so, or at least not in front of me. Thus, even though ‘the baby’ did not seem ‘real’, she/he or the pregnancy was given some priority in life, as is implied in the quotations below:

Sometimes pregnancy is wonderful, but on the other hand it is really boring as well or like the beginning really, you fell [...] In the end [it’s different] when the baby, hey, is coming soon, and you feel the movements and everything then. But in the beginning it’s a bit like, you can’t do this and that, I can’t do this and that, but there is nothing concrete yet and all that. You can’t eat this or that, or drink that, but yes, nothing there yet. They are [a part of] pregnancy. The best thing, however, is when you get to the end. You are excited about when it’s time to go. And then of course the baby. That’s the reason one is there [in pregnancy, doing things in pregnancy], to get a baby.

(Pregnant woman 1, age 24, 39+ weeks of gestation, second child, third pregnancy)
By eating and exercising [taking care of oneself in pregnancy]. I have always walked a lot, but now I always try to walk to work and back home, to get the exercise and so that I would not gain weight and that kind of thing. Surely it is good for joints and for everything if you exercise. I went swimming there for a while but now I haven’t gone for certain reasons [...] because I have a swimming buddy and she had surgery and because she got ill she has not been able to come swimming, and I haven’t gone by myself. But that [swimming] was one of those things that I started because I am pregnant, because it is a good form of exercise [for pregnant women]. [...] Sometimes it annoys me that you can’t do any of these unhealthy things. You’re not allowed to smoke or use alcohol or feast on treats or anything else. I do eat sweets and other stuff sometimes. I think that this is such a little sin that one is allowed to feast more sometimes when one knows that one is not going to have a cigarette or have a drink. I haven’t had a drop of alcohol even though it is said that a little dosage wouldn’t hurt, but I haven’t had even that. I can’t think of anything else off the top of my head that has changed.

(Pregnant woman 3, age 28, 27 weeks of gestation, first pregnancy)

Sometimes this taking care of oneself in pregnancy annoys women, especially in the early stages when the pregnancy itself and the unborn seem ‘unreal’ or ‘not concrete’. Yet they take care of their health anyway by consuming healthy food and avoiding unhealthy food or drink, and by staying in shape and resting. All this taking care of one’s health is mainly done for the sake of something or someone else.

The valued object is often implied to be ‘a healthy baby’. Hence what is assumed to be doing ‘good’ for the unborn, turning it into a healthy newborn, is not necessarily doing ‘good’ for the pregnant woman. However, since the unborn by definition develops within the woman (e.g. Bordo 1993, 86–88), nurturing, nourishing or doing anything to/for the unborn is doing it to the pregnant woman. This is not to say that choosing healthy lifestyles that are usually in line with medical and healthcare instructions is somehow ‘bad’ for pregnant women. In fact women regard new lifestyles as good for their own health as well (see also Markens & Browner & Press 1997, 360–366); furthermore, pregnancy as a site for altering one’s bodily activities, being and appearance is also perceived as liberating.

Pregnancy signs in the body and even the sometimes unpleasant symptoms fascinate
women, and women become much more aware of the materiality of the body. One is not able to do everything, such as working, cleaning and carrying things, as one did before pregnancy, and one has to ask for help from other people. The new-found materiality of the body is realised, first of all, in its laboriousness. The body that changes its boundaries, and eventually the big belly, are in the way and make moving and doing more challenging. One also has to learn to move and do things differently, and the body keeps surprising pregnant women by being new and strange. The sensation is described in terms of ambivalence: the body is a stranger and yet one’s own, and as soon as one finally ‘gets used to it’ or ‘accepts it’ it changes again:

Q: If you think specifically about how pregnancy has altered […] or what bodily changes and symptoms have felt like? What kind of thoughts have they evoked during either one of your pregnancies?

A: In principle, in this second pregnancy, I have enjoyed it when the belly came and all that. And one knows that one can get rid of the extra weight if one wants to, and I haven’t even cared even though I got some [extra weight]. Actually I have gained just as much as in the first pregnancy. So I don’t think I have had any problems at any stage. In the first pregnancy, I had a little bit of an identity crisis, because of the bodily changes. Of course it changes quickly as the pregnancy proceeds and like that, it becomes all different. But even then when I went to the swimming pool and everything, well, I did all kinds of things, so I didn’t not go to the swimming pool or anything like that because I had a bit of a belly and some extra fat. But I do remember that I rebelled a bit more [in the first pregnancy] and that when I started to accept it [the body] at the end then I gave birth. I said that it is funny that suddenly the body changes again just when I have accepted it. Though this belly is here now and it is like this and it is huge […].

Q: What is it that is so great about the belly?

A: I think that the thing that is great it that there is this beginning of a life inside. Maybe it is just great or great, but amazing. Yes that, when you know that it is there underneath the belly skin, that it is somehow real. And when one knows that as the belly grows, the child grows too and then when one feels the first kicks and everything, it is great. It is something in itself. And surely there is a purpose for the fact that it lasts nine months in that you get used to the idea that the child is coming from there. And on the other hand the clumsiness and everything that is part of the last stages [of pregnancy], when you are not able to do anything, that is something that in a way eases the fear of giving birth in a way, that you start hoping that the birth should start now. When at first you’re a
little scared that terrible, what’s going to happen at birth. But at the end you are so clumsy and you can’t do anything that then it is just lovely when the labour starts, a good thing. Then you can put dishes in the dishwasher and take them out and the belly is not in the way.

(Pregnant woman 4, age 39, second child born one month before interview)

It is implied in the quotations that pregnancy is a process in which the self is attuned both to human life and a baby growing within oneself and to the new awkwardness, clumsiness and size of the body. Sometimes the changes in the body that come with pregnancy may forge ‘identity crises’ like negative experiences of the self, but it seems that unless there are some major complications in one’s pregnancy, these experiences are regarded as temporary. Rather, it may be said that pregnancy emphasises embodiment in agency and subjectivity, but not in a generally alienating or negative way. The body may be visible, uncontrollable and material, but it is still, at least in an obscure manner, part of women’s sense of self (see also Young 1998, 279). Women talked to me also about ambivalent feelings of being oneself and yet not oneself. That is obviously not the same thing as saying that one’s body is one’s own and yet not one’s own. It is as though pregnancy is a process in which selves are distributed and bodies are shared.

Iris Marion Young (1998, 279) has noted that, in pregnancy, the materiality and ‘weight’ of the body may even empower women. This was, in my view, realised in a comment I once got from a woman who told that in pregnancy it is finally ‘legal’ to get fat ‘but in a perverse way and without the need for justification’. In my material, the big belly in particular is something that women anticipate and are proud of, as for the woman who told me that she was so proud of her belly that she intentionally wore tight shirts to emphasise it:

**Q**: What is it that is so lovely about the showing belly?

**A**: I don’t know. I think that it is something like when I see other women that are pregnant I think that the belly is somehow beautiful. Maybe it is that there is the beginning of a new life there, there is something symbolic about it.

(Pregnant woman 6, age 33, 31–32 weeks of gestation, second pregnancy)
The big belly ‘symbolises’ or works as a sign of the unborn, and it is – and according to pregnant women should be – public. However, being public does not imply a loss of bodily integrity in the women’s accounts. The belly may be something that ‘was shown to everybody’, but ‘if people stared and came to touch that was a bit weird’ (pregnant woman 4, age 39, second child born one month before interview).

The belly as a signifier of pregnancy and the baby-to-be also seems to work as a signifier of a body in a physical process that has a purpose:

Q: What have all the bodily changes felt like, what have you thought about them?

A: First I thought that this is terrible. Well first well, my breasts became sore, that was the most terrible. But after that, because I have always been really slim, then when I started gaining all this blubber when the belly still wasn’t round, and I just saw the numbers on the weight scale, I went this is not true. It was like, no. And of course I have also got terrible acne all over, so occasionally it was like no, for god’s sake. But it was during the weeks 17–18 when the belly is a bit harder and you can see that it is really round and like motherly, and I am proud of it. Now it has changed so that as long as I don’t stare at the number on the scales, I feel beautiful now and it doesn’t matter even if I have some spots. I feel different otherwise as well than in the beginning. But it is probably getting more concrete that there is somebody else there and it is more important than some blubber around my waist. It also has an influence on the fact that I feel really positive now. I hope that lasts. It is difficult when I was eight and a half weeks pregnant […] now everything feels really positive. This is how it was supposed to go.

Q: What is so wonderful about the firm belly?

A: Because it is concrete, then people see and you yourself fully realise that you are pregnant. You’re not just swollen from eating too many pastries, that you really get it. Every time you look in the mirror, you go oh yes, there is that. It is there. So it is really not merely a normal person’s little blubber but […] what it could be, not everyone has this. That’s it.

(Pregnant woman 2, age 30, 20 weeks of gestation, first pregnancy)

It is implied that a woman with a child is going through a physical process with an important purpose, and thus is and should be liberated from worrying over every bit of fat, the numbers on the scales and spots on the skin. Liberated from the ideal of bodily control,
in other words. This is something that is often done in a coordinated and shared manner in
that other people must recognise the visible signs of pregnancy, notably the big belly,
before one is ‘fully’ free to enjoy one’s pronounced material body. One is ‘finally free to
eat what she desires’, I was once told. One of the women I interviewed analysed the logic
of staying trim and the changes in her thinking:

_Truly for the first time in my life [I don’t mind the bodily changes]. I mean women have this kind of
a mould that they should fit into so that you shouldn’t be too fat and you shouldn’t be too thin and
you shouldn’t be this or that, and you should be like this. Well, I kind of haven’t so faithfully
followed or thought that I should look a particular way earlier either. But if I have gained fat in my
stomach that has been terrible for me and I have tried to get rid of it and stuff. In a way all that
comes from somewhere where it is said what women should be like. So for the first time I am like
that, that if I gain some fat on the belly, it is not a bad thing. So in a way I have been more pleased
with my body than before this [pregnancy]. So if I don’t take the nausea into account, and think
only about bodily changes, they have been solely positive things. There haven’t been that many
changes yet, but of course my waistline has got bigger, but for the first time in my life it does not
matter, it feels good._

(Pregnant woman 5, age 33, 14+2 weeks of gestation, first pregnancy)

However, it seems that what often follows from relaxing one’s bodily control is devoting
oneself to the child. The extra fat, the terrible acne or the stretch marks do not matter, at
least not as much as they would have if it were not for the pregnancy. The ideal of bodily
control is replaced by the ideal of mothering in the context of pregnancy. Phrases like
‘natural condition’ (pregnant woman 5) or ‘sense of purpose’ (pregnant woman 4) used by
women in this context imply that bodily functions and changes are ascribed to (mystical
and biological) ‘nature’, so that selves are disentangled from control without being
problematically associated with chaotic bodies.

I suggest that the pregnant body is, and is felt to be, uncontrollable in comparison with the
(Western ideal of) the unchangeable (male) body (see e.g. Elias 1992/1940–1950, 111,
115–117; Lupton & Barclay 1997, 32), but it is controlled in its uncontrollability when it is
known as a pregnant body. Thus, nature here does not refer to the culturally dangerous raw
‘other’, but to nature already known and controlled (by biosciences) (e.g. Bordo 1989,
Further, it is a nature with a purpose. All the aches, pains, nausea and divergence from the ideals of beauty are either ‘for the best interest of the child’, ‘worth it all’ or even make pregnancy more ‘concrete’ for the self and/or the partner, as in the following quotations from an interview with a woman who had serious nausea:

A: When it grows [belly] one has the certainty even more that this is really true that this is really happening. When even now sometimes I have this feeling that how do I know it isn’t suddenly dead, that there isn’t anything there and these kind of slightly silly thoughts. And I believe that it’s important to [partner’s name] because he does not feel the sensations I have, although I of course tell him and he asks about them and everything else. But maybe it is then […] I suppose then when other people see that I suppose it is somehow something to be proud about somehow.

Q: […] Do you have any other thoughts, have you thought at all about the changes [in the body] that might still be ahead?

A: Sure, I have thought about stretch marks. And then because I am this kind of small-size person, and I have looked at my sister and remember my mum’s, I have younger siblings, and mum’s pregnancies. Like now it’s going to start to put pressure here in the groin, because I am such a midget. I am sure that my feet will swell up quite nicely and varicose veins and everything else really beautiful I have to look forward to. I must enjoy these three months that should be like these easier [months] […] so-called […] as it is said. Should now enjoy these [months] very much and the three last ones [months] can be[…] Don’t know if I’ll be able to go to work when my feet are like bread loaves and my back hurts. Otherwise as well of course, now that my overall physical shape has worsened and all that, and we have figured that that has affected how I manage carrying. It [pregnancy] does bring a lot of extra weight, 16 kilos around the belly button here and elsewhere in the organism. Surely it places extra strain on the back. I have a little bit of a bad back anyway, your basic Finnish swayback that, as I have understood it, will get overstrained. So while waiting for that.

Q: Are you worried that the last part of your pregnancy will be difficult then?

A: I don’t think about it like that. I would surely bear everything if I just knew that I will have a healthy baby, that is worth it all. I don’t think about it like that. I would throw up all the nine months non-stop, if I knew that everything was going well [for the baby]. I do try to bear everything persistently. So I don’t worry it like that.
I also talked and asked women in the interviews directly about how pregnancy had altered their self-image and what they thought would lie ahead for them in family life. As in the quotation that started this chapter, the transforming self in pregnancy is associated with the shifting relations to one’s own body that I have already discussed, or with transforming into a mother who is, for example, ‘an adult’ and ‘responsible for somebody else than herself’ (e.g. pregnant women 3 and 7). Transformation into motherhood is mostly described in the women’s accounts not in terms of the transformation of one’s bodily being in pregnancy, but in terms of one’s potentiality, one’s ability or lack of ability, to acquire elements of cultural competence assigned to motherhood (see also Piensoho 2001, 122–123).

In the women’s accounts, working as an ideal mother – which the women wish to become but also question – means unselfish and responsible nurturing, protecting and childrearing. Good and desirable mothering seems to be associated with quite a fixed image: a ‘good’ mother does not get tired or upset, and she does not yell or discipline too harshly while protecting her child from the dangers and concerns of the world (on culturally ideal mothering see e.g. Chodorow & Contratto 1982; Katvala 2001; Niemelä 1991; Jokinen 1997). This supermum is able to exist because of her ‘maternal instinct’, which appears to be anchored in conceptions of ‘women’s nature’ (cf. Nätkin 1991, 12). ‘Maternal instinct’ was really difficult for the women to put into words. All I was able to tease out were few descriptions of the maternal instinct as an instinctual understanding of the baby’s communications (i.e. crying and other behaviour), as in the following quotation:

Q: You talked about maternal instinct in coping [with protecting the child from the world of drugs and crime]. What kind of instincts should a mother have in your opinion?

A: Overall, to know when your baby is in distress, what a specific cry means, when to feed, how to handle the baby in general. When you don’t really know anything about breastfeeding, and already

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63 This does not mean that I think that there is no such thing as (bodily) motherhood in pregnancy. Here, I am just referring to the theme that women themselves call motherhood. Relating to one’s body in accordance with ‘the best interests of the child(-to-be)’ is certainly ‘motherhood’ in pregnancy.
in the hospital you should know how to do it somehow. And everybody […] when I ask my mum, [she says] it will come. You will know what to do when you see the baby. Well, so, overall, [to know] that the baby feels good and to not panic over little things. If she/he cries, you would know that ok this is normal and she/he is just grumpy. I suppose it will all come slowly but there are still many question marks on the way.

(Pregnant woman 2, age 30, 20 weeks of gestation, first pregnancy)

‘You will know what to do when you see the baby’ suggests an idealised biological process and a nature that automatically delivers nurture. The downside to this kind of a fantasy of the prefect mother is that when this nature fails to deliver, women feel disappointed and guilty about being bad mothers. Breastfeeding was the one specific theme that was a major concern for pregnant women, as it has been a recurring theme and an endlessly debated health issue in the Finnish media and social and healthcare arenas. Women do acknowledge and are ‘realistic’ about the possibility of not being able to breastfeed at all, or even for as long as the national recommendations advice at the time. However, not managing to breastfeed brings up profound emotions and fears.

Overall, pregnancy seems to transfer women in their bodies into a relationship with the unborn. At the beginning of the pregnancy, or sometimes even before pregnancy, the women themselves alter their everyday life for the sake of somebody or something that does not even seem real to them. Taking care of one’s own health is nurturing a human life in itself, transforming it into a healthy newborn baby, albeit not yet ‘my newborn baby’. Later on, when the body and the belly grow, show symptoms and become laborious, the pregnant body becomes a shared body in the women’s accounts, and the ambivalence recedes. According to my analysis there is a shift from a sense of distributed self (the body-that-I-am) to a sense of sharing the body (the body-that-I-have), and this happens at turning-point events. Strange bodies and selves taken over by human life, ‘the best interest of the child’, healthcare instructions, uncontrollable nature and the cultural competence of mothering are managed through a bonding process in which the unborn becomes personalised and enacted social connection and kin. I will elaborate on that process in the next section.
From peanuts and bubbles to little sisters and brothers

In one of my interviews a pregnant woman told me that she and her partner had chosen a working name for their unborn, Sikke (derived from the Finnish word for foetus, *sikiö*), because, according to her, they needed a name to be able to talk about the unborn, which she considered to be a baby and ‘a complete [person]’ already. When I asked her why they needed a name to talk about the unborn, she elaborated:

*It would be difficult to talk about it [the unborn] otherwise. It [Sikke] just came from the fact that how else could we name it [the unborn]. Well, that it is there or then foetus or something. In a way maybe so that for it to become a family member, it needs to be named somehow. It does not entail, Sikke is really a woman’s name, but it does not entail that. However, I don’t know if it’s going to, if it’s going to be a boy, what happens then if we say Sikke for nine months.*

*(Pregnant woman 5, age 33, 14+2 weeks of gestation, first pregnancy)*

Although the pregnant woman says that she considers the unborn in her belly a complete person and a baby, the nickname Sikke associates the unborn with the (biological) process of *becoming* a person and a baby. It would seem that the act of naming is required for the unborn to start the processes of transforming into a family member and entering into family relations. In other words, naming here is also an act of relating. The unborn that is given status as a creature in a process of biological nature is transformed into a baby and a social person through the act of naming. This is further emphasised in the woman’s concern over the gender implications of the name Sikke. Although not all of the women that I had the chance to listen and interview felt the need to name their unborn before birth. The pregnant woman quoted above was exceptional in experiencing her unborn as a baby and a person at quite early stages of pregnancy (14+2 weeks of gestation). However, in all of the interviews and in many discussions, a cumulative process of the personification of the unborn emerged. Women spoke of babies

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64 Among Finnish women’s names, Sikke could be a nickname for, for example, Sirkka, Sirpa, Sinikka or Sirkku.
becoming ‘concrete’ and ‘real’. Often such becomings were associated with turning-point events such as feeling the unborn’s movements for the first time, hearing the heartbeat for the first time, or seeing the unborn in an ultrasound screening. These events were described as emotional moments when the relation to the unborn and to oneself shifts:

Q: What did it feel like when you felt the movements for the first time?

A: It felt like wind at first before I realised that, oh, this is like constant simmering, it is this simmering. Then I realised that I see. [...] It is really brilliant when you realise at that moment that there is really somebody there hanging from the umbilical cord, that now I am hungry all the time. But it is the ultrasound tomorrow one really waits for the most now.

Q: Have you had the…?

A: Nuchal translucency screening [niskaturvotusseulonta in Finnish], yes. But it was this peanut-like thing and now I could maybe see a baby already.

(Pregnant woman 2, age 30, 20 weeks of gestation, first pregnancy)

It looked surprisingly like a human being already, like I thought that it would be more like an organism, but it was. In a way it was lovely when it became concrete and it helped my nausea a lot. Well not physically but psychologically helped to cope in that if there is something like that, I will surely cope.

(Pregnant woman 5, age 33, 14+2 weeks of gestation, first pregnancy)

Now that the movements are so strong that my man can feel them when he touches the top of my

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65 Foetal movements are usually felt at around 16–20 weeks.
66 Foetal heartbeat can be heard via the foetal Doppler machine at around 12–14 weeks of gestation.
67 In most municipalities in Finland two ultrasound screenings are offered during pregnancy, in line with national recommendations (Screening and collaboration in maternity healthcare 1999). The first scan, the nuchal translucency screening, usually takes place between 11 and 14 weeks of gestation, and the second, the targeted ultrasound, between 18 and 22 weeks.
68 One must not forget that seeing and hearing, for instance, (i.e. the ultrasound picture and sounds from the Dobbler device) are embodied experiences – albeit ones ‘experienced from a distance [...] as opposed to direct bodily experience of the foetus’, as noted by Sallie Han (2009, 288). Furthermore, as my own and previous studies show the importance to pregnant women of having a picture to match or ‘connect to’ their positive pregnancy tests, pregnancy symptoms and movements in the belly (e.g ibid., Clarke 2004), the ultrasound is without a doubt a kind of a somatic experience.
69 The expression ‘my man’ is a direct translation from Finnish. In Finland such an expression is used to refer not just to one’s husband but also to a common law husband or a boyfriend.
belly, it’s becoming more and more real. Of course at these ultrasound screenings that we have been to, then already when one sees the child for the first time that there really is somebody there. Then you feel it. And when I went to this second, targeted ultrasound [rakennenuotultraäänis in Finnish], I thought that he [gender known] had grown a lot. He looks like a real baby already. Yes, we look at it so that in a way we think of ourselves as a mother and father already, even though it is unborn.

(Pregnant woman 3, age 28, 27 weeks of gestation, first pregnancy)

It is as though one’s bodily coherence is questioned: there is really somebody there. Yet even though there is this sensory connection to the unborn, the feeling of unreality or blurred conception of self and other may endure, as is evident in this interview with a woman quite close to her due date:

I have never had any funny nicknames like it is that or baby or something like that. Now that there is this three-year-old I talk to him about a little brother or sister. We tend to try quite often especially now that the birth is close to say things like is it nice that [he/she] is coming and then you will be a big brother and we try to talk in this way. But when if I for example talk with my mum about this baby it is still more like it kicks me and it hurts and thinking about what clothes to get. Or it is I mean like he/she is not yet focused on. How could I explain? We organise things for him/her and all that and see not now. Since everything is all right and there are no signs and nothing to be worried about in that [the unborn] grows and so it is a bit of an outsider in a way. For the sake of our son [name] we try more to talk so as to humanise or how could I explain. That he/she will come and he/she is, you can play with him/her someday, but right away he/she won’t know how to play and everything. But like, now it is just a little it is a little bit part of me, it is not its own self yet.

(Pregnant woman 1, age 24, 39+ weeks of gestation, third pregnancy, second child)

In the quotation, the pregnant woman tells me how, despite the work of personalising she and her partner do with their three-year-old, she is not fully able to grasp the unborn as her/his own self. In the woman’s experience, then, the unborn is transformed into its own self and a subject more or less gradually. This may happen through turning-point events and experiences or in the step-by-step process of getting used to the movements, pregnancy symptoms or growing belly. The latter was especially the case when women found no joy in the first movements or did not perceive them as signs of human life:

At first I doubted that there is really anything there. But there is, it has like changed all the time
more real and into a person, a real human, and not just some parasite growing there.

(Pregnant woman 3, age 28, 27 weeks of gestation, first pregnancy)

Sometimes first movements may stir up fears and be confusing, as well as be associated with some unknown outsider taking over the pregnant body. Unlike babies, ‘parasites’ and ‘aliens’ are not positive others within, as I have concluded elsewhere. Such conceptualisations may lead to experiences of the body as uncontrolled and needing to be reclaimed (Homanen 2007). It has also been noted in other studies on pregnancy that some women do not experience any special intimacy with their unborn, but feel rather that they have been seized (e.g. Young 1998, 277).

Women also enact foetal personhood by both responding socially to the experience of carrying an unborn in their womb and engaging in interaction with the unborn, thereby constituting social identity. An unborn jumping on a woman’s bladder may cause irritation, but also leads her to attribute the in utero activity to the unborn’s (presumed) temperamental character. Older siblings’ personality traits are also transferred onto the unborn, or at any rate the unborn’s presumed personality is enacted in relation to the older siblings, as in the following dialogue between a pregnant woman and me:

**Q**: How do you imagine [your baby-to-be]?

**A**: Maybe I, well, I don’t know. This is just a gut feeling. I think that maybe she/he will be a little bit feistier than our first one. Or I don’t know, it is like maybe […] can’t remember everything about the times during pregnancies, but I feel that this one bashes me up even more. Or like, I imagine, whether it will be even more temperamental. I also think about the appearance, maybe I imagine him/her looking like our son, so brown eyes and the same kind of hair, but she/he may be blond as well. You never know. Somehow, I don’t know. Maybe I imagine it looking more like a boy, because I can’t imagine what my daughter would be like, because I don’t have a daughter.

(Pregnant woman 1, age 24, 39+ weeks of gestation, second pregnancy)

Not only personality traits but also gender and social identity are being done here. Even when, as in this case, the sex of the baby is not known, women sometimes gender their babies-to-be. Here this is being done in reference to the first child. The same is true of
appearance: the unborn is imaged as looking like its sibling. This does not mean that women do not, on other occasions, at other times and places, imagine things differently or reflect on their possibly ‘incorrect’ assumptions. However, the unborn are given (gendered) qualities or potentials in a relational and social way: by talking for instance about a big head, apparent in the ultrasound image, as inherited from the father, or by relating heavy kicking in the belly to one’s own lively behaviour as a child.

I heard descriptions of imagined gendered identity most often when the sex of the unborn had already been imaged, i.e. if the pregnant women (and their partners) had wanted the sex determined at an ultrasound screening (cf. Han 2009, 287–288). So, in other words, for the women the enactment of gender seems to require the discovery of biological sex (cf. Franklin 2001, 310–311). Not all women or their partners want to know the sex of their baby-to-be before birth. In both cases, the women seemed to find it difficult to answer my question why.

Women who did find out the sex beforehand usually gave me accounts of the practical issues of finding out, such as being able to buy the ‘right’ colour clothes, choose a name and so on. They also always remembered to add that whichever sex it is, they will be happy. It was as if there were something socially unacceptable about finding out the sex prior to birth – as if it suggested a preference.

With women who did not want to know the sex of their unborn, on the other hand, I kept getting the answer that they wanted the baby’s sex to be ‘a surprise’; more specifically, a surprise that would be pleasant either way. One of the women I interviewed gave me the following answers regarding not finding out about the sex:

Q: Are you going to find out about the sex?

A: If it’s just possible, no.

Q: So unless you see for yourself.
A: Yes. And it is then, if the doctors say that this is a clear case [...] only a boy is a clear case. I mean that if something shows. A girl is always uncertain in that maybe the testicles are hidden somewhere. So we don’t want to [find out] unless it automatically comes across.

Q: Why not, what is it that you don’t [...]?

A: We don’t care whichever [it is] [...] Then we would, and then [...] Well, that’s not really an argument that we don’t mind. We don’t care at all, I mean, both [girl or boy] are welcome, but I suppose it’s maybe the suspense. It would be a little like opening Christmas presents in advance to ask about it [the sex].

(Pregnant woman 5, age 33, 14+2 weeks of gestation, first pregnancy)

‘It would be like opening Christmas presents in advance’ is, in my view, the key phrase here. It is as though finding out the sex prior to birth is a ‘sneak peak’ or preview that one is not supposed to have, and if one does use this technological time machine called the ultrasound scan there is some explaining to do. It seems that, unlike confirming the physical normality, size and age of the foetus, confirming the sex must be explained by using the ‘best interest of the child’ argument in a particular way. The sex of the foetus is not a health issue in the same way as abnormalities, age or size (the latter two establish the due date) – confirmation of which is an increasingly ‘common’ experience in pregnancy, according to Lisa M. Mitchell and Eugenia Georges (1998). Finding out about the sex, then, has to be enacted as ‘the best interest of the child’. This is what women do when they argue that they will find out or have found out the sex so as to be able to prepare the practicalities and materialities of baby life, and/or to prepare themselves well in advance as parents not just to a baby, but to their own baby, a person (with gender identity). In conclusion, not postponing gender identification to the postnatal future and experiencing this ‘technological quickening’ of finding out the sex – sometimes several weeks before sensing foetal movement in the body (Duden 1992) – and thus quickening the transformation into a gendered being suggests a shift in the matter and values of pregnancy. It adds to the child’s (physical) well-being the additional ‘good’ of the emotional transition to parenthood and the socio-material settings of family life.

Women also directly interact with their unborn and ‘learn’ the foetal personality through
interaction. I was told about learning how to soothe the unborn to sleep by experimenting with, for example, how to lie in bed, how to breathe and so on. It is believed that other things that women do have an effect on the unborn as well: singing, dancing or getting stressed about work. It seems that women try to find a shared habitual rhythm and to manage their doings as well as they can for the ‘best for the baby’. In doing so they come to know their ‘baby’.

This coming to know and interaction with the unborn is gradual and follows the progression of pregnancy. Take sleep, for example: it is not until around 33 weeks of gestation that foetuses develop the brain capacity for the sleep-wake experience that we have and can recognise. At that time the foetus also takes up more space in the uterus and is generally more capable of responding to the outside world (Rothman 1989b, 98–99). This is something that pregnant women become aware of:

Q: How do you imagine this baby-to-be at this moment? Do you have any ideas?

A: I would think that she/he is quite temperamental judging from those kicks and movements, and probably energetic. Somehow it feels that [she/he is] is sensitive. It feels like, if I have, how should I put it, so much to think and all that, well, it feels like the baby senses it, and it isn’t the things that go round and round in my head necessarily that keep me up, but that the baby reacts to it and the kicks keep me up at night. Something like that.

Q: Do you have any images of what the baby will be like after she/he is born?

A: It seems that quite energetic, and feels that my first child had a little bit of a day-rhythm. At least she didn’t keep me up a lot at nights, but it feels that this one may around the clock [kick, move around]. I don’t know whether it is a difference in character or is it so that the way in which a rhythm is formed, like when [she/he] hears voices from outside and when not or what it is.

(Pregnant woman 6, age 33, 31–32 weeks of gestation, second pregnancy)

Although my second question here refers to images of the future and does not specify where the images come from, the pregnant woman uses experiences from the womb to constitute a personality. Later in the interview, she also comments on the possibility of her actions – worrying about things, having noise around the house during late hours and thus
forming a rhythm in her life – affecting the unborn’s behaviour, and maybe even its character. A clearer example of pregnant behaviour or interaction aimed at the unborn comes from an interview in which the pregnant woman told me about attempts to affect the baby-to-be’s likes and dislikes (see also Leppänen 2005):

Of course one thinks all the time about what she/he will be like, which one of us […] what she/he will look like, and what kind of personal traits she/he will have. Both of us [partner and I] are really […] music is really important for both of us. My man is a music teacher and I myself also, of course, like music a lot, listen to music and go to concerts and all that. So it has been really important then. We have already thought whether we should get one of those headphones that can be placed around the belly. So, what music we should teach her/him to listen to, straight away some good music, so that she/he wouldn’t start to listen to any bad music. Yes, we talk like that.

(Pregnant woman 7, age 28, 13 weeks of gestation, first pregnancy)

Obviously, not every woman engages in interaction like this to try to cultivate a lifelong self prior to birth. Nevertheless, all women engage in interaction with their unborn as the pregnancy progresses. Evidently, then, pregnancy is not just a physical relationship, but a social one as well. Better yet, the physicalities of foetal development and movement also form the basis for interaction and transformation into social beings. In sum, enacted sociability, social identity and personhood or the lack thereof are not just attributed to the unborn, but are also the unborn’s first social experiences, as noted by Barbara Katz Rothman (1989b, 98–105).

Finally, personhood is actively done and pursued in the women’s accounts for the sake of other participants in the pregnancy. In the quotation above the pregnant woman says that she and her partner try to talk to their three-year-old first child in a way that already enacts a baby sibling and a playmate. This is usually done with the intention to prepare the older sibling for the changes in family life that will follow the birth of the younger sibling. This is apparent in a snapshot from another interview with a pregnant woman that identified the older sibling’s presumed reaction as the biggest issue in regard to imagining the unborn. The woman here is explaining to me how she and her partner prepared their first child for the fact that the baby-to-be would be a boy, and not the girl that the child had hoped for:
It went like that [first child’s name]’s nursery friend [name] got a little brother. We took that as a starting point to prepare like, now that [nursery friend’s name] got a little brother wouldn’t it be nice to have a little brother as well. [Nursery friend’s name]’s little brother’s name is [name]. Well then [first child’s name] started to say that it [the unborn] will be [friend’s little brother’s name]. It went really easily in fact then. And then she started […] then she had drawn a family portrait in the nursery in the beginning of May where there was herself in pink, myself in red, dad in blue and the baby in pale blue. […]From there on it started. When we were visiting my friend who has three boys […] They are slightly older boys and two of them played a lot with [first child’s name] and she was really excited. And then I asked in the car on our way back home that wouldn’t it be nice to have a brother as well. And then it came that yes, it would be lovely. And after that we started to talk about a brother. And then I thought great. It was like that. When we thought if it’s a girl, it would be easier for her to accept. For us [me and partner], of course, it does not matter, we will take either. But so that this sister accepts it [the unborn], so that she does not start to cry at birth that she won’t take that home.

(Pregnant woman 4, age 39, baby one month old, second child)

The object of care and transformation, here, is not the unborn but the older sibling. Nonetheless, preparing the older child becomes part of preparing for the newborn-to-be, organising social family relations.

In a strikingly similar fashion, partners are enacted participants in pregnancy and in relation to the unborn. In general, partners are usually regarded as bystanders to a certain degree, especially in the maternity healthcare contexts (as are even pregnant women sometimes: see chapters 3.2 Knowing pregnancy and the unborn, 3.3 Maternity healthcare relations: a pregnant girl’s best friend? and 4. Pregnant selves and unborn relations in the paths of maternity healthcare), and because of their inability to physically experience pregnancy) which has been observed in other studies on the position of men in pregnancy (e.g. Locock & Alexander 2006). ‘It is a little different for men, the baby is not in their belly’ (pregnant woman 1, age 24, second child, third pregnancy), as one of pregnant women put it. Yet women actively engage their partners by translating their bodily experiences into children-to-be. Certain sites become more crucial than others in constituting a baby in relation to her/his other parent.

When I asked about the role or participation of partners in maternity healthcare in general,
the usual answer was that at first partners attend with high hopes, but after they realise that
the appointments consist of the quite standardised routine activities of measurement and
discussing health issues, they tend not to attend any longer. One of the women I
interviewed put in these words:

[He] has this bystander role, because there is really nothing for the father.[…] Okay, that here we
do this […] take the blood test and urine sample and step on the weight scale and that’s it. So it’s
partly very mechanical, those particular things. There is certainly some discussion as well but
especially with the first child we expected something big and brilliant when I was pregnant and
went to the maternity healthcare clinic, well something, something maybe concrete. But now one
already knows how it goes, surely there are routines.

(Pregnant woman 6, age 33, 31 weeks of gestation, second pregnancy)

Some participation, however, is required, or at least wished for from partners, at least at
certain maternity healthcare appointments, and also in pregnancy outside the clinic. When
I asked one pregnant woman about the different roles of the different participants in
pregnancy she had just named, she gave me the following answer:

Yes little yes, different things. And I wanted to say about my man that, he doesn’t […] If I come
around and go hey, come see how the baby moves and my belly is jumping, he won’t come [laughs].
I mean that he […] Or if I say look now it’s moving. Please just a little while so you’ll see, he is not
able to concentrate. But the baby itself. I try to understand that it is different for men because they
don’t have the baby in their bellies. It will be different when it comes out, then it’ll be a whole
different thing. I don’t get upset anymore even if he does not come running to look at the movement.
He has been a really participatory dad, he has taken care of stuff sometimes probably more than I
have, very active. Many of my friends have been amazed that he takes care of it like that. I have
been positively surprised.

(Pregnant woman 1, age 24, 39+ weeks of gestation, second child, third pregnancy)

Later in the same interview, when I asked whether her partner had attended any of the
maternity healthcare appointments, the following dialogue emerged:

A: He hasn’t been to any of the appointments [with the public health nurse] if I remember correctly.
He didn’t attend during the first pregnancy either. He did come to both of the ultrasound screenings
when I was pregnant with our first child, and now with this one he only came to the first ultrasound,
because of work stuff. I was a bit like, why can’t you come, but it isn’t after all. He isn’t at the clinic, I understand that he would be bored looking at how much the woman weighs and how much she has this. I’ll tell him if there is something [to worry about]. I understand that it is a little bit my thing or something like that. I don’t [see] then if somebody’s man every time [goes with her to the clinic], I don’t understand the sense in being with me. Even though it is a question of a baby that belongs to both of us, but I wouldn’t myself go with my man if they were just going to measure his blood pressure and weight. I don’t know how to explain. Ultrasounds would have been nice though, if the man could have made them in this pregnancy as well.

Q: What kind of a clinic, in your opinion, would be the kind that would interest men as well?

A: I don’t […] They could well yes they could. I suppose some men want to come every time and they are certainly allowed to. Somehow I understand that every time isn’t so interesting because it’s always the same things. Maybe the ultrasounds are the ones where they can see. I understand that they interest men more. It makes it concrete, well, the baby shows.

(Pregnant woman 1, age 24, 39+ weeks of gestation, second child, third pregnancy)

In the transcription sequence it is implied that although it is understandable that the partners do not share the intimate connection to the unborn, they should make an effort or be encouraged by the pregnant women to identify the unborn to some extent as its own separate and independent self and thus to start a mental journey towards parenthood. Interestingly, this is done by inviting the partners to share the same turning-point events that often start the early bonding process and the process of personification for the pregnant women: feeling the movements, seeing the ultrasound and hearing the heartbeat.

Finally, the moment of birth results in the baby transforming into a tangible, concrete (to use the women’s terms) human subject that is separate from its mother, for both the pregnant women and the partners, who may have really actively prepared and transformed things, often around the household (see next section, Transforming the materialities and practicalities of everyday life) for the baby-to-be. However, it is possible to conclude that in the women’s accounts unborns become significant by transforming somatic experience and knowledge of biological entities in developmental processes into babies and people with social specificities and (kin) relations: by naming, bonding, finding out the sex, encouraging to touch and hear and see, relating, attributing personal qualities, establishing
rhythms and so on.

In my study on the changing relations between the body and the self in first time pregnancy (Homanen 2007) I concluded, that when considered in relation to the whole trajectory of pregnancy, giving birth does not, surprisingly, appear to be as significant and self-altering an event as it has been described in studies that focus on childbirth exclusively or in relation to life stories or cycles (e.g. Martin 1987; Nätkin 1997; Akrich & Pasveer 2004). Rather, it is the realisations of the transformations, just described, from doing things in the interest of human life or a baby in general to doing things in the interests of one’s own baby or child with at least some qualities and potentials before birth.

**Transforming the materialities and practicalities of everyday life**

Pregnancy as care, bodily and otherwise, of the unborn is shared care, although this care is often mediated by the pregnant woman and the main responsibility seems to be assigned to women. Nevertheless, taking care of the unborn as at least a potential person is about sharing tasks. Whereas pregnant women take care of their health, go regularly to the maternity healthcare clinics, bond physically and socially and encourage others to bond and so on, the unborn, partners, and other people and entities involved in the pregnancy do a lot of things too. In the previous sections I have addressed what the women do, and what the unborn, ‘nature’ and the body do, as well as ideals of beauty, bodily control and mothering. I have also touched upon what maternity healthcare (advice) and partners do in the accounts of women. In this section my aim is to explore more closely what partners and other close people, as well as things, do in the private realm of pregnancy, how they are consequently transformed and how they transform pregnancy together with pregnant women and their unborn.

Although partners and other close people lack the somatic experience of pregnancy, they are enacted as participants in pregnancy by being encouraged to take part (by pregnant women, maternity healthcare personnel and so on). With and without encouragement, they often do a lot in relation to preparing the materialities and practicalities of and for family life.
On many occasions, when asking women about changes in self-image or family life, about preparing for life after the birth, and even about finding out the sex of the unborn, I heard lists of things that had been or were to be bought before the birth. I have to admit that I was expecting less banal answers, and this is also visible in the transcripts of my interviews: I kept looking for ‘deeper’ answers, and steered the interviews towards allocated themes, such as ‘mental preparation’ and ‘preparing to be a parent’. It was only after reading Alison J. Clarke’s (2004) article, *Maternity and materiality*, that I started to realise that there are ‘deeper’ issues at stake in the relationship between reproduction and consumption/materiality in the social transformation of the mother/unborn relation.

Having a baby (in itself an interesting expression) seems to mean lots of purchasing and rearranging of the home, in terms of both social relations and physicalities. ‘The pending shift in the composition of the household’, in Clarke’s (2004, 70) words, is manifest in rooms changing owners, new and more childproof vehicles, cupboards filled with the ‘right’ colour clothes and so on. Sometimes buying and acquiring goods at the beginning of pregnancy was considered ‘too early’:

*Q:* Do you think that pregnancy has affected your self-image, your self.

*A:* [...] I think that it will be a bigger change when [the pregnancy/baby] becomes more concrete, when the belly grows and this becomes closer. Now I don’t dare to look ahead too much just because I have been so scared all the time that it [the pregnancy] won’t last. And I don’t want to think ahead, because then one is afraid that one has planned something a lot and thought things over and created, you know, one’s own world of ideas about all of this. All of that would fall to pieces [in case of miscarriage], and that would be terrible. Of course it would be terrible anyway, but somehow I think it would be even worse. We have been [...] Sure, I sometimes say something like, oh, that is the kind of crib I want and, please, [partner’s name] let’s get that. Then he says that don’t go there yet. Let’s just live in this moment now.

(Pregnant woman 7, age 28, 13 weeks of gestation, first pregnancy)

Linda Layne (2004) has attributed this kind of caution to superstition about pregnancy loss attached to the acquisition of goods too early in pregnancy. Superstition or not, the process
of becoming a mother (or losing the baby) involves a simultaneity of materiality and social conceptualisation (Clarke 2004, 56) – both thinking about the unborn as a person and a baby and about oneself as a parent, as well as buying, borrowing or receiving baby goods prior to birth.

In one of my interviews, after the pregnant interviewee herself had brought up the issues of parenting, transition to parenthood and purchases they had made for the baby-to-be, I asked if there was anything else she or her partner had been doing that she perceived as preparing for the future. She gave me the following answer:

_We have made some purchases after we went to the first ultrasound or maybe after the second one there started to be some clothes when we found out the sex [of the baby]. Then we bought some clothes. I know where I am going to get a baby buggy and a cradle. We don’t have them at home yet. Then we have arranged our bedroom so that the cradle will fit. [We] need to think other […] where to place things and we talk about that._

*(Pregnant woman 3, age 28, 27 weeks of gestation, first pregnancy)*

It may be that the materialities of the home are subordinated to other kinds of ‘preparing’. In fact, even in those cases where I first received a list of purchases in answer, women remembered to emphasise the secondary importance of materialities in comparison to the ‘mental transition to parenthood’, such as negotiating parenting principles and tasks with one’s partner and taking special care of one’s partnership before birth. So it would be unfair to state that women prepare by or perceive preparing for the newborn to consist first and foremost of redecorating and rearranging the household. It is more precise to say that transforming the materialities and physicalities of everyday life manifests the changes in social relations, and is itself (a practice of) changing social relations. In an ever-increasing way, consumption clearly enables motherhood, as well as taints it, in consumer-capitalist society (Taylor 2004a, 8).

Take for example making everyday life ‘secure’ and ‘childproof’. Many of my informants told me in more or less explicit terms that they had been making or intended to make rearrangements in the household to make life secure for the baby-to-be. This included, for
example, the acquisition of car seats, ‘safer’ cars such as estates, and various items of baby equipment, as well as rearranging furniture and even building a house. Security and safety issues thus encompass a lot of different kinds of ‘safeties’ and ‘securities’. Overall it appears that what is being built and bought are ‘fit homes and environments’ for the babies-to-be. This is implied in the women’s eagerness both to describe their purchases and homes and to explain themselves at length if they had yet not started to transform the materialities of their household. Sometimes even prior decisions about living environments were questioned, as in the following quotation:

Q: Have you prepared for life after birth and for the baby-to-be in some way?

A: [...] Yes, probably I don’t even really acknowledge consciously that it is the future I think about from this perspective [the baby is coming]. When I am thinking [...] when I have this thought of let’s move back to the countryside, let’s move. It is kind of part of this. I have always said [before] that I will never go back, I will live in the city centre as long as I am alive. But always the way of thinking changes. Quite normal plans for the future, I suppose. And then of course fears about whether [...] what kind of a mum I will be and what kind of a dad I will be and all that.

(Pregnant woman 7, age 28, 13 weeks of gestation, first pregnancy)

Whether it is blissful countryside accommodation away from the urban mess, or a cosy family bedroom with a special place for the newborn so that night-time breastfeeding and nurturing will go smoothly and without delay, or even a newborn’s own nursery with a Scandinavian ‘graphic natural look’, a ‘child-centred space’ is being constituted. A type of mothering and mother/infant relationship is simultaneously being enacted, with a particular expression of it associated with each space (Clarke 2004, 61).

Women also worry about making ends meet in the new life circumstances to come. This is obviously not just worries about not being able to provide the baby-to-be with every consumer good available, but such worries are partly linked to worries about becoming/being a mother worthy of social recognition. As such, worries of this kind are also worries about being unable to enact oneself as fit or good enough for parenting, or to enact a well provided-for newborn in a world where, in Janelle S. Taylor’s (2004a, 5) words, ‘consumption has become a more fitting way of understanding reproduction than
production.’

It is not only pregnant women, their partners and the unborn – ‘the-family-with-children-to-be’ – whose relations are enacted and transformed here. In fact, transforming materialities and physicalities in pregnancy is a site where other close people, together with the objects purchased, borrowed, received and so on, take an active role in the social process of making babies and mothers. Thus there is a larger social network and exchange at play.

First of all, it appears to be something of a ritual to give baby gifts – gadgets, clothes and so on – to a pregnant woman, although the concept and practice of the baby shower has not really arrived in Finland yet. Women told me how their family members, friends and colleagues had brought over second-hand and new maternity and baby clothes, and had offered to help with bigger purchases and with money in general. Sometimes mothers and female relatives in particular were described as being a bit too eager to lend a hand, even as ‘patronising’. They ‘fuss the most, but fuss in a good way’ as one pregnant woman put it (pregnant woman 5, age 33, 14 weeks of gestation, first pregnancy).

Apart from the women’s partners, significant others usually become involved in pregnancies at around 12–13 weeks of gestation, when the probability of a miscarriage reduces significantly. It seems to me that not telling other, even close, people about the pregnancy before this medically constituted milestone is part of not personifying the unborn, and is thus a technique to ease one’s anxieties about the possibility of losing the ‘baby’. This has also been noted in Linda Layne’s (2004; 2006) study of pregnancy loss: part of what makes having a miscarriage so painful is that women start personalising their unborn early in pregnancy. Understandably, telling others makes the pregnancy and the unborn ever more ‘concrete’, and hence more real, as a process of somebody in becoming.

Other people do more than just buy and give. Parents may move to be closer to their expectant children, and together with other relatives and friends they give hands-on help around and outside the household, i.e. work with materialities and physicalities:
Q: In what kinds of ways have you prepared for the future in your pregnancy?

A: Well, talking about the material, we have dug out some clothes a bit and put them in order. Now a few days ago we finally found the missing screws of the cot [that used to belong to the first child]. My man and son put it together. There isn’t any mattress in it yet, so we are taking our time. In practice, my man will start his paternal leave when it’s time to go [to give birth]. Then my mum is on summer holiday for the whole July and she has promised to come and help […] then take the older boy out or something if I am tired. So, I feel at ease in that I know that I won’t have to be alone with two kids right away. I will have the opportunity to get used to having a baby again. So, we have this three-year-old who is really active and all that and there is somebody to do things with him if I don’t have the energy or something […] so he won’t be left without attention right away. So he won’t think that, ok, we got this baby and nobody notices me anymore.

(Pregnant woman 1, age 24, 39+ weeks of gestation, second child, third pregnancy)

Mums, partners, siblings-to-be and so on not only help out when they change their daily routines for the sake of the newborn(-to-be) and the everyday practicalities of baby life, but they also at the same time transform and add (the unborn) to social relations and kin networks. Even a mother making a supportive and often informative daily phone call to her pregnant daughter can not only give reassurance and a boost to self-confidence, but can also have material and social consequences in the pregnant woman’s life if, for example, she decides to follow some of the advice given.

Good female friends, old and new, who have babies or are pregnant themselves become of importance for many during pregnancy. They might even be called a second family in the sense of forming ‘a mummy club’, and, like one’s ‘real’ family, they are in a key position to share the task of constituting the unborn’s personality and social connectedness, both by exchanging knowledge and baby things and by sharing experiences and hands-on practical tasks (see also Pietilä-Hella 2010, 106–116).

Although other family members and friends share the task of rescheduling life during pregnancy and after birth, most of the work of figuring out how daily activities should be rearranged is done between pregnant women, partners and siblings(-to-be). When pregnant
women lack energy, are feeling ill, or when their bodies just refuse to take on certain tasks around the house or at paid work, others fill in. As I have discussed earlier, partners often participate in pregnancy particularly by doing practical household chores and caring for the children and their pregnant partners, sometimes with the help of other family members and so on. However, this is not the end of the story.

During the process of gestation, pregnant women and their partners already worry about recreation, ways to take care of their partnership with a newborn in the household, and about day care. This involves not only creating a child-related timetable that works for everybody involved (including whoever does the babysitting, gives lifts and so on), but also money.

Recreation and taking care of one’s relationship by going out certainly costs money, but both are doable without enormous amounts of cash. Furthermore, day care in Finland is a universal service, provided equally for all, mostly in municipally owned facilities and for pay adjusted to salary scales. Using private day care is still statistically marginal in Finland (e.g. Repo & Kröger 2009, 204). Thus it seems fair to say that, unlike in studies conducted in countries with more liberal welfare services and more visible class divisions and structures such as the UK (e.g. Miller 1997; Clarke 2004), in Finland in general, and in my material in particular, choosing such child/family-related activities is not so much ‘shopping for class’ (Miller’s 1998 term). It is more about constituting a maternal/paternal identity and a future life cycle in order to hold together all the elements of family life fitted together as well as possible with the help of the human and non-human resources that are already available or are made available during pregnancy.70

As I have hinted in this section and even earlier, family, friends and other significant people during pregnancy, especially in maternity healthcare, as well as non-human actors such as bodies, technology, the unborn, ‘nature’ and objects – from the safety instructions of a car seat to the variety of different nursery-room styles – all play a part in getting to

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70 Issues of class and doing class that are readable from my material will be addressed in the later parts of my thesis, however.
know one’s pregnancy and one’s unborn. Before turning to that more specifically, however, I want to address those accounts that in some respects depart from the logic of transformation enacted in most of the pregnant women’s accounts.

**When bodies don’t work**

In all the pregnancies I had the opportunity to observe and talk about, there were fears of physical complications. Women seem to monitor their bodies and behaviour on a whole new level. Even the smallest symptoms may be very frightening, but in the case of actual serious complications the course of pregnancy and the relation to oneself and one’s body take a turn. Complications transform pregnant life into feelings of guilt, looking for something to blame, and living with a body that is disabled and with the potential prospect of intrusive medical interventions such as a Caesarean section. It is only after the complications pass or after birth that women reconnect with their embodiment, and in some cases with the unborn:

"Actually, that’s still been the case [have not talked about or named the unborn]. That will surely change into something totally different in the future […] thinking that it has only been a week since we went to the ultrasound. It was a kind of a moment to get the information that everything is all right now. That eased our minds. And it looked like a human being this time and it wasn’t this shrimp anymore. The thought got concrete, and now for a week we have dared to talk more. In the beginning it was like we tried to duck the issue to protect ourselves from the fear."

(Pregnant woman 7, age 28, 13 weeks of gestation, first pregnancy)

The pregnant woman in the quotation has been bleeding for several weeks and has been on sick leave, and in the quotation she elaborates why she and her partner have not talked about the unborn or named it in any way. She explains that not talking (and thinking) about the unborn as ‘a human being’ was a way to ease their anxieties (about the bleeding and about losing the unborn). It was not until the ultrasound scan, when they found out that everything was fine, that they ‘dared’ to talk about it. Not talking about the unborn – in terms of a baby or a human subject – is nevertheless almost explained away, as is implied here in the phrase ‘duck the issue’. So while not personalising the unborn is justified in light of the prospect of miscarriage, it is also implied that enacting a person by
naming and so on is the norm.

More precisely, in tragic accounts of this kind, the normativity implied is concerned with (losing) one’s bodily control in mothering. When the unborn is in danger women emphatically cannot do things they would if it were not for the complication, and consequently they feel guilty. They feel guilty that their bodies cannot function properly, and also that they cannot go to paid work, do housework or take care of their children, as in the following long quotation from an interview in which the pregnant woman, who had severe premature contractions and pains, felt guilty about pretty much everything:

Then it was Christmas. I was able to handle Christmas, but after Christmas I couldn’t move almost at all anymore. I spent the whole spring at home lying down. There were all kinds of feelings coming and going. Of course, I did as much as watch television. I couldn’t really take a shower […] I could take a shower and then I had to lie down. I blow-dried my hair and I went to lie down. It might take three, four hours for me to get ready to go to the maternity healthcare clinic. It is about 150 metres from our place, but I had to ask somebody to take me there and back by car, I could not walk. I was on sick leave a long […] well, all the time, I didn’t work at all, at all. I can’t remember, was it all the way from February that I was on sick leave? And of course our four-year-old girl, or then three or something, who demanded a lot of attention and was at an obstinate age and was jumping in my face all the time. Then we got feedback from the kindergarten that she needs more discipline. And I cried because I must be a bad mother, because I am not able to discipline the girl. […] I was so annoyed that I couldn’t go anywhere. Sometimes some friend took me for a coffee and took me to town. There is this one café where one can park right by the door, and we went there for a while and then back home. It was so that I could get out for a moment. […] I couldn’t read books or anything like that, I couldn’t concentrate in anything like that. I was so worried, I suppose, about the situation that I couldn’t concentrate. […] I think it was embarrassing to keep going back to the clinic to beg for more sick leave. Once I went to my [private] occupational healthcare clinic, and my parents took me there by car. I had constant contractions then. The occupational doctor said, oh my god, these kinds of things can be taken care of over the phone, and you do not need to drag yourself to the doctor with these kinds of contractions. I don’t think the maternity healthcare worked really well. The public health nurse would have given me sick leave. She, if I remember correctly, was like … said that you just rest now. But the [maternity healthcare clinic] doctor gave me a guilty conscience for asking for sick leave because I couldn’t work. I think that pregnant

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71 On feelings of guilt in maternity when women juggle between paid work and mothering, a common combination historically in Finnish society, see Jallinoja 1995, 90; Rantalaiho 1994, 21-27.
people […] most of them want to work if you are in good health, and you don’t complain about back problems or anything like that, in principle. When I was pregnant with [first child’s name] I worked and exercised until the end. And if one [a doctor] asks a little bit about the background, one surely understands that this person doesn’t want to lie at home and suffers from it. […] But I don’t enjoy it. I would have wanted to stay at work with my belly until the end. I bought all the baby clothes and maternity clothes on the Internet, because I couldn’t try clothes on in the fitting room. […] Even that was like […] Once I tried to go to a shop. Well, I could not bend over to put clothes on. […] All these kind of things. Really interesting pregnancy, very different. But with the first child I went swimming and to the gym, and did everything just a little bit more lightly and went dancing and everything. There weren’t all these obstacles.

(Pregnant woman 4, age 39, second child born one month before interview)

Characteristic of an account such as this of bodily oddity and uncomfortable being is the innocence of the pregnant women, who are often not to blame for their complicated condition and yet have to tolerate being embarrassed at not being able to work or discipline their older children on top of it all. This kind of account evokes sympathy and directs attention to the restoration of the sensation of bodily control, for example by referring to one’s bodily self in previous pregnancies when one was able to go ‘swimming and to the gym’ and do ‘everything just a little bit more lightly’ (see also for similar results Homanen 2007; Carter 2010; Martin 1987, 79).

The feeling of guilt, which was not always understood or elaborated on by the women themselves, makes sense through the logic of the ideal of bodily control. As I discussed earlier, pregnancy as a bodily transformation is at best (potentially) controlled in its uncontrollability through knowledge about it as a medical condition (see also Carter 2010, 998–1001). However, when an illness interferes with the process of pregnancy, the control is lost once again (see also Thomas 2003, 397). All the women in my material who had complications either caused or triggered by pregnancy, were cured either during pregnancy or when they gave birth. I never had the chance to talk to women with chronic illnesses, and I am sure that their accounts of pregnancy would be quite different (see also ibid.).

Pregnancy with complications occurs more frequently than not in the healthcare environment, and is tied more tightly to biomedical knowledge. The main object of care
and knowledge, however, seems to be not the woman but the unborn. The woman is
certainly the one who is diagnosed and treated, in most cases, and there is a limit to how
far the unborn is protected at the expense of the woman: in life-threatening conditions the
foetus’s life is subordinate to that of the pregnant woman. Nevertheless, before this remote
limit is reached, all the painful medical procedures, endless appointments, Caesarean
sections and so on are tolerated and justified ‘in the best interest of the child’ – protection
provided by the public health services. This was put nicely by one pregnant woman who
had had two Caesarean sections due to complications: ‘I was just happy that the birth was
over and the baby snuggled on me. That was enough’ (Pregnant woman 4, 39 years, baby
one month old, 2nd child)

Emily Martin (1987, 79) has characterised Caesarean section as the furthest shore of
separation between the mind and the body, and thus as alienating and intrusive for women.
The importance of medical interventions is not, however, questioned in women’s accounts,
and women seem to rely more on medical knowledge in such cases than in ‘normal’
pregnancies. The most frightful situation appears to be not knowing what is wrong, what is
happening in the body, as in the case of the woman quoted in length above:

Q: Did they have any suggestions in the maternity healthcare clinic or in healthcare in general
about why it went so badly [with premature contractions and pains so that the woman couldn’t
move at all]?

A: In [name of the clinic] the doctor said nothing. She was like, I see, I see, so resting helps. Then
we went to [name of a local hospital] right in the beginning for ultrasound and there was this
doctor that was absolutely brilliant. I don’t remember the name of the doctor anymore, but she/he
was really good. My man was there with me, luckily. While we were there I had one contraction so
bad that I cried. I don’t cry that easy usually if I get some pain or something. I thought that I had
gone into labour. So it was in a sense good that it happened there. The doctor gave me the
ultrasound and said that it’s nothing like that it [the baby] is coming. Every place was shut
[dilation of the cervix had not begun]. He/she suspected that, because my first child was delivered
by Caesarean section, there might be some adhesions so that my belly stretches, and that causes the
pain if I get even the smallest contraction. So it is both and. So he/she suspected this and said that
the pain can be hard. I said that it has been hard all the time and I feel like the child is coming right
now. So he/she had this theory, and it satisfied both me and my man so that we said finally
somebody is saying something about what might be causing this. I myself was like if the baby is not coming then is there something else wrong, like tumours or something that puts pressure or something. I did start to wonder what was going on. It was the only [time] […] what then. But the doctor at the maternity healthcare didn’t […] yes I wondered about that. I think that such a doctor [who works in a maternity healthcare clinic] should be able to say something. Did she ever think about it […] and gave always quite a short sick leave.

(Pregnant woman 4, age 39, second child born one month before interview)

Not knowing is obviously a crippling position to be in. Actions available consist of things such as merely tolerating it, trying to find out again and again, or going with the flow and letting one’s agency and knowledge of the unborn, the body and so on fall into the hands, the ‘protective’ hands, of healthcare actors and the unpredictable ‘nature’. It would be unfair to the pregnant women, however, to claim that the medical knowledge about natural processes is the only form of knowledge and medical-professional practice the only logic of activities attributed or available to pregnant women with perinatal complications. In fact, women attune themselves to medical information in different ways, and are thus different kinds of ‘patients’.

Let’s look at another sequence from an interview with a woman who had had severe and unexplained bleeding and had been ordered to bed rest for about five weeks:

Q: What kinds of thought were going round in your head when you had to lie in bed scared at home?

A: It was really tormenting all the time, you see, in that I imagined that now it feels as if something is bleeding out and then run to the bathroom and [check] is there blood and like that even. Occasionally I thought that I was going mad. It was a little bit like too much monitoring and then all the time every time when […] And of course when there are these growing pains in the womb, which are normal and may feel like pinching and stabbing and aching and like that a little. When I started having those too, of course I always wondered whether this is normal or is there […] is this linked to this [abnormal bleeding] and all that. […] I was scared that I would miscarry all the time really, it was something on my mind all the time. Even though one knows that if it happens [a miscarriage], it happens, that one can’t do anything about it. But it is anyway terrible somehow, I don’t know, terribly scary, although I thought that I am not like that because I have always been a really rational person.
I want to draw your attention to the tension enacted here between being a rational person and being scared and tormented by the thought of miscarriage. What is entailed is that when one knows ‘the facts’ (read medical facts), i.e. that miscarriage is a naturally occurring event that (often) cannot be altered, one should take action accordingly in a rationalised manner, and not get emotional. Why worry and grieve, then? Obviously people do not just play by the rules of singular logics, medical or otherwise, and even rational women do crumple sometimes. In other words, there are multiple logics realised in the lives of pregnant women with complications as well. In this particular sequence, there are the clinical and medical terms that define a condition and a foetus as a mere developing body, and also a mute fear of something that is definitely not neutral. There is a sense of someone who is maybe not yet fully a person, but is worth grieving for and worth saving.

3.2 Knowing pregnancy and the unborn

In this section, I will discuss how women individually come to know their unborn and their pregnancies, and how they exercise (a degree of) agency in deciding which of these kinds of knowledges has more authority than the others at various points in their pregnancy journeys. I will also attend to new material from the accounts of pregnant women on the information sources used.

I am applying Donna Haraway’s (1991a) concept of situated knowledges to make sense of the process of knowledge production that is both located and embodied (and ultimately informs maternity healthcare). The process of coming to know is incomplete and material-semiotic, and as Carol Kingdon (2007, 112–153) found in her study on ‘knowing giving birth’, knowing pregnancy too is a fluid mixture of multiple interacting information sources, and comprises both what is felt inside (emotionally and physically) and outsider knowledge (‘facts’ and others’ experiences).

The process of knowing is thus adapted to the individual embodied life circumstances of the women and, as I will show, doing pregnancy, like doing birth (Kingdon 2007, 157–
162), is fundamental to knowing pregnancy. As I have already elaborated at length, doing pregnancy and the unborn is about sharing tasks, and for the most part cannot be equated with agency as grand social action and transformation. However, it is not passivity or merely subjecting oneself to cultural/institutional subject positions or to self-surveillance in accordance with desirable biographies imposed upon one.

Just as pregnancy is a socio-material process, so is knowing it. It is situated knowledge in the making (cf. Haraway 1997), not a static product but a continuous journey of transformation at various time-points in pregnancy. Furthermore, as women engage with pregnancy and attune to it they acquire new knowledges that manifest their new positions in the networks of social relations.

As I discussed earlier, making sense of pregnancy starts before there are any signs or sensations of pregnancy, or any notable changes in everyday life such as visiting the maternity healthcare clinic or rearranging home and daily routines. Sometimes the sense-making and corresponding activities start before women actually get pregnant, and it is definitely an ongoing process during the early stages of pregnancy when women experience feelings of ambivalence and unreality. Changing lifestyle and planning pregnancies to occur during ‘suitable’ life circumstances, for example, involves a lot of knowledge of healthcare and rules of social conduct in regard to the ‘ideal’ courses of life. Furthermore, the fact that the unborn is given priority in life even though it rarely feels ‘real’ or ‘concrete’ for women at the beginning of pregnancy suggests that women are attuned to cultural competences of mothering. Such ideals and competences, according to which one is assumed to know how and when and for the sake of whom to get and to be pregnant, suggest traces of a life cycle model in which the life of a woman is equated with motherhood and her relationship to her children (see also Nätkin 1997, 193).

**Encountering medical and nursing knowledge providers**

It would seem that in the early stages of pregnancy, especially in the first pregnancy when women do not have any prior experience from which to draw knowledge, women rely more on outside knowledge of pregnancy and the unborn. They learn by doing, as
elaborated above, but also actively seek and gather information on pregnancy and the unborn. Here maternity healthcare as a platform for information and advice is crucial. Almost exclusively, women told me that the top priority of the maternity healthcare service is and should be both to secure the health of the unborn and the pregnant woman and to give support in the form of discussion and information:

**Q:** What do you think is the most important function of maternity healthcare?

**A:** First of all, this health dimension in, as I have emphasised already here, that it is checked that all is fine, haemoglobin and so on and then the doctor’s appointments. Well yes, the health dimension shall be this quite brute first item before going to the mental dimension. The second thing, in my opinion, is peer support or in a way one can’t speak of peer support, because the clinic aunties [nurses] are not pregnant at the same time, so they can’t do that. But let’s talk about just support in that moment, because of course there are people that have not experienced pregnancy themselves and I don’t mean that they should, but they have the education and knowledge, so just as well they can advise and support.

(Pregnant woman 5, age 33, 14+2 weeks of gestation, first pregnancy)

The screening of physicalities, also emphasised in the above quotation, is itself linked to coming to know one’s pregnancy and the unborn. Finding out about foetal and maternal health is not just part of securing the health and well-being of oneself and the unborn, but is also integral to surviving pregnancy. Uncertainty and not knowing whether things are all right or what is wrong seems to be an unbearable situation for pregnant women. As discussed in previous sections, knowing pregnancy, especially medically, is controlling the uncontrollable.

However, what is new and interesting in this quotation is that professional experience and knowledge transferred to pregnant women is called ‘peer support’, and this is revealing of the way women attune to and express preferences over the forms of knowledge given at the clinics. Women do appreciate general health education and information on physical and psychological progression and the monitoring of pregnancies that is the same for everybody. This is so even in cases where women are already familiar with a lot of the general information and advice given to them before going to the clinic. They realise that a
universal service such as maternity healthcare must target its services to all women, regardless of their intellectual capital and resources. However, most of the women I talked to or interviewed expressed a preference for knowledge that was tailored to their needs as those needs emerge in the course of pregnancy, as in the following answer to my question about the most important function(s) of maternity healthcare:

A: So of course these general health things are looked at, that the baby grows and health it is always, but also this mental side or this that they [staff] support. The relationship between the mother and the public health nurse would be warm. It is a comprehensive thing. Of course these health things are important, but […] well they could […] I don’t know if there is anything in some brochure or handout [distributed at the clinics][…] but they could stress that one can talk if something is bothering one. Or somehow emphasise that side more.

(Pregnant woman 1, age 24, 39+ weeks of gestation, third pregnancy, second child)

It is not just medical knowledge, advice or other expert opinion, then, that is sought, but discussion per se, which obviously may result in pregnant women coming to know their pregnancies in medical, psychological or social terms, but which seems to have first and foremost a therapeutic goal. Being able to discuss any worries about pregnancy may ease anxieties and give reassurance and thus in itself contribute to the increasing awareness that specific things particular to individual pregnancies are, for instance, not something that needs to be worried about, and that one can learn to live with them.

Therapeutic and tailored support as one comes to know by doing often takes the form of hands-on guidance:

Q: Can you think of an example of something that has been especially nice [referring to previous answer, according to which the pregnant woman has had generally good experiences of maternity healthcare]

A: For example the visit to the [name of the clinic] where we’ve been for the ultrasounds. Well there the nurse [ultrasound technician] explained all the time what she was doing and what was showing [on the screen]. I thought that was really nice. […] Then I think that they [the public health nurses] have time to talk and listen and explain about stuff on these regular appointments.
Q: Can you think of any other special service that the clinics offer that you think is important and that you consider helpful in your pregnancy?

A: Well it was good that I was referred to a nutritional therapist. I mean that is not a mandatory visit but [it was offered] if I wanted [to go] and at one point I did want to go. That was a good thing. Then now that the heartbeat is listened to every time [at the appointments]. Well, it is always nicely calming to hear them and that they sound good and that everything is fine. Then of course these practical documents that have been sent, the applications for maternity benefits, to Kela [Social Insurance Institution of Finland]. I have got guidance for that [to fill them out]. I have read about them somewhere beforehand but then I have been all confused about how one is supposed to fill them out and how and where and what, but they helped me there [at the clinic] so much about what to do and when to send them. […] But quite good cooperation has been done for example in this nutrition planning in that in the beginning I had to add milk products [to my diet]. It was a thing that annoyed me a bit, but I do understand that I need to get calcium. I don’t normally use milk products that much. So I had to force myself to eat yoghurt and stuff to get any milk products down. Together we planned [with the therapist and nurse] what I could eat.

(Pregnant woman 3, age 28, 27 weeks of gestation, first pregnancy)

In the quotation, the pregnant woman comes to know her pregnancy by negotiating and trying out what kinds of milk product she might tolerate. She also comes to know her unborn, not just as some entity that needs calcium, but also as a physical and healthy human being, at for example the ultrasound scan when the technician tells her what is showing on the screen.

Women always remembered to emphasise to me that screenings such as the ultrasound and listening to the foetal heartbeat are important first and foremost because they are concerned with foetal health. However, as touched upon earlier in this chapter, women are also interested in determining the sex and seeing the foetal image, although this has to be subordinate to caring for health issues and is explained in terms of ‘the best interest of the child’. It is as if a ‘good mother’ who cares about her unborn is not allowed to be too interested in foetal gender or in ‘seeing the baby’. But she should not be totally uninterested either, because that would imply unwillingness or inability to get to know one’s baby, to start the mental and social transformation into a caring parent who already bonds with her baby prior to birth (see also Mitchell & Georges 1998, 111–112).
Furthermore, because discussions, advice, screenings and so on have a special therapeutic dimension, they can be understood as ritualistic. The ‘need’ to get screenings and advice in order to soothe the nerves and ‘to hear that this and this is just normal’ (Pregnant woman 3, age 28, 27 weeks of gestation, first child) suggests a symbolic value, especially when we take into account that there is no medical reason for the routine use of screenings. By attending the screenings women get assurance not just that the unborn is healthy but also that it is ‘real’, and they get a kick-start in the process of personalising and bonding with the unborn, as elaborated earlier. Thus the screenings and appointment discussions serve to satisfy emotional needs and strengthen social bonds, which are both common to ritual activities (on rituals see e.g. Douglas 1984/1966).

Screenings and discussions as therapeutic activities seem simultaneously to serve the purpose of moral and social education into parenthood. Women describe the personification and bonding process as a must, and put great emphasis on the knowledge about pregnancy and the unborn provided by healthcare actors as therapeutic. It is a relief not just to find out what one is not supposed to eat, drink or do, but also to find out what one is allowed to feel and think about the ‘baby’, one’s partner or the uncertain future. Women especially appreciated the nurses’ friendly and ‘equal’ approach, and their detailed and closely examined answers about and descriptions of, for example, foetal anatomy on the ultrasound screen or feelings of unfitness to meet the demands of motherhood. However, according to the pregnant women, social and mental aspects of pregnancy were concerns that were the most neglected ones, and something that should be an explicit focus in maternity healthcare:

Q: In general, if you could change maternity healthcare in any way what would you change?

A: Well, maybe it would be linked more to this mental side. I think there has been rather little about it at any stage, that mental change when one becomes a parent. Because you really don’t understand fully during pregnancy how much it changes your life. There is some mention about it in all those millions of brochures [handed out in the clinics] but it is something that could be paid attention to as early as the beginning of pregnancy. And I don’t know, but maybe that way men could get more out of the appointments if we were approached as a family that way […] that there
is in those millions of brochures and papers [...] there is about partnership and what happens when you become a family and so on. But I don’t think we have discussed a lot about it yet. Even now for example about how the first child will encounter the baby. We haven’t discussed a lot about that. It is more like I have searched for information on my own.

(Pregnant woman 6, age 33, 31+ weeks of gestation, second child)

What is suggested in this quotation is not that there is no room for the discussion of mental or social transitions to parenthood and family life, but that such issues should be raised in discussion and advice by the staff. In addition to hoping for more guidance, women sometimes critiqued the brochures handed out at the clinics, and the one family counselling class on parenthood provided by the clinics and available for all. In all three clinics where I had the opportunity to attend this class, it was often taught by a priest from the local parish. This provoked some confusion and upset. On occasion I heard deep sighs and mutterings when an instructor with a clerical collar stepped into the room. I never had the chance to discuss the feelings women associated with having a priest as an instructor for family counselling. However, the nurses filled me in by telling me that pregnant women and their partners do sometimes object to a religious professional giving advice on family matters. Similarly, the brochures and advice in general were criticised for having a too narrow a view of parenthood and family relations, as in the following snapshot from an interview:

Q: How about, you know, issues concerning parenthood and partnership, that are not really factual [...] Have they corresponded with your perceptions?

A: What irritates me about that is that they are really generalised, those partnership issues everywhere. A man is like this and a woman is like this. That is true up to a certain point but when you think that people are individuals. I bet I have many masculine characteristics and my man has something feminine in him. [...] Then there are these things that at least in our family we have always taken as self-evident, such as that communication must work. When we have from the beginning talked really openly. We are able to talk about things and feelings and everything. One must take care of one’s partnership, it is said always in these brochures. We have taken that for granted and because of that [...] We didn’t get married right away, and we didn’t even think about having kids [...] we wanted to get to know each other first and live together and children will come later if they are to come and if we want. Of course not everybody can have children even if they
want to. They [brochures, classes] do defend the expectant mother […] that the man must
understand that there is going to be hormonal mood swings and stuff. You shouldn’t leave all the
housework for the woman. And then they show the man that, look, you should help and you should
understand. But a modern man has read about that stuff a little [before hand].

(Pregnant woman 3, age 28, 27 weeks of gestation, first child)

In this quotation it is implied that the advice is too generalising, stereotypical and even
outdated. It is something that both women and men already know. Here again specificities
and individual guidance are wanted. Another thing that was described as good about
certain counselling classes, and that was missing from most of the activities offered by
maternity healthcare, was peer support. In one of the clinics, the nurses had arranged ‘a
breastfeeding model’, a woman who had recently given birth, to attend a class on birth and
breastfeeding to tell about and discuss her experiences. This was something the women
liked a lot, and I never heard such excited and active conversations in any other classes.
Mostly, then, for peer support, as well as for more specific and additional information,
pregnant women have to rely on other available resources.

Knowing by doing and sharing experiences with others

In the quite early stages of my fieldwork I observed how the frontline setting of maternity
healthcare and the encounters taking place in it were organised by a wide range of
translocal documents and ways of interpreting them. One of the most contradictory sources
of information seemed to be the Internet. Pregnant women told me that they actively and
widely searched for textual and visual material on pregnancy, especially on the Internet.
This did not always go down well with the maternity healthcare nurses or midwives.
According to them, there are a lot of competent and recommended (‘truthful’) websites,
such as state research institutes and NGO sites. However, since they cannot control the
search results, they are forced to spend time correcting false assumptions and calming
down women who come to appointments terrified after viewing pictures of malformed
foetuses, for example. Although the Internet is certainly more open than traditional media
to genres of representation other than the medical (e.g. Moore & Clarke 2001), the
pregnant women I talked to and interviewed seemed quite critical of Internet sources. They
select the forums carefully:
Q: Where have you got and searched for information about pregnancy? You already talked about this diary you follow [a book on pregnancy progression step-by-step][…]

A: Quite old-fashioned literature. But some from the Internet. I have visited these discussion forums where there are expectant mothers. It has been a really good thing. You don’t necessarily get any knowledge but peer support. Never information, you can’t trust it because there aren’t any professionals to answer what is the cause of this and that. Those are the two main things. And of course something like ‘Vauva-lehti’ [a popular Finnish periodical on pregnancy and baby life] and others that my sister has given to me.

(Pregnant woman 5, age 33, 14+2 weeks of gestation, first pregnancy)

Q: Have there been any other sources of information [in addition to the public health nurse at the clinic], where you have [got] information on pregnancy from?

A: Well the library. The library and then of course all the magazines. Well, in principle all, because it [pregnancy] always appears somewhere and you remember that you could check this out. But the Internet as well, when anybody can put anything on there. Somebody just forbade using nail polish, because it poisons the baby. I just told myself that now I am going to move to a different site. They are a bit dodgy.

(Pregnant woman 2, age 30, 20 weeks of gestation, first child)

Q: Where have you got and searched for information about pregnancy?

A: Well the Internet of course. It is probably the same for many. Discussions with my mum, I really don’t have anybody but mum. Reading all the Internet discussion forums and all that. I haven’t read any books or anything.

Q: Is it different compared to your first pregnancy?

A: Well, I know more already and all that. And then I filter information differently. Like in some forums, people have their own opinions, so more[…] Don’t take something on board, because it is not a really trustworthy source after all. So one reads things and thinks about them but doesn’t take anything too literally.

Q: What kinds of sites?
A: I visit the ‘vauva.net’ site. It is a fun and no-nonsense site. But if I really had something that worried me I would call the clinic. It is the most competent place after all.

(Pregnant woman 1, age 24, 40+ weeks of gestation, second child, third pregnancy)

The Internet seems to be subordinate to library material, periodicals and especially healthcare professionals’ advice when the knowledge obtained is assessed in terms of validity. In fact, what is sought on the Internet is peer support and accounts of experience, rather than ‘facts’ about health issues. It is apparent that pregnant women long for and seek personal stories about pregnancy matters and forums for sharing experiences of pregnancy. Others’ experiences of pregnancy and of carrying the unborn within, then, are part of coming to know one’s own pregnancy and the unborn.

As in one of the quotations above, pregnant women’s mothers and other close female relatives and friends are often mentioned as sources of experience and advice:

Q: You talked about it in the beginning. I would like to ask you in a different way to tell me more. Who and what do you think have been your companions in pregnancy?

A: Well, maternity healthcare of course. Mostly I think my own mum. And then my man of course, but he’s not interested in hearing about everything, you know, every ache and all that. I mean he is with me […] It is different talking to one’s own mother than one’s man. It has been really nice to talk with my mum about pregnancies and compare and all that, I didn’t have any friends who had children when I was pregnant for the first time but now one has a tiny baby. So it has been nice to be pregnant at the same time and discuss how it has gone. It is a great support in this.

(Pregnant woman 1, age 24, 39+ weeks of gestation, second child, third pregnancy)

There seems to be a kind of a division of labour in informing women about pregnancy, the unborn and family life. Simplistically put, ‘facts’ about health and biological processes are assigned to healthcare actors; experiential knowledge is assigned to female friends, relatives and other peer discussion forums. Moral and social education into motherhood, parenthood and family life, instead, are not identified with any particular participant in pregnancy. Sometimes they are situated in the information received from the clinics, sometimes in abstract cultural expectations with no apparent source and so on.
However, being informed by other people or things is not all there is in coming to know one’s pregnancy, as I have hinted earlier in this section. Women come to know their pregnancies and unborn also by doing and living pregnancy in a shared manner. It is mostly in the early stages of pregnancy that outside information and discussions are the most essential ways of getting to know, and thus of altering one’s life accordingly.

First of all, women come to know their pregnancies and the unborn through bodily sensations and bodily change. A laborious body forces them to learn to do things differently, and, thus to become aware of the new-found materiality of the body and its changing boundaries. Bodily coherence is questioned as the unborn starts to show signs of existence. Through these bodily experiences and interactions women come to know their unborn as well. The sensations are transformed into the personal and social identity and kin of ‘my baby’, and not just any baby, by women responding socially to movements and other bodily experiences: establishing rhythms, altering daily routines, relating sensations to kin attributes, and engaging other people with one’s physical laboriousness and sensations.

Other people and things are not just invited to participate in individual pregnancies but actively involve themselves, and thus become part of coming to know pregnancy as the pregnancy progresses. Often pregnant women put pregnancy on hold by not telling friends and extended family before 12–13 weeks of gestation and the first ultrasound screening, because of the fear of miscarriage or foetal abnormalities (see also Mitchell & Georges 1998, 111). While close people are not yet engaged, medical models of pregnancy as divided into temporal units are invoked as women draw up timetables for their pregnancies.

It is not just formal (medical) scientific ways of knowing pregnancy or their (technological) realisation in clinical practice that impinge upon pregnancies by constituting the ‘nature’ of pregnancy. Different kinds of natures are at work when women engage in mental journeys to motherhood. Ideals of mothering that manifest themselves in women’s accounts and lives as worries over the acquisition of instinctual competence in
mothering suggest a (even mystical) ‘woman’s nature’ that delivers nurture. Ideals of mothering, then, are cultural nature in pregnancy, and they do things like obligating pregnant women and their partners to start the bonding process of getting to know their baby and ‘the best interest of the child’, or blaming women for worrying about appearances, not breastfeeding, or being too interested in foetal gender, for example.

When other people are invited – either by being told or by seeing the sign of the big belly – to share the tasks of pregnancy, they add to transformations that enact particular babies, (fit) family homes and parenthood in socio-material ways: by changing social and kin relations through attending to the (perceived) needs of the pregnant woman and the material settings of the home. By attuning their lives to the (perceived) agendas of the family-to-be, relatives and friends contribute to coming to know one’s pregnancy and the unborn. Stepping into a ‘baby-centred’ world full of secure gadgets, different styles of nursery space and constant hands-on help and advice from female relatives are life-altering experiences that have to be lived to be fully realised. Each gadget, comforting piece of advice or surprise visit bears implications for how one knows and remembers one’s particular individual pregnancy and the well provided-for ‘baby’ one is carrying in one’s belly in the (remade) socio-material networks of kin and social connectedness.

Overall, the transformations both in the social lives of women and in knowing one’s life during the process of pregnancy are mediated by the ‘best interest of the child’ value object. The ‘best interest of the child’ is also where the state services, the institution of maternity healthcare, involve themselves in the pregnant women’s life the most (see also e.g. Nätkin 1997; 2003). The logic of ‘the best interest of the child’, in effect, draw heavily on the (political) imaginaries of maternity embedded in different expertise and ideas of cultural competence (see also ibid.). These areas of expertise can roughly be said to include expertise in social, psychological and health matters in pregnancy and family life, in their popular, professional and scientific modes. Enmeshed with each other, they sketch ‘natural’ transformations, such as biological courses of progression and development brought on by (even mystical) predetermined nature and emotional/mental growth into parenthood. They suggest an instinctual knowledge of mothering, as is implied
for example in notions like ‘maternal instinct’ and one’s ‘purpose to continue life’ (e.g. pregnant woman 5, age 33, 14+2 weeks of gestation, first pregnancy).

So the rationale is not in itself fully scientific (bioscientific, psychological and so on) in style, but its rhetoric is based on a quite domestic assessment of values, virtues and gendered notions of men’s and women’s positions in society. Finally, in the pregnant women’s accounts, attuning to these values and gendered virtues and norms is a way of coming to know and bond with the unborn care object, ‘the best interest of the child’ and oneself in relation to the figure of a fit mother. ‘The best interest of the child’ is a fluid, multiple and abstract or open-ended concept that is used to argue for many different, even contradictory, changes and choices in pregnancy, from lifestyle choices via use of technology to consumption and working on family relations and parental identity and so on.\(^{72}\)

Thus although there are certainly vernacular, ‘irrational’ and mystical logics of social ordering at play in the coordination of the accounts and lives of pregnant women, the technoscience and psychosocial knowledge of (maternity) healthcare still seems to win the day in that the contest over knowledge about pregnancy and the unborn is usually won by expert knowledge (Lawler 2000, 135–138). Expert knowledge, however, is much fuzzier that one might think. It is pragmatic and practical, sociotechnically constituted, and the formal and informal are completely entangled in its organisation (see also e.g. Vuori 2001; Miller & Rose 2008). That is also where room for agency emerges.

3.3 Maternity healthcare relations: a pregnant girl’s best friend?

A: Tests and other bodily interventions [reads from the list of services provided by maternity healthcare]. At least I don't have any problem with them. Thinking that there are people that fear needles and don't like it in general, but I don't have any problems. I think that it is just positive in that sense that I like the fact that things are checked out. It gives this feeling of security and, like I said earlier, I like it that the doctor examines me, because it makes me feel that everything is fine.

\(^{72}\) On the fluidity, multiplicity and historically contingent character of the abstract term, see e.g. Nätkin 2003; Kurki-Suonio 1999.
Then all should be fine. There is this scientific evidence that [...] I suppose I always need that kind of proof.

(Pregnant woman 7, age 28, 13 weeks of gestation, first pregnancy)

As the above quotation shows, bodily intervention during pregnancy is justified in terms of foetal health and feelings of ‘security’ which are provided by ‘scientific’ clinical examination and knowledge. However, as I have discussed earlier, the ‘scientific’ examination and knowledge are never realised in some ‘pure’ and universal form, but are practical compromises managed in a social, cultural and political context. When one analyses the women’s accounts, multiple narratives and logics begin to appear. And when these logics and conceptualisations that they harbour are built into large-scale bureaucracies and institutions such as healthcare systems, then the power of those concepts and perceptions is strengthened (see also Bowker & Starr 1999). Before moving into the clinics to look at these multiple logics and then moving on to the relations between individual accounts of experience and institutional activities, I want to explicitly discuss women’s perceived positions in maternity care. Then I will finally feel that I have outlined the partial perspective, the entry-points and the standpoint, that organises my analysis into the social relations coordinating the activities at the clinics.

Women are mostly satisfied with the services provided by the clinics. They do wish for more tailored services and more time for the often therapeutic discussions with the nurse, but overall everybody I talked to realised that limited time and resources cannot provide everybody with their hearts’ desires. The doctors at the clinics, whom pregnant women without complications visit approximately three times, were perceived as quite distant, but their professional opinions, examinations or other bodily interventions were rarely questioned. Furthermore, health education and advice on parenting provided by the public health nurses were regarded as adequate, although sometimes stereotypical, quite general and too standardising. Consequently, for example, nurses’ remarks on weight gain and standardised advice to eat regularly to ease nausea were sometimes critiqued by the pregnant women. However, the public health nurses were assigned the most important and closest position in the maternity healthcare system in the women’s accounts.
The nurses appear as professionals and service providers with whom a ‘friendship-like’ relationship is formed over time. A cosy atmosphere was the common impression I gained at the clinics. Nurses already greet their client-pregnant women in the hallways, remember everybody’s name and family background, and create an environment that is informal. This was greatly cherished by the pregnant women:

Q: Could you tell me about your experiences and feelings in general about maternity healthcare?

A: I think it is always exciting or I mean that when I was expecting my boy it was really exciting to go there. And it’s really nice to talk there. I have had really nice people as my clinic aunties [public health nurses] so it has been nice to talk about everything. Then it is really nice to get attention or that kind of attention one gets when one is pregnant. I have nothing negative to say. Sometimes [...] [asks me to repeat the question which I then do] So positive, I like to go there. It is always nice to go to the clinic. What is developed is or not [...] well, in a way kind of a not exactly a friendship but what is nice is when you develop this relationship with your auntie because she is the same one the whole pregnancy [...] well it is somehow. And then it is nice when they [public health nurses] remember then. They remember what we have discussed earlier, and that makes one feel that one gets attention and all that. I imagine it is possible that not everywhere where there are lots of clients they remember personal things.

(Pregnant woman 1, age 24, 39+ weeks of gestation, third pregnancy, second child)

Well, ‘not exactly a friendship’, as the woman put it, but something more personal than the kind of relationship one is used to having with healthcare or social services is being enacted. In fact, later in the same interview, the pregnant woman goes on talking about the conversational style of advice and concludes by saying: ‘[It is not like] you are this hatchery [and] you come to visit here and to check these things and then you leave. This is so that you develop a friendly relationship and you are able to talk.’

Furthermore, public health nurses and midwives, as in this quotation and quite commonly in Finland in general, are called ‘aunties’, and this associates clinic nurses with nursery nurses, who are often also called ‘aunties’. This does not suggest, in the Finnish context, any real resemblance to kin relations (sometimes all adult women are referred to as aunties when talking to a child), but it does suggest a cosy and friendly atmosphere where confiding relations are built. It is implied in the quotation that this confidential and
informal relationship is achieved through long-term acquaintance and the continuity of the relationship (see also Vaittinen 2011).

Along with the time-consuming process of getting acquainted, building a confidential relationship seems to require an aspiration to ‘equality’. ‘Equality’ is the key to opening up a conversation where there is space for negotiation:

*Q: What kind of a role do you consider you have in the clinics?*

*A: The kind where I am appreciated as a client there and the interaction is equal so that they [nurses] are not above me and tell me how things are and what I should do. One can discuss things there.*

(Pregnant woman 3, age 28, 27 weeks of gestation, first pregnancy)

There is a peculiar vocabulary for talking about one’s position in the activities at the clinics here, and in other accounts as well. In relation to the nurses, pregnant women are ‘clients’ and not, for example, friends or patients. What kind of ‘equality’, then, is manifest in women’s accounts? The term ‘client’ suggests a market reasoning where clients choose and professionals offer (care) ‘products’. However, given that care work is a process of transformation and coming to know, how is one able to ‘choose’ something that is produced in a shared manner and is open-ended? (On market logic in health care see Mol 2008a, 14–28.)

In the model of ‘equality’ in the women’s accounts the different roles of clients and professionals are recognised but no one has authority over knowledge or pregnant bodies. They seem to be suggesting a relationship that ‘is moulded in the form of a [civic] contract’ (Mol 2008a, 30). In a civic contract clients/patients are traditionally emancipated into citizens (ibid., 29).

In addition to and linked to these traces of market and civic standards, there remains something fuzzy about the positions and relations of nurses and pregnant women. ‘Equality’ in the relationship between pregnant women and public health nurses is not just
problematic in the market model, but also in the citizenship model. Citizens are free to choose through a bodily autonomy that is achieved through the taming of the body, and only when bodies are controlled can medical authority be done away with (Mol 2008a, 30–37). In pregnancy, however, bodies cannot be fully tamed nor are they fully autonomous. Bodily boundaries fluctuate, and the common characteristic is the uncertainty of the future. Thus it would be wrong to state that the nurses do not tend to have medical or other authority over the pregnant women. This is also realised in the women’s accounts:

**Q:** When you think about the appointments as situations, what is your own role among everybody else there?

**A:** To be a mother. It feels like that when one is pregnant. Well, of course elsewhere as well […] everybody of course, when they realise that you are pregnant they start instantly to talk about the baby. And now of course […] because the premise of maternity healthcare is that everything is fine with the baby. Somehow I sometimes feel myself like, well, here I am, it [refers to the unborn] is there, that I am this hatchery there, when the baby is the focus of so much attention. But one is allowed to say for herself there how one feels. [Her nurse’s name] will listen.

**Q:** Do you have any example of how it shows that the baby is in the main role?

**A:** First of all, when they start to ask how you are doing in the plural [in Finnish there are different singular and plural second person pronouns ‘you’]. And then, that ‘well the baby is feeling good today and here are the heartbeats’, ‘when you do this, the baby feels good.’ That the baby and how are you [plural] doing is in every sentence. It is like, well, I am no longer doing well.

(Pregnant woman 2, age 30, 20 weeks of gestation, first pregnancy)

The pregnant woman here recognises the open space for compromises and negotiation, but also that the object of care at the clinics is often the unborn and that her own activities are being prompted to work in cooperation ‘for the best interest of the child’. In this quotation the woman obviously does not fully appreciate the baby-centredness of the care, but this is not always the case:

**Q:** Can you think of some significant experiences and feelings linked to maternity healthcare?
A: I think it was nice that right from the beginning they talked about this baby as she/he. She/he is growing in your belly and she/he starts to move then. First it made me laugh terribly that they already said she/he. But then it did show great appreciation for new life to address already as a person, she/he.

(Pregnant woman 3, age 28, 27 weeks of gestation, first pregnancy)

Overall, then, doing babies and children, parents, and knowledge is something that is done in cooperation, especially with the nurse, and that may on occasion be smooth and on other occasion be full of friction. However, it is teamwork. Furthermore, it is an open-ended process of transformations. The situatedness of knowledge seems also to have implications for the notions of ‘choice’ and ‘autonomy’, which are the prevailing notions in contemporary debates on reproductive issues and rights (Kingdon 2007). For if there is no single point from which to know, can there be a single point from which to make an informed static choice to attend screenings, express preferences over birth method and so on? This is illustrated nicely in an account of ‘choosing’ to go to an ultrasound screening:

Q: I would love to hear more about them [screenings], about the thoughts they provoked and what did they feel like?

A: Of course we thought at first that of course we will go. When it is totally voluntary, one does not have to go to the Nuchal translucency screening [niskaturvotusseulonta in Finnish] at all. First it was clear as day that we would go there and we didn’t even think that we wouldn’t. And the main reason for that was that it would be nice to see what kind of a chap there is and that everything is all right. But then in a way […] when we explored the issue at length and thought it over and I had read this article where there was this mum that had given birth to a disabled boy and had taken this screening very hard and everything had been really terrible and hard for the rest of the pregnancy. Then it just somehow came to mind that I have heard that one of my friends had it so that [in the ultrasound screening] it showed something, that there was something abnormal. The child turned out perfectly healthy eventually but what kind of feelings [friend’s name] must have had when obviously she was afraid that now something is wrong and stuff. And it is not really a hundred per cent [reliable] [ultrasound examination results] then it just came to mind that what if there is something […] I would have something vague that they wouldn’t know what it is and then I would be referred for further examinations […] when it could actually be just healthy. And also that I could never get an abortion anyhow unless it was clear that the child was so severely disabled that she/he wouldn’t survive. Yes, it went so that I soon had to think it over whether I should just cancel
it [the ultrasound appointment] when it is already on Tuesday next week. So, it is in a week now. But we didn’t then. I think now that I will go there since we already went there to the ultrasound last week because of the sick leave [the pregnant woman has had severe nausea and been on sick leave and referred for an additional ultrasound because of that]. So there already, although it was quite early, the doctor checked out the organs and the anatomy in general and the nuchal translucency values and everything was fine at least then. Now it is easier and I don’t have to think about it because she/he [the doctor] already examined. Although I didn’t really feel anxious about it and I didn’t think about it. Good thing as such, but there are these issues. (Pregnant woman 7, age 28, 13 weeks of gestation, first pregnancy)

In the quotation, the pregnant woman with her partner, through the process of reading and talking to friends about experiences linked to abnormal screening findings, has started to change her mind about attending the ultrasound screening. Then, because of an unexpected doctor’s appointment due to nausea, she was referred for an ultrasound at the hospital. In the end she decided to go to the maternity healthcare ultrasound too, because she already knew that it was really unlikely that there would be any abnormal findings. Thus finally going to the screening involved lot of coming to know, and during the process the reason for going was transformed from finding out about foetal health as the main reason for seeing the ‘chap’. ‘Choosing’ could be described as coming to know one’s choice.

Overall, although women also consider themselves as having the main role at the clinic, the tension between the ‘good’ for the unborn and the ‘good’ for the pregnant woman is often managed by choosing the unborn as the object of care. This choice is not neutral: should the focus of concern be the assumed health implications of one’s lifestyle on foetal development, or the mental well-being of the pregnant woman, or perhaps the well-being of an older sibling who needs care and attention at the expense of the pregnant woman’s rest? And, since choices made often lead to action, what might they cost?

Maternity healthcare visits do provide pregnant women with feelings of ease and well-being in many ways, but also enact value-laden social relations and bonds between parents and the unborn through doings that are precarious and minimal and yet have major implications for the participants. Care work as managing uncertainty, therapeutic work and producing social ties can also be understood as a practice of biopower that constitutes
selfhood prior to birth. Next I will move on to see how all of this is articulated in everyday encounters at the clinics.
4. Pregnant selves and unborn relations in the paths of maternity healthcare

In the previous chapter I have shown that pregnancy is accounted for as a set of transformations within which selves are born and selves shift. Furthermore, I have taken issue with the social relations that coordinate pregnant lives and selves in and outside the clinics and that are accessible to and articulated by women. Informed by this experience-based knowledge, in this chapter, my focus will shift to the practical and specific realities of everyday work at the clinics that for some parts are not verbally accessible to the pregnant women and beyond their experience. I ask how the logics of transformation and teamwork in making babies, children, mothers, kin relations and so on are actually realised in clinical work.

To do this, I will move into the clinics and follow the different objects and subjects of care around which actors construct meaning and organise their work practices (see also e.g. Casper 1996; 1998). I have chosen to go about my journey in the same way as pregnant women do. That is, I will follow the paths from the first appointment onwards, in line with the progression of pregnancy. In this way I will be able to address the situational relations between the physicalities and social aspects of pregnancy: how the material and symbolic characteristics and properties of the objects (the unborn, conceptions of motherhood and so on) shape work practices, and how the objects themselves are mutually shaped by the work and its social context. I will also be able to tease out the continuities and discontinuities of subjectivities (see also Moser & Law 1999), as well as the overall logic(s) of the trajectory of maternity healthcare doings, in accordance with the relations of pregnant women and the unborn.

4.1 Getting acquainted, assessed and slotted into the system

The first and the second trimester (8–30 weeks of gestation) appointments (including approximately three visits to the nurse, two visits to the doctor and one or two ultrasound
screenings) can be characterised as filled with activities within which pregnant women, their partners and the unborn are being assessed and then slotted into the systems of primary healthcare, hospital wards and the welfare (parental) benefits system. These activities make their cases actionable, and ensure that they are informed of formal recommendations and that their health and other concerns are kept track of.

Entering women into different systems of record-keeping according to which further action is taken is also entering them into a (systemic) process that to a certain degree predetermines their futures in pregnancy. It thus distributes pregnancy concerns, such as birth mode, postnatal livelihood and so on, over time and across sites of maternity care. However, it is not just ‘the system’ that the women (and men) become acquainted with, but also the competences of mothering and fathering, their unborn, and their own positions as clients as realised in the institutional practice of maternity healthcare. This is further realised in the casualness and cosiness of the care work and its socio-material setting.

**Filtering and advising on potentials**

The first time I arrived at each field clinic I was always somewhat scared, confused and yet excited to be starting my fieldwork. It seems that, especially in first-time pregnancy, women and men are also scared, confused and yet excited – but obviously for quite different reasons. The first and lasting impression of the socio-material setting of the clinics however, was very relaxing and welcoming, at least for those fond of family-centered spaces. My impression, as well as that of the women I talked to and interviewed, was that the overall setting did not greatly resemble that which many of us are used to in other clinical healthcare contexts. As one steps through the doors into the waiting room, informal chatting, often about baby-related issues, is going on between people who do not even know each other. The nurses stop for a familiar chat with the pregnant women, their partners and children in the halls leading to appointment rooms, and there are colourful decorations, toys, magazines and information leaflets everywhere. It is like a gateway to a child-centred space, as well as a space for healthcare.

By the time pregnant women arrive at their first maternity healthcare appointment, they
have already been in phone contact with the nurse assigned to them and have received some brochures and forms to fill out for the appointment. Over the phone the nurse, after warmly congratulating the future parent(s), takes standard personal and medical information that might affect the medical plan for the care of the pregnancy, such as diabetes, the starting date of the last menstrual period, and the number of earlier pregnancies. The information package the pregnant women and their partners receive by post includes brochures on local maternity healthcare activities and actors, and on maternity, paternity and family benefits (Welcome to maternity healthcare 2007), and on screenings for foetal abnormalities (Foetal screenings I 2007; Foetal screenings II: nuchal translucency screening 2007). They are also sent standardised forms of personal information, intoxicant use (Audit – the Alcohol Use Disorder Identification Test), and nutrition and other lifestyle issues (see Appendix II). All this is a kind of preparatory work for the first appointment, the first face-to-face encounter during which the information is discussed and entered into the computerised casebook system.\footnote{The collection of information has been coordinated by a computerised casebook system since the early 2000s (Iivari & Korhonen 2007, 14). Public health nurses are required to enter the results of routine tests taken at every appointment (urine tests for sugar levels and protein, blood pressure, foetal heartbeat and weight) and any other information that comes up about physical and mental health, family and other social relationships, and financial matters of the women and their partners. They also use the system to retrieve information entered by physicians, hospital staff and ultrasound technicians or midwives. While the system is often used only briefly during the appointments, and information is mainly entered after the appointments themselves, during the first appointment information is filled in on the spot.}

When pregnant women and their partners arrive with their completed forms for their first appointment, the nurses come and greet them in the waiting room and lead them into the appointment rooms, which look like hybrids of examination rooms, offices and nurseries. There is usually time for some sympathetic discussion of general feelings about the beginning of the pregnancy,\footnote{One of the issues discussed is whether the pregnancy was something hoped for, or at least accepted. The issue is obviously crucial in the sense that it has implications for the care plan: the relationship between an unwanted unborn, a pregnant woman and her partner becomes a particular object of care.} but after that, in the case of the first appointment, it is strictly business according to the agenda set for the appointment.

Most appointments during pregnancy take about 30–40 minutes. The first appointment, however, takes about one or one-and-a-half hours, which is the recommended time in local
guidelines (Handbook of maternity healthcare 2007). Compared with other MCH services systems, such as the British system, this might seem like a relatively long time to interview pregnant women and (possibly) their partners. However, during this time slot the first formal assessment needs to be completed for the individual pregnant woman’s case to become actionable; the nurses are required by administrative standards to complete a scripted assessment. Furthermore, the nurses also need to give advice and information concerning future visits to the clinic and healthcare during pregnancy, including screenings, nutrition, consumption of intoxicants, exercise and other issues linked to lifestyle, as well as physiology, psychology and medical procedures in pregnancy (ibid.; Screening and collaboration in maternity healthcare 1999). In the clinics where I did my fieldwork, the nurses also gave a tour of the clinic, and if the pregnant women asked for it, which they usually did, the nurses would sometimes try to get a heartbeat sound with a foetal Doppler device.

Given this institutional context, it is understandable that time is scarce. All the topics on the forms filled out by the pregnant women (and possibly their partners) need to be covered and entered into the system, and the standardised first appointment information and advice has to be given manner (Handbook of maternity healthcare 2007). However, there are no written guidelines as to how or in what order to give advice linked to the topics on the form. Thus some protocols are laid down, but others are not.

During the first appointment in particular, the forms, and thus the computerised casebook system, interfere to some extent with the raising and discussion of any pregnancy concerns not covered by the fixed topics on the form or the agenda for advice set for the first appointment (e.g. Handbook of maternity healthcare 2007). This in turn means that what can become most institutionally meaningful during this particular appointment are the categories used on the form and/or in giving advice and information related to them. One might say that the form has a standardising effect in that it works as a filter, and as such to some degree it may sanitise the detail that the pregnant women and their partners potentially bring to the work of assessment (Smith 2005, 170–180; see also Law 2009). Further, the nurses at the clinics where I did my fieldwork had all been trained in interview
methods and were quite reflective about how they opened and conducted the conversation. Hence the form’s and computerised system’s ‘interrogatory’ structure, and the closed questions that they impose on the conversations, seem to limit interview methods that are seen as more sensitive to pregnant women’s individual worries and experiences.

The nurses are quite critical of and apologetic about the filtering work of the forms and the casebook system during these appointments. I have heard them apologise to pregnant women and their partners for sitting by the computer and entering data while they talk. One of the nurses once used the expression ‘let’s create your pregnancy on the computer here’ (VideotapeP40), which sums up the role of the casebook system at the first appointment. I have also had many discussions about the occasionally absurd order of items the system offers; for example, from last menstruation straight to family relations. The nurses would also rather have more informal discussion with the pregnant women, in order to better start to establish a trusting professional relationship and to fulfil the task of scheduling and organising all the individual appointments and sequences of appointments according to the individual women’s (and men’s) needs.

All in all, the first appointment agenda is both to assess and slot the pregnant woman, her partner and in a sense the unborn into the maternity healthcare system, and to start getting acquainted. Although the forms do ‘govern’ actions here, as they often do (Smith 1987; 2005; for slightly different kinds of approaches see also e.g. Martin 1987; Oakley 1984), they are not the sole actors in the transformation work done during the first appointment: there are also particular women, men, nurses and the unborn, and these are not wholly predetermined by the classifications used in the forms and protocols.

In my material there are 10 first appointment videos, all of which seem to follow a similar pattern in how the relationship between the pregnant women and the unborn become enacted in the work of being slotted and getting acquainted. The interview with the forms and advice-giving is thus for the most part concerned with pregnancy as a physical and psychological process, and with what might be called its ‘environmental factors’, such as the incidence of disease or mental illness in the family, available social support, weight
problems, attendance at screenings, intoxicant use and so on. Looking at the forms or the casebook system entries (see Appendix II), or listening to the nurses listing various diseases when assessing any (prior) diseases that the future parents or their close family have, one might think that the logic of gathering information and giving advice and information is about addressing pregnancy issues in purely (medical) scientific and technical terms. However, the ways in which information and advice are given are often profoundly social in style, and full of expressions and metaphors that are by no means (scientifically) neutral.

This is mainly so in relation to health matters that have been labelled as something people should and could have control over: intoxicant use, nutrition, exercise and work-family balance:

It is a first appointment, and the pregnant woman and the nurse have just gone through the eating habits item in the interview. The nurse gives a little concluding speech about the importance of paying attention to one’s diet in pregnancy. She comments on the pregnant woman’s being slightly overweight by telling her that even though the normal weight gain in pregnancy is considered to be around 12 to 15 kilos, it is better for overweight women like her not to gain so much. She uses the expression ‘one does not have to eat for two,’ and goes on to educate the woman about how ‘pregnancy is a good place for many women to think through and change their habits for the sake of the baby and for themselves as well,’ and how sometimes habits ‘may change naturally and the weight might even go down’. At this point the nurse starts to explain how eating habits and being overweight have ‘concrete consequences for the baby’. She tells the pregnant woman that if her sugar levels are high, the baby’s sugar levels will be high as well, and the baby will be big and that might cause problems during birth. Furthermore, when the umbilical cord is cut, the baby’s sugar levels will drop and he/she will have to be admitted for observation. ‘Not to mention the long-term effects on breastfeeding.’ After listening to all these horrid consequences, the woman is reminded again by the nurse that ‘pregnancy is not, however, a disease, and one should not be too strict’; ‘one can feast as well, as long as the entirety is healthy.’

(Videotape P18N, first pregnancy)

The nurse, here as elsewhere, gives a medically and biologically correct explanation of the mechanisms by which the woman’s sugar levels affect the size and sugar levels of the foetus. However, the unborn and the pregnant woman are by no means totally
decontextualised or disconnected from their social/family contexts (see also Parry 2009; Bäckstrand 2004), or from expectations concerning maternal competences. The scene of activities is not entirely framed by the biological object, the foetus or the biochemical process between it and its maternal body. Rather, by naming the unborn as ‘a baby’ and then relating food intake with individual choices to be made during pregnancy, nurses render the situation into a site of moral education and even guilt for women who have the potential to harm their babies (see also Rothman 1989b, 95) and who should learn maternal responsibility. Often in the videos this is also done in reference to the whole family: new choices and changes in eating habits, as well as in alcohol use and in scheduling family time, are suggested both to partners and to pregnant women in the name of the ‘baby’. In all of these cases, then, the scientific explanation, whether medical or, for example, developmental-psychological, is mobilised to legitimate the social virtues and (family) values raised by the nurses.

When asking and advising about prior and current diseases and pregnancy symptoms, women are not nannied or patronised in this fashion at all. This is most likely because (excessive) weight gain, intoxicant use, (lack of or excessive) exercise and work-family balance issues are considered and further enacted at the clinics as (potential) causes (of pregnancy-related disease and social problems), and not as general symptoms of pregnancy (Rothman 1989b, 93). With weight gain in particular there is a long history of medical emphasis that has had major social and psychological implications for women, in that they have learned not to trust their bodies or themselves in pregnancy (ibid., 93–95).

The same is true of breastfeeding, which for some is an unachievable goal, as is losing weight while pregnant. However, breastfeeding is not just recommended because of its health implications for the child, as in the ethnographic snapshot above, or for the fact that it is supposed to speed up the woman’s recovery. It is also recommended for its perceived psychosocial benefits for the child. It is framed as a crucial early interaction and a bonding practice. And what woman would not want to engage in a bonding practice with her child? Breastfeeding is not, however, an issue that is usually discussed in detail during appointments in the early stages of pregnancy. If it is brought up it is just briefly touched
upon, as in the snapshot above. I will therefore return to it as we get to those later stages of pregnancy.

It seems that when it comes to causes of pregnancy-related diseases, such as diabetes and toxaemia, advice-giving at the first appointment, and later on as well, can be quite normative, and can imply that women are sources of potential harm to their babies and themselves. However, it would be unfair to claim that the nurses are invoking some unitary ideal of bodily control. ‘Pregnancy is not, however, a disease, and one should not be too strict,’ was how the nurse concluded the snapshot above. Women are even encouraged to take pleasure in this new freedom to consume (food).

Furthermore, especially in relation to beauty ideals and ideals of working life for women, the nurses do quite a bit of work to get women to go easy on themselves, albeit often on behalf of the best interest of the baby-to-be and in a style that implies a clear normative preference. There are numerous tiny dialogues about body image and weight issues that are repeated throughout the sequence of appointments; for example, after weighing them, nurses will compliment the pregnant women’s bellies and ‘check’ that their weight gain does not bother them: ‘This is not something that is preying on your mind, is it?’ (Videotape TP12N, 18 weeks of gestation).

The information and insights gathered and discussed during the first appointment do not only travel to different places via the casebook system, but also travel in time to the subsequent appointments. The nurses check the progression of things, be they physical, psychological or social in nature. The computerised casebook system plays a lesser role during the subsequent appointments, because after the first appointment it is only used briefly to retrieve information entered by doctors, ultrasound technicians, hospital staff or psychologists, and the results of routine tests and concerns raised in discussion are entered mainly after the appointments themselves are over. However, the case history, computerised or not, seems to reinforce the nurses’ concerns. Overall, it works as a distribution tool across different sites (contexts and places) and over time.
Addressing the futures in pregnancy

The beginning of the sequence of appointments is about getting slotted not just into the maternity healthcare system, but also into the system of maternity and paternity benefits. Maternity healthcare and the benefits system are linked together so that payments are conditional, as women are required to visit a nurse, midwife or doctor before the 16th week of pregnancy in order to be eligible for these benefits. During the application process, the healthcare professional who is visited – often the public health nurse – will write out a certificate of pregnancy, which is then sent to Kela (the Social Insurance Institution of Finland) along with the application forms completed by the parents-to-be.

Furthermore, the nurses are required to inform the parents about parental benefits (i.e. payments and leave) and child benefits at around 22 weeks of gestation. In practice the nurses give hands-on help with the tricky application procedure and filling out the forms. In this way the parents-to-be, especially the pregnant women, can go on leave if they submit their applications at least two months before the estimated date of birth. Partners’ benefits do not need to be decided at this time: they can be applied for later, if and when the couple decide to share the parental leave. This seems to lead to a situation where women (are advised to) submit applications as the sole beneficiaries of parental benefits (disregarding the three-week paternal leave and the so called ‘daddy month’ granted to all). The taken-for-granted assumption seems to be that women will stay at home with the baby for at least the first half of the parental leave. This is manifest in the appointment videos, for example, in default comments such as that ‘if a mother thinks that the father will stay home at the end of the period [of parental leave] when the child is about six to eight months old [then one can put that on the application form before the birth]’ (Videotape TP1N&M).

The logic behind this kind of thinking is most likely associated with the belief that women are the primary care-givers to children, especially to infants (see also Lammi-Taskula 2007). This belief is loosely tied to somewhat outdated biomedical and developmental-psychological thinking about the importance and benefits of nursing and breastfeeding.
However, given the state of current cooling technology for storing breast milk and the psychological reasoning according to which one caring adult parent, regardless of his/her sex, is sufficient for well balanced mental development, this argumentation does not hold. Furthermore, the choice of using six to eight months as the timeline for mother-infant togetherness interestingly coincides with current recommendations for the minimum duration of exclusive breastfeeding (e.g. Screening and collaboration in maternity healthcare 1999; WHO statement 2011).

Usually at around 20–22 weeks of gestation, during the third appointment, a birth referral to the hospital is submitted. Even though I was aware that most deliveries in Finland take place in hospitals, I was amazed that alternative birth methods were discussed in none of my video-recorded appointments. Delivery in a hospital setting seems to be a taken-for-granted value, one that does not even have to be put into words, either at the appointments or in the guideline documents (e.g. Handbook of maternity healthcare 2007). This is so also at the policy level, where support for hospital birth has a long history and is realised in the two-tier maternity health care system (prenatal care at clinics, births at hospitals) (Benoit et al. 2005, 727–728; Wrede & Benoit & Sandall 2001, 40). At the clinics, the nurses merely ask for consent to send in the information collected thus far, and, in my material, women themselves are attuned to this presupposition of hospitalised delivery.

During the same appointment, fears of giving birth are discussed. In cases of severe fear, a referral to a special outpatient clinic (Pelkopolikliniikka) is made, and a Caesarean section is only planned if the pregnant woman and the outpatient clinic staff fail to work out a vaginal birth delivery plan that eases the pregnant woman’s anxieties.

However, in such cases a discussion, or series of discussions, at the maternity health clinic precedes the birth referral. On a few occasions I was puzzled by the nurses’ tendency to push the decision about the birth mode (vaginal or Caesarean) into the future. I tended to

75 In 2010, according to the National Institute for Health and Welfare, among 61,371 births there were only twelve planned home births. During the same year, 61 unplanned deliveries outside hospital took place, and 20 of which there is no information. 57 babies were born on the way to the hospital (Newborns 2010).
interpret this as some sort of reluctance to take into account the pregnant woman’s concerns over delivery, as in the following description from one such interchange:

A pregnant woman and a nurse are talking about a counselling class arranged at the local hospital maternity ward. The nurse has just been explaining about all the counselling classes the municipality offers [two family counselling classes at the maternity health clinic and one on delivery at the hospital ward]. She explains that at around 35–36 weeks of gestation one should contact the hospital to attend the class. The agenda for the class is to go over ‘the normal course of delivery, pain relief, suction cup use […] and abnormal births as well’. At this point the pregnant woman first expresses her fear of medical instruments by saying that she has heard criticisms of the class, and that she cannot stand doctors’ equipment. They make her feel disgusted and she does not want to be near such things. She further asks the nurse’s opinion about whether she should attend at all. The nurse comments that ‘of course one does not have to go,’ and then goes on to explain all the ‘useful and good information’ one gets from the classes, saying that even women with fears and phobias about hospitals and delivery have found the class good. She then goes on to describe this useful information [tour of the ward, information about when to leave for the hospital and so on] and suggests that the woman could skip the second hour of the class when a video of a real birth and the instruments involved in birth are shown. ‘Good stuff that all women wonder about’ is her last comment on the issue, and then she moves on to ask the pregnant woman if her partner wants to attend the birth. The pregnant woman replies ‘yes, but we will see,’ and the nurse then explains about the family counselling classes the maternity healthcare clinic provides. The pregnant woman remains quiet at first, and then interrupts the nurse by repeating her worry about the delivery class and instruments. She emphasises her fear and her problem by saying that she even hates going to the dentist. At this point the nurse asks the pregnant woman how she thinks she will handle the birth itself if she is so worried about attending the instruction class. It turns out that in fact the pregnant woman does not know if she will be able to handle a vaginal birth because of her fear. She emphasises the problem further by reminding the nurse about her chronic stomach problem and her GP’s concerns. All the while the nurse seems be looking for chinks in the hope for a Caesarean section: she uses closed questions and comments, such as ‘but you don’t have this feeling that you absolutely want a section, do you’ and so on. The pregnant woman says that she is not sure how scared she is of vaginal birth, and that she has actually thought that she will just have to ‘survive’ the vaginal birth if there are no physical obstacles to it. Here the nurse seems to reassure the obviously worried woman by telling her that she will certainly refer her to the outpatient clinic, and that nowadays it is possible to perform a Caesarean without a purely medical reason. She talks about patient autonomy, and according to her characterisation a birth should be ‘an active event’ so that ‘nobody is forced into a vaginal delivery.’ However, the nurse wants the pregnant woman to calmly think things through, because ‘there is still a lot of time before [the estimated birth date] and
because ‘one might think differently later on [in pregnancy].’ The pregnant woman seems more relaxed now, and tells the nurse that she is happy to hear about these kinds of things. Still, they return to the issue of delivery twice before the end of the appointment. First the pregnant women worries about cultural conceptions according to which ‘one doesn’t become a mother before she has given birth.’ The nurse is quick to disregard such notions, and compares them to measuring motherhood in terms of breastfeeding, which not everyone is capable of doing. Furthermore, both of them agree that it is unfair to judge women who cannot give birth vaginally because of placenta blockage. Finally it is agreed that they will talk again after few months about the birth mode, and the nurse tells the pregnant woman how a Caesarean birth is planned.

(Videotape TP14N, 22 weeks of gestation, first pregnancy)

This video clip was one of the clips shown in the workshops arranged for the participant nurses after the actual fieldwork period. At the workshop, because the nurse did not want to say anything before us researchers, we started the conversation by pointing out to the nurse that she did not really answer the pregnant woman’s question about her opinion on whether or not she should attend the counseling class in the hospital and that she pushed the decision on referring the pregnant woman to the outpatient clinic to the future. This comment was based on our’ puzzlement over the nurses’ tendency to push the decision about the birth mode (vaginal or caesarian) into the future and interpretation of reluctance to take the woman’s concern into account. That is, in other words, reluctance to abide by the principle of Western medical ethics, namely beneficence. (Homanen 2012, 229.)

The nurse then explained in a frustrated manner that the pregnant woman asked her questions that she could not really answer, because, as the official protocol has it, women have to make the choice themselves. In this way, she, in fact, addressed the medical-ethical logic of doing care brought implicitly into discussion by us researchers but from another angle, from the principle of respect for informed choice and autonomy. Then, she went on to elaborate that her professional experience is that women change their minds about the birth mode, sometimes many times, as the pregnancy proceeds. Thus, it made no sense to her to make any definite decisions about the birth mode at this early stage of pregnancy. (Homanen 2012, 229.)
Going back to my notes back at the university office, the nurse’s comments started to make me reflect on my interpretations on what is going on in the video clip. By re-framing my inquiry to include her commentary I analysed the nurse’s meeting with the client as not just disregarding her client’s concerns or needs. The nurse’s elaboration allowed me to look at care work as work within which choice is not just some static activity but something that is achieved in a process of coming to know. I realized that the activities (in the video) and the nurses’ experience-based knowledge and accounts are constrained by the old ethical-medical mantras realized in terms of ‘patient autonomy’, birth as ‘active event’ and ‘parental choice’. This is the voice of the institutional order deriving from policy documents and nursing education. However, the nurses’ intention and perspective remake it or give new context to it whereby the realities of care lead to respect for informed choice as a process rather than a static activity. (Homanen 2012, 230.)

That is how ‘beneficence’ concerning the choice over birth mode in the working lives and experiences of the nurses is realised, and that is how it, as a institutional and standardising standard, ‘works’, I concluded in social scientific terms. The nurse does move the concern about giving birth into the future, ‘for one might think differently later on’ in pregnancy. Later, she will take action if the woman feels it necessary. She does not by any means deny the woman’s concern, but encourages her to do more pregnancy in order to know her preference for birth method. (Homanen 2012, 230.)

Furthermore, the nurse takes seriously the pregnant woman’s concerns over not fulfilling the cultural position of ideal motherhood according to which a woman is not ‘fully’ a mother if she does not give birth vaginally. The nurse comforts the pregnant woman and reassures her that this is not so, just as not being able to breastfeed cannot be equated with bad mothering. Not being able to give birth vaginally because of extreme fear is also equated, in collaboration with the pregnant woman, with not being able to do so because of a physical condition. It seems to me that we see here a manifestation of the common

Further, there is an overall tendency to express a preference for vaginal birth (and for preparing for it by attending the counselling class held in the hospital) both here and in other contexts of maternity healthcare, such as the family counselling classes I have observed on birth and baby care. There certainly is a strong emphasis on the physical risks of the Caesarean operation and the advantages of vaginal delivery for the woman’s physical recovery and the psychological transition to motherhood.
medical logic and official protocol according to which the primary reason for Caesarean section has to be of physical origin (see e.g. Rouhe & Halmesmäki & Saisto 2007) or rendered physical-like (in psychiatric diagnosis). In other words, fear is medicalised, defined in terms of bodily illness (see also Liljeroth 2009). As such, it appears socially unacceptable to accuse women of bad mothering – as if they had a choice.

Again we find ourselves in the midst of the problematics of choice in healthcare. On the one hand the notion of (informed) choice and autonomy appears as a taken-for-granted ‘good’ that ‘should’ organise healthcare activities. On the other hand, looking more carefully, it turns out that in practice the medical ethical repertoire of static choice operates merely as phrases in a dialogue that the nurses are required to utter, and obviously, in cases of ‘certainty’, to act upon. In my view, then, in maternity healthcare practices it is to a certain degree realised that a choice is a process (see also Kingdon 2007). Thus there are two logics of choice here, which are related, but in a frictional way.

Thus it is a question of not only the requirements of the protocol set for the particular appointment (in this case, assessing the birth method and making the referral), but also the individual social and psychological realities of the pregnant woman, as well as less formal knowledge of the procedural character of coming to know pregnancy concerns (in this case, the birth method). The beginning of pregnancy in the institutional setting of maternity healthcare is largely shaped by the filtering work of the formal systems of infrastructures (patient records, guidelines, benefits and hospitals) and their built-in classifications. However, the women (and men) get slotted not just into ‘the systems’, but also into fit and unfit mothering and fathering, and into positions as clients in institutional practices of maternity healthcare. This is further emphasised in the casualness of the care work.

77 Since the mid-1990s special attention has been given to treating birth-related fears, and special outpatient clinics have been established in hospitals with antenatal wards. The methods of care include discussions with midwives, doctors and psychiatrists, and psychotherapy and group therapy (Saisto 2000). In the Nordic countries the terms ‘fear of birth’ and ‘care for fear of birth’ have become institutionally established, whereas in some other Western countries the preferred terms have been ‘Caesarean on maternal request’ or ‘Caesarean on psychosocial indication’ (Rouhe & Halmesmäki & Saisto 2007; see also Liljeroth 2009).
Building rapport and solidarity

As discussed earlier, the atmosphere at the clinics is quite casual, informal and friendly, and the relationship between pregnant women and nurses was often referred to as ‘friendship-like’ and described in terms of ‘equality’ and ‘peer support’. Stepping into the clinics’ waiting rooms is like stepping into a half-nursery, half-health clinic. The floors are covered with scattered toys, crawling babies and playing preschool children. There are plants, colourful curtains, and walls and noticeboards full of colourful baby-related posters and adverts. The same is true of the appointment rooms: toys, children’s drawings, posters and baby care tables sit alongside the office equipment, examination couch and medical equipment.

Nurses try to arrange the chairs around their desks as if for an informal discussion, and when they do not need to use the computer they push themselves closer to the pregnant women and their partners. Children are welcome to come in and play with the toys, wander around the room and make a noise. They are also enacted as participants in conversations with the parents by talking about their doings, the Doppler heartbeat sound, their mothers’ being weighed and so on. It is not uncommon to hear discussions of the health and developmental issues of these children, even though the visit is maternity healthcare-oriented. Overall, the impression of the socio-material arrangements of the appointment is cosy, casual and informal.

Obviously, such a cosy and friendly atmosphere has professional implications and goals that are further emphasised by the style of the discussions and other activities (see also Kuronen 1994a; 1999). It is about building rapport and trust between the nurse and especially the pregnant woman. There seem to be numerous ways of doing this. The nurses give an impression that there is never too strict an agenda for the appointments (with the possible exception of the first appointment), so that older siblings’ issues and women’s (and men’s) individual concerns can be addressed. Casual conversation is used to keep...

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78 In small municipalities or remote municipal areas, the clinics are often situated in larger healthcare facilities, and thus the atmosphere may be a little more clinical (e.g. National Institute for Health and Welfare 2011).
track of pregnancy concerns, and even quite unrelated chatting is common. By their second and third appointments, some women carrying their first child are already complementing the nurse for being such a great nurse, and there is rarely any hesitation about telling her about very intimate issues and worries.

Even sharing the nurse’s own experience of pregnancy and motherhood is not uncommon:

It is a first appointment, and the pregnant woman and her partner (a man) have just asked whether the nurse will try to get the heartbeat sound. Since it is already at 11 weeks of gestation, the nurse promises to try. The partner comes to one side of the examination table, and the nurse stands on the other side. Before starting the procedure, the nurse assures the parents-to-be that there is nothing to worry about if she can’t get the heartbeat sound at this stage of pregnancy. While the nurse moves the sensor around the pregnant woman’s belly, the partner asks when the belly will start to grow. The nurse says that it is very individual, but that since the pregnant woman is very slim it will pop out quite soon. Then the nurse makes a reference to herself: ‘I am at 15 weeks of gestation myself now. I have this small, really small. This is from a second child though.’ At this point a big smile suffuses the pregnant woman’s face, and she and her partner look at each other. The nurse goes on to estimate that at around 16–20 weeks the pregnant woman will definitely notice the swelling of the belly herself.

(Videotape T5N&M, first pregnancy, first appointment, 11 weeks of gestation)

It is no surprise then that pregnant women describe their discussions with the nurses in terms of ‘peer support’ and other related phrases. Obviously not all nurses are pregnant themselves, but advice and information, sometimes quite clinical in content, is given through stories of one’s own or other observed pregnancies. Invoking memories of earlier pregnancies in pregnant women in their second or later pregnancies is also common. One can easily see that invoking and giving concrete examples and sharing experience is a powerful tool in building a trusting relationship compared with abstract advice-giving according to an institutional agenda. However, it is also a powerful tool to reinforce specific enactments of motherhood (and fatherhood) and baby-mother relations in pregnancy: that is, the enactments that individual nurses themselves value in their personal as well as professional lives.
Making reference to one’s own pregnancy, motherhood and experiences of family life can be understood as part of the agenda and as a working method which the nurses call ‘equality’. In fact, the nurses emphasise their own motherhood and family background as something that strengthens their professional skills. The nurses use terms such as ‘cooperation’, ‘empathising’ and ‘fellow-travelling’ when describing their relationship of ‘equality’ to me.

In addition to stressing that everybody is working as equals and in cooperation in pregnancy, the nurses highlight how, despite the difficulty, they strive to treat everybody ‘equally’ despite their background (such as class, age, ethnicity or civil status) or problems. It is almost too obvious, how beautifully these characterisations and the associated working methods coincide with the ideal of civil logic and equality applied to healthcare, and more specifically to the Finnish welfare system and politics. We have a historic public service that has been built and institutionalised on the basis of population-policy anxieties about different women’s lives, and which is granted to all free of charge in the name of the ‘common good’– how else could the work, as a matter of principle, really be characterised by those who do it?

Nor is it a surprise that, in the actual care practices, one can find a rationale of solidarity, justice, mutual respect and caring – the common denominators of both the logic or rationale of care and the logic of citizenship rights discussed in many prior studies of care (e.g. Mol 2008a; Harbens, Stollmayer & Mol 2002; Anttonen & Zechner 2009; Helén & Jauho (eds.) 2003). What has been less discussed, however, is how care work, as work associated with kindness, affection, belonging and rights, is specifically entangled with technologies, nature, and the science of conditions and objects such as pregnancy and the unborn.

**Teamwork**

According to my observations at the clinics, collaboration with both clients and other professionals and interactional skills in nursing in maternity healthcare are increasingly emphasised in order to reach working solutions for both clients and professionals. The
nurses reflect, and are trained and encouraged by the administration in different nursing interventions to reflect, constantly on their methods of interaction with client families at the appointments and with other professionals. Every six months, for example, the nurses attended a regular meeting arranged by the municipality to reflect on and assess their working methods, and they are encouraged to make an assessment of client interaction together with their clients whenever possible.

In the clinics where I conducted my fieldwork, interprofessional cooperative work was carried out in the so called multi-professional team meetings, in which experts are pooled together from the fields of early social and healthcare of children to solve the problems of families. According to the guidelines for multi-professional team work ‘[f]amilies in need of support have diverse problems, and cooperation of professionals from healthcare, mental health and social services is needed to support these families […] In a MCH clinic the public health nurse and the doctor are not solely responsible for supporting clients, but responsibility is shared with a multi-professional team’ (Kangaspunta and Värri 2007, 3–4; see also Kangaspunta et al. 2005; Aims and scope of the Family-centred MCH clinic 2008–2009; Hakulinen-Viitanen, Pelkonen and Haapakorva 2005).

In all the interviews and discussions I had with the nurses it was pointed out to me that, in practice, collaboration and interaction with not just clients, but with other professionals as well, involves a process of building rapport and trust and informal conversation. Teamwork with other professionals involves collaboration and interactional skills that are not based so much on building trust and rapport or carefully getting to know others in

79 The guidelines also specify the requisite members of the team: a social worker from child services, two family care workers, an obstetrician/paediatrician, a psychologist, two public healthcare nurses, in alternate team meetings a social worker from a family counselling centre, and a day care representative when needed. Additionally, these guidelines also include rules designed to provide the foundation for the organisation of team work. The team must choose a new leader periodically amongst the team, and this leader works as a secretary for the team meetings. (e.g. Kangaspunta & Värri 2007.) Each member should bring in cases to discuss in multi-professional meetings and, where possible, they should invite families for a consultation meeting. In practice, at the clinics where I did my fieldwork, the nurses were the permanent team leaders and they invited all the families to come to the meetings, and proposed the most cases to be considered at the meetings. The general view, as well as the operating principle, was that the team works as a consultation aid for the nurses, especially in the doctors’ opinion (interviews). So the client flow is not redirected in a large degree here; they still travel into the other welfare services in accordance with the nurses’ judgment.
order to get them to reflect or share information. Rather, they involve negotiations about how to coordinate different professional agendas and knowledge of aspects of family life as well as possible for the individual family in question. A cooperative agreement must be found between social workers who work with ‘responsible parents’, ‘children in need of protection’ and ‘families in need of financial aid’; psychologists who are concerned with family relations and family members’ emotional life; doctors who attend to the physicalities of pregnancy, the foetus and small children; and, finally, family care workers who do hands-on work with the materialities of home life and child care. The nurses seem to be intermediary actors who have some authority for all the ‘clients’ visiting the clinics.

The atmosphere in the multi-professional team meetings at the clinics every two to three weeks was very friendly, and resembled more an informal conversation among equal colleagues than a formal consultation with professionals from different structural positions in the institution, with different educational backgrounds and different kinds of work experience. In the meetings held in the clinics’ coffee rooms or seminar rooms, all the professionals commented on nearly all the issues that came up about the families’ lives regardless of their field of expertise and formal professional agenda. The result was that the practical details and objectives of each professional suggestion were opened up and even forced open when different professionals called on each other to argue for their suggestions for action. Furthermore, regular meetings treated teamwork as a process: if something had gone wrong earlier, what was it that had gone wrong with the actions? How could we make a better assessment now? It is impossible to be sure what the best course of action is, and what the consequences of each decision might be, but in a team one does not have to think this through alone (see also Mol 2008a).

In general, then, it can be said that nursing in the institution of Finnish maternity healthcare is work in which client-families and various health and social care professionals participate as equal partners in enhancing child health, development and family welfare. This is in line with recent national and municipal recommendations that suggest a discursive shift from protectionist education to working in a collaborative manner in
multiple partnerships (see also Ministry of Social Affairs and Health 2004; Handbook of Maternity Healthcare 2007; Jallinoja 2006).

4.2 The emergence of the unborn

‘Babies’, ‘babies-to-be’, ‘foetuses’ or ‘womblings’ as the unborn are sometimes called at the clinics or their best interests are not the same from site to site or time to time. Rather they are multiple, as are other concerns in pregnancy, and they travel in accordance with the progression of pregnancy and the logic of the sequence of appointments. The nurses have told me that in general evoking mental images of the baby-to-be’s personality, kin attributes and early interactions – talking about babies and children, in general – is something that they focus on later in pregnancy.

However, babies and children do appear even at the first appointments. First of all, the unborn are occasionally called babies and children even at the beginning of pregnancy. This is not done consistently in the early stages, but of course it has consequences nonetheless. For instance, pregnant women have told me about their feelings of bewilderment when nurses talk about babies at a stage when they have hardly grasped that they are pregnant themselves.

It is not just a question of occasional naming of the unborn, however. Not only are the unborn objects of care or harm, they also do things, as in the following ethnographic description of a first appointment:

_The nurse is interviewing the pregnant woman about her use of milk products. The pregnant woman has stated on her form that she drinks two or three glasses of milk a day. The nurse asks an additional question about whether the pregnant woman eats yoghurts and other such products. Turns out that she has sour whole milk a few times a week. Altogether, then, the amount of calcium she gets a day is too small for the needs of a pregnant woman. The nurse comments on this and explains the extra need of about 200 milligrams by saying that ‘as a woman you need calcium. The baby will take all she/he needs but if you don’t take care of your calcium intake during pregnancy you will make your bones very brittle.’ Then she goes on to talk about the extra need for vitamin D during pregnancy and breastfeeding and other nutritional concerns in pregnancy._

(Videotape T7N, first pregnancy)
Thus not only do pregnant women do things to their unborn, but the opposite also occurs, even in the early stages of pregnancy and during the first visits to the clinics. The unborn ‘take’, ‘need’ and ‘require’, and it seems to be a maternal responsibility to attend to these needs and requirements. One can see that addressing nutritional issues in pregnancy by using a rhetoric of foetal demand and maternal supply has the potential to affect pregnant women’s sense of self and activities quite differently than, for example, reassuring them that the foetus will get all its nutrition from the maternal body.

Despite all these doings associated with the unborn, however, it is apparent that they are enacted more vaguely and are more like a developing human life, or potential for human life, in general. Social, ethical or moral issues to do with the unborn are by no means marginalised, but they are secondary objects of concern at the beginning.

The unborn also arise as a specific issue in discussions about screenings for foetal abnormalities, which are raised as early as the first appointment. This is because the first ultrasound, the nuchal translucency screening, is done during the 13th week of gestation, and thus before the nurse and pregnant woman meet for the second time. Surprisingly, the nurses are rather reticent about the screenings. They often refer to the material sent in advance, and sometimes just ask if the pregnant woman and her partner have decided to go. If they do give any further elaboration, they usually restrict themselves to ‘neutral’ information like this about screening, and emphasising informed choice in the decision about attending:

_The nurse has been entering information about the pregnant woman’s last menstruation, and since the pregnant woman has already been to an additional ultrasound because of some bleeding she asks to see some documentation from the ultrasound to find out the estimated birth date. The discussion turns to the standard ultrasound when the nurse makes a reference to the brochure about screenings that was sent by post, and asks if the pregnant woman and her partner have thought about choosing to go to the screenings. The pregnant woman says yes, and the nurse books an appointment via the computerised booking system. Then she starts to explain what one can and cannot see at the ultrasound: ‘The so called 13th week ultrasound is this nuchal translucency screening, and it is the measurement of the back of the neck that is mainly looked at. It is possible_
that all the structures don’t show yet, for example, often the structures of the heart, because of the foetus’s position and the place of the placenta [...] so they don’t show. They [technician, nurse] will automatically give you a new appointment for the 20th week [if they cannot get enough information from the picture]. But the measurement of the neck one can get, and to estimate how far along the pregnancy is and to check the placenta.’ Later the nurse assures the woman, who asks about further screenings, that she will be getting another ultrasound in the late stages of pregnancy, if there are worries over the size or the position of the unborn.

(Videotape P40, second pregnancy, first child)

It is close to the end of a first appointment. All the information-gathering and standard advice-giving have been completed, and the pregnant woman and the nurse have gone to the laboratory room to test the pregnant woman’s urine for sugar and protein. The pregnant woman’s [male] partner stays in the appointment room. When the nurse returns, he asks when one can know that the child is healthy. The nurse explains that no one can guarantee it with a hundred per cent certainty. The man qualifies his question by asking: ‘as far as it is possible to know?’ The nurse responds by elaborating on the procedure: ‘Well, in the first ultrasound examination, structures are looked at. So one is able to see that there are no severe structural defects. They [technician, nurse] measure and look at the length of the thighbone and the girth of the head, and then they relate these to normal measurements. And then it is possible already to see things about internal organs and the heart and things like that.’ After a little pause the nurse goes on to repeat that the examination leaves many uncertainties, and then asks the partner whether they have thought about what to do in the situation of an abnormal finding. The partner then bypasses the question by merely saying that they will just think things through as they come. The nurse pauses for a while as if waiting for further elaboration, and then starts talking about how the pregnant woman is still young and that disabilities and so on are more likely when the maternal age gets higher.

(Videotape T5NM, first pregnancy)

Nowhere in the sequences of explaining the screening procedure and examination – here or in the other videos – is there really reference to the unborn as more than a foetus in the purely technical terms of the ultrasound technology’s capabilities: ‘structures’, ‘measurements’, ‘lengths’ and ‘girths’ of necks, heads and bones. The technology appears as a realistic, transparent and a direct gaze into the womb at its occupant in a ‘natural’ bodily process and at the possible environmental factors, such as in cases of genetic abnormality or lifestyle-related syndromes (cf. Eräsaari 1997). Women may consequently appear as merely maternal bodies – and thus as the sum of their lifestyle (see also Markens
& Browner & Press 1997), age and genotype – and their relation to the unborn as that of quantifiable cause and effect and an indicator of possible defect.80

Purely technical and medical foetuses and maternal bodies, however, only exist in theory, in systems such as medical classifications (the International Classification of Disease, for example). Furthermore, the technology’s lack of ability to see everything, and the remaining doubt and uncertainty of the examination results, are also realised in practices (see also Schwennesen & Koch 2012). It is not just that the early ultrasound at 13 weeks’ gestation is not sharp enough, but also that the screenings are never sharp enough. Even the brochures on screening sent to the parents-to-be take note of this and other related uncertainties, such as the risk of miscarriage associated with the most common further screenings (amniocentesis and chorionic villus sampling).

The leaflets reveal that the screenings disclose ’50 % of the major structural deformities, almost 100% of structural defects of the brain, but only 10–15 % of heart hamartia’ (Foetal screenings I). On the other hand, it is said that even ‘a normal finding does not guarantee a healthy child at birth,’ (Foetal screenings I; Foetal screenings II) and ‘only in one in four of the pregnancies that have tested positive in the nuchal translucency test and/or serum test show anomalous chromosomes in the amniocentesis or chorionic villus sampling tests’ (Foetal screenings II). Furthermore, the leaflets, as well as the nurses’ choice of approach, take patient autonomy as a self-evidently good by stressing (in bold) in five separate paragraphs within six pages of text that the choice to attend the screenings is and should be voluntary, and that the difficult decision about further ‘care’, which usually means terminating the pregnancy, is one that only the parents have ‘a right’ to make.

In all, both the leaflets and the nurses’ answers and explanations at the clinics are framed by a medical ethical repertoire in alliance with biomedical (population-based) knowledge of mechanisms for the genesis of abnormalities. Similar observations on distanced and (seemingly) neutral science-oriented approaches have been made in studies of genetic

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80 The partner’s lifestyle and genotype are also addressed, but rarely in reference to ultrasound screenings.
counselling, for example, in Finland and in the United States (Meskus 2009, 176–179; Rapp 2000, 63–73).

This is also in line with the local and national instructions and recommendations. They are quite technically oriented instructions, and ethical considerations are scarce (e.g. Handbook of maternity healthcare 2007; Screenings and collaboration in maternity healthcare 1999). Yet there is some discussion:

Screenings should be considered ethically as well, because screening decisions draw from both [medical] knowledge and values. […] The decision to attend the screenings and how to use the results of the test is the responsibility of the parents. The task of the community is to support the parents in finding the right decision for them and bearing the consequences. […] The power to decide does not mean that they are responsible for their child’s disability if they do not want to attend the screenings or have the pregnancy terminated. […] It is ethically wrong to make anyone confront this kind of question [to attend the screenings and decide what to do with the test results] without preparation. […] Pregnant women are to have adequate information on the decisions that attending the screenings might require beforehand.

(Screenings and collaboration in maternity healthcare 1999, 48–49)

The medical ethical and/or biomedical reasoning linked to policy guidelines is not, however, the only way of referring to screenings. It seems that it governs reasoning only when decisions about attending are discussed. After the actual screenings, in cases where there are no serious findings, and even during the appointment when decisions about attending have to be made, the rationale changes. Take for example the appointment just quoted above. Later during the same appointment:

The pregnant woman and the nurse are finishing up the first appointment. Before going to the laboratory room to check the urine sample for protein, the nurse reminds the pregnant woman that her man is welcome to attend appointments in the future. They joke a little bit about the partner’s forthcoming summer vacation: ‘then he can’t use work as an excuse not to come to the clinic.’ The nurse gets serious and lists the appointments that might be of special interest for the partner. ‘When we start to talk about family counselling classes, it would be very nice if you both could attend them, and ultrasound appointments are good and make the pregnancy concrete […] this proof that many seem to need.’
When comparing the earlier snapshot to this one, one can see that there is a shift in repertoire. Here the ultrasound still appears as a neutral medium and evidence-making machine, but not so much for the physical attributes of the foetus as for foetal and pregnant reality. What is being sought is the paternal response to pregnancy. Inviting partners to be participants in pregnancy in this way can be understood as invoking the start of a bonding process within which paternal (and maternal) selves are conceived, as are their foetuses, babies and children.

Furthermore, instinctual and bodily knowledge from within oneself about the unborn is evoked in association with ultrasound-mediated knowledge. Sometimes this instinctual gut experience of something clashes with the ultrasound information, and sometimes it coincides with it, as in the following description from an appointment:

The pregnant woman is lying on the examination couch and the nurse is measuring the size of her uterus. They chat casually about how it has started to get uncomfortable for the pregnant woman to sleep on her belly. Suddenly the nurse asks the pregnant woman whether she and her partner have asked about the gender of their unborn at the ultrasound appointments [they went to the 20 weeks’ gestation ultrasound]. The pregnant woman grins and says that it is a boy. The nurse asks if the pregnant woman had any ‘feelings’ prior to the ultrasound [about the gender]. The pregnant woman admits that she had started to think that it was a boy. ‘It is just this feeling that one has,’ the nurse agrees, and moves on to find the foetal heartbeat.

(Videotape TP17N, first pregnancy, 22 weeks of gestation)

Here it is implied that the ultrasound technology confirms the premonition-like bodily knowledge women may have of their unborn. It is as if there are feminine qualities that mystically enable us to know from within such things as the foetal sex, in this case, but also about foetal health. To provoke such qualities and affects is, in my view, to mystify (female) nature. However, it also erodes the omniscience of the ultrasound technology by giving precedence, on occasion at least, to maternal experience-based estimates over technological measurements. Technology in a way allows women to know something that they already knew in maternity health care practices.
Making foetuses, babies, children and persons in general and in specific family relations in care practices is not just an issue of different agendas and concerns. It is also a temporal issue. It could be said that when pregnant women and their partners are introduced to foetal screenings, biomedicine, technoscience – ‘the facts’ – and family values and virtues are just starting to get mixed together.

Shifting the repertoire from the value-laden unborn with social ties to ‘scientification’ and talking about the unborn in clinical and technical terms can be understood as orienting to the unpredictability of pregnancy and screenings. This is something that the nurses also are aware of: they try not to personify the unborn in any way, so as to ease the anxieties women (and men, and even the nurses themselves) might have concerning the foetal screenings. For some nurses there appears to be an acknowledged timeline according to which unpersonalised foetuses belong to the beginning of pregnancy and personalised babies to the later stages of pregnancy:

*Q: I noted when you described your work in general that it includes discussion and on the other hand screening and guidance. When you said that it is about screening the health of the mother and the foetus. So how do you talk about the foetus here at the clinic, or do you? Does it vary according to the situation or something?*

*A: Often, when I think about it now, I say […] probably I use the word foetus more in the beginning of pregnancy. Then when the pregnancy progresses into the second half and further, then it does change into a baby, it is then a baby. The reason why there is this divide is that when you go over 20 weeks of gestation and beyond the child can survive [premature birth]. If it is born earlier ‘foetus’ is maybe a bit less of a personal expression, if one has a miscarriage or developmental disorders [that have been diagnosed in the screenings]. I am not sure whether we are protecting the clients or ourselves but one does tend to use that word [foetus] more often.*

*(Public health nurse 3, age group 20–30)*

So the repertoire shifts not just because of the unpredictability of the screenings and for the sake of managing emotions concerning them, but also because of the unpredictability of (premature) birth and miscarriage. This coincides with pregnant women’s hesitation to personalise the unborn, to rearrange the material setting of the home and to share their
pregnancies with others before 12 weeks of gestation when the probability of a miscarriage reduces significantly and around which the first screening results come in (discussed in more detail in the previous chapter). The pregnant women and the nurses who often have more medical knowledge thus attune themselves to medical calculations of probability and estimations of the worthiness of human life.

There is, in fact, a shift in care work in relation to enacting the unborn and its relation to its mother and mothering later in pregnancy, as implied in the above quotation. However, as already discussed in relation to the first screening and giving information and advice, the unborn is more than ‘the foetus’ in medical-technical depersonalised terms in the early stages in pregnancy. This is especially so in the case of two routine examinations – listening to the foetal heartbeat and enquiring about foetal movements – and in the numerous leaflets and brochures sent and handed out to pregnant women.

The foetal heartbeat can be heard at around 12–14 weeks of gestation, sometimes even earlier. Depending on the length of gestation when the pregnant woman attends the clinic for the first time, the foetal heartbeat is heard for the first time during the first or second visit. The unborn, be they called foetuses or babies or whatever at this point, do a lot of different things after the foetal Doppler device’s sensor touches the pregnant woman’s belly. Let’s look at one of my ethnographic descriptions of one such event:

*It is near the end of the appointment, and after weighing her the nurse leads the pregnant woman to the examination couch to get the foetal heartbeat. The nurse explains she will now do some external examinations: measuring the length of the uterus from the pubic bone to the belly button area, and taking the foetal heartbeat [in fact, later she will also feel the position of the foetus]. While doing the measuring she asks whether the pregnant woman has had any pinching feelings in the belly [uterus growing pains], and makes a remark about men not being capable of growing a muscle that doubles in size. The length of the uterus/belly is 18 centimetres, and the nurse explains that this will work as a starting value for comparison at later stages. She further explains that the measurement is compared to a curve [drawn on the basis of mean values], and reassures the woman that her measurement value is just normal, and that anyway the rate of growth is individual in any case. The nurse prepares the Doppler machine, spreads gel on the woman’s lower abdomen and starts moving the sensor around the area. She comments that [the unborn] seems active [moves*
from under the sensor]. Then she states that the heart rate of the unborn is 150 times per minute, and explains that the pregnant woman’s and the unborn’s heart rates are out of phase [this explains how one can distinguish the foetal heartbeat from the maternal heartbeat]. The pregnant woman then starts to talk about her ultrasound screening: the unborn seemed active there too, and the technician could not get a proper picture at all. The unborn was ‘just showing the back of its head’. When the nurse and pregnant woman return to their seats the pregnant woman finishes her story by saying that the unborn must have been nervous about the ultrasound, because it kept on shifting away from under the ultrasound machine sensor.

(Videotape T15N, first pregnancy, 20 weeks of gestation)

Both the pregnant women and the nurses enact ‘active’, ‘moving’, and ‘nervous’ qualities for the unborn in dialogues involved in measuring the foetal heartbeat. The Doppler technology, in turn, seems to set the boundaries of the kinds of qualities that can emerge, in that the sensor has to be directly over the foetal body to get the heartbeat sound. If the unborn moves away or turns around a lot, the measurement cannot be accurately obtained. Thus the vocabulary with which the activity of qualifying the unborn is performed is that of motion. The unborn often do things, as well as are things, of movement: they ‘flee’, ‘roll around’, ‘turn’, ‘stretch’ and so on. It is this (detected) physical movement that appears to evoke characterisations of activity, nervousness and so forth.

In the ethnographic description above, the particularity of the somatic experience of pregnancy, which women have and men lack, is also implied. It is not pronounced here, but my interpretation is that it is the lack of bodily experience of pregnancy, as well as lack of the physical relationship with the foetus, in coming to know and doing pregnancy and the unborn that is behind the strong encouragement given to men (partners) to attend screenings (a physical experience of seeing) and other appointments where parenthood is discussed. This is often implied in suggestions such as ‘getting proof’, making the pregnancy ‘real’ or ‘concrete’ and so on. At the same time, however, partners, usually men, are assigned a quite narrow and stereotypical position in pregnancy as a technology- and knowledge-oriented witness who is engaged by appealing to these (perceived) masculine traits.
By 16–20 weeks of gestation, pregnant women should start to feel foetal movements in their belly. As part of the maternity healthcare appointments from around those weeks of gestation, the nurses ask about foetal movements and contractions. The formal agenda for this is that abnormal foetal movements and contractions may be signs of problems, with foetal health in the former case or of early labour in the latter (Handbook of maternity healthcare 2007). However, in practice, monitoring these ‘facts’ of individual pregnancies is not the end of the story, for physical rhythms (of movement and contraction) are simultaneously transformed into social (inter)actions and relations.

Here is an appointment snapshot in which the pregnant woman, her partner and the nurse discuss feeling the foetal movements and contractions:

The nurse asks the pregnant woman if she has felt the foetal movements clearly yet. The pregnant woman gives an affirmative answer, and the nurse turns to the (male) partner to ask if the movements are so strong that one can feel them on the top of the belly. The partner says yes. The nurse then suggests that in this way the partner is given access [to participate in pregnancy, to be part of the pregnancy] in a different way. The partner starts saying that the pregnant woman did not at first realise that it was foetal movements that she was feeling. He goes on that he himself was not at first sure whether it was a kick that he was feeling [with his hand], but now that they have both got used to it it is easier to tell. The nurse says something about the feelings of movement being related to the overall anatomy of the individual pregnant woman, and then goes on to ask if the couple has been able to detect a rhythm of any kind in the movements. The pregnant woman tells that she has just noticed that sometimes the unborn moves a lot, sometimes a little less and sometimes not at all. The nurse concludes that the pregnant women has experienced ‘sleeping periods’ [of the unborn] and the unborn reacting to the pregnant woman’s ‘pace’ by saying that ‘if you have this fast-paced day she/he [the unborn] will wonder what is going on and when it is calm then it is [different].’ Then the nurse moves on to enquire about contractions by asking whether the pregnant woman has had this feeling of stiffness in her belly. The pregnant woman has experienced it, and they start discussing when she has felt it and how it feels. The nurse explains the reasons for feeling these kinds of contraction at this stage of pregnancy by saying that they are ‘a response to it [the foetus] starting to turn around, and the foetus starts to stretch the uterus as a space’. Then she moves on to describe abnormal contractions that need medical attention.

(Videotape TP1N&M, 21+3 weeks of gestation, first pregnancy)
What I want to highlight here is what the nurse does after it is established that there are foetal movements that the pregnant woman can feel. She involves the partner in the discussion (and thus in the physical experience of pregnancy), and then tries to establish some rhythm in the foetal movements with the pregnant woman. When she fails to do so, she educates the pregnant woman about the foetal movements’ connectedness with her doings by telling her what the unborn ‘does’ and ‘thinks’ when it reacts. In effect, it is established that women (and men) can (socially) influence their unborn by managing their own rhythms.

Although there is a suggestion to the parents to engage in interaction with their unborn, or at least to think about it in terms of daily rhythms or activities, it cannot be said that foetal personality is really invoked here. This is further emphasised when the nurse addresses early contractions: the unborn is certainly doing things, but in quite technical terms which cannot be associated with specific personality traits or kin relations. Whether enacted as a particular being or not, at these stages of pregnancy, the unborn is still a maternal/paternal responsibility.

**4.3 Probing and observing the materialities of/and family life**

Around the beginning of the third trimester, at around 30 weeks of gestation, it could be said that the actual coaching into parenthood begins at the clinics. The nurses themselves acknowledge the shift in caring for pregnancies, and according to them the timing has to do with the psychological transition into parenthood and the practicalities of pregnancy. What is meant by this is, first, that by 30 weeks of gestation pregnant women and their partners should already have mental images of their unborn and of themselves as parents, and that those images should be reflected upon. Second, there seems to be a common understanding about the physicalities, sensations and symptoms of pregnancy, transforming pregnant women into mothers as pregnancy progresses. For partners, since there is no somatic experience, encouragement and steering appears as necessary in the practices.
Finally, the third trimester is described as a practical time to explicitly address issues of parent-child relations, interaction, everyday life and its material foundations. The nurses have told me that it would not really be practical to discuss issues to do with buying baby goods or parenting when the pregnant women and their partners have barely come to terms with their pregnancies. The more topical matters of concern in the beginning are the physicalities of pregnancy, the here-and-now social and psychological problems that pregnant women and men might have, and the planning and discussion of nearer futures in pregnancy, such as the birth method, family benefits and screenings.

The transformation in matters of concern can also be found in the guideline material. In the local instructions for nurses, the *Handbook of maternity healthcare* (2007), which is organised according to each visit, a family-related agenda is assigned to the family counselling classes (at 28–30 weeks of gestation), and the two appointments at 30–32 and 32–34 weeks of gestation. There is also separate guideline material for the counselling classes (Family counselling files 2008).

During the counselling classes and appointments, the nurses must initiate (and continue) conversations and assess the pregnant women and their partners on ‘breastfeeding’, ‘partnership’, ‘parenthood’ and ‘support persons’, and inform them about the family care workers available for families with small children. Issues of baby care and physical recovery from pregnancy are assigned only to the counselling classes (Handbook of maternity healthcare 2007; Family counselling files 2008).

As it stands, there are various modes and styles of addressing and assessing the psychological and social concerns of family life. In the guideline material the instructions are short and vague, and reference is made to a seven-page chapter on interviewing and the psychological development of infants and family relations (Handbook of maternity healthcare 2007) and to the *Family counselling files* (2008), which is a longer text but is pitched at quite an abstract level of knowledge of parenthood and so on. Furthermore, the nurses have all had training in interviewing and early interaction in families, the content of which according to my inquiries is consistent with the *Manual for training of primary care*
staff (Davis et al. 2001, European Early Promotion Project). The training for the implementation of the new family-centred MCH care model, which I attended in the spring of 2007, addresses issues of family relations and interviewing, with specific protocols for raising and assessing related concerns. This new intervention also introduced home visits during late-term pregnancy.

Despite all these protocols and guidance, the nurses feel that their professional skills are inadequate to address ‘psychological’ and ‘social’ issues. They seem to identify more with concerns related to the physicalities of pregnancy, although it is acknowledged that the nursing approach is quite different from that of doctoring. In Geoffrey Bowker’s and Susan Leigh Star’s (1999, 265) words, nurses are ‘the humanist counterbalance to an increasingly technology-driven medical profession’. The public health nurses are keener on informal methods, which they call ‘probing’, than on using (structural) forms when screening for problems. ‘Probing’ can be understood as intuitive and practice-oriented clinical decision-making, often assigned to nursing, as opposed to the more visible, measurable and transparent doctoring (in e.g. ibid., 229–254). However, the existing guidelines and procedures, and the categorisations embedded in them, have to be fitted together with the somewhat infinite and unaccountable logic of nursing.

As a consequence, attending to parenting and family concerns takes multiple forms at the clinics where I did my fieldwork, to say the least. The informal and working experience meets the formal and new administrative interventions. In the future the practice of using the assessment form and related working methods will probably be more fully and consistently applied to care work, and the obvious awkwardness that comes with the early stages of any new organisation of work will vanish.81

81 In fact, it can be presumed that standardised working methods focusing on psychosocial support and assessment will or have become more widely used, because in 2009 the Council of State passed an Act making it mandatory for municipalities to provide welfare assessments of the whole family at specific points in pregnancy and childhood (Council of State Act on MCH care, school and student healthcare and preventative dental care for youth 380/2009)
Time for transformations

Family counselling has a long history in Finland. It has its roots in the institutionalisation of maternity healthcare in the 1940s, when exercise classes were arranged to improve maternal health (Paunonen & Vehviläinen-Julkunen 1999, 169). In the 1960s counselling was labelled maternal counselling, and by that time it included a focus on psychological development, mental well-being and preventive care (Yesilova 2009, 49–81). In the late 1970s and 1980s yet another shift in focus took place. In policy-level discussions birth and childbearing were emphasised as an event for the whole family, and the counselling was renamed family counselling (Paunonen & Vehviläinen-Julkunen 1999, 169; Viljamaa 2003, 37). Fathers were both included and conditioned to take part, as attending was a precondition for accompanying pregnant women during delivery (Viljamaa 2003, 37). Riitta Pietilä-Hella (2010, 56) has noted that inviting fathers (not gender-neutral ‘partners’) to participate transformed the agenda for counselling, from preventing clear-cut physiological and psychological complications to pursuing more abstract well-being and health in terms of ‘motherhood’, ‘fatherhood’ and ‘parenthood’.

In recent years the concerns over parenthood, the well-being of families and family relations has intensified (Jallinoja 2006; Takala 2005, 7; in relations to fathers specifically Kuronen 2003, 109–112; to mothers Tyler 2005). It is not surprising that transformations in counselling and the tone of discussions are in line with transformations in the whole of maternity healthcare. However, as there are no state requirements for municipalities to arrange classes (separate from appointments), the form and content of counselling varies considerably among municipalities. In 2007, two per cent of all the maternity healthcare clinics in the country arranged no family counselling at all (Hakulinen-Viitanen et al. 2008, 3, 28), and it has been reported in several surveys in the 2000s that there are huge differences among municipalities according to implementation and quality of service (Hakulinen-Viitanen & Pelkonen & Haapakorva 2005; Hakulinen-Viitanen et al. 2008; see also Julkunen 2006, 162).
Despite such differences in implementation, there is a common emphasis on ‘peer support’ and ‘group work’ in counselling in public administration documents and guideline material (Ministry of Social Affairs and Health 2004; Family counselling files 2008). ‘Peer support’ and ‘peer-group work activities’ are concepts that were frequently used in policy documents in the beginning of 2000s. Pietilä-Hella (2010, 179–181) argues in her study of family counselling that such a shift from protectionist education to multiple partnerships in healthcare counselling can be understood as a shift from welfare-state model activities to project-society/civic-society model activities, in which ‘patients’ and ‘citizens’ actively exercise choice to participate (or not) and work in partnership.

In the municipality where I conducted my fieldwork, four different classes were implemented for all families expecting their first child. These included the themes of breastfeeding, baby care, parenthood and partnership. The first two classes were held in one one- or two-hour meeting, as were the last two. During my fieldwork I heard about an occasional ‘fatherhood class’ in which men attending the clinics were invited to participate. The classes were instructed by either a ‘male work professional’ (äijätö) or a male employee from the local parish. However, I had no chance to participate since women were excluded from attending such classes. Because I was not granted access, I cannot address the fatherhood classes here, but it seems worth noting that men (not even ‘partners’) are offered forums for ‘peer support’ or establishing networks in the realm of family issues, in addition to being invited to attend the appointments and to ‘attend’ the pregnancies. There has been a lot of public debate about and interventions implemented to include men (often partners as ‘men’, and with the emphasis on the nuclear family) (Lammi-Taskula 2007; Aalto 2004) in maternity healthcare. I was familiar with the extensive debate on the issue when I started my fieldwork, and was surprised at the extent to which men are offered activities at the clinics, even gender-exclusive activities.

The formal agenda for the counselling, as is suggested in the guideline material, is to ‘establish optimal premises for the times of pregnancy, delivery and puerperium’ and ‘to support the physical, mental and social well-being of the whole family’. Throughout the material, various small group work assignments are suggested to promote ‘self-reflection’
and ‘self-evaluation’ by both the parents-to-be and the nurse-instructor on issues of family life, transformations into parenthood, and partnership. An additional aim is to establish peer relationships between expectant families. (e.g. Family counselling files 2008.) Overall, the guideline material coincides perfectly with policy ethos on ‘equal’ partnership between all the participants.

All eight of the counselling classes I attended were held after office hours and in the clinics, as is customary. Chairs were gathered either into the waiting room or in a conference room if one was available. An overhead projector and VCR were often used to show transparencies and a video on breastfeeding and baby care during the class, and there was a table already covered with baby equipment, from breast pumps to dummies, when the parents-to-be arrived. While the initial setting gave the impression of a classroom for baby issues, the space was transformed when the group work commenced. Chairs were pulled together to form small circles around the room and women and men were encouraged to come and explore the baby equipment hands-on.

The classes consisted of general information and advice, both in lecture form and in the form of small-group work, and discussion of the particular worries the parents-to-be might bring to the discussion. Formally, the counselling classes are the first occasion when the futures of baby life are addressed, including the physical, mental and socio-material transformations required. As suggested above, these issues do tend to arise at the earlier appointments, but then the discussions are tied to different contexts and are not on the formal agenda. In addition to group assignments and information, the nurses use a baby doll and other equipment to demonstrate hands-on the different positions for breastfeeding, newborn anatomy, position in the uterus and so on. At one of the clinics the nurses also arranged a ‘breastfeeding model’ to come in with her newborn and give an experienced-based account of giving birth, breastfeeding and baby care. Sometimes the classes had other visitors as well, such as a representative from a local breastfeeding support group or a family worker from the municipality.
In the group-work assignments the parents-to-be were divided either into couples or into two groups according to gender. Men and women, then, were advised to think through the pros and cons of breastfeeding, changes, expectations and hopes, for life in general and in relation to the relationship with one’s partner, and more specific and practical aspects of surviving family life and caring for one’s partner. This seemed to be a good way to get the parents-to-be talking, compared to the silent groups at classes where more slides, videos and lecturing was used.

Overall, there is a jump in the focus of interest and object of care in the family counselling compared to the preceding appointment work. It is no longer futures of pregnancy that are addressed, but futures following birth. Preparatory work is expected of the parents-to-be during pregnancy here as well as in earlier encounters at the clinics, but the counselling classes seem to initiate work directed at mental preparation or mental transformation into family relations in all their socio-material settings.

The parents-to-be are asked to reflect, at a class meeting or later among themselves, on their capacities and potential for physical, psychological and social relationships in family life. The nurses do give concrete and direct advice and information when it comes to ‘facts’ about bodily physicalities, such as the nutritional needs of the newborn, physical complications after or during the birth and so on, but they seem to avoid giving highly normative comments on mothering, fathering and family life. Rather, they talk about ‘sufficient parenthood’, which obviously draws from cultural competences assigned to parenthood but remains surprising vague.

Clinical ‘facts’ such as nutritional needs and physical complications cannot escape uncertainty, and are thus entangled with values and social life. Hence they too are on occasion brought into the realm of something that is at least potentially transformable by the women or men, or that when actualised requires transformations of the self. One such example is breastfeeding:

*It is a counselling class on breastfeeding and baby care with four couples. The nurse has first suggested that the couples think among themselves and write down on a piece of paper the pros and*
cons of breastfeeding in contrast to using formula. After five minutes or so she gathers the papers and asks the group to say what they wrote down, and starts writing down the answers on a blackboard and commenting and adding to them. The pros the couples came up with include the practicality of nutrition (‘easy to travel with’, ‘free of charge’, ‘adequate and best for a newborn’ and so on), the physical benefits for the mother (‘reduces cancer risks’, ‘losing of baby weight’, ‘possibly no menstruation’, ‘general recovery of the mother’ and so on), early interaction and bonding between the mother and baby (‘closeness’, ‘communication’, and so on). The list of cons produces less conversation. The cons include sore breasts, the exclusion of the father and problems getting the breastfeeding started. Sore breasts are simply bypassed by the nurse, who comments that ‘they are not that sore’ and introduces nipple covers to ease the soreness. The exclusion of men is taken up by discussing all the other ways men can be physically close to babies and the importance of physical closeness, and the ways in which men can care for mothers, for instance by seeing that they eat enough healthy food. Before moving on to summarise breastfeeding, the nurse expresses her wonderment that nobody brought up the issue of breasts starting to look ugly, and she makes an odd comment that probably the only advantage for men is the affordability of breast milk. Overall, it seems that the assignment works as an entry point into discussion and advice on physicalities, physiology and nutritional issues concerning breastfeeding for both the women and the newborn, and on breastfeeding as early interaction and thus as important for the mental and social development of the child. On three occasions the nurse addresses the issue of difficulties in breastfeeding. The first time she assures the women that they need not worry if there seems to be little breast milk in the beginning by saying that even a drop might be enough because of its nutritious composition. She also gives advice on how to get the milk flowing and on feeding babies formula as a supplement, and reminds the group that if the weight of the baby drops too much the clinics will come to the rescue. The second time the issue arises is in relation to breastfeeding as a form of ‘closeness’ and ‘communication’. After all the talk about the importance of physical closeness, the nurse notes that no matter how motivated the women might be, breastfeeding is not possible for some: ‘one just has to get over it. Everything else can be given [closeness in other forms].’ The last time trouble with breastfeeding comes up by implication is when the nurse is summarising the breastfeeding part of the counselling meeting. She concludes that breastfeeding is ‘family-specific, depends on life circumstances, but it does not make anyone blissful [implying that not being able to breastfeed is not the end of the world], although it is a good and incredible experience and the child enjoys it.’

(Fieldnotes, clinic P, 23 April 2007)

Seemingly, breastfeeding is presented ‘neutrally’ in the sense that the parents-to-be get to choose the specific topics, and both the pros and cons are taken into account. However, the cons of breastfeeding are discussed less and in less detail, and they are not all presented as
such disadvantages that they would encourage women not to breastfeed. Only soreness of the breasts might be considered a deterrent, as are worries over the appearance of the breasts. However, I would have been surprised had issues of appearance or (mere) soreness become such problems, here or elsewhere, that breastfeeding was abandoned altogether, or if they had been used as justifications at the clinics. At any rate there are no such videos or observations in my material. Breastfeeding has become such a normative must in the name of the ‘best interests of the child’ – not only in appointment interactions and material distributed to the families (see Research materials), but in public and policy debates as well – that it would seem like social suicide to deny one’s baby the benefit of breastfeeding because of ‘superficial’ reasons such as a ‘little’ pain or one’s appearance.

In the quotation above it is also apparent how preference for breastfeeding is enacted. Breastfeeding seems to be good for everybody involved and in every sense. It is advantageous for women in that it assists physical recovery from pregnancy and delivery, and thus helps them to regain their physical appearance (note the contradiction). It is easy, practical and economical, and perhaps most importantly, provides a practice of bonding in the development of the mother-child relationship. By implication, breastfeeding as a bonding practice and process is crucial for the newborn’s psychological and emotional development and transformation into family interaction and relations, not to mention the physiological gain of giving ‘the best nutrition’ available.

The motivation and willingness to breastfeed is taken as such a self-evident value that it does not even seem to need justification. What mother would not want to engage in bonding with her child and promoting its health and happiness? It is only when there are, implicitly at least, physical obstacles to breastfeeding that this normative demand loses its hold. As with not being able to give birth vaginally, physical conditions seem to be acceptable reasons not to take to breastfeeding, because they are not affected by will or choice. By implication, physical conditions – the ‘natural course’ of pregnancy that may lead to one’s not being able to breastfeed or to one’s having trouble with it – are considered a fate brought on by nature. When such an unfortunate fate is visited upon someone, the way to deal with it, both in this snapshot and elsewhere, is to help the
women ‘to get over it’. This seems to involve, in the case of ‘mere’ trouble, encouragement to try again (according to advice on how), to trust one’s body (to deliver milk and to feed the baby) and to rely on the maternity healthcare staff’s helping hand. In the case of being unable to breastfeed at all, women’s anxieties are to be dealt with by reassuring women (and men) of the ‘sufficiency’ of giving everything else – without belittling breastfeeding, of course. Will and choice, then, are needed to adapt to the unfortunate situation as well as possible.  

Because the biological bodies of partners (often men) exclude them from breastfeeding, they are attributed different, equally sufficient, ways of bonding (physically) with the newborn. In fact, breastfeeding is constituted as something that has basically no benefits for men – not even indirectly in the name of ‘the best interest of the child’. Only affordability is mentioned, as if household economics is particularly essential for them. Their participation in breastfeeding is that of a supporter or supplier: taking care of the mother by making sure she eats properly and so on. A rather conservative division of labour by gender is implied, according to which women nurture the babies and worry about nurturing them, and men worry about material household issues and providing the women with care and nurture.

The division of labour is not this clear-cut when it comes to activities and effects on parenthood not linked to the reproductive capacities of the female body. However, there is still such a division all the same, and it is quite a gendered one. Fathers-to-be are granted potentials and attributes that include them in baby care and family relations differently than mothers-to-be. There are activities in care that both men-fathers and women-mothers can perform in a similar fashion, such as changing nappies, soothing babies to sleep, taking them for a stroll and so on. However, there are also tasks assigned exclusively to men, such as supporting the woman and providing ‘protection’, and others assigned exclusively to women, such as breastfeeding, recovering from birth and not being too

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82 There are enormous differences in practices promoting breastfeeding across different countries. For example Marjo Kuronen (1999) found in her study comparing Finnish and Scottish maternity healthcare in the 1990s that in Scotland breastfeeding is enacted more as the woman’s choice and bottle feeding is a real alternative, whereas in Finland breastfeeding is by default acted out in practice as every woman’s preference in the best interest of the child (ibid., 214, 216-222).
possessive of their babies (e.g. class at clinic P 14 May 2007; Family counselling files 2008).

There are also tasks and competences that must be acquired by the parents-to-be, which are assigned in a different manner to men and women and are related to bodies, time and space, and thus to gender. Let me elaborate on that through an ethnographical snapshot from a counselling class on partnership and parenthood:

The nurse has just finished a lecture with transparencies about partnerships and how to take care of them in families with small children. The overall message seems to be that couples need to take time to take care of their relationship by getting babysitting help from relatives and/or from a family care worker in the municipality. By taking ‘together time’ the parents are actually doing ‘good’ for their child. She starts the parenthood part of the meeting by showing transparencies on the overhead projector. There are different transparencies for ‘fatherhood’ and ‘motherhood’. The fatherhood transparency describes fathers in terms of safety, love for the family, friends to mothers and caretakers to babies. The nurse acknowledges that work sets limits on participation, and emphasises that the company of another adult is important. Then she notes that the role of the father is different than the mother’s, and that women have a nine-month head start for motherhood. Then she goes on to describe what kind of effects pregnancy might have on fathers: weight gain, nausea and fear. Women, on the other hand, according to her, have pregnancy and related issues on their minds all the time during pregnancy. She introduces a model according to which there are three phases in pregnancy [in relation to preparing] for women: in the first phase women curl up into themselves and need a lot of attention. In the second phase they feel the movements, and they should involve men in that. In the third phase it is time to prepare the home/environment for the family. Next comes the motherhood transparency entitled ‘The birth of motherhood’. Basically, there is motherhood in pregnancy, after delivery and progressively as the child grows. The nurse explains how one’s own experience of mothering, support from other mothers and the growing of one’s own ‘maternal intuition’ (‘special sensitivity and love’ for one’s own child, as well as for children’s issues in general) are involved in the threefold process of becoming a mother. Then she reminds the audience that the father’s role is mediated by being a spouse in a ‘triangular relationship’. Before going on with the transparencies, she notes that everybody does [motherhood and fatherhood] in their own way. The same is stressed with the issue of ‘a well functioning family’, to which are attributed qualities of ‘teamwork, communality and individuality, borders, humour, respect, intimacy and trust’. The nurse expresses her own opinion about parents not being ‘friends’ to their children, and a preference for an upbringing that is in line with ‘the border between generations’ and relies on ‘traditions and commitment’. Sometimes professional help may be
needed, but otherwise parents can trust to their own resources. These comments work as a link to the issue of ‘sufficient parenthood’. The nurse describes this as attachment to the child, workable everyday life, warm atmosphere and clear ground rules.

(Fieldnotes, 14 May 2007, clinic P)

Sharing tasks in parenthood, then, is implicitly linked to the ideal of the nuclear family as it is understood nowadays: mothers and fathers (who are men, not gender-neutral partners) take care of children in an equal manner (see also Vuori 2001, 355–356). The activities referred to include everyday care tasks that keep babies alive, happy and healthy, and often closely related activities that are described in abstract terms, such as developing ‘attachment to the child’, creating a ‘warm atmosphere’, setting ‘clear ground rules’ and so on.

However, this ideal of shared parenthood has been criticised for making mothers responsible for fathers’ ‘rights’ to fatherhood (Sevón & Huttunen 2002, 89; Sevón 2009, 86–87). This distribution of responsibility is observable in my material when women are warned not to be ‘too possessive of their babies’ and are obliged to ‘involve men’ when they start to feel the movements of the unborn.

Men, then, are enacted as potentially equal care-givers: potential in that they need special invitations to the transformation into fatherhood which involve sharing the sensations of the movements of the unborn (by touching the belly and discussing them), caring for the child and so on. As a consequence, it is implied that they too may have ‘pregnancy and related issues on their minds’: in other words, they are starting the process of becoming a father. More specifically, they are starting a mental – or ‘psychosocial’ to use the institutional terminology – process of becoming a father. Women instead seem to be granted such mental process endogenously and by virtue of their bodies having more direct access to the unborn. Because of that access to the unborn, and thus, it seems, to the mysteries of parenthood and parental identity, women have a duty to share that experience and knowledge with their partners to get them started. Thus men need to engage (through women’s encouragement and involvement) in activities to transform themselves into fathers, while women primarily acquire the necessary (mental) transformations and
competences ‘naturally’ and even mystically. It is as if physical changes in the body automatically make women act appropriately. Men, instead, appear as incapable of taking on parenthood and parental identity independently.

This is not totally clear-cut, however. Men are also enacted affective and bodily changes and symptoms in pregnancy on occasion. Interestingly, their ‘nausea’, ‘weight gain’ and ‘fear’ coincide with bodily symptoms and changes assigned to pregnant women in medical literature and clinical practice. However, it is not mentioned that such symptoms are considered to follow from quite different reasons in men and women. One cannot help but think that within the repertoire of shared parenthood, parallel physical symptoms are also a tool for the inclusion of men in pregnancies. Simultaneously, the bodily experience in pregnancy as some kind of a psychosocial engine is emphasised.

Male pregnancy symptoms, both affective and physical, are not a chance observation, but a phenomenon the origins of which have been studied (e.g. Munroe & Munroe 1973; Storey et al. 2000). There is no common understanding of its causes (biological, psychological and/or sociological), but nonetheless it is used in counselling, both in the classes and in the brochures distributed to the families (e.g. Expecting a baby 2008; Partnership book for parents 2005). If any causes or meanings are explicitly attributed to these symptoms, they are associated with ‘sympathy’, ‘lack of time [to exercise]’ and ‘putting the needs of the child before one’s own’ (e.g. Expecting a baby 2008, 41; Partnership book for parents 2005, 10).

The relationship enacted between mothers and fathers in relation to tasks in pregnancy and early childhood is further revealed in comments on the supportive and caring role of the father. The father’s ‘role’ is characterised in terms of giving ‘attention’, providing ‘love’, ‘safety’, being a ‘spouse in a triangle relationship’ and so on. It would seem that what is being sketched here is a version of the ideal of a nurturing mother, which assumes a male breadwinner (Vuori 2001) who also prefer hands-on/technical tasks in pregnancy and childbirth (Dolan & Coe 2011). It is implied that the father’s job is to ensure the prerequisites for the women to concentrate on being pregnant and caring for the newborn
and the family. Financial matters are not explicitly mentioned, either here or generally in the context of assigning tasks in parenthood. It is (nowadays) subtler than that. However, in other contexts, such as discussing changes in life and household chores and daily schedules, it is simply assumed that one’s partner’s work must be worked around, just as it is assumed that household economics is a concern of particular interest for men. This is also emphasised in the men’s own responses in group-work assignments in the counselling classes (e.g. counselling class November 2007, Clinic T).

It is rarely explained, at least not thoroughly, how to achieve the competences for the different parenthood tasks presented in the classes. This is especially so in the case of abstract and vague tasks, such as creating and maintaining a ‘warm atmosphere’ or ‘attachment to the child’ or ‘growing one’s own maternal instinct (special sensitivity and love)’. As explained earlier, it is simply assumed that women acquire competences through ‘naturally’ occurring transformations affecting their bodies, minds, and activities. Men/partners need instead to be physically included and encouraged to act to start their transformations into a parenthood of the mind.

This is not the end of the story, however. Some actors, doings and sources of information and help are appointed. Coming to know and enact parenthood involves doing pregnancy and early motherhood/fatherhood (manifest e.g. in terms of different ‘stages’ of becoming), the company of other mothers (or fathers), and occasionally professional guidance. Thus both experience (-based knowledge) and ‘scientific’ professional aid and knowledge are depicted as needed in the transformation into parenthood. On the one hand, couples are perceived as possessing all the ‘resources’ required, as is apparent in the invoking of imaginaries of natural courses of attachment and instinct, and of tradition. On the other hand, mothers (and fathers) may need to be ‘scientifically’ pushed in the right direction by professionals.

This twofold approach to women coming to know and do mothering has been traced to a shift in ideology concerning motherhood. It is no longer enough to have a maternal instinct and love for your child in order to acquire sufficient competence in mothering.
Professional training is also required (Hays 1996: 39–43; Vuori 2003: 44–45; Helén 1997; Yesilova 2008; 2009). In Finland, according to Jaana Vuori (2003), it was after the wars (ending with the Lapland War in 1945) that professional help in and knowledge of motherhood began to be stressed in approaches to and discourses on childcare. Vuori (ibid.) has termed this shift ‘a psychosocial view of the family’ (psykososiaalinen näkemys perheestä), because it was not just that scientifically based knowledge was perceived as important, but that the kind of scientific knowledge perceived as important was family- psychological in nature. That is, psychosocial concerns refer first and foremost to concerns within family relations. The ‘social’ in the term psychosocial is reduced to immediate social relations, and is approached through individuals and psychology. The cultural and social factors that exceed immediate interaction are left for the most part unattended (ibid.; Nätkin & Vuori 2007, 14). In other words, the social side of being is, in effect, psychologised: it is the social in the head.

By implication, the woman’s relations to her child(-to-be) are enacted as a close attachment and potentially over-solicitous attentiveness, realised, for instance, in terms of being too possessive of her child (see also Vuori 2003, 44–45). This competence to act lovingly but not too lovingly is achieved through sharing tasks within the family and one’s peer groups, and between the family and healthcare professionals. It is also achieved by coming to know it in a bodily process of acquiring experiential knowledge, ‘instinct’, ‘common sense’ and ‘tradition’.

This intermingling of ‘instinct’, ‘common sense’, ‘tradition’ and professional approaches in the transformation into parenthood is often also realised in terms of ‘sufficient parenthood’. This term was introduced into public discussions at the turn of the century (e.g. Pietilä-Hella 2010: 52), and is often used by the nurses at the clinics. It has been linked to another fashionable term, ‘responsible parenthood’, which is part of a wider discussion of conditions and support for ‘good’ parenting. Good parenting is obviously not a static category, but changes in accordance to the concerns of the time (Vuori 2001: 125). In particular, views on sharing the care of children have changed over time. Around the time of my fieldwork the discussion and interventions stressed (once more) the importance
of both parents’ presence and interactions with the child. Thus the responsibility for ‘good’ care and parenting was assigned to individual families and people.

However, there was another strand to the debate, namely a strand introducing ‘(family)- communalism’, which noted that solving and preventing the problems of families required a wider circle of actors than just responsible and loving parents. The range of actors included ‘the whole village’: professionals in healthcare, social services and education – all welfare professionals – and all family members themselves, social support networks, peer families and pretty much anyone one could think of (Jallinoja 2006, 154–159). The novel line of thought in this approach is not that professionals and professional knowledge, and thus societal interference, are viewed as important in bringing families together to perform the task of ‘good’ parenting, but that laypeople work with each other and with professionals in a community-like formation. Hence the expression and ideal, ‘the whole village’.

I agree that ‘sufficient parenting’ as an ideal and repertoire is linked to ‘good’ parenting – perhaps it is even one of the present versions of ‘good’ parenting – but I also would argue that it is ontologically different. In the context of everyday work practices at the clinics there are certainly ‘good’ and ideal acts of parenthood, and then there is ‘sufficient’, ‘good enough’ parenthood. Whereas ‘good’ and ‘bad’ parenting are quite easily identifiable, ‘sufficient’ parenting seems to escape any clear definitions. It is the vague borderland between ‘good’ and ‘bad’ parenting that is now increasingly defined in terms of (scientifically known and measurable) psychological models of family interaction and relationships, as explained above (see also Lawler 2000).

In the family counselling classes, issues of family psychodynamics are introduced and discussed in quite abstract terms. How, then, to address the specificities of particular

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83 The metaphor and ideal of communality and community is not in itself novel. In studies conducted in the 1990s the ideal of community is taken up only in reference to the welfare society and its professionals doing ‘societal motherhood’ (yhteiskunnallinen äitiys) together with biological mothers (and to some extent fathers) (e.g. Nätkin 1997; Anttonen 1994; Helén 1997). This is in essence what is meant when the (Finnish) welfare state is said to be a woman’s ally (Anttonen 1994). This concept of community, related to welfare politics, is not, then, to be confused with some communitarian notion that refers to ideas of some community origins of people.
couples and families in their transition to (desirable or sufficient) parenthood during an appointment encounter? There are the new welfare assessment form interviews specifically developed to assess the psychosocial dynamics of families and the (often emotional) support needed. However, support in the transformation into parenthood, in its (family-) therapeutic forms, has been part of the nurses’ job description in general, and not just in counselling classes, since as early as the 1970s according to some estimations, when the objectives for social and health services for families started to emphasise preventive care for all and the emotional and psychological support of families as a whole (e.g. Yesilova 2008, 102–103; Pietilä-Hella 2010, 56).

It would seem that the nurses at the clinics have a rather historical intuitive and practical ways to address the transformations into baby life and parental identity in pregnancy. The approaches also vary. Some nurses have a structured schedule in which there is a special appointment time for all when such issues are discussed; some prefer to slip in a question here and there when discussing other concerns in pregnancy; some trust their instinct and ‘feeling’ they have acquired about couples and families by the time of 30+ weeks of gestation (by which time they have met the families approximately six or seven times), and address parenthood issues accordingly. If and when concerns are brought up at the appointment, the discussion resembles a therapy session in many respects:

A pregnant woman has just arrived for her 30th-week-of-gestation appointment. After briefly discussing the woman’s sugar levels, which have been alarmingly high in the past but are now within the normal range, the nurse steers the woman to reflect on the whole process of her pregnancy so far by saying: ‘It’s 30 weeks of gestation now then. That is quite far along. What do you think about your pregnancy so far? How has it been for you?’ The pregnant woman starts explaining how difficult the beginning of her pregnancy was: she was throwing up all the time, and she remembers that time as being ‘a black hole’. She states that she does not understand how she got through that phase. The nurse confirms this by commenting that the pregnant woman has certainly been really resilient. The woman goes on recalling her unfortunate troubles in the early stages of her pregnancy. Work was extremely hard. She works at a school, and once she had to leave the classroom because she could not fight back the tears any longer. It was because she was so sensitive to the harsh language of the pupils. She is now afraid that she failed to be professional in her work. The nurse rushes to ease the mind of the woman by telling her that children do not think in terms of being professional or not, and that there is nothing bad in letting children see
one’s ‘human side’. The pregnant woman then states that now there is nothing special going on: ‘it’s just normal life’. The nurse comments as if asking a question: ‘So you have being feeling good?’ The pregnant woman mentions that she was quite tired and swollen at one point when she was working long hours, but now her maternity leave has started. Apparently the tiredness and swelling can be regarded as part of ‘normal’ pregnancy symptoms, because the conversation moves on to feelings and thoughts about the life changes that leaving work and maternity leave entail. ‘How has the change seemed to you?’ the nurse asks. The woman replies that she only started her leave the day before. So far it feels nice, but it is a bit weird because she has never not been working and she wonders what there is to do during the day. She and her partner are moving house soon, though. The nurse comments that the strange feeling about not working is common to women used to working life. The woman continues exploring her thoughts: she has been thinking about how to manage mentally and physically when the baby comes. The nurse supports this as something that is good to think about before birth. The pregnant woman responds by saying that she certainly needs to think of ‘ways to get out to be able to breathe’, since a year [the approximate length of maternity and parental leave in Finland] is a long time. The nurse stresses the importance of thinking about one’s own needs, and tells the woman that ‘the baby’s well-being goes hand-in-hand with your well-being’. The pregnant woman adds her concerns regarding the well-being of one’s relationship with one’s partner. She expresses her worries over the future of her own relationship, because she and her partner had been together for only a few months when she got pregnant. The nurse wants to know more, and asks: ‘Are you able to talk freely [in your relationship]?’ The pregnant woman says that they are, which in her opinion is surprising because they have not been together long, ‘like engaged and living together for two years’. At this point the nurse takes up the woman’s obvious worry over her ‘inappropriately’ short relationship with her partner by assuring her that the length of a relationship per se does not denote happiness.

(VideotapeP36, 30 weeks of gestation, first pregnancy)

The pregnant woman is encouraged to talk about her past and present thoughts, and the experiences and feelings related to them. More specifically, she is encouraged to reflect on her pregnancy as a mental and emotional journey and change into and as a parental(-to-be) self. That also seems to be the way she orients herself to the actions and questions of the nurse. She has survived the beginning of a pregnancy full of hardship, and has now been exploring her inner self to find ways to manage the future of baby life that lies ahead of her with her quite new partner and outside (paid) work.

This kind of self-orientation to therapeutic conversational support can be understood as orientation to a practice of self-confession (Foucault 1990/1976; Skeggs 2004, 120–121).
In the snapshot above it seems that the pregnant woman successfully masters the therapeutic code of the practice: the conversation flows smoothly and without misunderstandings. The pregnant woman is heard, encouraged and supported emotionally in her struggle to become a mother-person who is willing and able to fight for a ‘proper’ family with two parents, even if she has not had a ‘normal pregnancy’. She would like to read more about couples like her and her partner (revealed later at the appointment), talks freely with her partner, and thinks about a lot of things both in retrospect and in advance. She seems like a poster girl for ideal clienthood in maternity healthcare: she conforms to the position of a cooperating client who can be ‘merely’ supported to help herself, supported to become self-reliant.

Supporting her to help herself in this case does not involve promoting the ideal of a nuclear family when the pregnant woman expresses her concerns over the continuity of her relationship with her partner. Rather, when she further emphasises her worry by saying that she ‘could not have done this [pregnancy] alone’,

the nurse replies by telling the woman that the fact that none of the usual habits will have developed in a relationship that is still young [when pregnancy commences] can be a good thing too. The woman nods but goes on that she keeps comparing herself to ‘normal pregnancies’ and feels bad when other people express pity at her situation. The nurse makes a comparison to all relationships by saying ‘that 40 per cent of “normal families” split up’. The woman says that she has not been able to find any literature [on couples who get pregnant early in their relationship] and repeats that she ‘just couldn’t do it alone’. The nurse then continues by saying how many different kinds of family formations there are in the world and visiting the clinic. ‘[…] There are many lone parents, but now that you have decided on this family model you should take care of your relationship. You can see the well-being [of the relationship] in your baby. There is a natural process then by which parents develop an attachment to the baby,’ she says. The pregnant woman seems confused and matters: ‘We will see about that.’ The nurse rushes to specify that one does not need to feel love at first sight [of the baby], but that the affection will grow in time. The pregnant woman sighs that ‘it would be just terrible if the baby felt like a stranger when it came.’ Now the nurse wants to hear whether the woman has any feelings for her unborn at this stage. The pregnant woman starts saying that she and her unborn have a ‘shared life’. Her man has been telling her that they seem to have their own world from which he is excluded. She talks about having a common rhythm: in the evening when she calms down after work, the unborn starts moving. The tone of the discussion appears more relaxed and cozy now that it has shifted to talking about the unborn. Both the nurse
and the pregnant woman laugh about the unborn ‘liking’ bus rides, which the nurse then links to newborns enjoying travelling in baby buggies. They discuss how it is different for men in pregnancy when in a way only women attune to ‘being with a child’. They discuss, in an quite informed way in my opinion, how the unborn’s sensory system is very developed at this stage: how they can hear voices, feel movements and are generally affected by things around them; how they are even able to distinguish songs their mothers sing to them. Songs from their mothers’ own childhoods, more specifically. Before the end of the appointment and the routine tests they discuss how the woman has experienced the change in lifestyle. It seems that nothing too alarming comes up, because the nurse seems content and goes on to explain about the physical changes to be expected and how to respond to them, including more frequent counting of the number of movements.

(VideotapeP36, 30 weeks of gestation, first pregnancy)

It is implied that forms of family other than the nuclear family, while perhaps not as good, are sufficient, and that in any case families often enough split up at some point. Overall the nurse keeps looking for the good aspects of the pregnant woman’s situation. The pregnant woman is reassured about her life situation, and then supported on the basis of that situation. The work of reassuring is done by redefining the ‘normal pregnancy’, ‘the norm’, through (statistical) probabilities, such as the high rates of divorce and lone parenthood, and the probabilities of succeeding in a new relationship. These probabilities are then shown not to correlate with any psychosocial problems in young children.

What is stressed in effect is that lone motherhood or young relationships per se are not risk factors for child well-being. What really makes a difference in relation to child well-being is one’s own well-being, which is implied to be transferable to the child, and attachment to one’s child, which is said to come naturally. It is as if nature delivers attachment automatically in its mysterious ways. However, the nurse also draws on statistical knowledge of the probabilities of family well-being at the population level, and on theories about the average psychological/psychosocial attachment to one’s child. Thus predetermined nature appears not just as some mystical origin of love and attachment that is known only through common sense or instinct, but also as empirically measurable and ‘objective’. As this is a kind of natural law, the particular processes of attachment to one’s

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84 I use the term ‘lone motherhood’ in reference to both single pregnant women and to divorced or separated pregnant women, although I know that in some texts distinguish between them (e.g. May 2001). It will be made clear whether it is single women or, for example, separated women in the case in question.
unborn (and later child), and certain family forms and practices, appear as value-free scientific facts. As such they are also strongly normative: working for one’s relationships with one’s partner and unborn becomes a must: establishing rhythms, communicating through talk, touch and song, and including partners in pregnancy.

It would be an exaggeration to argue that, in maternity healthcare practices or elsewhere in Finland, lone motherhood has become ‘an average’ or ideal family form, or that it is no longer treated as a risk variable. It is rather tolerated and accepted as a life condition that has to be lived with. Further, it is perhaps because of the risk of lone motherhood that the nurse encourages the pregnant woman so strongly, here as in other appointments, to work on her relationship with her partner. In cases of lone motherhood, other social contacts and relationships are usually overtly sought in the appointment interchanges. It is not just lone motherhood that seems to evoke professional concern and different working methods, but also age, socio-economic status, education, residential area, home environment, and behaviour at appointments. I will return to these issues in the subchapters on physical, psychological and socio-material concerns in pregnancy. Suffice it to say here that as long as there do not seem to be too many or too severe risk ‘variables’ associated with child well-being, the overall temporal logic of maternity healthcare is not affected. Until there are serious concerns, what is sought is not interventions and control but ways to support early interactions with the unborn, personalisation of the unborn, and shared care for the unborn, all while honouring autonomy and the principle of protecting The Family.

**Screening tools of parenthood**

As mentioned above, all the clinics where I did my fieldwork took part in the new family-centred MCH care intervention, and were thus required to use a ‘welfare assessment’ form to interview pregnant women and their partners. These form interviews and the risk assessment practices that accompanied them can be understood as a way to make the work of screening for psychosocial problems in pregnancy both measurable and visible: to gauge the probability of a ‘problem family’ and standardise the practice of support for the transformation into parenthood, motherhood and fatherhood. Consequently, the unborn and its relationships with people around it become to some extent ‘standardised’ and
defined in terms of probabilities and variables. This is in itself a paradox given that immaterial reproductive care and nurture, mothering, are considered to fit poorly into measurable terms (Kinnunen 2000, 145–147).  

Although the clinics were required to use the forms, in practice they were used inconsistently and according to the perceived need for further discussion. It also became obvious that the nurses did not want me videotaping the assessment appointments. I was never directly denied access; but there never seemed to be any such appointment available during my fieldwork periods. However, my research project was granted consent to videotape eight such appointments at a fourth clinic in the municipal area.

The new welfare assessment forms were developed specifically for the new maternity and child healthcare clinic work. The structure of the form is in line with the ‘psychosocial welfare’ division (see my chapter on Recent organisational changes), and the form itself is presented in Appendix II. This rather numerical form was developed in collaboration with staff from the Department of Psychology at the local university, and with practising maternity and child healthcare psychologists who at the time also worked for the municipal administration of maternity and child healthcare. Apart from three open-ended questions at the very end of the form, couples are asked to give their answers on different scales according to how well a given statement corresponds to their own situation. Hence the forms are very fixed and compartmentalising.

The forms consist of eight different, more or less standardised, multi-item scales. The scales are supposed to ‘screen’ for and report on available social support (the revised Perceived Social Support Scale), mood (the Edinburgh Depression Scale), use of intoxicants (a shortened version of the Alcohol Use Disorder Identification (Audit) scale), resolving conflict (the Strauss Conflict Tactic Scale), stress in the family with small children (a 10-item scale developed by the project team for stress related to new parenthood and life in general), financial situation (a two-item scale developed by the

85 The same applies to nursing work, and, thus, the aim to make it more visible (and perhaps then culturally more appreciated) by making it measurable means that historical doctoring order is imposed on it. It is as if cultural ‘women’s work’ is being described in terms of cultural ‘men’s work’ (on such a cultural division of labour, see e.g. Kinnunen & Korvajärvi 1996).
project team), fears and worries of the expectant (essentially for fears about childbirth, a seven-item scale that is widely used in Finland, developed by Katariina Salmela-Aro and Jari Erik Nurmi) and mental images of the baby(-to-be) (a 12-item scale developed by the project team to assess images of early temperament and early interaction) (Kangaspuntau & Värri 2007; Kangaspuntau et al. 2005).

As a practice (of representation) in itself, the form thus assumes a pregnancy to which quite specific qualities can be attributed and quantified in these specific and detailed ways. Psychological and social concerns in pregnancy seem to include only emotional and behavioural concerns: stress, fears, images, conflict, social support and childhood experiences within the immediate family and social relations. The only social problem that cannot be fitted into family interaction and intoxicant use is one item on the financial situation. Surely, there is more to pregnant couples’ (family) life and background. For example, what about working life and work-related stress? The form merely assumes that stress appears either from nowhere or from baby and family-related issues.

The form also assumes a person who is capable of doing the work of attributing to and quantifying her/himself when it comes to emotional, psychological, social and economic issues. Thus it also assumes a person with a fixed or frozen sense of herself, her/his pregnancy (matters) and her/his social relations. It could also be added that the forms assume that behaviour derives straightforwardly from feelings, thoughts and attitudes, since the forms express the demands of the protocol and policy of family-centered MCH care that aims to screen for psychosocial problems and at thereby to prevent problematic behaviour (Kangaspuntau & Värri 2007; Kangaspuntau et al. 2005). The forms, then, work as a kind of *materialisation* of the demands of the protocol.

However, the form does not exist in a vacuum. First of all, there is the guideline protocol disseminated at training events and in written form, which focuses on the use of the form. Second, the protocol, with its material tools, does not merely replace and standardise procedures and guide staff, pregnant women and their families, but also *transforms* the practice and is itself *transformed* in the processes of the construction and implementation.
of the protocol (Berg 1998, 229–232). I will try to address these issues in the following paragraphs.

According to the guideline protocol, the nurses are supposed to make numerical assessments based on the forms, and the written protocol includes instructions on how to do this, with benchmark scores given for each scale. The guideline protocol also states the further action that should be considered in cases where a benchmark score is exceeded. However, the texts are quite abstract and brief on this. Further action is usually described in terms of consulting a doctor, referring to a psychologist or bringing the issue up at the multi-professional team meeting (Kangaspunta & Värri 2007; Kangaspunta et al. 2005; observations at nurses’ training, spring 2007).

In addition to instructions on how to enter information about the assessment into the casebook system and thus into case histories, there are some written guidelines on how and when to use the forms in the interviews. Generally the instructions are quite short and vague. Nurses are instructed to give the (pregnancy) forms to couples at around 24–26 weeks of gestation, and to make a one- to one-and-a-half-hour assessment interview appointment with the couples at around 28–30 weeks of gestation. They are advised to ‘use their interviewing skills obtained from training on “early interaction”’, that ‘the forms should be used merely as tools for bringing up difficult issues in discussion between couples and between the couples and nurses,’ and that ‘the interviews should be done with every couple to avoid labelling families, and to find out about problems that may not

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86 Furthermore, the information provided by future parents on the forms is not entered into the patient casebook system at all. In fact the assessments are meant to be entered into the case files only in cases where some of the scores exceed the benchmarks for a given scale. Moreover, the casebook system does not include an online form identical to the paper one. Hence although the form itself is structured as a series of ‘if one gets a score like this, then further action must be taken’ statements, the knowledge obtained does not travel into the casebook system in the form of formal, well-defined and clear-cut input. The nurses have told me, and it has been said at the training events I have observed, that only statements such as ‘assessment has been done and there seems to be no cause for concern’ or ‘the pregnant woman seems not to relate to her unborn baby in any way. A visit to a psychologist was brought up, and she promised to think about it’ are entered. Also, the material forms themselves are not to be held on file.

87 Both the pregnant woman and her partner are expected to attend the appointment, unless of course the woman is a lone expectant.

88 All the nurses at the clinics where I did my fieldwork had had this training, which concerns interviewing skills with expectant families and families with small children and aims to bring up problematic issues (see also Davis et al. 2001).
surface otherwise’ (Kangaspunta & Värri 2007; Kangaspunta et al. 2005; material distributed at nurses’ training, spring 2007). Thus, although the guideline protocol statements do not seem to be designed to standardise methods of interviewing with the forms, they do articulate activities across different sites and times: the nurses know when to hand out forms, when to do the interviews, who is to be included, what might be expected and how the interviewing activities fit into the overall picture of maternity healthcare work and actors. The guidelines also redirect some client flow, in that clients are channelled through these interview sites into team meetings and other healthcare services.89

The form to a certain extent pre-structures the nurses’ and other maternity healthcare staff’s work environment, and guides the staff through sequenced paths of action, geared toward certain features of the pregnant women, their families and their current life situations (cf. Berg 1998, 232). It thus coincides with the psychosocial pregnancy in the sense that there is a common object behind both sites for doing pregnancy. The results of the aggregate scores and the interview are presumed to overlap. They are to be added together when screening for problems.

In the actual interviewing that takes place during the clinics’ everyday work, this overlapping appears quite complex. Furthermore, when the form does intersect with the

89 Yet there is an apparent tension between the precise and detailed material forms as tools for interviewing and the flexible and brief guidelines for using them in the protocol. To explain this one has to go back to the construction of the protocol. Originally the forms were used for quantitative comparative research in which a sample of families from a pilot family-centered MCH clinic were compared with a sample from a clinic using traditional working methods (kangaspunta et al. 2005). It is understandable that, in a research setting like this, a formal questionnaire/form is used that operates by specific explicit rules and requirements about the data, the results, and the relation between them: the data items are fixed statements; the result items are numbers on a scale, and the relationship between statement data and number results only makes sense if they are related in a clear-cut way to each individual screening scale. It was only after the pilot study that the protocol to be implemented in other clinics was written and training commenced. It was in these texts, and the negotiations that led up to them within the research/development project, that the guideline statements were constructed as they are today: in this way, the forms work as channels or tools to structure accounts of experience. (Representations of) pregnancy and pregnant actors interviewed as written down in the protocol guidelines are not the same as in the forms. Whereas the form assumes fixed characteristics of psychosocial pregnancy and personhood, the more flexible guideline material does not. The way the tension has been resolved in practice is by distributing it over different sites of maternity healthcare: the site of researching psychosocial pregnancy, and the site of making a practice-oriented protocol to screen psychosocial pregnancy.
work practice involved, it is only possible to observe how the report about the psychosocial situations of the families is really about translating those situations and negotiating detail into a mode (of knowledge) that can then be moved (or not) to other sites, such as team meetings or specialised clinics.

I will illustrate this in relation to interviewing about the scale for mental images of the baby(-to-be), which is presented in Figure 1. The statements on the scale concern both images of the unborn’s personality (items 1, 3–4, 9–10: moods, orderliness, calmness) and early relationships (items 2, 5–8, 12: familiarity, pleasure, breastfeeding). The focus of the scale is on the unborn as a baby with potential personality characteristics, and on bonding experiences with it. However, the statements attribute the baby and its relations with characteristics in a way that leaves no room for statements other than those determined a priori.

![Figure 1: Mental images of the baby(-to-be) scale](image)

The next questions are concerned with expectations that you might have as a parent about your child-to-be. Assess how well each statement corresponds with your own mental image.

<table>
<thead>
<tr>
<th>I think my baby-to-be will:</th>
<th>Not at all</th>
<th>A little</th>
<th>I can’t say</th>
<th>A lot</th>
<th>Very much</th>
</tr>
</thead>
<tbody>
<tr>
<td>sleep regularly</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>be difficult to breastfeed</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>have a regular feeding schedule</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>be happy and satisfied</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>feel strange to me</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>be happy by her/himself</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>calm down easily in my arms</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>be hard to calm down</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>wake up all the time during the night</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>be restless and impatient</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>be disarmingly cute</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>give me great pleasure</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

However, in the actual interviews, the questions on the mental images the couples have of their unborn take the form of a therapeutic discussion. Here is a snapshot that captures quite well the manner in which the issue is approached:

*It is quite close to the end of an assessment appointment. A couple with their first child are being interviewed. The nurse looks at the couple’s forms in front of her, and notes aloud that ‘we have*
some quite lively mental images about the baby here.’ She then addresses a question to the pregnant woman: ’The baby does not seem like a stranger to you. At what point did it start to feel familiar to you, mother? First when you think that in the early stages of your pregnancy it was still a little bit […]’ The woman recalls that she started to get feelings of familiarity around the time when she started to feel movements. The nurse now asks the partner to try to specify when it was exactly that he felt that the baby was not strange, when it was that he ’felt that there really is this baby in the mum’s belly’. The partner replies that it was as early as when they were planning to have a baby in a way, and when hearing the heartbeat. The nurse is happy about the positive and strong images the couple has, and expresses this by saying so. She also explains why: ‘It is emphasised by those wiser people [referring to studies and theories of early interaction and the psychological transition to parenthood] that it is useful to have and open oneself to having images [of the baby-to-be] as early as during pregnancy. To indulge in images of the baby. Then it is easier in a way to understand the baby and one’s relationship to it. Even in relation to taking care of the baby. Taking care of the baby can be hard sometimes […] There is this positive effect on recognising the baby’s needs and understanding the baby.’

(Videotape L1NM, 36 weeks of gestation, second pregnancy)

Here, as well as in other interviews, the nurse diverges from the structure of the form by summarising the whole topic in one relevant question about the familiarity of the baby-to-be, and then gives information about the psychological benefits of early interaction and mental preparation in relation to mental images of the unborn’s characteristics. She does not go more deeply into the couple’s responses on the form about the other attributes describing their baby-to-be or early interaction with their newborn. Most likely the scores were satisfactory in terms of active bonding, but it is also noteworthy that the lowest score is not given for having only negative images, but for not having any images at all (Kangaspunta & Värri 2007, 42). Overall, reflecting on the images, i.e. bonding in professional terms, per se is perceived as enough to prepare oneself to take care of and understand a newborn’s needs. Even negative images or reflections are better than no imaginings or reflections at all. This is not to say that positive images are not encouraged. On the contrary, they are strongly evoked in expressions such as ‘indulging in images of the baby’ and in praise for positive images.

All the topics on the form are covered during the interview appointments, and sometimes in the same order as in the form, but never in a structured way. In fact in the appointments
I observed the nurses did not always look at the parents’ completed forms. They simply kept an empty form in front of them so as to keep track of the overall structure.

The rigidity of the form is further transformed when the nurses approach a whole topic from a different angle, encourage the couple to talk in their own words and not to use the forms statements, return to earlier discussions at other appointments, and offer support (advice, encouragement and confirmation). They also give information about the forms in general, about the ‘meanings’ of particular questions, and about questions quite unrelated to the forms, such as about physiology, medical procedures and so on. In fact, it seems that it is the pregnant woman or her partner more often than the nurse who relies on the fixed categories of the form. The nurse may start off with an open question, such as: ‘How do you deal with conflicts in your house?’ and the woman picks up the form and starts reading the statements and giving numbers. This can be attributed to the fact that the form, with its items and scales, gives the impression that it is assessed numerically.

Furthermore, in contrast with other interviewing sites such as the first appointment, during the assessment the nurse does not sit in front of a computer at all. Instead chairs are arranged around a table. In effect the space is organised not as a formal interviewing space, but rather as if for a casual conversation. The appointments usually start off with a general discussion about what has happened since the last appointment and how the pregnant woman and her partner are doing. By this time, nurses usually know the pregnant women and their partners quite well, because these interviews take place when the women are approximately 28–34 weeks pregnant: they will have met with the same nurse approximately six or seven times, and in most cases they will have consulted with them over the phone as well. After this warm-up discussion the nurses describe the forms using terms such as ‘tools for discussion for future parents’ and ‘not compulsory’, and they emphasise the fact that the information given is not entered into any official records.

It is only when the nurses seem to detect a problematic answer (in terms of the guidelines distributed to clinics, and on the basis of their own ‘sensitive probing’, which nurses usually attribute to ‘work experience’ and ‘people skills’) that they look carefully at the
answers filled in by the pregnant woman or her partner. In these instances, the conversation on a specific topic lasts longer and becomes more detailed, and this is initiated by the nurse. On other occasions, when nurses ‘see nothing worrying’, the topic can be passed over quickly. If one partner in the couple indicates particular worries at any point during the session, the nurse tries to address them as thoroughly as possible, given that there is a time limit on this appointment too.

The overall object of concern, and the agenda for the forms and the interviews, seems to be to assess and then influence potential competences for motherhood (and fatherhood). However, these competences are confined to emotional and behavioural concerns within immediate, informal, close social relations that exclude any aspect of the socio-material setting of family life other than the financial situation.

Of course, since the actual interview situations are not totally predetermined by the forms, a wider variety of issues may be dealt with. Furthermore, where the forms can be seen as imposing a certain ordering and segmentation on the appointment and practice of inquiry, in practice the process and continuity of care prevail. Time is still ‘a central force in nursing’ pregnancy (Bowker & Star 1999, 274):

*It is an assessment interview appointment. A 30-something couple is being interviewed. The partner of the pregnant woman is really talkative and, judging from the nurse’s interest in interviewing him more often than the pregnant woman, she is concerned about his behaviour, attitudes and feelings regarding life in pregnancy and the family. He tells the nurse that he has had great difficulty in confiding in people (an item on the form). Just lately he has tried to change that a little. He also finds it difficult to ask for help or any kind of support from anybody, even when they offer it. He does not want to feel that he owes anything to anybody. He has not even accepted any of the baby items offered to them, and he works at three different jobs so as to be totally self-sufficient. The nurse tries to challenge his attitude by asking what they will do if something really bad happens, and by trying to get opposing opinions from the pregnant woman, who does not respond to this call to disagree. The nurse comes up with all kinds of horrific situations, like the woman having a bad breast infection that requires hospitalisation. Finally he admits that in that case he might consider help from his mum or the in-laws. The nurse seems content, and talks about grandmothers’ rights to the baby. Further along the interview, it turns out that the partner has some fears concerning the health of the baby. He has invested lots of hope in this child-to-be, and is scared that things will go*
wrong somehow. He has had trouble sleeping, and refuses to talk about his problems to anybody or to go to the doctor. The nurse tries to bring him around by giving yet more examples from baby life that require opening up and confiding in other people. Finally she gives up, saying that they should revisit these issues later. The interview moves on to intoxicant use. The partner has stated on the form that he only drinks once a month or less. However, he stated that he consumes 10 or more units each time, has hangover drinks, and feels guilty about drinking. The nurse indicates that she is worried and wants to hear more, especially because the partner had similar scores in the first appointment interview. It turns out that when the partner does go out drinking, the drinking usually lasts for between a couple of days to almost a week. He had interpreted hangover drinks to include drinking sprees of more than one day. Furthermore, he elaborates that feeling guilty does not mean that he thinks that there is something wrong with his behaviour. Rather, he associates the feeling with the features of a hangover. He does not think anybody ever criticises him, and has said this also on the form. At this point his pregnant wife joins in to defend him. She says that she does not think this kind of once-in-a-while drinking is a problem, and that she always knows where her husband is while he is on a drinking spree. The nurse seems not to be convinced, and advises on the dangers of heavy drinking. She also works on the couple's feelings about drinking by suggesting in various ways why they should be worried and critical about drinking in this particular way, and how pregnancy is the time to make changes before the birth for the sake of the child. She appeals especially and repeatedly to the pregnant woman by asking her about her feelings about being left alone for days and about the 'normality' of this kind of drinking. What if something happens with the baby while the partner is out drinking? The couple is convinced that they are in control of the situation and always have a back-up plan when the partner goes out drinking. Finally the nurse moves on to other issues on the form, and says that they will certainly come back to the drinking issue [in the following appointments].

(Videotape L2NM, 32+ weeks of gestation, first pregnancy)

What seems to reinforce the nurse’s concern here is the case history, the client itinerary, which works as a tool for distribution across different sites at the clinic and over time. In the case of this particular family, the nurse has already given some attention to the partner’s drinking habits at the first appointment interview, and the Audit test scores have been entered into the patient casebook system, where they can be retrieved and brought into the discussion at the (assessment interview) appointment. The nurse is especially worried because the drinking habits have not changed ‘for the better’. In this way, the form interview is brought into care work that is a process. This is also apparent in the handling
of the partner’s refusal to confide in people or receive help from others. The nurse wants to keep working on the problem.

In many ways, then, the form interview does not differ much from the other interviews at regular appointments. However, and since the practice of interviewing and discussing the psychological and social aspects of the transition to parenthood and family life appears to be inconsistent among the nurses, the form interview appointment ensures that such issues are addressed at the appointments and not just at the counselling class, which is targeted only at couples who are pregnant for the first time.

Another point of interest here is the nurse’s affective work on feelings about drinking. The best interest of the child and the couple’s responsibility before birth to make changes in their lifestyle are strongly invoked in this couple’s therapy-like encounter. Through appeals to the woman’s feelings in particular about the insecurity of a home with a father who disappears on drinking sprees, a ‘right feeling’ towards drinking is being constituted through an ideal family life that has settled down for the sake of the baby’s needs.

Overall, increasing the standardisation, and thus the visibility, of the work of assessing psychosocial concerns in pregnancy (by both the nurses and the couples), defined in terms of the psychodynamics of early interaction and immediate family relations and behaviour, has its pros and cons. Classifying psychosocial concerns, as on the assessment forms, renders knowledge of them potentially comparable in research and record-keeping across different settings of healthcare and social services. However, there is a danger of losing local sight of problems not included in an interview structure designed for all. The visibility of nursing work and the particular problems families might have is self-evidently a good thing in general. A problem arises, though, when trying to measure uniformly something as situated and subjective as psychosocial well-being. A grey area of common sense will – and perhaps should – remain. However, there is then a danger of such areas disappearing all together. Furthermore, making work visible by making it measurable always runs the risk of exposing workers to social control (see also Bowker & Starr 1999, 240–50).
Making fit homes, making fit parental relations

One fairly recent research project on the impact of maternity and child healthcare methods (Pelkonen & Löthman-Kilpeläinen 2000) found a positive correlation between home visits and ‘psychosocial’ well-being. According to quite new Finnish national recommendations, nurses should make a home visit at around 32–34 weeks of gestation, and pregnant women’s partners should also be present during these visits (Ministry of Social Affairs and Health 2004). Indeed, home visits were highly valued by both public health nurses and the pregnant women I interviewed and talked to in the waiting rooms and halls of the clinics. The pregnant women usually referred to the post-natal visit, and they appreciated the fact that they did not need to visit the clinic so soon after birth as well as the advice they received from the nurses regarding breastfeeding and childcare.

The nurses I interviewed, by contrast, described the home visits as occasions for observing family interactions and the material conditions of the home. They reported that they would pay attention to the cosiness of family life: the way family members talk to each other and the way they arrange their home activities, including the place for the baby(-to-be). They stated that they would attend to the smells, the dirt, the equipment for the baby, the safety of the accommodation for children and so on. In a word, they noted the materialities of the domestic environment. They also observed the sociability of the practices and materialities.

Home visits are thus a particular site for enacting pregnancy. For the health visitors, they are sites for observing family life. Pregnancy is enacted through the material practices of a home. What is sought for are proper and fit homes and conflict-free and attentive interactions ‘fit for parents’. Pregnant actors are the observed, possibly in need of protection from future problems or of immediate intervention of some kind.

However, although pregnancy as observed materialities and material practices nicely coincides in research settings and guideline documents with the other assessments of
pregnancy at different sites in the clinics and in different work practices (such as interviewing and hands-on investigation), in fact the two aspects clashed at the clinics where I did my fieldwork. This is not because the materialities of the home somehow failed to contribute to the assessment of the psychosocial welfare of the family, but because the nurses I followed had to attend to appointment work at the clinics first. At the time of my fieldwork there was not enough time or staff for antenatal visits at all. As a result it can be said that a hierarchy is established, and the pregnancy as observed socio-materialities of the home is an impossible condition, simply because the home visits were not done at this point because of lack of time and other resources, and because they were not prioritised over appointment work at the clinics.

Materialities and practicalities of the home and household, however, were attended to in other sites of maternity healthcare. As discussed in the section on transformations into motherhood, fatherhood and parenthood (*Time for transformations*), the home environment, with all its socio-material settings and practices, is part of the agenda for late-term maternity healthcare. However, it is observable that the materialities of the home are enacted as subordinate to ‘mental’ preparation, such as thinking about childrearing, although buying equipment and making changes to the household seem to be perceived as part of that mental reflection.

Basic baby equipment, such as feeding bottles and feeding pillows, is introduced in a hands-on way at the counselling classes, and the nurses make sure that the parents have or are planning to acquire a baby care table, a cot and a baby buggy, and possibly a car seat. They also check whether the parents have received the maternity package, a benefit provided for all families by the Social Insurance Institution of Finland,90 which includes clothes and other baby goods. The nurses emphasise that it is enough just to own the basics, and that one does not have to spend a fortune. It is suggested that as long as the babies-to-be receive ‘proper’ care and love in a ‘safe’ environment, everybody is happy.

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90 Every mother, biological or adoptive, who lives permanently in Finland is entitled to a special one-off (per child) maternal benefit of either €140 or a maternity package sent to their home after 154 days of gestation.
Purchases and material arrangements are, however, treated as signalling this proper care, love and safety.

Safety, understood broadly as securing adequate social, psychological and physical development, is the key term here, in my view. When parents-to-be care for their baby-to-be’s safety they make household arrangements, not just in the sense of rearranging spaces and acquiring material goods, but also in the sense of arranging household life cycles, for example by taking maternal/paternal/parental leave and getting hands-on help and support from spouses and relatives. Making household arrangements, both practical and material, then, is a manifestation of the changes hoped for in social relations between the unborn, the pregnant woman, her partner and other close people, and indeed is in itself changing these social relations (see also Taylor 2004a, 8). The material and practical arrangements, with their associated social worlds (brands of objects, decorative styles, plans to be a stay-at-home mum vs. a career mum, etc.) become tied to those babies-to-be, and come to make their personhood (see also Clarke 2004, 71).

4.4 Preparing and waiting for the birth

From 30 weeks of gestation onwards the pregnant women (and their partners) and public health nurses meet every other week, and from around 37 weeks of gestation they meet every week until the birth (see also Handbook of maternity healthcare 2007). The further the pregnancy has proceeded, the further the appointment agenda shifts to the follow-up of the physical conditions of the pregnancy and the emotional and physical preparations for giving birth (ibid.). Obviously, any concerns of a psychological or social character that have been determined in the maternity healthcare context, are returned to.

However oriented the late-term appointments might be to physicalities in pregnancy and birth on a strategic level, addressing these physicalities is by no means purely ‘physical’. Issues, such as foetal presentation, foetal heartbeat, foetal size, contractions and delivery are approached in a manner that does not escape emotional, moral or social realms of pregnancy. As such, seemingly (scientifically) neutral ‘foetuses’, ‘natural processes’ and
‘maternal bodies’ are attributed qualities that somewhat dissolve the medically assumed organic connection and technical orientation to bodies (that work).

Overall, as long as there seem to be no severe physical, social or psychological complications, the late-term appointments serve the ritualistic goal of finalising the social and moral education concerning family life, which paradoxically is left a little vague and ambivalent. However, all this work is done in an affective, cautious and non-coercive manner (see also Bredmar 1999).

By 32 weeks of gestation, the unborn is considered to have the same hearing functions as it will have after it is born. It is also taking up more and more space in the uterus, and is essentially shaped like a newborn. As a physical creature a foetus is thus not that different from a born baby (see also Rothman 1989b, 101). This physiological continuity is strongly reinforced at the clinics, and is associated with more than just the physical spheres of life. I will elaborate on this through an ethnographic snapshot:

The pregnant woman, her partner and the nurse are discussing the regularity of foetal movements. The nurse inquires about the movements, and the pregnant woman says that everything has been the same [since the last time they met]. She elaborates that the unborn moves mostly in the evening, and that lately the movements are like heavy ‘thumbs’. Her partner agrees by saying that one can see a leg swing and the whole belly jiggle. The woman jokes that she feels that she is swinging along with it. The partner specifies that ‘the movements feel vigorous, not delicate [any longer] but real big turns when you feel with your hand.’ The nurse explains that ‘the baby is really close to the surface now. There is only the thin abdominal wall.’ The pregnant woman and the nurse start to discuss the amount of amniotic fluid at this stage, and the nurse remembers from last time when feeling the shape of the unborn that ‘her/his profile felt small’ [i.e. there was no concern about a shortage of fluid]. Later, when feeling the shape and position of the unborn, the nurse talks as she is touching the pregnant woman’s belly: ‘this has to be the bum because it is so high, and I wonder if these are the little legs.’ Then she asks the woman if the unborn has changed sides yet [about 90 per cent of unborn with cephalic (head-first) presentation have their back towards the left side of the woman’s abdomen]. The woman explains that it is sometimes hard to know which side the kicks are coming from, but lately she has felt them on the right side [shows with her hand on the top of her belly]. The nurse explains the likelihood of head-first babies turning their back to the left side, and then comments that ‘maybe she/he thought that he/she will do this according to the normal model, he/she
is conforming. There is no [medical] significance, though. Maybe he/she has noticed that there is more space this way or whatever.’

(Videotape Tp21NM, 38+6 weeks of gestation, first pregnancy)

In the quotation a physically baby-like creature is implied in the way its actions and physical features are described. At late-term appointments, the unborn are most frequently called babies, and their baby size is taken up in different contexts; they fill up the limited space of the uterus, and their movements and kicks are no longer delicate sensations felt only by women but are strong thumbs that move the pregnant woman’s whole body. Furthermore, the baby is physically very close – only the abdominal wall separates it from outer world. The physical features are now felt through the belly by hand, and not just observed via ultrasound.

More importantly, attention is drawn not just to identifiable human features or structures, such as limbs, but also to baby-like features. The babies have ‘little legs’ and ‘bums’ and not, for instance, lower limbs and buttocks. Moreover, the unborn at this stage of gestation are enacted sentience: they ‘think’, ‘conform’, ‘notice’ and act accordingly, often in relation to the physicalities and physical process of nature around them. This is also observable in situations where the unborns’ physical ability to hear, feel and remember in and from the womb are emphasised in late pregnancy.

It is as though there are two ‘natures’ and two bodies, which are more clearly separable and autonomous in late-term pregnancy care than in early-term pregnancy. There is the physical hands-on material nature of the unborn, and then there is the nature of pregnancy that the unborn (and pregnant women) are or are not in tune with. The nature of pregnancy is realised in the abstract and in sometimes mystified, sometimes medical terms, such as in expressions about ‘wombs practising for birth’ and ‘women just knowing when it is time to go to the hospital’.

The maternal body, on the other hand, is where the late-term sentient unborn resides. The relationship between the nature of pregnancy and the bodies attuning to it is realised in the
power to make a choice. Choice, in turn, seems to determine normative expectations in relation to actions taken, as noted many times earlier in this chapter.

When there seems to be no choice but to attune oneself to the ‘will’ of the ‘nature’ of the unborn, women are encouraged and confirmed in their feelings of anxiety about birth and nurturing the baby and the laboriousness of the extreme materiality of the late-term pregnant body. For instance, the exact time of going into labour is not just unpredictable but also something about which pregnant women have no choice. This is apparent during the appointments in the words and ways of explaining about the near futures of late-term pregnancy. For example, during one appointment, the nurse laughed as she said ‘then you can give birth [after the last doctor’s check up] whenever you want,’ implying a shared knowledge of the fact that giving birth is not really a choice. Then she went on to reassure the woman that she ‘can freely do any kind of chore now [since during late-term pregnancy there is no harm in early delivery], the baby will determine her/himself when it comes into the world’ (Videotape T35, 34 weeks of gestation, first pregnancy).

Of course, the nurse is aware that it is not really the unborn who decides when to be born. Overall, the medical understanding of the process of going into labour is not clear. However, it has been noted that the foetal body seems to emit biochemical and hormonal signals that affect the placenta around the time of birth. The placenta in turn sets off a complicated hormonal process in the maternal body. The unborn, then, is enacted, both in the medical literature and in clinical practice, as having an active role in labour: as a physical entity and a baby with sentience and will. The pregnant women’s tasks are just to keep track of movements and contractions so as to know when to get ready for the arrival of this ‘willing’ and ready person: to go to the hospital, have the home ready with all the equipment, and to be mentally set for motherhood.

4.5 The divergent paths

*Of course everybody had these problems that belong to normal pregnancies, and then I advised them accordingly.*

(Public health nurse 2, age group 20–30)
The above quotation from an interview with one of the public health nurses who participated in my study demonstrates what counts as (in)ability in doing pregnancy in maternity healthcare according to professional concerns. When the nurses’ assessment is that the pregnant women and their partners can be guided onto the ‘right’ track with the means available to them, they are not labelled ‘problem families’ or ‘risk families’ but are treated as able subjects in maternity. Professional concern is raised and action taken when this is not the case.

So far I have concentrated mainly in the processes of care practices that maintain and produce institutionally desired outcomes – the ‘right’ tracks, ‘healthy’ babies and parents. Obviously, however, things do not always go according to plan. This is also one of the basic lessons of STS: things get complicated and messy when one looks more closely at material practices (Law 2004; Mol 2008a; 2002). With this in mind, I will now move on to travel the divergent and broken paths in maternity healthcare.

By divergent paths I mean care processes in pregnancies with ‘complications’. In most common-sense and healthcare repertoires, the term ‘complication’ is associated with physical or psychological problems that require interventions of specific kinds. Drawing the line between a complicated or ‘risky’ pregnancy and a non-complicated one is not, however, an easy task, even for healthcare professionals. Carole H. Browner and Nancy Ann Press (1995) note in their article on antenatal diagnostic screening that because of the cultural preoccupation with notions of risk and uncertainty, there is a predominant belief that all risk can and should be minimised through human intervention. They argue that pregnant women are put under specifically normative pressure, because risks are ubiquitous in pregnancy in both popular and scientific discourses. That is, (scientific) uncertainties in pregnancy have rendered it a condition where anything might harm the unborn, and scientifically based maternity healthcare is pregnant women’s only culturally legitimate means to reassure themselves and others that they are doing everything they

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91 However, there are more or less clear cases. Most likely everyone would agree that, for example, a miscarriage is a complication.
can. In one sense, every pregnancy is enacted as a risky pregnancy. This is very much in line with my observation that even the smallest concern may lead to further assessments and interventions in the maternity healthcare, although not all such concerns can be regarded as complications. Furthermore, taking a divergent path at one point in one’s pregnancy – say, to the maternity ward in a hospital because of early contractions – does not mean that one will be treated in practice as a complicated case for the rest of one’s pregnancy. Identifying and treating a condition or a concern as a complication, then, is a slippery business.

For this reason I have decided not to draw any clear lines between cases of complications and those of non-complications. Analytically, I will follow the divergent institutional paths and meaning-making that involve enacting any kind of socio-material and discursive concerns and conditions that seem to render some women (and men) institutionally unable to deal with problems in pregnancy and push them onto institutional paths that diverge from the logic of care set for able pregnant subjects. Sometimes those paths may be broken altogether, as in the case of pregnancy loss or stillbirth. Consequently, these conditions order social relations in pregnancy and help to constitute subjectivities that diverge from the normative subjectivities of maternity healthcare.

Assessing families and family members is not an easy or simple task or process. Take for instance substance use as an object of concern:

*In recent years, although the area has remained the same [the area assigned for the nurse], I have noticed these increased problems in the population. Substance abuse is something that has become more visible. Not perhaps alcohol use, because that is something that is still this hidden thing that is kept in the family. It is one of those areas of people’s lives where I wish one could identify the users better and intervene. Drug use, instead, shows totally differently. We are aware of the users [through their known use of other services], especially the heavy users, and referring to further care is easy in those cases.*

*(Public health nurse 1, age group 31–40)*

Uncertainty about the situation in the family makes the nurses doubt their own ability to help. When the nature of the problem is known, on the other hand, it seems easier for the
nurses to adjust further care to fit the problem. It appears, that this is usually so in clear-cut cases of prior physiological, psychological or lifestyle-related concerns. In severe and clearly defined cases of ‘complications’, care for pregnancies generally cannot be handled in preventive care such as maternity healthcare, because the situations of the families are already in crisis (see also Nätkin & Vuori 2007, 19).

Furthermore, precisely because maternity healthcare services are by definition a preventive agency, in many cases raised concerns lead to referrals of pregnant women and/or their partners to specialised services, and thus possibly place them beyond the scope of my research. However, I have been able to follow the routes many pregnant women and their unborns take, and the modes and styles by which they are transformed as the process of care diverges.

The practices of identifying problems and assessing which actions to take can roughly be divided according to the origins of the problems. It seems to make a difference whether the concern at hand is (enacted as) of physical or ‘psychosocial’ origin or is linked to the socio-material conditions of pregnant people’s lives. In each individual, yet related, set of practices, specific social relations are associated with the pregnant family unit.

**Physical concerns**

There are numerous physical concerns in pregnancies that vary in severity. Some of them are considered to various extents to depend on pregnant women’s lifestyles and other doings, while some are not. When the problem is perceived, at least partly, as a result of a woman’s behaviour and/or as potentially transformable by the pregnant woman, as in the case of gestational diabetes, she is given a moral and social lesson on the harm inflicted on the baby-to-be (as elaborated in the previous chapter). When, instead, there is no (scientific) basis on which to blame or to educate the pregnant woman, the course of care and the style of addressing the issue takes a turn.

Below is a good example of that from an account by a senior nurse. She had just answered my interview question about problems of the families she had encountered in her long
career. According to her, the worst cases had involved the death of a child, including stillbirth. The loss of a child, born or unborn, was for her ‘the biggest loss a person can have in her/his life’. I asked if she could describe to me the ways in which she handled situations where she suddenly could not get the foetal heartbeat with the women and their partners at the appointments. She explained to me with tears in her eyes and a trembling voice that:

*Usually the mother realises herself suddenly that now there is something wrong here when they can’t hear anything. Then I tell her that I can’t find the heartbeat. Of course it depends on how far along the pregnancy is. If it is only few weeks of gestation, it is no wonder one can’t hear them. In those cases, we check when they have their ultrasound appointment and discuss how they feel about waiting until then. I know that usually women can’t wait. When they close the door behind them, I presume that they run to the first possible ultrasound available to check out the situation. Early pregnancies are different. If it is, let’s say, 30 weeks of gestation, and I can’t hear the heartbeat. Then I say that I am going to make a referral to the hospital and they will see what the situation really is. I help the mother by touching her. I hug a lot. Of course, I assess whom I can hug. I want to […] I think touch is important, and thus presence, like I am here for you. Then I help her up from there [the examination couch], and explain to them, if both mother and father are there, that I am writing the referral and you will go to the hospital to the maternity ward where they will do an ultrasound examination and that way you will find out what the situation is. The same thing is if I hear some changes in the heartbeat or something like that. If there is a lot of amniotic fluid or something. I have worked at the maternity ward so I know right away what it could be. I think that these things cannot be postponed. They will go then. I ask how they plan to go there [hospital]. Are they taking a taxi or their own car? If it is just the mother, [I will ask] how she would like to go there, shall we call her man to come along. My aim is that the woman does not have to be alone with that thought [of stillbirth]. Or if there is a sister or somebody who could go along if the man is out of town for business or if there isn’t a man. Then they will go to the hospital and I hope and tell them that I will call you the first thing the next day or that we will call each other about what the findings are and how things proceed.*

*(Public health nurse 4, age group 41–50)*

Although it cannot be denied that there is great concern over the life of the unborn implied here, what is being described is concern over and care of the pregnant woman’s well-being and coping with the fear linked to the observed risk of losing the unborn. It would seem that in situations such as this, where the conditions of further care depend on ‘natural fate’
– or more precisely on the techno-diagnostic confirmation of the fears the nurse has arrived at through her professional experience and sometimes through the intuitive bodily feeling of the pregnant women – the agenda of care work is affective management of the woman’s feelings in particular. Not everybody (nurses or pregnant women) is keen on touching and hugging, but offering support in the form of presence and conversation is common. Furthermore, women (and their partners) are not left alone to cope with disturbing news like this: nurses try to ensure that the women are accompanied on their divergent journeys to the hospital or other special services. Nor is their path in maternity healthcare totally broken, even in cases of stillbirth: nurses stay in contact after the examination or procedures in the hospital.

Care for pregnant women with a history of stillbirths, miscarriages or infertility issues is organised in different terms than care for women with no such concerns. In this way, a broken path in maternity healthcare may be resumed. According to the nurses, the fear and stress these women have over losing the unborn is often evident, and they need special attention, sometimes in the form of ‘facts’ about their limitations and options to secure the continuity of their pregnancies and foetal health, and sometimes in the form of therapeutic conversation. This is also the case with so-called risky pregnancies (e.g. case of mature maternal age or multiple pregnancy), which by definition are pregnancies with an increased risk of foetal distress.

Sometimes, however, the very worst fears come true. Abnormal findings are made in the screenings, miscarriages and stillbirths happen, women get gestational diabetes that may cause different kinds of foetal harm or give birth to disabled babies with no prior diagnostic warning. In some cases women and their partners are faced with heartbreakingly difficult choices concerning termination and life changes involved in nurturing a disabled child with no certainty about the future of pregnancy or childhood (see subchapter 4.2 The emergence of the unborn on the uncertainty of foetal diagnostics and the care logic involved). In some cases there are no choices available or actions to take. In all cases, even when pregnancies end in termination, the unborn is
characteristically transformed into a patient who is further examined, sometimes treated and sometimes lost.

By implication, pregnant women who undergo examinations and treatment on behalf of their unborn are rendered less visible as actors, as also noted by Monica Casper (1994; 1998) in her study on foetal surgery. The focus of care in hospital surroundings is on the maternal body as a techno-material environment for foetal patients (Casper 1994, 844), and to be an advocate for anything else, for example, psychosocial well-being and integrity of the pregnant woman, is, as Casper (1998, 47–48) puts it, ‘really hard work, because the medical professional voice is heard the most clearly’. This is not the whole truth, though, when considering care for pregnancy as a multiple whole. At the maternity health clinics, the worries, health and well-being of pregnant women are of utmost importance. However, overall it is a question of trying to manage and control the uncertainties and misfortunes, of physicalities and the social, that are thus transformed.

One of the most touching stories I heard involved a pregnant woman who gave birth to a baby with multiple abnormalities. Her story is telling, both of the work of managing and of that management’s miserable failure:

I first heard about this young woman and her disabled child in the coffee lounge during lunch hour at one of the clinics. One of the nurses brought in a medical record sent from the local hospital, and handed it to the nurse whose client the woman was. The second nurse explained that the child had had multiple defects at birth. She said that the baby had scored only three out of 10 points on the Apgar scale. He had ‘no anus at all and everything,’ she sighed. She then continued that there had been nothing in the screenings to suggest any obvious defects during the pregnancy. The pregnant woman herself, however, had expressed a vague worry ‘that something is wrong’, and later in pregnancy it had been observed that the foetus was small. The nurses started to talk about similar cases in terms of pregnant women’s intuitive knowledge of problems within. The nurse responsible for the case in question said that often in such cases ‘nature aborts a child that is

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92 The Apgar score is determined by evaluating the newborn baby on five simple criteria on a scale from zero to two, then adding together the five scores. The resulting Apgar score ranges from zero to ten. The five criteria are appearance, pulse, grimace, activity and respiration.

93 Structural anomalies in the anus (especially an imperforate anus), short stature and severe disabilities suggest that the baby is suffering from FG Syndrome (FGS, also known as Opitz-Kaveggia Syndrome). It is a genetic syndrome linked to the X chromosome.
severely defective, but for some reason this one survived. There was some bleeding [during pregnancy], but still. The conversation went on to premature births. One of the nurses expressed her opinion that in some cases technology should not be so developed. ‘There has to be a reason for some of them coming out so early.’ The nurses continued to criticise the professional practice and requirement to keep every premature baby alive at all costs. They all seemed to agree that it absurd that ‘these totally incomplete creatures are taken to intensive care units when at the same time others are aborted and thrown into the rubbish’.

(Fieldnote observations 15.3.2007, clinic P)

Later, I was able to identify the pregnant woman in a videotape of an appointment in my material. After watching the video again, I was not surprised that I had made no special note of it. At the appointment:

The pregnant woman and the nurse start by discussing the doctor’s appointment the woman has just been to. The nurse had apparently advised the woman to ask about an additional ultrasound to find out why the unborn seemed so small in the routine measurements made at the nurse’s appointments. The pregnant woman has received a referral for an additional ultrasound for the following Friday at the maternity ward of the local hospital, because there are no available ultrasound appointments at the central maternity healthcare clinic [where routine examinations are usually conducted]. The nurse seems a bit apologetic when she tells the pregnant woman that she had suspected that ‘the baby was going to be small.’ ‘I started to feel bad, because I could have sent you in earlier,’ she says. The pregnant woman consoles the nurse by saying that she is kind of glad that the nurse didn’t make a fuss about her concerns earlier, because then she would have just worried longer ‘for no real reason’ [in light of her current knowledge, obviously]. She does express her slight concern, though, about what the issue of small size might entail. The nurse seems relieved and confirms the woman’s self-assessment about worrying too much: ‘That’s why I didn’t want to scare you by saying something [about the concern that the foetal size might drop off the scale in late pregnancy]. I know you that well by now.’ The nurse then tells the woman that at the hospital they will find out what the situation is, and reassures her by saying that in general it is normal to worry when one is referred for additional follow-ups. After this conversation, which lasts less than five minutes, they move on to discuss the blood tests taken at the doctor’s. There seems to be nothing alarming in the results, and the topic of discussion shifts to contractions, foetal movements and sleep deprivation in late pregnancy. The nurse takes the pregnant woman’s blood pressure and gives her a handout about how to prepare when going to the hospital for delivery, and they briefly talk about the counselling classes the pregnant woman has participated in and her (few) thoughts on the forthcoming birth. It is not until the very end of the appointment that the concern regarding foetal size is briefly returned to. It is when the nurse takes the routine measurements: the size of the uterus
(with a measuring tape), hands-on feeling of the size and position of the foetus, and the foetal heart rate with the Doppler device. The nurse describes the foetal movements in a relatively ordinary manner, describing the unborn doing different things: ‘responding’ to touch by moving and kicking, and being a ‘mobile baby’. However, she also notes that the ‘placenta seems to be working well even though the one inside is a tiny little thing’. Also, when discussing the fluctuation of the uterus measurements [by a few centimetres], she comments that the active character of the unborn and its small size may be causing it [because there is room to be active and the measurement is always taken from the same place along the abdominal wall]. There are no worried faces or remarks. It is as though it is taken for granted that the unborn is just small but otherwise in perfect health. Finally, when the nurse and the pregnant women are scheduling the next appointment, the nurse explains what is done at the additional ultrasound appointment. She says that the appointment will take about two hours, because they will want to make a longitudinal examination of the foetal heartbeat, and do the ultrasound and the standard doctor’s examination. The appointment will also serve as the standard birth-planning appointment. ‘How convenient,’ the nurse says jokingly, and they both laugh.

(Videotape P12N, first pregnancy, 37 weeks of gestation)

My general impression of the appointment was that it largely resembled an ordinary late-term appointment during which certain physicalities are addressed and which is quite short in duration (27 minutes), as appointments where there is nothing major to worry about are. It is not uncommon to refer women for ‘additional follow-ups’, and it is my understanding that women’s instinct-like sensations of something being wrong with their unborn or their pregnancy turn out more often to be ‘false’ than ‘true’, i.e. the worries are not technologically verified. It is understandable, then, that the nurses are careful about when and how to express their worries. After all, affective management of anxiety associated with unpredictable futures in pregnancy, physical or otherwise, appears to be a somewhat informal yet dominant logic of care, as discussed earlier.

It can be said that in this particular case, the nurse seems to be able to reassure the pregnant woman to the point that she stays fairly calm and they are able to move on to routine tests and conversation, and even to joking about the further examination at the hospital. Even when the foetal size is taken up again during the routine measurements on

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94 Compared to first and second trimester appointments, which have an agenda to address and which assess somewhat vague and abstract issues of motherhood, fatherhood and parenthood, and getting acquainted. See subsequent chapters for a more detailed account.
the examination couch, the unborn is enacted as a potentially perfectly healthy ‘baby’ with the personal qualities of being ‘mobile’ and ‘active’. Just as in appointments where there is no cause for concern over the health of the unborn, the nurse’s account is full of action verbs implying foetal agency and even sentience: it ‘responds’ and ‘moves’.

I do not intent to imply, however, that the nurses, here or elsewhere, merely tiptoe around problems the pregnant women might have in the name of managing emotions at appointments, and that they subsequently look for something to blame (like ‘nature’) and tell other nurses contradictory moral and mystified stories about instincts and the unpredictability of nature. In fact, and this has been noted in prior research as well (e.g. Scamell 2011), making the unusual normal may be a strong paradigm of maternity healthcare practices (e.g. Bredmar 1999), but in our risk society, nurses and midwives work has also stirred towards medicalisation of pregnancy and childbirth. I do not, however, conform with the view that nurses are true believers in the omniscience of technoscience who will not raise issues like diagnostic complications with their clients until the medical examinations have had the final say. It is more complicated than that. I would rather argue that the nurses organise their work activities according to multiple logics, in which the informal and formal are intertwined.

First of all, nursing in maternity healthcare is characteristically intermediary work. The nurses have no diagnostic rights, regardless of their professional experience or knowledge or their personal beliefs. By protocol this fact has to be integrated into clinical practice. They can inform clients about their observations and refer to the ‘appropriate’ professional, but they must leave the diagnostic terminology and treatment decisions to that professional. It is only after diagnosis, if and when the pregnant women return to the clinic, that they have the authority to address the problem as a condition affecting the care plan. Thus they are obligated to a certain extent to wait for technoscientific confirmation from a doctor.

However, one cannot escape the strong emphasis on maternal experience-based estimations and the critique of medical-technological professional practice found in the
nurses’ accounts. Furthermore, at the appointments, the nurses provoke feminine bodily qualities that (even mystically) seem to enable women to know from within about such things as foetal health (as elaborated in the previous subchapter). Thus both medical-technological ‘facts’ (through medical examination) and coming to know one’s unborn in an embodied process are taken into account in the care practices of pregnancy. The intensity of the orientation to problematisation varies in style situationally, which can be explained through not only the need for technological confirmation but also the maternity healthcare system’s historical principles. Marjo Kuronen (1994b) makes a similar observation in her ethnography of maternity healthcare in the 1990s. She suggests that since the primary agenda of maternity healthcare has been to do regular follow-ups on pregnancies and child development in the whole population, the nurses need to secure the continuity of client–professional relationships and to build trust (ibid., 350).

A friendly and sensitive atmosphere certainly has an impact on the fragile client–professional relationship. However, a sensitive and soothing approach to issues has other professional goals as well: to manage negative emotions and build not just trust but also rapport (see previous chapter for a detailed account), and self-reliance (see also Bredmar 1999). A more humanist counterbalance to medical practice seems to be needed, both to address sensitive issues, such as problems in the family and intimacy, and to reassure pregnant women and translate doctoring practices and terminology for them. This division of labour became quite obvious during my fieldwork. It was not uncommon to hear women complain about their treatment and ask the nurses about the implications of something a doctor had said or done, and the nurses would empathise and give explanations.

The unborn as a patient is thus mainly constituted elsewhere (hospitals, special clinics and so on) and then brought into the maternity healthcare clinics. However, the unborn’s health as a care object and agenda remains in the hands of the doctoring professionals, and in most of the cases the care for and follow-up of the particular pregnancy is completely moved to hospital settings. It is then left for the maternity healthcare work, possibly postnatally, to come to terms with the new-found physical and mental qualities, or more
precisely potential qualities (given the unpredictability of the severity of many conditions), attributed to the unborn/child. What this means is that the work of transforming the unborn from mere foetuses, babies or human life in general to particular babies with a social identity, kin ties and responsible parents diverges.

The condition of the unborn and the potentials associated with it always determine the work of ‘mental’ preparation for parenthood and material and practical arrangements, including the socio-material settings of the home environment and family practices such as the division of labour, the work-family balance and life cycle arrangements. The unborn with disabilities are attributed potentials, or a lack of them, that require pregnant women and their partners to make life transformations quite different than in cases where there are no abnormal screening findings. A variety of changes in social relations are evoked and enacted as necessities. The means to do this include buying assistive devices and medical supplies, rearranging the household and rescheduling one’s own life to ‘fit’ the baby-to-be’s special needs, and building a special social network of family, friends, peer groups (including patient organisations) and professionals to hold together all the elements of working daily life as well as possible. Obviously, each of these preparatory activities is constitutive of a type of mothering and mother-infant relationship: there is an expression of mothering a disabled child built into each activity and space.

‘Psychosocial’ concerns and the socio-material conditions of family life

The analysis of practices involving physical concerns quite clearly shows that it is at least on the face of it in line with the historical citizenship model of welfare services (reached in Finland around 1980s according to many estimates; see e.g. Nätkin 2006, 36). In simplified terms, working with laypeople in the name of equality and autonomy within services that are provided equally and in an equal manner to all (Helén & Jauho 2003; cf. Satka 1995). This is, when dealing with physical problems that are perceived as something any pregnant woman may face during her pregnancy. The object of care, then, is to a large extent the ‘average’ woman, man and unborn.
However, when it comes to concerns characterised in abstract terms as transformation into and well-being in motherhood, fatherhood, parenthood and family life, the picture becomes more complicated. As elaborated in the previous subchapters, screening for problems in and educating pregnant women and their partners about family life is determined to a large extent by so-called psychosocial knowledge, which concentrates on the emotional and behavioural concerns of the immediate family and social relations, such as presence, attachment and interaction, even prior to birth. It is, then, (only) specific problems that may become problems in the care setting. The new form interviewing practice in particular has the potential to overlook the specific problems individual families might have (see Chapter Screening tools of parenthood for a detailed account).

Like already discussed, according to the guideline protocol, nurses are supposed to make a numerical assessment based on the form interviews which have been developed to report on mental well-being and early interactions in the family unit. The more ‘traditional’ appointment practice of long-term affective ‘probing’ for risks of problems achieves the same goals (and more), but does so in a less standardised, visible and measurable way. The form practice of risk assessment has the potential to define the unborn and the people around it in terms of probabilities and variables associated to them on the form, and then referring those with critical scores to further care as specified in the guideline manual. It could be argued that the form practice has the tendency to draw on statistical knowledge of probabilities of multiple risk factors at a single moment in time, and consequently enact ‘problem families’, ‘risk families’ or ‘families with multiple problems’ in need of intervention.

The form, then, has the potential to reinforce the power of risk variables and averages produced at the level of population statistics in assessment work, and to override the local recognition of problems in nursing practice not included in the practice designed for ‘the average family’ (see also e.g. Bowker & Starr 1999, 240–250; Skeggs 2004; Gubrium & Holstein 1999; Yesilova 2008; 2009). However, statistical knowledge is still a part of the assessment and argumentation used in the regular appointment work practices. It is just that it is used in a more intuitive and situational manner.
Professional concern and the reorganisation of care plans seems to be evoked particularly in cases of substance abuse, domestic violence, mental problems, poor home environment, socio-economic status, youth and ‘poor’ behaviour at the appointments. When one of these unfortunate matters of concern is manifest (in the past or present), the nurses usually inquire into the details and the pregnant women’s own estimations of the severity of their current situation and their need for help. If and when the life conditions of those whose lives have been affected by such problems are such as to assure the nurses that the situation is under control – meaning that there is or has been professional involvement through some relevant welfare service – the nurses often stick to giving the advice that pregnancy is a special time to make life changes (including seeking outside help) and work on one’s own mental and emotional issues in the name of the baby-to-be. What is implied, obviously, is that babies-to-be ‘need’, ‘require’ and ‘deserve’ mentally stable and preferably of-age parent(s) in financially stable homes where there is no substance abuse or violence.

Referral to further services may be offered but it is never imposed, most likely out of respect for choice and autonomy in healthcare. Furthermore, since care for pregnancy is a process of assessment and intervention, any problematic issues will always be returned to later, and in the meanwhile the nurses will also pay special attention to appointment interaction and the women’s (and men’s) accounts of other possibly related issues in their lives. This is something that the nurses also openly talk about to the pregnant women. They explain, for instance, that it is good for them to be informed about the women’s previous problems and treatments, even from long ago, ‘because then in your case we will need to keep special track of things’ (e.g. prior depression and bulimia in videotape P42N, and depression in videotape P39N).

In cases of multiple problematic life conditions, concern accumulates accordingly. For example, nowadays lone motherhood in itself rarely appears to raise major concerns at the appointments. However, if coupled with the prospect of future unemployment or a refusal

95 Unless, of course, there are obvious signs of psychotic behaviour or similar issues.
to accept advice, it may set off an alarm. Below is an ethnographic snapshot of one such appointment:

It is a special appointment in that the nurse and pregnant woman have not met before, and the pregnant woman is already at 33+5 weeks of gestation. She has been seeing a public health nurse, but in a different municipality area by mistake. There seems to have been a mix-up involving a change of residence. To start, the nurse asks the pregnant woman to reflect on her pregnancy in general. It turns out that the woman has been feeling, in her opinion, surprisingly well, and that she only found out about the pregnancy when she was already at 19 weeks of gestation. The nurse expresses her utter surprise by opening her eyes wide open and exclaiming ‘Oh no!’ . The nurse then wants to know about her life situation, ‘this being such a surprise’. The pregnant woman explains that she and the father-to-be are not living together and she wants to think through the whole relationship carefully. The father already has a child with another woman. She also says that she got an internship at an art project about eight months ago, so her life has been ‘balanced’ since then. The nurse asks about her plans after the project. The woman only has plans to go on maternity leave and live on benefits. The nurse then moves on to ask about the father-to-be’s arrangements with his ex-partner and child. She also wants to know how everybody gets along now and if the pregnant woman and the father-to-be have time to spend together. When the pregnant woman merely replies that they get along and have time, the nurse asks directly about the couple’s relationship. The woman then explains that it is she herself who has doubts, and that she does not want ‘any extra stress now and doesn’t want to think about another person now’. The nurse continues to probe: ‘Did you have a relationship before, though?’ The pregnant woman merely states that they have been going out since the previous summer [which would indicate that they had been together for at most about four months when she got pregnant], and then talks about how the weeks go by so fast and how excited she is, and says that her mother is coming to the delivery with her. The nurse moves on to ask about any family living nearby. They briefly discuss friends and the father-to-be’s family, who do live in the municipality, and that the father-to-be will be moving soon when his work contract ends. After that, the nurse wants to return to the issue of the father-to-be’s role, this time by asking about the delivery: ‘So your mother is coming. What about your man? Does he want to?’ The woman dismisses the wants and needs of the man: ‘I suppose he will be there too, but it is so important to my mother.’ The nurse then tries to educate the woman about the importance of having the father take part: ‘It is also important to this child, the father. Also for the beginning of [transformation into] fatherhood.’ The woman repeats her argument that it is a big thing for her mother [to participate], because it is her first grandchild and with a newborn one can’t travel [to see grandparents] right after birth. The nurse seems a bit frustrated and gives up for the time being. She then turns to ask again about plans the pregnant woman might have for a future career: ‘Do you have any plans to go to school?’ It turns out that the pregnant woman
dropped out of (practical) nursing school after one and half years. However, she does think that she might finish the degree at some point, because, as she points out, she is worried about her income without any occupational training. The nurse seems content with this kind of self-exploration, and they continue for a moment about how income issues get more relevant when a baby is coming and how much the pregnant woman has already rearranged the household and purchased baby equipment. Before going into the routine tests at the end of the appointment, they have a serious discussion about some notes on substance abuse that the previous nurse entered into the computerised patient record system. The nurse asks first about the ‘experimenting’ with drugs that appears in the case file. She wants to know if the pregnant woman has used any drugs during the pregnancy, and how regular use ‘experimenting’ implies. The pregnant woman explains that since she was about 18 her use has been irregular, and that she had only had alcohol until she found out about the pregnancy [which was quite far along]. The nurse wonders aloud why the previous nurse did not send the pregnant woman ‘to a special baby-family unit’ [outpatient clinics for substance users]. The pregnant woman further assures the nurse that it has been good to talk about these things but they already discussed the matter at the previous clinic and she had assured the nurse there that drug use was no longer a problem. Since the pregnant woman still smokes cigarettes, they have a little talk about the hazards smoking may cause for the baby-to-be. Finally, the nurse returns to the father-to-be in the context of practical help with the newborn baby. The pregnant woman says that they will see each other no matter what, and that he will be able to help, but she does not know if he is going to take paternity leave or not.

(Videotape T22, first pregnancy, 33+5 weeks of gestation)

Comparing this appointment with others with lone mothers in my material, there seem to be differences in the way single parenthood as a matter of concern is handled in the sequence of action, as well as in the style of addressing it. I would argue that this is probably not just because there seems to be more than one alarming life condition (drug abuse, cigarette-smoking, no education, low income) in the pregnant woman’s life, but also because she appears not to conform to the preference for the nuclear family expressed by the nurse in her systematic insistence on talking about and reflecting on the matter over and over again. The pregnant woman keeps deflecting and downplaying the nurse’s concern over her ability to manage her baby’s and her own life without the presence or support of the father-to-be.

This is not usually the case in appointments with lone mothers: lone motherhood is often enacted as a condition without a choice (see also May 2001). Here, however, the pregnant
woman herself emphasises on a few occasions that it is she who is having doubts about staying together with her partner. She also thinks that trying to work things out would cause her too much stress. It is as though she is not orienting herself to the cultural competence of families staying and working together implied in the nurse’s account of the importance of a paternal presence and the emotional transformation into fatherhood, as well as of workable household arrangements for infants. In a sense, the nurse here fails in her attempt to affectively evoke the ‘right’ maternal response to the situation.

Not orienting oneself to maternal competences and thus to the ‘virtuous’ transformation into a maternal self and starting the bonding with the baby-to-be (and being at 19 weeks of gestation before getting a pregnancy test is not a good sign in this regard, according to the temporal logic of care) under these conditions can also be interpreted as not orienting oneself to the conversational support offered by maternity healthcare. As already discussed, this conversational support is both ritualistic and therapeutic. That is, it is about both moral and social education, and relies on confessional methods such as ‘self-reflection’ and ‘self-exploration’ (e.g. Foucault 1990/1976; 2007; 2008/1977–1979; Skeggs 2004, 120–134; Yesilova 2008; 2009; Miller & Rose 2008). Not all people, however, have the same competence or will to act in therapeutic encounters, and consequently some can become the objects of professional concern and intervention.

In the snapshot above, as well as in many other appointment videos in my material, the pregnant woman partly succeeds in mastering the therapeutic code of the practice: the conversation flows smoothly without misunderstandings or tensions when, for instance, discussing the baby-centred space required in the home, or when reflecting on giving up substances and on career plans so that the pregnant woman will not have to rely on the state benefit system. However, it is not surprising that pregnant women already know the working methods and the vocabulary of therapeutic encounters with public services, given that affectively and therapeutically oriented support has been common in a wider range of welfare services for families since at least the 1980s (Yesilova 2008, 102–103; Hämäläinen 1992, 224–227).
However, it cannot be denied that in the case above, as well as in others like it, the pregnant woman is not totally emotionally supported in her choices and struggles over becoming a single mother-person, for she is not ‘willing’ to fight for a ‘proper’ family with two parents including a psychosocially attentive father. She does speak freely about her situation, but she is reluctant to re-evaluate and reflect on her choice. She does not conform perfectly to the position of a cooperating client (in preventive care) who can be ‘merely’ supported to help herself.

This woman’s apparent reluctance to conform by reflecting on her choices and life conditions according to the institutional scheme, as well as the multiple social problems in her life, have rendered and may again render her (and others like her) an object of intervention. Katja Yesilova (2008; 2009) has noted that in modern family education, not adapting to the practice of therapeutic narration and having attributes such as low social status, education or income (all of which are also expressed in the socio-material settings of people’s lives) may become signifiers of inability and failure in family life and parenthood, and thus become justifications for intervention. She further argues that in order to understand the apparent contradiction between an ideal of preventive agency that emphasises choice and autonomy on the one hand, and the legitimisation of forceful intervention on the other, we need to look at the relations enacted between the individual (families) and society. The logic of care assigns autonomy and choice to people who not only master institutional social conduct but are also autonomous in relations to society, whereas those who are (too) dependent on society, for income, services and so on, are enacted as justifiable targets of intervention by virtue of their conditions (ibid.).

Overall, it could be said that lack of competence or willingness to follow the institutional form of telling the (maternal) self may result in failure to acquire the institutional form of subjectivity and thus the relation to one’s unborn. In the institutional context, this maternal self is someone who responds to certain moral standards that are not just associated with love and care for one’s unborn on an emotional and attentive level, but are also linked to particular family relations, household arrangements and life cycles. It is implied that the
relations between pregnant women and their unborn are manifested and done in such relations and household arrangements.

This is not to say, however, that orientation to the affective and therapeutic repertoire and to the maternal competences and choices suggested is only required of those with multiple problematic life circumstances. In fact, in relation to youth and education (which may also relate to income), the nurses perceive young and uneducated women as being even easier to work with, as in the following quotations from interviews with two of the nurses in which they are describing differences among clients:

*Those who read a lot and are well educated think about things, maybe a little too much, things like interaction [with the child] or separation anxiety. They even use [professional] terminology that obviously comes from something they have read or heard. And then we have this 18-year-old young mum and she does everything just as well as this 40-year-old educated mum, but it comes naturally [for the 18-year-old]. The premises are just different. It may be that we end up dealing with the same issues, but the way they start producing things [issues perceived as important in parenthood] and what they ask are different.*

(Public health nurse 1, age group 31–40)

*Then there are these very young pregnant people, because I have these rental buildings [in her area] with tenants who have started their studies and then got pregnant. They set totally different requirements for my work than these people who have studied for a long time. With them we even start with things like cooking and nice things that I think I know very well and then I am a shoulder to cry on and I listen carefully. Then nowadays there are these people who have had fertility treatments. They are pretty hard for people in the early stages, because they are something that the people have hoped for and that feel unique. There is this feeling all the time that one wants to make sure that everything is really fine. Sometimes I feel that it is not natural anymore. It is a really great thing, though, that nowadays the treatments have developed so that they help people and that people can have children that way.*

(Public health nurse 4, age group 41–50)

In these quotations it seems that a preference for a certain kind of client performance is being sketched. An ideal pregnant woman for the nurses here does not act as if she is too informed, or at least does not use professional terminology, about pregnancy and childcare. It is even implied that education (especially about parental issues) may not help
at all, because arriving at issues that need to be dealt with before birth also comes ‘naturally’. However, a combination of youth and lack of education requires the nurses to attend to the basics of household work and so on, which is not seen as necessary with more mature pregnant women.

Ideally, the pregnant women have got pregnant without fertility treatments, the ‘natural’ way. As the second quotation shows, pregnant women with a background in fertility treatments require frequent (affective) attention to reassure them that the pregnancy and the unborn are doing fine.

All of these qualities attributed to different pregnant women are then associated by the nurses with educational level, age and living arrangements, which may or may not make the nurses’ work difficult. It is nevertheless implied that there are ‘natural’ ways of getting and being pregnant, and hence ‘unnatural’ ways of doing pregnancy that require special care and attention from the nurses.

‘Unnatural’ or ‘abnormal’ ways of doing pregnancy at the clinics do not only seem to result in associations with particular social positions or resources, but also in character statements about and pathologisations of the pregnant women. This is apparent in the next ethnographic description:

*It is a multi-professional team meeting among professionals only. As a final case, the team psychologist wants to discuss what to do with a pregnant woman who is really maternity healthcare critical. She explains that the woman has major issues about motherhood and that she is fairly old. The woman had been asking her whether the whole maternity healthcare is compulsory. Apparently, she is against being weighed and having her baby measured and so on. She has booked appointments but then often cancelled them. She also thinks that since she is in healthcare work herself she can do her own measurements. The psychologist comments that she has never encountered anything like it and that the woman is ‘really aggressive’. At this point another nurse joins in by saying that she remembers the woman and that she had asked her when she next had to come in. The nurse says that the woman and her partner will next come for the appointment where benefits are discussed, and in the meantime she will be taking her own blood pressure and urine tests. The social worker has also been working with this pregnant woman. She remembers that there*
has been some trouble in the relationship between the pregnant woman and her partner. It turns out that the pregnancy was a total surprise. The couple is in their 40s [the woman] and 50s [the man], and had got used to life without children. The discussion gets to wondering about the pregnant woman’s attitude, which seems weird to the team members. ‘Some women ask if they can come earlier,’ says the nurse. The psychologist tells the group that she has spoken over the phone to the woman, and that over the phone she was really pleasant and was thanking her for all the help. She had promised to call again but never had. She wonders again about the oddity of such an attitude against maternity healthcare, and characterises the woman as confrontational. The social worker from child welfare compares the woman to people who refuse vaccinations. They joke that at least the woman can’t perform a doctor’s examination on herself, so she will need to come to the clinic for those. Also the fact that the woman has been happy with the nurse’s and the psychologist’s work is discussed as a sign of hope for her future attendance. The nurse then suggests that the pregnant woman is in denial about the pregnancy. She thinks that the woman does not want to think about the whole issue, and unlike other women she does not think about the baby-to-be as looking like somebody and having a name. Furthermore, she is not buying baby goods or calling the clinic all the time as women usually do.

(Videotape multiprofessional-team meeting 8.11.2007, TpTiimi2)

Here we have a pregnant woman who refuses to attend maternity healthcare services on a regular basis and is openly critical of them. It seems that she has had trouble adapting to life with a surprise baby at a more mature age, and apparently her relationship with her partner has suffered from it. However, this is in no way really linked to her critical position on maternity healthcare. The team members seem to be looking for reasons in the woman’s character and state of mind. She is characterised as ‘aggressive’ and ‘confrontational’ as by implication are people who refuse to have their children vaccinated. Further along the line, it is speculated that the woman is having problems starting her mental transformation into motherhood. In other words, she is psychopathologised in relation to her failure to do pregnancy according to the terms and forms of self-narration and attendance laid down by the institution of maternity healthcare.96

96 For instance, Minna Kelhä (2008) has had similar results in her research on experiences of women having their firstborns.
Overall, it would seem more precise, then, to argue that in the institutional context of maternity healthcare, the way to display ability in pregnancy in terms of ‘proper’ motherhood (and hence to have a chance of avoiding unwanted intervention) is through institutionally legitimated techniques of self-narration. However, the ability to display respectability, and thus to become an agent in the practices of subjectification in maternity healthcare, is different for people from different social (or socio-material) backgrounds, although not wholly determined by those backgrounds. To be able to tell oneself in an institutionally appropriate way – for instance, by expressing guilt, willingness to change one’s lifestyle and life conditions, or conforming to the competences of motherhood and cooperation with professionals – is a way to be heard as an able subject in motherhood in maternity healthcare. However, the moral stories with moral mother-subjects enacted in encounters at the clinics may be enforced on some people. This happens when people are conditioned to either tell stories that do not fit their experience or story-telling styles in order be accounted for as respectable maternal subjects. The issue will be returned to in depth in the next chapter.

4.6 The logic of the trajectory of care: the birth of the social self

In this chapter I have analysed the practice of pregnancy care at the maternity healthcare clinics, where the formal and the informal are fitted together to form a network of heterogeneous materials of care. To borrow the standard lesson from STS: ‘if the networks are in place […] then there is ability. If they are not, well then, as is obvious, there is disability’ (Moser & Law 1999, 201). In this chapter I have concentrated on the networks in-the-making to produce ability to take the normative and institutional path(s) in pregnancy. I have followed those paths set for subjects in the orders of the material and discursive conditions of maternity healthcare. I have thus been tailing the normative subjectivities along the paths deemed important in the practices.

My analysis can be summarised as the following non-coherent and non-linear temporal path according to the agenda set for care practices:

1) Entering the system
2) Transforming lifestyles  
3) Addressing futures in pregnancy  
4) Doing pregnancy and making choices  
5) Counselling and advising on motherhood, fatherhood and parenthood  
6) Self-reflection and transforming selves and social relations  
7) Preparing for birth  
8) Birth  

The odd-numbered ‘steps’ represent the tasks set, and the even-numbered ones represent the desired consequences. Obviously, in specific paths of the maternity care of specific pregnant people, any one of the hoped-for consequences of care may fail to come true. In those cases, it seems to be the logic of care to try again and try something new. The path should also be understood as a compilation of my understanding of care for pregnancies (as enacted in the practices): the logic behind the observed care for pregnancy seems to be the same.

What, then, are the overall logic of the paths of maternity care? What does this process of care tell us about the relations between the pregnant woman and the unborn, and what are the social implications for the pregnant woman’s agency? It is possible to interpret the transformational agenda so that first the unborn is enacted as a foetus, a baby and a (potential for) human life in general, in quite technical medical terms. However, the unborn emerges as someone who is a maternal/paternal responsibility, and the work of building a sense of kin and transforming social relations begins with the start of a bonding process with the unborn in response to seeing the ultrasound image, hearing the foetal heartbeat, feeling the foetal movements and coming to know the potential harm caused to the unborn by one’s lifestyle.

The beginning and middle stages of pregnancy are also a time to make choices, not just in lifestyle but also about futures in pregnancy and early childhood, namely about birth method and parental leave. A preference for vaginal and hospitalised delivery, and for women as primary care-givers of infants, is expressed in the appointment work. However,
pregnant women and their partners are encouraged to do more pregnancy in order to know their own preferences. As such there are two logics of choice incorporated into clinical work: choice as a static activity, and choice as a process of coming to know. Making these choices is also manifest in choices about the life cycles of households and the division of labour within couples, which are often between men and women and thus expressive of particular type of woman-baby-to-be relation.

Around the beginning of the third trimester, there is a kind of leap in the unborn-woman relations in care. As the formal agenda has it, it is time for focused work on the transformation into motherhood, fatherhood and parenthood. Pursuing abstract and complex psychosocial well-being in terms of parenthood is quite a different kind of work than caring for clear-cut physiological and psychological complications. There are more and less standardised and formal ways of doing this work of transforming women and men into parents and the unborn into personalised children. On the one hand, there are the gradual changes in the ways the unborn are conceptualised throughout pregnancy. The nurses themselves recognise that the unborn become babies in their discourse in line with the progression of and care for pregnancy: when the risk of miscarriage diminishes (at 12 weeks of gestation), when there is a statistical possibility of survival for a premature infant (at 22 weeks of gestation), and when there are no abnormal findings in the foetal screenings (at 13 weeks or 20 weeks of gestation). The appointment practice also seems to reinforce the physiological continuity between a late-term unborn and an infant, and to associate the physical with the social and with sentience.

On the other hand, there are the less intuitive and more formal protocol-oriented ways to work on transforming social relations in pregnancy that involves transforming the interactions between couples and other close people, the physicalities, materialities and practicalities of everyday life and home, and images of oneself and one’s child-to-be. There are the counselling classes and appointment work, with and without standard forms, which invoke ‘self-reflection’ and ‘self-evaluation’ as working methods. What is then sought for is a transformation of the self to adapt and attune to physical realities and certain family values and virtues in early childhood in the name of bonding with the baby-
to-be. Overall, the transformation into family life and parenthood is conceptualised in terms of ‘psychosocial’ knowledge that focuses on the emotional and behavioural concerns of the immediate family and social relations, such as presence, attachment and interaction, even prior to birth. The unborn therefore emerge as babies and children with potentials through early interaction and emotional qualification. Although the scope of maternity care is defined as care and advice in both pregnancy and baby life, when advising on things associated with child-friendly life, such as setting rules, not suffocating children with too much maternal love and creating a loving atmosphere, the scope is widened to include more distant futures in childhood. Thus it is not just babies who are not forever babies that are being enacted, but also children who always remain one’s children.

Overall, the unborn as an object of care starts its journey as a technologically and scientifically known foetus and human life organically attached to its mother. It is performed as bound by nature to the pregnant woman (and by invitation to her partner). Still, as a human life it seems to have moral (and political) value per se, and since it grows inside a woman, she appears by nature to be more responsible for its health and care than, for example, her partner. The scientification of the unborn (in medical terms), then, works in concert with political and ethical preferences as to whose rights and autonomy should be protected in pregnancy (e.g. Patchesky 1987). This is not to say that pregnant women’s somatic experiences and feelings are not taken into account in maternity care or in making the unborn an object of care. On the contrary, the care work is characteristically affective work that among other things evokes feelings towards and images of the unborn so as to provoke maternal and paternal responses, builds self-reliance and manage anxieties about unpredictable futures in pregnancy. Furthermore, in nursing it seems that women’s instinctual knowledge of pregnancy and the unborn is granted status as knowledge alongside medical measurements as noted in other studies as well (e.g. Davis-Floyd & Davis 1996).

As pregnancy progresses, the unborn and its relation to its mother is transformed gradually through a bonding process supported by maternity healthcare and in line with the progression of pregnancy. Doing pregnancy in the body – i.e. establishing rhythms, feeling
the movements and the laborious body, seeing the ultrasound, hearing the heartbeat, talking to and imagining the unborn, inviting partners to interact through the abdominal wall and so on – is encouraged and taken into account in clinical work to make women know and care for their pregnancy and unborn.

However, since this instinctual and bodily work is not sufficient according to the current ideology on maternal competences, multi-professional and other help is perceived as necessary. Pregnant women are scientifically educated in family psychology to know their baby-to-be’s needs and demands, and thus how to care for their baby. The relations between a pregnant woman and her unborn, in effect, are enacted as psychological (and social) attachment, interaction and a potentially over-solicitous attentiveness in need of possible intervention.

The maternal competence to bond with one’s baby-to-be without smothering the child is achieved through teamwork. Whereas scientisation (in medical and technical terms) of the early-term unborn somewhat marginalises the social, the scientisation (in psychosocial terms) of the late-term unborn does not. In fact, psychosocial knowledge appeals to the ‘social’ and relies on family members and peer groups, even ‘the whole village’, for social support and ordinary reasoning to support women and men to learn to help themselves. It seems that in early pregnancy medical actors, such as reproductive technology, examinations and doctors (and to some extent nurses), are the key advisors. Conversely, framing pregnancy and the unborn as social, psychological and moral issues opens up pregnancy for the scrutiny and ownership of a multitude of actors.

This is not to say that the unborn is not a social or moral concern at all in the early stages of pregnancy, but that it is so in more intensified and complex terms later on. It could be said that the organic and sensory connection to the pregnant woman dissolves gradually in care practices when it is slowly transformed into a particular social being with personality traits, and inserted into a particular household and family unit that has been made by transforming socio-material relations within the group of people expecting it.
There is also a division of labour in the work of transformation, manifest for example in the preventive and supportive role of maternity healthcare in helping couples to help themselves, in the technology mediating the unborn and social relations, and in nature – both as mystical instinct and intervener and as scientific, empirically measurable natural law – taking over bodies and family realities. Furthermore, the division of labour is a gendered one, since the default composition of couples seems to be enacted as woman-mother and man-father, regardless of the biological sex of the actual partner. In simplified terms, women are assigned more tasks of (bodily) nurture and men more tasks of household economy and around the home, even though the division has opened up somewhat in the sense that a male presence and childcare by men are perceived as important, as is the attentiveness of other close people. The nuclear family is not such a normative must that other family formations would be considered to be in need of specific interventions. Partners and other close people and helping hands are, however, represented as being in need of special invitation into relations with and care of the unborn, and the task of making the invitation is assigned to pregnant women. This consists in encouragement to touch, feel, see and hear the unborn, often through technology: to get physical sensations so as to achieve mental motivation which women are granted by the virtue of their ‘natural’ bodily process.

All this is in line with what could be characterised as the current citizenship model of healthcare: working in multiple partnership between professionals and laypeople in the name of equality and autonomy. Services are provided equally and non-coercively for all. This is also apparent in the casualness and friendly atmosphere of the clinics. However, since the manner in which the services are provided appears to be characteristically affective and therapeutic in nature when it comes to family matters (see also Yesilova 2008; 2009), the civic model is not without problems, since not all people have the same competence to act in therapeutic encounters. As a consequence, they may become the objects of professional concern, and thus intervention.
5. Multiple ruling relations in making the unborn–woman relations

As demonstrated in the previous chapters, the temporal movements in the processes of care for pregnancies follow the logic by which mental and socio-material transformations are encouraged to develop from nurturing and caring for a foetus, a human life and a baby in itself to attending to one’s own particular baby and a child with at least potential personality traits, gender and social identity, and kin ties. In the practices of maternity healthcare these ties and social relations to one’s unborn are enacted as, above all, emotional affection and preparation, early interaction and, potentially, over-attentiveness, that coincide with psychosocial knowledge of and approaches to the abstract issue of parenthood.

The temporal logic of the enacted relationship between the pregnant woman and the unborn does not, however, exhaustively explain the formation of the multiple relationships in maternity healthcare practices. As already hinted earlier there are other thematic logics at play that cannot be linked to any specific phase or point in the trajectory of care. They do, however, relate to the temporal logics: they are also indicative of the ruling relations coordinating work activities at the clinics, and, more specifically, of the organisation of maternal–unborn relations. In this final analytical chapter, I will attend to all of these logics in detail, and at a more abstract level than previously.

The themes in making unborn relations are technoscience-in-the-making, politics/citizens-in-the-making, divergence/class-in-the-making and consumers/product-fetishes-in-the-making. These logics of making actually make and break the temporal logic of transforming foetuses, human life and babies in general into particular babies and children with identities and social bonds. When chained together in a process – science-politics-class-market – the process is analogous to that of the (ideal) temporal process of care: foetus as technical-clinical creature is the product of reproductive science, and as it enters social practice it is quickly transformed into a question about values, responsibilities and
politics in reproduction. As Donna Haraway (1997, 189) puts it: ‘reproductive politics are at the heart of the question about citizenship, liberty, family and nation’. The work of transformation into the psychosocial attentive parenthood and desired family relations towards the unborn involves a reflexive work of self-formation that is linked to citizenship rights, responsibilities and belongings, and liberties. Such work is organised not just in terms of the nation but also of social class. Finally, in today’s consumer culture and societies in late capitalism, it is no wonder that becoming a baby and a (respectable) mother is organised as well in terms of consumption and the market, which have also altered care for pregnancies.

5.1. Technoscientification of the unborn–woman relations

According to a long tradition of feminist and gender studies research, alongside the development, implementation and increasing (routine) use of reproductive technologies, pregnancy has been altered, in Barbara Duden’s words (1993, 2), into ‘a process to be managed, the expected child into a foetus, the mother into an ecosystem, the unborn into a life, and life into a supreme value’ (e.g. Franklin & Lury & Stacey 2000, 36; McNeil 2007). In the following sections I will shed light on the meaning of this quotation, and relate it to my own research.

The foetus as a concept or an actor in pregnancy has not always existed. It has its origins in different visualising techniques, from anatomical drawings of the early nineteenth century to the use of ultrasound technology on pregnant women from the 1960s onwards, and other medical technologies, procedures and discourses of the more recent past (Duden 1993; 1999). A common understanding of the effects of reproductive technology, technology-driven healthcare practice and their offspring, the foetus, on the unborn–maternal relation seems to be that they disconnect the unborn from the pregnant woman, which has been viewed both as providing reproductive freedom and as stripping women of agency (e.g. Firestone 1971 vs. Oakley 1984, 155–187). Technology and medical practice are observed as dissolving women’s bodily boundaries, undermining their experiential knowledge, and representing the unborn as an autonomous, separate and conscious being (e.g. Mitchell & Georges 1998; Oakley 1984; Martin 1987; Wajcman 2000). It is easy to
agree with this characterisation when thinking about, for example, the ultrasound picture that enables a view into the previously opaque womb. In the picture, the foetal figure is enlarged and maternal ‘adhesions’, such as the womb walls, umbilical cord, mucus membranes and so on, often barely show. Simultaneously, as it is possible for others, partners, relatives, friends and healthcare personnel, to observe and monitor the foetus, so the unborn is transformed into a social being in a network of social relations. (see also e.g. Bordo 1993, 85–87; Morgan 1996, 47–48; Rothman 1989b, 104.)

Technology and medical practice have been seen as having a more woman-friendly face, as well, and my own findings have convinced me that this is the case. Technological development has been seen as providing women with improved well-being and freedom from the constraints imposed by the biological reproductive functions of the female body, especially by such hopeful advocates of the first two generations of feminists as Simone de Beauvoir (2011/1949) and Shulamith Firestone (1971). Removing reproduction and, thus, the foetus from the female body has even been perceived as making sexual difference redundant, as it cannot then be mobilised to uphold women’s subordinate positions (Burrell 2003, 13). Optimistic views on reproductive technology and its practices, often assigned to liberal feminists, have diminished as the realities of the use of reproductive technology and science have become clearer. The promising scenarios seem to have turned into scenarios of greater control over women’s reproductive lives in a world where, for example, a technological intervention becomes a must in pregnancy (as my study shows) and where legal documents on fertility treatments cast single women and women couples as selfish for wanting a child (Burrell 2003, 48). When legislative and medical actors push themselves into the front stage of procreation it cannot be stated that the technological foetus, the product of technoscience, is really providing freedom, well-being or agency for women.

According to my own observations and interviews the unborn is rarely referred to as a mere foetus in purely technical–medical scientific terms of the capabilities of the ultrasound or other reproductive technology. In fact babies and children that do things and are attributed qualifications and potentials appear in care practices right from the outset. It
is only in the context of making choices about attending foetal screenings and methods of birth, as well as discussing physical uncertainties in pregnancies, that the nurses tend to adhere somewhat systematically to technical information about the examination in line with the formal protocols set for maternity healthcare work. When talking about and using technology in other contexts, especially ultrasound, even during the same appointment, the biomedical models lose their hold. Overall, there is a certain inconsistency to the temporal logic of transforming the unborn from a being that has value as a human life and human characteristics in itself to a particular human being with social relations and attributes.

The logic of this inconsistency resides, in my view, in the affective management of the fears and anxieties experienced about unpredictable screening results by pregnant women (and their partners), as well as the nurses themselves. Avoiding personification of the unborn by using technical measurement language and/or not attributing the unborn any agency or socio-material place in the family life is a way for nurses to be considerate towards pregnant peoples’ emotions, and for the pregnant women to be emotionally prepared for the worst-case scenario. More generally, it seems that the physical uncertainties in pregnancy, especially those that require making choices about taking action, such as birth mode and breastfeeding, seem to evoke the mobilisation of medical and biological ‘facts’ or even the medicalisation of emotions, such as fear of birth, for emotional and therapeutic purposes. Biological processes, objects and ‘facts’ – ‘the fate of nature’ – are interestingly used to affectively ease the culturally normative pressure regarding maternal competences and identity in situations where pregnant women are faced with uncertainties about the physicalities and health of themselves or their unborn. In other contexts, these biological facts turn into cute babies and kin responsibilities that are used to work affectively on emotional (maternal/paternal) responses toward the unborn (cf. on agency of affects Ahmed 2004; Gorton 2007).

This is the informal order of things, however. There is, obviously, a more formal explanation for being reticent and not mixing biological ‘facts’ with (family) values, virtues and emotions, namely, the one major principle of Western medical ethics: respect for autonomy and informed choice in medical decision-making. It is not surprising that a
line of argument that relies on biomedical ‘facts’ is chosen in the context where healthcare staff are held accountable to clients for not influencing their decision in any way. Biomedical scientific knowledge is a powerful cultural tool for such a purpose of expressing ‘neutrality’ because it holds its position as the form of a supreme ‘knowledge-power’, to use a Foucauldian term, of our times (see Haraway 1997, 217; Franklin 2001, 309, 312; Foucault 1990/1976, 68, 71).

This means that the ‘neutrality’ or ‘objectivity’ of the medical-scientific knowledge and discourse is, in fact, a culturally and historically constituted product of power (Foucault 1990/1976; as related to affects Hardt 1999; Hardt & Negri 2001, 264–365): ‘certainties’ about pregnancy and foetuses are in fact historical contingencies (Duden 1999). Biomedicine and biology as discourses and practices have gained a power position to give us ‘facts’ and findings about what we really are, ontologically, via a historically specific (political) process that has placed bodies centre stage in subject formation and study (Foucault 1990/1976; see also Franklin 2001, 312; Haraway 1997, 217). More specifically, these ‘facts’ and findings are enacted in various practices of ‘(re)naturalisation’. That is, the object (and product) of biological and biomedical study, the nature of things, is (re)made in an ongoing process of grounding it in cultural meanings and practice in an effort to authorise it to stand for an a priori immutable law and origin of the world (Franklin & Lury & Stacey 2000, 19–21; Williams 1980, 67–68). As ‘neutral’ and ‘objective’ products of naturalisation of a knowledge form and the basis for determining the very essence and futures of human subjects, biomedical and biological facts serve the purpose of management of life.

Further, historically, this management of and power over life, biopower, that ‘knows’ biomedically, is strategically focused on women and children. The female body has been medicalised and bound to reproduction in the name of the family institution, the health of children and the whole population – in the name of the continuity of the whole society. In this way the female subject has also been ‘sexualised’: gendered healthcare practices have been aimed at regulating sexuality (Foucault 1990/1976, 144, 146–147, 153) Another way of saying this is that the (techno)scientification of reproduction (as well as bodily functions
in general) is and has been deeply gendered and sexualised (e.g. Haraway 1991a; 1997; 2004a; Franklin, Lury and Stacey 2000, 45–47; Strathern 1992).

In short, the technoscientifically known biological nature (of women) has been perceived as feminised anew by the masculine (as perceived) philosophy deriving all the way from the Enlightenment period. ‘The modest witness’\(^\text{97}\), as Donna Haraway (1997, 22–25) delightfully calls the central figure of modern science that insists on transcendental truths about the object world, was instrumental in both sustaining and crafting new gendered ways of life (ibid., 28). Women became associated with nature and the natural not just in terms of their feminine ‘natures’ (‘unruly’ natural capacities) of the more distant past, but also as the feminine and the natural became metaphorically linked. Femininity that was linked to the subjective and bodily could not be the source of the virtue of the ‘man-scientist’, the new masculine virtue. The virtues of modern science, then, became the virtues of the mind, such as transparency and self-invisibility. These virtues were perceived as crucial in giving credibility to descriptions of different kinds of ‘bodies’ and their ‘natural’ secrets which, in turn, were associated with femininity. (ibid., 29–33.) Thereafter the so-called biological facts of sexual reproduction have been used to restrict women’s role in science and society, and to sustain gendered assumptions shaping reproductive processes, sex categories and so on (Haraway 1991a; 1991b, 152, 167–173).

In the powerful gendered practices and processes of naturalisation, the foetus has been claimed to have transformed into an icon and a symbol of life, humanity, and its fragility and exposure to risk (Franklin & Lury & Stacey 2000a, 11–12: 2000b, 33–36). The combination of apparent autonomy and permeability in the conceptions of the foetus and foetal–maternal relations leads to a particular understanding of risk and responsibility (ibid., 36; Hartouni 1999; Petchesky 1987). The foetus is threatened by the negative influences of its ‘environment’, the maternal body, and, thus, the (medically informed) discourse on the foetus invokes collective and individual responsibility for the future of life (itself). The duty, and the ‘imperative must’, of the pregnant woman, then, is to

manifest in her behaviour the fact that she is the custodian of a new life (Franklin & Lury & Stacey 2000b, 36; see also Duden 1993). Such is the foetal power.

Given the contemporary discursive climate of custodian responsibility it is, then, understandable that the women in my study are constantly monitored: they are, to a large measure, held responsible for their lifestyle and expected to comply with medical advice and information, as well as to use any technology available for the monitoring of themselves and their unborn during pregnancy, in and outside maternity healthcare. Likewise, it comes as no surprise that women attune to these normative expectations to a great extent, as documented in Chapters 3–4. Biologically, biochemically and biomedically grounded advice, information and style of argumentation seem to be ‘stating the obvious’ about the matters at hand to such an extent that they do not require justification in other terms.

**The foetal patient and the authority of the medical profession**

The subject of medical practice is ‘the patient’. From the legal perspective, the foetus is not a subject in Finland, and there remains a lack of agreement on its moral status (Burrell 2003). However, it has been observed that the medical technologies and practice tend to promote a model of ‘two patients’ in pregnancy (Williams 2005, 2087; McLean 1999). Sheila McLean (1999) has noted that the problem with the notion of two patients is that the principles of Western medical ethics – justice, respect for autonomy, beneficence and non-maleficence – are highly individualised concepts not capable of balancing competing needs of patients. Due to this lack of capability there is a danger of promoting foetal personhood in the increasing discourse around foetal patienthood, which may in turn affect the status of the pregnant woman.

Monica J. Casper (1998), for example, has argued in her study of foetal surgery that despite variation in the constitution of foetuses as patients or persons across different sites of practices, foetuses are institutionally defined as the most significant object of the work. Institutional hierarchies shape the process of patient selection. Although ‘non-clinical’ factors do to some extent affect the ‘who’ of foetal surgery, it is often the clinical factors
that win the day. Surgeons may have the decisive power over criteria for choosing good candidates for surgery but other healthcare staff, such as obstetricians and social workers, have a say about the treatment through activities that promote maternal (and foetal) health and well-being.

Supporting the work of Casper (1998), Clare Williams (2005) concluded in her study on foetal patienthood in medical literature and professional accounts that ‘the increasing number of diagnoses of foetal conditions, leading either to foetal surgery or to treatment post delivery, has at least the potential to shift the status of the foetus towards that of a patient, with possible links to personhood. At the same time, this shift can alter the status of the pregnant woman, increasing her responsibilities [to attend surgery], whilst potentially making her less visible.’ (ibid., 2092.) What we have here, in fact, is the longstanding feminist argument about reproductive technologies’ potential to ‘erase’ women while constructing foetuses as subjects (Oakley 1984; Martin 1987; Petchesky 1987). This does not mean that pregnant women cannot be active agents in clinical practice or in relation to technologies, nor that technology or maternity healthcare cannot provide feelings of security and welfare for women. There are, however, subtle signs, with new options being offered in new reproductive medicine, that the concept of responsibility is being expanded along the options of technology. (Beck-Gernshein 2000; Markens & Browner & Press 1997, 353.)

Foetal patients sometimes appear in the everyday work practices of the maternity healthcare clinics but they travel there from the hospital via patient records, telephone calls and medical literature, as discussed earlier in the cases of divergent paths (Chapter 4.5). There are also similarities in the ways viability is linked to the status of the unborn, and how unborn/foetal agency is enacted. Like in medical practice and literature, as the pregnancy proceeds to the 20-something weeks of gestation entitlement to protection increases (discussed in terms of ‘beneficence’ in medical practice) in line with the perceived physical capabilities of the unborn. Also, how agency is attributed similarly includes physical hands-on intervention, guidance and a line of argument within which the unborn do and are a lot of things that cannot be reduced to technical–medical terminology,
both at the doctor’s office/hospital and the clinics. (see also e.g. Casper 1994; 1998; Williams 2005, 2088–2093.) Despite these links between the concept of foetal patienthood and my own study, the unborn emerging in the practices of nursing in maternity healthcare in Finland, can hardly be conceptualised in terms of foetal patients. The status of the unborn is more or differently multiple, if you will, and the model of ‘two patients’ in pregnancy is from the start a problematic concept in the Finnish welfare services context. I will return to this issue in the next subchapter.

For now it is sufficient to say that the institutional hierarchies and history of maternity healthcare set this order of things where nurses do not make diagnostic and treatment decisions that shape foetal patients (cf. Kuronen 1994a; 1999). Foetal patients, then, are merely transformed at the clinics, through working for emotional, psychosocial and socio-material transformations in family life to adapt to the particular disability at hand, possibly postnatally.

Above all, there is no denying the influence of the medical practice in the (cooperative/team) work organisation at the clinics. They are not just granted power over diagnostic and treatment decisions when it comes to physical health and illness (or psychological diagnostics and treatment in case of a psychiatrist/psychologist) but also argumentative authority, like in the following ethnographic snapshot from a team meeting:

*It is a multi-professional meeting for interprofessional consultation only [no clients]. The nurse brings up a case she feels problematic. She elaborates that she has a client who has had mental problems during and before pregnancy and is now having problems with feeding the baby and being totally exhausted. The woman refuses domestic help from family care workers, recommendations to start antidepressants or ‘anything the nurse suggests’. She does, however, regularly meet with a psychiatrist. The nurse describes the woman as ‘hanging on the baby’: she does not want even the dad to take care of the baby and is worried sick over the baby not eating enough, although the nurse thinks that the baby has grown according to the growth curve. The nurse has emphasised to the woman the importance of establishing daily eating rhythms. The social worker, here, asks if the woman has a mother or anybody who could help and teach the woman [to establish rhythms]. Apparently both her and her husband’s parents are at home [a reference to them being retired] but she refuses help from them, and she does not want to join the mothers’*
group that meets at the clinic. ‘She even hogs the baby from the dad’, says the nurse according to her observations at the appointments. The social worker, then, asks if the nurse thinks that some sort of joint intervention with more professionals might help the woman. The other social worker from child welfare services joins in by suggesting a meeting with a doctor: ‘advice that carries weight’. The social worker from family care work agrees by saying that ‘doctors’ advice does carry weight’. The other social worker goes on to suggest that the doctor could work through the importance of eating rhythms, and how a child can learn, with the woman. The nurses express their doubt about this woman listening to a doctor. The discussion turns to talking about problems with the baby’s motor skills which are, then, related to the woman not letting the baby crawl on the floor. Discussion moves to analysis of the mother not wanting the baby to want anybody but her as its caregiver. They think through bringing the dad for more support, and about the sufficiency of the meetings with the psychiatrist. The team psychologist notes, here, that a psychiatrist is a [medical] doctor. The nurse, then, explains how she came to find out about the mental problems by accident really, and how the woman had confessed that she had deliberately kept the information to herself. The team talks about how admitting mental problems might bring into question her [competence in] maternity. Finally they decide to try to arrange a joint intervention in which the dad will also participate. The attendance of the doctor is raised once more, but family care workers are also invited to come along to visit the family. It turns out that the woman is ready start antidepressants as long as she manages to stop breastfeeding, and the team thinks that they might be able to convince the woman that she needs help at the point when she starts the medication.

(Videotape TPTeam2, 8.11.2007, doctor not present)

Most of all this is a description of performing maternal over-attentiveness as well as psychosocial problems. It is clear that the nurses, family care workers and social workers are not questioning their own expertise in solving such problems, but they grant the medical profession a certain authority in arguing their case more strongly. However towards the end of the sequence, when the problem of the woman is negotiated as being a need for domestic help when giving up breastfeeding and starting antidepressants rather than a need to be convinced by a paediatrics professional that her baby needs a regular eating rhythm, the authority of the doctor is diminished a little.

It would be an overstatement to say that, despite the official division of labour and care agenda or tasks in the institution, the doctors have a say in other areas of care too. Rather, I would argue here, as elsewhere, that the nurses (and social workers etc.) strategically use/think about using the strong cultural authority granted to the medical expertise (see
also e.g. Oakley 1984, 250–274). However, in the Finnish context, one has to be careful about overemphasising the control of medical practice and knowledge. Firstly this is because, historically, midwives and public health nurses have for the most part worked together with doctors as professionals in establishing and maintaining maternity healthcare services both at the level of policy and practice (Wrede 2001; Henriksson 1998; Kuronen 1994b). Secondly, the services in Finland contain a lot of the elements that feminist critique of maternity healthcare during 1980s and 1990s demanded from maternity healthcare: social support on the side of medical screenings, midwives and nurses to replace doctors and long-lasting client–professional relationships (see e.g Oakley 1984; 1992; also Kuronen 1994a, 130; 1999).

Furthermore, medical technological (professional) practice is also openly critiqued at the clinics by both the pregnant women and the nurses. In the critical repertoire doctors and medical professional culture are characterised as sometimes ‘too theoretical’ to deal with family life and parenthood issues (e.g. Videotape Team1, 16.10.2007), as giving ‘too obscure’ terminological answers and as being inconsiderate about or even neglectful of people’s hardship. The use of reproductive technology is also critiqued. It seems that, especially in the nurses’ accounts, technology should be used to help ‘nature’ run its course. Sometimes, however, nature makes ‘mistakes’, like in the case described earlier of a severely disabled baby (Videotape P12N, first pregnancy, 37 weeks of gestation). Then, according to the logic of this line of argument, people in charge of the technology (doctors) should maybe refrain from using the technology and, in a manner of speaking, allow nature to correct its mistake. Occasionally the nurses appeal critically to a different domain and practice where the unborn are equally as salient as dispensable human life, namely abortion practice and politics (Field note observations 15.3.2007, clinic P). They wonder about the rationale of using technology to keep alive severely disabled babies while potentially perfectly healthy unborn are ‘thrown to trash’ elsewhere. In this way, they are politically aware of the ambiguity of the use of reproductive technologies. By implication the unborn that stir no social or political ambivalence about the worthiness of care and life are those who survive full term pregnancies, birth and infant life without major technological interventions. The same kind of rationale is applied to infertility
treatments as they are sometimes, although in a less political manner, described as resulting in ‘unnatural’ pregnancies.

Nature, in the critical repertoire of my informant nurses, is understood as both ‘bodies out there’ (of foetuses and pregnant women) and as remade through technology. The body out there is separate from biology/biomedicine that, as established, is after all a material-semiotic practice and discourse (see Haraway 1997, 217). This natural body, then, should not always, according to the nurses, be ‘assisted’ or remade through technology (culture) (on culture/technology as assisting nature see e.g. Franklin & Lury & Stacey 2000 [eds.]; Strathern 1992). Some remade bodies seem ‘unnatural’ in the sense that they threaten a cultural understanding of natural limit regarding kinship, relatedness and identity (Franklin 2001, 313–314; Haraway 1997, 56).

The bodies out there, in the nurses’ accounts, are not complexes that are not ordered by biologically produced ‘facts’ or ‘laws. Paradoxically, in a way, the body out there and the remade body are the offspring of reproductive technologies and technology-driven medical practice (Rabinow 1996; Strathern 1992). The difference in the meaning-making is that pregnancy, as this relatively separate domain subject to its own orderliness (the ‘natural course of pregnancy’), has been renaturalised, and pregnancy with major assistance and intervention is denaturalised. Given the historical process by which reproduction and pregnancy have become the objects of intense scrutiny and fascination it comes as a no surprise that the processes of (re/de)naturalisation raise major ethical, moral, political and social concerns. This is apparent, for example, in a line of argument that draws disturbing parallels between ART, foetal surgery, post-delivery treatment and abortion (practices and politics).

In effect, the activities at the clinics, including meaning-making, cannot be explained thoroughly just by concluding that they rely on the omniscience of technoscientific confirmation and treatment that follow the logic of medical ethical models of preserving life at all costs i.e. having some control over ‘the fate of nature’. Medical scientific and biological models in alliance with medical ethical models certainly order care practices.

This is not to say that maternalism, a pro-natalist population policy and medical authority have not had their conflicting interests or positions on how policy or the service system should be organised. Rather, the history of conflicting interests and different positions between various political agencies can be seen as leading to the model of Finnish maternity healthcare and family politics and legislation, where medical actors do not have a central role and the unborn is protected indirectly through protecting the pregnant woman, her personal liberty and integrity, as noted in many studies (Wrede 2003; Nätkin 1997; 2006; Burrell 2003). Hence medical models and reasoning are transformed, and they often work as a complement to a less visible and formal logic of provoking feminine bodily qualities and affects.

As demonstrated in Chapters 3 and 4 these qualities are implied to enable women by the virtue of their ‘nature’ to know foetal health and sex of their unborn. This is clear, for example, when nurses ask pregnant women if they had peculiar feelings about the sex of the unborn before the ultrasound technician gives her opinion, and when they stress maternal feeling about ‘something being wrong’ after this is found to be the case medically by technological means. Technology and medical examination, then, seem to allow women to know something that they might already have known. In practice, in fact, feelings based on maternal experience (‘maternal instinct’) sometimes take precedence over technological measurements. This partly mystifies the female nature, associating women with nature and the natural capacities of reproduction but not wholly with the biologically known nature. It is as though feminine ‘destiny’ as an origin of life still complements biological nature in the practices of maternity healthcare (Williams 1980). Simultaneously, paying attention to estimates based on maternal experience at the clinics erodes the omniscience of technoscientific knowledge about pregnancy and does not dissolve the organic/somatic attachment of the unborn and the pregnant woman as medical-technological practices and discourses tend to do.
Modern biological and biomedical knowledge and technology are crucial in (re)shaping our understandings and practices regarding not just gender but also kin relatedness (Franklin 2001; Haraway 1997, 53, 217). A common understanding in both popular discourse and anthropological theory has been that the so-called biological ties seen as an artefact of ‘natural’ facts of sexual reproduction are the bases of kinship. This view has been challenged since about the 1980s, especially by feminist writers, along the lines of challenging the biological facts per se as a prediscursive objective truth about the world (e.g. MacCormack & Strathern [eds.] 1980; Yanagisako & Delaney [eds.] 1995; Franklin & McKinnon [eds.] 2001). It has been argued that just as gender is not some symbolic construction that comes after fixed and inevitable ‘natural’ sex categories neither does kinship naturally follow biological reproduction (of those sexes) (Franklin 2001). In other words the biological model of reproduction is, in fact, naturalised as some primordial natural and factual origin out of which kin ties are seen to be constituted. More recently, kinship has been understood and analysed as performed in material-semiotic practices and processes where culture and nature are connected in culturally specific ways (ibid).

Such an approach, that we might call ‘kinship-in-the-making’ along with Sarah Franklin and Susan McKinnon (2001, 1), has ‘consequences not only for how one understands what kinship is, means and does, but also for how kinship can be seen to illustrate culturally specific features of what a Euro-American “understanding” is comprised of in itself’ (ibid., 5). This view has expanded the applicability of the concept of kinship and its contexts of investigation. As examples, international adoption (e.g Howell 2001), global capitalism (e.g. McKinnon 2001), virtual life (e.g. Helmreich 2001) and lesbian and gay cultures of relatedness (e.g. Hayden 1995), as well as (new) reproductive technologies (Edwards et al. 1999; Bouquet 2001) have been studied as sites of and challenges to enacting kinship.

In the context of reproductive technology and healthcare, it has been argued that the result of ‘performing’ kinship in this way is both the destabilisation of who is kin, and the categorical reinforcement of kinship (Franklin 2001, 311–312; see also Cussins 1998).
Charis Thompson (1998; 2001; 2005), in her ethnography of infertility treatments, shows how a combination of bodies of gestation, intent, genetics and financial transactions or emotional/familial commitments produce maternal ties. The clinical practice of the treatment raises a challenge to biological essentialism, for example, in that it shows how the egg, gestation and biological mother are, in fact, separable. The practice also maintains essentialism, for example, by strategically naturalising genetic cognate ties in the choices of egg/sperm donor from the same ethnic group or family.

In my own material there is often merely brief references made to getting pregnant by using infertility treatments. Below is a snapshot of one such case. It is a very short appointment for both the pregnant mother and her firstborn six-month-old baby:

The nurse starts the appointment by asking the pregnant woman holding her firstborn in her arms about the due date of the unborn and congratulates her. After establishing the due date the nurse asks if this pregnancy was also conceived with artificial insemination [as apparently was the case with her first pregnancy]. The woman replies that yes it was and that ‘it succeeded the first time. Even the doctor was surprised when they changed the treatment method’. She continues that she already has an ultrasound appointment scheduled for nuchal translucency at the hospital. The nurse and the pregnant woman go on discussing the woman’s short return to work before her next maternal leave and pregnancy symptoms. When the nurse asks about earlier births and pregnancies, it is revealed that the woman had also been pregnant in 2005. At this point the woman herself makes a point about not telling anybody about the pregnancy before the first scan. For the rest of the appointment nothing related to ART comes up anymore.

(Videotape T24N, second child, third pregnancy, 8+3 weeks of gestation)

Despite the occasional comment made about the ‘unnatural’ character of infertility treatments (e.g. interview Nurse 4) at the clinics, I would argue that, especially low-tech, assistive reproductive technologies in achieving pregnancy are to a large extent naturalised in the sense that there seems to be no uncertainty or confusion surrounding producing kinship this way. In the above snapshot the assisted nature of the pregnancy is not really treated as something that should necessarily affect the care (plan) of the pregnant women. As noted in the previous chapter, some women with infertility issues have such fears and

Surely, there is also appointment work where infertility treatment background raises concerns as suggested also by the nurses concern over the care for women and men with fears linked to infertility treatments.
anxieties that they need special reassuring and attention from the nurses, but this attention
does not often challenge the sense of natural limit to kinship or maternity (or paternity).

Even less ambivalent seems to be the relation to routinely used reproductive technology,
such as the ultrasound, Dobbler device and the tests and measurements done to women
during pregnancy. They seem to be taken for granted ‘goods’ of pregnancy, part of
having a normal, natural pregnancy (cf. Franklin 1997). That is, in everyday life in and
outside the clinics, the custodial role of technology is overlooked, and the foetus as kin and
as a person with gender identity as an artificial and culturally and historically specific actor
does not emerge as being of an ‘unnatural kind’.

It may even be said that the reproductive technology used to monitor pregnancies at and
through the clinics has become a ritualistic practice of kinship, family and gender identity
(see also Han 2009). Sallie Han (2009) has argued for a ritualistic understanding of
reproductive technology in the context of ultrasound scanning. According to her argument,
reproductive science and medicine ritualistically assign personhood to the unborn before
birth in the Western world. This granting of personhood and individualising rite of
passage, if you will, is, however, highly culturally specific. Across cultures and their
histories anthropologists have shown that pregnancy may only be confirmed with the birth
of a living child, and the status of a social and gendered person and identity may only be
obtainable through rituals and rites of passage long after birth (ibid., 275–276; Kopytoff
2009).

I want to broaden Han’s argument to include all reproductive technology, old and new,
low- and high-tech, used to monitor pregnancies at and through the clinics. Ultrasound
scanning, as a ritual practice of seeing, is culturally especially powerful in that it has been
enacted as a pivotal site for seeing one’s ‘baby’ for the first time, getting ‘the baby’s first
picture’ and a site boosting the bonding process and the process of acquisition of maternal,

99 Including blood testing for syphilis and HIV.
100 All these tests are voluntary in legal terms, but looking at the activities and interchanges at the
appointments it appears that attending them has become so taken for granted that, with the exception of
foetal screening, the nurses often do not even ask for consent.
and, according to my findings especially, paternal identity and competences (ibid., Taylor 2004b; Mitchell & Georges 1998). Further, the ultrasound stands as one of the biggest ‘tests’ that women need to ‘pass’ as pregnant women (Han 2009). This is implied in comments about not telling anybody about the pregnancy before the scan, like in the snapshot above, and not making any household arrangements or purchases or even thinking about the unborn as ‘real’ or a baby, as discussed in Chapter 3. What is implied, then, is that the biomedical ‘facts’ delivered by this testing practice have an enormous power in the constitution of kin relations embodied in different kinds of preparations involving material and social arrangement in the making of family (practice). Such preparations include everything from establishing daily life cycle with other (extended) family members to taking care of the unborn and later on the baby, to decorating a nursery to match one’s sense of style and buying childproof equipment, as elaborated in Chapters 3–4.

Even if not as evidently, however, the pregnancy test, the routine testing of blood sugar levels, blood pressure, protein in urine and weight gain, listening to the foetal heart beat, hands-on measurement of the abdomen, and further foetal screenings can also be viewed as rites in the passage from woman to pregnant woman to mother. Such tests and monitoring technology screen foetal and maternal health but, in practice, attending them is also a performance for the symbolic value of respectability as a mother(-to-be). C. H. Browner and Nancy Press (1996) have argued that adherence to reproductive technology in pregnancy is the only culturally approved way to reassure oneself and others that one is doing all she can. Submitting to regular testing has become the prerequisite of showing one’s affiliation to one’s baby(-to-be) in the normative orders of maternity healthcare.\footnote{Margareta Bredmar (1999) has made a similar observation in her study on the communicative interaction between midwives and pregnant women in Sweden in the 1990s. Her emphasis, however, is on the ritualistic character of early-term examinations. She argues for the symbolic value of examinations and testing in the early term, because the pregnancy is not yet bodily visible or often intelligible for the pregnant women (ibid., 134–135).}

In these orders, maternal competence is performed by attending per se, and by attuning to the normative requirement of using every technology possible as a way both to find out about foetal health and to (use these facts to) come to know one’s unborn, as well as
preparing mentally and socio-materially for family life. It is as though the cyborg foetus stimulates maternal (and paternal) response, reduces anxiety and improves compliance with advice (see also Palmer 2009). When looking at the practices of introducing and advising in accordance with the technoscientific ‘facts’ more closely, one notices that the physicalities of the foetus and its relationship to the pregnant woman are associated with the socio-material spheres of life. This is apparent in, for example, reinforcing the physical continuity between the late-term foetus and a newborn when advising women to (encourage men and other relatives to) follow the sleep-wake rhythms of their unborn and to interact with their unborn by singing, talking and reducing stress, because foetuses older than 32–33 weeks of gestation have brain capacities to have sleep-wake experience, to hear and respond in other ways to the outside world. This argument, however, is not technoscientific but draws attention to baby-like features, activities and sentience, as discussed in subchapters 3.1–3.2 and 4.2–4.4.

In sum, it can be said that biological knowledge, especially when backed by the power of technology, has the power to create kinship ‘in and of itself’ (Franklin’s 2001 expression) in the practices of maternity healthcare. Kinship seems to be defined as biogenetic by default. Lastly, this is implied in numerous inquiries into the attendance and support from partners, grandparents-to-be and siblings. Blood relative participation and encouragement to participate is sought above all other participation. It is as though knowledge of ancestry delivers relationships and (family) identity in itself (Franklin 2001, 306). Further, biogenetic kinship seems to be strategically used to build parenthood and kinship relations:

A pregnant woman and a nurse are discussing if there are any babies on the way in the pregnant woman’s circle of friends. The pregnant woman answers that there are actually a lot of babies being born among her intimates. She goes on to say that her brother’s wife has just had one, and that the baby is really tiny and has black hair. She is surprised about the small size because she herself was a big baby. The nurse replies that with babies even 100 grams may make a big difference [in looks], and expresses her satisfaction about the woman having lots of families with babies in her life. The pregnant woman agrees and talks about her friend’s baby that was born prematurely but is doing fine now. At the end of the appointment they return to the issue of the brother’s baby when talking about having dreams and images of the unborn prior to birth. The pregnant woman says that she thinks the baby looks like her when she was small. Apparently she
Knowledge of biogenetic or blood ties seems to have highly personal and intimate effects in the constitution of relationships and identity. Why else would observing features of relatives be so magically different than ‘doing the maths’ with non-relatives? According to Marilyn Strathern (1992) it is because scientific knowledge is seen as objective and universal. When it comes to biosciences, we Westerners tend to assimilate it as accounting for the identities and relationships we possess as individuals (ibid.). The kin and personal attributes of one’s child-to-be are enacted via inherited physical attributes. It seems that in this respect the realities of maternity healthcare are an eternity away from, for example, Donna Haraway’s (1997) ambivalent position on kinship in which she on the one hand mocks the naturalness of genealogy and on the other introduces explosive, even transgressive, unions, such as transgenic animals and humans via branding.

5.2 Politicisation: making fetishes, families and citizens

Pregnancy or the unborn are not just (and no longer) an ambiguous stage in a woman’s somatic experience of ‘being with a child’. Nor is the ‘foetus’ confined to the sites of

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102 I should mention here that my material is restricted inasmuch as there are no videotapes or observations with information on a family in which near relatives were, for example, a same sex partner, nor were donated gametes brought up as concerns. The nurses, however, did bring up how they would like training and supervision for ‘special’ client encounters, such as appointment work with same sex couples and immigrant families. This supports my interpretation that the working methods and professional skills of the nurses are geared toward working with heterosexual and native Finnish couples and blood relative families (see also Kuosmanen 2007; Sandall 1995) whose situations are not ‘complicated’ by e.g. transnational family ties (see e.g. Vuorela 2002).
scientific investigation or clinical examination which are, themselves, socio-material practices. In line with the increasing authority of biomedical definitions of human ontogenesis in Western cultural understandings of ‘life before birth’, the foetus has escaped the laboratory contexts, if you will. The foetus is enacted increasingly as a (public) participant in pregnancy and mobilised for different social practices and purposes. One such purpose is personification effects in healthcare practices (see also Williams 2005; Mitchell & Georges 1998) and, thus, in the everyday lives and meaning-making of pregnant women (see also Rothman 1989b; Mitchell 2001; Homanen 2007) and men (see also Draper 2002; 2003; McCreight 2004).

The fantasy of (relative) autonomy or lack thereof from the mother provided by reproductive technology and medical practice is also extended further in popular representations and for political purposes, such as in pro-life politics, and politics of reproduction in general (Patchecky 1987; Oaks 1999; Duden 1993; Homanen 2011, 51–53). In fact, it has been noted that mainly (Anglo-American) anti-abortion activism has influenced the worldwide imaginary of the unborn through the circulation of foetal representations in different media (Oaks 1999, 176). This foetal semiotics has its origin in new reproductive (visual) technology, but it can hardly be described in terms of scientific objectivity. An image of, for instance, an aborted foetus is more likely to stir up associations linked with violence. The foetus, then, does not appear as some ‘neutral’ biological creature or a creature in a biological process but as a victim of brutal assault. Anti-abortion activism often uses spectacle and emotionally intensive images of aborted foetuses, and electromagnetic pictures (such as those of Lennart Nilsson) and ultrasound pictures of late-term foetuses to create an imaginary of the foetal victim (Stagile 1999; Homanen 2011, 52).

In Finland shocking images of foetuses do not really belong to the local (visual) culture. The argumentative style is much more informative and plain, and political sentiments about whose autonomy and ‘rights’ should be of issue in pregnancy are much more subtle, less polarised and less public than in the Anglo-American world (see also Tuomaala 2011, 196; Homanen 2011; Julkunen 2004, 22). Certainly debates on ‘foetal rights’ and abortion
arise periodically in Finland but they are not too loud or frequent. Reproductive politics is historically usually discussed in the context of welfare services and politics, and carried out at the level of health education in the services provided by state and the civil societies. The foetal victim or its counterpart in pro-choice imaginary, the ironic or absent unborn (Homanen 2011, 52–53), are politically framed in quite a different way than even the most outwardly normative material I have come across during my research process, namely the brochures and guidebooks distributed to pregnant women and their partners.

The brochures and guidebooks (see Research materials) do have a clearly biased take on the woman–unborn (maternal–foetal) relationship in favour of a mother–child relation already implied in pregnancy. It is manifested in calling the unborn a baby, a child, a human life and a foetus as if the terms were equally substitutive, and in the discussion on early interaction and emotional transformation into parenthood that relies on quite conservative family values.

The relationship is further enacted in the overload of tropes and analogues that associate the unborn in its relation to the pregnant woman with, primarily, romantic union and even systems thinking (see also Martin 1998). Telling of such associations are expressions such as:

‘Placenta – the tree of life’
‘You are the world for your child’
‘You are the channel to the world for your child’
‘What is happening inside you follows the same formula as in the beginning of times’
‘Think about it: you are carrying the future inside you! [...] There is something nearly magical in the round belly of the mother. It is, after all, a symbol of hope for the future and its possibilities’
(Expecting a baby 2008)

There is certainly an emphasis on the separateness of the unborn from the mother and the relative permeability of the relationship in that the mother is presented as the context, ‘the world’, the medium, ‘the channel’, or the host ‘for the future and its possibilities’, for the child-unborn. However, as separate entities they are enacted as elements of a whole that
functions according to some ahistorical formal logic through ‘the tree of life’. I am tempted to interpret this kind of sacralised union by referring to Barbara Duden’s (1993) and Donna Haraway’s (1997, 174) arguments about the parallels between the icon of the foetus and the planet earth. According to them, the metaphorical interchanges between foetal and planetary imaginary have rendered the foetus an icon of ‘life itself’ floating in ‘space’, the relative environment, that ensures (and potentially threatens) its future existence (ibid.; see also Franklin & Lury & Stacey 2000b, 33–36).

Sometimes a further parallel between the two icons is drawn insofar as they both tend to lose sight of the context, the horizon and the mother (Franklin & Lury & Stacey 2000b, 36), thus invoking foetal independence and individuality. However, the discursive style of the brochures cannot be said to do this. Independence and individuality have been noted, for instance, by Sarah Franklin (1991, 202–203) and Emily Martin (1998, 134) as characterising medical models of the mother as a passive vessel or the ‘foetus-killing’ mother. In such an imaginary, the mother is said to disappear to protect the masculine individuation from pregnancy as a culturally threatening state of dividing the undividable, the individual (body) (ibid.).

Rather, the texts may be said to imply a woman–unborn relation as a kind of ecosystem. If there were not such a strong tendency to overly romanticise the union as some god-/destiny-given origin of life, I would even call it feminist in the sense of returning the unborn to the body and knowledge of the pregnant woman. Romanticising, as Emily Martin notes (1998, 139) runs the risk of avoiding thinking through the incompatibilities between pregnant women and the unborn, such as medical conditions affected by pregnancy. Systems thinking, instead, may lead to elevating the importance of the system over any of its elements (ibid.), which is clearly happening in the quotations seen above when the abstract concept of ‘life’ is glorified at the expense of particular women with particular circumstances.

In other contexts of Finnish maternity healthcare, however, at least relative foetal independence is evoked, as made clear in many instances in the previous chapters. Here, I
want to take up the trope used often by the nurses: ‘the wombling’ (kohtulainen). I find the term at the same time adorable and disturbing. I find the term ambivalent because by combining the word ‘womb’ (kohtu) and the suffix ‘-ling’ (or ‘-ant’ or ‘-zen’) (-lainen) the term, on the one hand, does not attribute the unborn with a status of a ‘foetus’ or a ‘child’ but, on the other hand, it does imply occupancy. It is a creature that has taken up residence in the womb, and thus I cannot help but associate the term with medical metaphors such as the woman’s body as a nation state and an inert host that the unborn as a little commander of the womb controls (Martin 1998, 134; Franklin 1991, 193).

**Foetal fetishism**

What is happening in politicising and mixing (family) values with biological and biomedical models in different practices is symbolising ‘life’ in the abstract. Rosalind P. Patchesky (1987), Janelle S. Taylor (2004b) and I (Homanen 2011) have all suggested the use of the concept of fetishism in analysing and conceptualising the foetal figure as a product of science and technology as well as politics and values (see also Haraway 2004b; Sasson & Law 2009 [eds.]; Martin 1989). In her classic essay, *Foetal Images: The Power of Visual Culture in the Politics of Reproduction*, Patchesky argues that the use of the ultrasound image as a cultural practice fetishises the foetus, dissolving it from its social and experiential family contexts to signify political human life or its loss in general. Taylor (2004b), by contrast, has written from the framework of Marxist commodity fetishism. She notes that technology that allows others to look past the pregnant woman straight into the foetus enables a fetishisation in which the foetus is not only dissolved from the pregnant woman and the social context but also from the context of producing the foetal image, that is, from the historical clinical practices. It is this separation that enables the ultrasound image to be associated (even magically) with ‘the baby’s first picture’ and become a means to strengthen the bond between ‘a baby’ and the parents. In fact, according to Taylor (2004b), these are discursive ends by which the ultrasound has been justified and made desirable for families as a routine practice in prenatal care (see also Eräsaari 1987).

It is possible, then, to turn an image of medical research into a product and fetish object that represents the unborn as something that has the value of human life in the abstract (see
also Franklin & Lury & Stacey 2000b, 36). I have suggested elsewhere that, compared to Patchecky’s and Taylor’s work, mobilising the concept of fetishism in my own research requires further development and differentiating of the concept, which needs to be conceived as both commodity/consumer fetishism and anthropological fetishism (Homanen 2011). In Patchecky’s (1987) essay the concept of fetishism is not opened up to closer scrutiny, and it is applied only in lay terms. Further, like Taylor (2004b), Patchecky focuses merely on the use of ultrasound pictures. Finally, it seems that for both writers the relationship the fetish object has with the value-laden cultural concern signified by the object through fetishisation is based on familiarity and close context. In particular the foetus represents the ‘result’ of the pregnancy, the baby or human life in general. The relationship is thus metonymical. The temporally preceding biological creature, the foetus, represents the latter, the baby, and the concrete, a particular woman’s ultrasound picture, represents the universal and abstract.

I have argued that foetal imaginary is used in fetishised ways that cannot be reduced to metonymical relations. Further, fetishising the foetal image can be seen as crucial in the processes of enacting the unborn as not only a sacralised and politicised image of an endangered life and future, but also as a particular being that is associated with personal and social meanings and value. However, the unborn as a fetish has its origins in visualising technology and in the displacements and shifts in scale that the cultural practice of the use of technology makes possible. (Homanen 2011.)

The context of my arguments about fetishisation was a study of pictures of human foetuses, with captions, that have been published in the Internet (Homanen 2011). As I mentioned above, the Internet is acknowledged by the nurses as one of the main sources of information in pregnancy and is widely used by pregnant women. This observation led me to analyse systematically how foetal imaginary is attributed meaning, and how different representations and their context of display are related to each other. By using Erving Goffman’s (1974; 1979) frame analysis coupled with methods of analysing pictures (Luhtakallio 2005: 2010; 2013) I was able to show that the ways in which foetal figures vary and are associated with each other are enacted in processes of fetishisation. These
processes politicise the foetus from biological creatures into political victims of violence or technology and vice versa (pro-life, pro-choice and science fiction contexts) but also into products that bear value to its owner and into nurtured and protected babies.

I was most surprised to find pictures of foetal products or commodities in Internet shops. There are, among other things, foetal pen holders, foetal jewellery, foetal Christmas decorations, foetal cookie moulds, foetal art, and t-shirts on which one can print one’s sonogram picture. My first reaction was utter amazement over how banal the foetal figure has become in addition to its publicity. The Internet has been known to commodify and commercialise in general (e.g. Paasonen 2006) but I was startled nonetheless. Thinking about my affective reaction in retrospect, I suppose it emerged from a feeling that economic principles had invaded the sacralised world of family and kinship (see also Kopytoff 2004). I had experienced a similar feeling when I realised how far consumption, especially of ‘right’-coloured baby clothes and other equipment representative of the newcomer, has become part of transforming into parenthood, as I have elaborated in the chapter Transforming the materialities and practicalities of everyday life.

I will return to the issues of moral threat in the commodification of reproduction and economics of kinship in depth later. Here I want to focus on the particular mechanisms of the process of fetishisation where it is possible for the foetus to be ripped away from (particular) pregnant women and a family context to represent abstract cultural and social values and fears that are not necessarily automatically or self-evidently associated with the ‘product’, the photogenic foetal figure, at hand. Further, I will show how the foetus associated with ‘life’, future and risk and responsibility for them in the abstract is also manifest in the ordinary as well. In the former process the foetus is fetishised in a sense of consumer fetishism, and in the latter in a sense of anthropological fetishism.

Foetal products made for sale or for one’s own pleasure are harder to interpret in terms of a commentary on social relations (to mother, father, politics and so on) than in the political imaginary. Rather, they are often framed as commodities that provide value for the consumer: value in terms of social status or capital, not in terms of use value. A foetal
figure in a key chain or hanging from a necklace is advertised as providing personal status for the consumer, such as ‘uniqueness’ in one’s community, neighbourhood, circle of friends, and not, for instance, as a practical way of carrying keys (Homanen 2011, 54–55). Thus I think it is more pertinent to talk about consumer fetishism than commodity fetishism. Among others Judith Williamson (1978) and Jean Baudrillard (1998) have discussed how, in mass-markets and in advertising, objects are associated with personal and social meaning and thus linked to desires and aspirations that might have almost nothing to do with the concrete use value of the commodity advertised.\(^{103}\)

Anthropological fetishism, instead, relies on familiarity and the connection made ‘in advance’. Often the foetus is a fetish object that represents the yet absent child that is loved and ‘worshipped’ in this framework. However this metonymical relation is not necessarily utilised for constituting a public figure to participate in struggles for power and legitimacy (Homanen 2011, 62). On Internet blogs, in private living rooms, photograph albums and sonogram rooms across the Western World, women, men and healthcare professionals are circulating private sonogram pictures and videos to family, friends and complete strangers. In the practice of showing sonogram pictures, people name their unborn, gush about their features, thrill at seeing the sonographic penis or vagina and make a point about resemblance to parents-to-be or other relatives, and use them as a charm to transform men from technical to affective fathers, as discussed in Chapters 3 and 4. The ultrasound scan seems to mediate social relations in a way similar to the family photography as a ritual of imaging and imagining kinship (Han 2009, 279).

In theories of anthropological fetishism, the fetish object is understood as immanently carrying a sacredness that it brings closer to its holder. It has been suggested that a broader understanding could be integrated with this religious, often ritualistic, conceptualisation of anthropological fetishism, an understanding that includes Western and modern life worlds and social context largely structured by consumer and commodity production (e.g.

\(^{103}\) This line of analysis is, in fact, post-Marxian in the sense that it is more fruitful to interpret the images through consumption than production. Thorstein Veblen (1899) was the first to approach commodity fetishism through consumption. For him, consumer fetishism refers to ‘conscious consumption’. After him many have developed the concept to better suit the contemporary complex processes of fetishisation.
Gamman and Makinen 1995, 18). In this way the category of sacredness would broaden to include other culturally sacralised things whose absence and intangibility form the basis for fetishisation as an activity and a practice. Looking at the practices surrounding the foetal image and imagining via different products acquired, the foetus is without doubt such a sacred and loved absentee in the public sphere as well as in domestic contexts (Homanen 2011, 56).

The world-making force of the foetal image is, however, different in different parts of the Western world. I noted this in my inquiry into foetal representations on the Internet, and have since oriented my study of practical care work around that fact. In the case of the Internet pictures, I deliberately analysed Finnish-language-area web pages separately from foreign language area pages. The analysis showed that the processes of fetishisation politicise the foetus slightly differently in the Finnish context. The Finnish foetal figure is less political, less public and not so contradictory in relation to woman’s bodily autonomy than its foreign counterpart. Additionally, although the foetus in particular pictures signifies politically charged human life, it is not juxtaposed to the pregnant woman according to its rights. It is, instead, fetishised as representing shared responsibility for children and a population policy concern over the lifestyle of pregnant women. The arguments of the brochures handed out at the clinics and the way of addressing lifestyle choices at the appointments accord, to some extent, with this kind of ‘politics’ that relies on moral pedagogy in the name of a national and population level ‘common good’. This is the specific topic of my next subchapter.

Social rights and civil responsibilities

As discussed in previous chapters, when it comes to advising on lifestyle choices such as eating habits, drug and alcohol use and even career-oriented lives, pregnant women (and their partners) are more often than not given a lesson on maternal responsibility linked to individual ‘choices’ that seems to be justified in terms of scientific knowledge on biology or family psychology. It is explained that pregnant women’s actions have consequences, for example, for foetal health but not in technical terms of maternal bodies and foetal demand. It is ‘babies’ that ‘need’, ‘want’ and ‘require’ and ‘parents’ who should make the
'right choices’. By implication, the unborn is a biological foetus and someone who does not have a choice, but who should.

Clearly, the unborn has no voice to speak its choice and thus cannot partake of the kinds of agency recognised in any of public sphere that might have implications for its life or status. Who, then, is to give voice to this being and its choice? Pro-life activists attempt to do so, as do most conservative right wing and religious groups across the West. They aim to establish the autonomy of the unborn individual and to show how the precarious unborn as a full ‘citizen’ is dependent on adults as ‘citizens’ to hear its cries (Berlant 1997, 98). In order for the unborn to gain the right to vote it must be given a mode of representation that merges the political and aesthetics of personhood, ‘imputing a voice, a consciousness, and a self-identity to the foetus’ (ibid., 98).

The same applies to other civil rights, social and political in nature, and, by implication, civil responsibilities. In the liberal models common to Anglo-American debates, the unborn and the woman are positioned as competitors for whose social and political rights should matter the most. Even though there are nowadays to some extent organised anti-abortion activist groups in Finland using similar arguments and presentations as the Anglo-American activists (see e.g. www.lopettakaatappaminen.info; www.abortionno.org), the overall tone of the Finnish public debate and reproductive politics is and has been different, and the unborn and the pregnant women are not in principle set against each other according to their civil rights (cf. Tuomaala 2011, 12). It has been claimed that the reason for this is that in the social democratic welfare ideology abortion is politically acceptable and therefore it has to be offered to all in an equal manner (universally) and in the name of social equality. To put it simply, in Finnish welfare thinking, the social beneficence of the woman takes preference over that of the unborn, unlike the liberal models where protection of the basic individual rights – especially the right to privacy and autonomy – of all participants in pregnancy are emphasised. (Julkunen 2004, 22; O’Connor & Orlof & Shaver 1999, 160–185.)
This does not mean to say that the Finnish, Nordic or other models of welfare state and society that prioritise social rights over individual privacy, to some extent, do not attend to the unborn and its status, and thus to women as reproducers. In fact writers on welfare society have observed that corporeal relations have more easily become objects of social and welfare policy and intervention, usually in the name of ‘the best interest of the child’ (protection) as opposed to a more liberal view of privacy (see e.g. Julkunen 2004; Pulkkinen 2003; Nätkin 1997). In the case of abortion, however, Salome Tuomaala (2011) has noted that despite the legal right to have an abortion in Finland how abortion is experienced and ‘chosen’ by women suggests that there are many actors – political, religious, cultural and medical authorities – that constrain women’s actions and disregard their knowledge and will to have an abortion. In my own study, the mere existence of advice that hints that mothers-to-be need to be ‘scientifically’ pushed in the right path in taking foetal choice into account by altering their lifestyles implies that the welfare service practice is in tune with a specific logic of state paternalism.

The nation acts as the parent to the unborn in both the Anglo-American cultural and political logics that have been claimed to have taken up the foetus and the pregnant woman as icons of the traumatised citizens exposed anew to mass-mediated identity politics and the historical Finnish welfare politics and ideology. Lauren Berlant (1997) has argued that since the rise of the right-wing Reagan regime, new alliances between imperialism and pro-life patriotism, between anti-choice, pro-natalist, anti-drug propagandas and pedagogy have been made to produce collectively a figure of a mother who poisons and aborts her baby – the new minority stereotype of trauma in America. The national membership of the pregnant woman is, thus, dependent on her ability to answer the moral call to exchange her privacy protection, autonomy and creative agency for procreation and motherhood as an end point of woman’s ‘natural development’. The notion of natural development and the feminine value attached to it in national stereotypes is quite traditional: women are described as naturally developing from heterosexual womanhood to pregnancy and motherhood. Nor is it novel that women are compelled morally or even juridically to attune to this ‘natural’ destiny in national contexts. (Berlant 1997, 98–104.)
What is different, however, compared to earlier eras of intensified moral panic over women’s reproductive agency, is that the pregnancy of the modern woman is not only seen as a potential rupture in the continuity between feminine value and motherhood but likely ‘to threaten the national future as well’ (Berlant 1997, 99). Anxieties linked to the relationship between proper womanhood and motherhood are no longer dealt with in terms of reform of the sexuality of the poorer and racially marked immigrant women as they have been in the middle-class-identified women’s reform movements since the mid-nineteenth century in America as well as in Finland. However, as Berlant (1997, 99) argues, ‘now the gendered class hierarchy is often reversed by pro-life women, as they seek to reform the sexually profligate sisters blinded by selfish unwomanly fantasies of economic privilege and/or sexual autonomy’. Further, (feminist) counterclaims for female authority in reproductive issues are seen as blocking or distorting this ‘natural development’ not just of women and foetuses but of national history and future (ibid., 100).

In a way, what Berlant is describing as happening in America, ‘the pro-life nation’ – the fetishisation of both the pregnant women and foetuses – is, in my view, part of what has been termed postfeminism, in the negative sense of that contested term (McRobbie 2009; Gill 2007). According to Angela McRobbie (2009, 12) the phenomenon involves first of all the promotion of neoconservative values in relation to gender, sexuality and family life while simultaneously the liberalisation of choice and diversity in domestic, kinship and sexual relations is being advanced (see also Jallinoja 2006). Second, it encompasses the existence of feminism transformed into a common sense or popular form and, at the same time, being belittled and even hated. What this implies for the unborn and the pregnant woman is both a fracture and a normative fantasy of their reunification.

Even though applying the concept of postfeminism to the Finnish society of Nordic welfare and state feminism is not without its problems (Hasanen & Koivunen & Kolehmainen 2010, 43–45), it is a useful concept to describe some tendencies apparent in Finnish society as well (Julkunen 1994). It demonstrates the complexities of fitting together individual choice and consent that appear free from structural constraints, such as
patriarchy, and (re)traditionalised values and lifestyle. Women are invited to ‘freely choose’ to attune to conventional lifestyles via subtle ways of persuasion that, according to McRobbie (2009, 46), are nothing but ‘a feature of resurgent patriarchalism, in the guise of the seemingly benign power of unfolding social transformation’ that has supposedly made feminism redundant, and even ridiculous as a combative political movement, by achieving all its goals.

I want to take up these subtle ways of (affectively) transforming women into certain kinds of parents as something that is seemingly their own ‘choice’. These subtle ways of doing care work simultaneously draft the logic of the nation-making function of maternity healthcare as it stands today. It has been argued in prior research that the maternity healthcare has been part of constituting maternalistic citizenship by civil education (Nätkin 1997; 2006). Historically maternity healthcare can, thus, be perceived as one of the national institutions within which individual(s) (families) have been ritualistically incorporated into the nation in order to fulfil their responsibilities as (mother) citizens in the name of pro-natalist population and family politics and concerns.104 Pregnant women have borne responsibility for attending care since 1941, and until about the 1960s the ideal of transforming women into mothers according to the moral standards of a middle-class homemaker went uncriticised (Werde 2003, 85–86).

As described in Chapter 2 the (population) policy concerns and debates on the agenda for, and in, maternity healthcare have changed over the roughly 100 years of its existence (Wrede 2001; Nätkin 2006), and so have the approaches and organisation of care work. It seems quite fair to conceptualise maternity healthcare work as state paternalism in the literal meaning of the term, both in provision of care and in the disciplinary forms of advice that enacted clearly what a good and moral life for women (in families) should be until about the 1960s/1970s. Since then we have seen partners (fathers) invited to attend maternity healthcare, a reappearance of social concerns in the form of psychosocial concerns and wider concerns over citizen intimacy in welfare society, and actions taken to answer those concerns. Further, according to my own study and studies on historical

104 To the extent that women have been historically given the status of a full citizen (e.g. Pateman 1988).
changes of care (policy) (e.g. Wrede & Benoit & Sandall 2001), it would be an overstatement to characterise the care work taking place at the clinics as reliant on disciplinary practices of making healthcare in pregnancy a civil responsibility. I would rather describe it as transformed into a rational risk management of lifestyle combined with a more traditional affective and moral pedagogy. The welfare service is moving away from being a custodian to the unborn, at least when it is not perceived to be in too much risk.

As also elaborated earlier, both the nurses and the pregnant women describe their (ideal) relationship in terms of ‘equality’, and both emphasise autonomy as a principle of good care. Further, this ‘equality’ does not translate into the principle of ‘sameness’ in the sense of offering the same care to all, but tolerates and adjusts care to people’s different backgrounds. The nurses seem to view themselves as co-participants in different pregnancies, facilitators between special services and pregnant people and mediators of science-based knowledge rather than some holders of universal moral authority.

Co-participation and encouragement to autonomy or empowerment are also explicitly emphasised in more recent guidelines for care work. Below is an extract from the Handbook of Maternity Healthcare (2007) which gives advice to nurses on how to ‘support early interaction’. The passage quoted here is titled ‘The expert role’:

*Professionals in healthcare services should think through their conduct and objectives when they are creating a relationship with their client and client-family. Effective help depends on the relationship that develops between parents and an expert. Images, presumptions and attitudes and the expectations of parents affect the interaction encounters. Our professional behaviour often implies the role of an expert and a belief that we must find a solution to all the problems [...] The role of an expert may lead to such a professional behaviour that may be harmful to clients and the process of help, in part because it is unrealistic and its motivation is assertion. In the expert role, one easily takes the matters into one’s own hands, asks questions, makes decisions and takes action or dictates it. This may lower the clients’ self-esteem, make them dependent on the professional and increase their passivity, which will further decrease their involvement in the interaction [...] The basic skills needed in helping come from respect, humbleness, sincerity, empathy and silent enthusiasm, basic attitudes that are closely related to each other in practice. They are needed in*
constituting interaction and exploring problems. To make care plans and implement them a professional needs to be able to create an open and trusting relationship with the client. It is essential that the client feels that she is heard and understood – the client needs to feel the same kind of interaction with the professional as she should be able to have with her child[to-be] […] The task [of the nurse] is to give parents a chance to explore the mental image they have in order to anticipate events in their worlds and to help them make a clear picture of it. This is reached through changing the way of doing practical work, and learning better communication skills and […] obtaining effective parental guidance skills that help her to work with parents by supporting them […] and to help parents take care of their own problems more effectively […] attuning effectively to the role of a helper and minimising the excessive influence of one’s own suggestions and opinions. Learning when and how to refer them [parents] to specialised care.

(Handbook of Maternity Healthcare 2007)

In the quotation it is implied that to achieve the goal of a trusting relationship and (relative) autonomy where pregnant women and their partners become agents of their own (family) life, the nurses should remain at a certain distance. They are advised not to take a strong stand on issues at stake in order to make independent parents that reflexively produce their own ‘right’ ideas of family life and social relations. Further, it is implied that abiding by these principles will involve improving one’s communication skills and reflecting on one’s interactional skills.

When watching the appointment videos it seems that the nurses do use quite subtle ways of persuasion, and even if a preference is articulated it is not imposed. Preference for action is often presented in the form of a suggestion, as something to reflect on that is backed up by (popular understanding of) ‘scientific knowledge’ about child or family psychology or biomedicine. Further, the same issues are attended in a process, again and again perhaps from a different angle, like in the next ethnographic description of an appointment:

It is an appointment for both the pregnant woman’s 22 weeks of gestation check-up and for her firstborn’s one-year check-up. The woman’s partner has also come but just plays with the child during the beginning of the appointment. They start with different motor skills tests and measurements done to the child and the pregnant woman and the nurse discuss simultaneously the health and development of the toddler and the family’s search for a new house in the area. After
taking the measurements, while she is preparing the child’s vaccinations, the nurse asks the partner about his work situation. Apparently the man is an entrepreneur and seasonally has to work long hours. The nurse then asks the couple if they have had any help from grandparents. The pregnant woman answers that, yes they have, but that she is quite bad at accepting help from anybody. The nurse then replies that it’s important to remember that this is a phase when one has to think about one’s strength. Then she attunes to the woman’s characterisation of herself and asks if she is one of those people who feel that they have to survive on their own. The pregnant woman concurs but then downplays the situation a little by saying that the child has been in care at least once a week. The partner then cuts in and says that according to his recollection the baby has not been babysat that much. In fact, he remembers only about five times within the last year that the baby has stayed overnight somewhere else than home. The pregnant woman seems confused, and confesses that she has been thinking that when ‘the help is really needed, when the other baby comes then [she’ll ask for it/take the grandparents up on their offer]’. The nurse repeats her comment about how it is topical now to ‘ponder a little about one’s strength’. The woman says that she knows that, after which the nurse goes on to reassure the woman about her own competence to evaluate herself: ‘I am sure you have heard this from close people all the time and surely you will manage for a while by yourself but then it’s like it does not work anymore. I am sure you yourself know best but there are these family care workers that you might want to keep in mind. Some people have this that they don’t want to have grandparents involved. They want to be on their own, you know. So this [family care workers] is an option as well especially when the baby is born. The woman nods and agrees, and then suddenly starts to say that about three weeks ago she had ‘a sort of a burnout’. She had ‘blow ups’ and first thought she was just tired. She explains that she has now been at home with the baby for a year and just tried to cope on her own. She describes her feeling as ‘fury’ that came after the feeling of tiredness had passed. ‘I have an urge to attack but don’t know whom’, she says and looks at her partner. ‘He has been the innocent victim of my blaming then. It woke me up’, she goes on. The nurse tells the woman that it is a good thing that she recognises these warning signs herself. The nurse then starts to give the vaccinations to the baby sitting on the partner’s lap. They return to the issue of the pregnant woman’s strength several times during the rest of the appointment. The pregnant woman brings it up when the nurse asks about potty-training: she has been too tired to do it consistently. The nurse rushes to assure the woman that they should not feel stress about the potty-training for there is plenty of time to do it more consistently. When they turn more specifically to pregnancy issues, the nurse asks if the tiredness is now in the past and inquiries if the situation was the same with the firstborn. The woman confesses that actually the tiredness is back again a bit and that, in fact, it was the same with the firstborn. The issue of the woman’s exhaustion also frames the discussion of eating habits: The woman analyses her feasting on goodies lately as a result of her being so tired. The nurse plays down her worry about eating ‘terribly’ by telling her it is typical for couples with small children just to lie on the sofa after putting children to bed and eat, and that it is just fine considering that the parents have decided on a totally substance free life.
Finally she adds that the pregnant woman will lose the weight easily after birth in any case. The issue of tiredness is returned to again when the nurse asks the partner if he was able to take parental leave from work with the firstborn. It turns out that he is a ‘super-entrepreneur’ [the pregnant woman’s term] who found this impossible. The pregnant woman expresses her anxiety about the state of things by saying that she is nervous about how they will cope. The nurse empathically turns to the man, saying ‘You must have quite big pressures about this when you have to be at work and at home. You are needed everywhere’. The man nods and says that he has lost 10 kilos over the spring. The nurse expresses her worry by crying out ‘Jesus’ and then goes on to advise that talking about these things helps in a partnership. The pregnant woman jokes ironically that sometimes it is hard as well. She explains that she sometimes waits at home for the partner to come from work and then he just complains that she has been at home all day and ‘you haven’t done anything’. They talk about blaming each other in this way and the associated feeling of guilt, and then turn to talk about the everyday life of the woman at home. The woman is apparently quite strict about housework [discussed previously, it would appear, because the nurse makes such a comment]. She feels that it is part of her well-being that the house is in order, even ‘a way to relax’. What makes it hard is that their firstborn is constantly hanging on her legs. The nurse gives an explanation in child development psychology about children’s phases of interdependence and the feelings of exhaustion and inadequacy often experienced by parents. The nurse then links the discussion to the pregnant woman’s exhaustion, saying that this interdependence surely just adds on to the drain on mental strength and brings up the family care work service again. She says she wants to give the contact information anyway, and tells them that one can make a long-term service contract with the workers so they come regularly over a period of time. She also makes a point about the workers’ role as domestic help and not as guests one has to attend to like grandparents. ‘One can just sleep and gain energy for when somebody [a ‘real’ guest] comes over’. She further emphasises that this sort of assistance is part of preventive care so that the situation of a family does not turn into a bad one. ‘It does not mean that .. People often find it hard to contact this help because they think that they will be classified as problem families’. The pregnant woman finally agrees to accept help by saying that she would be delighted to have the workers over.

(Videotape TP24N&M, second child, 22 weeks of gestation)

In the extract, the nurse quite skilfully and in a therapeutic manner convinces the pregnant woman finally to accept domestic help from family care. She does not, however, do so by establishing the position that she is an expert herself, which would imply a position of authority (of knowing best). Rather, by giving authority to the pregnant woman’s own sense of self and reflections, and by empathising with her particular situation, she positions herself as a facilitator who guides at a distance and does not take a strong stand on what
should be done. This is further reinforced by the way she promotes the pregnant woman’s ability to make the ‘right choice’ in the name of an apparently neutral moral goal of mental health. Ultimately the responsibility to follow the advice is left to the pregnant woman (and her partner).

It cannot be argued that here or in other instances of advice giving in my material pregnant people are merely disciplined into some universal and normative cultural competences and ideals of motherhood via moral and social education. What we are also witnessing is the emergence of another rationale in welfare services and prevention techniques that insists on persuasion rather than regulations and paternalistic sermons. Further, this persuasion, especially in concerns over the abstract issues of parenthood and family life, relies on people’s own rationality and capacity to come to know their own (family) life.

Pekka Sulkunen (2009) has termed such an approach in preventive social and health policy ‘epistolary power’. According to him during the last three decades of the twentieth century the welfare state has had to answer the growing demand for managing risks but without determining the ‘good life’ for its citizens. Autonomy and the intimacy of individuals must be simultaneously guaranteed for citizens and responsibility decentralised in the welfare state in transformation, according to its critics. The response, according to Sulkunen, has been ‘the ethics of not taking a stand’ that differs from the techniques and power logic of the paternalistic welfare state, ‘the pastoral power’, that is characterised as infantilising citizens in the name of progress, universal individualism and knowing the ‘good life’. (ibid., 141–157; 2007, 27–32.)

None of this means that pregnant women and men are not held accountable for how they behave in pregnancy under this logic of care. When parents-to-be neglect the parental responsibilities, no matter how vaguely the responsibilities have been presented to them,

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105 This discursive shift can be understood in terms of what Louise Phillips (2011) has termed the dialogic turn in the production and communication of knowledge. She argues that practices in the dialogic turn are constituted within a discourse of dialogue, participation and empowerment; within the discourse, communication is conceived as a dialogue among participants in which knowledge is co-produced collaboratively, rather than as a one-way flow of knowledge to a less knowledgeable target group (Phillips 2011, 3-5).
they get at least a moral lesson. Sulkunen (2009) has also noted that, in fact, our contemporary sensibility to the rights of the victim gives a new emphasis in both the public debate and in the action taken in state institutions. In the case of foetal rights, one such manifestation, in my view, is the debate and the bill on the coercive treatment of pregnant women with alcohol or drug abuse problems. In a debate that first began at the end of 1980s and has erupted periodically ever since (Leppo 2012, 48–49) it is less that the victim’s, the unborn’s, interest is subsumed within the public interests than that its rights (to a healthy environment, to life and so on) and pains are emphasised (e.g *Helsingin Sanomat* 7, 9, 11–12, 14–15.4; 3.5.2010; 22.2; 6.11; 8.11.2012).

In the debate, the role of maternity healthcare has also been emphasised in recognising substance abuse problems, in treatment, and in referring clients to further and specialised care as an alternative to coercive treatment (Ministry of Social Affairs and Health 2009, 4; Leppo 2012). Under this approach the needs of the ‘offending’ woman and her family are understood and the aim is to rehabilitate the pregnant woman rather than punish and show no mercy as in some extreme suggestions of, for example, coerced abortions for women with drug and alcohol problems. Following this political debate after conducting my fieldwork at the clinics, I could not help but think that although the unborn does not have civil rights or citizenship in the juridical sense, a right to health seems to be a social right that is in practice being granted to it (on health as a citizen right see e.g. Helén and Jauho 2003, 25–30). How else can one interpret the consistent legitimising of advice with references to apparently neutral scientific knowledge on the unborn’s health, physical and mental(-to-be)?

How far, and in what form, institutional (state) services take on responsibility for the unborn’s health determines the extent to which pregnant women are held responsible as well, because the unborn still develops within her body. In the case of law on coercive treatment, there is a danger of delegitimising women’s agency, making them more minor and less politically represented than the unborn. In the case of preventive measures in maternity healthcare, pregnant women may be held more responsible for the health of the
unborn but at least, according to my own study, they are not stripped of their civil rights from the start, and the orientation to solutions that are based on consent remain.\textsuperscript{106}

The fact that in the epistolary model of care and welfare service logic the modes of responsibility or rules of conduct are not clearly stated or imposed, and the practices of care are constituted within a discourse of empowerment, does not mean that control is not exercised over the lifestyles of pregnant women (see also Sulkunen 2009, 176). This control is, however, simply indirect and does not rely on disciplinary techniques. The principles of agency, autonomy and intimacy of the individual (family) require that cooperation is (at least seemingly in the case of maternity healthcare) voluntary, and, thus individuals are not directed by others but direct themselves toward others, to their (sense of) well-being. Committing oneself voluntarily to attend care and to the advice given is, however, simultaneously attaching oneself to a cluster of common values of health, well-being and security in family life. The values, such as health, have become so wide and vague that they have been described as a ‘degree of normality: the maximum quality of life that care and treatments can offer in each condition’ (Sulkunen 2009, 154), realised in such fashionable terms of the family work field as ‘sufficient parenthood’ and ‘responsible parenthood’. The responsibility for determining the specific contents of, and means of achieving, health, well-being and security – the targets set by policy and other institutional actors – is a shift to a number of local actors, often in partnership with publicly funded projects (ibid.; Julkunen 2010, 104, 216).

This is realised at two levels of organising maternity healthcare. First, recent interventions attending to concerns over the psychosocial health of families conducted in different municipalities in Finland, including one in the area where I conducted my fieldwork, have been executed in projects funded by designated state and municipal funds rather than municipal budgets. Second, as I discussed earlier in terms of sharing care, teamwork and ‘peer support’, advisory practices seem to direct parents(-to-be) towards working with

\textsuperscript{106}I find it interesting in this context that, according to the nurses in my study, pregnant women with alcohol and drug abuse issues are quite motivated and agreeable to attending treatment for their addiction. This kind of knowledge has not been widely acknowledged, at least, in the recent public discussions on coercive treatment. The focus has been merely on the statistics on Foetal Alcohol Syndrome and other substance related foetal health implications in Finland.
professionals, of several kinds, and laypeople in a community-like formation. Expressions used by the nurses, such as ‘the whole village’ and relying on ‘tradition’ in care and upbringing and constant concern over helping hands in family life are good illustrations of this tendency. A good example is also group work activity in family counselling classes and peer groups, where parents discuss together tasks and expectations in parenting and family life and then the issues they bring to the agenda are discussed together with the nurse, and so the process goes on. The nurse operates from a distance and guides the discussion like an apostle, who claims no authority over knowledge or bodies in pregnancy but whose different role and knowledge is acknowledged, rather than that of a shepherd, to use Sulkunen’s (2009, 148) Foucauldian-oriented (2007/1977–1978) concepts.

The romantic nostalgia of community-like care in abstract issues of parenting and family life is, then, complemented with a trust in the individual common sense of parents(-to-be): they are expected to come to know themselves as parents and homemakers with a little help from the professionals. The practices of parents-in-the-making are gendered, though, as I have shown: women are associated with a ‘natural’ order of things where, by merely doing pregnancy, they come to know childcare and parenthood. Men, instead, are treated as being in need of programmatic invitation and persuasion by their masculine ‘nature’. (cf. Vuori 2003; Eräranta 2007.)

Above all, what is being outlined in the material and the discursive practices is a communitarian ideal where the representative of the welfare state authority does not attempt to solve the conflicts between different kinds of family values but lets the citizens do so together within their community (Sulkunen 2009, 151; Benhabib 1992). The potential problem with sharing care, responsibility and values is that power to determine ‘good life’, ‘common good’, ‘normality’ and well-being for the pregnant people is merely redistributed. Communities may even have far stronger constraints on individual choices and freedoms than the welfare state ever had (Sulkunen 2009, 152). Take for example religious groups or other groups with neoconservative family values just discussed in reference to postfeminism: ‘modern women’ with career dreams and aspirations and
babies in their bellies from the moment of conception might not match the fantasies of the reunification of women and the unborn of the contemporary kind.

5.3 Practices of diverging

The current citizenship or civic model operating in the maternity healthcare practices can be characterised as a hybrid of pastoral and epistolary forms of organisation or a move towards a more epistolary ethos of ‘not taking a stand’, especially when it comes to the psychosocial dynamics of parenting and family life. All individual family members are empowered to make changes and choices, as argued also by Raija Julkunen (2010, 106) about the emerging (since the 1990s) welfare citizenship. This does not mean that preference for certain kinds of action or competence is not expressed, and one must remember that nurses and midwives had already been advised to work as friends to pregnant women and share their life burdens in the 1930s i.e. the nursing approach has never been coercive (Wrede 2003, 70–71). Preference is just expressed in subtle, persuasive ways that appeal affectively to the feelings of parents(-to-be) about the security, well-being and health of the baby(-to-be). As I have illustrated earlier, the appointment encounters where such ritual work of social and moral education takes place resemble a (family) therapy encounter. ‘Right feelings’ are invoked through a therapeutic code of interaction where pregnant women and their partners are called upon to reflect on their lives and pregnancies as emotional journeys into parental selves together and individually, as discussed in Chapter 4. It seems that they are to realise the need of reflection and change themselves.

In principle everybody is offered the same care in the name of equality and autonomy. Further, privacy and intimacy are highly valued as rights of the individual family (members). When it comes to physical concerns in pregnancy, especially those that cannot be blamed on the lifestyle of the pregnant woman or family (psycho-) dynamics, these principles and standards set for care are met, as discussed earlier. For the most part this was the case with all the women I had a chance to interview or just talk to at the clinics. What does this say in relation to my study?
The pregnant women I interviewed were not totally happy or comfortable with their pregnancies and care. However, it cannot be said that their pregnancies really took any institutionally determined divergent paths or that, in their accounts of their experience, the nurses had failed to orient themselves to the women’s perspective or particular concerns. In fact, the bodies that failed to work – that was the main condition about which women complained – were met with compassion at the clinics and the nurses (but not the doctors) were for the most part described as allies.

I suppose the reason for such a contented group of women’s accounts is chiefly down to the selection of the interviewees. I have already discussed in Chapter 3 how it is understandable that people with a background of socially problematic issues might not have participated in the study. Now I want to take this thought further. I suggest that the women I interviewed represent women who have mastered the therapeutic code of conduct when discussing issues related to family life and psychosocial concerns. If this were the case it would make sense for them to feel that they have been treated in an equal manner and that their intimacy and privacy have been (relatively) respected in pregnancy. Then, and unfortunately only then, the civic model works without problems, implying that one then fits into the continuum of ‘an average family (member)’.

The following subchapter explores the breaking down of ‘the average family’ and the consequences of such a breakdown for pregnant women, their unborn, and the civic model of care. I will also honour the promise made earlier on this issue and make it a class issue, so to speak. In my view, it is definitely a class issue, but not in the sense of categorising people into classes according to socio-economic or other characteristics and then caring for and controlling them or individual family members differently. Rather, it is a class-in-the-making in the material-semiotic practices of care and doing pregnancy. Socio-economic issues are related to such a constitution of classed positions, but not in a straightforward way. (see also Tolonen 2008; Skeggs 2004, 120–134.) It is not just a way of looking methodologically at class but also at how class is made in (preventive) healthcare today, in an era of population-based control not of people per se but of people-specific risks.
‘The average family’ breaks down

It is a consultation team meeting. A 15-year-old teenage girl who is pregnant, at 34 weeks gestation, and her mother are coming to the meeting. The meeting starts with the public health nurse describing the situation to the other team members. She explains the situation, and the others ask questions. Before the pregnant girl and the mother enter, the team agrees how to proceed in the discussion with them, and agrees an initial plan of referring the pregnant girl to different welfare services. The story of the girl goes as follows: at the age of 14 she met an 18-year-old man online. They met up and had sex a few times, and now the man refuses any contact with her, even after having been informed about the pregnancy. The girl became pregnant and had been hiding the pregnancy until just a few weeks ago. Finally somebody at school informed the school nurse who after meeting with the pregnant girl made her take a pregnancy test. After a positive result the girl’s mother was informed and the maternity healthcare clinic contacted. The girl had met with the nurse once a week after the visit to the school nurse, and soon after that a consultation team meeting was suggested to the girl and her mother. The public nurse describes the girl as very confused and silent, scared about giving birth and not knowing how to take care of the baby. The nurse had brought out the question about making a criminal charge against the father of the baby-to-be, but the family of the pregnant girl does not want to do that. The girl has said fairly little about the father of the baby-to-be and ‘seems to be hoping for some kind of relationship with him’. At this point the nurse expresses her regrets that the social worker from child welfare services could not attend the meeting because she would have had knowledge about the procedures involved in making criminal charges without the family’s consent. The psychologist expresses at this point concerns over the emotional relations of the child(-to-be) and her father. Finally the team decides to deal with child welfare issues of any kind later on, maybe even after birth, and only regarding the social rights of the baby. The protocol for the meeting is agreed: to go with the practical worries the pregnant girl and her mother have right now, such as planning a Caesarean section and arranging for help from family care workers (TTteam 1.4.2008).

I want to draw attention first in this ethnographic snapshot to the fact that the decision to perform a Caesarean section had been arrived at before the team meeting and after the young woman had made only one visit to the clinic. In Finland, and in the clinics where I did my fieldwork, deciding on a Caesarean section because of fears about giving birth is regarded as a last resort, as mentioned before. Usually healthy (physically and psychologically diagnosed) women expressing fears about the prospect of giving birth are referred to psychologists and/or to a special hospital outpatient clinic (pelkopolikliniikka). (see also Liljeroth 2009.) The particularities of the (psycho)social context of teenage
pregnancy are taken in themselves as signalling the need for treatment, even though this is not indicated by the overall health of the pregnant woman.

Obviously, age is the determining factor here that has altered the care of physicalities in pregnancy, combined with the stated fear of giving birth. The overall context is quite problematic as well, namely the unfortunate circumstances within which the girl got pregnant and then had to cope with being pregnant before someone intervened. Generally she is being treated at the team meeting as a victim of a crime, a mentally confused child who does not (and cannot?) possess the maternal competence to care for a newborn and a person who in her social relations is in need of several professional social and healthcare actors: the police, child welfare services, family care workers and medical doctors (and implicitly psychologists) in sustaining everyday life to make a fit home environment for a mother–baby relationship.

The unborn on its physical and ethical journey into a child with social and emotional rights is also arrived at explicitly when the psychologist expresses her concern over emotional family relations between the (unborn) child and her father and paternal response. Further, the child welfare action is moved in time to the postnatal future, and its object is transformed into the newborn that the unborn is transforming into.

How does the psychosocial context of this teenage pregnancy, then, work as signalling a need for medical and other intervention? The only explanation I can come up with is that here we have a case where problematic life conditions have accumulated to the point where the risk of the pregnant woman not coping on her own is too high for the professionals involved. It is not to say that poor, teenage and lone mothers are thought of as a group of people incapable of proper mothering per se, or that social background characteristics automatically result in diagnoses of moral inadequacy. This is already clear in the nurses’ insistence that age, education or wealth do not determine problems in family and care for pregnancies discussed in Chapter 4.

\[1^{107}\] In Finnish legal jurisdiction the age of consent is 16 years.
Rather, it seems that the label of a ‘problem family’ or ‘a family with multiple problems’ can be attached to anybody who steps out of the scale of ‘normality’ and enters into the zone of high risk (see also Yesilova 2008; 2009, 177–201). Who fits within ‘normality’ is determined by (changing) standards of life as in average. Average, on the other hand, is a family that fits within the normal distribution in risk scales. Thus we are talking about breaking down the characteristics of family life and individuals into measurable units and then fitting them into the framework of multiple social and health risks to form population-based statistical knowledge for health and social work professionals to draw on (Helén & Jauho 2008, 28; Yesilova 2008, 113). Class and morals come later, so to speak. Seemingly neutral and apolitical scientific (statistical) knowledge is used to make moral judgements about people’s lives, identifying them as abnormal and unnatural. Interestingly, as Katja Yesilova (2008; 2009) has written in the context of family education, statistically produced bundles of risks to a sufficiently good family life and well-being coincide with characteristics that used to be associated with the working class, while the normal and ‘ordinary’ are associated with the middle class (see also Skeggs 2004).

As I have discussed in Chapter 4, drawing on statistical knowledge when assessing risks in maternity healthcare varies by situation. There are multi-item forms that have the potential to define pregnant women and their relation to the unborn in terms of probabilities and variables in a singular moment in time and to override the local nursing practice that is more intuitive, procedural and less systematic and standardised. Currently they coexist almost as complementary tools. The form is transformed in practice into a tool for keeping track of concerns raised earlier and for bringing up new concerns in pregnancies. However, as the nurses have indicated and as the form itself suggests, the form is rather exhausting to complete and it has the potential to overlook problems outside the definitions of risks based on psychosocial knowledge. Further, as the form was originally developed for use in quantitative research and the characteristics of ‘well-being’ had to be broken down to fixed statements and numbers on scales, pregnancy and personhood appear as measurable scores (of risk).
When critical risk scores and/or concerned responses are triggered by discussion of lone motherhood, mental problems, substance abuse, family violence and so on that can be associated with problems in family life predictable at a population level – when family life in the average zone of well-being seems threatened – the principle of protecting autonomy, privacy and intimacy of family relations is more easily overridden by attempts to intervene and control. Take, for instance, the case of the teenage pregnancy quoted above: even making criminal charges without the consent of the girl or her parents is considered. It is as if the girl and the parents are perceived as totally incompetent as (legal) subjects.

Even though some people are not categorically a priori associated with an inability to sustain ‘normal’ family life nowadays, they are treated as such through the practices and processes of assessing. Simultaneously, they are enacted as unable to come ‘naturally’ to know and care for family life and, in this case, the unborn. ‘Naturally’, here, refers to a sense of population-based (statistical) knowledge on the laws and regularities of social life – ‘the social naturalness’ (Foucault 2007/1977–1978, 348–351; Yesilova 2008; 2009; Helén & Jauho 2003, 16).

Poor economic status and low education as such do not directly lead to intervention, as the nurses in my study also emphasised. People with such qualifications may even be regarded as ‘easier’ to work with than highly educated middle class women. However the nurses do tell moral stories, based, for example, on observations made during home visits and appointments: they talked about messy and inadequately furnished homes, and dirty babies that leave dirt marks on weight scales. Even though home economics is not mentioned, stories like these are linked to the socio-material life conditions of the people in question. These kinds of material circumstance are seen as problematic, because they are read as indicating problems in social relations, for example not being committed to do housework for the sake of the baby and so on.

What we are talking about, then, is behaviour that signals poor management of family life, including housekeeping, financial matters and so on, within the framework of social (family) relations. Yesilova (2008; 2009) has argued that in family education, where the
approach nowadays is one of the psychodynamics of family relations, the solution to (perceived) poor circumstances is to offer not financial help but emotional support. Whether a pregnant woman and other members of her family are then referred for further care and intervention, or are morally judged by nurses and other maternity healthcare staff, seems also to be linked to the pregnant woman’s ability to attune to the emotional support offered, according to my observations. In the snapshot above, this might be understood to include the pregnant girl (or her parents) not attuning to the advice about making criminal charges, not being responsive at the nurse’s appointment and behaving in a manner that led to them being characterised as ‘being confused’.

**Strategies of respectability**

As I have demonstrated in Chapters 3 and 4 the discussion style used in supporting client parents’ psychosocial transformation to parenthood often resembles a (family) therapy session. This includes not just therapeutic intervention to correct problems in family relations but also practices of assessment available: the standard forms, as they are translated into nursing practice, as well as informal methods the nurses call ‘probing’. They understand ‘probing’ as intuitive and practice-oriented clinical decision-making that is less visible, measurable and transparent than counting risk scores.

In the therapeutic repertoire of assessing, the parents(-to-be) are expected to open up about their inner thoughts and experiences and feelings related to them. The aim is to tutor them into reflecting on their pregnancies as mental and emotional paths towards parental(-to-be) selves that show love, attachment and attendance to their child(-to-be) in their own autonomous way. The nurses, then, in the light of these reflections, reflect on their previous assessments of the situation of the family and give support and advice accordingly, which in turn may result in further elaborations from the family members, and so the process goes on.

Obviously, the ‘love, ‘attachment’ and ‘attendance’ have to meet with some commonly shared, yet not too specific, standards. If the views of the pregnant women and their partners diverge in some respects from what is conceived as normal in psychosocial terms,
the reflections are geared towards fixing the social relations in the family unit to make family life and household affairs (more) workable, like in the following snapshot.108

The nurse and the woman are discussing the baby’s sleeping patterns. The nurse asks how the woman is able to sleep. The woman replies that usually she is able to sleep just fine but ‘now that he [the baby’s father] is coming tomorrow to visit’ she has not slept well the previous night. The nurse says that ‘so you have been thinking how things will go’. ‘Is he coming alone’, the nurse then asks. The woman explains that yes he is and that they are all together because he does not come often and she thinks that he would not cope with the baby alone. The nurse comments to the baby in the woman’s lap that ‘you have a chance to get to know your dad a little’ and goes on to ask the woman if the father is ‘doing any better now’. The woman says that she does not know because she cannot trust the man. The nurse replies that ‘tomorrow you will see then what the state of him is’ and asks if the man has himself kept in contact. The woman says that this time he did contact her. The nurse seems content by commenting that ‘so he is interested and motivated to keep in contact’. The woman downplays the willingness to contact by saying that it is the man’s parents usually that encourage him [to call]. ‘So I don’t know if it can be [called] his own initiative.’ The nurse goes on to ask if the man has been paying his alimony payments. The woman tells that he did pay last month but this month when she did not receive the payments she text messaged him, and then talked to his mum when there was no reply to the message. Finally she had got a message from the man saying that he will be in touch when he has the money. Apparently he had been fired from his job and it will take time before he gets daily unemployment benefits, and can pay. He had said that it would take couple of weeks but the woman does not seem sure that this is or will be the case: ‘It really depends on what mood he is in’, she says and explains that they had an agreement that he would always pay 150 euros a month ‘no matter what’. The nurse asks if the woman has enough money now to pay for diapers and other essentials. The woman answers yes, but complains about the overall situation where all the bills have piled up. The nurse wants to know if the woman’s own parents keep in touch. The woman tells her that they call every week and try to talk to her about keeping communication lines open to the father ‘so that it would not just be fighting all the time’. That seems to be the case all the time: ‘every call ends up in a fight’. The parents have tried to talk to her about reconciling ‘as if I could just forgive him for everything that he has done and forget’. The nurse replies that trust is a process and asks if the woman and the man have thought at any point about ‘going somewhere to talk about these issues [arbitration, family therapy]’. The woman firmly replies ‘no’. The nurse then asks if it feels like a too distant thought that they would get back

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108 This video is actually from a child healthcare appointment. I included it because reference was made to problems already dealt with before birth during maternity healthcare, and because it is illustrative of keeping families together somehow even in problematic circumstances (not common material in my data otherwise) and because it was used in the workshops.
together. The woman laughs and says that ‘we will not get back together’. The nurse goes on to explain about the family counselling centre in the municipality where there is arbitration as well as therapy for couples: ‘they have outsiders that guide the discussions’, she argues. The woman replies that she does not think that that will help in their case and that she does not think that anything will change. The nurse tries once more by saying that nothing will change in one day and that from the father’s perspective it would be good to attend the services: he might get his act together and then caring for the child would be shared more.

(Videotape T12N, first child, 5 months)

This clip was discussed in the workshop arranged for the nurses in our project. We asked the nurse why she did not seem to take into account the pregnant woman’s obvious concern that the father was not reliable when it comes to his attendance in the baby’s life. This interpretation was based on the nurse’s insistent preference to conclude that the situation with the father had got better, although the pregnant woman kept on repeating her claim from different angles. The nurse in question told us that, in fact, she had discussed the father’s problems, drug abuse and mental health issues (manic-depressive disorder), and their influence on family life several times from the pregnant woman’s orientation. However, here she wanted to discuss the possibilities for an emotional bond from the baby’s point of view: the preference being that such a bond is good for the child, whatever the circumstances.

Both our original interpretation of neglecting the woman’s concern and the nurse’s elaboration on her behaviour as assuring paternal contact, hint at an orientation to hold the family together, not under the same roof obviously, but by keeping them in touch for the sake of the child. This is in line with the observation on family education and care in general: rather than breaking up the family, parents are educated to bring up their children and repair their relations in a therapeutic encounter (Yesilova 2009, 190) – to which I would add the comment ‘insofar as it is possible in the given circumstances’.

The woman in the snapshot is apparently not attuned to the nurse’s line of discussion. She keeps on escalating the problems and the nurse keeps on insisting, so the conversation does not flow very smoothly and the pregnant woman is not emotionally supported in her reflections on family life and relations. The woman refuses to follow the therapeutic code
of interaction and, by implication, refuses her baby paternal relations by not trying every possible way of reconciling with the father. It is as if refusing to take on the nurse’s interpretation itself works as a signifier of (a small) failure in family life.

As discussed earlier, refusing or not knowing how to attune to the social conduct of the therapeutic code, including refusing attendance altogether, may lead not just to erratic flows of interaction and self-narration as co-produced at the appointment or intervention in terms of (suggestions for) further care, but also to a psycho-pathologisation of the process of transformation into motherhood, and character descriptions like ‘confrontational’ and ‘aggressive’. Paradoxically, being ‘dependent’ on professional help is not viewed as good either. Overall, professional help is positioned as something that merely helps women (and men) to help themselves: autonomy, privacy and ‘normality’ are, in material-semantic practices, granted to those that accept the support offered but do not become too dependent on it. Acceptance here refers to willingness to attend care and ‘willingness’ (as interpreted) to follow the therapeutic code of interaction and transformation into parenthood. (see also Yesilova 2008; 2009; Skeggs 2004, 120–134; 1997; Miller & Rose 2008.)

Not fulfilling the cultural (vague and varying) ideals of motherhood in pregnancy does not result per se in the fracture of the therapeutic code, however. Beverly Skeggs (1997, 56–72; 2004, 120–134) has argued that confessional methods of self-reflection and self-narration are a way to display cultural ability not just for the affluent but also for the ‘unprivileged’. The unprivileged, here, refer to people with not just poor socio-economic conditions but who may diverge from the ‘average family’ circumstances in other ways as well. As I have tried to show, proving oneself capable involves attuning to the competences of mothering, even if they seem like an unattainable goal in the given circumstances. It seems that even if, for example, the nuclear family is not a choice, one should at least express the desire to have one, and try one’s best to get one. Or to show remorse or guilt for eating too many sweets or having unacceptable drinking habits, and express willingness and effort to change. These are the ways to be heard as able subjects in maternity healthcare – the strategies of respectability in the institutional orders.
Generally, we are talking about taking up the familial responsibilities offered to gain status and respectability that, according to Beverly Skeggs (1997, 1–4, 52–54) are often offered to working-class women (in the form of care) because respectability is usually a concern of those who are not seen to have it. It is also a central mechanism and a signifier of social class. Thus the position of the respected appears as something that should be enjoyed because it is seen as a property of those that are valued and legitimated in our societies. ‘To not have respectability is to have little social value and legitimacy’, which is obviously not an appealing position for anyone in any given context (ibid., 3). No wonder that a lot of women actively produce culturally respectable meanings for the positions they inhabit in life.

Class relations have changed through different historical time periods, and the concept of class cannot be fully interpreted in the same terms in the Finnish context as in the English context which is Skeggs’ research setting (1997; 2004), but some common features remain. Even if ‘class’ has been taken to pieces and an a priori moral authority has been replaced by an authority of knowing ‘naturalness’ of different kind (biomedical or psychosocial), the methods of class-in-the-making in practices still remain: the techniques of the self – self knowledge, self-reflection and self-examination (through narration). They often become the form of self-surveillance for those trying to escape the culturally negative classifications easily inflicted upon them: the financially dependent, the lone mothers, the mentally ill and so on. This, according to Skeggs, is because the methods of the self, the therapeutic form of telling and the subjectivities it entails in a given context of confession, are historically a middle class experience that has been used to condition, for example, poor relief. (Skeggs 2004, 5, 120–124.)

In a way, then, moral stories and moral mother-subjects are forced on some people at the clinics. They are given the terms in which to tell their stories in order to become respectable and self-reliant. If they refuse they are characterised as ‘abnormal’ and ultimately refused a position as a moral being – a fit mother who is willing to adopt any competence, emotional attachment or professional support and who wishes for the ‘better’, even if ‘the better’ is unobtainable because of physical obstacles (for example with
breastfeeding), irreconcilable problems with the partner (the ideal of the two-parent household) or other important (supportive) parents or, for instance financial problems (like having a nursery space for the baby(-to-be)). In the current ethos of preventive healthcare, within which everyone who walks through the door is in principle ‘the same’, one can be morally judged without having poor life circumstances, as one would have been assigned to lower social classes in the more distant past. However, it can also be seen how such a judgment could happen more easily to people in such circumstances.\textsuperscript{109} Thus it is a classed practice, although not in an a priori determined way.

The practices of therapeutic narration are also related to citizenship in the second sense of the concept, national belonging via civil responsibilities (on the two senses see e.g. Helén & Jauho 2003; Urponen 2010). National belonging constitutes the symbolic capital of the national context – belonging is to be legitimate and to benefit the nation (Skeggs 2004, 19, 54). The cultural imaginary of maternal competence, related to physical, psychosocial and socio-material aspects of pregnancy, is, as elaborated in the previous section, enacted as a national responsibility for the sake of the unborn’s future and the national future. Displaying the accumulation of competence in the practices and processes of maternity healthcare, then, is to display belonging. Ultimately this means that a right to ‘choose’ (lifestyle, family form, birth mode and so on) in maternity healthcare, as well as other national institutional contexts, involves a normative demand for ‘civic’ argumentation. For women in reproductive issues this means an insistence on adapting to specific maternal self-narration and subjectivities of respectability. The problem is that attuning to such a normative practice of display is not the same or as easy for all.

5.4 Economics of kin

My ethnographic inquiry into pregnancy as a social relation in and outside the clinics has provided me with several moments of utter surprise and astonishment. Most of them, I have to admit, had to do with economic/market logic as realised in pregnancy. First, it took

\textsuperscript{109} This is, in my view, also more likely to happen because of the historical context of the constitution of the maternity healthcare institution: despite the involvement of the working class women’s movement, the middle class movements eventually won the day in determining the organisation and contents of the care (Wrede 2003).
me a while to get used to pregnant women and their partners being called clients/consumers (asiakas) in the interviews and talks I had with the nurses and in official documents. It just did not fit, in my view, with the cozy and friendly atmosphere of the clinics, where everybody remembers your name. Second, I was not expecting the foetal figure to be commodified and fetishised as it was in the Internet imaginary or private photo albums. Third, I kept on looking for ‘deeper’ answers than banal lists of things that were bought or were to be bought from the women I interviewed in regards to preparing for family life after birth.

My affective reaction may have emerged from a feeling of economic and consumer principles invading the sacralised world of family and kinship (see also Kopytoff 2004), but also from presuppositions concerning maternity healthcare as a historically special welfare state service. I suppose I had been under a naïve assumption that, somehow, the achievement of Finnish welfare state project, the maternity healthcare, had survived the pressures of adjusting public management to the intensification of global capitalism. I thought so even despite the fact that the market logic in management and service provision have been observed to have had a definite effect on women as both professionals and clients since the early 1990s (Wrede & Henriksson 2004).

When looking closely at the care practices I was able to see the more subtle ways the market and consumer reasoning come into play. In fact, whatever contradiction I first encountered between economism and kinship-in-the-making was a matter of cultural perception – and, further, an ethnocentric one. Igor Kopytoff (2004) has argued that in the pre-capitalist West there was no sense of ethical contradiction or moral impropriety such as we see and experience nowadays in the sentimental and spiritual world of kinship or other informal social relations lending themselves to the world of economics perceived to belong to materialism. He illustrates his point by showing how in numerous societies rights-in-persons organise social arrangements, and these rights are transacted through payments in money, commodities and animals. Such arrangements include inheritance, marriage, reproduction and rights over children and sexuality (see also McKinnon 2001). Even nowadays there are logical interconnections between kinship and economism which
are in an inconsistent manner seen as a cultural threat and ethically problematic invasion by ‘economy’ of society. On the one hand, for instance, people treat themselves to the moral luxury of spending on various baby goods and ultrasound pictures and videos (from private clinics especially) as it contributes to parental bonding and personhood constitution before birth, as my own study also demonstrated (ibid.; Taylor 2004b.) On the other hand, the development of reproductive technologies and expansion of cross-national adoption have raised public concern over the distinction between persons and things available in most countries only for affluent people (Anagnost 2004).

In this subchapter that concludes the thematic ways of reasoning and doing care and pregnancy, I will attend to the both sides of the market impact on social relations in pregnancy: the production end and the consumer end of care and babies(-to-be). Both of these illustrate how the socio-materialities that organise and transform social relations in practices are associated with market logic.

**Prenatal mothering as consumer-citizenship?**

While some pregnant women certainly enjoy buying, borrowing and being given baby goods and gadgets, and furnishing households to be baby-proof and pretty for the upcoming newcomer, it cannot be concluded that they engage with the enormous market for baby goods just for their own private pleasure. It would be more accurate to say that mothers are even encouraged to take pleasure in consuming not just materialities for baby-centred spaces but also food: however that is not the whole story either for the pleasure, here, is not enacted as that of a greedy consumer but a consumer transformed to be sensitive to her surroundings.

The ultimate problem in fitting citizens and consumers together has been identified as originating in the definitions of citizens as willing to serve the ‘common good’ and consumers seeking for pleasure (Schudson 2006; Mol 2010, 207). These characteristics do not seem to sit well together, especially in public service contexts (Clarke et al. 2007). Can one simultaneously care about the collective and oneself in one’s choices? Pregnancy seems to offer such a place in- and outside the maternity healthcare service context.
Annemarie Mol (2010) has noted how difficult it is to imagine a public health campaign calling upon people to listen to their pleasure-seeking bodies, or a political campaign for fair trade persuading consumers to serve their own interests when they consume. In public health campaigns and information material, like the brochures handed out at the clinics, ‘healthy’ food and other health-promoting goods can hardly be described as a source of private pleasure. Healthy eating and consuming is, rather, as Annemarie Mol (2010, 272) puts it, a civic duty, and the concern is not ultimately with the one who is expected to act but with the health of the population.

Let us apply this to the everyday realm of maternity healthcare practices. In the practices, I do not see such a contrast between health and pleasure. Women and their partners are even encouraged to combine the two. They are persuaded to attend the ultrasound screening (regardless of cost) to enjoy seeing the ‘baby’ for the first time and to start the ‘healthy’ process of bonding with it and their transformation into parenthood, which is especially seen as needed by the (male) partners.

While nurses have told me that they are careful about not advertising products to buy for the home and the baby(-to-be), and stress that only basic equipment is needed, they do check with the pregnant women if they have bought this and that for the baby and prepared a space for the baby and so on. This ‘checking’ is not merely checking, however, as the nurses want to find out what it feels like to prepare, and they engage in gushing with the pregnant woman over what kind of cute and adorable baby clothing they have found and ease the minds of those pregnant women who feel that they have got too excited and bought too much. These activities elicit responses from pregnant women in the sense that they seek transformations in the organisation of households as part of the essential patterns of transformation into parenthood, in the name of the child. Pregnant women themselves legitimise the acquisition of various goods including determining the foetal sex in the ultrasound (to buy the ‘right’ coloured clothes and so on) for the sake of the baby: to make a home ready and good for her or him.
Lastly, healthy eating and advice to eat healthily during pregnancy is not just about counting calories to avoid pregnancy-related diabetes or getting all the nutrients needed in pregnancy to provide for the unborn. This is clear from conversations where pregnant women are told to indulge themselves during this special time and not to be too strict with themselves (as long as they do not get carried away). This is also implied in the pregnant women’s accounts in which, even though paradoxically, they embrace pregnancy as a time when women are finally ‘allowed’ to eat. It is as though fat gained from pregnancy is culturally not ‘bad’ fat but fat that also liberates (see also Berlant 1997, 95–97).

In the practices of maternity healthcare and doing pregnancy, pregnant women as citizens are not expected merely to silence their desiring consumers inside. Rather, they are encouraged to enjoy, as they do, food, using reproductive technologies, baby goods and household items (or even new houses) and by doing so they practice solidarity, gain health and well-being for a sake of ‘a common good’, the baby(-to-be). Babies(-to-be) in the historical context of maternity healthcare welfare services truly are ‘the common good’ of the institution. They are the ultimate object of concern, the health and well-being of many kind of the population of Finnish foetuses in transformation.

The pleasure invoked, however, cannot be wholly regarded as invoking consumer choice or agency free from constraints because it can also be seen as an affective working on women’s positive imaginary about the upcoming baby-life. So, doing good like this is not just a side effect of taking pleasure but an obligation, and as such even pleasure is a result of power.

**Production of choice and autonomy**

Global market forces, consumerism included, have been seen as eventually leading to ‘the commodification of children and proletarianization of motherhood’ (Rothman 2004, 19). What is meant by this is that capitalist ideology, property relations and ownership have been extended to motherhood, albeit disguised in the language of ‘rights’ to one’s body and one’s child(-to-be). Barbara Katz Rothman (2004, 21) claims that even feminists have ‘capitalized on the value of ownership’ to grant (reproductive) rights for women partly as a
result of a line of argument based on the basic values of capitalism that emphasise private and not collective ownership, resource and control of bodies, babies and so on. However desirable this end has been, it has borne costs for both women’s bodies and children. Women have gained legal rights to protect themselves from state control and outside invasion, but the combination of patriarchy and capitalism in a liberal political tradition have made sure that the body of a mother is cheap and her ownership does not extent to the other body growing inside her. If, following market logic, women’s labour was valued, a claim for equity for women in their babies could be made. However, this is not the case in the world as it stands today. Further, if women own their body-space it follows logically that it may be rented out for hire, for surrogacy, within which a baby(-to-be) belongs by contract to the donor family. Nobody is technically selling a baby here, which would be illegal, but money is changing hands and consequently children are commodified all the same. (Rothman 2004; see also Mol 2008a, 14–28.)

One can easily see that the American model does not fully apply to the Finnish context of social liberal ideology or even the legal system (surrogacy, for example, is illegal). Furthermore, despite the debate on the crumbling of the welfare state, society and services, healthcare and technology (e.g. Anttonen & Sipilä 2000; Julkunen 2001), issues linked to health and reproduction cannot be characterised as blatantly exploited for profit to the extent that may be happening in the Anglo-American world, at least not yet. However, the currently operating model of management and, thus, doing care, although not fully operational or coherent, at least in the care practice, bears traces of market logic in its relation to those managed, be they ‘clients/consumers’, institutional workers, partners and so on: they are contract relations.

In fact, the techniques of ‘not taking a stand’ – subtle persuasion, abstract guidance (into parenthood), seemingly neutral scientific argumentation and growing insistence on informed choice beyond medical ethical principles – can be associated with the (Nordic) welfare services’ managerial response to the demands of capitalism (Sulkunen 2009; 2007; Julkunen 2010, 104–120; on the consequences in more general terms see e.g. Eräsaari 2010). Above all it can be seen in their response to the demand to increase
autonomy/choice and privacy/intimacy. Regulation of choices regarding lifestyle would interfere with the neo-liberal free market and consumer freedom. Although the formation of the welfare state has, since World War II, been about fitting ideals of individual freedom and choice into the ideals of independent families – the core object of welfare policy – Pekka Sulkunen (2009) claims that we are witnessing a growing demand for autonomy and intimacy.

The crisis in consciousness stems from the friction between the two demands. Autonomy presupposes sameness: rights, responsibilities and services should be offered equally and in an equal manner to all, regardless of their differences. Intimacy, instead, is based on difference: taking into account the individual right to be different. Thus, taking a stand on the responsibilities and services needed to constitute a ‘good life’ for all citizens may seem like exercising state paternalism. (ibid., 119–139.) As a result, the state and public services no longer define the ‘good life’ but try to deliver it all the same from a distance as a partner in multiple partnerships, where responsibility for health and well-being is shared by citizens, communities, the third sector and the private sector. The networks of shared care hang together by a contractual type of social bond that is based on voluntary partnership and not universal inclusion in a similar way to market contracts. (ibid., 148–151, 175–176, 182–183.)
6. Conclusion

I first became interested in studying pregnancy and the social relations related to it when my sister got pregnant for the first time ten years ago. I was fascinated by her constantly changing body and the sensations it caused. I was never tired of discussing with her how it felt to share a body with an unborn, the kinds of mental images of the unborn that pregnancy evoked, and the kinds of thoughts she had about her changing body and its symptoms. I have to admit that I tended to mystify pregnancy and the pregnant body: my sister’s volatile emotions and apparently uncontrollable changes were associated in my head with some ‘underlying’ mysterious and anonymous power.

After she gave birth to her firstborn, she used to make people – women, needless to say – laugh, by telling a story about her stay in the hospital before the actual birth. Her overall experience of being in labour was not funny at all, however. Her pregnancy ran two weeks over the estimated due date, and the last weeks were bodily very uncomfortable for her. After her waters broke she was in labour altogether for 48 hours. She was constantly examined, the epidural did not ease her pains, and finally childbirth had to be induced by which time she was too tired to push by herself. The story she used to tell, however, concerns her own behaviour at the hospital ward.

During her long wait for the birth, she was offered zone therapy. She gladly accepted. Without hesitation she stripped off her underwear in front of a very confused therapist who had come to do the zone therapy treatment to her feet. Next day after her delivery she was told that a doctor would come to check the constriction condition of her uterus. At this point of the story, my sister usually puts on an obedient face and demonstrates how she pulled down her pants once again and got into the hospital bed. The state of constriction examination is an external hands-on measurement of the abdomen.

What is it about this story that makes it funny? What makes being so consumed by the aches and pains of pregnancy and childbirth that one acts absurdly humorous, especially
for women? I suppose it is the irony over what it means for women in their bodies to bear children in medical settings. My sister’s story, then, has to be interpreted in the frame of medical care for pregnancies and experiences shared by many women. The story, and the sarcastic gestures my sister makes, parody medical practice and, thus, highlight and make trouble for a medical practice that more often than not turns its technological attention to the foetus through the female body (parts). In effect the medical setting, professionals and technology do not come across as protecting the mother-woman in order to protect the unborn that is also constitutive of experience-based knowledge. Rather, they seem to dig into the residential chamber of the foetus, treating and protecting it as a separate being, like a metaphorical father, as Merete Lie (2002) puts it.

My sister’s experience, experience-based knowledge and the thoughts that they evoked in me both at a personal and scholarly level worked as my first point of entry into studying pregnancy and maternity healthcare as socially organised phenomena. In other words, the dialogue between my sister and me produced knowledge that is experience-based but oriented, first, to the focus of a childless and astonished close relative, and, later, a sociologically aware feminist student. Later, when I started my doctoral study, I brought in social science and formulated research questions without, however, losing sight of my sister’s voice. I set out in this thesis, first, to inquire into women’s experience-based knowledge and viewpoints of volatile changes and the unborn in order to establish associations with the maternity healthcare institution. Then, informed by these associations, I asked how at the practical level of care activities social relations with the unborn are being crafted, and how women are engaged in the institutional orders thus established.

Choosing maternity healthcare as a subject and a field setting, that in Finland is mainly a nursing practice that differs from medical clinical practice in many ways, was also a decision that originated in discussions with my sister. I wanted to examine how, and how far, medical models and the medical profession are articulated in the practices of maternity healthcare. Surely pregnant women do not have to submit to gynaecological interventions everywhere and at all times, I thought. Moving into doing research has involved multiple
new voices and knowledges that have been integrated into this thesis. In my cumulative process of IE inquiry, interchanges between myself and pregnant women and public health nurses, along with video clips and observations of the activities at the clinics, have resulted in an analytical journey where interpretations have been reframed again and again to include new observations, new commentaries, new viewpoints, new theory and so on.

In this concluding chapter, I will first reflect on my theoretical and methodological choices. More specifically, I will discuss the benefits of combining insights from science and technology studies on material-semiotic practices into my institutional ethnographic project. My reflexive inquiry will also include a discussion on what is it that falls beyond the scope of this study. Next, I will move on to the results of my ethnographic research. I will start with the pregnant women’s experience-based knowledge of their activities, and, by following that, move on to the field of maternity healthcare with its institutional orders and out-of-orders that coordinate the enactment of woman–unborn relations in practices temporally and topically. Here, I will also relate my results to Foucauldian concepts of biopower and biopolitics in order to conclude about the authority of science-oriented knowledge in transforming forms of care from state paternalism (and maternalism) to guidance from a distance. Then I will discuss in explicit terms the spaces and places for women’s agency in and outside the institutional orders. Finally, I will present some implications for maternity healthcare practice and policy that would support the (re)location of pregnant women as the central site in pregnancy and its care without losing the sight of the morality and identity of the unborn.

6.1 Theoretical and methodological reflections

Throughout my research my objective has been to incorporate pregnant women’s self-knowledge and the meanings they articulate into knowledge that resides in material practices that may or may not be accessible to pregnant women’s own cognition or articulable to the researcher. In order to do this I have collected ethnographic research material that consists not just of observations and video recordings of the activities taking place at the clinics and documentary material used and produced by the institutional actors, but also of interviews to acquire personal accounts on experience. For the same reason I
have adopted institutional ethnography, theorised by Dorothy E. Smith (1987; 1990; 1998; 2005), as my theoretical and methodological orientation.

Smith’s concept of standpoint offered me a way of dialogically orienting research to the local particularities of pregnant women’s bodily lives in- and outside the maternity healthcare clinics. It has worked as a methodological organiser for larger power relations manifest in activities taking place in maternity healthcare practices, in that it is situated knowledge(s) telling of pregnant women’s positions in social networks of care.

However, as Smith is not a theorist of concepts of agency, subject or physicalities/embodiment, I have also brought into my theoretical and methodological framework insights from particular writers in the field of (feminist) studies of technoscience in material-semiotic practices, such as Donna Haraway (e.g. 1991a; 1997), Annemarie Mol (e.g. 2002; 2008a) and others. From them I have adopted an analytical perspective that acknowledges the heterogeneity, instability and fluidity of subjects, objects, logics and agency in practices. I found it useful to alter things and people symmetrical for analytical purposes to escape being locked into looking only for strategic coherence in enactments, relations and agency.

I did not, however, stop at the actorial concept of agency provided by these particular science and technology studies thinkers. This is where the concept of standpoint comes into play again. Natural things and physicalities, non-humans and not-yet-humans, as well as technology and other materials may work, do things, act and enact, but I have not granted them agency, not because I think it would be an insult to some ontology of human superiority, but because, at bottom, my scholarly interest lies in telling situated human stories of pregnant women as they participate in institutional orders and outside them. Agency, then, is actorial, relational and a modality of actions that escape power relations, not just because power forms do not have the ability to keep their hold on the world consistently all the time but also because its objective is to seize the world somehow. If that makes my application of the concept somewhat humanistic in ontological terms, so be it – it has served its purpose.
My hybrid theoretical and methodological framework has allowed me to inquire into a multitude of logics of power in a network of social relations carried out in the practices of maternity healthcare, both formal and informal. Further, navigating by the standpoint, the dialogically produced experience-based knowledge, I have been able to see spaces and places for vague agency for pregnant women in their families. I will return to the specific results shortly, but first I want to address what falls beyond the scope of this study because of its approach.

First, despite efforts, there remained limitations in the dialogue between all the research participants (including myself), and thus knowledge produced, that could not be overcome. IE theory acknowledges these difficulties and limitations in that people in institutional surroundings – in my study the university and the maternity healthcare – remain to some degree subjugated by an abstract institutional language that has the tendency to escape dialogue and marginalise people’s perspectives. Some of the limitations, however, originated from the original design of the research and the context of suspicion linked to my position in relation to the nursing administration. The top-down model of acquiring consent from the participants, especially during periods of organisational changes, was not productive in a sense of gaining trust and rapport. Instead, it led to a situation of power imbalance that could not be totally removed. All of this affected what was and was not discussed, how much access was granted, which voices were given most importance and from which perspective.

Another result of the original design of the research was that most of the activities observed and stories heard in my fieldwork involved pregnant women from ethnically homogeneous backgrounds and without socially (or socio-economically) problematic conditions. To include more diversity in these respects I would have had to conduct fieldwork at specialist clinics and with specialist nurses. Moreover, I would have had to have worked on my persuasion skills, because members of ethnic minorities were the most reluctant to give consent: this is understandable inasmuch as their position in Finland must be more precarious than that of natives, especially in relation to institutional state
authorities. Obtaining the stories, perspectives and activities of these different people more comprehensively has been on the agenda of other research into welfare services (in Finland Leppo 2008; Leppo & Perälä; Keskinen 2011), and would be an interesting area of further research for me, too.

Lastly, my study makes no arguments about the prevalence or the extent to which the results on the logics and social organisation of women–unborn relations can be generalised. That is obviously the case in all qualitative research, but it has a specific character in IE. IE explicitly seeks, cumulatively and through a particular standpoint, to identify differences and similarities across actors’ experiences and activities to account for ways of reproducing power relations in practices, and not to make generalising statements of commonalities in the accounts of participants, observations and so on. In fact, pursuing the generation of theories or conceptualisations – even in a qualitative research manner – that are somehow expressive of what is found to be happening in the research material would be against the whole epistemic project of IE. Rather, IE’s agenda is to put terms and concepts – social, theoretical and institutional – to the test by finding out how activities in the field and the accounts of all research participants make use of and realise such concepts and terms. Certainly how the social is organised in institutional practice travels from specific field settings to others, as has been shown repeatedly and is inherent in IE theory. What cannot be assumed, however, is the standardising effect of institutions and how institutional standards work in practice, as I have shown in my study as well. IE projects may not be generalising projects but they are robust in the sense that they orient their analysis to people’s experience, interests and practices, and, thus, produce contextual knowledge that transcends authoritarian limitations and existing norms in institutional orders (see also Gunnarsson 2007, 354–355).

6.2 Doing pregnancy and the unborn…

According to my findings, pregnant women themselves do a lot of work that directly and indirectly constitutes their relationship with the unborn. By ‘doing’ pregnancy, pregnant women also come to know their unborn to whom by the end of the pregnancy are attributed at least potential personal characteristics, gender and social identity and kin
relations. This work of attributing appears to be a cumulative body-bound process somewhat in line with the progression of pregnancy: via pivotal experiences the unborn shifts from ambivalent feelings of unreality and sense of distribution into something more concrete, a human life, a baby and so on.

In the pregnant women’s experiences, enacting the unborn in this process involves many socio-material activities. Pregnant women carefully attend to their bodily sensations and their mental associations of the unborn, find out (or do not) about the sex, health and physical features of the unborn in ultrasound screening and through other screening technology, learn the daily bodily rhythms of the unborn and seek professional and popular as well as experience-based knowledge on pregnancy and babies. These activities are, then, seen as indicative of the unborn person that needs attending prior to birth by naming, tolerating (or not) medical interventions, acquiring baby goods and gadgets, rearranging the household, life cycles and social relations by engaging others, especially the (male) partners, in participating both emotionally and practically.

Attending to the unborn that is known to be of a certain sex and to look like something or somebody (often like an older sibling or other relative) and doing things in a certain fashion in these ways are themselves expressive of the mother–baby(-to-be) relationship and the extent to which pregnant women attune to the cultural competences (as perceived) assigned to motherhood. Different kinds of relationships are enacted in different settings and circumstances. Consider, for example, a peaceful suburban house with ultrasound portraits hanging on the wall and closets full of pink clothing and, then, a plain but functional single-parent household where there is only basic baby equipment and gender neutral clothing ready, because the lone mother-to-be wants the sex of the baby to be a surprise or wants to pamper the baby-to-be not with material goods but with a lot of attention and affection from herself and eager grandparents. All socio-material arrangements, including consumer choices, and mental manoeuvres to transform oneself into a loving parent, then, are manifestations of a particular unborn in the process of becoming a person with social and kin ties, gender and character.
Preparation in the lives of the women I had the chance to interview and talk to is done, or at least is argued to have been done, in the interest of the baby(-to-be). In fact, ‘the interest (or the best interest) of the baby/child’ is a rhetorical device and a value object that is used to justify a lot of activities, choices and responsibilities in the women’s accounts, ranging from learning or not learning the sex of the unborn, via attending all the painful examinations available to know any foetal health risks, to spending enormous amounts of money on new and secure houses and cars.

It seems, then, that in the private lives of pregnant women ‘the best interest of the child’ argument, which is an institutional (policy level) term and a concept with an amazingly vague and fluid content and usage, is used to explain one’s own actions and to demonstrate cultural maternal respectability. Such usage implies that pregnant women are faced with enormous responsibilities both as the guardians of the unborn and providers of in utero security and as the managers and mediators of the unborn’s other social relations and household practicalities. These peculiar employments of notions of risk, responsibility and security enact in a process ultimately a mother–child relationship that is highly individualistic: pregnant women are the ambivalent high commanders who may have the responsibility to choose how and what kind of maternal selves to become, obviously within some parameters of normality inherent in the vague and abstract value of the best interest of the child.

6.3 …in institutional orders and out-of-orders

How is all this realised in the nursing practices of maternity healthcare? The pregnant women themselves explained that, at best, the relationship with the public health nurse is one of equals: trusting and cooperative, and offering therapeutic conversation. After observing the activities and the cozy atmosphere of the clinics for months, I can conclude that characteristic to the nursing practice is the aim of building trust and solidarity, and cooperation and teamwork between all kinds of professional and lay partners in pregnancy. There are professional objectives to this kind of agency, including building a rapport so as to be able to assess potential emergent problems of the pregnant women and their
families(-to-be), affectively managing pregnant women’s and their partners anxieties about the unpredictabilities in pregnancy, and persuading changes in lifestyles in subtle ways.

These subtle ways, for nurses and other healthcare and social service professionals, appear to include taking up a position as a mediator of scientific ‘facts’ about, for instance, foetal damage and psychosocial risks, and not taking a strong stand on good parenting and parent–child relationships. Authority is given, especially, to pregnant women and their sense of self and their reflections on their journeys toward specific self-determined parental selves. Self-reflection and self-narration in a (family) therapy session-like encounter seem to be perceived as themselves leading to sufficient parenthood and family life (via self-reliance).

It would be wrong to argue that pregnant women and their partners are offered only cold facts and advice built on scientific reasoning and then left on their own in their communities to arrive at their own family values and well-being in family relations. It is, rather, that moral preferences about lifestyle and building a relationship to one’s unborn are in a sense disguised and distanced from maternity healthcare professionals. Talking about one’s own choices and experiences in pregnancy and returning to a troubling issue again and again are subtle, but not forceful, ways of persuading pregnant women to think through their choices, feel responsibility, and then, perhaps, make changes. Similarly, scientific facts are geared toward a maternal and paternal emotional response to change lifestyles and to bond with the unborn when their cultural authority is strategically used. In these ways, multiple unborn are performed.

In situations in which women (and men) are being informed about foetal screenings and other physical uncertainties in pregnancy, biological, technological and medical ethical facts reign, and a technical-clinical foetus as merely a creature in a biological process is enacted. However, in other situations, the custodial role of (visualising) technology and medical science is to some extent erased when technological and scientific ‘discoveries’ about foetal life are naturalised so as to appear to be some innate origins of emotional kin ties, gender identification and pregnant women’s position as a custodian of children
within. The transparency of the technology makes it possible for gendered divisions of labour and virtues in family life to enter into the nursing work that then guides pregnant people to attend to scientific facts and visions as (semi-)separate human actors to whom they are accountable for physical health and psychosocial well-being in the future.

In the care practices, there is a temporal, yet somewhat incoherent, logic to enacting the unborn that accords to physiological development, and the viability and ability of the foetus as scientifically known. The unborn are gradually transformed from foetuses, human life and babies in general to particular babies and children in a more distant future. In effect, the relationship of sensational connection to the pregnant woman is both dissolved and maintained. Associating the unborn with the social and sentience obviously makes the unborn the concern of others and other things as well and, hence, decreases the importance of the sensational connection as a source of knowledge and authority.

The authority of the women as knowing the unborn and its interests is maintained, as the activities at the clinics do not totally rely on the omniscience of technoscientific confirmation or models in determining unborn–woman relations. Rather, according to my observations, (medical) scientific models work as a complement to less visible models of ‘female instincts’ of more distant past in origins – models that sometimes mystify nature by allowing women to know from within such things as foetal health, sex and the competences of motherhood. Paying attention to maternal experience-based knowledge surely erodes the omniscience of scientific knowledge and attaches women differently to the unborn than medical-technological discourses and intervention do. However, provoking female instinct and nature is associating women, once again, with natural destinies of reproduction, albeit not biological ones.

Sometimes medical professional practice and technology are even contested and openly critiqued at the maternity healthcare clinics. In the critical repertoire I became acquainted with during my fieldwork, the medical professional culture was seen as too theory-oriented and obscure to provide the social support needed in the transition to parenthood. The use of technology, instead, is contested, to the extent that it seems to threaten the prevailing
cultural understandings of ‘natural’ limits regarding kinship, relatedness and identity. In particular, this historically and culturally contingent limit seems to be reached in maternity healthcare today with high-tech assisted reproductive technologies (ART) and invasive post-natal interventions. Routine use of monitoring technology and low-tech ART, instead seem to have become a ritualistic and self-evident part of the (seemingly) natural course of pregnancy.

Further, the two subjects of medical care models and practices, the foetal patient and the maternal patient, do not fully emerge in maternity healthcare practices in Finland. As I have shown there are similarities in the practices of enacting status for the unborn and foetal agency. These similarities include the ways viability and physical capabilities are linked to the entitlement to medical protection and the ways in which agential attributes are given to the unborn in hands-on and verbal consultation practice. The unborn as an agent obviously has the potential to be pitted against the woman as a reproductive agent and thus to increase responsibilities imposed on her to use (more) reproductive medicine and technology.

Foetal patients, to the extent that they are realised, travel to maternity healthcare from hospitals and other specialised services because the historical institutional division of labour grants diagnostic power and treatment decisions to doctors and hospital wards in Finland. I argue that, in maternity healthcare, foetal patients are transformed into more ambiguous beings and the focus shifts toward the pregnant woman and her (immediate family) social relations. Care work, then, is directed at emotional, psychosocial and socio-material transformations of the pregnant woman and other family members in family life to attune to the particular disability or illness at hand.

Emotional, psychosocial and socio-material transformation in unborn–woman relations, as well as in other immediate social relations, is on the agenda in general around the third trimester of pregnancy. It is working on transformations to provide abstract and vague psychosocial well-being in terms of ‘motherhood’, ‘fatherhood’ and ‘parenthood’, often for an equally abstract and vague goal, the ‘best interest of the child’. This is quite
different work than working with clear-cut physiological or psychological problems, and, thus, enacts the unborn and its relations differently. In the field clinics, there are both more and less standardised and formal ways of supporting the transformation into parenthood and screening for problems in that transformation. On the one hand, there are standard interviewing forms and special counselling classes on parenthood. On the other hand, the work insists on informal methods of discussion.

The nurses understand discussion as intuitive and practice-oriented clinical decision-making often assigned to nursing as opposed to more visible, measurable and transparent doctoring. In my view, the style and mode of that discussion takes the form of (family) therapy that has been common to family education in public services for a few decades now. That is, the parents are encouraged to talk about their past and present thoughts, experiences and feelings related to them. More specifically, they are encouraged to reflect and evaluate on the pregnancy as a mental and emotional journey towards their parental(-to-be) selves. The nurses, then, in the light of these reflections, consider their previous assessments of the situation of the family and give support and advice accordingly which, in turn, may result in further elaborations from the pregnant women and their partners, and so the process goes on. The overall transformation sought is an emotional transformation of the self to attune to family values and bond emotionally with one’s own baby and child that already has potential subjective characteristics and social identity. Since family life and parenthood are conceptualised and approached in terms of psychosocial knowledge, this bond is enacted as an emotional and behavioural concern in immediate family relations, and is expressed in activities such as presence, attachment and interaction, and possibly over-attentiveness. For the most part it is left up to the pregnant families to come to grips with concrete contents and styles of attentiveness by reflection, as discussed earlier.

Accordingly, as the apparently neutral and relatively autonomous foetus, the ambivalent experience-based somatically attached sensational being and life within and a baby in general enacted in the early-term pregnancy somewhat marginalise the social and the political (by no means entirely) in the care practices, so the late-term unborn does not. As
pregnancy proceeds, the unborn and its relation to the pregnant woman is cumulatively transformed by encouraged engagement in interaction not just with the unborn and partners invited to participate in interaction and household material arrangements, but also with a wider social network of actors and activities. In fact, psychosocial knowledge appeals to the ‘social’ and relies on family members, peer groups, a wide variety of professionals, even ‘the whole village’ for support in assisting women and men to support themselves. Thus, compared to the early stages of pregnancy and their limited range of medical and nursing advisors, late-term care pregnancy raises the unborn up for the scrutiny and performance of a multitude of actors.

Multiple support groups including multi-professional support are perceived as necessary in the current ideology on maternal competence, according to which women need to be educated scientifically to know their baby’s needs, ‘choices’ and demands and according to which (public service) professionals should not take a (strong) stand but work as equal partners with citizens in the name of greater choice and autonomy for them. In this current model of citizenship in (maternity) healthcare, nurses as public servants do not wholly have the authority to act as parents or custodians to the unborn. In line with the model of guiding from a distance, they are careful not to patronise pregnant women and turn them into middle-class homemakers of the pre-1960s ideal of maternity healthcare, nor to establish a position as an expert because that would imply a position of knowing best. This does not mean that state paternalism is not at all exercised over pregnant women and their unborn (relations), as can be seen, for example, in state regulations that make attendance compulsory in order to qualify for parental leave and benefits. Such paternalism, that also makes healthcare in pregnancy a civil responsibility, coexists with the emergent rationale in which, especially in issues of psychosocial family life and parenthood, risks are managed and securities established through prevention methods that do not wholly determine a priori the ways and forms of well-being.

The problem with this epistolary logic, to use Pekka Sulkunen’s (2009) term, is that the practices that are built on the beautiful principles of empowerment, agency and voluntary partnerships also allow control to be exercised over pregnant women. If maternity
healthcare actors are not always willing to give, at least officially, specific contents to wide and vague family values and well-being realised in such terms as ‘sufficient parenthood’, other partners in the multiple partnerships sought for to support motherhood-to-be and woman–unborn relations certainly will.

The romantic and nostalgic communitarian ideal where the maternity healthcare service representatives do not solve the controversy between different family values and maternal competences may just distribute determining ‘normality’ and ‘common good’ to other willing partners in pregnancy. Communities may even have stronger constraints on individual reproductive choices, agency and freedoms than the welfare state has ever had, especially given that the Finnish service system is built on a historical social liberal line of thinking and legal opinion that does not juxtapose the unborn and the pregnant woman according to their civil rights to autonomy and privacy, but rather protects the pregnant woman in order to guard the unborn.

In the intensified contemporary discursive atmosphere of postfeminism, familism and neoconservatism regarding family values and life, manifest, for example, in the heated debate about coercive treatment for pregnant women with substance use problems where the social right to health is basically being granted to the unborn, there is a potential danger of delegitimising women of agency and making them more minor than the unborn. Advancing freedom of choice and diversity among women, then, may be linked to the rise of neoconservative values in relation to gender, sexuality and family life that together invite women to ‘freely’ choose conventional family lives. What it is hoped to achieve via this subtle work is to weld together the enacted fracture between the modern career-oriented and sexually liberated woman and the unborn that she has abandoned when given reproductive autonomy and authority (to use technology). Behind this fantasy to reunite the woman, any woman, and the unborn are anxieties over women’s reproductive agency that is seen to lead to a technological ‘destruction’ where women abandon their

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110 The same tendency is observable in new child welfare legislation in 2010 that introduced the concept of ‘preventive child welfare’ and obligated municipal services, including maternity healthcare, to provide such services (Lastensuojelulaki 3 § 88/2010). Basically, the law holds the services accountable for child welfare measures in situations where the well-being of a child is seen to be in danger before birth.
'natural development’ and thus put the unborn, fetishised to stand for national future and life itself, in danger.

It seems safe to say that the unborn as a foetal citizen or victim with ‘choice’ and ‘rights’ and advocates of its own, totally fetishised apart from its (particular) mother and family context, is not (yet, at least) a reality in the Finnish cultural context nor in maternity healthcare. I argue that in the practices of maternity healthcare, the pregnant woman has not disappeared in favour of protecting the unborn somehow apart from or despite its mother with personal integrity and liberty. Despite the distance from the mother–child relationship (as the institutional strategy sees it) the unborn–pregnant woman relations are also constituted as a romantic ecosystem with multiple protective layers. Further, even though differences in family forms are tolerated quite differently than before (noted also by Julkunen 2010, 174), the ideal remains a committed family with two heterosexual parents of opposite sexes expecting (see also Kuosmanen 2007; Sandell 1995). In this ideal family, the woman is assigned tasks of bodily nurture and the position of mediator between the unborn and the male partner who is the biological father of the baby-to-be and who then will take care of the household and be an attentive father to the child. Ultimately, this may amount to an enormous responsibility for a pregnant woman: responsibility for her unborn, for herself and (parenthood of) her partner.

The ethos of not taking a stand in advising freely choosing modes and styles of parenthood, should not, then, be understood as necessarily providing women with much reproductive freedom or agency. The power to determine and organise social relations in pregnancy is not only distributed as just discussed – possibly into antagonistic hands – but also redirected to work from below. What I mean by this is that pregnant women are certainly held accountable at the clinics for their ‘choices’ and behaviour when they do not fit into the scale of normality in family life. Such accountability, however, tends to be arrived at through care practices of assessing (statistically oriented) risk factors and not through a priori categorisations of people. As such, relationships between certain pregnant women and their unborn may be established as poorly managed and known by the woman as they diverge from more or less measurable scales that happen to accord to a large
degree with the characteristics of class divisions. What has thus entered the practices is the population level concern for the unborn defined by (lower) class indicators.

This is not the whole story, however, for inherent in the method of epistolary guidance, the therapy-like mode of addressing and assessing (emotional) transformation to parenthood, are strategies of respectability. Mastering and attuning to these strategies and the therapeutic code of the assessment encounter, seems not only to imply establishing oneself as a respectable maternal self in maternity (healthcare), but also a change to avoid unwanted intervention, be it moral judgment or referral to specialised care. In a nutshell, these strategies or techniques of the self, as Beverly Skeggs (2004, 127–134) puts it, self-reflection, self-knowledge and self-narration, are required to follow the appointment interaction and are used to express preference for certain competences in motherhood, such as working relations with one’s partner, even if they are unattainable, and a willingness to try to change for the ‘better’. Consequently one can see how women and their unborn in poor life circumstances may become objects of intervention and paternalism when they are more easily given terms to talk about their hardship than more privileged pregnant people. Refusing or not knowing how to comply or attend the services altogether appears to at least evoke psychopathologisation and sententious character statements. A right to choose, then, means adapting to maternal self-narration and subjectivities of respectability, and it does not include the right to choose not to attend or challenge the service.

Overall, attending per se and engaging in therapeutic self-narration, learning the code, and using every technology to know the health and ‘personality’ of the unborn available resembles, in my view, an (ideal) rite of passage from a woman to a pregnant woman to a mother in the institutional orders of maternity (healthcare). Maternity healthcare provides useful advice, health, well-being and (feelings of) security and choice, but attending it is also a performance for the symbolic value of respectability as a competent mother(-to-be) in her relation to the baby(-to-be). Additionally, in themselves beautiful operating principles of (more) choice, autonomy, rights, privacy and shared care are, at the end of the day, also demands of consumer capitalism and a managerialist response of the welfare
services to its demands. Pregnant women as providers for their unborn are enacted increasingly as clients or citizens who can ‘freely’ choose ‘goods’ for their family life and parental selves in a network of resource-offering partners. As I have shown, women are not really free to choose whatever they desire, and market models fit poorly to care relations that demand time and attentiveness from each of the participants.

6.4 Biopower and biopolitics, and the maternity healthcare institution

In this thesis I have briefly touched upon the concepts of biopower and biopolitics (Foucault 2007; 2008/1977–1979) in various sections. I have not chosen to use the concepts as an explicit analytical approach, as explained in the methodological chapter. However, here at the end of my research, the concepts offer tools for further conclusions at a more abstract institutional level about the power of science-based (understood broadly) knowledge in the rationale of modes and styles of care and advice provided by maternity healthcare today. They can be understood as biopolitical techniques of governing and power that are productive of selves and social relations and that are based on guidance through (scientific) knowledge on populations. Because of that, I will now elaborate how in particular it is that biopower works in the constitution of the unborn–woman and the mother–child(-to-be) relations at the practice level to see how well and how far Foucauldian formulations of power that rules on the basis of authority to know work.

To do so I will turn biopower upside down. That means that it will be considered as operating from below (Michael Hardt’s term 1999) to match my IE project and ontological commitments from the field of FT/STS. Forms-of-life, sociality and subjectivities are, then, seen as produced in the multiple logics of in-the-making, in practices (Haraway

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111 I understand the relationship between Foucault’s concepts of biopower and biopolitics in line with Michel Senellart’s (2007) commentary on the course context of Foucault’s Lectures on Security, Territory and population (1977–78) when he writes that ‘The analytical perspective of “governmentality” is not … a break in Foucault’s work with regard to his earlier analysis of power, but inserted within a space opened up by the problem of biopower. So it would not be accurate to claim that from this time the concept of “government” replaces that of “power” … The shift from “power” to “government” carried out in the 1978 lectures … result … from its extension to a new object, the state, which did not have a place in the analysis of the disciplines’ (382). Biopolitics, then, as I understand it, refers to the governamentalisation of the state, the state politics and mechanisms that follow.
1991a; 1997; Mol 2002) that are messy and produce multiple and heterogeneous orders where no discourse or other formation of power wholly determines action.

It is evident in my material that women themselves not only subject but also subjectify themselves to institutional power and governing in attuning to advice explicitly and implicitly based on science – biomedical, psychological and social science – and scientific facts on family life that appear most productive in terms and calculations of risk at a population level. Further, for the most part they are not strongly disciplined or regulated to abide by the advice or information, but are expected to act accordingly just by being informed of things or by subtle ways of encouragement and persuasion. In other words, the practices support the ‘natural process’ of becoming a maternal self, articulated, for instance in the insistence on maternal instinct, like notions and self-reflection that in themselves are perceived to supply knowledge and acts of motherhood.

This naturalness is, as Foucault describes it, ‘not the naturalness of nature itself, as the nature of the world, but a process of a naturalness specific to relations between men [and women and the unborn, I would add], to what happens spontaneously when they cohabit, come together, exchange, work and produce.’ The state (services) does not, then, (need to or should not) operate via negative control techniques of disciplining and regulation because changes will to a large extent take place by themselves (Foucault 2007/1977–1978, 349). The state should only facilitate this natural well-being and manage to ensure that the internal and natural regulations work or create regulations that enable natural regulations to work. In other words, natural phenomenon need to be secured via mechanisms of security, in the case of my study, through assessing, ‘early intervention’, preventive child services, household security items and so on (Foucault 2007/1977–1978, 352–353). This, in fact, is what Sulkunen’s (2009) term epistolary power also implies: a respect for a natural process.

In effect, as discussed earlier, the population as the object of governance and thus biopolitics is no longer a population of a collective of subjects but a set of natural phenomena (ibid., 352). In maternity healthcare practices, this results in people not being
categorically associated a priori with the inability to turn their woman–unborn relationship into a mother–woman relationship. However, they may be enacted as such through the practices of assessing, and then be denaturalised to be in need of state (services) biopolitical intervention.

6.5 Pregnant agency?

Biopower and biopolitics rely on pregnant women to self-reflect by themselves and in collaboration with their intimates. However, self-reflection is not the same as encouraging women to reflect and then express themselves in whatever alternative way they can imagine or desire. Narrating oneself and then making life changes is confined to a vague and obscured realm of normality with contingent and messy borders defined situationally in assessing risk (factors) in relation to the (potential) best interest of the baby(-to-be) in care practices. This is how pregnant women are engaged in care of and into a relationship with the unborn as it stands in the institutional agenda.

The messiness – the fact that no form of power relations has the ability to impose a totalising hold on pregnant women’s lives – makes it possible for them situationally to escape ruling institutional constraints and enact the unborn and relations to the unborn or pregnancy in ways that have the potential to remake the institutional category of, at least, a tolerated transition to parenthood. These deeds and enactments are often not socially impressive, i.e. they often stay within the abstract agenda of producing ‘sufficient parenthood’ and ‘psychosocial well-being’. They may, however, simultaneously, embrace the life worlds of women in some new a priori undetermined way in which abiding by advice and guidance from maternity healthcare, acting in the common interest of the unborn within and authorising for oneself a space where it is permitted to lose control and be creative, are collaborative projects.

In the case of the maternity healthcare as it stands today, I argue, then, that while the methods of care – guidance from a distance, not taking a stand and therapeutic interviewing – exercise power over women unevenly and have undesirable implications, they also have the potential to provide room for agency, albeit more for particular women
(the well-off, Finnish national, middle-class, heterosexual, married and, above all, socially skilled women). I would argue that this is so maybe more than before, when healthcare workers were more eager to define family values and well-being in family relations. Market demands for more choice and autonomy, then, also work in desirable ways when women (with their men and/or other close people) realise their potential as parents and maternal selves in concrete every day socio-material and emotional terms of their family lives.

Further, the long tradition in maternity healthcare of relying on professional experience-based knowledge gained through working with pregnant women and their partners over a long period of time is attuned to pregnant women’s agency in establishing social relation(s) with the unborn (for good and bad). According to my observations, it is realised in the activities taking place at the clinics and the accounts of the public health nurses that pregnancy is a process of coming to know one’s unborn and one’s choices, and then acting on the basis of that coming to know: stepping into motherhood, building maternal relations and baby-centred worlds are a slow process that starts in pregnancy and has to be experienced to be fully known. It is also realised that that process should not be messed with but supported. In that processual understanding of support, medical and medical ethical principles of choice and beneficence imposed on care sometimes bring about friction.

Supporting the process of coming to know one’s unborn, pregnancy and choices and then acting upon that knowledge supplies women with the time and space to think through how and when to built relations with the unborn and bond with it (within some institutional scope, of course), as well as the time and space to take private pleasure in pregnancy that is not totally linked to the preparations for the interest of the baby(-to-be). This is, according to my findings on women’s own accounts, what women also do. There is a form of subjectivity being drafted in the women’s accounts that corresponds to a physically ambivalent strange body and belly within which agency cannot be explained away by a mere fascination with the pregnant body as a cultural fetish that stands for new, yet still absent, human life. Rather, the body, bodily consumption and losing bodily control are
fascinating and empowering (also) in themselves when they change, move boundaries and become laborious.

The suggestion I have made about conceptualising the subject (position) in maternity healthcare today as a consumer-citizen illustrates also the ambivalent and minimal or vague agency. Consuming – food, technology, baby goods, household furnishings, cars, gadgets and institutional care intervention ‘goods’ – in pregnancy is not just about making fit homes and emotionally prepared mother-women in the common interest of the baby(-to-be) but also about taking time and pleasure in those ‘consumer choices’ and making prenatal relations within a slightly wider scope of institutionally tolerated options for doing parental relations than before. The subject position of a consumer-citizen as well as my inquiry into the economics of kin in pregnancy and maternity healthcare in general are areas I have not been able to pursue too deeply in this thesis. My intention, however, is to look into the market logic of ordering care practices in subsequent research by asking what kind of a partner in care the market economy really is and what the social implications of this partnership are for pregnant women.

6.6 Implications for maternity healthcare

Care for pregnancy in maternity healthcare is, at least in principle, managing a natural process of making social relations with and for the unborn and coming to know how to make them, via establishing epistolary security mechanisms for the natural process. According to my observations, the facilitating of that process implies that women come to know and care for the unborn slowly through bodily sensations, technological interventions and self-reflection. Accordingly, public health nurses are careful about attributing personal characteristics and personalising the unborn in early term pregnancies as this might disturb the natural process. However, there seems to be some inconsistency to this logic. Babies, children and beings that do all kinds of things and need bonding emerge even during the first appointment in the discussion for different (affective) purposes.
Refraining from encouraging prenatal bonding until later pregnancy is, in my view, a good practice. It should also include avoiding baby talk as it might result in women thinking that the pregnancy will automatically sustain pregnancy until the birth of a living baby. Linda Layne (2006, 586) has even suggested that it should include withholding discussion of the due date until after the high risk for miscarriage is past. This is also reinforced by the women’s experience of confusion expressed in my material when some nurses address them as mothers and their unborn as ‘womblings’ or babies early on and not themselves wanting to personify their unborn by naming them, telling others or acquiring baby goods before 12 weeks of gestation or foetal screenings.

My second suggestion for the implications for maternity healthcare involves another aspect of the specific practices of securing the natural process of pregnancy and the science-based knowledge and politics they are built upon. Further, it involves the move that has been taken away from the historical welfare model of protecting motherhood, where the mother and the child are cocooned in the private core of the family and the nation. In my view the ideal of shared parenthood, gender equality in families and emphasis on individuality that have been seen as integral to changes in welfare and family politics, and, thus, in healthcare services since the 1960s and 1970s are reinforced in the psychosocial knowledge and approach in healthcare. Psychosocial knowledge reduces social relations to immediate family relations and is approached through (reflexive) individuals and psychology, and cultural and social factors that affect families beyond immediate interaction are not attended to. By implication, the woman’s relations to her child(-to-be) are enacted as a close emotional attachment and potentially over-solicitous attentiveness that is solved by inviting others, especially, the (male) partner, to share the parenting.

There is nothing wrong about sharing care, quite the contrary, or emotional love, care and attentiveness acquired via reflexive methods of self-formation practiced in prenatal clinical work. However, healthcare policy, nursing training and professionals should work on integrating larger social issues into care protocols, or at least acknowledge the potential problems of individualistic approaches. For instance, not taking a stand on family values
and formations but evoking self-reflective changes may, as I have shown, lead in itself to undesirable interventions, as not all people attune (by will or inability) to the therapeutic code of the assessing practices. The therapeutic code, then, also brings the risk of forcing people to modify their stories in order to be viewed as respectable parents, which may, as Beverly Skeggs (1997, 72) has noted, ultimately become a form of self-surveillance for them. In that way, enforced institutional self-narration is not supportive of (all) pregnant women producing their own self-narratives and maternal selves.

Further, as discussed, it should be recognised that not taking a stand and calling on multiple partners may lead to pregnant women’s lives and choices being controlled by communities far more patronising than the state. In those cases, the extra choice and autonomy established at the front stage of maternity healthcare services do not go beyond the consultation offices. Integrating issues assessing larger social circles and cultural agents like these into the assessing tools, standards and discussion might prove useful for women in the (self-reflexive) work on the outside of the clinic setting’s social relations and family life that would support their reproductive freedom and agency.

Social factors also affect health-related behaviour, and thus merely making women feel guilty for their living habits, such as overeating or smoking, and thus responsible for putting their unborn at risk, in no matter how subtle a way, may not be productive at all. It is not merely psychosocial or medical logic by which women (are able to) lead their lives. I am not saying that the maternity healthcare institution should or could take on the responsibility of finding whatever ways to make women change their lifestyles, or that it should refrain from the attempt completely, but it should be acknowledged that women consider multiple issues, including foetal health and well-being, in their lifestyle decisions. As of now, issues such as work-related stress or stressful living conditions, the effect of other people’s living habits, personal convictions and desires and so on, are only briefly discussed in a regular and consistent manner, and even that is restricted to immediate family members. Acknowledging decision-making that is multiple could lead to more positive attention being systematically granted to negotiated care of the unborn, such as
smoking less or switching to a lighter brand of cigarettes which in turn might result in support to quit smoking all together (see also Oaks 2000, 98–99).

What I am raising here comes close to the approach of feminist healthcare advocates who attend to both the specificities of women’s bodies, health and lives and changes in social, cultural and political contexts (Boston Women’s Health Book Collective 1998). Larger forces, then, should be addressed. Maternity healthcare practices cannot be expected to change societies, but they are in a position to inquire into differences in women’s and their unborn’s circumstances, and the ruling relations in which women are embedded.

All this said, there are a lot of excellent practices in maternity healthcare that I have tried to describe in this thesis that (re)focus care and attention on the pregnant woman (and their families). They critically rework the medical-technical foetal person, and insist on time, trusting professional relationship and the experiences of different women (and men). The moderate mode and style of personifying the unborn through the pregnant woman’s thoughts and activities is expressive of the historical legal and welfare societal protection of the unborn through the (nowadays more individual and personal) mother via social and healthcare services. This is how the unborn may be granted human dignity without necessarily personal subjective integrity.
## Research materials

### Appointment video recordings:

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<th>Transcription Information</th>
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<td>TP7N</td>
<td>41 min 9 s</td>
<td>7.6.2007</td>
<td>1: pregnancy, about 20 weeks of gestation</td>
</tr>
<tr>
<td>TP7N2</td>
<td>58 min 52 s</td>
<td>7.6.2007</td>
<td>Partly 1: pregnancy, 22 weeks of gestation</td>
</tr>
<tr>
<td>T2N</td>
<td>58 min 52 s</td>
<td>7.6.2007</td>
<td>Partly 1: pregnancy, 33 weeks of gestation</td>
</tr>
<tr>
<td>T2N2</td>
<td>42 min 8 s</td>
<td>9.8.2007</td>
<td>2: pregnancy, 1: child 6th months, maternity &amp; child app.</td>
</tr>
<tr>
<td>T28N&amp;M</td>
<td>1 h 18 s</td>
<td>9.8.2007</td>
<td>Partly 1: pregnancy, 17 weeks of gestation</td>
</tr>
<tr>
<td>T28N</td>
<td>53 min 22 s</td>
<td>30.8.2007</td>
<td>3: pregnancy, 29 weeks of gestation</td>
</tr>
<tr>
<td>T29N</td>
<td>58 min 9 s</td>
<td>31.8.2007</td>
<td>1: pregnancy, 16 weeks of gestation</td>
</tr>
<tr>
<td>T31N&amp;M</td>
<td>30 min 16 s</td>
<td>31.8.2007</td>
<td>Partly 1: pregnancy, 39 weeks of gestation</td>
</tr>
<tr>
<td>T37N</td>
<td>42 min 51 s</td>
<td>31.8.2007</td>
<td>Partly 1: pregnancy, 22 weeks of gestation</td>
</tr>
<tr>
<td>TP7N&amp;M</td>
<td>53 min 52 s</td>
<td>24.9.2007</td>
<td>Partly 1: pregnancy, 36 weeks of gestation</td>
</tr>
<tr>
<td>T37N2</td>
<td>44 min 35 s</td>
<td>24.4.2007</td>
<td>Partly 1: pregnancy, 18 weeks of gestation</td>
</tr>
<tr>
<td>TP25N&amp;M</td>
<td>9 min 20 s</td>
<td>24.9.2007</td>
<td>Partly 1: pregnancy, 22 weeks of gestation</td>
</tr>
</tbody>
</table>
* Data code consists of the code letter for the clinic (P, T, PT, L), the code for the cereal number of the video recording, the code for participants (N=woman, M=man) and the number for video-recorded appointments from same people.

**Multi-professional team meeting video recordings:**

<table>
<thead>
<tr>
<th>Data code*</th>
<th>Date</th>
<th>Duration (min)</th>
<th>Transcription</th>
<th>Client present</th>
<th>Additional information</th>
</tr>
</thead>
<tbody>
<tr>
<td>T-tiimi1</td>
<td>19.2.2008</td>
<td>90</td>
<td>Partly</td>
<td>no</td>
<td></td>
</tr>
<tr>
<td>T-tiimi2</td>
<td>19.2.2008</td>
<td>85</td>
<td></td>
<td>no</td>
<td></td>
</tr>
<tr>
<td>T-tiimi3</td>
<td>28</td>
<td></td>
<td></td>
<td>no</td>
<td></td>
</tr>
<tr>
<td>T-tiimi4</td>
<td>1.4.2008</td>
<td>82</td>
<td>Whole</td>
<td>yes</td>
<td>Client refused, recording was stopped</td>
</tr>
<tr>
<td>T-tiimi5</td>
<td>22.4.2008</td>
<td>99</td>
<td></td>
<td>no</td>
<td>Managers present</td>
</tr>
<tr>
<td>TP-tiimi1</td>
<td>18.10.2007</td>
<td>91</td>
<td>Whole</td>
<td>no</td>
<td></td>
</tr>
<tr>
<td>TP-tiimi2</td>
<td>8.11.2007</td>
<td>91</td>
<td>Whole</td>
<td>no</td>
<td></td>
</tr>
<tr>
<td>TP-tiimi3</td>
<td>65</td>
<td></td>
<td>Whole</td>
<td>no</td>
<td></td>
</tr>
<tr>
<td>TP-tiimi4</td>
<td>65</td>
<td></td>
<td>Whole</td>
<td>no</td>
<td></td>
</tr>
<tr>
<td>TP-tiimi5</td>
<td>18.2.2008</td>
<td>58</td>
<td>Partly</td>
<td>no</td>
<td></td>
</tr>
<tr>
<td>TP-tiimi6</td>
<td>70</td>
<td></td>
<td></td>
<td>no</td>
<td></td>
</tr>
</tbody>
</table>

*Data code consists of the code for the clinic (T, TP, L), the term 'tiimi' referring to 'team' and the cereal number for video recording

**Observational material:**

(500 pages of handwritten fieldnotes of 62 days i.e. 12 workweeks)


**Seminars and training sessions attended:**

- Spring 2007 training for the multi-professional team members on family-centred MCH (3.4, 17.4, 8.5, 22.5.2007)
- Training afternoon for the multi-professional team members, 22.5.2008

**Interviews:**

**Pregnant women:**

<table>
<thead>
<tr>
<th>Interviews</th>
<th>Clinic</th>
<th>Date</th>
<th>Duration (min)</th>
<th>Background information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pregnant woman 1</td>
<td>TP</td>
<td>13.6.2008</td>
<td>65</td>
<td>24 years, 39+ weeks of gestation, 2nd child, 3rd pregnancy</td>
</tr>
<tr>
<td>Pregnant woman 2</td>
<td>P</td>
<td>1.7.2008</td>
<td>53</td>
<td>30 years, 20 weeks of gestation, 1st pregnancy</td>
</tr>
<tr>
<td>Pregnant woman 3</td>
<td>T</td>
<td>22.5.2008</td>
<td>96</td>
<td>28 years, 27 weeks of gestation, 1st pregnancy</td>
</tr>
<tr>
<td>Pregnant woman 4</td>
<td>P</td>
<td>26.8.2008</td>
<td>72</td>
<td>39 years, baby month old, 2nd child</td>
</tr>
<tr>
<td>Pregnant woman 5</td>
<td>TP</td>
<td>26.6.2008</td>
<td>51</td>
<td>33 years, 14 weeks of gestation, 1st pregnancy</td>
</tr>
<tr>
<td>Pregnant woman 6</td>
<td>T</td>
<td>27.5.2008</td>
<td>59</td>
<td>33, 31+ weeks of gestation, 2nd child</td>
</tr>
<tr>
<td>Pregnant woman 7</td>
<td>P</td>
<td>1.7.2008</td>
<td>83</td>
<td>28, 13 weeks of gestation, 1st pregnancy</td>
</tr>
</tbody>
</table>

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Public health nurses:

<table>
<thead>
<tr>
<th>Interviews</th>
<th>Date</th>
<th>Duration (min)</th>
<th>Age group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse 1</td>
<td>27.5.2008</td>
<td>65</td>
<td>31-40</td>
</tr>
<tr>
<td>Nurse 2</td>
<td>30.5.2008</td>
<td>76</td>
<td>20-30</td>
</tr>
<tr>
<td>Nurse 3</td>
<td>12.6.2008</td>
<td>71</td>
<td>20-30</td>
</tr>
<tr>
<td>Nurse 4</td>
<td>12.5.2008</td>
<td>66</td>
<td>41-50</td>
</tr>
<tr>
<td>Nurse 5</td>
<td>6.3.2008</td>
<td>88</td>
<td>31-40</td>
</tr>
<tr>
<td>Nurse 6</td>
<td>13.3.2008</td>
<td>63</td>
<td>41-50</td>
</tr>
<tr>
<td>Nurse 7</td>
<td>15.4.2008</td>
<td>92</td>
<td>31-40</td>
</tr>
</tbody>
</table>

All the nurses worked at the field clinics of my study (T, TP, P) and consented also to observation and video recordings of their appointments and team meetings. I decided not to link individual nurses to individual clinics, because of the risk of identification. For the same reason their age is present in age groups.

Documentary materials:

Published documents:


Other documents:


Family counselling files (Perhevalmennus kansio) (2008) Unpublished material compiled for clinics by the municipal administration for maternity healthcare (received 15.5.2008).

Guidance material for future parents:


Every baby wants a non-smoker mum (*Kaikki vauvat tahtovat savuttoman äidin*) (2007) Pfizer, Helsinki. (Only distributed where seen as relevant to the case).


Leaflets by the municipality and commercial corporations on testing for dental caries, nutrition recommendations (for different needs), exercise, dental care, foetal movements, information sheets on medical population research on pregnancy conducted in the area, family counselling, sufficient parenthood, partnership in baby-life, being in labour, baby care and early development, breastfeeding, family care work in the municipality, acknowledgement of paternity guidance for unmarried couples, pregnancy diabetes prevention, contraception, intoxicants, smoking, car safety, durable nappies, Christian advice about parenting, peer groups (Some were only distributed where seen as relevant to the case).


*Pregnancy and intoxicants (Raskaus ja päähteet)* (2008) The Federation of Mother and Child Homes and Shelters, Helsinki. (Only distributed where seen as relevant to the case)


We are going to have a baby. A guide to expecting and taking care of a baby (Meille tulee vauva. Opas vauvan odotukseen ja hoitoon (2007). National Research and Development Centre for Welfare and Health, Helsinki.


**Forms and questionnaires:**

Application forms for parental leave and benefits (and instructions)

Audit form (with questions of drug use)

Expecting mother’s / father’s eating habits

Maternity card

Maternity healthcare preliminary information

Welfare assessments form

**Statistical data from Statistics Finland and the municipality of the field clinics:**

Statistics Finland (2010a) [Name of the region] Families and families with children according to family form and number of children (Perheet ja lapsiperheet perhetyypin ja lasten lukumäärän mukaan). Statistics Finland, Helsinki.

Statistics Finland (2010b) [Name of the region] Population according to age (5 years), main activity, profession and gender. (Väestö iän (5-v.), pääasiallisen toiminnan, ammattiaseman ja sukupuolen mukaan 31.12.2009). Statistics Finland, Helsinki.

[Name of the city] (2012a) [Name of the city] Residences 2010. Statistical publication. [Name of the City].

[Name of the city] (2012b) [Name of the city] Households 2010. Statistical publication. [Name of the City].
References


Paavilainen, Riitta (2003) Turvallisuutta ja varmuutta lapsen odotukseen. Äitien ja


Smith, Dorothy E. (1977) Feminism and Marxism: A place to begin a way to go. New Star Books, Vancouver, BC.


Tiitinen, Sanni & Homanen, Riikka & Lindfors, Pirjo & Ruusuvuori, Johanna (forthcoming) Approaches used in investigating family support in pregnancy and early childhood: lack of studies on practices and processes. Accepted to be published in Health Promotion International.


Vehviläinen, Marja (1997) Gender, Expertise and Information Technology. Department of Computer Science, University of Tampere, Tampere.


Appendix I: Interview outlines

Interview outline: Pregnant women (note: questions in phases 2 and 3 asked in line with the style of the ethnographic interview adopted) (In English)

Background information

- Age, education, official rank or equivalent
- Number of pregnancies? Weeks of gestation?

1. PHASE: 'Main story'

- I would like you to tell me the story of your pregnancy. Please reflect on it in the frame of your life as a whole. You may, for example, include all the experiences and feelings that you consider important for yourself. You may start from wherever you wish and use as much time as you like. (I will be taking notes for later use)

2. and 3. PHASE*:

Pregnancy as a whole

- How did everything begin? How did you find out you were pregnant? How have things been after that? How do you feel now?
- How has the pregnancy affected your activities in everyday life? Has anything changed? How have you been taking care of your health? Has your lifestyle changed in pregnancy? How about in your previous pregnancy/pregnancies?
- How do your experiences in this pregnancy differ from your previous pregnancy?
- How has the pregnancy affected you, your sense of self? How about your body image?
- How do you speak about the unborn in your everyday life? Or do you?
  - What do you imagine your unborn to be like now?
  - What kind of a child do you think your unborn will be like?
  - In what kind of ways have you prepared for the future?
  - Who and what agencies do you think have an effect on your images of the unborn and of pregnancy? How?
  - Who and what agencies do you feel have been and are supporting you in this pregnancy? How?
  - From what sources have you retrieved and got information about pregnancy?

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Maternity healthcare in pregnancy

Problems and solutions

- Have there been any problems linked to your pregnancy? If so, could you tell me about the circumstances? What happened then? Did you share the problems with someone close to you?
- How are things now?
- How were things handled at the maternity healthcare clinic?
- Who is your public health nurse?

Maternity healthcare-related perceptions and actions taken concerning self, body, close social relations and the unborn

- Could you tell me more about your experiences and feelings about maternity healthcare (in general)? Have the appointments differed in some way from your experiences in your first pregnancy? How?
- Could you tell me about situations where you have been offered something at the clinic that you did not like?
- Which services do you think have been useful for you? Which service do you consider the most important one?
- What do you think is your role at the clinic? How have the staff attended to your actions and behaviour? How about your own accounts of pregnancy, the body, and the changes you have experienced?
- Could you tell me about situations in which changes in your self image were dealt with at the clinic? What did it feel like? How about your body image?
- Does your partner come to the appointments? How does he/she participate during the appointments? What kind of a part does he/she play in the maternity healthcare in your opinion?
- Have mental images concerning the unborn been discussed at the appointments? If so, how? Could you give examples?
- What has the role of the foetus looked like at the clinic?
- In what ways has parenthood/partnership been dealt with at the clinic? Does this fit your own ideas?
- Maternity healthcare has nowadays been called family-centred/client-oriented/preventive work? Could you tell me about situations where this in your opinion was realised?

TAKE OUT A LIST OF SERVICES: important experiences, feelings and situations that come to mind (may choose any or all of the services to talk about)
Screenings

Tests taken after the first appointment:
- Where you told about the possibility to attend the serum screening (for over 35 years of age)? Could you tell me about that situation? What kind of thoughts and feelings did it provoke? How about now?

Ultrasound:
- Had you ever seen an ultrasound picture prior to your own examination?
- Could you describe the course of the examination? What kind of thoughts did the appointment provoke? How about now?
- Who participated in the screening?
- Do you/did you want to know the sex of the unborn? If so, why/why not?
- Was the screening discussed in any way at the nurse’s appointments?

Tests and other bodily interventions
- How were you asked about your willingness to attend different kinds of tests (like blood tests to screen for syphilis, HIV, hepatitis)? What did you think about the need to take all these tests? Has your opinion changed in any way?
- What did you think about the routine tests taken every appointment? Has your opinion changed in any way?
- What kind of thoughts did hearing the heartbeat evoke?
- How did you experience interventions into your body?

Health education
- What kinds of thoughts did health education and inquiries about your lifestyle provoke in you?
- How do you think it could be improved?
- How did you experience conceptions concerning the speciality of pregnant embodiment?
- Were images concerning body images dealt with at the appointments? If so, in what kinds of situations? Are there any good/bad sides to it in your opinion?

Information gathering and the forms
- How did you experience all the ways of gathering information (like aAudit and welfare assessment forms)?
- What do you think about the forms that have to be filled in before the first appointment (show forms)? Could something be changed in your opinion? Did you discuss some of the things that came up in the forms at the appointment? Did it correspond to your needs?
- Did you discuss issues that the forms evoked at home? How?
- Did you give a name for the unborn in the referral to the hospital? How did you come up with the name?

Family counselling and the guide books
- Did the information correspond to your own conception about partnership/parenthood/child care/body image/lifestyle in pregnancy? Was the material in your opinion adequate?

Birth
- How has giving birth been handled at the clinic? Did it correspond to your wishes? What kind of birth methods have you been offered?
Finish

- What is the mission of maternity healthcare in your opinion?
- If you yourself could change something in maternity healthcare what would it be?
- When you think about the way you view your own pregnancy, do you have a 'philosophy of pregnancy'? What do you orient your perceptions that have come up during this interview to (education, work experience, particular theories, or life experience)?
- Is there anything else you would like to say?

*Underlined questions/topics are considered the most important ones for the study.

Interview outline: Pregnant women (note: questions in phases 2 and 3 asked in line with the style of the ethnographic interview adopted) (In Finnish)

Alkuvirittely

- Ikä, Koulutus, virka- asema tai vastaava,
- Kuinka mones raskaus? Missä vaiheessa?

1. VAIHE: Pääkertomus

- Haluaisin sinun kertovan minulle tarinan raskaudestasi. Peilaa raskauttasi koko elämäsi kokonaisuuteen. Voit esimerkiksi ottaa tarinaasi mukaan kaikki tuntemukset ja kokemukset, jotka ovat olleet sinulle tärkeitä. Voit aloittaa, mistä haluat, ja käyttää niin paljon aikaa kuin tarvitset. (teen myöhempää käyttöä varten jotain muistiinpanoja)

2. JA 3. VAIHE*:

Raskaus kokonaisuutena

- Miten kaikki alko, huomasit tulleesi raskaaksi? Miten kaikki sen jälkeen on sujunut? Miltä tuntuu nyt?
- Miten raskauskokemus eroaa aikaisemmista raskauksista?
- Entä miten raskaus on mielestäsi vaikuttanut itseesi, minäkuvaasi? Entä kehokuvaasi?
- Miten puhut syntymättömästä arjessa? Vai puhutko ollenkaan?
- Millaiseksi kuvittelet syntymättömän nyt?
- Millaisen ajattelet tulevan lapsesi olevan?
- Minkälaisilla tavoilla olet valmistunut tulevaan?
- Mistä tahoilta tai keiltä ihmisiltä ajattelet tulevan vaikutuksia mielikuvissasi syntymättömästä ja raskaudesta? Miten?
- Ketkä tai mitkä tahot koet olleen ja olevan mukana ja tukena tässä raskaudessasi? Miten?
- Mistä eri lähteistä olet saanut ja hakenut tietoa raskaudesta?

Neuvola raskaudessa

*Ongelmat ja niiden ratkaisukeinot*

- Onko raskausaikaasi liittynyt jotain ongelmia/ongelmallisia asioita? Jos, niin voisitko kertoa tilanteesta, jossa ne ilmenivät? Mitä sitten tapahtui? Kerrotko läheisille ihmisillesi?
- Miten asiat ovat nyt?
- Miten niitä käsitetiin neuvolassa?
- Ketä on TH?

*Itseen, kehoon, läheissuhteisiin, (syntymättömään) lapsen kohdistuneet toimenpiteet, ratkaisut ja käsitykset neuvolassa*

- Voisitko kertoa lisää kokemuksestasi ja tuntemuksistasi raskausajan neuvolasta (vyenäs)? Eroavatko käynnit jotenkin verrattuna ensiraskaukseen? Miten?
- Voisitko kertoa tilanteista, jossa sinulle tarjottiin neuvolassa jotain, josta et pitänyt?
- Entä mistä palveluista sinulle on ollut apua? Mitä palvelua pidit erittäin tärkeänä?
- Minkälainen oma roolisi neuvolassa mielestäsi? Miten suhtaudit käyttäytymiseen neuvolassa entä arvioihin raskaudesta, kehosta, muutoksista?
- Voisitko kertoa tilanteista, joissa sinun minäkuvaosi muutosta käsiteltiin neuvolassa? Miltä se tuntui? Entä kehokuvaasi?
- Osallistuiko kumppanillesi neuvolakäynteihin? Miten he osallistuivat neuvolakäynteihin? Minkälainen kumppanisi osa on neuvolassa?
- Käsittelijöidä vastaanottokäynteiden syntymättömänä liittyvä mielikuvia? Jos, niin miten? Voisitko antaa esimerkkejä?
- Millaiselta sikiön rooli näyttäytyi neuvolassa?
- Millaisilla eri tavoilla neuvolassa käsiteltiin parisuhdetta/valhemmuutta? Sopiiko se omaan käsitykseesi?
- Neuvolatyötä kutsutaan nykyään perhekeskeiseksi/asiakasläätiöinen/ennaltaehkäisevä. Voisitko kertoa jostain tilanteesta, jossa se mielestäsi ilmeni?

LISTA ESIIN: tärkeät kokemukset, tuntemukset ja tilanteet, jotka tulevat mieleen
Seulonnat
Raskauden ensikäynnillä otettavat testit:
- Kerrottiko sinulle mahdollisuudesta osallistua seerumiseulontaan (35v-)?
Voisitko kertoa hieman tuosta tilanteesta? Minkälaisia tuntemuksia ja ajatuksia se herätti? Entä nyt?
Ultra:
- Oletko ikinä ennen nähnyt ultrakuvaa ennen omaa tutkimustasi?
- Voisitko kuvailla ultrakäyntien kulkua? Minkälaisia ajatuksia ultraäänikäynti teissä herätti? Entä nyt?
- Ketä kaikkia oli mukana ultraäänessä?
- Halutteko/halusitteko tietää syntymättömän sukupuolen? Jos niin miksi?
- Käsiteltiinkö ultraa jotenkin neuvolavastaanotolla?

Testit/näytteiden otto ja ruumiiseen kohdistuvat muut toimenpiteet
- Miten sinulta kysyttiin halukkuudesta osallistua erilaisiin näytteiden ottoihin (, kuten verestä otettavat syfilis, Hiv, Hepatiitti)? Mitä ajattelet kaikkien testien tarpeellisuudesta? Onko mielipiteesi jotenkin muuttunut?
- Mitä ajattelit neuvolakäyntien rutiiinisteistä? Onko mielipiteesi jotenkin muuttunut?
- Minkälaisia ajatuksia sydänäänentä kuuntelu herätti?
- Miten koit ruumiiseesi kohdistuvat toimenpiteet

Terveysneuvonta
- Minkälaisia ajatuksia elintapoja koskeva terveysneuvonta ja tiedustelut elintavoista sinussa herättivät?
- Miten sitä voitaisiin mielestäsi parantaa?
- Miten koit ruumiiseesi kohdistuvat käsitykset raskausajan erityisestä ruumiillisuudesta?
- Käsitteletkö kehoon liittyviä mielikuvia vastaanotoilla? Jos, niin miten ja millaisissa tilanteissa? Mitä hyviä/huonoja puolia siinä oli?

Tiedonkeruu ja lomakkeet
- Miltä kaikki erilaiset tiedonkeruun tavad (kuten Audit ja HV-lomakkeet) tuntuivat?
- Mitä olet mieltä esitetyttävistä lomakkeista (lomakkeet mukaan)? Voisiko jotenkin muuttaa? Keskusteltiinko niissä esille tulleista asioista neuvolan vastaanotoilla? Vastasiko asioiden käsittely tarpeitanne?
- Keskustelitko lomakkeiden herättämisistä asioista kotona? Miten?
- Annoittekö [sairaalan nimi] synnytyslähetteeseen syntymättömälle nimen? Miten nimi syntyi?

Valmennukset ja esitteet
- Vastasiko informaatio omaa käsitystäsi parisuhdeesta/vanhemmuudesta/ lapsen hoidosta/kehkovasta/ raskauden ajan elintavoista? Oliko materiaali riittävä?

Synnytys
- Miten synnytystä käsiteltiin neuvolassa? Vastasiko käsittely toiveitasi? Minkälaisia synnytysvaihtoehtoja sinulle tarjottiin?
Lopettelu

- Mikä on mielestäsi äitiysneuvolan tehtävä?
- Jos voisit jotakin itse muuttaa neuvolatoiminnassa, mitä se olisi?
- Kun ajattelet, että miten miellät omaa raskautasi, niin onko sulla joku "raskausfilosofia? Mihin perustat tätäkin haastatteluussa esiin tulleet käsitykset (koulutukseen, työkokemukseen, erityisiin teorioihin, elämänkokemukseen?)
- Tuleeko mieleen vielä jotain, mitä haluaisit sanoa?

* Alleviivatut kohdat/kysymykset on ajateltu tärkeimmiksi tutkimuksen näkökulmasta.

Interview outline: professionals (note: questions in phases 2 and 3 asked in line with the style of the ethnographic interview adopted) (In English)

Background

- Age, education and work history (How did you become a public health nurse at [name of the clinic]?)

1. PHASE: ’Main story’

- Orientation: In this interview, I am widely interested in your work, especially your own perceptions, experiences and feelings based on your working experience and life experience.
- I would like you first to tell me freely about what it is that you do overall. Think also about what the work has been like for you, what kind of changes has there been and what kind of feelings has the work evoked in you. You may start from wherever you wish and use as much time as you like. (I will be taking notes for later use)
- What kind of pregnant women do you have as clients at the moment? Can you give examples?

2. and 3. PHASE*:

Problems and solutions (at this time I will explain that maternity healthcare is my focus, not child healthcare)

Intervening in problems and tools of intervention

- Imaginary situation: A partner gets a critical score of 17 points in the audit scale. The mother-to-be clearly does not approve of the drinking habits of the partner. What is your method of handling this situation?
- Alternative case: a swelling in the back of the neck has been detected at an ultrasound screening. How would you deal with the situation at the appointment? How about screening in general?
- How in general are problems detected? How can one intervene?
Problems in your work, from the perspective of the pregnant women, the unborn and the professional

- What kinds of pregnancy-related problems have you come across in your work?
- Worst cases? Examples? What kind of help do they need?
- Does maternity healthcare have the adequate tools to prevent the problems faced by the pregnant women, their intimates and the unborn in your opinion? How about securing further care (other professionals)?

Work ‘object’: social relations, communities, individuals and bodies

Describing appointments, functions and interaction

- Which appointments do you consider the most important? Have you developed special appointments yourself?
- What do you think about the necessity of all the appointments, tests, including screenings, and interventions for pregnant women? What purpose do they serve?

The unborn, women (mothers), men (fathers), social relations

- How is the foetus talked about at the clinic? How about pregnant women? What is their role like at the appointments etc.?
- Do you discuss mental images concerning the unborn at the appointments? If so, how? Could you give examples? Do you try to build a relationship between the baby and the mother before birth?
- What kinds of problems concerning the images do you face in your work? Where do such problems come from in your opinion? How can one intervene?
- How does the self image of women change in pregnancy? How is it dealt with? How does their position in close social relations appear to you in your encounters with them and according to your job description?
- To what extent do men or other close people attend the appointments and other functions? Has the role of men changed somehow in your opinion?
- In what ways do you aim to support close social relations and parenthood? What is a good close relationship/parent like in your opinion?

Embodiment as a work object

- How does the body image of women change in pregnancy? Is it dealt with at the clinic?
- What kinds of problems concerning images have you face in your work? Where do you think they come from? How can one intervene?
- How do women take care of their health? Do you have to interfere, and if so, how?
- What sources do women use for information? Does that come up in any way at the appointments?

The interpretations and practices of principles of family-centredness, client-orientation, prevention and early intervention and early interaction.

- It is said that one of the aims of maternity healthcare is family-centredness/ client-orientation/prevention/ early intervention/early
interaction. Can you tell me about situations in which the concept is realised in practice?
- How do these terms appear in your work?

Assessment of work results

Assessments on the purpose, agency and future of the institution
- What do you think is the most important function of maternity healthcare?
- Which things support the actualisation of this function?
- Which things hinder the actualisation of this function?
- Can you think of any specific needs for development?

Perception of ‘own’ professional skills
- What aspects determine the professional skills of a maternity healthcare public health nurse? Could you tell me something about the best/worst moments in your work?

Work tools

What kinds of tools?
Booking and distributed material in maternity healthcare
- What kind of information is entered into files and where? How do you assess what is entered into files and what not? Is the entered information adequate considering the aims of your work in your opinion? What is good about the present system? How could it be improved (e.g. concealment issues)? Could, for example, the patient record system be altered somehow (take out the form)?
- The functionality of welfare assessment form – does it really chart potential problems? How would you change it?
- Is the information recorded on the welfare assessment form entered into any information system at your clinic? How? What kind of implications this might bear for parents and the unborn in your opinion?
- How well does the distributed material work? Do you wish for more information on some topic?

Family and birth counselling
- What is the main purpose and benefit of the counselling?

Home visits
- The recommendation is to make a home visit also during pregnancy. The resources do not allow this at the moment. Do you think there is a reason to make one from the perspective of the pregnant woman, the unborn and other close people? Please assess the basis.

Satisfaction and guidelines and administrative constraints of work. Good and bad sides/the relationship between protocol and practice
- What guideline materials do you use in your work (Handbook of maternity healthcare in intranet, Screening and Collaboration in maternity healthcare 1999 – others?)? In what kind of situations do you rely on them? What kind of information do you look for?
- Which tasks do you consider the most important in your work? Could you describe how working time arrangements, division of labour questions etc. administrative conditions affect your work? Good sides, bad sides?

Co-operative partners and modes (functionality)?

Finish

- Do you have any philosophy of life or view of life according to which you do your work? What is the basis of care work for you? How has it developed (education, work experience, particular theories, or life experience)? If you could change the maternity healthcare agency somehow, what would it be? Is there anything else you would like to say? Instructions to new public health nurses in maternity healthcare?

*Underlined questions/topics are considered the most important ones for the study.

Interview outline: professionals (note: questions in phases 2 and 3 asked in line with the style of the ethnographic interview adopted) (In Finnish)

Alkuvirittely

- Ikä, koulutus ja työhistoria (Miten sinusta tuli [Neuvolan nimi] neuvolan terveydenhoitaja?)

1. VAIHE: Pääkertomus

Pääkertomus

- Virittelyä: Olen tässä haastattelussa kiinnostunut laajasti neuvolatyöstäsi, erityisesti omista käsityksistäsi ja tuntemuksistasi, jotka pohjautuvat työkokemukseesi ja elämänkokemukseesi.
- Haluaisin sinun aluksi kertovan minulle minulle vapaasti siitä, mitä teet työssäsi, mitä teet työssäsi kaikkiaan. Pohdi myös minkälaista työ on ollut sinulle, minkälaisia muutoksia on ollut ja minkälaisia tuntemuksia työsi on sinussa herättänyt. Voit aloittaa, mistä haluat, ja käyttää niin paljon aikaa kuin tarvitset. *(Teen muistiinpanoja)*
- Millaisia raskaana olevia naisia sinulla käy tällä hetkellä? Voisitko kuvailla jotain esimerkkejä?

2. JA 3. VAIHE*:

Ongelmat ja niiden ratkaisukeinot (Tässä vaiheessa kerron, että äitiysneuvola keskiössä)

Ongelmiin puuttuminen ja työvälileet

- Kuvitteellinen tapaus: Raskauskäynnillä mies saa Audit-lomakkeesta alkoholin käytöstä hälyyttävät 17 pistettä. Tuleva äiti paheksuu selkeästi
mihensä alkoholin käyttöä. Mikä olisi sinun tapasi läheteä puuttumaan tilanteeseen? VAHTOEHTO Raskaana olevalla naisella on rakenneultrassa havaittu sikiön niskaturvotusta. Miten käsittelisit neuvolakäynneillä asiaa? Miten seulontoto ja yleensä haluaisit tukea sitä?
- Miten ongelmia voi yleensä havaita? Miten niin niin voittaa?

**Ongelmat työssäsi, raskaana olevan naisen, syntymättömän ja muiden läheisten kannalta sekä ammattilaisen**

- Minkälaista raskauden ajan ongelmia olet kohdannut työssäsi?
- Vaikkeimmat tapaukset. Esimerkkejä? Mitä he tarvitsevat?
- Riittävätkö neuvolan keinot estämään raskaana olevan naisen, hänen läheisten ihmisten ja syntymättömän ongelma?

**Työn "kohde": sosiaaliset suhteet, yhteisöt, yksilöt ja kehot**

**Neuvolatilanteiden ja -tilaisuuksien ja vuorovaikutuksen kuvalu**

- Mitkä ovat mielestäsi tärkeimmat neuvolakäyntikerrat? Oletko itse kehitellyt jotain erityisiä käyntejä?
- Mitä mieltä olet kaikkien käsittelyjen, testien, mukaan luettuna seurannat, ja toimenpiteiden tarpeellisuudesta naiselle? Mitä tehtävää ne palvelevat?

**Syntymättömät, naiset (äidit), miehet (isät), sosiaaliset suhteet**

- Miten sikiöstä puhutaan neuvolassa? Vaihteleeko se jotain tilanteen mukaan? Entä raskaana olevista naisista? Minkälaiset on heidän roolit vastaantuloilla yms?
- Käsittelyt Explosion vastaanottokäynteillä syntymättömään liittyviä palveluita? Jos, nii miten? Voisitko antaa esimerkkejä? Pyritäänkö vauvan ja äidin suhdetta rakentamaan jotain ennen syntymää?
- Millaisia ongelmia näihin mielikuviiin liittyen kohtaat työssäsi? Mityä ne mielestääsi johtuivat? Miten niin niin voittaa?
- Miten naisten minäkatapu muuttuu raskaudessa, miten sitä käsitellään/huomioidaan? Millaisena heidän asemalta näyttää lähiseinä, joita kohtaa ja työnkuvassasi?
- Osallistuvatko miehet tai muut raskaana olevien läheiset ihmiset missä määrin neuvolakäynneille ja muihin neuvolatilaisuuksiin? Millaisena heidän roolinsa näyttävät työssäsi? Onko muistien osa mielestääsi jotain muutunut?
- Millaisilla eri tavoilla pyrit tukemaan läheissuhteita/vanhemmuutta? Minkälainen on heväs läheissuhde/vanhempi?

**Ruumillisuus työn kohteena**

- Miten naistenkehokuva muuttuu raskaudessa? Käsittellään sitä neuvolassa?
- Millaisia ongelmia näihin mielikuviiin liittyen kohtaat työssäsi? Mityä ne mielestääsi johtuvat? Miten niin niin voittaa?
- Miten naisten hoitava terveyttään? Joudutko puuttumaan siihen, miten?
- Mistä naisten hakevat tietoa raskaudesta? Miten näkyy vastaanotoilla?

**Perhekeskeisyden, ennalta ehkäisyyn sekä varhaisen puuttumisen ja vuorovaikutuksen periaatteiden tulkinnat ja käytännön työ**
- Sanotaan, että perhekeskeisyys/ennalta ehkäisy/varhainen vuorovaikutus/asiakaslätöisyys on yksi neuvolatyön tavoitteista. Voisitko kertoa tilanteista, joissa käsitte ilmenee neuvolan työssä?
- Miten nämä tavoitteet näkyvät työssä?

**Arvio työn tuloksista**

*Neuvolalaitoksen tehtävän ja toiminnan tarkoituksen arvio, tulevaisuus*
- Mikä on mielestäsi äitiysneuvolan tärkein tehtävä?
- Mitä asiat edesauttavat tämän tehtävän toteuttamista?
- Tuleeko mieleen joitain erityisiä kehitystarpeita?

*Käsitys ”omasta” ammattitaidosta*
- Mitä seikat määrittävät terveydenhoitajan ammattitaitoja? Voisitko kertoa jostain työsi huippuhetkistä/ pahimmista hetkistä?

**Työvälineet**

*Minkälaisia työvälineitä?*
- Äitiyshuollon kirjaaminen ja jaettavat esitteet
    - (salassapitoasiat) Voisiko esimerkiksi potilastietojärjestelmää jotenkin muuttaa? (ota Riikka mukaan lomakepohja)
    - Hyvinvointi-lomakeiden toimivuus, kartoittaako potentiaalisia ongelmaa? Miten muutaisit?
    - Tallennetaanko hyvinvointi-lomakkeiden tietoja neuvolassanne jotenkin tietojärjestelmään? Miten? Mitä seurauksia tästä voi olla vanhemmille ja syntymättömille?

*Hyvinvointilomakkeiden toimivuus, kartoittaako potentiaalisia ongelmaa?*  
- Miten hyvin erilaiset jaettavat esiitteet toimivat? Kaipaisitko jostain aihealueesta lisää informaatiota?

**Perhe- ja synnytysvalmennus**
- Mikä mielestäsi on valmennusten pääasiallinen tarkoitus tai hyöty?

**Kotikäyntit**

**Tyytyväisyys ja työtä ohjaavat ohjeistot sekä hallinnolliset ehdot. Hyvät ja huonot puolet/käytännön ja ohjeistusten ristiriidat**
- Mikä ovat työtäsi ohjaavat ohjeistot (Intranetin käskirja, Stakesin Seulontatutkimukset 1999 – onko muita)? Minkälaisissa asioissa turvautut niihin? Minkiläista tietoa niistä yleensä etsit?
- Entä mitä pidät tärkeimpänä yötehtävänä? Voisitko kertoa miten työaikajärjestelyt, työnjäämiset kysymykset ym. hallinnolliset ehdot pitteistavat työtä? Mitä hyviä puolia on ollut?
Yhteistyökumppanit ja –muodot (toimivuus)?

Lopettelu

- Onko sinulla jonkinlaista elämänfilosofiaa/elämänkatsomusta, jonka mukaan teet työtä?Mitä siis pidät hoitotyön perustana? Miten se on sinulle kehittynyt?
  (koulutukseen, työkokemukseen, erityisiin teorioihin, elämänkokemukseen?)
- Jos voisit jotenkin muuttaa neuvolatoimintaa, mitä se olisi
- Tuleeko vielä mieleen jotain, mitä haluaisit sanoa? Ohjeita uusille terveydenhoitajille?

* Alleviivatut kohdat/kysymykset on ajateltu tärkeimmiksi tutkimuksen näkökulmasta.

Appendix II: Forms

Maternity health care preliminary information form (In English)

<table>
<thead>
<tr>
<th>Maternity health care preliminary information</th>
<th>Will be attached to patient records</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Personal Information</strong></td>
<td></td>
</tr>
<tr>
<td>Mother's name</td>
<td>Prior last names</td>
</tr>
<tr>
<td>Social security number</td>
<td>Family relations of the mother</td>
</tr>
<tr>
<td>Street address</td>
<td>Unmarried</td>
</tr>
<tr>
<td>Postal code and city</td>
<td>Widow</td>
</tr>
<tr>
<td>Phone number (home/work/mobile)</td>
<td>Married year</td>
</tr>
<tr>
<td>Place of domicile</td>
<td>New marriage year</td>
</tr>
<tr>
<td>Profession</td>
<td>Divorces year</td>
</tr>
<tr>
<td>Employer</td>
<td>Common law year</td>
</tr>
<tr>
<td>Name of the father (or other contact person)</td>
<td>Registration authority</td>
</tr>
<tr>
<td></td>
<td>(parish/registry)</td>
</tr>
<tr>
<td></td>
<td>Profession</td>
</tr>
<tr>
<td></td>
<td>Full time work</td>
</tr>
<tr>
<td></td>
<td>Shift work</td>
</tr>
<tr>
<td></td>
<td>Part time</td>
</tr>
<tr>
<td></td>
<td>Unemployed</td>
</tr>
<tr>
<td></td>
<td>Not in workforce</td>
</tr>
<tr>
<td></td>
<td>Social security number of the</td>
</tr>
<tr>
<td></td>
<td>father</td>
</tr>
<tr>
<td>Family relations of the father</td>
<td>Living at the same address</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>----------------------------</td>
</tr>
<tr>
<td>Unmarried</td>
<td>Other address</td>
</tr>
<tr>
<td>Widow</td>
<td></td>
</tr>
<tr>
<td>Married year</td>
<td></td>
</tr>
<tr>
<td>New marriage year</td>
<td></td>
</tr>
<tr>
<td>Divorces year</td>
<td></td>
</tr>
<tr>
<td>Common law year</td>
<td></td>
</tr>
<tr>
<td>Phone number (home/work/mobile)</td>
<td></td>
</tr>
<tr>
<td>Profession</td>
<td></td>
</tr>
<tr>
<td>Employer</td>
<td></td>
</tr>
<tr>
<td>Full time</td>
<td></td>
</tr>
<tr>
<td>work</td>
<td></td>
</tr>
<tr>
<td>Part time</td>
<td></td>
</tr>
<tr>
<td>Number of children in your household</td>
<td>Your and your partner's children in your family, name , age</td>
</tr>
<tr>
<td>Previous menstruation, date</td>
<td></td>
</tr>
<tr>
<td>Normal</td>
<td></td>
</tr>
<tr>
<td>Menstrual cycle days</td>
<td></td>
</tr>
<tr>
<td>Exigous</td>
<td></td>
</tr>
<tr>
<td>Age when started</td>
<td></td>
</tr>
<tr>
<td>Bleeding lasts</td>
<td></td>
</tr>
<tr>
<td>Bleeding</td>
<td></td>
</tr>
<tr>
<td>Heavy</td>
<td></td>
</tr>
<tr>
<td>Exigous</td>
<td></td>
</tr>
<tr>
<td>Normal</td>
<td></td>
</tr>
<tr>
<td>Pains</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Moderate</td>
<td></td>
</tr>
<tr>
<td>Hard</td>
<td></td>
</tr>
<tr>
<td>Pregnancy test</td>
<td></td>
</tr>
<tr>
<td>Negative, date</td>
<td></td>
</tr>
<tr>
<td>Positive, date</td>
<td></td>
</tr>
<tr>
<td>Have you used contraceptive pills</td>
<td>No, Yes, total years, Brand</td>
</tr>
<tr>
<td>Side effects</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Yes, what kind?</td>
<td></td>
</tr>
<tr>
<td>Use finished, date</td>
<td></td>
</tr>
<tr>
<td>Year</td>
<td></td>
</tr>
<tr>
<td>weeks of gestation</td>
<td></td>
</tr>
<tr>
<td>Health</td>
<td></td>
</tr>
<tr>
<td>Birth weight</td>
<td></td>
</tr>
<tr>
<td>The course of pregnancy</td>
<td></td>
</tr>
<tr>
<td>Duration of labour</td>
<td></td>
</tr>
<tr>
<td>Place of care</td>
<td></td>
</tr>
<tr>
<td>Exercise: How often, what kind</td>
<td></td>
</tr>
<tr>
<td>Leisure</td>
<td></td>
</tr>
<tr>
<td>Work-related travel</td>
<td></td>
</tr>
<tr>
<td>Health of the mother</td>
<td>Tick the illnesses that you have had and when</td>
</tr>
<tr>
<td>----------------------</td>
<td>---------------------------------------------</td>
</tr>
<tr>
<td>Heart disease</td>
<td></td>
</tr>
<tr>
<td>Hypertension</td>
<td></td>
</tr>
<tr>
<td>Kidney disease</td>
<td></td>
</tr>
<tr>
<td>Liver disease</td>
<td></td>
</tr>
<tr>
<td>Anaemia</td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
</tr>
<tr>
<td>Lung disease</td>
<td></td>
</tr>
<tr>
<td>Thyroid disease</td>
<td></td>
</tr>
<tr>
<td>Rheumatism</td>
<td></td>
</tr>
<tr>
<td>Epilepsy or other neurological disease</td>
<td></td>
</tr>
<tr>
<td>Psychiatric disease</td>
<td></td>
</tr>
<tr>
<td>Medication and time of use</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Health of the father</th>
<th>Has the father of the child had any of the above diseases and when?</th>
<th></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Illnesses in the immediate family</th>
<th>Please describe any diseases in the family of the mother and who has them (e.g. diabetes, hypertension, heart disease, mental disability, deformity, hereditary diseases or other)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In the immediate family of the father:</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pregnancy</th>
<th>Your own assessment of your health at the moment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Do you have fears linked to the pregnancy</td>
</tr>
<tr>
<td></td>
<td>In regards to your health</td>
</tr>
<tr>
<td></td>
<td>In regards to giving birth</td>
</tr>
<tr>
<td></td>
<td>In regards to miscarriage</td>
</tr>
<tr>
<td></td>
<td>In regards to the child-to-be</td>
</tr>
<tr>
<td></td>
<td>Other, what kind?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Expectations and hopes concerning the maternity healthcare clinic</th>
<th></th>
</tr>
</thead>
</table>
Maternity health care preliminary information form (In Finnish)

<table>
<thead>
<tr>
<th>Äitiysneuvolan esitiedot</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pvm</td>
</tr>
</tbody>
</table>

**HENkilö-
TIEDOT**

<table>
<thead>
<tr>
<th>Äidin nimi</th>
<th>Aik. sukunimet</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hankilönummus</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Kuulooaite</th>
<th>Äidin perhesuhteet</th>
</tr>
</thead>
<tbody>
<tr>
<td>Naimaton</td>
<td>Leski</td>
</tr>
<tr>
<td>Naimissa v.</td>
<td>Uusi avioliitto v.</td>
</tr>
<tr>
<td>Eronnut v.</td>
<td>Avoliitossa v.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Puhelin, kotiv/työn, matkapuh.</th>
<th>Kotikunta</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Ammatti</th>
<th>Työnantaja</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kokopv/työ</td>
<td>Vuorotyö</td>
</tr>
<tr>
<td>Ei ansio-</td>
<td>Osapv/työ</td>
</tr>
<tr>
<td>Työntyötä</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Lapeen isän nimi ( tai muu yhteyshenkilo )</th>
<th>Isän henkilötunnus</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Muu osioita</th>
<th>Isän perhesuhteet</th>
</tr>
</thead>
<tbody>
<tr>
<td>Naimaton</td>
<td>Leski</td>
</tr>
<tr>
<td>Naimissa v.</td>
<td>Uusi avioliitto v.</td>
</tr>
<tr>
<td>Eronnut v.</td>
<td>Avoliitossa v.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Puhelin kotiv/työn, matkapuh.</th>
<th>Isän ammatti</th>
<th>Työnantaja</th>
</tr>
</thead>
</table>

**PERHE-
Yhteisö**

<table>
<thead>
<tr>
<th>Taloutenne kuuluvien lasten lukumäärä</th>
<th>Perheeseen kuuluvat Sinun tai kumpiapaasi läpisot, nimi, kä</th>
</tr>
</thead>
</table>

**KUUKAUTIS-
TIEDOT**

<table>
<thead>
<tr>
<th>Viimeiset kuulaudet, pm</th>
<th>pm</th>
<th>normaalit</th>
<th>Raskauskoe negatiivinen, pm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kuukautokerran pituus</td>
<td>v.</td>
<td>miukat</td>
<td>positiivinen, pm</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Alkamiskä</th>
<th>Vuoto</th>
<th>Vuoto</th>
<th>Rungsas</th>
<th>Huokka</th>
<th>Tavallinen</th>
</tr>
</thead>
<tbody>
<tr>
<td>v.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**EHKÄISY**

<table>
<thead>
<tr>
<th>Oletko käyttänyt E-pilleriä</th>
<th>E-pillerien kestä</th>
<th>Käyttänyt, yhteensä vuotta merkki</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ei</td>
<td>Merkki</td>
<td>E-pillerien kestä</td>
</tr>
<tr>
<td>V</td>
<td>Merkki</td>
<td>E-pillerien kestä</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sivuoreita</th>
<th>E-pilleriälopettu, pm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ei</td>
<td>E-pilleriälopettu, pm</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Onko Sinulla ollut kierukka</th>
<th>Sivuoreita</th>
<th>Käyttänyt, millialisia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ei</td>
<td>Sivuoreita</td>
<td>Käyttänyt, millialisia</td>
</tr>
</tbody>
</table>

| Milloin olette kpettaneet eikäkösäväiden käytön? |

**AIKAISEMMAT RASKAUKSET**

<table>
<thead>
<tr>
<th>Vuosi</th>
<th>Raskaus-</th>
<th>Terveys</th>
<th>Synymä-</th>
<th>Raskauden ja synnytyksen kulku</th>
<th>Synnytt</th>
<th>Messä</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>vikko</td>
<td>panon</td>
<td>rydian</td>
<td>kulku</td>
<td>kesto</td>
<td>hoitettu</td>
</tr>
</tbody>
</table>

B4000 L-9: Potzt1b464apulet.1.doc/11.2003/kn
<table>
<thead>
<tr>
<th>ELINTAVAT JA TOTTUMUKSET</th>
</tr>
</thead>
<tbody>
<tr>
<td>Liikunta: Kuinka usein, mitä liikuntaa?</td>
</tr>
<tr>
<td>Vapaa-aika</td>
</tr>
<tr>
<td>Työmatkat</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ÄIDIN TERVEYDEN-TILA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ratkita sairaudet, jotka olet sairasastunut ja milloin</td>
</tr>
<tr>
<td>sydännsairaus</td>
</tr>
<tr>
<td>verenpainetaulu</td>
</tr>
<tr>
<td>munaistaulu</td>
</tr>
<tr>
<td>maksasairaus</td>
</tr>
<tr>
<td>anemia</td>
</tr>
<tr>
<td>sokeritauho</td>
</tr>
<tr>
<td>keuhkosairaus</td>
</tr>
<tr>
<td>kilparauhassairaus</td>
</tr>
<tr>
<td>reuma</td>
</tr>
<tr>
<td>epilepsia tai muu neurologinen sairaus</td>
</tr>
<tr>
<td>psykykinen sairaus</td>
</tr>
<tr>
<td>Leikkaukset</td>
</tr>
<tr>
<td>verensirto v.</td>
</tr>
<tr>
<td>ylimääräisyys (alasma, allerginen ruoja, lääkeaineet,</td>
</tr>
<tr>
<td>ihonmukuisuus)</td>
</tr>
<tr>
<td>viitasotetehdus</td>
</tr>
<tr>
<td>klamydia, sukueinherpes</td>
</tr>
<tr>
<td>C-hepatiitti</td>
</tr>
<tr>
<td>muu, esim. kordyloomat</td>
</tr>
<tr>
<td>PAPA-koe</td>
</tr>
<tr>
<td>viimeksi vuonna</td>
</tr>
<tr>
<td>Hammaskello</td>
</tr>
<tr>
<td>viimeksi vuonna</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ISÄN TERVEYS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Onko lapsen isä sairasastunut jotakin em. sairauksista ja milloin?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SAIRAUDET LÄHISUUVUSSA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kerro, mitä sairauksia ja kenellä (esim. sokeritaudit, verenpainetaulut, sydännsairaudet, keihystyvämisaste, syynynnätiset</td>
</tr>
<tr>
<td>epämuidostumattomat, mahdolliset periytyvät sairaudet tai muu sairaus)</td>
</tr>
<tr>
<td>Äidin lähisuvussa</td>
</tr>
<tr>
<td>Isän lähisuvuussa:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>RASKAUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oma arvo terveytestäsi tällä hetkellä</td>
</tr>
<tr>
<td>Onko Sinulla raskauteen liittyviä pekoja</td>
</tr>
<tr>
<td>tarvittasi suuteen</td>
</tr>
<tr>
<td>synnytyksen suuteen</td>
</tr>
<tr>
<td>keskenmenon suuteen</td>
</tr>
<tr>
<td>Lulevan lapsen suuteen</td>
</tr>
<tr>
<td>muita, miltälaa</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ODOTUKSIA JA TOIVO-MUKSIA ÄITYSNEUVOLAILTA</th>
</tr>
</thead>
</table>

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383
Expecting mother’s / father’s eating habits form (in English)

Expecting mother’s / father’s eating habits

Name

Date

Fill the form in line with your normal eating habits!

Meal times:

<table>
<thead>
<tr>
<th>Breakfast</th>
<th>Lunch</th>
<th>Snack</th>
<th>Dinner</th>
<th>Evening snack</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time____</td>
<td>Time____</td>
<td>Time____</td>
<td>Time____</td>
<td>Time____</td>
</tr>
</tbody>
</table>

Other

Time____

Do you have a special diet?

No

Yes, what_______________________________________________

What foods do you use?

1. Milk products

Skimmed milk
Semi-skimmed milk
Whole milk (farm/organic)
Yoghurt, sour whole milk, which?____
1% fat milk
Kulutusmaito [old term for whole milk]
Sour milk
I do not use milk or sour milk products

Daily amount_______________

2. Cheese brand you usually use__________________Light Normal

The amount consumed daily about__________________ slices (with a slicer)
2. Fats

On bread in cooking
Butter
Margarine
Light margarine
Oil
Other

4. Meat products

Meat Chicken Fish

Daily consumption times

5. Grain products

Wholegrain bread
Mixed grain bread, yeast bread
White bread
Ordinary coffee bread
Other coffee bread
Hulled grains, flakes in porridge and gruel

Daily consumption slices/plates

6. Vegetables consumed on about days a week

Do you consider your consumption of vegetables

Insufficient average heavy

7. Berries and fruits consumed on about days a week

8. You drink about times a day

Water
Light lemonade/regular
Other juices
Mineral water
Coffee/tea

9. Sweets, chocolate, crisps, salty nuts etc. nibbles

You consume times a day/week
I do not consume

10. Salt consumption is in your opinion
Insufficient average heavy

11. Do you use supplements?
Vitamins
Minerals
Natural products
Something else

How many times a day/week?
Which brands?

12 Problems linked to diet
Heartburn
Bloating
Nausea
Constipation
Something else?

Follow up plans
(For nurses’ notes)
Expecting mother’s / father’s eating habits form (in Finnish)

<table>
<thead>
<tr>
<th>ODOTTAVAN ÄIDIN / ISÄN RUOKATAVAT JA TOTTUMUKSET</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nimi __________________________________________</td>
</tr>
<tr>
<td>Päivämäärä ____________________________________</td>
</tr>
<tr>
<td>Täytä lomake normaalien ruokailutottumustesi mukaan!</td>
</tr>
<tr>
<td><strong>Ateria-aikasi:</strong></td>
</tr>
<tr>
<td>Aamupala</td>
</tr>
<tr>
<td>klo ____</td>
</tr>
<tr>
<td>Onko sinulla erityisruokavaliota?</td>
</tr>
<tr>
<td>□ Ei  □ Kyllä, mitä ______________________________</td>
</tr>
<tr>
<td>Mitä ruoka-aineita käytät?</td>
</tr>
<tr>
<td>1. Maitovalmisteista</td>
</tr>
<tr>
<td>□ rasvaton maito □ ykkösmaito</td>
</tr>
<tr>
<td>□ kevyt maito □ kulutusmaito</td>
</tr>
<tr>
<td>□ täysmaito (maatila-/ luomu-) □ piimä, mikä</td>
</tr>
<tr>
<td>□ jogurtti, viili, mikä __________________________</td>
</tr>
<tr>
<td>□ en käytä maito- / hapanmaidotuotteita</td>
</tr>
<tr>
<td>Maitojuoman käyttömäärä päivässä __________________________ lasillista</td>
</tr>
<tr>
<td>2. Juustomerkki, jota yleensä käytät</td>
</tr>
<tr>
<td>_______________ □ kevyt □ tavallinen</td>
</tr>
<tr>
<td>Juuston käyttömäärä päivässä n.</td>
</tr>
<tr>
<td>_______________ □ silvua (höylällä)</td>
</tr>
<tr>
<td>3. Rasvoista</td>
</tr>
<tr>
<td>leivällä □ ruuanvalmistuksessa</td>
</tr>
<tr>
<td>□ voi □ jääkaappimargariini</td>
</tr>
<tr>
<td>□ talousmargariini □ kevytleite</td>
</tr>
<tr>
<td>□ öljy □ muu</td>
</tr>
<tr>
<td>4. Lihavalmisteista</td>
</tr>
<tr>
<td>□ liha □ kanaa □ kalaa</td>
</tr>
<tr>
<td>□ lihaa □ kanaa □ kalaa</td>
</tr>
<tr>
<td>Lihavalmisteiden käyttömäärä päivässä __________________________ kertaa</td>
</tr>
</tbody>
</table>

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5. Viljavalmisteista
☐ täysjyväleipä (ruis-, näkkileipä)
☐ sekaleipä, hiivaleipä
☐ valkea leipä (ranskanleipä, vehnäsämpylät)
☐ kahvileipänä tavallinen pulla
☐ muu kahvileipä, mikä

Viljavalmisteiden käytöömäärä päivässä sinua/ lautasellista

6. Kasviksia ja vihanneksia käytät noin päivänä viikossa
Kasvisten ja vihannesten käyttö on mielestäsi
☐ niukkaa ☐ keskinkertaista ☐ runsasta

7. Marjoja ja hedelmiä käytät noin päivänä viikossa

8. Juomina käytät noin kertaa päivässä
☐ vesi ☐ limonadi light/ tavallinen ☐ muut mehit
☐ kivennäisvesi ☐ tuoremehu ☐ kahvi/ tee

9. Makeisia, suklaata, chipsejä, suolapähkinöitä ym naposteluun
☐ käytät kertaa/ päivässä/ viikossa
en käytä ollenkaan

10. Suolan käyttö on mielestäsi
☐ niukkaa ☐ keskinkertaista ☐ runsasta

11. Käytätkö lisäraavintovalmisteita
☐ vitamiineja ☐ kivennäisainevalmisteita ☐ luontaistuotteita
muuta. Kuinka usein käytät? päivässä/ viikossa
Minkä nimiä valmisteita käytät?

12. Ruokavalioon liittyvien ongelmien esiintyminen
☐ närästys ☐ pahoinvointi
☐ turvotus ☐ ummetus

☐ muuta

Jatkosuunnitelma
(terveydenhoitajan merkintöjä varten)


S4022 LипштейнаБегунаK.m.n, suokatav.a1.doc/11.2003

388
Audit form (with questions of drug use) (in English)

Questionnaire for future parents

__________________________
Name (mother/father)

Questionnaire on alcohol consumption
The questions are based on the World Health Organisation's Audit-test

One standard drink=
Bottle (33cl) of medium strength beer or cider,
Class (12cl) of wine,
Small class (8cl) of fortified wine or
Shot (4cl) of spirits

Key to calculate standard drinks:
Pint (0.5l) of medium strength beer or light cider = 1.5 standards
Pint (0.5l) of strong beer or cider = 2 standards
Bottle (0.75l) of wine = 6 standards
Bottler (0.5l) of spirits = 13 standards

Please circle the response that best fits your drinking.

How often do you have a drink containing alcohol?
Please include the times you consume only little amounts, e.g. a bottle of medium strength beer or a dash of wine.

0 Never
1 Monthly or Less
2 2 - 4 times a month
3 2 - 3 times a Week
4 4 or more times a week

How many standard drinks do you have on a typical day when you are drinking?

0 1-2
1 3-4
2 5-6
3 7-9
4 10 or more

How often do you have six or more standard drinks on one occasion?
How often during the last year have you found that you were not able to stop drinking once you had started?

0 Never
1 Monthly or Less
2 Once a month
3 Once a Week
4 Daily or almost daily

How often during the last year have you failed to do what was normally expected of you because of drinking?

0 Never
1 Monthly or Less
2 Once a month
3 Once a Week
4 Daily or almost daily

How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?

0 Never
1 Monthly or Less
2 Once a month
3 Once a Week
4 Daily or almost daily

How often during the last year have you had a feeling of guilt or remorse after drinking?

0 Never
1 Monthly or Less
2 Once a month
3 Once a Week
4 Daily or almost daily

How often during the last year have you been unable to remember what happened the night before because you had been drinking?

0 Never
1 Monthly or Less
2 Once a month
3 Once a Week  
4 Daily or almost daily

Have you or someone else been injured because of your drinking?
0 No  
2 Yes, but not in the last year  
4 Yes, during the last year

Has a relative, friend, doctor, or other healthcare worker been concerned about your drinking or suggested you cut down?
0 No  
2 Yes, but not in the last year  
4 Yes, during the last year

In a week I drink____standard drinks. In this test I scored_______points. Is it time to readjust my drinking?

You are in: “the green zone” 0-7 points  
You are in: “the yellow zone” 8-13 points  
You are in: “the red zone” over 14 points

If you scored 8 points of more or your weekly consumption exceeds 16 standard drinks (women) or over 24 standard drinks (men) you should stop and start monitoring your consumption. Negotiate with your nurse or doctor if needed.

**Questionnaire on drug consumption**

Instructions: circle the response that best fits your situation

1. Do you smoke cannabis?   a) Yes b) No
2. Have you ever smoked cannabis?   a) Yes b) No
   If yes, when did you start/quit__________________________

3. Do you use sedatives, anti-depressants or sleeping medicine?   a) Yes b) No
4. Have you ever used anti-depressants or sleeping medicine?   a) Yes b) No
   If yes, when did you start/quit__________________________

5. Do you use amphetamine or ecstasy?   a) Yes b) No
6. Have you ever used amphetamine or ecstasy?   a) Yes b) No
   If yes, when did you start/quit__________________________

7. Do use heroine?   a) Yes b) No
8. Have you ever used heroine   a) Yes b) No
   If yes, when did you start/quit__________________________
9. Do you use cocaine  
   a) Yes  b) No
10. Have you ever used cocaine  
    a) Yes  b) No
   If yes, when did you start/quit__________________________

11. Do you use other drugs (morphine, LSD etc.)?  
    a) Yes  b) No
12. Have you ever used other drugs (morphine, LSD etc.)  
    a) Yes  b) No
   If yes, when did you start/quit__________________________

13. Do you smoke?  
    a) Yes  b) No
14. Have you ever smoked  
    a) Yes  b) No
   If yes, when did you start/quit and how many cigarettes do you smoke/smoked daily?__________________________

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## KYSELY ALKOHOLIN KÄYTÖSTÄ
Kysymyksiin perustuvat Maailman terveystärkiin kehitettämiin AUDIT-testiin

<table>
<thead>
<tr>
<th>Yksi alkoholiannos = pullo (33 cl) keskiolutta tai sideriä, lasi (12 cl) mietoa viinä, pieni lasi (8 cl) väkevä viinä tai ravinto-annos (4 cl) väkevä</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annonen laskualueen: iso tuoppi (0,5 l) keskiolutta tai mietoa sideriä = 1,5 annosta</td>
</tr>
<tr>
<td>iso tuoppi (0,5 l) A-olutta tai vahvaa sideriä = 2 annosta</td>
</tr>
<tr>
<td>pullo (0,75 l) viinä (12 %) = 6 annosta</td>
</tr>
<tr>
<td>pullo (0,5 l) väkevä = 13 annosta</td>
</tr>
</tbody>
</table>

---

### Ympyröi kustakin kysymyksiin sekä vaihtoehto, joka lähinnä vastaa tilannettasi.

- Kuinka usein juotut, viiniä tai muita alkoholijuomia? Koeta ottaa mukaan myös ne kerrat, jolloin nautit pieniä määriä, esim. pullon keskiolutta tai tilkan viinää.
  - 0 en koskaan
  - 1 noin kerran kuukaudessa tai harvemmin
  - 2-4 kertaa kuukaudessa
  - 3-2-3 kertaa viikossa
  - 4 kertaa viikossa tai useammin

- Kuinka monta annosta alkoholia yleensä olet ottanut viinä päivänä, jolloin käytit alkoholia?
  - 0 1-2 annosta
  - 1-3-4 annosta
  - 2-5-6 annosta
  - 3-7-9 annosta
  - 4 10 annosta tai ememmän

- Kuinka usein olet juonut kerralla kuusi tai useammin annoksia?
  - 0 en koskaan
  - 1 harvemmin kuin kerran kuukaudessa
  - 2 kerran kuukaudessa
  - 3 kerran viikossa
  - 4 lähes päivittäin

- Kuinka usein viime vuoden aikana sinulle kävi niin, että et pystynyt lopettamaan alkoholinkäyttöä, kun aloit ottaa?
  - 0 ei koskaan
  - 1 harvemmin kuin kerran kuukaudessa
  - 2 kerran kuukaudessa
  - 3 kerran viikossa
  - 4 lähes päivittäin

- Kuinka usein viime vuoden aikana et ole juomisen vuoksi saanut tehtävä jotaan, mikä tavallisesti kuuluu tehtäviä?
  - 0 ei koskaan
  - 1 harvemmin kuin kerran kuukaudessa
  - 2 kerran kuukaudessa
  - 3 kerran viikossa
  - 4 päivittäin

---

### Viikossa juon anosta. Testissä sain pistettä.

| Olen menossa: AVhreällä = 0-7 pistettä |
| AKentaisella = 8-13 pistettä |
| APunaisella = yli 14 pistettä |

---
Jos saat edellisen sivun kysymyksistä 8 pistettä tai enemmän tai jos viikkokokouksesi on yli 16 annosta (nainen) tai yli 24 annosta (mies), on sinun syytä pysähtyä tarkkailemaan alkoholinkäytöäsi. Neuvottele tarvittaessa hoitajan tai lääkärin kanssa.

KYSELY LÄÄKKEIDEN JA HUUMEIDEN KÄYTÖSTÄ

Vastaamisohje: Ympyröili parhailleni omaa tilannettasi kuvaava vaihtoehto!

1. Poltatko hashista? a) Kyllä b) En
   Jos kyllä, milloin aloitit/lopetit?

2. Oletko aiemmin polttanut hashista? a) Kyllä b) En

   Jos kyllä, milloin aloitit/lopetit?

4. Oletko aiemmin käyttänyt rauhoittavia-, mielilää- tai unilääkkeitä? a) Kyllä b) En

5. Käytätkö amfetaminia tai ekstaasia? a) Kyllä b) En
   Jos kyllä, milloin aloitit/lopetit?

6. Oletko aiemmin käyttänyt amfetaminia tai ekstaasia? a) Kyllä b) En

7. Käytätkö heroinia? a) Kyllä b) En
   Jos kyllä, milloin aloitit/lopetit?

8. Oletko aiemmin käyttänyt heroinia? a) Kyllä b) En

   Jos kyllä, milloin aloitit/lopetit?

10. Oletko aiemmin käyttänyt kokaiinia? a) Kyllä b) En

11. Käytätkö muita huumeita (morfiinia, LSD:tä tms)? a) Kyllä b) En
    Jos kyllä, milloin aloitit/lopetit?

12. Oletko aiemmin käyttänyt muita huumeita (morfiinia, LSD:tä tms)? a) Kyllä b) En

13. Tupakoitko? a) Kyllä b) En
    Jos kyllä, milloin aloitit/lopetit ja montako savukuutta poltat/poilit päivässä?

14. Oletko aiemmin tupakoinut? a) Kyllä b) En

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394
Welfare assessments form (in English)

On the front page of the forms it says: ‘Dear parents, Expecting a child and giving birth are huge reasons for joy. They bring along, however, also new challenges into family life and partnership. This form will help you anticipate and evaluate issues that are linked to having a child. You may use this form to contemplate on your own experiences and feelings and to use it as a basis for discussion at the maternity healthcare clinic’.

<table>
<thead>
<tr>
<th>When you are in need of support...</th>
<th>Disagree</th>
<th>Rather disagree</th>
<th>N/A</th>
<th>Rather agree</th>
<th>Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>I have an important person in my life who supports me when I need help</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I have an important person in my life with whom I can share joys and sorrows</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>My family always supports me when I need help</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I have an important person in my life who consoles me</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>My friends really support me when I need help</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I am able to talk about my problems with my family</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>When I need to make important decisions I get help from my family</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I am able to talk about my problems with my friends</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Close people in my life help me with practical things</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Close people in my life won’t let me down if I have financial trouble</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

| Mood |

Answer the following questions by circling the option that corresponds to your feelings during the last 2 weeks.

<table>
<thead>
<tr>
<th>I have been able to laugh and see the bright side of things</th>
<th>I have been looking forward to the future</th>
</tr>
</thead>
<tbody>
<tr>
<td>Just as much as before</td>
<td>Just as much as before</td>
</tr>
<tr>
<td>Not quite as much as before</td>
<td>Not quite as much as before</td>
</tr>
<tr>
<td>Clearly less than before</td>
<td>Clearly less than before</td>
</tr>
<tr>
<td>Not at all</td>
<td>Not at all</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------------------------------------------------------------</td>
<td>-----------------------------------------------------------------</td>
</tr>
<tr>
<td>I have blamed myself for no reason when things have gone wrong</td>
<td>I have been anxious and worried for no apparent reason</td>
</tr>
<tr>
<td>0 Just as much as before</td>
<td>0 Just as much as before</td>
</tr>
<tr>
<td>1 Not quite as much as before</td>
<td>1 Not quite as much as before</td>
</tr>
<tr>
<td>2 Clearly less that before</td>
<td>2 Clearly less that before</td>
</tr>
<tr>
<td>3 Not at all</td>
<td>3 Not at all</td>
</tr>
<tr>
<td>I have been scared and frantic for no apparent reason</td>
<td>Things seem to be falling on me</td>
</tr>
<tr>
<td>0 Just as much as before</td>
<td>0 Just as much as before</td>
</tr>
<tr>
<td>1 Not quite as much as before</td>
<td>1 Not quite as much as before</td>
</tr>
<tr>
<td>2 Clearly less that before</td>
<td>2 Clearly less that before</td>
</tr>
<tr>
<td>3 Not at all</td>
<td>3 Not at all</td>
</tr>
<tr>
<td>I have been so unhappy that I have had trouble sleeping</td>
<td>I have felt sad and miserable</td>
</tr>
<tr>
<td>0 Just as much as before</td>
<td>0 Just as much as before</td>
</tr>
<tr>
<td>1 Not quite as much as before</td>
<td>1 Not quite as much as before</td>
</tr>
<tr>
<td>2 Clearly less that before</td>
<td>2 Clearly less that before</td>
</tr>
<tr>
<td>3 Not at all</td>
<td>3 Not at all</td>
</tr>
<tr>
<td>I have been so unhappy that I have been crying</td>
<td>I have thought about hurting myself</td>
</tr>
<tr>
<td>0 Just as much as before</td>
<td>0 Just as much as before</td>
</tr>
<tr>
<td>1 Not quite as much as before</td>
<td>1 Not quite as much as before</td>
</tr>
<tr>
<td>2 Clearly less that before</td>
<td>2 Clearly less that before</td>
</tr>
<tr>
<td>3 Not at all</td>
<td>3 Not at all</td>
</tr>
</tbody>
</table>
### Use of intoxicants

<table>
<thead>
<tr>
<th>How often do you drink beer, wine or other alcoholic beverages?</th>
<th>Have you ever been criticised for your drinking?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>Yes</td>
</tr>
<tr>
<td>Once a month or less</td>
<td>No</td>
</tr>
<tr>
<td>2-4 times a month</td>
<td></td>
</tr>
<tr>
<td>2-3 times a week</td>
<td></td>
</tr>
<tr>
<td>4 times a week or more</td>
<td></td>
</tr>
<tr>
<td>Have you ever felt guilty because of your drinking?</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How many units of alcohol do you consume on the days, when you do use alcohol?</th>
<th>Have you ever taken a hangover drink?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-2</td>
<td></td>
</tr>
<tr>
<td>3-4</td>
<td>Yes</td>
</tr>
<tr>
<td>5-6</td>
<td>No</td>
</tr>
<tr>
<td>7-9 portions</td>
<td></td>
</tr>
<tr>
<td>10 or more</td>
<td></td>
</tr>
</tbody>
</table>

### Resolving conflicts

People have different ways of acting in conflict situations. What do you do when you have arguments or disagreements with your partner? Try to remember situations during the last year, and assess how well each statement corresponds with your way of acting in a conflict situation.

<table>
<thead>
<tr>
<th></th>
<th>Never</th>
<th>Hardly ever</th>
<th>Sometimes</th>
<th>Rather often</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>I discussed things rather calmly</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I tried to explain my view on things</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I debated fiercely, but did not yell</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I yelled and/or called my partner names</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I moped and/or refused to talk about things</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I threatened to hit my partner or to throw things at my partner</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I grabbed my partner or pushed my partner</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>The fight ended up in an assault</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I left to avoid talking about things</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I went out to get some fresh air</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>We made up and were relieved</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I am worried about the psychological violence in our relationship</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am worried about the physical violence in our relationship</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

397
Our child/children have heard our domestic violence
Our child/children have seen our domestic violence

Stress in the family with small children
There are also stress and worries during pregnancy. Here follow some questions about your feelings and thoughts during the last two weeks. Assess how well each statement corresponds with your feelings.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Not at all</th>
<th>Some</th>
<th>I can’t say</th>
<th>Often</th>
<th>Very often</th>
</tr>
</thead>
<tbody>
<tr>
<td>I have felt myself ‘stresses’</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I trust that everything will be just fine in my life</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Difficulties have grown so big that I cannot control them</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I feel that my child will make me feel good</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I am afraid that I will be left alone with my child</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I am worried about the development of my child</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I feel that I am not able to care for my family</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I feel that I am in trouble with issues related to parenthood</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I am afraid that a child would limit my life too much</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>My current life is unsatisfactory to me</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

Financial situation

Does your family have a hard time paying regular bills (e.g. electricity, phone, water)

<table>
<thead>
<tr>
<th>Scale</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>Extremely hard</td>
</tr>
<tr>
<td>4</td>
<td>Rather hard</td>
</tr>
<tr>
<td>3</td>
<td>Quite hard</td>
</tr>
<tr>
<td>2</td>
<td>A little</td>
</tr>
<tr>
<td>1</td>
<td>Not at all</td>
</tr>
</tbody>
</table>

How much money does your family have left before the next payday

<table>
<thead>
<tr>
<th>Scale</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>There is more than enough</td>
</tr>
<tr>
<td>2</td>
<td>There is some left</td>
</tr>
<tr>
<td>3</td>
<td>Just enough to cover expenses</td>
</tr>
<tr>
<td>4</td>
<td>There is not enough to cover the expenses</td>
</tr>
</tbody>
</table>

Fears and worries about the expecting
Pregnancy is a happy time of waiting, but there might be some fears and worries connected to it as well. Below you will find a list of some common fears that parents have. Assess how far you share these fears.

<table>
<thead>
<tr>
<th>Fear</th>
<th>Not at all</th>
<th>A little</th>
<th>Some</th>
<th>A lot</th>
<th>Very much</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am afraid that I might fall and hurt my child</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I am afraid of the pain of childbirth</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I am afraid that my child is not normal</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I am afraid of hospitals</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I am afraid that my wishes won’t be heard at childbirth</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I am afraid of giving birth</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I am afraid of having negative feelings toward my child</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

**Mental images of the baby(-to-be)**

The next questions are concerned with expectations that you might have as a parent about your child-to-be. Assess how well each statement corresponds with your own mental image.

<table>
<thead>
<tr>
<th>Image</th>
<th>Not at all</th>
<th>A little</th>
<th>I can’t say</th>
<th>A lot</th>
<th>Very much</th>
</tr>
</thead>
<tbody>
<tr>
<td>I think my baby-to-be will:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>sleep regularly</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>be difficult to breastfeed</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>have a regular feeding schedule</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>be happy and satisfied</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>feel strange to me</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>be happy by her/himself</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>calm down easily in my arms</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>be hard to calm down</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>wake up all the time during the night</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>be restless and impatient</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>be disarmingly cute</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>give me great pleasure</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

**Me as a mother/father (open questions, RH)**

What kinds of good experiences did you have as a child that you would like to pass on to your child?
What kinds of bad experiences did you have as a child that you would not like to pass on to your child?
How do you think/would you like your and your partners' parenthood to develop?
Welfare assements form (in Finnish)

Hyvät vanhemmat

Lapsen odotus ja syntyminen ovat suuria ilonaiheita. Ne tuovat kulkenkin myös uusia haasteita perhe-elämään ja parisuhteen. Tämä lomake auttaa teitä ennakoimaan ja arvioimaan lapsen tuloon liittyviä asioita. Lomaketta voitte käyttää omien kokemustenne ja tuntemustenne pohtimiseen sekä keskustelan virittäjänä neuvolassa.

Nimi__________________________ Pvm________
KUN TARVITSET TUKKA...  
ALLA ON KUVATTU SOSIAALISEN TUEN LÄHETIÄ. ARVIOI ÅSTEIKÖLLÄ 1-5, MITEN SINULLA ON SAATAVILLA TUKEA JA APUA. MERKITSE JOKA VÄITTÄMÄSTÄ YKSI PARHAIN SINUUN SOPIVA VAHTOETO.

<table>
<thead>
<tr>
<th></th>
<th>Eri mieltä</th>
<th>Melko eri mieltä</th>
<th>Ei samaa edellä eri mieltä</th>
<th>Melko samaa mieltä</th>
<th>Samaa mieltä</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minulla on joku tärkeä ihminen, joka tukee minua, kun tarvitsen apua</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Minulla on joku tärkeä ihminen, jonka kanssa voin jakaa elämän ilot ja surut</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Perheeni tukee minua aina, kun tarvitsen apua</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Minulla on joku tärkeä ihminen, joka lohduttaa minua</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Ystävänä todeellu tukevat minua, kun tarvitsen apua</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Voin keskustella ongelmistani perheeni kanssa</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Tehdessani tärkeitä ratkaisuja saan perheeltäni apua</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Voin keskustella ongelmistani ystävieni kanssa</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Lähiseinä auttavat minua käytännön asiissa</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Lähiseinä eivät jää minua pulaan, jos joudun taloudellisesti vaikeuksiin</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

MIELIÄÄ

VASTAAMAN KYSYMÖSYN YMPYRÖMÄLLÄ SE VAHTOETO. JOKA ENITEN VASTAAN TUNTEENUKSIASI VIIMEKSI KULUNEEN KAHDEN VIKÖN AIKANA.

Olen pyystänyt nauramaan ja näkemään asioiden hauskan puolen | 0 | yhtä paljon kuin aina ennenkin | 1 | huutavähemmän kuin aikaisemmin | 2 | selvästi vähemmän kuin ennen |
| Olen ollut peloiissani tai hädissäni ilman erityistä selvää syyttä | 3 | en ollut peloaan |
| Olen ollut olleet onnettomat, että minulla on ollut univäikekästä | 0 | ei, en ollut peloaan |
| Olen olleet niin onneton, että olen olleet univäikekästä | 1 | ei, en ollut peloaan |
| Olen olleet niin onneton, että olen olleet univäikekästä | 2 | ei, en ollut peloaan |
| Olen olleet niin onneton, että olen olleet univäikekästä | 3 | ei, en ollut peloaan |

Asiat kasautuvat paikalleen | 0 | ei, olen selvinnyt yhtä hyvin kuin aina ennenkin |
| Olen olleet olleet onnettomat, että olen selvinnyt melko hyvin | 1 | ei, olen selvinnyt yhtä hyvin kuin aina ennenkin |
| Olen olleet olleet onnettomat, että olen selvinnyt melko hyvin | 2 | ei, selvinnyt yhtä hyvin kuin aina ennenkin |

Ajtatus itseä vahingoittamisesta on tullut mieleeni | 3 | ei, selvinnyt yhtä hyvin kuin aina ennenkin | 1 | tuskakin | 2 | joskus | 3 | melko usein |
### PÄHTEIDEN KÄYTTÖ

**SEURAAVASSA TIEDUSTELLAAN ALKOHOLIN JA HUUMEIDEN KÄYTTÖÄ. YMPYRÖI SINUUN SORIVA VAHTOEHTO.**

**Kuinka usein juot ollut, viinä tai muita alkoholi/yöpimää?**
- Ei koskaan
- Noin kerran kuussa tai harvemmin
- 2–4 kertaa kuussa
- 5–9 kertaa viikossa
- 10 tai enemmän

**Oletko koskaan käyttänyt alkoholia yleensä olet ottanut minä päivänä, jolloin käytät alkoholia?**
- Ei
- Kyllä

**Oletteko koskaan ottanut spikuja ilman alkoholia?**
- Ei
- Kyllä

**Oletko koskaan käyttänyt alkoholia kokeillut muita pahittaita kuin alkoholia?**
- Ei
- Kyllä

**Miten hoiutetaan (kuten LSD, amfetamiini, heroin, eristä):**
- Lääkenteitä

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### RISTIRAITTOJEN RATKAISU

**IHIMELÄ ON ERIKÄSIÄ TAPAAMAT TOIMIA RISTIRAITTAISETTAA. MITÄ SINÄ TEE TILILLÖIN, KUN ON RITTOJA JA ERIKÄSIJÄRYKSIÁ PUOLISOJEN KUMPPANISI KANSGA. PALAUTA MELEESI TILANTEESTA MELEESI SIVUJEN AJALTÄ.**

**ARVIOTO: KUNNA HYVIN VAIITTAA PITÄÄ PAJANKAAN KUVAAAMAA SINUN TAPAASI TOIMIA RISTIRAITTAISETTAA.**

<table>
<thead>
<tr>
<th>Keskustelun asia</th>
<th>Ei lainkaan</th>
<th>Tuskin koskaan</th>
<th>Vain silti tällöin</th>
<th>Melko hyvin</th>
<th>Täysin</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pylin parustelevaan näkemykseen asiasta</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Välttelin kilvaasti, mutta en huutanut</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Huusin jältä haukuin puolisoani</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Murjotin jältä kielätyynin keskustelemasta asiasta</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Uhkasin lyödä tai heiltää puolisoani jollakin esineellä</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Heittin kumpapani jollakin esineellä</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Turtuin puolisoani kiinni tai tönin häntä</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Riihelyyn päätyni pahoinpitelyyn</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Poistuin palikalta välttäkseni keskustelemasta asiasta</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Lähin ulos haukkaamaan raitista ilmaa</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Teimme sovinon ja olime helppotunteita</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

**Minulla huolestuttaa hankinen väkivalta parisuhteessamme**
- Ei
- Kyllä

**Minuilla huolestuttaa fyysinen väkivalta parisuhteessamme**
- Ei
- Kyllä

**Lapsemme on ollut kuullessaan perheväkivaltaileita**
- Ei
- Kyllä

**Lapsemme on nänyt perheväkivaltaileita**
- Ei
- Kyllä
## VAUVAPERHEEN STRESSI

Raskauskaasut voivat aiheuttaa stressiä. Seuraavassa on kysymyksiä tuntemuksistasi ja ajatuksistasi viimeisen kahden viikon aikana. Arvioi, kuinka hyvin kuninka vääntämä kuva sinua.

<table>
<thead>
<tr>
<th>Olen tuntenut itseni &quot;stressantauneeksi&quot;</th>
<th>Ei lainkaan</th>
<th>Jonkin verran</th>
<th>En osaa sanoa</th>
<th>Hyvin</th>
<th>Erittäin hyvin</th>
</tr>
</thead>
<tbody>
<tr>
<td>Luoton, että kalikki sujuu hyvin elämässäni</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Vastoinkäymiset kasautuvat niin suuriksi, että en pysty niitä hallitsemaan</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Odotan, että lapseni saa minut tuntemaan oloni hyväksi</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Pelkään, että jään yksin lapsen kanssa</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Olen huollissani lapseni kehityksestä</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Minulla on tunne, että en pysty hoitamaan perheitä hyvin</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Tunnen olevani pulassa vanhemmuuteen liittyvän vastuun kanssa</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Pelkään, että lapsi rajoittaa liikaa elämäni</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Nykyinen elämäättömine harmittaa minua</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

## TALOUTTELLINEN TULANNE

Onko perheitöissä vaikuttavat maksaa säännöllisesti tulevia taksuja (esim. sähkön, puhelin, vesi)?

| 5 | Äärimmäisen vaikea |
| 4 | Hyvin vaikea |
| 3 | Mielo vaikea |
| 2 | Vähä vaikea |
| 1 | Ei lainkaan vaikea |

Mitä paljon perheitöissä on rahaa käytössä juuri ennen palikkapäiviä?

| 1 | Rahaa on jäljellä enemmän kuin tarpeeksi |
| 2 | Rahaa on jäljellä jonkin verran |
| 3 | Juuri tarpeeksi, että meniit tulevat kataanuksi |
| 4 | Rahaa ei ole tarpeeksi menojen kattamiseksi |

## ODOTTAJAN PELOT JA HUOLET

Raskauskaasun vaikutukset on kiistelty, mutta siksi se saattaa liittymä hyväksi myös huoltojen ja pelkojen. Alla on luettelot jotain tavanmukaista pelkoa. Jotain odottavilla vanhemmilla on arvioida, kuinka paljon sinulla on mainittuja pelkoja.

| Pelkään, että voisim kaatua ja loukata lapsen | En lainkaan | Vähän | Jonkin verran | Paljon | Erittäin paljon |
| Pelkään, että lapseni on normaali | 1 | 2 | 3 | 4 | 5 |
| Pelkään, että lapseni on normaali | 1 | 2 | 3 | 4 | 5 |
| Pelkään, että lapseni on normaali | 1 | 2 | 3 | 4 | 5 |
| Pelkään, että lapseni on normaali | 1 | 2 | 3 | 4 | 5 |
| Pelkään, että lapseni on normaali | 1 | 2 | 3 | 4 | 5 |
| Pelkään, että lapseni on normaali | 1 | 2 | 3 | 4 | 5 |
| Pelkään, että lapseni on normaali | 1 | 2 | 3 | 4 | 5 |
**MIELIKUVAT VAUVASTA**

Selainavat kysemykset koskevat odotuksia, joita sinulla on tulevana lapsen vanhempaan. Merkitse, miten hyvin kyseiset tulevaisuustavot vaativat omia mielikuviasi.

<table>
<thead>
<tr>
<th>Kysymyksen tulos</th>
<th>Eli lainkaan</th>
<th>Jonkin verran</th>
<th>En osaa sanoa</th>
<th>Paljon</th>
<th>Erittäin paljon</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nukkuu säännöllisesti</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>On vaikka imettää</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Neudattaa tarkkaa syömisyrimä</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>On tyytyväinen ja onnellinen</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Tuntuu miusta vierealla</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Vähäy itsekseni</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Rauhoittaa helposti sylissäni</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>On vaikka rauhoittaa</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Herää lee jatkuvasti öisin</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>On tuskairen ja rauhaton</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>On hellittävän suolainen</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Tuottaa minulle suurta iloa</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

**MINÄ AITINÄ/ISÄNÄ**

Mitä hyvät lapsuudeessa on ollut, jonka haluaisi siirtää omalle lapsellesi?

Mitä sellaista lapsuudeessa on ollut, mitä ei haluaisi siirtää omalle lapsellesi?

Miten ajattelut ovat sinun ja puolisasi yhteisen vanhempuiden kehittyvän?

Lomakke on kehitetty Tampereen hyvinvointineuvonta-tomintamallin yhteydessä (päivitys 9/2006).
Appendix III: Research information sheets

Research information sheets for parents (in English)

Dear parents

We are asking you to participate in a study in which interaction between family members and professionals in maternity and child healthcare is explored. The Committee of Research Permissions for Welfare and Health Institute of [name of the city] has given research permission for the study. The research material collected will be used in scientific research that aims at, amongst other things, improving appointment interaction quality for a more patient-friendly interaction.

You have come to maternity or child healthcare appointment/counselling class. The video recorded appointment and the questionnaire you complete after the appointment are used to study how interaction with the care provider, a public health nurse/doctor, takes place and how satisfied you are with the interaction. By observing care practices (like family counselling) we collect knowledge about maternity healthcare practices on a more general level.

In this study, we request your consent to the following sub-studies (delete where necessary):

a) video recording of client encounters
b) participation in an interview or questionnaire
c) observation of interaction in the public spaces at the clinic (e.g. family counselling class)

Researchers will not be present at the appointments or the multi-professional team meetings.

The material of the study (video recordings, questionnaires, interviews and observations) will be handled in the following manner:

1. Restricted access to the material will be secured, and everybody who handles the material will sign a discretion agreement.
2. The material will be converted to texts so that your name or information about your agency will not come out.
3. When reporting on the study all knowledge that might enable identification will be altered.
4. The material collected will be further used only for scientific research after the above-mentioned study is over.
5. The material will be stored for scientific research at the Department of Sociology and Social Psychology for 25 years after the research is conducted.
6. With my separate consent (see consent form) the material may be used for healthcare occupational and university education.

Participation in this study is voluntary. You have the right to withdraw your consent at any time without an explanation and request that previously recorded material be destroyed.

If you have any questions or would like any additional information we are glad to answer.

Researchers:
Doctor of Social Sciences Johanna Ruusuvuori*, docent, assistant professor, [contact information]
Doctor of Social Sciences Pirjo Lindfors**, researcher, [contact information]
Master of Social Science Riikka Homanen***, researcher, [contact information]
Agency: Department of Sociology and Social Psychology*, Department of Public Health**, Department of Women’s Studies ***, 33014 University of Tampere

Research information sheets for parents (in Finnish)

Hyvät vanhemmat

Pyydämme Teitä osallistumaan tutkimukseen, jossa selvitetään perheenjäsenten ja ammattilaisen välistä vuorovaikutusta äitiys- ja lastenneuvoloissa. [Kaupungin nimi] kaupungin tutkimuslupatoimikunta on antanut tutkimuksesta myönteisen lausunnon. Kerätettyä tutkimusaineistoa käytetään tieteellisessä tutkimuksessa, jonka avulla pyritään mm. parantamaan vastaanottovuorovaikutuksen laatua potilasystävälliseen suuntaan.


Tutkimuksessa pyydämme lupaanne seuraaviin tutkimusosuiksiin (tarpeeton yliiviivataan):
- a) asiakastapaamisen nauhoittaminen
- b) haastattelun tai kyselyyn osallistuminen
- c) vuorovaikutuksen havainnointi neuvolan yleisissä tiloissa (esim. perhevalmennus)

Tutkijat eivät ole itse länä vastaanotoilla tai tiimikokouksissa.

Aineistoa (videonauhoitukset ja kyselylomakkeita) käsitellään seuraavasti:
1. Aineiston salassapito turvataan niin, että aineistoa käsittelevät allekirjoittavat vaihtolositoumuksen.
Dear maternity and child healthcare professional

We are requesting your consent to participate in a study on [name of the city] maternity healthcare in which a reform, family-centred MCH, is being implemented. The aim of the research is to map different working methods and practices of interaction both in traditional care and in the new model of work. We are interested also in the employees’ well-being and their own perceptions concerning these different working environments. The Committee of Research Permissions for Welfare and Health Institute of [name of the city] has given research permission for the study.

In the study, we request for consent to the following sub-studies (delete where necessary):

- a) video recording of client encounters
- b) video recording of multi-professional team meetings
- c) participation in an interview or questionnaire
- d) observation in public spaces at the clinic
Researchers will not be present at the appointments or the multi-professional team meetings. Families will be asked for their consent individually.

The material of the study (video recordings, questionnaires, interviews and observations) will be handled in the following manner:

1. Restricted access to the material will be secured, and everybody who handles the material will sign a discretion agreement.
2. The material will be converted to texts so that your name or information about your agency will not come out.
3. When reporting on the study all knowledge that might enable identification will be altered.
4. The material collected will be further used only for scientific research after the above-mentioned study is over.
5. The material will be stored for scientific research at the Department of Sociology and Social Psychology for 25 years after the research is conducted.
6. With my separate consent (see consent form) the material may be used for healthcare occupational and university education.

Participation in this study is voluntary. You have the right to withdraw consent at any time without an explanation and request that previously recorded material be destroyed.

If you have any questions or would like additional information we are glad to answer.

Researchers:
Doctor of Social Sciences Johanna Ruusuvuori*, docent, assistant professor, [contact information]
Doctor of Social Sciences Pirjo Lindfors**, researcher, [contact information]
Master of Social Science Riikka Homanen***, researcher, [contact information]
Agency: Department of Sociology and Social Psychology*, Department of Public Health**, Department of Women’s Studies ***, 33014 University of Tampere

Research information sheets for professional (in Finnish)

Hyvä neuvolatyön ammattilainen

Tutkimuksessa pyydämme lupaanne seuraaviin tutkimusosuuksiin (tarpeeton yliviivataan):

a) asiakastapaamisen nauhoittaminen
b) tiimityökokouksen nauhoittaminen
c) haastatteluun tai kyselyyn osallistuminen
d) vuorovaikutuksen havainnointi neuvolan yleissä tiloissa

Tutkijat eivät ole itse läsnä vastaanoitoilla tai tiimikokouksissa. Perheiltä pyydetään erillinen suostumus.

Tutkimuksen aineistoa (videoonauhoitukseen, kyselyitä, haastattelujen ja havainnointia) käsitellään seuraavasti:

1. Aineiston salassapito turvataan niin, että aineistoa käsittelevät allekirjoittavat vaitiolositoumuksen.
2. Aineisto muutetaan tekstiksi siten, etteivät nimeäni ja toimipaikkaani koskevat tiedot käy ilmi.
3. Tutkimusta raportoitaessa kaikki tunnistamisen mahdollistavat tiedot muutetaan.
4. Tutkimuksessa kerättyä aineistoa käytetään yllämainitun tutkimuksen päättymisenä vain tieteellisissä tutkimuksissa
5. Aineistoa säilytetään tieteellistä tutkimusta varten Tampereen yliopiston sosiologian ja sosiaalipsykologian laitoksessa 25 vuotta tutkimuksen päättymisen jälkeen
6. Erillisellä luvallani (ks. suostumuslomake) aineistoa voidaan käyttää terveydenhoitoenkilökunnan koulutuksessa sekä yliopistollisessa opetuksessa.

Tutkimukseen osallistuminen on vapaaehtoista. Siitä on oikeus kieltäytyä milloin tahansa syytä ilmoittamatta ja pyytää, että mahdollisesti jo nauhoitettu aineisto tuhotaan.

Mikäli Teillä on kysyttävää tai haluatte lisätietoja, vastaamme mielellämme.

Tutkijat:
YTT Johanna Ruusuvuori*, dosentti, yliassistentti, [yhteistiedot]
YTT Pirjo Lindfors**, tutkija, [yhteystiedot]
YTM Riikka Homanen***, tutkija, [yhteystiedot]
toimipaikat: Sosiologian ja sosiaalipsykologian laitos*, Terveystieteen laitos**, Naistutkimuksen laitos***, 33014 Tampereen yliopisto