

6 Institutional ethnography and feminist studies of technoscience: the politics of observing Nordic care¹

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Introduction

This chapter is about doing politics in theory. Specifically, it is about how and what institutional ethnography (IE) and feminist studies of technoscience (FT) allow us to observe. I ask how one might conduct studies that explore normativity, not only in the researcher-author-subject relationship but also in the subject matter (cf. Mol and Mesman 1996). What kinds of (observed) realities might be viewed as politically acceptable?

I tackle these questions by combining IE as theorised by Dorothy E. Smith (1987, 2005) with FT as theorised by Donna Haraway (1996, 1997) and Annemarie Mol (2002, 2008a, 2008b) in an effort to discuss how the support provided by public Nordic maternity healthcare can be viewed as both controlling and enabling motherhood. I show that combining IE with certain insights from FT – which draws on science and technology studies, feminist research and actor-network theory – offers a better grasp on why the subject of care, in the context of Nordic (maternity health) care services, cannot and ought not to be reduced to a disciplined product of idealised governmentality.

The Nordic welfare service model is simultaneously criticised as a mechanism of authoritarian control and admired as a guarantee of social support, care and equality (Homanen 2017a, 2017b; Nätkin 2006; Sulkunen 2009). In my study of maternal-foetal relations in maternity healthcare practices, I was interested in both these aspects (Homanen 2017a, 2017b). My theoretical and methodological starting point was IE, an excellent tool for explicating the institutional power relations enacted in nurses' work. However, IE does not provide many tools to look at the 'goodness' of Nordic care and its inherent (political) ontology of care: the social equality and support that provide people with agency. Care often both exceeds and collides with the logics of governance and valuation. To explore the 'goodness' of care I therefore employed an alternative ontology that was situational and unstable but allowed room for agency, and for subjects of institutional value beyond the dominant symbolic.

The politics inherent in IE and FT are widely applied by social scientists and feminist researchers studying institutions and/or science, technology and medicine. Drawing on ethnographic material including observations, video-recordings, interviews and documents from four maternity healthcare clinics in Finland,² this chapter demonstrates how IE and FT can be combined in a hybrid text in which the theoretical repertoires coexist, although not (always) simultaneously. I conceptualise IE and FT as two modes of ordering in the form of theoretical repertoires that relate to each other in many ways but cannot, and need not, be neatly synthesised or conflated if one wishes to apply them both. In my analyses there are simultaneous narratives from both orderings that are ultimately coordinated: they hang together, but not as one. As I show, irreducible differences in ontological commitments boil down to the (in)coherence of institutional agency and power: the political orders observed, and the alternatives arrived at, are different in nature. Before explicating this in more detail, I briefly introduce maternity healthcare in Finland.

Maternity healthcare in Finland

In Finland, maternity healthcare services are provided by public health nurses rather than doctors. The service is located in primary healthcare maternity clinics, rather than in hospitals. Pregnant women meet their appointed nurse approximately 10–13 times. The care is state-funded and offered by municipalities free of charge. It involves advice on matters such as healthy lifestyles and preparing for birth, and the monitoring of somatic changes experienced by the pregnant woman and baby-to-be. Attention is increasingly also paid to the psychological and home environment by encouraging future parents to consider parenting issues (e.g. Handbook of Maternity Healthcare 2007).³ In addition to meeting pregnant women and their partners individually, nurses also give counselling classes for groups of parents-to-be, and they work in teams with other social care and child healthcare professionals. These teams meet regularly to assess and resolve families' problems.

Finland is different from many other Western countries, which offer more technologically oriented medical care provided by doctors (Benoit et al. 2005, 727–729). While researchers and activists elsewhere have identified the medicalisation of maternity healthcare as key to the history of care for pregnant women (Martin 1987; Oakley 1984), this pattern is not fully applicable to Finland (Kuronen 1999). Sweden and Denmark have similar systems: in Sweden, nurse-midwives

provide antenatal care, while in Denmark it is nurses. In Norway, while general practitioners are responsible for care most women visit midwives/nurses.

Nurse-midwifery-centredness in maternity healthcare is not an exclusively Nordic phenomenon. For example, in the Netherlands and the UK care is provided by midwives and involves elements of demedicalisation, such as social support. It is not only in Nordic societies that nurses in maternity care offer a more personalised counterbalance to the medical profession, whether as performers of emotional labour, mediators between discourses of normality and risk, or intuitive and practice-oriented decision makers. However, I was empirically studying parental support in the practical context of its provision, not assuming it. 'Nordic-ness' was thus understood as produced in moment-to-moment everyday practices.

Historically, Finnish maternity healthcare has been a key institution for incorporating women into the nation to fulfil their responsibilities as mother-citizens in the name of pronatalism. All pregnant women have borne responsibility for attending healthcare institutions since the end of the 1940s, when maternity benefit was made conditional upon such attendance. In the early decades of organised maternity healthcare, motherhood was protected under a pronatalist population policy. The 1970s marked a turning point for the protection of motherhood, part of a more general shift in governance as an effect of cultural individualisation (Homanen 2017a; Sulkunen 2009). Welfare policy shed its pronatalist elements and placed a more gender-neutral and individual emphasis on parenthood. In this new model of the family, both parents participate in care (including maternity healthcare), and they procreate by choice rather than by obligation to the nation (Benoit et al. 2005, 728; Nätkin 2006). Despite the emerging emphasis on individual preferences, and even a tone of empowerment, attending maternity healthcare remains obligatory: women are required to visit a nurse or doctor before the 16th week of pregnancy in order to qualify for maternity benefit.

It is against this historical background that the particularities of Finnish care practices are realised as a subjectification into motherhood. I now move on to discuss the politics of exploring these practices through IE and FT.

From foetus to baby

IE is explicit about its politics. It usually takes people's subjugated experience-based knowledge as its methodological starting point (Smith 1987, 78–88, 2005, 7–25). The overall aim of IE is to explore social power relations as they organise the everyday practice of institutional work. IE research looks at how (unequal) power relations are realised in institutions, and it seeks their institutional 'function' or purpose. At the end of the research process, IE gives voice to experience-based knowledge that more often than not has been silenced by abstract, institutional, privileged representations and interpretations of things and actions (Smith 2005, 50, 62, 66). This is a profoundly political process, since many forms of social control rest on the erasure of various institutional actors, 'deleting their work from representations of the work' (Leigh Star 1991, 267).

To map out the ways in which institutional power relations operate in practice, the institutional ethnographer cumulatively orients herself to the other's interests, positions and knowledges, which transform, often unpredictably, across time and place (Homanen 2013; Smith 2005, 135). IE always avoids objectifying descriptions of peoples' lives. It does not produce nominalisations out of the commonalities found in participants' accounts or seen in observations, but rather puts them to test (Smith 1987, 135–142; 2005, 187–190).

At maternity clinics, I explored how the unborn foetus was allocated a place in the parents-to-be's mental images, households and kin relations. I asked the maternity nurses how they discussed the foetus during appointments with pregnant women, and whether their way of talking changed according to time and place. Many nurses reported that they purposely refrained from personalising the foetus during the early stages of pregnancy. This was a way to manage anxieties about screening results or miscarriage during early gestation. By talking about 'foetuses' and not 'babies', and focussing on the technical-medical aspects and 'facts' of screening technologies, nurses distanced pregnant women from the foetus on an emotional level. They told me that during later pregnancy they behaved differently, as that was the proper time to counsel parents-to-be about the transition to parenthood (see also e.g. Handbook of Maternity Healthcare 2007).

This temporal logic for enacting parental relations and the foetus was not entirely coherent, however. I noticed from my appointment video-recordings that even during the first appointment,

nurses might talk about 'babies'. These babies were enacted with personal characteristics, identity and kin relations. For example, the ultrasound scan was promoted as a chance to 'see the baby' for the first time. How to explain this seeming contradiction between what was said and done, drawing on IE insights about how to study social relations that organise activities?

First of all, as IE suggests, my observations of activities and nurses' accounts made me look further into my research material and ask the nurses more questions about referencing the foetus at different sites and times of prenatal care. That is, rather than making a generalising statement that nurses followed a certain temporal logic during care but unconsciously also broke that logic, I (also) used the accounts to point to the next step in a cumulative enquiry into the institutional process (Smith 1987, 2005). I discovered that during early pregnancy the nurses did indeed talk less about parenthood issues or in terms of babies than during late pregnancy. Further, they never talked in terms of babies in the discursive context of foetal screenings or miscarriage risks. They did not, then, really misrepresent their activities.

By reframing my analysis through both the nurses' insight and my own observations, I was able to see that the focus during early appointments might be on parenthood and life with a baby when the nurses were soliciting parental commitment to the baby-to-be and the pregnancy. This might take place, for example, when the partner's possible attendance at appointments was discussed. In sum, the nurses seemed to vary the ways of relating to the foetus according not just to gestational time but also to the context of the discussion.

Furthermore – and this brings me to my second point – talking about parenthood issues, and attempting to create parental emotional commitment to the foetus even at the beginning of pregnancy, serves an institutional purpose. When actual parental counselling starts (at around 30 weeks' gestation), it is institutionally useful for there to exist some prior level of transition to parenthood to build on. To conclude at a more abstract social-scientific conceptual level, this is the everyday concrete nursing work that goes into achieving the institutional agenda of subjectifying women into (good) mother-citizens who take responsibility for their babies.

Using IE as a source of inspiration, we can see how (some) nurses' work is hidden, and how it can serve the purpose of pushing pregnant women to conform to the position of mother-citizen. This is the

politics inherent in IE. It makes silenced work (by nurses, in this case) audible, and brings the process of institutional subordination (the subjectification of pregnant women, in this case) into view.

Agency for women, moral value for the foetus

Nurses' work often rests on experience-based knowledge gained through direct personal encounters with clients over a long period. It is a historical, local and intuitive practice. Pregnant women are not merely disciplined to conform to specific institutional family values at the clinics. My research showed that even when mothers-to-be were not seen as fit mothers, and when there was intervention and judgement, women were not left alone with their feeling of not fitting in, and their experience-based knowledges were not negated. Rather, practical everyday solutions were sought by a team (Homanen 2017a, 2017b). Different parenting values could be recognised, or at least tolerated (Homanen 2017b, 365).

How to account for this kind of attentive and inventive care, which seemed to exceed the interests of institutional governance and valuation? My answer was to integrate analytical insights from the FT writers Donna Haraway (1996, 1997) and Annemarie Mol (2002, 2008a, 2008b) on the performative character of subjects, thereby widening the analytical IE perspective, particularly regarding the agency of both woman and foetus. This involved perceiving the social world in terms of material semiotics, which, in turn, considered social relations that institutionally existed not just between people but also with non-human or not-yet-human entities such as the foetus.

Material semiotic analysis – or material semiotics, as it is also called (Law 2008) – does not deny the foetus moral value or even individual status. However, it *also* allows a reproductive politics that takes into account women's bodily integrity and rights. This is groundbreaking: within the humanist traditions of thought shared by many people and institutions, the foetus as a human life is portrayed as contending with the pregnant woman for individual agency. Concepts of individual agency tend to pit the interests of the foetus against those of the pregnant woman. Her responsibilities towards the foetus and her freedom of choice are placed in moral contradiction. Depending on the emphasis – as also apparent in my research material – the foetus is then represented either as an unborn child with social rights and autonomy or as a mere technically and clinically defined foetus. If

and when the foetus is granted social rights, such as the right to be healthy, the pregnant woman's agency and bodily integrity are subject to limitations, as the foetus literally resides within her body. Material semiotics makes it possible to view a creature like a foetus in a way that avoids the political and theoretical burden of individual agency (or lack thereof).

Material semiotics perceives social worlds as constituted semiotically, on the basis of endless processes of reference and association (see Haraway 1997; Law 2008). In addition to language systems, it broadens semiotics to include all social 'sign systems': networks of symbolic and material entities that appear to matter in social processes and practices (Mol and Messman 1996, 428–429). The concepts of agency and agent are thus broadened: whatever 'works' can be an actor/agent. In this framework, the contradiction between foetus and pregnant woman as (partially) separate individuals disappears as all actorial elements take equal part in enacting the foetus and its relation to the pregnant woman. The individual status or agency of the foetus is not presumed but turned into an empirical question (Mol 2002, 1–29).

Material semiotics has been characterised as a broad analytic orientation (Law 2008) that is generally associated with Latour's (1987) actor-network theory and its applications in science and technology studies. I am drawn to 'new' feminist material semiotics, particularly Donna Haraway's (1997; see also Haraway 1991b) political analyses. The 'newness' refers to the understanding of material semiotic enactment as performative. Networks of relations are viewed as unstable, context-specific, heterogeneous complexes in an ongoing enactment. Hence all entities enacted are also unstable, multiple and relational (Haraway 1997; Law 2004, 2008; Mol 2002, 2008a, 2008b).

Haraway (1996, 1997) focusses on movements and relations between the material/natural and the discursive/cultural. Through this orientation it is possible to enquire into how different power relations (historically) arrange people and things in asymmetrical positions in societal networks (Haraway 1997, 33–35). This is apparent when Haraway (1997, 35) criticises social science studies' blindness to certain asymmetrical historical relations: 'social science studies scholars, like Latour, [...] have mistaken other narratives of action about scientific knowledge production as functionalist accounts appealing in the tired old ways to performed categories of the social, such as gender, race, and class'.

Haraway does not presume categories but turns them into empirical questions.⁴ The ever-changing relations between material, physical and symbolic entities and the sites of their enactment bear traces

of (value) hierarchies that seek to sustain the authority of certain relations at the expense of others. To account for these traces of power, research must originate from the situated temporal and local characteristics of a given research field. These characteristics organise and are organised by historical social relations. Different hierarchies of value that tend to uphold the power and authority of some social relations instead of others organise the relations of different entities. For example, individualisation and neoconservative values have historical authority to reproduce the model where the relationship between foetus and pregnant woman is viewed as that between two individuals, rather than a model within which the foetus is part of the woman. This is also on the agenda of maternity healthcare institutions, as we saw above.

A Harawayan politics of the foetus is a politics that does not presume the essence of things or relations between things, but which can nonetheless point to when and why a particular perception of women's reproductive freedom and rights is the product of power and is open to question. Haraway's analyses typically also outline realities that are politically (more) acceptable (for example, the cyborg (Haraway 1991a) and companion species (Haraway 2008)).⁵

Let us return to the clinics to look at care realities. According to the material semiotic approach, the foetus is multiple, performed again and again during the care process. It does not necessarily have moral status in every situation. Enacted as a particular baby, it has a lot of moral value in most cases. Its enactment involves many material actors, who can be categorised as both human and non-human. Technological tests and devices, such as the ultrasound, have a special role as custodian apparatuses and are productive of social relations. The foetal figure they mediate is used to enact a foetus as kin and as an autonomous gendered individual, since routine use makes the intermediary role of the technology invisible.

The foetus, which is both produced through technology and based on women's experience-based knowledge, also 'enacts' itself and its relation to the pregnant woman, inside and outside the clinic. Its intrauterine activities define the ways in which relationships are formed. Nurses (and pregnant women), for example, interpret and translate these activities into the foetus' personal 'characteristics' and 'interests'. The activities are given meaning that derive not from the activities themselves, but from cultural and political preferences and agendas to make the foetus an active, autonomous and

purposeful individual who 'wants' and 'needs', for example, nutrition or 'a smoke-free mummy'. Furthermore, nurses encourage pregnant women to interact with their foetuses.

Personalising the foetus by interacting with it, making choices about screenings and changing lifestyles and households are all certainly necessary during the transition to parenthood. However, it should be remembered that the personalisation process takes place in a specific (cultural) context. Not all foetuses end up as babies, or as babies that accord with (maternity healthcare) cultural preferences: an abortion may take place, or the mothers may not fit the institutional norm.

However, even though women are presented with many restrictions and responsibilities at the maternity healthcare clinics, there is also room for agency and choice. Annemarie Mol's (2008a) 'logic of care' is useful here. The logic of care is that care is an open-ended process with no clear boundaries: if something does not work, nurses try something else to make things if not perfect, then as good as possible. Pregnant women's experiences are heard and their ideas respected in care decisions, making them more like 'team members' than 'care targets' (cf. Mol 2008a). Further, their experience is understood at the clinics as knowledge obtained in the process of experiencing and doing pregnancy. This logic of care is historical: long-term support, trusting professional relationships and listening to women's experiences have been the guiding principles of Finnish maternity healthcare since its establishment in the early 20th century (Wrede 2001).

The decentralisation of care across multiple partners and teams, and the shift towards more patient autonomy, has been interpreted as part of the emergence of a rationale in Nordic welfare services and governance techniques that insists on persuasion and encouragement rather than regulations and patronising sermons (Foucault 2007; Homanen 2017a; O'Connor, Orloff and Shaver 1999; Sulkunen 2009). This approach relies on people's rationality and capacity to come to know their own (family) life. Citizens' autonomy and privacy must be guaranteed and responsibility decentralised under the welfare state. Control is exercised, but it is indirect and does not rely on disciplinary techniques.

Rational (economic) parents are certainly enacted in care practices. The subject of care in maternity healthcare, however, cannot be reduced to a (successful or failed) neoliberal individual who is responsible for her own shortcomings. Not taking a strong stand on 'good' parenthood does not mean that nurses just leave parents-to-be and their communities to figure parenthood out by themselves. The care approach is *also*, and historically, about the transition to parenthood as a process of coming to know one's own parental identity through experiencing pregnancy supported by a long-term, trusting

client-professional relationship. Nobody is left alone to reflect on the cultural competences of motherhood or their feelings of inadequacy. Thus institutional power does not have a totalising hold on practices and actors.

Semiotic analysis, then, reveals that encouraging women to interact with their foetuses and to come to know them slowly in the course of pregnancy can (also) be viewed as enabling subjectivities (maternal and foetal) and family life that result from contextualised reflection, interaction and the practicalities and materialities of everyday pregnant life. The institutional context of maternity healthcare can hence be viewed as both controlling and enabling motherhood.

Thus maternity healthcare protects the foetus through the woman and not in spite of her. When we do not make presumptions about agency, forms of being or institutional power, we can see how the foetus with its 'rights' and 'interests' is not (always) pitted against the pregnant woman. This is how a foetus can have moral status and value, without individual or personal integrity. This – very situated, partial and fragile – reality can be seen as a politically acceptable model for care in pregnancy.

Conclusions

In this chapter, I have unravelled the politics one performs when using one theory instead of another. The presumption on which I have worked is that methods make the normative order of the field under study. IE asks one to follow different people in institutions and to tease out their experience-based knowledge about their daily activities to account for the ways in which power relations and institutional agendas organise those activities. IE is a process that involves reframing the ongoing analysis through new, dialogically produced knowledge, with the aim not to make generalising statements about commonalities in participants' accounts, observations, video-recordings and so on but to put them to the test. IE opens up a space where the worlds of institutional (human) actors – in my case, nurses and pregnant women – are made audible. The erasure of these worlds is often the basis of the institutional control inflicted on actors in the networks of power relations that organise the institutional practice. IE is on the side of the weak.

FT and material semiotics are also concerned with actors, but not just people. It regards people and non-human entities as signs that co-constitute each other in an endless open-ended network or logic, 'an Order of Things' (Mol and Mesman 1996). The Order of Things that is in the

interest of FT approaches is concerned with signs and entities not incorporated into the Order, rather than people erased or silenced. Material semiotics reveals the effort it takes to constantly keep certain entities – be they values, people, technology, not-yet-humans or whatever – out of the Order. It also illustrates how fragile the established Order is, and how it requires constant upkeep. Material semiotics also demonstrates that the Order is not one but multiple. What is kept out of one Order is incorporated into another. Life can be different; different logics coexist. This is where its politics lies: it exposes orderings and excavates alternatives (which may have been hidden in the existing world all along).

In the care practices in my research, there are coexisting logics for enacting the foetus (in relation to its mother). There is the institutional agenda of subjectifying women into mother-citizens who take responsibility for their babies, which is actualised through temporal and site-specific parental counselling. In the process, the foetus is rendered into a kin person-individual with rights, needs and interests. The counselling work in many ways rests on experience-based knowledge that is historical, local, intuitive and to some extent hidden. This is what we learn with IE.

FT semiotic analysis shows us that this one institutional reality is not the only one, although perhaps it is the one that is culturally enforced. Nor is it stable. The logic of Nordic maternity care work is to listen to pregnant women's experience-based knowledges, to work with them in a team on a consistent long-term basis, and to look for practical everyday solutions to improve the lives of all participants. The foetus is not a (semi-)individual pitted against the pregnant woman in this reality of care. Rather, it is part of the woman. Yet it may still have moral value, and women may have freedom of choice and agency. This is politically acceptable.

It is also a (fragile and partial) political reality that is specific to this Nordic welfare service-in-the-making. In order to observe it and its coexistence with disciplinary and subtler ways of subjectifying women into responsible mother-citizens, I needed this particular form of exploration that combined IE with FT.

The great difference in ontological commitment between IE and FT boils down to the fact that the institutional power relations and hierarchies scrutinised by IE are productive of only one alternative –

which FT sees as a situated and unstable reality. Furthermore, in IE social orders exist only between people enacted as subjects, whereas in FT humanity loses its special status. Non-humans and not-yet-humans may be acting subjects too. These different commitments result in different politics.

The difference is not, however, a conflict that needs to or can be resolved. Neither can or need IE and FT be fused into some smooth theory. To use them both is to use a hybrid method and tell simultaneous stories – like those told above – that hang together, but not as one.

References

Benoit, C., S. Wrede, I. Bourgeault, J. Sandall, R. De Vries and E. R. van Teijlingen. 2005. "Understanding the social organisation of maternity care systems: midwifery as a touchstone." *Sociology of Health and Illness* 27:6, 722–737.

Foucault, M. 2007. *Security, Territory, Population: Lectures at the Collège de France 1977–1978*. Basingstoke: Palgrave Macmillan.

Handbook of Maternity Healthcare (Äitiysneuvolan käsikirja) 2007. [www document in the city healthcare intranet] (received 8.4.2007).

Haraway, D. 1991a. "A cyborg manifesto: science, technology, and socialist-feminist in the late twentieth century." 149–181, *Simians, Cyborgs, and Women: The Reinvention of Nature*. New York and London: Routledge.

Haraway, D. 1991b. "Situated knowledges: the science question in feminism and the privilege of partial perspective." 183–201, *Simians, Cyborgs, and Women: The Reinvention of Nature*. New York and London: Routledge.

Haraway, D. 1996. "Feminist diffractions in science studies." 428–442, *The Disunity of the Sciences: Boundaries, Contexts, and Power*, edited by P. Galison and D. J. Stump. Stanford, CA: Stanford University Press.

Haraway, D. 1997. *Modest_Witness@Second_Millennium.FemaleMan©_Meets_OncoMouse™: Feminism and Technoscience*. New York and London: Routledge.

Haraway, D. 2008. *When Species Meet*. Minneapolis & London: University of Minnesota Press.

Homanen, R. 2013. "Reflecting on work practices: possibilities for dialogue and collaborative knowledge production in institutional ethnography." 213–235, *Knowledge and Power in Collaborative Research:*

- A Reflexive Approach*, edited by L. Phillips, M. Kristiansen, M. Vehviläinen and E. Gunnarsson. New York and London: Routledge.
- Homanen, R. 2017a. "Enabling and controlling parenthood in publicly provided maternity healthcare: becoming a parent in Finland." *Sociology of Health and Illness* 29:3, 443–457.
- Homanen, R. 2017b. "Making valuable mothers in Finland: assessing parenthood in publicly provided maternity healthcare." *Sociological Review* 65:2, 353–368.
- Kuronen, M. 1999. The social organisation of motherhood: advice giving in maternity and child healthcare in Scotland and Finland. Doctoral thesis. University of Stirling, UK.
- Latour, B. 1987. *Science in Action: How to Follow Scientists and Engineers Through Society*. Cambridge, MA: Harvard University Press..
- Law, J. 2004. *After Method: Mess in Social Science Research*. Abingdon and New York: Routledge.
- Law, J. 2008. "On sociology and STS." *Sociological Review* 56:4, 623–649.
- Leigh Star, S. 1991. "The sociology of the invisible: the primacy of work in the writings of Anselm Strauss." 265–283, *Social Organisation and Social Processes: Essays in Honor of Anselm L. Strauss*, edited by D. Maines. Hawthorne, CA: Aldine de Gruyter.
- Martin, E. 1987. *The Woman in the Body: A Cultural Analysis of Reproduction*. Boston, MA: Beacon Press.
- Mol, A. 2002. *The Body Multiple: Ontology in Medical Practice*. Durham, NC: Duke University Press.
- Mol, A. 2008a. "I eat an apple: on theorizing subjectivities." *Subjectivity* 22:1, 28–37.
- Mol, A. 2008b. *The Logic of Care: Health and the Problem of Patient Choice*. London and New York: Routledge.
- Mol, A., and J. Mesman. 1996. "Neonatal food and the politics of theory: some questions of method." *Social Studies of Science* 26:2, 419–444.
- Nätkin, R. 2006. "Contradiction between gender equality and protection of motherhood: reproduction policy in Finland." 25–40, *The Policies of Reproduction at the Turn of the 21st Century*, edited by M. Mesner and G. Wolfgruber. Innsbruck: Studien Verlag.
- Oakley, A. 1984. *The Captured Womb: A History of Medical Care of Pregnant Women*. Oxford: Blackwell.

O'Connor, J. S., A. S. Orloff and S. Shaver. 1999. *States, Markets, Families*. Cambridge: Cambridge University Press.

Smith, D. E. 1987. *The Everyday World as Problematic: A Feminist Sociology*. Toronto: University of Toronto Press.

Smith, D. E. 2005. *Institutional Ethnography: A Sociology for People*. Lanham, MD: AltaMira Press.

Smith, D. E. 2009. "Categories are not enough." *Gender & Society* 23:1, 76–80.

Sulkunen, P. 2009. *The Saturated Society: Governing Risk and Lifestyles in Consumer Culture*. Los Angeles, CA: Sage.

Wrede, S. 2001. *Decentering Care for Mothers: The Politics of Midwifery and the Design of Finnish Maternity Services*. Åbo: Åbo Akademi University Press.

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² The data was collected during 2006–2008 and consisted of video tapes (68 appointments, 18 team meetings); observations from maternity healthcare appointments, professional team planning meetings (19), training sessions for nurses and family counselling classes at four maternity healthcare units; seven interviews with pregnant women, and seven with public health nurses; and documentary material used by the nurses in their work.

³ *The Handbook of Maternity Healthcare (Äitiysneuvolan käsikirja)* was a document published on the municipal healthcare service's intranet in 2007.

⁴ Smith does not presume them, either. Indeed, she explicitly questions them (see e.g. Smith 2009), but the way in which social organisation is realised in her theory does not include simultaneously looking for different orderings at the interface of the material and symbolic.

⁵ The cyborg and the companion species can be viewed as subjectivities that question the dichotomies human/animal and human/machine. As concepts, they show how humans, machines and animals co-produce each other in dialogue. These value-laden dichotomies are products of power, and anything but 'natural'.