Examining the social construction of surveillance: a critical issue for health visitors and public health nurses working with mothers and children

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Examining the social construction of surveillance: a critical issue for health visitors and public health nurses working with mothers and children

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Abstract

Aims and objectives: In this paper we will critically examine surveillance practices of health visitors (HV) in the UK and public health nurses (PHNs) in Canada.

Background: The practice and meaning of surveillance shifts and changes depending on the context and intent of relationships between mothers and HVs or PHNs.

Design: We present the context and practice of HVs in the UK and PHNs in Canada and provide a comprehensive literature review regarding surveillance of mothers within public health systems. We then present our critique of the meaning and practice of surveillance across different settings.

Methods: Concepts from Foucault and discourse analysis are used to critically examine and discuss the meaning of surveillance

Results: Surveillance is a complex concept that shifts meaning and is socially and institutionally constructed through relations of power

Conclusions: Health care providers need to understand the different meanings and practices associated with surveillance to effectively inform practice.

Relevance to clinical practice: Health care providers should be aware of how their positions of expert and privilege within health care systems affect relationships with mothers. A more comprehensive understanding of personal social and institutional aspects of surveillance will provide opportunities to reflect upon and change practices that are supportive of mothers and their families.

What does this paper contribute to the wider global clinical community?

- Health Visitors and Public Health Nurses work in a variety of global community settings where they care for mothers, newborns and children (MNC). Maternal health is a global health issue.
- Surveillance of mothers, newborns and children is a global health issue that is informed by health and medical discourses. Issues raised in our paper are transferable to communities around the world. We challenge all nurses to critique their own practices and understandings of surveillance through relations of power.

Keywords. Surveillance mothers health visitors public health nurses public health

Background and Aim(s)

Health Visitors (HVs) in the UK and Public Health Nurses (PHNs) in Canada work in the community with mothers and children from 0-5 years of age. Surveillance is an aspect of their work; however, what this means and how it is understood and constructed varies considerably. For example the term

surveillance might conjure up images of health care professionals checking on or monitoring various behaviours of mothers or it might refer to the collection of population health data regarding breastfeeding rates, cesarean sections or live births. In this paper we discuss how the meaning of surveillance is socially and institutionally constructed and how it shifts and changes depending on the context and personal experiences of HVs, PHNs and mothers. For example, screening mothers to determine how they are doing and whether they are coping well or are 'at risk' involves a type of assessment that measures mothers against particular criteria or normalized ways of parenting. While the intent is to help mothers we must also recognize that the relationship between nurses and mothers includes relations of power that are negotiated. The complexity of negotiations may include a variety of practices such as support, client centeredness, strengths based, or problem based assessments or judgments. The differences in understanding surveillance by HVs, PHNs and mothers may lead to misunderstandings and disagreements about what surveillance means and ultimately how it guides practice. Therefore, it is imperative that we critically discuss how practices of surveillance have been socially and institutionally constructed. The aim of this paper is to critically examine the practice of surveillance by HVs and PHNs using a lens of discourse analysis informed by Foucauldian concepts such as relations of power, governmentality, language and meaning.

Design and Method

Both authors have conducted research using Foucauldian methodology in the areas of maternal child health, surveillance, and the practice of HVs and PHNs who work with mothers. An extensive literature search was conducted using search terms such as HVs, PHNs, surveillance, child protection, monitoring, home visiting, and postpartum and includes articles over the past twenty years. Foucauldian concepts aligned with poststructuralism and discourse analysis (Foucault, 1979, 1982, 1984; XXXX, 2016; Cheek, Weedon, 1987) guide the discussion and offer a critique that raises questions pertaining to the understanding of surveillance and what it means for the practice of HVs and PHNs who work with mothers.

Health Visitors and Public Health Nurses in the UK and Canada

Health visitors and public health nurses have a long history of working in the community in the UK and Canada. In the UK health visitors work mainly with families with infants and young children (0-3yrs) providing a universal home visiting service oriented towards prevention, early intervention and support for parenting (Cowley *et al.* 2013). Health visitors deliver the national public health programme – known as the Healthy Child Programme (HCP) - support families with additional needs and play an important role in safeguarding and child protection (Public Health England 2016). In recent years the health visiting contribution to the public health of children and families has been strengthened and a new service model for health visiting developed.. This provides a clear framework for a progressive universal approach outlining different levels of health visiting service provision according to identified needs. 'Community' and 'universal' levels include community capacity building and delivery of the Healthy Child Programme while 'universal plus' and 'universal partnership plus' levels describe targeted provision to vulnerable families with additional and/or complex needs. In this way all families are offered a universal service and some will receive a targeted service according to identified need.. The framework also describes the pattern of universal contacts HVs have with children and families and the area in which health visiting work can make a significant contribution to improving outcomes for children, families and communities. These include transition to parenthood and the early weeks; maternal (perinatal) mental health; breastfeeding; healthy weight; managing minor illnesses and reducing accidents; health, wellbeing and development of child aged 2 years old, and support to be 'ready for school' (Public Health England 2016).

Similar to the UK, in Canada there is a significant focus on maternal newborn and child health both in the hospital and the community. Public health services and therefore PHNs offer a variety of programs and services for mothers, newborns and their families including home visiting (universal and targeted), phone consultations, parenting drop in centers, youth health centers in high schools and online information. Services may vary across the country as each province and local health authority develop programs differently; however the intent is the same to support mothers, babies and their families. Using the province of Nova Scotia in Canada as one example, PHNs are mandated to contact

all mothers postpartum either in the hospital before discharge or by phone or letter after discharge. This universal program is intended to connect with all mothers in the province to assess their level of health and need for health services (personal communication, Christine Hart 2016). During this time PHNs complete a screening tool with each mother to see if they qualify for the voluntary Enhanced Home Visiting program targeted for mothers 'at risk' (Healthy Beginnings Enhanced Home Visiting 2016). Home visits have historically been common practice often offered to all mothers postpartum across Canada. However fewer home visits are being offered and being replaced by drop in centres, phone calls and online information. Despite the differences and ongoing changes to programs and services the common denominators always include some form of screening support and information for mothers (Capital District Health Authority 2016). There are many other programs offered by public health and PHNs online and offline including preconception, prenatal, postnatal, early childhood, school programs ages 4-12 and 13-18, and sexual health (Healthy Development 2016)

Examining surveillance practices by HVs and PHNs

The work of HVs and PHNs has often been associated with different forms of surveillance. However, specific understandings and practices of surveillance continue to be debated depending on one's perspective. For UK health visiting the 'search for health needs' -undertaken at both the individual and community levels - has been an important concept underpinning theory and practice (Cowley & Frost 2006). XXXX (2002) has argued this has direct parallels with the Foucaldian concept of surveillance.

> *In other words health visiting combines both the surveillance of individual bodies with the surveillance of populations a set of practices that mirror Foucault's conceptualization of bio-power* (p. 375).

However whilst this concept implies surveillance in the professional literature it has not been considered in these terms.

XXXX (2002, 2008, 2015) has also used Foucault's concepts of power and surveillance in her research to analyze PHNs' practice with new mothers. For example, the majority of mothers across three different research studies expressed feeling nervous about the PHN coming to their home as they might be judged on their parenting abilities. This was seen to be associated with a negative surveillance discourse that had been socially constructed through the health care system of child protection services. PHNs had to balance positive support and safety of mother and baby. Although the majority of mothers were initially nervous they all felt relieved, reassured, supported and not judged once meeting the PHN, thus pointing to the complex and shifting meaning of surveillance. *"Although the intent may be to support the mother-infant relationship many mothers experience this expectation as a type of surveillance of their mothering abilities that may cause stress."* (XXXX 2008, p. 282).

Surveillance is a key element of public health work and in both the UK and Canada we can identify how this has become embedded in guidelines and frameworks underpinning health visiting and public health nursing. In the UK the regulatory body for nursing - the Nursing and Midwifery Council (NMC) - mapped the standards of proficiency for Specialist Community Public Health Nursing (the name for the health visiting qualification) to the principles of health visiting and of public health (NMC 2004). Maybe unsurprisingly 'the search for health needs' discussed earlier was mapped to the public health principle of 'Surveillance and assessment of the population's health and wellbeing'. Linked with this are 5 (out of the 24) standards of proficiency for SCPHN practice. These are; collect and structure data and information on the health and wellbeing and related needs of a defined population; analyse interpret and communicate data and information on the health and wellbeing and related needs of a defined population; develop and sustain relationships with groups and individuals with the aim of improving health and social wellbeing; identify individuals families and groups who are at risk and in need of further support; and undertake screening of individuals and populations and respond appropriately to findings (NMC 2004). Thus the regulatory body is making surveillance implicit within the standards for Specialist Community Public Health Nursing (health visiting) in the UK (NMC 2004).

Nursing organizations in Canada also incorporate guidelines for surveillance that are constructed to focus on identifying 'needs' of clients particularly those who are more 'vulnerable' or 'at risk' for poor health. The Community Health Nurses of Canada (CHNC) is a National organization that supports and offers guidance to the practice of community health nurses including PHNs. In their document Professional Practice Model and Standards of Practice (2011) Standard 2 focuses on prevention and health protection stating "Participates in surveillance activities; analyzes and utilizes this data to identify and address health issues within a population or community." The focus is broad and while interpretation is open there tends to be a leaning towards collecting epidemiological and population data. "Applies epidemiological principles for planning strategies such as screening surveillance immunization communicable disease response and outbreak management and education" (p12).

The Public Health Agency of Canada is another organization that provides guidance for health care professionals. In collaboration with CHNC they developed the document Public Health – Community Health Nursing Practice in Canada Roles and Activities (2010) in which there is extensive mention of surveillance. It deals with the roles activities and core competencies of nurses whose main focus is "health promotion health protection disease and injury prevention health surveillance population health assessment as well as emergency preparedness and response" (p.8) regardless of the settings in which they work. PHNs are to participate in the collection of data and application of "epidemiological principles and knowledge of the disease process so as to manage and control communicable diseases using prevention techniques infection control behaviour change counselling outbreak management surveillance immunization episodic care health education and case management" (p17) as well as "eco-social surveillance that focuses on broad multi-level conditions that contribute to health inequalities" (p 18). Central to these constructions of surveillance in public health work is the collection and use of data about an individual –and thus a population's- health and wellbeing. This involves formal practices such as screening and assessment and the wider collection of health measures/indicators. In the following section we will outline the HV and PHN role in relation to screening and assessment.

Screening and assessment tools as surveillance in the UK and Canada

In both the UK and Canada public health nurses and health visitors use screening and assessment tools in their work with mothers and children. For example the Parkyn Screening tool is used in Nova Scotia during the first few months postpartum (Baby Stories 2013). It is a comprehensive screening tool that includes physical, social, emotional, environmental, cultural and psychological aspects of a woman's postpartum situation to see if they are eligible for an enhanced home visiting program which some may refer to as a targeted program for 'at risk' mothers. In the UK health visitors undertake screening for post-natal depression employing particular tools such as the Edinburgh Post-Natal Depression Scale (Cox *et al.* 1987) to identify women at risk or displaying symptoms; these are used to guide referrals to additional services or plan interventions such as 'listening visits' (Morrell *et al.* 2011).

Of particular relevance to our debate about surveillance is the recent introduction in England of the Ages and Stages Questionnaire (ASQ) which is being used by HVs with parents at the 2yr -2 and half year review. Whilst this forms part of the overall assessment of their child's health and development the ASQ also has a wider public health function as data from it - collected individually - is recorded on e-systems and reported in data sets submitted regularly to Department of Health (Department of Health 2015). In this way the ASQ also serves as a population measure of the health of children aged 2 years (Kendall *et al.* 2014). Bedford *et al.* (2013) in a review of approaches to assessing the development of children aged 2 years did acknowledge tensions when tools are used both individually with parents and as population measures but further critical debate is not evident. The collection of data about the population in order to inform local and national health improvement is certainly a key feature of UK public health policy epitomized by the Public Health Outcomes Framework (Department of Health 2016). This was introduced to monitor population health and the performance of local health bodies and outlines a number of key indicators which health providers are required to regularly report upon. Those directly relevant to health visiting include reducing infant mortality, low birth weight, smoking at delivery, dental decay in children aged 5, improving breastfeeding initiation and duration, child development at 2-2.5 years population vaccination coverage and school readiness.

No specific outcomes relate to mothers postpartum although many indicators relate to overall adult health such as diet, activity levels and smoking.

In order to measure the health of the Canadian maternal and newborn population the Canadian Perinatal Surveillance System (CPSS) published a report of perinatal health indicators (2013) that included maternal smoking, alcohol consumption, rate of breastfeeding, live births, rate of caesareans, morbidity, preterm rates, postterm rates, large for gestation, small for gestation, fetal and infant mortality rates, congenital anomalies and multiple birth rates. We can see that the indicators are physical and primarily focus on the health of the fetus and infant and are in line with a more traditional statistical epidemiological discourse.

In this section we have presented an overview of how screening and assessment tools are used to support mothers, children and their families at both individual and population levels. Ultimately the intent is to ensure mothers and families receive appropriate services from HVs and PHNs. We will now turn to a discussion of how Foucauldian concepts of surveillance can be used to make sense of HV/PHN work with mothers and families.

Examining competing surveillance discourses

In 2002 XXXX published an article about surveillance focusing on disciplinary power and health visiting in the UK (XXXX 2002). This followed a theme developed by sociologists, historians and feminists writing several decades earlier which had discussed health visiting in terms of surveillance (Davies 1988, Dingwall & Eekelaar 1988, Abbott & Sapsford 1990, Bloor & McIntosh 1990). Much of this debate drew upon historical analyses of the development of the profession in the late 19th century when a combination of social, legal and political developments had created the space and opportunity for a state sponsored public health profession to emerge. Early health visiting was concerned with improving infant and maternal health and was undertaken largely by women who visited mothers at home. Davies (1988) uses the term ‘mother’s friend’ to describe how this relationship was constructed, arguing that the apparent informality that underpins this disguised the

type of activity that was taking place. As Davies (1988) pointed out this unique access to homes which was a key feature of early health visiting – and continues to be so today (Cowley *et al.* 2013) – enables a form of state surveillance of families with babies and young children. Dingwall and Eekelaar (1988, p. 353) suggest that reliance upon informality and friendship means this activity does not provoke resistance as '...families with no guilty secrets had no motive for refusing surveillance'. These analyses were particularly concerned with governmentality (Foucault 1979) – looking at how the state through the use of professionals interacts with, monitors and shapes the health and welfare of the population- particularly families with young children. Drawing upon the findings of an empirical study, Bloor and McIntosh (1990) developed the theme of surveillance further using a Foucaldian analysis to examine the power relations between mothers and health visitors (Foucault 1979, 1984). They argued that mothers undertook a range of forms of resistance to health visiting as ".... a reaction to the perceived social control function of health visiting" (Bloor & McIntosh 1990, p. 169-170). This included women challenging the legitimacy of health visiting claims to professional expertise regarding mothering which they considered a lay skill. Other examples included non-compliance with health visiting advice, avoidance of health visiting and concealing from the health visitor practices such as early weaning. As they argue

> '*The professional-client relationship is always a power relationship and even in the process of professional-client contest the two parties are locked into a disciplinary relationship'*
> (Bloor & McIntosh 1990, p. 180).

XXXX (2002) drew upon this wider body of work to further discuss surveillance in health visiting. In a study of health visiting work with mothers experiencing domestic violence XXXX (2002) argues that the techniques used by health visitors to find out about the families they are visiting - such as asking questions, talking and listening – can be understood as part of the exercise of disciplinary power developed by Foucault (1979, 1984). This paper also identified how mothers were engaged in these disciplinary practices discursively producing themselves as good mothers, subjects and objects of the health visiting gaze and also resisting health visiting work. This analysis highlighted how health

visiting work underpinned by the notion of 'health visitor as mother's friend' (Davies 1988) involves both supporting and policing mothers. As XXXX (2002, p. 375) has argued

> *Disciplinary power implied by the double-bind of welfare and surveillance suggests that the relationship between mothers and health visitors is complex. Understanding the policing role of health visiting alongside their supportive role draws attention to the exercise of power and the discourses that produce health visitors and mothers. This …. problematizes the notion that health visitors' relationships with mothers are simple and straightforward* (XXXX 2002, p. 375).

The context for this study is relevant as at the time domestic violence was marked both by its private nature and a prevailing professional silence. As XXXX (2002) acknowledged these may have provided opportunities for both surveillance and resistance thus enabling the disciplinary practices of policing and support to be clearly illuminated.

During the same time period that XXXX conducted her research, XXXX (2002) was also conducting research that examined the relations of power between PHNs and mothers in postpartum support groups. She found that PHNs consistently attempted to shift the relations of power to move from an expert 'top down' relationship to be more supportive and focus on mothers' expertise. This was a challenge as the majority of mothers continued to defer to the PHNs' expertise. Clearly communication between PHNs and mothers was regulated due to the medical system in which they were operating. *"These public health nurses and new mothers acknowledged in different ways and at different times that the public health nurse was a particular kind of expert one who controlled information exchange that was rooted in particular investments in medical discourse."* (XXXX 2002, p291).

Clearly the ways in which surveillance is understood and implemented raises a variety of conflicts, concerns and different interpretations. Since XXXX's and XXXX's papers were published over more than a decade ago there has been little critical debate about the meaning and practice of surveillance within health visiting or public health nursing globally. This was confirmed by Cowley *et al.* (2013, p. 157) who in a recent detailed literature review of health visiting suggested there had been little

subsequent professional curiosity or analysis along these lines. This may reflect a reluctance to engage with sociologically orientated analyses and consider professional roles in terms of power or social control (Abbott & Sapsford 1990, Bradbury-Jones *et al.* 2008). As Davies and Allen (2007) pointed out '*analysis of nursing work in terms of its social control functions has not sat easily with the profession's self-image: nurses appear more comfortable with formulating their roles in altruistic terms drawing on concepts such as caring and patient empowerment'* (Davies & Allen 2007, p. 366). Although Davies and Allen (2007) were referring to nursing more generally their argument is very evident in relation to the professional literature on British health visiting where a key concern has been emphasizing support, empowerment and partnership as important elements of the professional-client relationship (Cowley *et al.* 2013). These pieces have largely adopted a normative rather than a critical analysis of professional-client relationships with little consideration or understanding of power whether structural or post-structural (Bradbury-Jones *et al.* 2008).

A normative perspective upon professional-client relationships is also evident in some reporting of parental perspectives of the health visiting service. Machen (1996) for example draws upon a set of binary assumptions to argue that a high degree of satisfaction with health visiting reported by many of the mothers in her study refutes the possibility that health visiting practice is also concerned with surveillance. More recent work examining parental perspectives of the health visiting service has identified both positive and negative views. Parents who took part in the study conducted by Donetto and colleagues (2013) expressed largely positive views of the health visiting service although for some difficult professional-client relationships and tensions linked to home visiting were mediated by the access of other members of the team at additional services such as clinics or children's centres. A small study of parental views of child health surveillance services found more mixed views about health visitors; some participants identified positive experiences but many reported feeling judged or not receiving an adequate service because of perceived socio-economic advantages (Roche *et al.* 2005).

There is surprisingly little critical analysis or debate about health visitor's work with families in the contemporary literature. It is evident in the recently published work of King (2016) who in a paper reporting findings from a qualitative study of health visiting work conducted in Scotland draws upon health visitors' accounts of their observations and relationships-work. The paper addresses professional assessment and judgement particularly in relation to risk and provides useful insights into how health visitors 'get to know' the clients and families they are visiting. King (2016) identifies the processes whereby health visitors' everyday observations of homes, family relationships and routines as well as their embodied observations, relationships with clients and rapports that they establish, feed into and influence the assessment process.

In contrast to the professional literature, XXXX's (2002) paper about surveillance in health visiting did receive some critical attention in the social work and socio-legal arenas. Ferguson (2012) for example discusses how the contemporary emphasis on parenting has been translated in professional practice into a focus upon mothering and mothers; those who stray from idealized notions of mothering are policed by public services (Broadhurst & Mason 2013). We pick up some of these arguments in relation to mothering after a discussion of power and discourse analysis.

Relations of power and discourse analysis

Both authors XXXXXXXXX have used the concepts of relations of power, language, meaning, subjectivity, agency and discourse analysis informed by Foucault, Weedon and other authors to understand the practices of HVs/PHNs with mothers. We argue that it is imperative to understand the complexities of meaning and experience that is personally socially and institutionally constructed. Thus far we have provided evidence that the work of HVs/PHNs incorporates a variety of surveillance methods that are guided by their personal interactions with mothers. These practices might include assessing, screening, working with, supporting, advocating or providing advice/information to mothers. Practices are also influenced by institutional public health mandates. In all cases surveillance involves some level of power that is negotiated by people within certain contexts. In order to understand how power works we begin with an overview of Foucault's (1982) writings about how

relations of power are regulated through different forms of communication. Power is not an entity, it is a relation in which one action may influence the action of others and can only exist when it is put into action. Power is contextual and cannot be understood as a simple binary confrontation between two people. People place meaning on their interactions and thus power can be experienced and understood in different ways. Foucault writes "*what defines a relationship of power is that it is a mode of action which does not act directly and immediately on others. Instead it acts upon their actions: an action upon an action on existing actions or on those which may arise in the present or the future*." (1982, p. 789). Foucault believed that a binary opposite was a problematic construct that had the potential to lock people into narrow understandings of power and control. Instead it was important to critically analyze binary opposites and look at the complexities, nuances and negotiations that took place between people in order to understand not only their specific circumstance and feelings but also the larger social and institutional discourses that informed their beliefs and practices. He suggests that we need to question "the way in which knowledge circulates and functions [and] its relations to power" (781). "The main objective of these struggles is to attack not so much 'such and such' an institution of power or group or elite or class but rather a technique a form of power." (781).

Weedon builds on Foucault's ideas as she describes how discourses and relations of power operate. "Social structures and processes are organized through institutions and practices such as the law the political system the church the family the education system and the media each of which is located in and structured by a particular discursive field" (Weedon 1987, p. 35). She also writes that discourses can govern one's unconscious and conscious minds and emotions through relations of power and "…plays an important role in determining the individual's role as social agent" (Weedon 1987, p. 79)

When situating the practice of surveillance within different discourses it is important to examine how language is used. Foucault and Weedon challenge the notion of fixed definitions and universal truths.

> *...this common sense articulated in language represents quite specific values and interests.... It is the medium through which already fixed "truths" about the world society and individuals are expressed.... These meanings which inevitably favour the interests of particular social groups become fixed and widely accepted as true irrespective of sectional interests. All*

> *common sense relies on a naive view of language as transparent and true...* (Weedon 1987, p. 76-77).

Foucault and Weedon write that discourse analysis and relations of power can be used to enable us to see how language changes depending on the setting or context. Subjectivity or a person's subject position can be understood as relational and changes depending on who they are with and where they are. For example a woman could be a mother, teacher, daughter, nurse etc. and thus relate differently depending on who she is with. Subsequently the meaning of surveillance can also change depending on a person's experience. Scott (1992) and Butler (1992) say we need to examine both normative and different practices in a way that will allow us to understand "inner workings or logics" (Scott 1992, p. 25) and how they are relationally constituted.

The social construction of mothering and surveillance

In this section we will critically discuss the ways in which mothering and surveillance have been socially constructed using concepts from Foucault (1982) discussed above that provide an understanding of how relations of power position mothers, HVs/PHNs and surveillance practices in particular ways. Specifically we will look at how individual, social and institutional beliefs and practices about surveillance have been constructed through different discourses and negotiations of power.

Mothering and motherhood is a site of critical debate and an extensive sociological and feminist literature is evident. Of interest here are analyses which demonstrate how mothering is constructed and scrutinized through institutional discourses and practices (see for example Lupton 2011). Notions of 'good' and 'bad' mothers impact upon women's experiences and importantly how they are perceived by public services including health visiting/public health nursing (Abbott and Sapsford 1990, Lupton 2011, Broadhurst & Mason 2013). An example of this is provided by Lupton (2011) who in an Australian study which interviewed 60 mothers illustrates how pregnant women lie at the centre of a web of expert and lay discourses concerning the ways they should promote and protect the

health and development of their unborn babies and infants. One example of this is breastfeeding. In their research study Andrews and Knaak (2013) found that breastfeeding continued to be constructed through institutional practices leading to the medicalization of breastfeeding. They interviewed 33 Canadian mothers and 27 Norwegian mothers about infant feeding decisions and experiences and found that broader cultural pressures including competition, judgement and surveillance regarding breastfeeding, continued to influence mothering practices.

Romagnoli and Wall (2012) conducted research to examine the experiences of low-income mothers enrolled in an intensive mothering program. They found that the intensive parenting advice was prescriptive and regulative. They describe neo-liberal notions of individual responsibility and risk management as being problematic that portrayed parents as 'risk factors'. However they also found that the mothers resisted some of the advice and challenged prescriptive parenting. This demonstrates how certain discourses that have been institutionally and socially constructed continue to influence the practices of maternal support by health care providers and how mothers negotiate the relations of power.

In a Swedish study of public health nurses working with children and families, Baggens (2002) questions the extent to which these nurses are practicing in a manner which empowers parents. Drawing upon evidence from professional-client interactions Baggens (2002) argues that these nurses frequently offered advice rather than acting in an empowering way in partnership with parents. This was due to their self-evident authority – and expertise- that gave them control over the encounter. As she argues

> '*what the nurse says and does within the framework of child healthcare lends legitimacy to that which is regarded as socially valuable and worth striving for'* (Baggens 2002, p. 361).

This reinforces prevailing discourses about idealized parenting.

Currently in the UK neuroscientific discourses are particularly prominent and impacting upon policy and health visiting practice. Here we can see a body of knowledge about early brain development being translated into a more general concern with early intervention in the early years focused upon

supporting attachment and parent-child relationships. The first 1001 days agenda -from conception to 2years – has become a powerful policy mantra in the UK and has led to an intensification of scrutiny of parenting and parenting practices (Lowe et al. 2015) much of which is being carried out by health visitors (Public Health England 2016). This may be an example of what Abbott and Sapsford (1990) described a number of years ago when they argued that health visitors

> *'.... are not themselves aware of the ways in which they police the family: they accept as "truth" the discourses that inform their practice and therefore fail to recognise the ways in which they are used to shape the behaviour of their clients' (Abbott & Sapsford 1990, p. 148).*

DeSouza (2013) writes about the need for maternal child and family health nurses to examine how mothers have been historically and socially produced. She argues that the unrealistic 'good mother' myth continues to be perpetuated and that nurses can no longer be complicit in supporting the status quo that regulates normal mothering practices and blames mothers. She discusses how individual empowerment of individuals is not enough as it is too narrow a focus and does not interrogate how mothering continues to be institutionally regulated.

In a qualitative study which examined mental illness and motherhood Davies and Allen (2007) use a Foucaldian analytical framework to discuss disciplinary power and surveillance in health care. These authors were particularly interested in the social control function of healthcare activity and argue that it can be used positively to empower and support patients rather than just to control them. This is illustrated with reference to the experiences of women who are mothers and who have mental health problems. They argue that

> '*health visitors need to be aware how crucial their role is in the early detection and treatment of mental illness in mothers of pre-school children. By helping women realise that the role of mother is compatible with that of having a mental illness they are using their disciplinary power in a most beneficial way* (Davies & Allen 2007, p. 374-5).

Women drug users who are mothers of children under 5 years of age are the focus of the Australian study reported by Harvey and colleagues (2012). They examine how specialist and community and family health nurses successfully engage and provide support services to this client group. The authors argue that for women who are mothers of young children and also drug users having contact with nurses during home visits and attendance at child health clinics has the potential to cause anxiety and

> *'a guarded response …. if trust hasn't been established and the role of the nurse is thought to be one of 'surveillance' (and its unknown implications) rather than one of support'* (Harvey *et al.* 2012, p. 2534).

They go on to argue

> *'The meaning of surveillance varies according to the context where it is being used and in this instance includes assessment of risk to an infant. …. The effect of interpreting surveillance as merely observation and monitoring belies the underlying mandatory reporting and child protection role required of health professionals* (Harvey *et al.* 2012, p. 2534).

This illustrates the need for HVs and PHNs to recognize and negotiate the ways that their role in surveillance is experienced by mothers. It may also suggest that surveillance is more tangible in situations involving high-risk adults and children such as potential child abuse or domestic abuse (XXXX 2002, Harvey *et al.* 2012) rather than when working with low-risk mothers and children which as explained earlier may more easily lend themselves to a normative rather than a critical lens.

XXXX *et al.* (2014, 2016) examined the importance of relationships and how PHNs attempted to shift practices of surveillance and the hierarchies of health outcomes. While mothers expressed feeling a bit nervous before meeting the PHNs and worried about being judged, they also expressed great relief after meeting the PHNs and said that the PHNs helped them to feel confident, normal and to have more self-esteem, sometimes after only one visit. Although health indicators such as breastfeeding and physical well-being were often the primary reasons for the visits, both the mothers and PHNs

discussed the importance of feelings such as confidence and how this greatly impacted their abilities to care for their babies. This type of surveillance by PHNs includes physical, emotional, psychological, social and cultural aspects of health through relations of trust, empowerment, kindness, and feelings of relief. XXXX (2014, 2016) and Meagher-Stewart *et al.* (2009) agree with others and offer the term socio ecological surveillance to attempt to capture this comprehensive style of surveillance. This will be discussed in the next section.

Surveillance discourses and negotiating power

Socio ecological surveillance is a newer term that many nurses and health care practitioners are attempting to incorporate into practice; it focuses on relations between health care providers and clients. Meagher-Stewart *et al.* (2009) have argued that the practice of PHNs has incorporated socio ecological surveillance for decades; however because it was not specifically named and documented it had not been constructed as surveillance. For these authors socio ecological surveillance incorporates a focus on support and strengths based interventions and they argue that the everyday practices of PHNs such as building collaborative, supporting, trusting relationships and conducting comprehensive assessments are all part of socio ecological surveillance.. Mildon and colleagues (2010) agreed with Meagher-Stewart *et al.* that although it had not yet been fully incorporated into practice there had been increased attention to the surveillance work of PHNs particularly with the emergence of socio ecological surveillance and what it meant in practice. A socio ecological surveillance discourse incorporates strengths based language and practices such as being present with mothers and engaging in building trusting relationships that lead to supporting mothers' strengths and ideas (Cowley *et al.* 2013, XXXX 2014, Hartrick Doane and Varcoe 2015).

Meagher Stewart et al (2013) have argued that the socio ecological surveillance discourse is an attempt to make the softer friendlier practices of surveillance more visible. The construction of HV/PHNs as 'friendly visitors' although a necessary part of practice when supporting mothers and children is not in itself straightforward though (Davies 1988, XXXX 2002, Davies & Allen 2007). The representation of HVs and PHNs through terms such as nice, caring, friendly, positive and

calming (XXXX 2016) has both positive and negative aspects. While being 'friendly' or 'caring' are important practices they are also often socially and institutionally positioned as 'less important' than being 'professional'. While some may argue that all roles should be included, friendly and caring are predominantly positioned in a binary relation against professional. This creates a type of tension in the practices of HVs and PHNs who continue to balance the various roles that they know are crucial to their work with mothers and children. As previously discussed in the paper HVs could use their position as a friendly visitor to gain access into the homes of mothers in order to ensure they could monitor and survey mothers. This practice continues today with a balance between positive and negative images of health care professionals.

The meaning of surveillance shifts between these different discourses. HVs and PHNs talk about being friendly and caring as they recognize the socially and institutionally constructed negative image of a health care professional who 'surveys' mothers and families for the purposes of more punitive monitoring (XXXX 2015). Perhaps we can interpret this as a type of challenge or resistance to the image of negative surveillance. In order to gain trust and support, HV/PHNs know they need to begin with positive support so that they can establish a relationship whereby mothers will feel comfortable sharing their experiences. This could be understood as attempting to shift how surveillance is constructed to a more socio ecological focus (Meagher *et al.* 2009). It is illustrated in the research reported by Shepherd (2011) who examined the home visiting practices of child and family health nurses in Australia. Her study focused upon the ways that these nurses gained trust in their work with mothers and how this was used to go beyond a surface interest in the health and development of the child in order to address women's emotional health and wellbeing. In New Zealand Wilson (2001) also used a Foucauldian approach to examine the surveillance discourses of Plunket child health nurses when visiting with new mothers in their homes. These nurses practiced child health surveillance that included routine and unproblematic practices. The results of the study challenged the beliefs and practices of the partnership model claiming that power was not uniform but rather it was contextual. The relationship was not seen to be a partnership. Instead the relationship was seen to be dynamic and precarious where mothers had control.

Murphy (2003) wrote about how "the state's attempts to influence mothers' feeding practices operate largely through education and persuasion" (p. 433). This type of surveillance although starting from the perspective of health care professionals shifts to that of self-monitoring. However Murphy goes on to write about how mothers challenge and subvert the oppressive gaze of government and the health care system as they become experts in their own feeding practices with their babies. Foucault's concept of relations of power provided a lens to uncover the practices of mothers who challenge and resist conforming to medical advice that does not make sense to them. Greenway *et al.* (2008) wrote about the shifting practice of health visitors. These authors used Foucauldian concepts of discourse and knowledge to demonstrate how the government was attempting to shift the work of health visitors away from building supportive relationships with mothers and towards working with teams and focusing on health outcomes. The notion of governmentality can be seen to have potential impact on how surveillance is organized. In this case it appears that the more relational and process ways of connecting with mothers would be replaced with an outcomes model of surveillance.

The authors above have offered a variety of examples about the complexities of the surveillance of mothers. Both the variations and similarities are meant to provide evidence of how surveillance is socially and institutionally constructed in different ways. With this knowledge we can then continue to question the practice of surveillance with the intent of understanding how or if it aligns with health care practices and support for mothers in different contexts. We suggest that there is no 'right' way to practice surveillance; however we would recommend that as health care providers and in this case HVs and PHNs we need to continually question how we are practicing and challenging everyday practices to ensure we are not abusing relations of power but instead shifting relations to be empowering for mothers.

One of the key messages arising from our discussion is that practitioners, by better understanding how their role can be experienced by mothers, can thus become more aware of their own practices of surveillance. Often they present themselves as friendly and supportive and do not conceptualise their role in terms of surveillance or control. Understanding their role to be more than just a friendly visitor may enable them to develop a greater sensitivity to how they exercise their professional power in

developing relationships with clients. This requires a reflective stance- and occasionally viewing their work through a critical rather than a normative lens. Doing this will enable HVs and PHNs to practice surveillance whilst also being cognisant of the need to do this in a non-dominating manner.

Surveillance is also a practice with ethical implications. Public health work as a whole is undertaken in order to benefit the population and society as a whole. An example of balancing individual freedoms with the need to achieve the greater good for the population can be illustrated by public health measures such as banning smoking in public places and adding fluoride to the public water supply in order to protect childrens' oral health. But the ethical aspects of the public health work undertaken by PHNs and HVs are on the whole much less visible. Examples of searching for health needs such as post-natal depression, domestic abuse and child maltreatment – which may have remained hidden or unacknowledged without the input of a PHN/HV - demonstrate the value of surveillance and case finding in order to support population health. This is because such conditions impact upon both mothers and babies/children and if left undetected incur greater long term health, fiscal and societal costs. Other examples provided by XXXX (2002) suggest a more nuanced and questionable ethical picture in relation to surveillance undertakn by PHN/HVs.

Conclusions and Relevance to Clinical Practice

In this paper we have critically examined the HVs and PHNs surveillance literature that demonstrates how the embedded practices of surveillance by HVs and PHNs are socially and institutionally constructed through complex diverse binary and overlapping discourses. Applying a Foucauldian lens enables one to see how relations of power create particular interactions between mothers and HVs or PHNs. These interactions guide the type of support and care that mothers receive – all framed within a surveillance lens. Our critique of the literature focused on HVs and PHNs but our findings can also be transferable to the practice of social work and other health care professionals. Surveillance is complex, contested and shifting – and as this paper has demonstrated is experienced in different ways. As we have illustrated mothers often feel surveyed- but on the whole this has not been recognized or acknowledged by HVs/PHNs as part of what they are doing. This paper aimed to open dialogue about

surveillance which as we have argued is an implicit and embedded part of the PHN/HV role; we have made this work visible and have contributed theoretically to how this can be understood.

Underpinning our arguments is an acknowledgement of the different 'ways of knowing' that are employed in public health. These include ‘knowing’ the population in a scientific instrumental sense -best signified by epidemiology and the collection of routine data about health indicators. In contrast, 'knowing’ the population at an individual level is a more inter-personal approach and central to much of the individual work undertaken by HVs and PHNs. We have also demonstrated the different ways that 'surveillance' is constructed in the wider research literature drawing upon both the positivist empiricism that underpins epidemiology and the sociological analyses that underpin much research in this area. These different approaches and understandings about ‘ways of knowing’ in public health also create different avenues for research and scholarship in this area and thus different windows upon practice. So what we know about practice and indeed how we talk about practice is also shaped by the patterns of knowledge generation employed by our profession. As academics this puts us too in positions of power shaping discourses about our practice and we are of course aware of this.

Surveillance is part of PH and HV work; it is complex shifting and experienced differently by clients and professsionals.. Whilst some aspects of surveillance may be more instrumental than others ALL professional-client interactions are power relationships and surveillance is part of this. There has been little critical debate about the meaning and practice of surveillance within health visiting or public health nursing globally (Cowley *et al.* 2013) and in this paper we have attempted to theorize and make this work visible.

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