CULTURAL FACTORS AND COMPONENTS OF PRENATAL CARE FOR THE HMONG AND YIU-MIEN

by

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A Thesis

Presented to
the Oregon Health Sciences University
School of Nursing
in partial fulfillment
of the Requirements for the Degree of
Master of Science

June 10, 1988

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ACKNOWLEDGMENTS

A number of people generously contributed their time, their expertise and experience, and their good will to this project. Without their help it would have never been completed. We would like to thank each of them from our hearts. Some of those people are listed below.

Beverly Aiello, Nick Aiello, Kim Rilette, thank you for your time, cookies, front room, and introductions. David Hopkins, for your encouragement and methods explanation, and for hunting up those cross-tabs. Grace Merchant, thanks for collegial breakfasts, generous non-territoriality, and good ideas. Eric Crystal and Sylvia Lombard thank you for sharing your years of experience in working with the people. John Cha for your help and many contributions throughout the project. Nancy Saykeo and Tu Cha for your delicious feast and hospitality. Lee Poo Cha, Vera Cha, Mee Yang and Pia Cha for offering your insights. Phoua Xiong for your hospitality and generous gift of time. Kathy and Steve Kue for your aid in translation, taking time out of your busy lives and making this a priority. Donald Yongchu for help in giving us "the go ahead." Sua Lee Cha for your wisdom and for sharing your vast knowledge of cultural ways with us.

Laurie Moore, Nancy Donnelly, Helen Faller, Bruce Downing, Kathleen Morrow, Susan Clark, Debra Richman, Marshall Hurlich, and Jeff Mac Donald, thank you for taking the time to respond to the instruments. Seng Fo Chao thank you for your attention to detail, scholarship, and the time you took to assure accuracy of the cultural information. Ay Choy Lee, Yoon Chien Saechao Loo Hang Saechao thank you for your sensitivity and willingness to communicate. Yien Chan Saechao, Farm Seng Saepien, Mwong Sinh Saechao, Seng Chiem Saechao, Farm Pou Saechao, Seng Hinh Saechiou, Muang Saechao for your good humor and the kindness you showed us. San Seng Saephan and Long San Saechao, for your support of the study. Chiem Fien Saechao, Yao Fong Saechao, Chiem Kouei Saechao, E-Choy Saelee, Yoon Sang Saechao, Yoon Fou Saechao, Lai Chio Saechao for sharing your years of wisdom and caring that we "get it right."

Finally we would like to acknowledge our committee without whose inspiration, continued support, encouragement, and editing skills we would never have finished this project. Thank you Donna, Bruce, and Caroline.

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CHAPTER I

INTRODUCTION

Introduction to the Problem

"Cultural Factors and Components of Prenatal Care for the Hmong and Yiu-Mien" is a descriptive, ethnographic, study designed to validate perceptions of cultural values and beliefs which may influence components of prenatal care for Oregon's Hmong and Yiu-Mien populations. Two instruments, one for the Hmong and one for the Yiu-Mien, were developed for this study. The various parts of the instruments, including main headings, statements about the cultures, and the specific questions, as well as the response options, reflect the synthesis of a literature review, community needs assessments, and personal communications.

The primary objective of the study was to confirm and expand upon descriptions of Hmong and Yiu-Mien ways of life in order to describe to the professional community aspects of the Hmong and Yiu-Mien social worlds. The ultimate purpose was to provide a more complete body of knowledge so that cultural barriers to prenatal care may be reduced and health services may be more appropriately matched to cultural expectations.

Rather than a conventional discussion of the literature in the first chapter of this report, the literature review is woven into the "Results" chapter. The literature is discussed under each main heading of the instrument as it relates to both the creation of the instrument and the data gathered.

Statement of the Research Problem

A recent study by the Oregon State Health Division (1987), "Maternal and Infant Health Characteristics of Oregon's Indochinese Refugees, 1984-1985" indicates high rates of low birthweight infants born to both the Hmong and Yiu-Mien. The Hmong rate was 12 percent for 76 total live births; the Yiu-Mien rate was 10 percent for 74 total live births, compared to the overall Oregon low birthweight rate of 5 percent for 78,955 total live births (Oregon State Health Division, Center for Health Statistics [Hopkins], 1987). Both groups had a greater proportion of low birthweight infants in 1984-1985 than they did in 1980-1981 (Oregon State Health Division, Center for Health Statistics [Hopkins], 1987).

Furthermore, the study showed that both groups had higher percentages of inadequate prenatal care than other groups of childbearing Oregon women where the definition of inadequate care is "care starting in the third trimester or consisting of four or fewer prenatal

visits" (Oregon State Health Division, Center for Health Statistics [Hopkins], 1987, p. 22). More than one in five, 22 percent, of Yiu-Mien women in Oregon received inadequate prenatal care in 1984-1985. The Hmong ranked second for inadequate care, at 17 percent, compared with 7 percent for all Oregon mothers (Oregon State Health Division, Center for Health Statistics [Hopkins], 1987).

And, the infants born to Yiu-Mien mothers are at proportionally greater risk for morbidity and mortality than other infants as indicated by Apgar score. The Apgar score is a numerical expression of an assessment of the neonate's heart rate, respiratory effort, muscle tone, reflex irritability, and color. An Apgar score of seven or less measured five minutes after birth indicates that the infant is at greater risk of mortality or morbidity. Although Apgar scores for Oregon Hmong neonates were comparable to all Oregon neonates, Yiu-Mien neonates were three times more likely to have Apgar scores of seven or less (Oregon State Health Division, Center for Health Statistics [Hopkins], 1987).

According to World Health Statistics Quarterly (1980), "low birth weight is universally and in all populations the single most important determinant of the

chances of the newborn to survive and to experience healthy growth and development" (p. 197). The World Health Organization in 1948 adopted 2500 grams as the weight classification marker for neonatal risk. Prenatal care has been found to be significantly effective in reducing the chance of low birthweight among high risk women, "whether the risk derives from medical factors, sociodemographic factors, or both" (Institute of Medicine, 1985, p. 19).

Certain components of prenatal care were identified as "most effective in reducing the incidence of low birthweight" by the American Nurses' Association Consensus Conference Report "Access to Prenatal Care: Key to Low Birthweight" (American Nurses' Association [Curry], 1987, p. 14). Those components are: (a) initial and ongoing risk assessment, (b) individualized care, (c) nutrition counseling, (d) education to reduce or eliminate unhealthful habits, (e) stress reduction, (f) social support services, and (g) health education.

In this context prenatal care refers to that offered by the Western health care system. For the purpose of this study Western health care is defined as a system of health care delivery which professionally licenses its practitioners. This definition was chosen to encompass diverse models and disciplines of health

care and healing. It includes naturopathy, chiropractic, homeopathy, as well as the biomedical model. The term "professional" was purposefully eschewed because it was thought that this would exclude the professional cultural healers, such as the Yiu-Mien priest and the shamans of both cultures. Likewise, when discussing "cultural self care patterns" the term "folk system" was avoided. It was thought that the term "folk system" does not connote acknowledgment and respect for cultural practitioners and cultural healing practices.

Many culture groups have culturally specific expectations for prenatal self care patterns. These may or may not conflict with Western health care. The cultural group with its values, beliefs, and practices can have profound influence on when and/or if Western prenatal care is initiated and on the nature of prenatal cultural care the mother-to-be receives. An interest in exploring these cultural beliefs, values, and practices led to the research question: What are the cultural factors which influence the prenatal care of the Hmong and Yiu-Mien?

Community Access

The process of gaining permission to do research in the Hmong and Yiu-Mien communities took seven months. Other researchers of the Hmong reported their entree

strategies (Lee, 1986; Faller, 1985; Symonds, 1984). Lee (1986) suggested that a "failure to recognize and work within the Hmong social organization" increased the problems encountered in working with the Hmong people (Lee, 1986, p. 89). Therefore, in recognition of the Hmong social organization, access was approached through community leaders. Initial entrance was eased by Bruce Bliatout, Ph.D., Program Coordinator for Refugee Health with Multnomah County Health Division. A Hmong himself, and Chairman of the Board of Directors of the Hmong-American Association, Dr. Bliatout served as a liaison to the influential leaders of the Hmong and Yiu-Mien communities. His cultural perspective was invaluable during the access negotiations.

The initial meeting with the Hmong leaders took place at a local Vietnamese restaurant. The president of the Hmong-American Association of Oregon, Dr. Bliatout as chairman of the board of directors, the public relations officer, and the Association spokesman were all present. Formal introductions were made by Dr. Bliatout and socializing took place before moving to the business portion of the meeting. The leaders were given the Oregon State Health Division study and discussion followed. The Hmong leaders acknowledged the usefulness of further investigation. However, they stated concern

that previous researchers had been granted access to the community, but after gathering data had failed to report their findings back to the community. In this meeting it was agreed that the results of the study would be reported to the Hmong-American Association. A bound copy of the thesis will be presented to the Hmong-American Association.

Symonds (1984) reported that in her initial meeting with Hmong leaders she was questioned about her marital status and number of children. Personal information did not seem of concern to the Oregon leaders. However, professional qualifications and cultural experience were important. Perhaps the fact that one of the researchers was well known to the community eased acceptance. The Hmong leaders also expressed appreciation for the lengthy research time-line. "Other people come to do the studies and they want things right away. Its not fair to us or them."

Initial contact with the Yiu-Mien took place in a conference room at Multnomah County Health Division. We met with the president of the "Mien (Yao) Association of Oregon" and Dr. Bliatout to discuss the proposed research. The Association president stated that the Association was in the process of changing the name to "Yiu-Mien Association of Oregon." "Yiu-Mien" was the

name decided at a recent international conference, partially organized by the local Association president. He said, "`Mien' means people, and it doesn't make sense that we be known as the people people. We are the `Yiu' people." This name is not universally accepted within the community. The president was shown the Oregon State Health Division study and asked to share it with the Yiu-Mien Association board of directors. In addition, he was told, the board would be given a copy of the research results. Although he could not guarantee access without meeting with the board, he was encouraging.

Both the Hmong and the Yiu-Mien leaders suggested that formal letters of request for access be written to the respective Associations stating the purpose of the research. The letters were written (see Appendix A) and sent but before receiving permission from the Associations, another research project was initiated by Multnomah County Health Division and the International Refugee Center of Oregon (IRCO). Because of some similarities between the studies there was hesitation by the Yiu-Mien Association to grant us access. Continued contact with the Association president eventually eased the impasse. In October, 1987, seven months after the first contact in March, a letter of acceptance was

received from the Yiu-Mien Association. The Hmong letter of acceptance arrived in September. Both letters support this research (see Appendix B and C).

The Yiu-Mien Association was assured that they would receive a bound copy of the thesis. At the request of Hmong and Yiu-Mien culture members a picnic meeting with culture members from both groups was scheduled to make the presentations of the thesis copies and answer culture members questions about research findings.

The Early Phases of the Research

Preparation for this study began with a review of relevant literature. This included examining the general literature concerning the problems of low birthweight and inadequate prenatal care. Ethnographic information on the Hmong and Yiu-Mien populations was gathered and reviewed, from the early works of Iwata (1960) and Barney (1957) in Laos, to the more recent Hmong Resettlement Study in the U.S., directed by Stephen Reder (1985). In addition, refugee health research was examined with particular emphasis on prenatal care, nursing research, and health related studies on the Hmong or Yiu-Mien. Although there are numerous health related articles on "Southeast Asians", "Refugees" or "The Indochinese", these usually

concentrate on care of the Vietnamese or Khmer (Kampuchean), with few studies focused on the prenatal health issues of the Hmong (Faller, 1985; Lee, 1986; Richman & Dixon, 1985; Morrow, 1986), and only one (Ellis, 1982) mentioning the Yiu-Mien.

This study had its origins in community needs assessments begun in February, 1987, as a formal course assignment. The two needs assessments were designed to explore the problem of inadequate prenatal care in the two communities. With an "everything is data" approach, even the initial access meetings were written into field notes and analyzed. The data for the assessments consisted of two windshield surveys and nine interviews.

A car cruise through Halsey Square, the largest Yiu-Mien community in the United States (Knoll, 1982), and drive through surveys of the two areas of Portland with the highest Hmong population, the St. John's area, and the area around N.E. Fremont between 12th and 33rd, composed the two windshield assessments. Though somewhat voyeuristic, the surveys revealed the village-like atmosphere of the major Hmong and Yiu-Mien residential areas and offered a sense of the physical environment of the Hmong and Yiu-Mien of Portland. In the Fremont area, Hmong women in traditional dress worked in a community garden plot close to their

apartments. In Halsey Square an older Yiu-Mien woman in her black turban and red boa looked out from her upstairs window, eyes on us. Women swept sidewalks and sat or squatted in the front yards talking. They walked together with babies in colorful carriers on their backs. Young men met to chat and smoke behind the apartments in the play area. Impressions were recorded at the time of the surveys on a cassette tape recorder and later transcribed into field notes.

The nine interviews of the needs assessments were also transcribed as field notes. The interviews provided increased awareness of the complexities of the cultures. These interviews included three, one-to-two hour sessions with Dr. Bliatout, one session with the Hmong community leaders and two with the president of the Yiu-Mien Association of Oregon. One of the interviews was with a young Yiu-Mien woman who works as a translator and is well-known to one of the researchers. Another interview was with two Caucasian missionary women who live with the Yiu-Mien in Halsey Square. In addition there was a one half hour interview with David Hopkins, the researcher and analyst who compiled the Oregon State Health Division study, "Maternal and Infant Health Characteristics of Oregon's Indochinese Refugees, 1984-1985". Interviews were

either taped with a cassette recorder and then transcribed into the field note log or brief notes were taken during the interviews and transcription from the notes was done within a day. Data from the nine interviews was collected between February, 1987 and November, 1987.

The needs assessment reports compiled information about the cultures from the two data sources, the windshield surveys and the interviews. Analysis of the information began with the initial interview with Dr. Bliatout and continued throughout the interview and windshield survey process. The field notes were coded for themes and classification categories emerged. Many related to cultural factors, such as beliefs, social structure, and practices.

In addition to the literature review and community assessments, personal communications with eight professionals who had either worked or lived with one or both of the two cultures contributed to the data. Personal communication consisted of either telephone conversations, or brief meetings. Sylvia Lombard, a woman who lived with the Yiu-Mien in Laos, Thailand, and Portland over a twenty year period corresponded and answered specific questions such as "At what age are Yiu-Mien young men and women encouraged to marry in Laos?

in the United States?" The responses to these questions were considered data. In this contact the professionals were informed of our eventual research study and were asked if they would be willing to help. All responded positively.

CHAPTER II

METHODOLOGY

Introduction

It was hypothesized that the high rates of inadequate prenatal care by the women of the two culture groups that were identified in the Oregon State Health Division study had multifactorial causality. Two causes thought to be significant in contributing to inadequate care in the two ethnic groups were cultural factors such as beliefs or attitudes about pregnancy and cultural perceptions of the Western prenatal care system. Leininger (1985) states "ethnographic methods help the researcher enter the world of the informants to obtain their recurrent and familiar world views, meanings, attitudes, and lifeways" (p. 34). Ethnographic methods include focused interviews and participation with informants in their known or natural living environments. This ethnographic approach was chosen to describe Hmong and Yiu-Mien cultural factors and perceptions of the Western prenatal care system from the culture members point of view.

Information from the ethnographic literature, community assessments, and personal communication pointed to a study design which would include gathering data from both culture members and non-culture members

who have lived or worked with the cultures. In gathering ethnographic data Lofland (1971) suggests that one should not avoid consulting the "marginal" individual because "they are most willing to talk about what's happening", "are the most likely to leak confidential information about the setting", and "are the most likely to have novel views of the setting" (p. 111). Lofland's use of "marginal" refers to the individual who may be close to a people's world; in it but not truly of it. "He is so close that he can deeply empathize with local pains, joys, and boredoms, but these are not truly his own pains, joys, and boredoms...." (Lofland, 1971, p. 97). The "marginal" individuals consulted in this study were thirty-two non-culture member key informants who had worked or lived with one or both cultures. They were questioned on the same issues as culture members because it was thought that they could provide an added perspective on the cultures because of their "marginality".

Data collection focused on cultural beliefs and cultural self care practices and the extent to which those prescribed in the literature or inferred from personal communications were perceived as characteristic. Data collection also addressed the interface between these beliefs and practices and

Western care delivery. The method of the study was inquiry about cultural beliefs and practices wherein specific statements purported to be relevant were presented for verification and elaboration and for direct questioning regarding implications for health care.

A number of factors provided rationale for this approach. There is limited information available to explain cultural beliefs and practices for the Hmong and Yiu-Mien living in the United States. Most of the previous related research about the two groups was done by anthropologists in Southeast Asia. It was considered important to verify the nature and pervasiveness of the reported beliefs and practices in terms of the current living context [Oregon]. There are unexplored and unknown areas, such as cultural perceptions of fertility, that are felt to relate to cultural self care patterns. And, changes may have occurred in patterns of cultural self care as a result of the acculturation process. The more current and geographically appropriate information could prompt the creation of alternative patterns of Western health care that would be more culturally acceptable to the Hmong and Yiu-Mien client. This ethnographic approach adds to baseline nursing knowledge by giving information about general

cultural characteristics of the people as well as information about specific practice issues in nursing and health care delivery.

Design

The design of this study evolved as the quantity of information grew and needed organization and verification. The study used two different instruments, one for the Hmong culture, one for the Yiu-Mien. Key informants were asked to validate perceptions and cultural beliefs by responding to a mailed instrument or were interviewed using the same instrument as an interview schedule (See Appendix D and E). The key informants were also invited to suggest culturally relevant solutions to health problems and to comment on the cultural beliefs and values isolated.

Instruments

The two instruments were the result of an effort to organize primary and secondary data from the literature review, the community needs assessments, and personal communications. The main headings of the instruments came from a synthesis of ethnographic and prenatal care concepts. Each instrument had four main headings. For the Hmong instrument they were: Fertility in the Hmong Culture, Marriage and Childbearing, Nutrition, and Social Support and Kinship. Main headings for the Yiu-

Mien instrument were: Practices Related to Pregnancy, Beliefs Related to Pregnancy, Infertility and Adoption, and Marriage and Pregnancy. The differences in headings for these two instruments reflected the differences in the two cultures.

Under each main heading were six or seven statements. Most of the statements were expressions of ideas from the ethnographic literature. In the process of refining the statements for use in the instruments, perceptions of cultural practices and beliefs were often clarified with professionals who worked or lived with the cultures as well as with culture members working in bicultural positions.

The instruments asked participants to evaluate the statements describing possible cultural factors which might influence prenatal care initiation or other components of prenatal care. Respondents were asked to assess the accuracy of the statements and to include comments. Examples of possible response codes were: "1A. This statement is often correct, 1B. This statement is often correct in Laos but not in the U.S.." "2. This statement is partially true. Please write changes or additions to make the statement correct." Respondents were asked to select as many codes as apply to the statement. Statements could

require more than one code. Respondents were also asked to indicate if the statement is important for health providers to know by marking the column labelled "Important?".

In addition, questions were posed under each main heading which related cultural factors to components of prenatal care. The components were those aspects of prenatal care identified as "most effective in reducing the incidence of low birthweight" by the American Nurses' Association Consensus Conference Report "Access to Prenatal Care: Key to Low Birthweight" (American Nurses' Association [Curry], 1987, p. 14). The questions asked respondents to suggest culturally appropriate solutions to health problems.

The instruments were examined for clarity and readability by Dr. Bliatout, as both a member of the Hmong culture and academic advisor to the project, by another Hmong bicultural professional, and by Grace Merchant, a non-culture member, knowledgeable researcher who has worked with both cultures. In addition, three culture members pretested each instrument, Hmong and Yiu-Mien respectively. The "not true" response option was added according to their suggestions and several word changes were required to increase understanding. Culture members were informed that the purpose of the

questions about the statements was to determine the statements' validity.

A meeting with 15 culture members of the Yiu-Mien community concluded input into pretesting the Yiu-Mien instrument. Yiu-Mien priests and shamans, identified and respected by the community for their expertise in cultural and spiritual matters, attended this meeting along with other community leaders. This less formal group interview with the Yiu-Mien took place with one researcher present. The meeting grew out of a social invitation to a house warming. A past president of the Yiu-Mien Association organized this group of Yiu-Mien community leaders and four priests and shamans to be interviewed about cultural beliefs. Priests and shamans differ in the Yiu-Mien culture with shamans functioning most often in curing ceremonies. There are different levels of priests who use ritual texts in a variety of ceremonies (Lewis & Lewis, 1984). The group procedure proved to be an effective and exciting way to evoke data disclosure.

Instrument reliability and validity was considered during instrument construction. Polit and Hungler (1987) define reliability as the degree of consistency or accuracy with which an instrument measures an attribute. Leininger (1985) maintains that in

qualitative research reliability "focuses on identifying and documenting recurrent, accurate, and consistent (homogeneous) or inconsistent (heterogeneous) features as patterns, themes, values, world views, experiences, and other phenomena confirmed in similar or different contexts" (p. 68). In keeping with this focus emphasis was on acquiring information from the culture members' perspective and often in their own words. The instruments were designed to determine changes that may have occurred in cultural patterns with the changing context, to confirm or verify patterns and views. The different response options allowed for identification of cultural pattern changes in different contexts and with heterogeneous cultural groups. And, the presence of two researchers in the interviews increased reliability of interpretation of data.

Validity in quantitative research refers to the degree to which an instrument measures what it is supposed to be measuring (Polit and Hungler, 1987). Leininger (1985) contends that

> validity in qualitative research refers to gaining knowledge and understanding of the true nature, essence, meanings, attributes and characteristics of a particular phenomenon under study. Measurement is not the goal; rather knowing and understanding the phenomenon is the goal. Qualitative validity is concerned with confirming the truth or understanding associated with phenomena (p. 68).

The instruments isolated numerous phenomena in statements and provided a springboard for discussion of these phenomena, a starting place for respondents' descriptions of the "nature", "essence", and "meaning" of the phenomena. The decision to interview culture members in groups interviews may have enhanced reliability and validity because interviewees were careful to identify alternative opinions and in the case of cultural factors would often discuss a belief until all aspects were explored and consensus was reached. Consistency in response patterns was ascertained between group interviews with the same culture. Interpretations of data were discussed with culture members to ensure correct cultural translation. This process also increased the quantity and depth of the information.

Sample

Persons from three cultural groups comprised the sample for this study. One group consisted of Hmong culture members. A second group was made up of Yiu-Mien culture members. A third group was composed of non-culture members who had lived or worked with the Hmong, the Yiu-Mien, or both groups. Persons were selected for the sample on the basis of the likelihood that they would have knowledge on which to base their responses. For

culture members there was particular attention as to whether they had sufficient facility with English and prenatal or health care concepts or sufficient cultural acumen to provide useful information.

The sample for this study are identified as either key informants or general informants. Key informants are the ones who responded to the instrument(s). All key informants signed consent forms and all culture member key informants consented to the tape recording of the interviews. General informants denote culture members who offered information during instrument development but did not participate in the more formal, tape recorded interviews. These included two Hmong people, Dr. Bliatout and a bicultural Hmong man who inspected the instrument for readability.

Seventeen Yiu-Mien are included in the "general informant" category. Fifteen are the community leaders, elders, shamans and Yiu-Mien priests who were interviewed during instrument development. Data were compiled from informal notes taken at this contact and applied retroactively to the Yiu-Mien instrument. In addition, the young bicultural Yiu-Mien woman interviewed in the needs assessment, and a bicultural Yiu-Mien man interviewed during a pretest, comprise the Yiu-Mien general informants.

The "results" chapter of this report includes information from both key informants and general informants.

Hmong Culture Members

The first group of key informants are nine Hmong culture members. Selection for culture member key informants was through a combination of convenience and network sampling techniques.

Cultural members for the sample were either known by the researchers or were suggested by other culture member key informants or non-culture member key informants using the network technique. The sample of people selected from within the culture were bilingual and often were working in positions which required bicultural awareness.

In addition, during the first Hmong interview, Hmong key informants maintained that no exploration into cultural factors could be considered complete or valid without input from an elder traditional healing practitioner, a shaman. Culture member key informants arranged for an interview with with a male Hmong shaman and provided translation. Hmong shamans may be either men or women. Traditional healing practice for the Hmong combines animism and ancestor worship. Animism is the

belief that nature and natural objects have souls or spirits, that these exist separate from the body.

Faller (1985) states that in her research with the Hmong, small group interviews elicited spontaneous, open sharing of information. Two Hmong group interviews took place. The first Hmong group consisted of three married couples. The second group was made up of one Hmong couple, the Hmong elder, and one Hmong woman. Although culture members were telephoned and individually invited to the interviews, the researchers were never certain exactly how many interviewees would be present.

Hmong key informant demographics are shown on Table 1. Included on this table is information about age, sex religion, marital status, number of languages spoken, number of children, and years in the U.S. Table 2 shows frequency distributions for age and sex of the total Hmong sample including both key and general informants. Table 3 depicts the frequency of Hmong and Yiu-Mien religious leaders in the total sample of both key and general informants.

Yiu-Mien Culture Members

Nine Yiu-Mien key informants were interviewed using the Yiu-Mien instrument. Selection for the Yiu-Mien sample followed the same methods of convenience and networking techniques used in gathering the Hmong

Table 1

Frequency Distribution of Selected Demographic Characteristics of Hmong Culture Member Key Informants

Demographics	Total (N=10)	A	B	C	D	E	F	G	H	I	J
Age											
20-40		26	27	28	32	33	30	31	34	35	
40-65											63
Sex											
Male	5						+	+	+	+	+
Female	5	+	+	+	+	+					
Marital Status											
Married	9	+	+	+	+	+	+	+	+	+	
Separated	1										+
Children											
0	2				+					+	
2	2		+				+				
4	4			+		+		+	+		
5	1	+									
8	1										+
Religion											
Traditional	3		+				+				+
Christian	5	+		+		+		+	+		
Combination	2				+					+	
Years in U.S.											
10	4			+		+			+	+	
11	3		+	+			+				
12	3	+			+			+			
Languages											
4	4	+		+	+				+		
5	3		+				+			+	
6	3			+		+		+			

Table 2

Frequency Distribution of Age and Sex for Hmong Culture Informants

	Hmong Informants key (n=10)	general (n=2)	Total (N=12)
Age			
20-40	9	2	11
40-65	1	0	1
Sex			
Male	5	2	7
Female	5	0	5

Table 3

Frequency of Hmong and Yiu-Mien Christian and Traditional Religious Leaders in the Total Sample

	Hmong (n=12)	Yiu-Mien (n=26)	Total (N=38)
Traditional Religious Leaders	1	4	5
Christian Religious Leaders		2	2
Total	1	6	7

sample. Two Yiu-Mien group interviews also occurred. Two non-culture members who lived with the Yiu-Mien helped to arrange the first Yiu-Mien interview. They invited six women they felt would be able to respond with knowledge to the instrument, to participate as key informants. These six key informants were women who were interviewed together at Halsey Square, and are referred to in the "results" section as the "Halsey Square ladies." Although not all of these six worked in bicultural positions, they were fluent in English and all were knowledgeable about Yiu-Mien ideas of prenatal care.

Three of the Yiu-Mien key informants were men who were interviewed together. All worked biculturally and were fluent in English. Demographics on Yiu-Mien key informant sample characteristics are shown on Table 4. Information about age, sex, religion, marital status, number of languages spoken, number of children, and years in the United States are included in this table. Table 5 shows frequency distributions of age and sex for the total Yiu-Mien sample of both key and general informants. Frequency of Hmong and Yiu-Mien religious leaders, both Christian and traditional practitioners for the total sample of key and general informants is shown on Table 3.

Table 4

Frequency Distribution of Selected Demographic Characteristics of Yiu-Mien Culture Member Key Informants

Demographics	Total (n=9)	A	B	C	D	E	F	G	H	I
Age										
20-40		21	25	30	30	34		25	30	35
40-65							59			
Sex										
Male	3							+	+	+
Female	6	+	+	+	+	+	+			
Marital Status										
Married	8	+	+	+	+	+		+	+	+
Widowed	1						+			
Children										
1	3			+	+	+				
2	2	+								+
3	2		+						+	
4	1							+		
11	1						+			
Religion										
Traditional	5			+	+		+	+		+
Christian	4	+	+			+			+	
Years in U.S.										
8	6		+	+	+		+	+	+	
9	2	+				+				
10	1									+
Languages										
3	5	+	+	+	+	+				
4	2						+	+		
8	1								+	
12	1									+

Table 5

Frequency Distribution of Age and Sex for Yiu-Mien Culture Informants

		Yiu-Mien Informants key (n=9)	general (n=17)	Total (N=26)
Age				
	20-40	8	13	21
	40-60	1	4	5
Sex				
	Male	3	16	19
	Female	6	1	7

Non-culture Members

The third group of key informants consisted of the fifteen non-culture members who responded to the questionnaire by mail. Thirty-two non-culture members were identified as potential key informants and were mailed the questionnaire. Criteria for selection required that they either live(d) and/or work(ed) with one or both of the two cultures. These key informants were selected through convenience and network sampling techniques. They were identified by either their research publications or were recommended by other key informants. Two key informants were suggested by letter in a returned instrument; it read, "While I don't feel that I know

enough to respond, the two persons listed with addresses below have worked for years on just the issues you are studying." Six of the thirty-two were missionaries who lived/worked with the Yiu-Mien in Laos, Thailand, or the United States. The other twenty-six were professionals who work(ed) as midwives, nurses, nurse practitioners, physicians, anthropologists, researchers, or project coordinators with one or both cultures.

Fifteen out of thirty-two of the non-culture member key informants responded with sixteen usable instruments. One of the key informants was familiar with both groups and therefore completed both the Hmong and the Yiu-Mien instruments. Eight Hmong instruments were returned. Eight Yiu-Mien instruments were returned.

Non-culture member key informants were asked to include their age range, academic preparation, work with the culture, previous research and publications if applicable, and any other information about themselves they would like included in the description in the final project report (See Appendix F).

Procedure

Procedure differed between the sample groups. The Non-culture members were mailed the instrument(s). In contrast, the Hmong (culture group) were interviewed using

Hmong instrument and the Yiu-Mien were interviewed using the Yiu-Mien instrument (as an instrument schedule.)

Non-culture Members

The non-culture member key informants were mailed Consent Form A, For Those Responding to the Written Instrument (see Appendix G) and a cover letter (Addendum to Consent Form A) along with the instrument(s). Some of the key informants had experience with both cultures and were sent both instruments. Others were sent only the Hmong or Yiu-Mien instrument. The informants were asked to return the unfinished forms in the envelope provided should they choose not to participate in the study. If the instrument was not received three weeks from when it was mailed, the key informants were telephoned to ensure that the instruments had arrived.

Hmong and Yiu-Mien Culture Members

Culture member key informants were telephoned and asked for an interview. Experience during the needs assessment and the design of the instrument led to a decision to use the instrument as an interview schedule with culture members rather than as a mailed questionnaire. Four reasons lie behind this decision:

1. Interviews allowed flexibility for the determination of areas of sensitivity and to terminate discussion or move to other topics if culture members indicated discomfort.

2. Face to face interviews gave more opportunity for the researchers and culture members to process areas of cultural sensitivity to ensure correct interpretation of data.

3. Interviews allowed the researchers to observe non-verbal communication.

4. Interviews allowed for a less stressful, and more effective, method of communicating with people whose second language is English than would a written questionnaire.

Formal group interviews were scheduled to take place at culture members' homes or, in the case of the Yiu-Mien women, the apartment of non-culture members who live in the Yiu-Mien community. For the other three interviews different culture members who were well known by one of the researchers were asked to act as host and hostesses. In addition, given the bilingual, bicultural criteria, culture members were asked who they would enjoy inviting. Because of the support of the community leaders and close working relationships with community members, this method of organizing the interviews proved effective.

Four formal group interviews took place with both researchers present. The Yiu-Mien women brought children strapped on their backs and the interview with the Yiu-Mien men took place in the presence of one of the men's grandmother in traditional dress with turban and intricately needleworked trousers. At one Hmong interview, the hostess had prepared a Hmong feast as a prelude to the interview.

Each interview began with the culture members being asked to read the Consent Form B, For Those Respondents Being Interviewed (See Appendix H). One of the researchers also read aloud a copy of Consent Form B at the same time and answered any questions the culture member key informants had. The culture members were then asked to sign Consent Form B.

According to Merchant (1987), the concept of confidentiality does not exist for the Hmong and the Yiu-Mien, and information is considered confidential only if one does not say it. Nevertheless, culture members participating in the pretest of the instrument repeatedly requested anonymity and suggested that culture member key informants would feel protected and be more likely to respond truthfully if they were sure they would not be named. For this reason the researchers chose to ensure anonymity for culture member key informants for matters

over which they had control. But with group interviews confidentiality cannot be ensured.

An identification number was marked in the corner of each instrument. A list of the names of participants and their corresponding identification number were kept separate from the completed instrument as a means of safeguarding confidentiality. Signed Consent Forms B were kept with the list of participants' names. Culture members were asked their age range, gender, marital status, occupation, number of children, number of years in the U.S., and religious affiliation and this information was marked on the instrument. When culture members agreed, the interviews were tape recorded. After research results were written, the tapes were destroyed. All culture members agreed to the taping during the formal interviews. Responses from culture members were marked on the instrument and comments, opinions and elaborations were noted in the "comments" space.

Group interviews took between two and five hours. A small gift of fruit was brought to the interviews as a token of sincere thanks to culture members.

Analysis

Several methods of analysis were used in order to obtain a comprehensive view of the data within its cultural context. The analysis process took place over

time. The analysis moved through phases and included both the interpretation of the data and verification of that interpretation. During verification further interaction with culture members often produced more quantity of data and data of a more profound depth. This process of moving back and forth between gathering and analyzing sometimes happened simultaneously during an interview or days and weeks later.

Two examples illustrate the inductive and deductive analysis process. Analysis moved from specific information to explore its generalizability within the culture. For example, during the needs assessments interview with the young Yiu-Mien woman, she mentioned that a Yiu-Mien would not clean the stove during pregnancy. A literature reference was found which illustrated this specific practice and related it to broad religious and cultural beliefs.

Analysis also moved from the more general information to specific application. For example, most Hmong people believe in reincarnation. This belief has specific applicability when a Hmong person faces surgery because the removal of any body part threatens the physical integrity of the next incarnation.

Each culture was compared against an earlier stage of its own history. This historical perspective gave a basis for documenting the lifeways of each culture and for making inferences about their changes. Examination of current cultural beliefs and practices were made against historical reports found in ethnographic literature. From this examination, ideas were generated and additional questions were added to those asked on the instrument. For example, within the Yiu-Mien culture, Kandre (1967) found a 10 percent adoption rate. Was this related to the female sterility mentioned by Lemoine (1983)? Is female sterility a problem today with Yiu-Mien living in the United States? Are adoption practices similar to those observed by Kandre or have they changed?

The absence of historical data also lead to the formulation of new questions such as "how has relocation and acculturation affected time-honored beliefs and practices?" "Have cultural values changed with adaptation?" This analytic procedure was guided by ideas suggested by Schatzman and Strauss (1973).

Within each culture group analysis for differences and similarities of informant reports were made. Informants consistently reported differing categories of viewpoints which they related to age and religious views. For that reason when statements were evaluated particular

consideration was paid to characteristics which described informants, such as age. Moreover, analysis compared culture member responses with those of non-culture member key informants.

Findings were fed back into the inquiry process for verification. This approach led to the analysis of diversity in cultural perspectives and beginning evolutions of contrasts within the cultures. In addition this analysis led to deeper understanding of cultural practices and complexities, particularly those related to traditional religious beliefs.

The analysis process compared qualitative results from this and other ethnographic studies to the quantitative conclusions reported in the Oregon State Health Division, Center for Health Statistics [Hopkins] study.

Ethnographic methods allow the data to speak for itself. And, culture member and non-culture member informants offered data that spoke in ways that were moving, revealing, and sometimes profound.

CHAPTER III

RESULTS

Yiu-Mien Results

Introduction

Yiu-Mien results are being presented before Hmong results, although in the preceding portions of this report the Hmong are presented first. This is to denote no preference for either culture group by the authors; both are "number 1".

The four sections of Yiu-Mien results will be reported in the following format. First an introduction will outline each section. Each section corresponds to the different main headings of the Yiu-Mien instrument. The literature associated with the section will be discussed most often in a separate segment. In the Yiu-Mien results section on "Infertility and Adoption" the introduction and literature review are combined. When applicable, reference to the literature will also be included in response components and will be used to explain and/or expand upon responses. Culture member responses will be designated and separate from non-culture member responses. Finally implications for health providers will be identified.

Data for these four Yiu-Mien results were gathered from the formal interviews with the six ladies of Halsey Square and the formal interviews with the three bicultural men, all key informants. Ages for these key informants ranged from 19 to 59. Five practiced the Yiu-Mien traditional religion. Four were Christian converts. Data were also compiled from the informal interview with the fifteen community leaders including elders, shamans, and Yiu-Mien priests. Data were collected during a telephone conversation with one of the Yiu-Mien community leaders who was present also at the spontaneous interview. In addition, data reported here were collected in one interview with a bicultural man during the pretest of the instrument. Finally portions of the analyzed data were discussed with a Yiu-Mien leader. The purpose of this discussion was to verify quotations from the less formal interview with the fifteen Yiu-Mien leaders which had been attended by this man. A second purpose of the meeting was to clarify and expand upon data interpretation from the other interviewed sources.

Data for the non-cultural member components of each section came from instruments sent to the group of non-culture members. Eight non-culture members returned completed Yiu-Mien instruments.

Practices Related to Pregnancy

Introduction

This section includes a discussion of certain practices and behaviors of the Yiu-Mien related to pregnancy identified in the literature and in various personal communications. Specifically it is concerned with Yiu-Mien practices and behaviors surrounding the communication of pregnancy. Because some of these behaviors directly affect the Yiu-Mien interface with Western care providers, possible belief sources of behaviors are explored.

Culture members outlined various influences which affected initiation of prenatal care and this is discussed in the "Influences on seeking prenatal care" component of this section. Finally, the section concludes with a discussion of implications for health care providers. Implications are identified and suggestions from both culture members and non-culture members are offered to improve health providers' understanding of Yiu-Mien cultural behaviors surrounding pregnancy and Yiu-Mien understanding of Western prenatal care.

The Literature and the Yiu-Mien Instrument

The Center for Applied Linguistics, Fact Sheet #2, "The Mien", states "a Mien woman is reluctant to talk of being pregnant, nor does her husband or family talk about

it. Much of this is due to fear of evil spirits harming the baby or the mother" (Language and Orientation Resource Center, 1981, p.8). Do the Yiu-Mien of Oregon avoid discussion of pregnancy? If so, is this due to a fear of evil spirits or other cultural beliefs? The various statements and question of the "Practices Related to Pregnancy" component were designed to explore these questions and to capture how this might influence the Yiu-Mien woman's prenatal care. Finally, the instrument asks, in what ways could cultural mediation "bridge" Yiu-Mien and Western prenatal care practices, seeking suggestions for a smoother articulation between cultural practices and Western care. "Cultural mediation" refers to mediation as used by Tripp-Reimer (1984) "to understand, interpret, and intervene based on what both the physician and patient are perceiveing" (p. 103).

Cultural Members Respond

Fear of spirits.

Culture member informants agreed that the Yiu-Mien do not talk about pregnancy, however they actively denied that this was out of fear of intervention from evil spirits. When asked about evil spirits harming the baby or mother the spiritual and cultural leaders adamantly stated, "This is absolutely a false statement." However they acknowledged that this idea may have come from a

misinterpreted practice. They said in Laos virginity was highly valued in a girl. If a young unmarried girl became pregnant, her parents, to save face and cover up the disgrace, would tell her that if she spoke of this pregnancy to anyone, a bad spirit would overhear and it would harm or snatch the baby away. This group implied that this was to ensure the girl's silence rather than stemming from an actual fear of spirits.

"Because we are shy".

The Halsey Square ladies indicated that it was not because of fear of spirits that they avoided discussion of their pregnancies but because "we are shy." The men interviewed also agreed that the Yiu-Mien prefer to avoid discussion of pregnancy. In part they concurred it was out of "shyness" but they gave other reasons for this practice. One of these respondents stated that although fear of spirits "overhearing and causing harm" might be a belief in Laos or among older Yiu-Mien, for his generation, 20-35, this belief was not a reason for avoiding discussion of pregnancy.

Cultural appropriateness and respect for privacy.

"It is not culturally appropriate for us to discuss pregnancy. If someone asked me if my wife were pregnant, I would tell them the truth, but it would not be polite to ask. It's like `Don't get your nose in my business.'"

"Sometimes the wife will not even discuss it with her husband. He will find out because she will complain of headache, nausea, she won't eat so the family know. Then the mother or grandmother will talk to the son a little and advise him how to take good care of his wife. Some younger people are more open. Husband and wife have to discuss to see if they want abortion." "My husband did not keep it secret and I got mad at him." "If you consider yourself a good Mien you don't really like to talk about it."

Culture members were asked if discussion of pregnancy is "taboo". They responded "It once was taboo. Now only kind of. If I know you are pregnant and I talk about it, it is insulting." "It isn't the way." They intimated, though, that the reason for the avoidance of discussion was more related now to respect for privacy and familial confidentiality than out of fear.

Modesty.

The idea that the Yiu-Mien women are shy and modest was one that was often repeated in the culture member interviews. The issue of modesty was directly related to hesitancy to access Western prenatal care. "We hate to undress." "It would be better with a lady doctor." "We don't understand why they have to go inside us if nothing

is wrong." "If you examine my stomach why do I have to take off my trousers and shirt as well?"

The six ladies of Halsey Square suggested that they would prefer women translators. However in our interview with a male translator, he stated that he always let the Yiu-Mien woman know at the beginning of the interview that he would not be staying in the room when she undressed and this information usually relieved her discomfort. Culture members were asked if the Yiu-Mien woman might feel more comfortable if her husband were to accompany her for the examination. Although of course there are individual preferences, it was generally felt that most Yiu-Mien men would be embarrassed by this and that it might increase the woman's discomfort rather than decrease it.

Culture members also suggested that it would be best if medical and nursing students were not in the room during pelvic exams with Yiu-Mien women. They said patient embarrassment was decreased with one consistent provider. They further explained that when students were involved some Yiu-Mien felt that they were being used as "resources" or that "the doctor only wants to learn about them for experiment."

Culture members claimed that Yiu-Mien were only "shy" about discussing the pregnancy with friends, not with the doctor or health worker. However, this "shyness" may

contribute to delaying initiation of prenatal care in several ways. For example if it is inappropriate for the Yiu-Mien woman to discuss her pregnancy, it becomes much more difficult for her to marshal support to get to the prenatal appointment. She may need culture members to help with baby-sitting or transportation and might feel embarrassed to ask.

Non-culture Members Respond

It is interesting to note that seven of eight non-culture members respondents do state that fear of spirit intervention is in part responsible for the Yiu-Mien reluctance to discuss pregnancy. Some non-culture members stated however that this is more a factor for the older people who practice the traditional religion and in general is changing. Five non-culture respondents also indicated that this belief was "not widely admitted". Yiu-Mien traditional religion includes a combination of animism, ancestor worship, and Taoism as it was practiced in China in the 13th and 14th centuries (Lewis & Lewis, 1984; Lemoine, 1983). Their cultural and religious art includes sets of 17 paintings, depictions of the Taoist pantheon.

Influences on seeking prenatal care.

One statement on the instrument was designed to examine the relative weights of "restraining forces"

versus "driving forces" for the Yiu-Mien woman considering prenatal care (Lancaster & Lancaster, 1982). Culture members were asked if the risks of prenatal care were perceived as outweighing possible benefits.

Culture members had little difficulty identifying restraining forces. These included difficulty finding transportation and baby-sitting, fear of venipuncture, no medical coverage, embarrassment over disrobing particularly in front of a male, difficulty with the language, and the idea that they would once in the system, have to return every two weeks for follow-up. Also included in restraining forces is lack of perceived need. "They trust themselves a lot about their care. They don't see there is really a need until some trouble occurs and this then is the time they like to see a doctor." "They think the baby is not sure yet. They don't feel any movement so they kind of believe they're pregnant and kind of don't believe." "Their mother had six or seven babies in Laos and never saw a doctor so they think why get involved here."

It was difficult for culture members to identify driving forces or possible benefits of prenatal care. "Some Yiu-Mien feel that babies born in America are healthier and bigger than their brothers and sisters born earlier in Laos and they think this is because of WIC and

because of early prenatal care." Women, Infants, and Children (WIC) is a federal supplemental food program for low income qualifiers. In fact WIC was the most often mentioned benefit of prenatal care. In analyzing the culture member interviews other specific benefits of prenatal care were lacking.

Strategies for cultural "bridging".

Culture members offered several thoughtful suggestions for better articulation between their cultural self care patterns and Western health care systems. They suggested that it is important for health care workers to be aware of Yiu-Mien values of privacy and familial confidentiality and stated that this has direct effect on the "openness" of the culture member. "They are not very open and if you want to know more information, make sure you ask as many direct questions as possible. They will not tell you if you do not ask."

They suggest when possible that a consistent female health provider and interpreter be offered to women. When this is not possible it is important to make sure the Yiu-Mien woman client knows from the beginning of the interview that the male interpreter will not be in the room when she is undressed. They urge that providers be educated about the extreme embarrassment the Yiu-Mien woman might feel when asked to completely disrobe.

Another suggestion which came from culture members had to do with venipuncture. Yiu-Mien believe that taking blood causes weakness and energy loss. When this is necessary, they advise, take as small a sample as possible and provide an explanation, such as "more blood is needed to test different parts of the body."

Culture members also suggested that "newcomers", that is recent refugee arrivers, have friends accompany them on prenatal visits. This is so that the "friends can help them to know what is going on."

Non-culture members also had several proposals for "bridging". First they advise less intrusive exams, using culturally sensitive and trusted interpreters who are respected in the Yiu-Mien community. Second, they suggest educating the Yiu-Mien to the advantages of early prenatal care with emphasis on the improved health of the subsequent child. A third suggestion corresponds to the culture member's suggestion for a female, consistent, health provider with good understanding of the Yiu-Mien: "She should be trusted by the community."

Conclusion of "Practices Related to Prenatal Care".

Clearly, the practice of avoiding discussion of pregnancy continues and has important implications for the Yiu-Mien family considering Western prenatal care. In addition the Yiu-Mien woman's idea of modesty and her lack

of a perceived need unmistakably play a part in her hesitation to access prenatal care.

Beliefs Related to Pregnancy

Introduction

The idea that, as an element of the Yiu-Mien woman's self care during pregnancy, she would avoid cleaning the stove or sewing, emerged in the early phases of our research during the needs assessment interviews. Our informant was a twenty-one year old Yiu-Mien woman, working biculturally who had been in the United States for ten years. She told us little about these practices, but did convey both that the practices related to beliefs and that she would not "tempt fate" were she pregnant. "My cousin miscarried right after cleaning the stove." (We suggested that inhaling oven cleaner might be enough to cause miscarriage, but she laughed and said that this was a Yiu-Mien practice from Laos, long before the days of spray cleaners.)

Literature

The literature provided an explanation for these practices. The Lewises (1984) in their book, People of the Golden Triangle, write:

> Mien believe that during a woman's pregnancy the souls of the unborn baby do not yet reside in the fetus, but in various locations, depending on the month of the year. During the first and seventh months, the souls reside in the door of the house. The second and eighth months they live in the stoves. The third and ninth months find them in the rice pounder and the maize mill, and during the

> fourth and tenth in the floor near the altar. During the fifth and eleventh months the souls live in the mother's body, and during the sixth and twelfth in the mother's bed.
>
> Precautions must be taken to prevent miscarriage and deformity. For example, Mien will not strike the door or rice pounder with a knife of any kind. They are careful not to spill water on the fireplace, nor will they enter the bedroom of a pregnant woman for fear the souls of the unborn infant might be frightened away. (p. 156)

The Lewises were writing about Yiu-Mien of Thailand. To what extent were these beliefs shared by the Yiu-Mien of this area and how might these beliefs affect Yiu-Mien self care practices? Finally, might these beliefs affect Yiu-Mien access of Western prenatal care and is awareness of the beliefs of importance to Western health care providers? This section examines these questions.

Culture Members Respond

Souls of the unborn baby.

When asked if Yiu-Mien believe the spirit of the unborn child lives in different places of the house throughout the pregnancy depending on the month of the year, culture members responded, "It depends." "Some believe, some don't." Culture members stated this was a traditional belief and "for some people it is just as true here as it was in Laos." For others though, particularly for Christians and young people, it is changing. "If you are Christian, the spirit is in the body so it is not

true. This depends on how strong you believe and how educated in Christianity you are. Some new Christians say they believe in Christianity but still follow the old ways."

Beliefs and practices.

Beliefs about the soul of the unborn baby require that certain practices be maintained. For example during the months the unborn baby's soul resides in the mother, she cannot cut her hair, nails or mend her clothing. When the soul lives in the mother's bedroom scissors or other implements that might cause damage to material in the room such as a saw or hammer, cannot be used there. It is believed to do so can cause a deformity in the unborn baby, such as a cleft lip or palate. No one is supposed to clean the family's stove while the soul is living there. Likewise, no one can fix the bed while the soul resides in it. It was explained that these beliefs can present problems for Yiu-Mien renters. "I think this question is important because sometimes the apartment manager comes inside the apartment to fix the door. If the spirit of the baby is there, that would be real bad." It was further explained, though, that if the door is falling down and must be fixed, "the shaman will come to the house and do a ceremony before fixing. The shaman

uses the water to move the spirit out of the door so it can be fixed. Only a shaman can do this."

It should be noted that the Yiu-Mien have both priests and shamans. Culture members tended to use the term "shaman" rather than the more technical "priest" to designate a practitioner of traditional religion. Yiu-Mien priests are "mentored" for several years to learn the rituals required. In addition they must learn to read the ancient Chinese texts which are the reference books for the correct method in ritual and ceremony. The shaman "differs markedly" from the priest. "He has either inherited a capacity for possession by supernatural beings, or has been chosen by those beings to serve as a medium" (Lewis & Lewis, 1984, p.161).

Culture members thought that young people might not actually believe that the unborn soul resides in the various places but that they might still practice the required behaviors as if they did. "I don't think the teenagers care about those things." If however, "the teenagers are dependent on their parents they may still have that belief." "The parents are the main key to the whole thing." "A good daughter will usually listen to her parents. It doesn't matter if she believes or not. She will still do what the parents tell her." If she is

living with her husband's family she will follow the instructions of her mother-in-law.

It is considered the mother's responsibility to know where the baby's soul is located. A 59 year old woman practitioner of Yiu-Mien traditional religion was able to state which months went with which soul location. However, none of the younger women or men knew this. It was explained that the shaman, or traditional healer could "always look it up in the book". "The book" is the Yiu-Mien Book of Days (Thong So) and is one of the Yiu-Mien reference books. It is written in Chinese and, in addition to information on the location of the soul of the fetus, contains astrological information. "The book" is consulted before marriage by non-Christians to see whether a marriage will bring good fortune. The month and year of the bride and groom-to-be are compared (Lewis & Lewis, 1984). "The book" may also be consulted to determine an auspicious date for a house warming. This is only true for non-Christians. It is of interest to note that at one time many Yiu-Mien men were literate in Chinese.

Non-culture Members Respond

Souls of the unborn baby.

A non-culture member responding to questions on the Yiu-Mien instrument relating to beliefs and practices concerning "souls of the unborn baby" stated that some

beliefs and practices "although animistic are also cultural and may be practiced across the board by Christian and animist alike."

A non-culture member respondent related: "If there is a pregnant Mien woman in a house that you are going to visit it would not be uncommon for them to not allow you to come in during certain times of her pregnancy so as to avoid you offending the unborn child's spirit." Non-culture responders chose response option 3, "I don't know enough about this subject to respond" more often for these series of statements than any other and they, like the culture members, had differing opinions on whether these are important cultural concepts for health providers to know.

The Literature: The Wuen

Jacques Lemoine's work on "Yao Religion and Society" in McKinnon and Bhruksasri's book, Highlanders of Thailand, (1983) was also useful in exploring beliefs of the Yiu-Mien. The Yiu-Mien believe they have several souls. Lemoine describes the two sets, the be and the wuen. The wuen souls may have bearing on the Yiu-Mien prenatal self care.

> During pregnancy the mother gives the three wuen to her child. The wuen equate with life. Without them a child cannot live and will be still-born. When this happens it means that the wuen of the mother

> were not strong enough: the part she shared with her child was too weak. Another consequence of such weakness may result in the death of the mother herself after giving birth. (p. 207)

Culture Members Respond

The wuon.

This refers not to where the soul(s) live but from whence they come. When the six Yiu-Mien women were asked about the wuen they had a difficult time understanding our statement. "What is wuen?" they asked. "I don't understand this." When they finally recognized wuen as a Yiu-Mien word, they laughed both at our pronunciation and at the concept. "No," they said, "the mother does not give the baby the soul." (It was suggested that Lemoine's spelling of "wuen" is confusing in translation and the spelling "wuon" is more correct.)

The Yiu-Mien elders group explained, "The mother has her own soul and the baby has its own soul." If however, "the mother's wuon is weak, her health is weak, and if her health is weak, it could result in a complication to the baby and to the mother."

When asked in what ways the mother's wuon could be strengthened, culture members responded, the mother's health, not her wuon could be strengthened by certain interventions. And, should the mother suffer from tsang wuon or wandering souls, there was treatment. Treatment

to improve the mother's health included her husband offering up prayers for her. In addition the Yiu-Mien believe that when the soul is lost or wandering they might "have to sacrifice." "It doesn't make the wuon strong, it makes the woman strong. After the sacrifice, the wuon comes back to the woman's body so she can grow healthy."

Health protection in pregnancy.

In fact, "No matter how healthy you are or how weak, when you are pregnant everybody helps to protect that baby as much as we can, by sacrificing, certain ceremonies, offering a chicken or pig." "The shaman comes over to give a special ceremony for the pregnant woman." (Another culture member suggests that this is incorrect use of the term "shaman" and that the proper term is "priest".) The ceremony is done around the fifth and eighth months of pregnancy. And culture members claimed 99 per cent of the non-Christian Yiu-Mien population would have this ceremony as an aspect of prenatal health promotion and problem prevention.

Interface with Western care.

These beliefs, the idea that the the soul of the unborn baby exists in different locations that require awareness and avoidance of certain behaviors such as cutting or mending, the idea that ceremony and sacrifice

are preventative interventions that strengthen the mother and baby's health, and the idea that if the mother's souls are wandering they can be called back, are all aspects of cultural self care for the non-Christian Yiu-Mien woman. They are complex and subtle concepts and are not easily simplified for explanation. In addition the literature is sketchy and at times responses were confusing. Therefore, conclusions must be cautiously applied.

However, the beliefs do have implications in the culture member's interface with Western prenatal care. Again, culture members informants explained some culture members see no need to access western prenatal care and consider cultural self care to be adequate. "In the old time back in the old country, there is no doctor. Even here some people give birth to a baby in their home and the mother-in-law is doing the prenatal care. She is the nurse and gives advice and takes care of everything." For some the only "reason to see a doctor is for the benefits and the resources available." Others give birth in the hospital for two reasons. "The landlords won't allow you to have your child at home. They are afraid the landlords will find out and they will be evicted." "And they want the [birth] certificate." "They are afraid that the doctor or nurse will not believe that it is your own child

but that you steal from someone. They are afraid of many things."

Important for health providers?

Yiu-Mien had differing views on whether health providers need to be aware of these beliefs. One Yiu-Mien medical translator suggested that sometimes Yiu-mien women observing the practices related to the location of the fetus' soul might not cut or wash their hair or change clothes even though they may need mending. They would appear perhaps unkempt, or depressed and not "taking good care of themselves" when in fact they were ensuring a healthy baby. Other respondents felt that these practices were important for family members however were not of particular importance to health providers. Still other culture members believed that any cultural education of providers was useful in enabling them to provide culturally sensitive care.

A non-culture member suggested that the term wuon "really carries what Western medicine is concerned about in prenatal care. Gradually [Yiu-Mien] women will bring the two conecepts together in their thinking, perhaps. Better understanding between their culture and American methods" could help in the interface.

Infertility and Adoption

Introduction and Literature

When the Yiu-Mien instrument was originally designed this main heading was called "Fertility and Adoption", however "Infertility and Adoption" is a more accurate title, for it more clearly identifies the two subjects examined. This section of the instrument was created to elicit information about Yiu-Mien perceptions of infertility. In addition it explores the possible connection between infertility and the practice of adoption. Kandre (1976) suggests they are connected. He claims that because for a Yiu-Mien "being childless is a major individual and social problem, one always attempts to solve by adopting children...." (Kandre, 1976, p. 176). Lemoine (1983) makes note of adoption being an answer to the Yiu-Mien "need for additional labour, and the problem of female sterility" (p. 203). No documentation on rates of infertility or other reference to female sterility could be found in the literature. However, the subject of Yiu-Mien infertility did arise in personal communication with non-culture members (Lombard, S., personal communication, 1987; Rilette, K., personal communication, 1987).

This section investigates whether the Yiu-Mien of Portland perceive infertility as a problem. If infertility is of concern to local Yiu-Mien, what treatments might they consider? Finally, this section explores the well documented and reportedly widespread Yiu-Mien practice of adoption (Iwata, 1960; Lemoine, 1983; Lewis & Lewis, 1984; Kandre, 1967, 1976; Language and Orientation Resource Center, 1981).

Adoption is a time-honored, traditional custom for the Yiu-Mien. Kandre (1967), in his research in Northern Thailand and Laos, found that 10 percent of the Yiu-Mien population had been adopted from other ethnic groups (Kandre, 1967). The Yiu-Mien only offer their children for adoption to other ethnic groups in extremely rare instances such as the case of the Yiu-Mien child offered to and adopted by the King and Queen of Thailand. However, adoption does take place between Yiu-Mien families (Lewis & Lewis, 1984). Is adoption practiced by the Yiu-Mien in the United States? Do culture members associate the practice of adoption with infertility? Is there any difference in status for the adopted Yiu-Mien than the "born to" Yiu-Mien? These are questions explored in this section.

Infertility: Culture Members Respond

"Infertility is high for the people."

Investigation of Yiu-Mien infertility rates is beyond the scope of this study. However, respondents were asked their opinions about whether they believe infertility is a common problem for the Yiu-Mien. Whether or not Yiu-Mien infertility rates are high, infertility is perceived as a serious problem by culture members when it exists. Men and women culture members suggest that "there is lots of infertility with the Mien people." "Infertility is high for the people." It is believed the ability to conceive "depends on the husband's and wife's spirit. If their souls are matched together, then they might have a baby." One can tell if the "souls are matched" through use of The Book of the Days, Throng So. When the couple are to marry, their birth months and years are investigated. The Book of the Days, Throng So, is consulted to determine whether the match will be auspicious. The likelihood of the couple producing offspring is an important factor. "The shaman can look in the book to see if a couple matches and will have babies, but they cannot tell you how many you will have."

Another culture member stated, "the Throng So has two parts. One part relates to how the couples' match and the other part relates to the individual's life. The Yiu-Mien

priest (not shaman) cannot tell a couple the number of children from the part of the book that discusses the match. But, he can look at the section of the individual's life and tell."

Infertility, causes and treatment.

"In our culture it's OK for a boy and girl to stay together before they are married. The boy might have fooled around and have many kids outside the marriage. So when he marries with his own wife and has no children, that's how we know that the woman can have no baby. Sometimes the woman had a baby before she marries and after she marries has no baby so that is how we can know which one to blame, but you cannot just blame in general." Perhaps it is not surprising that male responders tended to infer that the problem of infertility was most often a problem of the woman while female responders intimated that the problem was most often with the man. The men identified several reasons for female sterility. "If you marry too young, then there is damage. Or the girl may have been sick at an early age and be damaged inside."

The leaders too discussed infertility. "This was a very serious problem in the past. After the first year of marriage you would wonder `why is this happening.' After the second year again you question `why?' The third year

you go to the shaman for advice and he will talk to the spirits. He will do `spiritual research' by entering the spirit world to consult the spirits to see where the problem is. He does this to get reconciliation with the spirits. The fourth year, adopt at once or perhaps get another wife."

The Yiu-Mien leaders identified three treatments used in Laos for infertility but said if the treatments failed, then it was usually assumed the girl was sterile. Perhaps "she had intercourse too early, had a boyfriend at too young an age. Maybe the boy damaged her inside." They denied that venereal disease was the cause of the problem. The treatments prescribed included a ceremony aimed at spiritual reconciliation, an herbal treatment which consisted of an herbal decoction made from jungle or forest plants, and intervention by the "burning doctor" who would burn the joints of the body. (The latter treatment was said to be quite painful.)

The Halsey Square ladies responded to the discussion on infertility with much giggling and at times outright laughter. They were familiar with the concept of artificial insemination but not with the medical term. They had many questions about this process. How long does it take? Is the doctor the donor? Does the doctor have a

picture of the donor? Does the woman have a choice over the race of the donor? Is it expensive?

They added that many couples in their strong desire to conceive would be open to Western medical treatment for infertility, and in fact some couples had availed themselves to Western intervention and been successful. However, the ladies of Halsey Square thought that the expense of medical treatment was a major hindrance to infertile Yiu-Mien couples considering this option.

Non-Culture Members Respond

Four of eight non-culture member respondent agreed that infertility did seem to be a common Yiu-Mien problem. One of these respondents thought however that it was more a problem for Yiu-Mien older than 25. Another suggested that it has been a problem in past years. Respondents speculated that "promiscuity", "poor hygiene", and "disease", might be causal factors. One respondent stated that this is "partially true," suggesting "there is some percentage of infertility but I don't know if it is a high rate." Three non-culture respondents thought that Yiu-Mien women would be interested in Western treatment for infertility but two of these respondents indicated that Yiu-Mien women might be discouraged from seeking care by their husbands and/or older family members.

Adoption: Culture Members Respond

"Infertility is only one of the reasons a Yiu-Mien couple would adopt."

Culture member informants report that adoption is common in the United States, but could not estimate its frequency. The elders stated, "It is practiced as much in the United States as in Laos." Other culture members felt that perhaps adoption was not as common in the U.S. as it was in Laos, but definitely agreed that the practice does continue. It was surprising to find that out of the nine formally interviewed Yiu-Mien, two were themselves adopted and three others had adopted children.

The traditional practice of adoption was related to social need. In the United States even though manual labor isn't needed, it was explained, a large family is important to work together to take care of each other, a form of social support and social security and a way to ensure continuity in worship.

Other culture members associated adoption with infertility and economics, Lemoine's "need for additional labour." "People adopt because they couldn't have their own but also because they needed more help like a baby-sitter to take care of all the little ones. In the U.S. we have no big farms so adoption is less here. In this country, if you have a lot of children it is very hard for

the mother and father because it costs so much money." This implies that the economic advantage of adoption in Laos might be offset by the different labor requirements and the high cost of raising a child in the United States.

"Infertility is only one of the reasons a Yiu-Mien couple would adopt. They would also adopt for economic reasons." "In our country adoption was adding a worker to your house, but here people still adopt. For example, I adopted two children. It's important that I have somebody who can carry on my name and also my spirit, my ancestors' spirit." This refers to the practice of ancestor worship which requires a male heir.

The "quiet" process of adoption.

There is a right and proper way that the Yiu-Mien pursue the process of interfamily adoption. "We think that children are very valuable. If I adopt a child, I have to know the other family's background." "The child must come from a good background...." In addition, we were informed, the adopting family will be investigated and must be considered a good family. "The [adopting] family is checked to see if they would be able to provide proper care. If the Yiu-Mien family is not able to afford it [the child], they like to give to close friend or relative." "The families still keep in touch. For

example, I bring my child back to visit the natural parents once a year or every six months. They live in Seattle."

"If we adopt from outside the Yiu-Mien culture, from other ethnic groups, we have to pay. If no Yiu-Mien offer you kids, then you adopt outside. Quietly." For adoption within the Yiu-Mien population "we don't talk about selling and buying children. But if you have many children, I may ask if I can adopt one. I can't come right out and ask for one, but I have to act some way to make you understand about adopting the baby, so you won't feel bad." Certain ways of asking might imply that the family giving up the child were not financially or otherwise capable and cause them to "lose face".

"A Mien couple would never <u>offer</u> their child to someone else for adoption. If a couple doesn't have their own, they would go to another couple who has five or six and ask them quietly, secret, `because I don't have baby can you give me one?' It is secret, if they say no." Culture members implied that there are subtle ways to go about negotiating adoption and that it is a private, quiet process. In addition, it is important to observe the proprieties for the process to be successful.

The "bridge" child.

"Bridge" ceremonies are a part of the Yiu-Mien religious tradition. They are thought to be useful for sickness and curing. In a way the bridge ceremony connects the world of the spirits with the material world. We were informed that about 90 percent of the adopted children of the Yiu-Mien are named "Chio" which means "bridge". It is believed the "bridge child" or adopted child can help an infertile couple conceive. "My mother adopted three and had three. Every time she adopted one, she had one."

"I love him the most!"

When asked whether adopted children were considered inferior or if there was shame attached to being adopted, a culture member who was herself adopted said, "My mom loved me and adopted me because she wanted me. She gives me everything." Another adoptee said "When I was adopted my mom was still not married yet, and my mom's parents did not have any boys, just all daughters. They wanted their daughter to stay home and marry and take care of them. So they adopted me to make her feel closer to them, more valuable. It was like a gift, to help her to stay home, marry, and take care of them."

Kandre (1967) in his discussion about children adopted from outside the Yiu-Mien ethnic group, states that he "discovered no sign of a feeling of shame or oddity or inferiority attached to being a `bought child', or being born to parents from another ethnic group....But `bought children' are not always treated with the same affection as the others" (Kandre, 1967, p. 594). Lemoine (1987) in Refugee Update claims, the Yiu-Mien "freely adopt children from neighboring tribes, and being free of racial prejudice, they consider cultural identity more important than blood origins" (p.7). In the course of the interviews discussion arose about a California Yiu-Mien family who adopted a Caucasian child. When asked whether he would be considered truly Yiu-Mien, culture members adamantly responded, "I've heard he looks like American people, his hair and eyes, but he speaks Mien. The skin and hair is different, but he is Mien on the inside." One member stated, "I know her [the mother] well. She said to me, `I chose to adopt this one and I love him the most!'"

Adoption: Non-culture Members Respond

Non-culture members suggested that the traditional practice of adoption might also be related to the high infant mortality rates of Laos, which one respondent estimated at over 20 percent. They also indicated that adoption often takes place in Yiu-Mien families without

male children. "Often adoption occurred because they had 5 or 6 girls and no sons to carry on the family line. This is very unfortunate because it is necessary for sons to pay homage to the ancestors and spirits." Finally in response to a question about the status and treatment of the adopted Yiu-Mien child, non-culture members for the most part agreed that there is no shame or inferiority attached to being adopted either from within or without the Yiu-Mien ethnic group. They agreed that one can be a "true Yiu-Mien without being born of the tribe." One respondent stated, "If ritually initiated into the family `spirit roster' a child has the same rights as an actual son and can inherit equally." However, non culture members reminded, the love an adopted child receives has wide variation and depends upon the individual family and circumstance.

Infertility, Adoption, and Western Medical Care

Opinions from both culture members and non-culture members varied on whether information about adoption practices were important for health providers to know. Culture members did concur that the traditional practice of adoption was in part related to infertility, but also occurred for other reasons. However, because there is no research on the incidence of infertility, Yiu-Mien

reproductive health concerns remain puzzling and in need of further investigation.

One male culture member respondent felt that it was crucial that health care providers be educated about a Yiu-Mien belief that has important ramifications for reproductive health. "Yiu-Mien believe that after delivery of a baby the woman's inside is `very young' and that anything cold, eaten or drunk, or even a cold draft will cause damage to the reproductive system or infertility. We don't want ice water or jello. We want to wrap up in blankets and drink hot water or eat hot food." Although it is difficult to speculate how this might affect components of prenatal care for the Yiu-Mien, it certainly could affect the appropriateness of post-natal Western care and might if incorporated into practice with Yiu-Mien clients improve Yiu-Mien perceptions of Western care in general.

Marriage and Pregnancy

Introduction

This section explores the relationships between cultural factors and three risk factors frequently associated with low birthweight. It identifies cultural values that might be related to these factors and investigates cultural reaction to birth control. In addition, important cultural practices "bride price" and "cultural marriage" are briefly discussed.

The Oregon State Health Division [Hopkins] (1987) study "Maternal and Infant Health Characteristics of Oregon's Indochinese Refugees, 1984-1985" examines several risk factors usually correlated with delivering low birthweight infants: age, marital status, and education. Women under 20 or over 34 are considered to be at higher risk, as are single versus married mothers. "Marital status is...related to low birth weight with an effect independent of the fact that many unwed mothers are teenagers" (Oregon State Health Division, Center for Health Statistics, [Hopkins], 1987,p.6). And, infants born to mothers with less than twelve years of education are more likely to have low birthweight.

The Oregon data for all births in the state analyzed by the Oregon State Health Division indicates a high prevalence of risk factors for low birthweight among the

Yiu-Mien. Forty-two percent of the Yiu-Mien mothers delivering in 1984-1985 were teenagers compared to eleven percent of all Oregon mothers. The study indicates that forty-five percent of Yiu-Mien mothers were "unmarried;" nineteen percent of all Oregon mothers were unmarried. And for the years 1984-1985, ninety-five percent of Yiu-Mien mothers had less than a high school education compared to nineteen percent of all Oregon mothers. Data for this study was complied retrospectively from birth and death certificates filed with the Oregon State Health Division's Center for Health Statistics.

Teenage pregnancy in mainstream America is associated not only with low birthweight but also is often associated with lack of family support and a decreased chance for education or economic advancement. This is not necessarily true for the Yiu-Mien. Yiu-Mien come from a swidden (slash and burn) agriculture economy where early pregnancy was encouraged because it increased the "labour pool", a factor discussed in the previous section. It also provided proof of the girl's fertility. Iwata (1960) mentions the "custom of trial marriage. The formal marriage rite is performed only after the child is born" (Iwata, 1961, p.6). Lewis and Lewis (1984) also describe a relaxed atmosphere surrounding courtship. "Young people are free to choose their marriage partners. The young man

may come to the girl's bedroom for a night, or indefinitely-if the girl consents. One or two children may have been born before the marriage ceremony is held" (Lewis & Lewis, 1984, p.182). A culture member was quoted as saying, "In our culture it's OK for a boy and girl to stay together before they are married."

Pregnancy, Marriage, and the Value of Education: Culture Members Respond

"No work, no job, no school."

Culture members discussed common ages for pregnancy as well as problems encountered in acculturation. "In Laos the girls were 12 [when they had their first child]. In U.S. they are 14. It is not OK because they cannot take care. No work, no job, no school."

"Yiu-Mien adapt to their changing situation."

The concept a "first class girl" was one which permeated culture members' discussions of marriage. They explained besides coming from a good family, "virginity was a sign of a `first class girl'and `first class girls' are worth more money [bride price]. Premarital pregnancy was a sign of a girl with `loss of control'. She is `spoiled whiskey'. However, 600 to 700 years ago in China, soil became poor and put new demands on the laborers. More laborers were needed. The need for population changed the moral ethic of the people.

Yiu-Mien adapt to their changing situation. Suddenly the value changed from virginity to fertility." "To adapt to the new demands of the land, today education has replaced virginity as the highest value." "The need for education is foremost! It is equal to the need for labor in the past. We want youth to behave themselves. All parents want virgins and educated girls." This outlines the conflicting values of the culture which esteems education and female virginity as well as female fertility.

Kandre (1967) claims the Yiu-Mien valued learning in Laos; however, formal education was not available to them. He writes, "The progressive-minded Iu Mien [sic] are well aware, and proud, of the fact that they differ from the other hill people because they have books." But, he says, they still "consider themselves inferior" to some. He quotes a Yiu-Mien informant, "The Yao [Yiu-Mien] have their own books, but few read them. The Meo [Hmong] in Laos have no books of their own, but they learn to read and write and speak an important foreign language." Some Yiu-Mien mothers in Oregon lack twelve years of education because formal education at the applicable time could not be obtained in Laos and they have not been in Oregon where it is available twelve years.

Other culture members discussed the problems associated with values and cultural factors in the process of change and the conflict that evolves. "Here the parents want you to have as much education as possible, but the girls just like the boys." "It's not that they don't want to go to school, they drop out when they get fat [pregnant] because they are shy." "They like to play around. They like the boys more than school."

"Premarital pregnancy at 18 or 19 to prove fertility is considered advisable." "No one wants to marry a `bad girl' but it's OK if she is fertile." "Today 18-19 is considered marriage age, after high school is finished." "A `first class' girl pursues education regardless of age. If pursuing education it is OK to be an`old maid'. If not pursuing education it's not OK. Married at 15-18 is OK but it's better to have education than babies. This community values education."

Marriage negotiation.

The process of marriage negotiation takes time. The boy asks the girl's father if they can marry. The father "should always ask the boy's information", his birth month and year so the Book of the Days, Throng So, can be consulted. "Even though the couple are not official the book may have been consulted. The second contact the boy brings a bracelet to the girl's parents and gives it at

the dinner table. The girl will often return the bracelet at least once even if she wants to marry the boy. Otherwise the boy might think she wants him too much. Or this is the time the family can say she is not ready to marry and they will return the bracelet. The third contact they are engaged and negotiations on the bride price can start.

Bride price.

The Yiu-Mien call the "bride price" the "departure announcing fee". It is the amount of money or silver that the boy's family will pay the girl's family to make the marriage contract valid. According to Kandre (1967), "marriage among the Iu Mien [sic] is a business transaction involving the transfer of important amounts of wealth...." (p. 593). The bride price is a very individual affair and depends upon many variables, such as whether the girl is a "first class girl" or whether the bride has children. When asked if the bride price was higher or lower if there are children, culture members informed us "we're talking about two accounts." The bride doesn't get a higher bride price, but the groom's family has to also pay for the child. "They are not paying for the value of a guaranteed fertile female, but for the extra laborer the husband's family would be getting." "If the groom has no money or no parents, or the girl's family

only has one girl, then the boy won't have to pay. He'll go stay with the girl's mother. If a man and woman get married and they go to live with her parents, it is her parents who have to pay." "Usually after marriage though, in about 90 percent, the couple will go to the husband's home."

Cultural marriage.

The Oregon State Health Division, Center for Health Statistics, [Hopkins] study shows high rates of single motherhood for the Yiu-Mien. How this factor increases risk for low birthweight is unknown, however it is speculated that social support may be one of the affecting variables. Contact with Yiu-Mien culture members introduced the idea of cultural marriage. This has bearing on the Oregon State Health Division, Center for Health Statistics, [Hopkins] findings. "Cultural marriage" is marriage that occurs within the culture. It may but often is not registered with the state. Two individual Yiu-Mien referred to the registration as "going to the judge." One cultural member reminded us "In this state there is a 17 year old age limit even if the parents sign so that's why some don't register." Other culture members said "There is a big party and everybody attends. It is not a secret. To get the license you have to go to the judge, right? They don't want to do that. They have

a celebration for the other people to know, but the judge doesn't know." "They are not aware or don't see it as a need to go to the judge to get married. Nobody explain to them that it is important. I think a lot of people just don't know that. They may not know about going to the judge. You see the parents aren't as educated as the children and can't tell them what to do." This suggests that in many cases, social support is not lacking for the "single" Yiu-Mien mother. In fact, she may have the support of husband, family, and community.

On the other hand, social support may be lacking for some. An elder Yiu-Mien priest and cultural leader had particularly sensitive insight into the social problems of teen pregnancy with unmarried Yiu-Mien girls. "They feel very frustrated with their pregnancy. They are lonely, filled with shame and depressed. So they lose their appetite, stop eating and the mother's health becomes poor resulting in small weak babies. The solution to this problem must be to support and encourage these girls, so that the baby will be happier and healthier."
Gathering information about cultural marriage was a particularly sensitive point in the data collection process.

Pregnancy and Marriage: Non-culture Members Respond

Most non-culture members stated that a Yiu-Mien girl over 18 and unmarried would be considered an "old maid" in Laos but that this is changing among the Yiu-Mien in the United States. They also thought that Yiu-Mien women who have a baby before marriage would bring a higher bride price. Only one non-culture member respondent was able to clarify this misconception. "Actually the bride doesn't bring a higher price, but the baby has to be paid for as well." This respondent went on to explain, "While the total price may be higher, they are distinctly less desired by the prospective husband than those who are young and childless." Another non-culture member explained "`Bride Prices' are never paid in full as this would be a great insult to the bride and her parents. Only animals are paid for in full in one payment. The Yiu-Mien do not think of the `Bride Price' as a sale of property."

One respondent wrote there are reasons for young Yiu-Mien women to delay pregnancy and in fact stated, "I think you would find abortion is common among many of the young American Mien women. They may not want to get married or may want to finish high school."

Five of seven non-culture members thought the statement on the Yiu-Mien instrument which read, "Cultural marriage is common among the Yiu-Mien" was correct. One non-member added "this is not widely admitted." Non-culture members thought information about cultural marriage important for health providers to know.

Birth Control: Culture Members Respond

"I don't think they are thinking about that."

The "Marriage and Pregnancy" section of the Yiu-Mien instrument outlined cultural practices related to marriage and pregnancy. In the process of gathering data about these practices, discussions about birth control arose. Culture members identified cultural feelings about birth control or delaying pregnancy. "In Laos there was no family planning method. It's acceptable but not desirable. It's kind of wrong." "Most young are under the parents' supervision and the parents have come from the culture that is not very strict." "They don't think about delaying pregnancy. It's like gambling. They just do it and if they get pregnant, fine and if not, it's OK too." "They really have no reason to wait until 18 to get pregnant. The smart kids today may use prevention, but I don't think they care very much. I don't think they are thinking about that."

The Halsey Square ladies were quite verbal about their concerns for their children and requested family planning information. They also had suggestions for interventions from health care providers. "The doctor or nurse have to teach them how to use birth control." "Educate in junior high and high school. Tell them about birth control because you never know what they are going to do." "Birth control is hard to know how to use, so we have to find someone to tell them how to use it." "Parents can't teach them because Mien parents can't read, so it's hard. I never use birth control." "You cannot stop them from playing around."

Implications for Health Providers

Several ideas about marriage, pregnancy and cultural responses to birth control have been discussed in this section. According to culture members and non-culture member respondents alike, Yiu-Mien encouragement of early pregnancy and marriage is changing. Although it is still "acceptable" it is not as "desirable" as it was in Laos. However, according to the Oregon State Health Division, Center for Health Statistics, [Hopkins] study the likelihood of a Yiu-Mien mother being a teenager increased between 1981-1982 and 1984-1985. In 1981-1982, 16 per cent of the Yiu-Mien mothers were under 20. In 1984-1985, 42 per cent of the Yiu-Mien mothers were under twenty.

The cultural values of education, virginity, and fertility may be confusing for the Yiu-Mien teenage girl.

Besides education about family planning in the high schools and junior highs, culture members suggested birth control information be made available in "classes on the weekend." They added this proviso. "If the leaders feel comfortable and say OK." This echoes the suggestion of a non-culture member for improving prenatal care, "outreach programs and getting the support of the men and shamans."

Hmong Results

Introduction

The four sections of Hmong results will follow the same format used in reporting the Yiu-Mien results. First an introduction will outline each of the four separate sections. The sections correspond to the main headings of the Hmong instrument. The literature will be discussed, most often in a separate component of the section but at times when applicable it will also be used to explain and/or expand upon responses. Culture member responses will be designated and separate from non-culture member responses. Finally implications for health providers will be identified.

Data for these "Hmong results" were gathered at two formal interviews. Hmong men and women were interviewed together. Six Hmong culture members participated in one of the interviews and four members participated in the other. One of the four was a shaman and community leader, revered for his knowledge and wisdom by other culture members. Five Hmong key informants were Christian converts. Five practiced the traditional Hmong religion. In addition to information from the formal interviews, information from two general informants is included in this section. They were contacted after the formal

interviews were complete. They clarified and added to the information gathered in the formal interviews.

Eight non-culture members returned completed Hmong instruments. Data from these are reported in the "non-culture members respond" component of each section.

Fertility in the Hmong Culture

Introduction

This section discusses beliefs of the Hmong related to fertility as well as Hmong ideas about causes of infertility, information about how a couple's ability to conceive might relate to their status in the community, and Hmong perceptions of birth spacing and family planning.

The Literature: Fertility

The Hmong Resettlement Study identifies "two features of the Hmong demography [that] stand out as having profound implications for the future of the Hmong population: its youth and its exceptionally high birthrate and predicted rapid growth" (U.S. Department of Health and Human Services [Reder], 1985, p. 40). Hmong fertility rates are reported to exceed the U.S. rate by over four-fold (Hopkins & Clarke, 1984). And, Oregon State Health Division, Center for Health Statistics, [Hopkins] (1987) found that Oregon Hmong mothers were more likely than other Indochinese refugee mothers or all

Oregon mothers to have had four or more live births. Forty-one percent of the Hmong mothers had four or more live births compared to nine percent of all Oregon mothers. This is significant because four or more live births is also considered a risk factor for low birthweight.

Delaying Pregnancy and Multiparity: Culture Members Respond

"Have mother drink. When she waits one month, no period."

Culture members interviewed were aware that birth spacing and multiparity might affect the health of the subsequent children. This awareness seemed to be based on empirical observation and traditional beliefs. "I have a feeling that your first three children should be healthy, and then after the third one, they will not be as healthy." This happened, they said, because the mother's "strength lowers" with each child. To determine the mother's strength it is necessary to look at her genetic history. "Let's say the wife's mother used to have healthy babies. Then the wife will have healthy babies. But if her mother used to have unhealthy or handicapped babies, then she will be the same."

Culture members described ideas about birth spacing. "Most people believe that it should be nine months before the next one. I'm not so sure it's as true now." "If you ask the younger group who grow up in this country they will not have that idea. But if you ask the group that is 35 or older they will believe that." Culture members explained, there are two groups to consider. "The woman who used to be pregnant in our country [Laos] now they stop. Mostly women now who have babies grow up in this country." "They will have them fast without spacing to get finished and then go back to school." "They don't breast feed that much anymore. They bottle feed so they get pregnant right away." "Women are breast feeding less and starting to get pregnant at a faster rate in the U.S." Symonds (1983) cites personal communication with M. Hurlich, which supports this. "For the Hmong in Laos it was usual for children to be born at least 24-36 months apart. In the United States, however, few women use this feeding method and infants are born every twelve to fifteen months" (p. 31).

One Hmong woman testified that breast feeding did not always delay pregnancy. "I don't believe it. After one month I got pregnant!" The Hmong shaman stated that some Hmong believe that breast feeding delays pregnancy but some don't. "Why is because the mother loses energy

[through milk production] so she won't have a period as fast."

The Hmong shaman expanded upon the idea of birth spacing. "They believe that if they have too many too close, the first baby won't get close [to the mother] and will be slowed down." He went on to say, "In Laos we had medicine to control." This medicine was a green herb which was boiled and the woman wanting to space her children would drink it shortly after she delivered. "Have mother drink. When she waits one month, no period."

Delaying Pregnancy: Non-culture Members Respond

Non-culture members had remarkably diverse opinions about whether or not Hmong women are aware that breast feeding might delay pregnancy. One respondent stated in her experience "most [Hmong] women will continue to nurse till she's [sic] pregnant again and wean the other child at the time of the birth. But they do not consider nursing a `birth control method.'" Another respondent stated that "many Hmong believe this to be an effective birth control method." Yet another respondent maintained "Younger women have been told this." Finally a respondent suggested "The delay [in becoming pregnant] was associated with breast feeding, unsupplemented by solids or formula. Confusion is likely to occur with U.S. feeding patterns."

She infers that in the U.S. infants are rarely breast fed without supplement.

The Literature: Status and Fertility

Symonds (1983) describes the name changes a Hmong goes through after marriage and childbearing. When a Hmong man has children he receives a maturing or adult name signifying his change in status. Symonds claims this is similar to the name change for a woman. Is the Hmong woman's status tied to her ability to conceive? What happens with infertile couples? Are the name changes Hmong men and women go through connected with status changes?

Culture Members Respond: Name Changes

"You feel your hair stand on end."

Symonds (1983) discussion of Hmong name changes includes a claim that status increased for Hmong men who had children. Culture members concurred stating "When you become a father it means you are mature now. You know what you are doing. The community will trust you. The name changes at this time and the man is called by a new adult name." "So that anybody hears that name will know you have a family."

Culture members informed us that a Hmong woman's name changes at the time of her marriage. She is not called by her own name but "Mrs. (her husband's given name)." "If

you call a man's wife by her name it feels like a very strong sense of taboo. It's in respect of their status. You have to keep it in a different form. It has a taboo feeling that is strong." "You feel your hair stand on end." "Your hair will go straight because it sounds so strange." "This is a community name change. Not a legal name change." When the husband's name changes (after the first or second child) then her name changes again." To clarify, how a Hmong person is addressed by another Hmong community member changes, not his or her legal name.

Within the Hmong culture status is tied to having children for both men and women. The "name taboo" that gives a woman a name associated with her status as wife seems concerned with respect and tradition. It may be confusing to health providers to be confronted with Hmong name changes and confusing and "hair raising" for the Hmong to hear Hmong women called by their given names.

Non-culture Members Respond: Name Changes

A non-culture member provided an in depth explanation of the Hmong practice of "name change."

> It is polite for an outsider to call a woman "wife of _____" if speaking Hmong. It is intimate to call her "mother of _____". It can also indicate the speaker's favorite child, say if a grandparent is talking. But the mother's name is not `lost' as long as her own generation is alive. It is true that old women, long called "mother of _____" may not be known in the community by any other name. The father is

> also called "father of _____"....so I think this shouldn't be made too much of.

Symonds (1983) implies that the woman's name change is a reflection of her status and states that "her personal identity is subsumed under this name change" (p. 21). However, this non-member respondent indicates that perhaps this is not the case.

Culture Members Respond: Fertility Issues

"You have no name."

Culture members related the need to have children to preservation of the "name". "We don't want loss of name. With no boys, name will be lost." "You have no name." "Loss of name" as used by culture members in this context is different from the name changes described by Symonds. "Name loss" as it is used here relates to family lineage and with the Hmong this has special spiritual importance. "Its because of their religious belief...." The Hmong culture includes ancestor worship in its traditional religious practice. Without a male heir to "carry on the name" there is no one to ensure proper care for the family's ancestral spirits.

Polygyny as a past solution to infertility.

During discussions about the relative status connected with having a child in the Hmong culture, discussion of infertility arose and with it the issue of

polygyny. Polygyny emerged as a cultural solution common in Laos when a family lacked a male heir. If this happened, the family might pressure the Hmong man to consider polygyny as an alternative to childlessness. "With couples who do not have a child, the husband really has pressure from his brother and sister. If you're married for a certain number of years and your wife does not, or cannot have a baby, the cousin, brother, or sister will say `well why don't you marry another lady. A second wife.'" "It happens almost to everyone." "It doesn't happen in this country now, but back in Asia." "The husband will take another wife to see if that `tree can produce any fruit.'" Geddes (1976) in his book on the Hmong of Thailand, Migrants of the Mountains, states that among the group he studied, "polygyny...is accepted as a legitimate and normal mode of marriage" (p. 84). Geddes found polygyny common among both fertile and infertile Hmong.

Impact of infertility.

During the interviews a Hmong woman stated, "Not all women will allow the man to take a second wife if the first one is infertile. If there is disagreement about this then [they] get divorce. Or in the U.S. the couple would go for fertility counseling." Clearly, the impact of infertility on a Hmong couple may be great. The Hmong

elder shaman remarked that you could never trust that an infertile couple would "go to the end". That is, the relationship could not be trusted to last.

Within the Hmong sample was a couple in their 30's who had not yet conceived a child. The woman of the couple was encouraged by another culture member to share her experience "because she doesn't have any kids of her own yet and we pray that someday she has." This woman responded that she did feel that her status in the Hmong community was less because of her lack of children. "I can't tell. I just keep it in my heart." She went on to say that the Hmong man's status was also affected by a lack of children. "It's not just the lady, but the husband too. Both of them feel less."

Beliefs related to reincarnation.

Cultural beliefs about reincarnation may increase the stress of infertility and also affect the childless individual's status. Culture members were asked to validate statements relating to beliefs about reincarnation which read "It is a Hmong belief that Hmong women are given a certain number of children to bear each lifetime. If the woman does not bear her specified number, she will have to return and bear them in another incarnation."

The Hmong belief in reincarnation permeates their spiritual and cultural ideology. One culture member stated "All Hmong believe in reincarnation. It doesn't matter whether you are a Christian or what." However, it must be remembered that individuals within the Hmong culture may hold diverse opinions particularly on ideas which are traditional/spiritual. In addition, one culture member stressed, "beliefs are always changing." The explanation that follows is not meant to represent all Hmong thought.

Reincarnation refers to the idea that the soul, after death will be born again in a new body, not always human. The new birth circumstances are related to the relative "merits" and "sins" of the previous incarnations. Therefore unfortunate circumstances are at times believed to be the result of "unpaid sins" from a previous incarnation. It should be understood that this explanation is a simplification of subtle and complex ideas.

The Hmong shaman suggested that the idea that women are given a certain number of children to bear each lifetime was an idea more prevalent in Laos. Other culture members explained "its not really exactly like that....but if I don't have all my kids, [it is believed] I have lots of sins." "For example I am only 20 and I

want to get pregnant but I cannot. Something is wrong with my tubes. The older [people] will tell me "its because you didn't pay for your sin. That's why you cannot get pregnant. Then you go to the health provider and he says `you need an operation.' You get two informations and its very confusing for the patient, the person who is the victim. It is very hard." "Emotionally and mentally it affects me a lot. It makes me think `what is really going on?'"

Explanations for high infant mortality in Laos were tied to belief about reincarnation and "paying the price for your sins." A Hmong woman related "when women have kids and die, have kids and die; that is why. They pay the price with their child because in the past life they did something wrong, like they either had an abortion or didn't pay all the price so the kid keeps coming back and dying, coming back and dying."

"It's like kids are their investment."

Culture members discussed the value of children from an economic standpoint. "It's like kids are their investment. Instead of having retirement and social security, their kids are their social security. There is no such thing as a nursing home. Their kids are their nursing home. I think they keep their heritage alive." "That's why its important for these people to have kids.

Its not just because they don't control themselves." "It is very important for health care workers to know this." Culture members felt that although Hmong still "value children highly," the economic significance that children once had is changing.

Moreover, culture members informed us that the "value" of children is "different" here because more children survive. "In Laos there was lots of disease and we keep having lots of kids. But here we think that lots of kids are going to survive so people stop having lots of kids. We do love kids the same and we want them the same...."

Non-culture Members Respond

Number and value of children and women's status.

Like the Hmong shaman, a non-member respondent suggested, the idea women are given a certain of babies to bear each lifetime "was correct in Laos but not in the U.S." Other non-culture member respondents had not heard of this belief and only one non-member respondent felt that awareness of this belief was important for health providers. But, seven out of eight non-member respondents declared the statement "Hmong value children highly", "correct" and important to health providers. Six of eight respondents thought that "one aspect of a Hmong woman's standing in the community is based on her ability to have

children" and five of this group suggested this information is important to providers.

Implications for Providers

Culture members.

Beliefs about reincarnation contain implications for health care providers. Any surgical removal would be highly traumatic for one who believed that this would so adversely affect the future incarnation. In addition culture members informed us that autopsy and organ donation were abhorrent concepts to many Hmong for a similar reason.

Induced abortion for Hmong is a related issue. Some Hmong believe that the soul that inhabits the fetus may come from the soul of an earlier family member. Although not consistently believed "there is a concept that after death the soul remains in the house and inhabits the next child of the family" (Barney, 1957, p.34). Some culture members agreed with that the soul of the fetus might come from a deceased relative or friend of the family and added, "A lot of youngsters now when they have abortion they don't let the parents know. They only make their own decision because as soon as you let other older people know that you are going to have an abortion, there is no way they are going to let you do that."

Culture members reported that beliefs about reincarnation definitely influence the decision to have a tubal ligation. "It is very very difficult for them to say yes, because they believe that once you take a part of body away, then at the time of reincarnation that piece of body or mind will be missing. That's why lots of people refuse. Because we believe that when you do it the next reincarnation will not be able to have any kids. These are some of the psychological beliefs or spiritual beliefs of the traditional Hmong. So the younger generation they think they like to do it, but when they come home the elders say `oh what have you done?' Then they become psychologically confused and in a position where they are very uncomfortable."

Culture members requested that health providers be educated about the Hmong beliefs concerning the value placed on children and the Hmong concern over not having a male heir. "I think these things are good for professional people to know."

Culture members suggested that it would be useful to educate Hmong families about the advantages of birth spacing. They relayed a Hmong interest in natural family planning as the most sought after spacing method. Some members also thought that this would be the most "popular" family planning method. "I think pills would be the

second most popular." "Women are still asking for injection" (depo provera). "They used to get it in the camp." "Now they know its not available."

In addition, culture members thought that it is important for health providers to be aware and sensitive to the conflicts between acculturating and traditional values. For example, a Hmong girl contemplating abortion may share traditional beliefs with her older relatives or may be influenced by them, making the decision to abort more difficult and this solution to unwanted pregnancy more painful. And, although tubal ligation is an option for some Hmong, for others adverse effects on a future incarnation are thought to be too likely for it to be considered.

Finally one culture member urged health providers suggesting family planning to the Hmong remember that "the Hmong have faced a holocaust. One third of the Hmong of Laos were killed. One third were disabled due to the war or various other reasons. You have one third of a small population left. Without a second thought everyone wants to revive the population."

Non-culture members.

Non-culture members had specific comments about birth spacing. Some of the non-culture member respondents have been in health care provider roles serving Hmong clients

and have had experience with Hmong prenatal care and family planning. It is interesting to note that here too non-culture member respondents experiences are diverse. One respondent stated "I have used IUD's but most select abstinence or condoms. None selected the pill. My guess is that the quality of life is improved in the U.S. and they don't perceive that their children's health may be jeopardized by having many children. Family planning doesn't seem important."

Another wrote "My sense was that Hmong women wished to learn about and adopt Western health care practices." Another non-culture member with experience in this area wrote, "I think the Hmong would consider using Western methods, that some do, and that some have been told that birth-spacing means healthier babies, but they don't really believe it. My opinion is that the women consider birth control more beneficial than the men. Which ones? injections and abstinence."

Finally, a non-culture member without health care providing experience but with extensive experience in working with the Hmong wrote, "They might, [consider Western methods of birth control] I think, if they were really convinced of the benefits of spacing babies. I suppose the pill would be most acceptable or IUD. This obviously not really my area, but I believe there should

be substantial information about prenatal care, American birthing practices, and family planning available for young people (10-13) in the schools."

Marriage and Childbearing

Introduction

This section of Hmong results examines age at marriage and childbearing. It explores cultural expectations and acculturation issues as they relate to marriage and childbearing ages. It investigates Hmong customs as they pertain to premarital pregnancy. And it identifies suggestions from the Hmong community and non-culture members for improvement in meeting the needs of young, American Hmong people and their parents.

The Literature

Lewis and Lewis (1984) in their 1948-1983 study of Thai hill tribe peoples write that most Hmong males marry when they are about 17 or 18 years old. They state Hmong females marry about the same age or somewhat younger. Contrary to this, Geddes (1976) estimates average ages of marriage for Hmong males at 15 or 16 and estimates females marry at least two years later when they are seventeen or eighteen (Geddes, 1976). Geddes' field work took place between 1957-1970, in Thailand like the Lewis'. He cautions the reader about specificity of these marriage ages, stating, "It is difficult to determine the average age of marriage in a society where there is no precise reckoning of chronological ages " (p. 80).

Merchant's (1987) recent "Lao, Mien and Hmong Family Research Project" indicates that "in the Mien and Hmong communities of Portland, there are large numbers of young teens with children; most in fact are culturally married by 16" (p. 33). Cultural marriage for the Hmong is similar to that for the Yiu-Mien. A marriage is celebrated within the ethnic community but may or may not be registered with the state. Merchant's study also indicates the young women of these couples will "quite likely not graduate from high school" (p. 33).

The U.S. Department of Health and Human Services, The Hmong Resettlement Study, under Stephen Reder's direction (1985), found with the exception of a few school districts, the school dropout rate for Hmong girls across the United States was between 80 and 95 per cent. This study found the reason that so many Hmong girls do not finish high school is "mainly due to pregnancy" (U.S. Department of Health and Human Services [Reder], 1985, p.179).

Culture Members Respond

"You are considered an `oldie' in Laos at 16."

What do the Hmong people think about the issues of early marriage, childbearing and the high school drop out rate for Hmong young women? Culture members responded, "you are considered an `oldie' in Laos at 16." "Many

people still have a feeling that if your son marries someone who is 18 or 19 then they have to consider that girl as a girl who is not very, how should I say, she's not a very good girl; not a number 1 girl. But if your son marries someone who is 14, 15, 16, a `fresh' girl, she has not `fooled around' for a long time." In our research, Hmong culture members were asked whether Hmong girls were in this area would be considered "faded" by seventeen or eighteen. Culture members responded, "If you are a `good girl' you would never last that long."

Symonds (1983) points out that adolescence is "culturally defined" and the "meaning attributed to this stage of life varies from society to society" (p. 2). In addition she claims that "attitudes towards early pregnancy in American society are not directly applicable to an understanding of early pregnancy in other societies, even those now living in the United States" (p. 4).

Culture members discussed the Hmong tradition of "early" marriage and problems associated with this practice as it occurred and was "culturally defined" in Laos. The Hmong shaman identified physical problems, risks to the health of the mother and children. "We do have problems with young pregnancy. When [the mother] gets old [she] always will have poor health and the children are not as healthy as a mature couple's. Her

body is not ready." Other culture members independently verified the idea of physical risk. "If married too early and had children too young, the mother will get old too soon, wrinkles and weak. Her body was not made to have babies too early."

In addition, culture members identified missed education opportunity as a problem with early marriage and pregnancy in the United States. "Older is better because you can get a better education to have a better life." "Attitudes are changing." "Now we have more girls graduate from high school." "If they marry and have children they go back to high school." Although many culture members expressed concern about early marriage and childbearing, this concern has not yet translated into impact upon the rates of teenage pregnancy which continue to be high for this group.

"Uncontrollable" children.

Problems evolve and conflicts may arise in the Hmong family when the young Hmong girl is "uncontrollable". From the parents viewpoint this means that she may "go with boys"or "disobey" them in other ways. One culture member identified the issue of the "uncontrollable" child as an "acculturation issue." He said: "From the child's point of view, the parents are strict and unadaptable. So it becomes an acculturation issue which no one is to blame

for." Then it may be preferable for the Hmong family to allow marriage before graduation. "If children are controllable, age 16 is the youngest age [marriage would be considered]." However, culture members suggested if the "11, 12, 13 year old child was uncontrolled" earlier marriage might be considered.

Merchant (1987) points out that "Almost every parent interviewed [in her study] said that `lack of control' was the primary problem they encountered with their teens" (p. 28). She claims "The prospect of the children going to school in the `free' atmosphere is more frightening to many parents than early marriage, which they understand" (p. 28).

Premarital pregnancy.

What does a young woman do if she becomes pregnant and her boyfriend can't or won't marry her? Culture members were asked to verify information about "a curse" that a pregnant girl could put on her baby's father and he "would have to marry her or die". The Hmong found this idea amusing, the ladies laughing the loudest. One joked, "That way all the men would die!" At this point in the interviews there was much discussion in Hmong to determine the origin of this idea. It was explained. "Let's say I have a girlfriend and she was pregnant and she said she was pregnant by me, but I refuse [deny]. Deep in myself,

I know she was pregnant by me, but I refuse because there is no scientific proof. And she brings me to Hmong court and she testifies that this is true. And I testify that it is not. So the court cannot decide, so the court has to make a judgement. To do that they will give the girl and the boyfriend a glass of water and they say all kind of bad words. Then each has to drink this cup of water and if this child is really your child, then you have to die. You will die by sickness, accident or any cause."

The culture members explained that the death would occur within a specified time frame determined by the court and specified in the "curse" and that the community would then "watch and see who dies." This explanation introduced the concept of "Hmong court," a council of wise men and elders.

Culture members said another possible court scenario would go: (This is said to the boy.) "Since no one agree, from now on you go out. You start the life. You get married. You will not have any child." The following is said to the girl. "And if this is not his child and you only make trouble for him, from now on if you marry, you will not have anymore babies."

Although this solution to the problem of denied paternity happened in Laos and the refugee camps, culture members denied that it occurs in the United States. In

the U.S. there is "too much opportunity for abortion to go so far as a trial by elders." "In the camps I heard about it a lot. Somebody dies within a few months and we don't know whether he had diarrhea, malaria, or a curse." "You see the curse said you would die of any cause."

If a girl becomes pregnant and her boyfriend marries someone else, suicide was identified by culture members as a possibility. Merchant (1987) found "suicide or running away were other frequently mentioned alternatives [besides abortion], which indicate the depth of problem for a girl in this situation" (p. 15). A culture member countered however, that in this locality there has been "no evidence of either suicide or running away."

Non-culture Members Respond

Non-culture members believe that "marriage and having a baby at a young age are not considered problems in the Hmong culture." Two of the eight respondents suggested that this is "correct for the majority but is changing." They added that "Some [Hmong] delay to finish high school or to enter college."

Non-culture members stated also that "some Hmong young women marry at 13 or 14." One stated, "getting pregnant and then married was not an overwhelming problem, traditionally." This may be linked with the Hmong

amusement over the premarital paternity "curse" on the father to "marry or die."

Implications for Providers

Culture members suggestions.

Culture members suggested that at least two groups of Hmong exist. "If you cut your population in two like we talked before, it could be that those older parents who are parents of teenagers now are pushing their kids to get married and get pregnant." "Education needs to focus on the youth. In addition, there needs to be a program or orientation seminar for the parents so they can be aware of the problem." Culture members suggest the "seminars" or "workshops" for the Hmong parents, focus on the economic effects of early marriage and parenthood and on the "missed" education opportunity.

Moreover, culture members say, education geared for the youth needs to concentrate on pregnancy prevention and on the complexities of relationships and marital issues. "We need a program to help these youngsters....This is not for the low birth rate problem only, but also to make these youngsters more prepared for the family before they get married." One culture member discussed his attempts at educating young people before they get married. He would ask if the couples know what marriage involves. "Ninety percent of them answer `No.' They say `I love

him' and `I love her' and `we want to be together and we thought that after we've been together we will experiment for ourselves.' But it doesn't happen like that. You get married, have children and you don't even have a job."

All interviewed culture members agreed that the education needs to come from outside of the Hmong community, "from clinics or the schools." Because parents just "don't know what to do." "It really depends on the [broader] community and the school." Culture members thought that most Hmong parents no longer actively encourage early marriage. "They don't really want it to happen, but those things just happen."

They also state there are fewer early marriage and pregnancy problems. Things are "going smoother." But this is from "learning the hard way. When you get in trouble the word spreads out and others are more cautious. They learn from the other people."

Non-culture members.

Six non-culture members think it is important for health practitioners to be aware of Hmong traditional expectations related to early marriage and childbearing, and the current problem of high school incompletion. Non-culture members were asked if they thought that the Hmong people are aware and concerned about Hmong youth having babies at a young ages and not finishing high school.

They were asked if they had any suggestions for solutions. One respondent suggested that the Hmong people "are aware and concerned, but the pressure can be overwhelming." This respondent suggested "special counseling about jobs, family, and their economic future....[and] programs to keep young mothers in school."

Another non-culture member stated that although the Hmong are perhaps aware of the problems of early pregnancy and high school incompletion, they are "probably not concerned, except for a few. The Hmong depend on the support network of their own community, as long as this remains important to them and effective in providing help to young families, they won't think of the future as problematic for people who marry very young."

A non-culture member states, "they are concerned, or say that they are. But these patterns are centuries old and people find it hard to adapt to new educational and employment patterns." This respondent's suggestions are similar to some of those suggested by the culture members interviewed. "There need to be alternative programs, perhaps `at home' tutoring to help girls finish school and there needs to be community outreach to explain changing patterns to parents of teens."

In parent education seminars it may be useful to identify those problems occurring with adolescent pregnancy in Laos that had to do with physical risks to the mother and child. Merchant (1982) in findings from the Lao, Mien, and Hmong Family Research Project points out that parents may be unaware of "parental rights." Concrete information to help parents understand their rights as well as American law may increase parental feelings of "control" and decrease fears about adolescent "freedom" encountered in school.

Nutrition

Introduction

Nutrition counseling was identified by Access to Prenatal Care Conference participants as "the single most important component of prenatal care effective in reducing the incidence of low birthweight in populations characterized by high percentages of low birthweight infants (American Nurses' Association Consensus Conference Report, [Curry], 1987, p.18). This section of Hmong results includes discussion of Hmong dietary practices during pregnancy. Nutritional beliefs of the Hmong and the effect these beliefs may have on the unborn child from the Hmong perspective are briefly described. Finally, this section offers suggestions from both culture members and non-culture members which might lead to improved nutrition.

The Literature

Symonds (1983) states that near the end of the pregnancy, the Hmong mother-to-be's diet was restricted to ensure a smaller fetus and ease of delivery. One of her informants stated, "In Laos we did not want big babies" (p. 22). "Big babies" may bring big problems in a land where there are no options but "natural" childbirth. With no hospitals or obstetricians in residence, Cesarean section was not an option. Ellis (1982) writes "many

[Southeast Asian women] are concerned that too great a weight gain will result in a large baby and a difficult delivery" (p. 192). This section examines the concept held by some Hmong women that "smaller is better" in terms of fetal size to ensure ease of delivery.

Many Hmong people either cannot tolerate or dislike milk or milk products. However, milk and milk products are often urged on expectant mothers by health providers. "The expectant mother needs a quart of milk or its equivalent daily" (Reeder, Mastroianni, Martin, & Fitzpatrick, 1976, p. 189). Milk has high calcium content that makes it almost indispensable for bone and teeth growth and in addition is a good source of protein and vitamins A and D. Hmong use of milk and milk products are explored and alternative sources of calcium and vitamins are proposed.

Hmong women and children have traditionally eaten separately and after Hmong men (Cooper, 1983). The extent to which this custom continues and how it might affect the weight gain of a pregnant woman is explored.

Culture Members Respond

"She will fatigue and get caught in delivery."

Hmong culture members reported that "some ladies don't want to eat too much vitamins or eat the food that has a lot of nutrition because the baby will get too big

and she will fatigue and get caught in delivery." However, they state this is more an individual than cultural practice. Fear of Cesarean was also mentioned as a reason individual women may limit nutritional intake. "The reason that they have fear of C-section is because they have the feeling that if your body is cut open then you might have poor health. That's the image everybody has." When asked if this was related to "soul loss", culture members denied the association.

"It has got to be good."

In the course of discussing the limiting of nutritional intake cultural beliefs arose related to prenatal diet. One belief has to do with "freshness". The Hmong shaman explained "As soon as they know the wife or the daughter-in-law is pregnant they never let her eat anything like meat that may be already spoiled. It has got to be good. Also the fruit has to be a good one. It cannot be a rotten one or have worms. Because we believe that if the lady eats something like that then it makes the baby abnormal or missing something, a mental problem or missing part of the body."

"Cravings."

Another cultural belief that emerged had to do with "cravings". "We do believe that if you are not able to find that thing [that you crave], that the child will miss

something." A Hmong woman elaborated, "For example, when I was pregnant with my first boy and we were in the camp I want to eat a chicken so bad. I took a chicken to my older sister to cook for me. But my other sister deliver her baby then and they cook for her so I never have that chicken. And when my son born he has little hole right here [on his ear]." Sometimes, culture members explained, if you do not get to eat your craving, your child will be born with something "extra". "If you want to eat ginger but you don't have ginger to eat, your child have extra finger or extra toe."

Pica emerged from the interviews as a practice of a few individual Hmong women. "Pica is a perversion of appetite with craving for substances not fit for food, as the practice by some women in pregnancy of ingesting starch, clay ashes, or plaster" (Thomas, 1976, p. P-83). The Hmong language, however, does not have a term for this practice. "Sometimes the pregnant lady likes to eat dirt or something sour." "My sister when she was pregnant she like to eat dirt. Not dirt on the floor, but soft rock, wet and hard to find."

Non-culture Members Respond

Non-culture members held diverse opinions about whether the pregnant Hmong woman would limit her intake to ensure ease of delivery and to prevent Cesarean section.

One respondent replied with her experience in caring for pregnant Hmong women. "The Hmong I took care of had very small weight gain in pregnancy yet the babies weighed 7 pounds or greater. I had no problems with small for dates babies. I believe they are aware that how they eat affects the baby and that the women want to have healthy babies. A focus of research could be to examine whether the difference of weight gain patterns in pregnancy. Possibly the American standard of a 25 pound weight or more during pregnancy is not realistic and another standard of nutritional measurement needs to be found. I used diet history and most women were eating well, but not gaining weight as proof of their dietary intake."

This same respondent added that she did not believe that Hmong women limit food intake to decrease the possibility of needing a Cesarean section. "My contact with the Hmong revealed a desire to sit or squat in labor and as a birth position. They often feel that C-sections are needed because they are forced to lie in bed during labor. They are used to being active, walking, doing things around the house in early labor. They feel lying makes them tired and unable to push well in second stage. They begged me to tell the doctors that they have to have their babies the way they are used to in Laos. They like the security of the hospital knowing if something happens

they can be helped. Yet often they complained the hospital also interfered."

Four non-culture respondents did believe that the pregnant Hmong woman might limit nutritional intake to ensure ease of delivery and to avoid Cesarean section. Two added that this is "correct for the majority but is changing." It is important to remember that often the young pregnant Hmong woman's closest advisor during her pregnancy is her mother-in-law, mother or an aunt who may have had her children in Laos, where if the baby gets "caught in delivery" it could be fatal to both mother and baby.

Milk Products: Culture Members Respond

Culture members were asked about milk and milk product ingestion. They responded "Some of the Hmong women drink milk. The younger ones below 30 years old. It is just because the doctor told them. And some try it and don't like it but just go ahead anyway." "The children really like it because when they go to school they drink it but most of the old age don't like."

Culture members discussed lactose intolerance. "I can't drink milk because I get diarrhea." "Myself too." They inferred that lactose intolerance is a common problem. "You try to pretend [you're OK] then one person says `gee I didn't realize I have a stomach ache and

couldn't go to sleep last night'. Automatically it affects the whole group." "My stomach makes a lot of noise so I can't sit next to you." Culture members claimed that this is "important for health care providers because when they go to the hospital they always try to feed them milk. They always encourage the mother to drink milk but they don't like it." "They will eat tofu for calcium, tofu and chicken."

Milk Products: Non-culture Members Respond

Many non-culture members were aware that milk and milk products are not often staples in adult Hmong diets. Rather than impose dietary changes, one non-culture member suggested that "we support their dietary patterns," adding that in her study (1980) Hmong "babies were not low birthweight or sick and the mothers did not have diabetes or toxemia." Another non-culture respondent states that suggestions for nutritional intake "would have to fit their cultural ideas of what is good for people. The biggest problems I think are: 1) mother's calcium intake 2) Vitamin C. Culturally appropriate ways to solve these problems might include suggestions they crack and eat the bone marrow or small soft bones of chickens and eat vitamin-rich vegetables like mustard greens, kale, broccoli, etc."

"Women Eat After the Men": Culture Members Respond

Cooper (1983) in his chapter "Sexual Inequality Among the Hmong" which appears in McKinnin and Wanat's Highlanders of Thailand, states "When guests are present in the house the women must wait until the men have finished eating before sitting down at the table." To what extent does this practice continue? During times of food scarcity does the woman get less? Does this practice affect the woman's nutritional intake?

A female Hmong when asked if Hmong women eat after the men responded, "Yes!" A male said "Let's break this down in more detail. That will help you. The man will eat first. Then the lady and the children will eat together. But only when we have guests or have somebody come to the house." "One of the reasons that we do that is because Hmong always have big families, average is 6-10, and when you have guests, you have too small a dining table." Hmong respondents stated that this custom was changing some in the United States. "We eat together here. Sometimes ladies first when in a line [buffet]." "We give the lady the first opportunity to `help themselves.'"

Culture members explained that it is considered the the man's responsibility to provide enough food for the family and the woman's responsibility to plan and budget

the amount of food cooked. Again culture members mentioned diversity within the culture. (In fact the previous statement brought a diverse opinion from within the family.) "It depends on the family." My father's older brother, he love his wife. Every time they come to eat he tells his wife. `You have to save some for you and for the children.'" Culture members did have stories about food scarcity and implied that this would affect all family members but women perhaps the most. However, all references to scarcity were in relation to Laos. "In a first class family there will be no problem. In a middle class family, no problem. In a lower class family even the husband won't get enough to eat." This custom does appear to be in the process of change and was one issue that Hmong men and women seemed to have differing opinions. In addition, it did not seem to have much bearing on nutritional intake for pregnant Hmong women in the United States.

Non-culture Members Respond

Non-culture members iterated that food scarcity is not a problem for Hmong in the United States. Some agreed that Hmong custom stipulates that men eat before women when guests are present, but no non-culture members thought that this was of particular importance for health care providers' awareness.

Implications for Health Care Providers

The incidence of lactose intolerance and information that milk and milk products may not be a part of adult Hmong diets was considered to be of importance to health providers by culture members and non-culture members alike. The use of tofu and soft bones from chicken as well as vitamin-rich vegetables as calcium and vitamin supplements were suggested as alternatives to milk and milk products.

The idea that Hmong women may limit food intake to ease delivery and decrease the chance of Cesarean section was not supported as a cultural practice by the data. However, on an individual basis understanding the original causes of these concerns could increase provider sensitivity.

The Hmong value children. Ellis (1982) writes that when health care providers "are able to convince women that certain practices will contribute to the well-being of the baby, the women have been cooperative in increasing their food intake, even their consumption of milk...." (p. 192).

Social Support and Kinship

Introduction

Kinship patterns and marriage are examined in this section of Hmong results. "It is the kinship system that determines the make-up of the family--in other words, how new members are recruited into the family (by birth, by adoption, by marriage, etc.)...."(Crane & Angrosino,1984, p. 45). Related to new member recruitment, the "meaning" of the traditional custom of "paying the bride price" is briefly described by a culture member.

The most encompassing category of Hmong social organization is the clan. Within the clans are individuals who share similar patrilineage. Patrilineage groups are the primary unit of the Hmong "extended family" (U.S. Department of Health and Human Services [Reder], 1985). Close ties and mutual responsibilities are shared by members of a patrilineage group. These individuals serve as each other's major social support network.

Ellison (1983) contends "the mechanisms by which social networks influence health status remain unclear...." (p. 19). Tilden (1986) states that research by a variety of disciplines "has consistently demonstrated the relationship social support and wellness share" (p. 60). Social support refers to emotional support; instrumental support, that is, tangible goods, such as

food or money; informational support in the guise of advisors or aids to problem solving; and appraisal support, which affirms self worth or gives feedback. How the Hmong social support system may affect the pregnant Hmong woman is investigated in this section of results. In addition, this section includes a discussion of culture members' descriptions of how social networks may impact the interface of culture members with Western prenatal care. Finally culture members' suggestions for ways to improve understanding between the Hmong social network and Western care providers is included in this section.

The Literature: Kinship and Social Support for the Hmong Bride

"When two Hmong meet for the first time, their immediate concern is to establish their clan identities so that they can relate to each other" (Lee, G.Y., 1986, p. 57). Lee (1986) writes that Hmong social groupings are generally the product of kinship organization. Among other ways, this is manifest through the rituals of ancestor worship (Lee, G.Y., 1986).

Reports on the number of Hmong clans vary. The U.S. Department of Human Services [Reder] reports the existence of approximately twenty Hmong clans (1985). Lewis and

Lewis state there are reported to be twelve clans. Some of the clans are divided into subclans (Lewis & Lewis, 1984).

Merchant (1987) states that "clan alliances were made through marriage" (p. 22). "A Hmong man must marry a girl of another clan or subclan" (Lewis & Lewis, 1984, p.126). Barney (1957) asserts that it is considered quite improper for a young man to even "manifest frivolity" with a girl bearing his clan name (p. 12). Geddes (1976) in his description of Hmong clan and marriage customs maintains that although Hmong men must marry outside their clan this does not necessarily preclude marriage within the village as different clans may live in the same village. He does claim though, that the "benefits of marriage outside the local community outweigh the disadvantages" (p.82). Extra-local marriages are more prestigious, elevating the status of both the bride and groom and their families. And, they "increase the range of social relationships for the marriage partners and their relatives" (Geddes, 1976, p. 82. However Geddes also identifies disadvantages of extra-local marriage. He writes:

> For a girl who leaves her home to join her bridegroom in a distant place the breach is severe. She is losing the clan membership which has given her security, comfort, and companionship all the years of her life to become possessed by strangers. Many Miao [Hmong] songs have as their theme the sadness of a

> girl at departing from her relatives and village, and her fear of the servitude and loneliness that may await her (p. 82).

The literature led to questions about the extent to which Hmong marriage in the U.S. might function as a way to achieve clan alliances. The Hmong instrument included a statement which read "Marriage to the Hmong people is a way of achieving clan alliances." Culture members were familiar with the term and comfortable with the concept of alliance. The literature also led to questions about the extent to which lack of social support may be perceived as a problem for the young pregnant Hmong woman.

The Literature: Bride Price

The Hmong have a long term and far reaching perspective on marriage. They, like the Yiu-Mien, have bride price to pay. No discussion of Hmong marriage, social structure, and clan alliance would be complete without exploration of the meaning of bride price. "`Bride price'" is a Western term and does not have translatable equivalence in the Hmong language. The term must be interpreted within the context of the Hmong culture to appreciate its meaning" (Thao, 1986, p. 79-80). Thao, a Hmong himself, explains that the bride price is representative of two important concepts associated with marriage. First, it acknowledges the parental

hardship of the bride's family in raising the girl, although the compensation is understood to not be equivalent to the hardship. It is a symbol that recognizes the effort. Secondly, the bride price represents concrete evidence of the promise to love. The groom's family through payment of the bride price is promising the bride's family that they will love and care for her. The bride price is kept as collateral for the contract between the families. Should the contract be violated, the bride price may be forfeited (Thao, 1986).

Culture Members Respond

"You are married to the whole family."

Culture members reported, "The Hmong people don't just marry the girl; they marry with the family. We shoot for the long run." "A good family is important for help from relatives, not just the satisfaction of the girl. You are married to the whole family." "About the `alliance', if we used to be good friends then, I would try to offer my son or my daughter in marriage and he would do that to me." The Hmong culture members inferred that although not unheard of, divorce is still unusual for the Hmong. There is much family and community pressure for a "marriage to work" and for the couple to stay together. In addition there is the contract between families symbolized by the bride price.

"Now everybody is sort of mixed together."

Hmong culture members were asked whether clan members lived together in specific locations in the U.S. They claimed in Laos clan members often lived in separate villages however, in the U.S. clan members are more scattered and "mixed together". "In the past the clans used to live in certain regions. Another clan will live in another village in another region, so they had to go from region to region. But right now everybody is sort of mixed together. We are not geographically separated. We're all mixed." "Family groupings are scattered throughout the U.S. Families try to stick together but it depends on the leader of the group. There are `Cha' [the clan with the largest Portland membership] in California, Minnesota, Oregon. There are other clans living in Oregon besides the Cha. We have a variety of clans: Vang, Lee, Thao, Kue, Xiong." Family location "depends on job and housing availability." "Families try to stick together but it depends on the leader of the group." The Hmong shaman explained, "If you have a clan with a weak leader, then the clan will move away, spread out to outlying areas. But if you have a clan leader who is [perhaps] not highly educated, but strong and sensitive for the clan, the clan will stick together, even if the members of the

clan have to spread out due to the job or employment opportunities."

"Daddy, why in Oregon we don't have the wife?"

Hmong cultures members were asked whether most wives go to live with their new husband and his family after marriage. They responded, "It's not most. It's everybody!" "There is a cultural restriction. Once you marry you [the Hmong woman] cannot live with your own parents." "She can stay with them for a short time." Culture members were asked if many wives come from out of state. "Ninety percent come from other states." "I think it's more than that." A Hmong community leader told a story which illustrates this: "My little son say to me, `Every time somebody marries they marry a wife from California. We have so many wife in California. Daddy, why in Oregon we don't have the wife?'"

"That is the culture."

With Geddes' description in mind of the Hmong woman being wrenched away from her family, culture members were questioned about whether the young, pregnant Hmong woman might lack social support or feel isolated, particularly if her first pregnancy was occurring away from her family of origin. They responded, "That's true, not just for the first pregnancy but for the next three children." "In our culture we never discuss about isolation or stress. We

don't talk about emotional things. We just never talk about that but it is a great deal of the problem." Another culture member stated that if the mother-in-law or husband's family were not supportive of the daughter-in-law, her mother would come and support her during the pregnancy. This culture member suggested that social support "problems occur more often when the bride and groom are orphans," a not uncommon occurrence in the Hmong culture.

Culture members were asked if lack of social support for the newly pregnant bride is more of a problem in the U.S. than it was in Laos. A Hmong man responded, "Whether you feel isolated, you feel so lonely; there is no other choice. OK? That is the culture. That seems to be like a system. I think back there [in Laos] they will be lonely or isolated more than here because the majority of Hmong villages are located in the central jungle so you have to walk several days to reach your parent's house or village. And you always feel isolated and lonely. But in the U.S. I don't think they feel as isolated as there. You can pick up the phone. You can watch television and go to prenatal care. You have an exchange of information."

A woman culture member added, "At home [in Laos] it was more isolated and lonely, but here it's more isolated and depressed. Because in here you heard so many things that are going on, but you don't get the right information or you are afraid of so many things that could happen. But at home [in Laos] you never talk about what's going to happen. You just wait."

Hmong social supporters.

One Hmong woman identified husbands as the key support people for the pregnant Hmong woman. "I think the husband is the great deal person because just from my experience working in the clinic and as a mother myself. A lot of times you see a lot of American husband come with the wife and the partner and a lot of Asian wives just come by themselves or even if their husbands come they just sit outside and don't want to go to the exam room."

A Hmong man said, "Let's look at the reason why. Because Asian men are not taught to do such thing, number one. Number two, Asian men feel embarrassed when the wife has to take off her clothes and the woman feels embarrassed too."

This man went on to say, "the other reason you feel isolate or lonely or depressed must be coming from your husband as well. If you have a husband who always with

you during the time that you are pregnant to provide the support the you need then you don't feel as much isolate as somebody that husband has to be back and forth."

"Usually the lady give advice to the lady."

When culture members were asked about advisors during pregnancy they responded, "The only advisors she has will be: 1) the husband, 2) the mother-in-law, and 3) if her husband happens to have a brother who already married and is also living in that same house, then the brother's wife can be an advisor to her." "Usually the lady give advice to the lady."

[In Laos] "Your mother-in-law will be the person who delivers the baby, and if she is a capable person she can provide this [prenatal] information to you while you are pregnant. She will help you along until you deliver the baby. So when you deliver the baby she is there, just exactly like the doctor, to do everything that she can to help. She's the midwife."

Non-culture Members Respond

Non-culture members all agreed that the Hmong practice exogamy within the clan and seven out of eight non-culture members concurred that marriage for the Hmong is a way of achieving clan alliances. The one dissenting non-culture member agreed that that marriage as a way of

achieving clan alliances is "true for the majority but is changing."

The Hmong instrument has two statements which read, "Most brides go to live with their new husband and his family or clan" and "One clan will often live together in the same region." One non-culture member pointed out the misuse of the word "clan" in these statements and suggested that "clan members" would be more correct. "Remember that a clan is composed of thousands of people. You can't live with a clan." "Members of extended families or kinship groups within a single clan will often live together in the same village, town, or region."

When asked whether the young pregnant Hmong woman may lack "good friends and advisors" because of a recent move to her new husband's home one non-culture member responded, "People think her new family will adequately advise her, especially her mother-in-law. But while her mother-in-law will know custom, she often isn't familiar with Western care practices....Her best advisors would be her husband and his mother. His sisters will be important, and his brother's wives. If these are few or uncongenial and if the mother-in-law is a `dragon,' the girl will have a hard time. She may have picked up culturally inappropriate ideas from public school about her own future, and this may give her a hard time letting

other people decide her life for her. She will not have lost touch with her own family, by the way."

Implications for Health Providers

Clan leaders and elders and their importance in health care settings.

During the conversation with culture members about clan location, a discussion ensued about the importance of clan leaders and their significance for the Hmong client in the interface with the Western care system. This does have implications for health providers. The shaman clarified, "Any decisions that the members want to do, they will always consult with the clan leaders before making that decision. Those decisions can be related to the medical decisions such as abortion, surgery. I think this is important for providers to know so they won't put pressure on the people. We want them to know that these people don't make decision for themselves. So they need time for the leaders to help them. So maybe it is important for the patient to have their leader or somebody to come talk to the doctor too. Then the doctor can make everybody understood. The leader can also help the doctor too, to try to help the patient make a decision."

Culture members also identified the elders as the "enforcers" or decision-makers for the young Hmong. "This is a new system [Western health care] and everybody is not

used to. Especially the elderly group who are still the enforcer; they aren't used to this system. They don't have enough knowledge of the system." "We can [get information to the elder group] by providing some kind of workshop or seminar to explain to them the importance."

Culture members suggested that orientation programs for community members include information about community resources and a tour of hospital facilities. "We do need certain time to tour the hospital, to make yourself comfortable. You know your community. You know your hospital. You know that if in emergency you can go to this hospital and here is the Emergency room and a room for people to sleep. Just know your community is the most important thing."

"A place where they can come together and learn so they can know the system"

The Hmong shaman suggested weekend orientation classes for both pregnant Hmong women and young girls needing birth control information. This suggestion is similar to that of the Yiu-Mien culture members. "It would be good if you have some kind of orientation classes like a weekend. We go to a certain place and call up a certain group for the young mother or young girl who is ready to go out; a place where they can come together and learn so they will know the system. And also come along

with a flyer with a short statement to prevent or to use those instruments to control pregnancy. That would be nice."

Language and protocol.

Another culture member suggested, like the Yiu-Mien culture members, that the community leaders be involved and that the classes be taught by Western health care professionals. "When you want to schedule something just write a letter to the president of the Hmong Association so they will spread the word and call up the group." "[The young girls] listen to Americans because sometimes the way we speak is not the same as in school and they don't understand."

Hmong culture members went on to describe the language issue. "The Hmong girls don't really understand Hmong. They would rather listen to an American in English. Especially because a lot of the teens have already been here for ten years. Like my daughter, if you speak Hmong to her she just goes, `What?' `Excuse me?' `What did you say?'" "The young girls speak more English than the interpreter for ages under 20. Most of them speak English. If the young lady goes to the clinic and a Hmong interpreter tries to help with translation, she gets confused, because she doesn't know what they mean."

Barriers to care.

Though translation for the young Hmong woman was not thought to be a major problem, transportation was identified as a primary barrier to accessing health care. "Transportation is a problem for young people because sometimes they don't have money to ride the bus."

The subject of modesty and fears about "what is going to happen" in a physical exam arose. "Most ladies prefer to see a female doctor instead of a male doctor." "The woman is afraid to go to the doctor because she is afraid of what the doctor is going to do to her." On the other hand culture members said sometimes fear is motivational for the young Hmong woman. "Some get early [prenatal care] because she afraid what's going to happen to the baby, but when they are scared of doctor she's not going to go get health care at all."

Hmong people, like the Yiu-Mien described themselves as being "shy" about discussions of pregnancy. "First baby always shy. You ask `am I going to be a mother?'" "For Hmong people you are not going to tell anybody for three or four months. You will wait to see big stomach. It is too embarrassing. They wear big clothes, eat normally and act normally. The woman is excited but won't tell. They isolate themselves because they don't want anybody to know. How will I tell them I'm pregnant? The

family will know because she has morning sickness. But she tells the family she has `motion sickness'"

"They have learned to distrust.

About a week before the formal interviews with the Hmong culture members began, a tragic death occurred in a large local hospital. Culture members related that a Hmong woman, pregnant with twins had gone for prenatal care and the twins were found to be dead. She was scheduled for a dilatation and curettage (D and C) the next day and died in surgery. Culture members were grief-stricken over the loss and also very concerned about the far reaching effects this tragic death might have on Hmong prenatal care in the future. "I'm real concerned about this incident because I think that it might really affect prenatal care in the whole Hmong community nationwide." "If anything happens over here in the next 24 hours, everybody in the nation will know about it. It not only affects the Hmong community but I received several calls from some other [refugee] community leaders who express their concern over this." "This really scared the whole community and the community wonder what's going on." "Most of the regular people will say `the doctor kill her.'" "Then they will have those kinds of feelings and this will discourage them to participate." "They say `if Western medicine is so great, why did they kill her this

time? Why she die this time? So they assume that something is wrong with the doctor." "They have learned to distrust."

Many Hmong culture members, drawing on their experience as community leaders or translators, stated that feelings of distrust for Western procedures came from a series of incidents where they Hmong lacked control, or lacked good explanations and translation. Fears about experimentation also were said to be common. Culture members gave an example of a situation five years ago where a doctor deemed it necessary to do a Cesarean section on a Hmong woman and asked her husband after the surgery was done to sign a surgical consent form. Although the mother and child were "saved", the father had "terrible" feelings about his lack of control. "The doctor said that it was really an emergency to save the mother and save the baby but we now want you to sign this. And then the father had a terrible feeling. He said `I don't think that it was going to kill my wife in 5 minutes. Why don't you come and ask me for permission? Is it something that they just want to practice themselves? Are they taking advantage of me because I don't know the system?'"

"The right to say yes or no on my own body."

The issue of autopsy arose in this discussion. It is unlikely that any Hmong would willingly consent to autopsy because of the beliefs about reincarnation discussed in the first Hmong results section. "Due to the scientific way it might not be true, but that is our belief and we have believed it for thousands and thousands of years and it's hard to change that."

Whether related to autopsy, surgery, or other Western care procedures, culture members report Hmong people want to have control over their bodies and good explanations with translation if necessary. They want the right to say no, the meaning implied in the concept of informed consent. "Why shouldn't I have the right to say yes or no on own body? So a lot of times when the doctor see that we don't speak English they assume that it is OK and they just go ahead and do it."

Summary of Yiu-Mien and Hmong Results

Introduction

This summary outlines the major findings of the study: 1) the major concepts identified in the Yiu-Mien and Hmong components of the "Results" chapter and 2) the implications for health providers that emerged. The summary not only identifies these concepts but also discusses to what extent if any the concepts are shared by the cultures. "Cultural Factors and Components of Prenatal Care for the Hmong and Yiu-Mien" was not designed as a culture comparison, however in the course of the study, commonalities emerged and are discussed in this summary. Some of the summary content represents information identified in the "Results" chapter. Some of the content, particularly in determining culture comparisons and contrasts represents information gathered in the course of this project but not previously reported. After the summary of Yiu-Mien and Hmong concepts have been outlined, implications for health care providers will be described. The focus for this study has been practices and beliefs about marriage, childbearing and pregnancy that might influence seeking prenatal care.

Concept Summary: Cultural Factors

An example of the fluidity of cultural beliefs was revealed in the results section on Yiu-Mien beliefs and

practices concerning the soul of the unborn child. Culture members reported that for Christians and young people some cultural beliefs are changing, but that this "depends on how strong you believe and how educated in Christianity you are. Some new Christians say they believe in Christianity but still follow the old way." On the other hand, some young people were described as not believing the old ways, yet behaving as if they did. Concepts about acculturation and Christian conversion do have implications for both Yiu-Mien and Hmong culture members as well as implications for health providers. Conflict related to coping with clashing cultural and spiritual values are identified by members of both cultures as highly confusing and stressful.

Infertility was said by culture members in this study to be a problem for some Yiu-Mien couples. Ancestor worship requires a male heir to "carry on the name and the spirit" and infertility becomes a major problem for culture members who practice the traditional Yiu-Mien religion. Infertility was identified by culture members as only one of the reasons a Yiu-Mien couple might adopt. Within the sample of nine key informants for this study, two were adopted children and three were adoptive parents.

Lewis and Lewis (1983) identified a desire for propriety as the Yiu-Mien culturally defining trait. This desire for propriety was crystallized in this study by Yiu-Mien descriptions of the "right and proper" way to go about adoption. The high rate and proper practice of adoption is uniquely Yiu-Mien.

The Hmong do adopt also. Three reasons were given for Hmong adoption: 1) out of neccessity if the child were orphaned, 2) if a child was unruly or disobedient he or she might be adopted out, and 3) if a child was ill or sickly, Hmong belief has it that the "child was born to the wrong family" and he or she may be adopted into another Hmong family. It was reported that both the parents and the child would "feel comfortable" with this and that there is no shame or inferiority attached.

Yiu-Mien culture members outlined conflicting cultural mores, placing a high price (literally in the form of bride price) on virginity, fertility, and education. They had empathy for the confusion the young Yiu-Mien girl may experience, caught in the conflicting messages of the culture and also perhaps in the conflicts between the Yiu-Mien culture and the "mainstream" culture. They added however "Yiu-Mien adapt to their changing situation." Cultural marriage, bride price and cultural response to early marriage and child bearing

emerged as concepts related to adaptation. All three concepts emerged as themes within the Hmong culture also.

Birth spacing, multiparity, breast feeding, the high value children have for the Hmong, and beliefs about reincarnation were all found to influence the number of children a Hmong family will have. In addition, the practice of ancestor worship which requires a male heir was reported to have impact on the Hmong desire for children. Hmong people report that in Laos there was family pressure on the man to "take another wife" when the couple was infertile. Polygyny was less common in Laos for the Yiu-Mien than the Hmong. The Yiu-Mien may "solve the problem of infertility" (and hence, lack of a male heir) by adoption. One culture member suggested that Hmong desire for children is affected by the fact that the Hmong "have survived a holocaust which killed one third of the Hmong population of Laos....And without a second thought everyone wants to revive the population."

High rates of early pregnancy and high school incompletion were found to be of concern to many Hmong parents. In addition parents expressed concern over "uncontrollable" children. They claimed problems with "uncontrollable" children have increased since moving to the U.S. (On the other hand it was reported that some Hmong children feel their parents are too strict and

"unadaptable".) If children are "uncontrolled" early marriage may be considered. Concerns about early pregnancy, high school incompletion, and "uncontrollable" children were identified by the Yiu-Mien as worrisome problems in their culture also.

In the U.S. Hmong clans are reported to be "scattered" and "mixed up" geographically; that is members of different clans live within the same area. Marriage was reported to be a way of achieving clan alliances. A large number of Oregon Hmong brides come from California. A lack of social support was described as a problem for some of the young brides, pregnant with their first child. This was thought to be a serious problem if both bride and groom were orphans. The Hmong bride's husband, mother-in-law, and sisters-in-law were said to be her main advisors and social support for the pregnancy. If these people were unsupportive, and if her mother was unavailable to her, she may experience isolation and depression.

Concept Summary: Prenatal Care

The Yiu-Mien avoid discussion pregnancy; "shyness" emerged as one of the reasons for this avoidance. Related to shyness, modesty emerged as a cultural value. The Hmong too identified "shyness" about discussion of pregnancy as an aspect of their culture and described much

the same feelings of embarrassment as the Yiu-Mien on being asked to disrobe in a physical exam; feelings related to a violation of modesty.

Yiu-Mien culture members identified the concepts of privacy and familial confidentiality as being important aspects of the culture which had impact on the discussion of pregnancy. These two concepts may influence Hmong discussion of pregnancy but did not emerge from the data as elements of the Hmong culture.

Many Hmong people cannot tolerate or do not like milk and milk products. However milk and milk products are often urged on expectant mothers by health providers. Hmong culture members reported that diarrhea was common for adult Hmong after consuming milk or milk products.

Culture members denied that limiting nutritional intake to ensure ease of delivery was a cultural practice, but did agree that it may occur with individual Hmong women. They described fears about Cesarean section and surgery in general. And, suggested that in Laos getting "caught in delivery" had extremely serious implications for the mother and baby. The Yiu-Mien too may be lactose intolerant and individual Yiu-Mien women may limit their intake to increase the likelihood of ease of delivery.

Summary of Implications for Health Care Providers

Yiu-Mien culture members suggested that culture members be served by one consistent, female health provider. When a translator is needed she should be female, or if this is impossible they suggest that the male translator leave the room before the female client disrobes. In addition he should let the female client know he will be leaving in the beginning of the interview so she will not be anxious throughout. Culture members also suggested that nursing and medical students in the room during pelvic exams was anxiety producing and not appropriate for two reasons; one, "modesty". And, culture members explained, many members had feelings about "being used as resources" or "experimented on" which would be exacerbated by students "practicing" on them.

Culture members identified what were categorized for the purpose of this study, "restraining forces" versus "driving forces" for the Yiu-Mien woman seeking Western prenatal care. Restraining forces included difficulty finding transportation and baby-sitting, fear of venipuncture, no medical coverage, embarrassment over disrobing, difficulty with the language, and the idea that once in the system, they would have to return every two weeks for follow-up. Lack a perceived need was also identified as a restraining force. Driving forces were

difficult for culture members to identify. WIC was the most often mentioned benefit of prenatal care.

Non-culture members suggested that less intrusive exams and educating culture members to the advantages of early prenatal care with emphasis on the improved health of the subsequent child may help "bridge" culture members understanding with the reality of Western prenatal care. The preceding would be useful suggestions and information for the health provider serving either the Yiu-Mien or Hmong client.

Another suggestion which was made by culture members is specific to the Yiu-Mien and relates to the ideas of privacy and confidentiality. They suggest "if you want to know more information, make sure you ask as many direct questions as possible. They will not tell you if you do not ask." This too may be useful for health providers serving the Hmong, but did not emerge as advice in the Hmong data.

Another implication for health providers had to do with a Yiu-Mien practice related to the location of the unborn child's soul. Depending on the location of the soul (which depends on the month of the year), the mother-to-be may not cut or wash her hair, or change, wash or mend her clothes. The health provider may assume she is "not taking care of herself" or is depressed when in fact

she is observing correct cultural practices to ensure a healthy baby. This cultural practice is specific to the Yiu-Mien.

Yiu-Mien culture members suggested that they would be interested in Western medical treatment to alleviate infertility. In fact, some Yiu-Mien couples had sought Western treatment and been successful in conceiving. Yiu-Mien people were interested in artificial insemination. The prevalence of Yiu-Mien infertility is unknown. Yiu-Mien reproductive health remains puzzling and in need of further investigation.

A culture member identified a Yiu-Mien belief that has implications for health providers. "Yiu-Mien believe that after delivery of a baby the woman's inside is `very young' and that anything cold, eaten or drunk, or even a cold draft will cause damage to the reproductive system or infertility. We don't want ice water or jello."

Yiu-Mien culture members describe cultural expectations for early marriage and childbearing as changing. They requested family planning for young people to be taught in the schools and in weekend seminars by health care professionals. They added that the support of the community leaders was important for this to be successful.

Hmong culture members too suggested seminars or workshops for both parents of teenagers and the adolescents. The workshops for the parents need to focus on the economic effects of early marriage and parenthood and on "missed" education opportunities. In addition it may be useful to provide parents with concrete information on "parents rights" and parenting teenagers in the U.S. Education geared for the youth needs to concentrate on pregnancy prevention and on the complexities of relationships and marital issues.

Both the Yiu-Mien and Hmong people requested that the seminars be run by non-culture members and have the support of the community leaders. English was identified as the "language of choice" for the younger people, while translation would be needed for some of the parents or for the elders.

A Hmong shaman related, "Any decision that the members want to do, they will always consult with clan leaders...." Community and clan leaders were identified as of particular importance in the health care setting. Leaders are consulted before making health decisions. "The leader can help the doctor too, to try to help the patient make a decision." Health care providers need to allot enough time to allow the patient to talk with the leader and may want to consider consultation with the

leader themselves. Leaders emerged as important resources for members of both cultures.

The elders were identified as the "enforcers" and decision makers for the young Hmong. And the elders may be unfamiliar with Western care. A workshop or seminar for the elder group was also suggested, complete with hospital tours to increase comfort with Western care facilities.

Hmong beliefs about reincarnation had important implications for health providers. These beliefs affect culture members response to family planning, abortion, tubal ligation, surgery, organ donation, and autopsy. Some of practices related to reincarnation beliefs are observed more by older culture members, however it was reported that the beliefs affect most culture members.

The Hmong culture members report the Hmong people want to have control over their bodies and good explanations with translation if necessary. They want the right to say no, the meaning implied in the concept of informed consent.

CHAPTER IV

SUMMARY, CONCLUSIONS, IMPLICATIONS, AND RECOMMENDATIONS

Summary

Using two instruments, one for the Hmong culture, and one for the Yiu-Mien, this ethnographic, descriptive study examined perceptions of cultural factors related to inter-cultural health problems, problems associated with perceptions of and contact with the Western health care system. The instruments identify cultural beliefs, values, and practices that relate to components of prenatal care for the Hmong and Yiu-Mien people.

Three groups of key informants were asked to comment on statements which isolated cultural factors and were asked to identify culturally appropriate solutions to problems encountered when culture members access Western health care. One group of key informants, non-culture members who have lived or worked with one or both cultures, were mailed the semi-structured instrument(s). Fifteen non-culture members returned sixteen instruments; one non-culture member had experience with both cultures and responded to both instruments. The second group of key informants were ten Hmong culture members. All but one were fluent in English and working in positions which require bicultural awareness. A Hmong shaman was also included in the group of Hmong key informants. Although

he was not fluent in English, translation was provided by Hmong culture members. He was included to provide a more in-depth illustration of traditional cultural beliefs. Hmong culture member key informants were interviewed using the Hmong instrument as an interview schedule. Two groups interviews took place with Hmong culture key informants. The third group of key informants were Yiu-Mien culture members. Nine Yiu-Mien culture member key informants were interviewed in two group interviews using the Yiu-Mien instrument as an interview schedule. Six Yiu-Mien women were interviewed together, all fluent in English. Three Yiu-Mien men fluent in English and with bicultural experience,were interviewed.

Data were collected from culture member key informants and general informants. Key informants were those culture members who were interviewed more formally, using the instruments as interview schedules and signing a consent form. Key informant interviews were tape recorded and the tapes were then transcribed. In addition to key informants, data was collected from culture member general informants. General informants offered information but did not participate in the more formal taped interviews. These included two Hmong persons and seventeen Yiu-Mien.

Data were analyzed using several methods to provide a comprehensive picture of the data within its cultural context. Each culture was compared to itself in an earlier stage of its own history. This historical perspective gave a basis for documenting the lifeways of each culture and for making inference about their changes. Analysis moved from specific information and explored its geralizability within the culture. It also moved from the more general information to determine specific application. Findings were fed back into the inquiry process for verification. This approach led to the analysis of diversity in cultural perspectives and to contrasts within the cultures. In addition analysis compared culture member responses with non-culture member responses.

Major concepts identified as important in relation to prenatal care for both cultures include (a) a reluctance to discuss pregnancy, (b) "shyness" influences the divulgence of pregnancy, (c) modesty affects culture members desire to seek prenatal care, (d) children are highly valued, and (e) concern over early marriage and childbearing and high school incompletion are common to both cultures.

Implications for health providers were also identified in results. These include: (a) a request for sensitivity to modesty with less intrusive exams, (b) a desire to be served by one consistent, female (in the prenatal context) provider, (c) family planning information as well as information on relationships be made available by health professionals to young members of both cultures in school and weekend seminars, (d) these seminars be arranged with the support of the community leaders, (e) weekend seminars for parents of teenagers to offer education about the economic and social implications of early marriage and pregnancy in the U.S., (f) health providers need to be aware that culture members depend on the leaders and elders to help in decision-making, (g) culture members want to have good explanations with translation when necessary and the right to "just say no", to have control over their bodies, to have the choice implied by informed consent.

Conclusions

It is important when reading the conclusions and implications of this study to keep in mind that individual culture members may have widely diverse opinions and that these findings represent the suggestions of a small number of the Yiu-Mien and Hmong people of Oregon and suggestions of a small number of professionals who have lived or worked with the cultures.

1. Cultural and spiritual beliefs are fluid; they may change.

2. The Yiu-Mien avoid discussion of pregnancy for a variety of reasons. One reason is because they are shy. The Hmong also report that they are shy and reluctant to divulge pregnancy.

3. Modesty is expected and valued in both cultures.

4. Yiu-Mien have high rates of adoption and there is a "proper" Yiu-Mien way to go about the adoption process.

5. Cultural marriage and bride price are cultural practices related to marriage that are found in both cultures.

6. Early marriage, early childbearing, and high school incompletion are common in both cultures and are of concern to some culture members.

7. Fertility rates are high for the Hmong and children are valued. Beliefs about reincarnation and ancestor worship may affect the number of and desire for children.

8. Patri-local marriage is common for the Hmong. The bride often comes from another city or state. Social support may be lacking for some young, Hmong pregnant women, especially if they have come to the area from another city or state.

Implications

Implications of the study fell into two sets. One set requests educational programs for culture members to be offered by health providers. These were identified as needed by the culture members themselves. Descriptions of what needed to be included in these were also provided by culture members. The second set of implications are those that apply to individual health providers and are changes or behaviors that were identified as desirable for improved articulation between health care systems.

Educational Programs

1. Workshops for young people with information about pregnancy prevention as well as information about the complexities of relationships and marital issues to be taught by health care professionals. The support of the community leaders is important for these to be successful.

2. Workshops for the parents of teenagers to focus on the economic and social effects of early marriage and parenthood and high school incompletion in the U.S. In addition "parent rights" can be discussed in these groups.

Implications for Individual Providers

1. Culture members requested a consistent, female (in the prenatal care context) provider.

2. Less intrusive exams with high provider sensitivity to the cultural value of modesty.

3. Providers be sensitive to culture members feelings about being "used as resources" or "experimented on" and be cautious in inviting medical or nursing students to observe or "practice" with culture member clients.

4. Providers serving the Yiu-Mien need ask many direct questions to ensure a complete data base, because "they will not tell you if you do not ask."

5. After delivery of a baby, providers may want to give the Yiu-Mien mother extra blankets, and hot fluids. It is believed that anything cold, eaten, drunk, or even a draft will damage the mother's reproductive system and may cause infertility.

6. Health providers need to be sensitive to the major role that community and clan leaders and family elders play in the decision-making process.

7. Hmong beliefs about reincarnation make any surgical removal highly traumatic. (The next incarnation will be missing the part taken.) Autopsy and organ donation are abhorrent for similar reasons. Conflict over abortion may be increased when the fetus is thought to be a new incarnation of a deceased family member or old family friend.

8. Culture members want to have control over their bodies and good explanations with translation when necessary, the right to say no, the choice implied in informed consent.

Recommendations

Recommendations from this study can be divided into two parts, suggestions that relate to research and those that relate to practice. Techniques and hints of what seemed to work well and were useful in this study are identified as are procedures that, in retrospect, can be seen as perhaps improving the study had they been designed differently. In addition suggestions for further research are outlined. Finally suggestions related to practice are offered.

Research

Hints.

1. It was useful to have a lengthy time line for the study. From start to finish it took 16 months. Culture members expressed appreciation for the lengthy time line.

2. Approaching the leaders of the cultures and requesting access through them gave the study official stamps of approval. The two letters of support from the Associations were powerful "door openers".

3. Group interviews were an exciting way to capture information and they were fun!

4. The instruments proved useful in providing structure and focus for discussion.

Alternatives, suggestions for changes.

1. The interviews with the Yiu-Mien were segregated by gender. It would have been interesting to have done separate interviews with the Hmong women and men also.

2. A Hmong woman shaman could have been an invaluable asset to include in the sample because of the study's emphasis on women and health issues.

3. The study could have been designed differently to better capture comparisons and contrasts between the cultures by using the same instrumment with both cultures.

Areas for further investigation.

1. Using some of the findings of this study, a comparative study of the two cultures may be designed which identifies the contrasts and differences between them. Methods could include combined group interviews with culture members of both groups.

2. A study of health care provider responses to the suggestions and recommendations made by the culture members and non-culture members may give added information about discrepancies between what culture members suggest they want and what they are offered.

3. An examination of the morbidity and mortality connected with low birthweight for these two groups in the U.S. may be useful in determining the seriousness of the low birthweight rates for these two groups in Oregon.

4. An investigation of Yiu-Mien infertility rates in the U.S. may give important information about Yiu-Mien reproductive health.

5. A cultural factors comparison that investigates culture beliefs as they exist now with either the Hmong or Yiu-Mien people in Thailand, with Hmong or Yiu-Mien people in the refugee camps, and with Hmong or Yiu-Mien people the U.S. may illustrate changes and similarities in beliefs and practices.

Practice

Health policy and program administrators are urged develop the outreach programs that were identified as needed by culture members. And, individual health providers who serve these two groups are urged to familiarize themselves with the cultural concepts identified and take seriously the suggestions outlined in implications for providers.

With warmth, generosity, sensitivity, and humor, members of both cultures shared glimpses of their worlds that will be cherished and treasured. Non-culture member professionals too, generously shared caveats from their studies and experiences. Being invited to "take a look", to share these worlds, was a gift most prized. It was a gift given freely by culture members and non-culture members alike, without thought of self-gain. Along with the wonder and delight in the exploration of new worlds comes a sense of responsibility to those worlds. The process of this research has changed the researchers, enriched our worlds. It is hoped that the only changes from this research that affect the members of the cultures will be those that do the same for them.

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APPENDIX A

Letters of Request

March 11, 1987

APPENDIX A

Dear Mr. Cha:

We are planning a research study in the Hmong community and are formally requesting your permission and aid. Oregon Health Division did a study that showed that some Hmong are having very small babies, some so small that it is difficult for them to grow or even survive. Although these numbers are not large, every child is a blessing and it is a tradegy when they do not survive. Of those Hmong ladies who had small babies, many did not receive adequate care before birth.

The purpose of our study is to identify the factors that are influencing initiation of prenatal (before birth) care by pregnant ladies in the Hmong community of Oregon.

We would like to talk to several different people in the community including both men and women, older and younger representatives , and English and non English speakers. We would like to get their ideas, attitudes, feelings, and understandings about this. We would like to use tape recordings, but the individuals names will not be used and confidentiality will be preserved. We will then analyze the conversations to identify and describe our findings.

We will be starting our conversations pending authorization from Hmong community leaders and Oregon Health Sciences University, and will be finished by the end of the year. We are both registered nurses and are working on Master's Degrees in nursing at O.H.S.U. It will be the two of us, Lydia Metje and Dawn Doutrich who will be doing the interviews.

We are hoping that we can use our results to educate nurses and other care givers about Hmong ways so that our care will more match your needs and expectations and so that your families will seek care earlier that even more Hmong babies will be born healthy and strong.

Respectfully yours,

Lydia Metje, R.N. B.S.N.
[redacted]
Dawn Doutrich, R.N. B.S.N.
[redacted]

March 11, 1987

Dear Mr. [redacted]echao,

We are planning a research study in the Mien communinty and are formally requesting your permission and aid. Oregon Health Division did a study that showed that some Mien are having very small babies, some so small that it is difficult for them to grow or even survive. Although these numbers are not large, every child is a blessing and it is a tragedy when they do not survive. Of those Mien ladies who had small babies in 1984-85, 43% did not receive adequate care before birth.

The purpose of our study is to identify the factors that are influencing initition of prenatal (before birth) care by pregnant ladies in the Mien community of Oregon.

We would like to talk with several different people in the community including both men and women, older and younger representatatives, and English and non English speakers. We would like to get their ideas, attitudes, feelings, and understandings about this. We would like to use tape recordings, but the individuals names will not be used and confidentiality will be preserved. We will then analyze the conversations to identify and describe our findings.

We will be starting our conversations pending authorization from Mien Community Leaders and Oregon Health Sciences School of Nursing, and will be finished by the end of the year. We are both registered nurses and are working on Masters Degrees in nursing at O.H.S.U. It will be the two of us, Lydia Metje and Dawn Doutrich who will be doing the interviews.

We are hoping that we can use our results to educate nurses and other care givers about Mien ways so that our care will more match your needs and expectations and so that your families will seek care earlier that even more Mien babies will be born healthy and strong..

Respectfully yours,

Lydia Metje R.N. B.S.N.
[redacted]
Dawn Doutrich R.N. B.S.N.
[redacted]

APPENDIX B

Hmong Letter of Acceptance

HMONG-AMERICAN ASSOCIATION OF OREGON, INC.
6425 S.E. 44th • PORTLAND, OREGON 97206
TELEPHONE: (503) 774-2988

September 8, 1987

Dawn Doutrich BSRN and
Lydia Metje BSRN
5475 S.W. Bonita Rd.
Lake Grove, OR 97035

Dear Ms. Doutrich and Ms. Metje:

The President of the Hmong-American Association of Oregon, Inc. has forwarded your letter to him, dated 8/15/87, to me, as I am the Chairman of the Board. In response to your request, the Board of Directors of the Hmong-American Association of Oregon, Inc. met on September 5, 1987.

At that meeting we agreed to support your study of Hmong low birth weight and grant you permission to approach our membership in trying to include them in your study.

If the Hmong-American Association of Oregon, Inc. can be of assistance to you regarding this matter, please do not hesitate to contact the President, John Cha.

Sincerely,

[redacted]

Bruce T. Bliatout, Ph.D.
Chairman of the Board

cc: Members, Board of Directors
Officers

APPENDIX C

Yiu-Mien Letter of Acceptance

LongSan Saechao
10937 NE Prescott St.
Portland, OR 97220

October 21, 1987

Dawn Doutrich BSN RN and
Lydia Metje BSN RN
5475 SW Bonita Rd.
Lake Grove, OR 97035

Dear Ms. Doutrich and Ms. Metje:

The Board of Directors, staff and members of Yiu-Mien Association of Oregon agreed to support of your study on the Mien Prenatal Care.

Sincerely,

[redacted]

LongSan Saechao
Chairman of the Board of Directors
of Yiu-Mien Association of Oregon

cc: Yiu-Mien Association (File)

APPENDIX D

Hmong Instrument

Oregon Health Sciences University

School of Nursing

Cultural Factors and Components of Prenatal Care for the Hmong and Yiu-Mien

Instructions: Select responses from those below that most accurately reflect your opinion and write as many of the number and letter codes as you think apply on the lines next to each statement. Statements were derived from ethnographic literature, analysis of interviews, and personal communication with professionals who lived or worked with the cultures. If you believe that the statement is important for health providers to know place a check mark under the column labelled "Important?".

For example if the statement is often correct, record 1A. If the statement is often correct in Laos but not in the U.S., record 1B. Statements may require more than one response. If you believe this statement is important for health providers to know, please mark a check in the column labelled "Important?" We also welcome comments, examples, or elaborations that might help illustrate your opinion. If you need more space for comments, please use the back of the of the page or the blank page provided.

Response options:

1. I believe this statement is often
   - A. correct.
   - B. correct in Laos but not in the U.S..
   - C. correct for the majority but is changing.
   - D. correct for the older people but not the youth.
   - E. correct but is not widely admitted.
2. The statement is partially true. Please write changes or additions to make the statement correct.
3. I don't know enough about this subject to respond.
4. I believe this statement is <u>not</u> true.

Cultural Factors and Components
of Prenatal Care for the Hmong and Yiu-Mien

Response Options: Write as many of the number and letter codes as you think apply under the column labelled "Response". If you think this statement is important for health providers to know put a check mark under the column labelled "Important?"

1. I believe this statement is often
   A. correct.
   B. correct in Laos but not in the U.S..
   C. correct for the majority but is changing.
   D. correct for the older people but not the youth.
   E. correct but is not widely admitted.
2. The statement is partially true. Please write changes or additions to make the statement correct.
3. I don't know enough about this subject to respond.
4. I believe this statement is not true.

Statements	Response	Important?	Comments
Fertility in the Hmong Culture 1. The Hmong value children highly.			
2. One aspect of a Hmong woman's standing in the community is based on her ability to have children.			
3. A Hmong woman's name changes when she gets married and changes again when she has children. Her name becomes "mother of (her husband's name)" or "mother of (her child's name)".			
4. The Hmong know that breast feeding can delay pregnancy.			
5. It is a Hmong belief that women are given a certain number of babies to bear each lifetime.			
6. The Hmong believe if a woman does not have her certain number, she will have to return to earth in another life and bear those babies then.			

Question: Would Hmong people consider using Western methods of birth control (IUD, pills, condom, injections of Depo-provera, abstinence at the time of fertility each month) if they were aware that the children born might be healthier? Which ones might be acceptable?

Response Options: Write as many of the number and letter codes as you think apply under the column labelled "Response". If you think this statement is important for health providers to know put a check mark under the column labelled "Important?"

1. I believe this statement is often
   A. correct.
   B. correct in Laos but not in the U.S..
   C. correct for the majority but is changing.
   D. correct for the older people but not the youth.
   E. correct but is not widely admitted.
2. The statement is partially true. Please write changes or additions to make the statement correct.
3. I don't know enough about this subject to respond.
4. I believe this statement is not true.

Statements	Response	Important?	Comments
Marriage and Childbearing			
1. Marriage and having a baby at a young age are not considered problems in the Hmong culture.			
2. Young Hmong women are expected to marry by age 15 or 16.			
3. Some Hmong young women marry younger, at 13 or 14.			
4. By age 17 or 18 Hmong women are often considered to be "fading" and are not as desirable as daughters-in-law as younger women would be.			
5. Hmong males do not achieve adult status until they have married and fathered a child.			
6. If a Hmong woman gets pregnant and she is not married she can put a curse on her baby's father. He must marry her or he will die.			
7. Most young Hmong women don't finish high school. They become mothers instead.			

Question: Are Hmong people aware or concerned with the problems of having babies at young ages and not finishing high school? Can you suggest solutions?

Cultural Factors and Components
of Prenatal Care for the Hmong and Yiu-Mien

Response Options: Write as many of the number and letter codes as you think apply under the column labelled "Response". If you think this statement is important for health providers to know put a check mark under the column labelled "Important?"

1. I believe this statement is often
   A. correct.
   B. correct in Laos but not in the U.S..
   C. correct for the majority but is changing.
   D. correct for the older people but not the youth.
   E. correct but is not widely admitted.
2. The statement is partially true. Please write changes or additions to make the statement correct.
3. I don't know enough about this subject to respond.
4. I believe this statement is not true.

Statements	Response	Important?	Comments
Nutrition			
1. Near the end of the pregnancy, the Hmong woman's diet is limited to ensure ease of delivery.			
2. Hmong women fear surgery and will limit food intake to decrease the possibility of needing a Cesarean section.			
3. Milk and milk products are disliked by most Hmong.			
4. Milk and milk products cause many Hmong people to feel sick.			
5. Women in the Hmong culture eat after the men and children have finished eating.			
6. When food is scarce, the women get less.			

Question: If the Hmong were aware of the relationship between the mother's nutritional intake and the baby's health risks, would they be more likely to make sure the mother eats enough nutritious food?

Cultural Factors and Components
of Prenatal Care for the Hmong and Yiu-Mien

Response Options: Write as many of the number and letter codes as you think apply under the column labelled "Response". If you think this statement is important for health providers to know put a check mark under the column labelled "Important?"

1. I believe this statement is often
   A. correct.
   B. correct in Laos but not in the U.S..
   C. correct for the majority but is changing.
   D. correct for the older people but not the youth.
   E. correct but is not widely admitted.
2. The statement is partially true. Please write changes or additions to make the statement correct.
3. I don't know enough about this subject to respond.
4. I believe this statement is not true.

Statements	Response	Important?	Comments
Social Support and Kinship			
1. Marriage to the Hmong people is a way of achieving clan alliances.			
2. Hmong marry outside the clan. It is forbidden to date or marry within the clan.			
3. Most brides go to live with their new husband and his family or clan.			
4. One clan will often live together in the same region.			
5. When Hmong people marry, the bride comes from a different clan and often from a different region.			
6. The new bride may not have good friends and advisors during her first pregnancy because of her recent move.			

Question: Are feeling isolated or lacking support problems for the young pregnant Hmong woman? Please describe. Who are the young pregnant Hmong woman's most important advisors?

Cultural Factors and Components
of Prenatal Care for the Hmong and Yiu-Mien

The previous statements are only some factors which may or may not be important in prenatal care. Can you tell us what in your opinion are the important factors? What might increase Western prenatal care use by pregnant Hmong women?

APPENDIX E

Yiu-Mien Instrument

Oregon Health Sciences University

School of Nursing

Cultural Factors and Components of Prenatal Care for the Hmong and Yiu-Mien

Instructions: Select responses from those below that most accurately reflect your opinion and write as many of the number and letter codes as you think apply on the lines next to each statement. Statements were derived from ethnographic literature, analysis of interviews, and personal communication with professionals who lived or worked with the cultures. If you believe that the statement is important for health providers to know place a check mark under the column labelled "Important?".

For example if the statement is often correct, record 1A. If the statement is often correct in Laos but not in the U.S., record 1B. Statements may require more than one response. If you believe this statement is important for health providers to know, please mark a check in the column labelled "Important?" We also welcome comments, examples, or elaborations that might help illustrate your opinion. If you need more space for comments, please use the back of the of the page or the blank page provided.

Response options:

1. I believe this statement is often
   - A. correct.
   - B. correct in Laos but not in the U.S..
   - C. correct for the majority but is changing.
   - D. correct for the older people but not the youth.
   - E. correct but is not widely admitted.
2. The statement is partially true. Please write changes or additions to make the statement correct.
3. I don't know enough about this subject to respond.
4. I believe this statement is <u>not</u> true.

Cultural Factors and Components
of Prenatal Care for the Hmong and Yiu-Mien

Response Options: Write as many of the number and letter codes as you think apply under the column labelled "Response". If you think this statement is important for health providers to know put a check mark under the column labelled "Important?"

1. I believe this statement is often
   A. correct.
   B. correct in Laos but not in the U.S..
   C. correct for the majority but is changing.
   D. correct for the older people but not the youth.
   E. correct but is not widely admitted.
2. The statement is partially true. Please write changes or additions to make the statement correct.
3. I don't know enough about this subject to respond.
4. I believe this statement is not true.

Statements	Response	Important?	Comments
Practices Related to Pregnancy			
1. The Yiu-Mien women avoid talking about their pregnancies fearing that spirits overhearing them will harm them or their unborn child.			
2. A non Christian Yiu-Mien would especially not want to discuss pregnancy with a Christian health worker.			
3. The Yiu-Mien women do not discuss their pregnancies because they are shy.			
4. It is considered improper for Yiu-Mien men to discuss pregnancy or prenatal issues.			
5. Yiu-Mien women don't like to discuss their pregnancy during prenatal visits.			
6. The risk may be considered greater than the possible benefit for the Yiu-Mien woman considering Western prenatal care initiation.			

Question: What are ways to "bridge" Yiu-Mien and Western ideas of prenatal care?

Response Options: Write as many of the number and letter codes as you think apply under the column labelled "Response". If you think this statement is important for health providers to know put a check mark under the column labelled "Important?"

1. I believe this statement is often
   A. correct.
   B. correct in Laos but not in the U.S..
   C. correct for the majority but is changing.
   D. correct for the older people but not the youth.
   E. correct but is not widely admitted.
2. The statement is partially true. Please write changes or additions to make the statement correct.
3. I don't know enough about this subject to respond.
4. I believe this statement is not true.

Statements	Response	Important?	Comments
Beliefs Related to Pregnancy			
1. The Yiu-Mien believe the spirit of the unborn child lives in different places of the house throughout the pregnancy, depending on the month of the year.			
2. The Yiu-Mien believe different precautions must be taken each month depending where the spirit is living in order to prevent miscarriage and deformity.			
3. The Yiu-Mien believe these precautions are an important part of their prenatal care.			
4. The Yiu-Mien believe that certain souls, the wuen, are given to the unborn child by the mother.			
5. It is thought that if the mother's wuen is weak, her baby will be stillborn or she herself may die after giving birth.			
6. The Yiu-Mien believe that if they practice the necessary precautions and the mother's wuen is strong, the baby will be healthy.			

Question: How is the wuen made strong? Can you suggest ways that Western care providers could mediate between Yiu-Mien beliefs and Western ideas of prenatal care?

Response Options: Write as many of the number and letter codes as you think apply under the column labelled "Response". If you think this statement is important for health providers to know put a check mark under the column labelled "Important?"

1. I believe this statement is often
   A. correct.
   B. correct in Laos but not in the U.S..
   C. correct for the majority but is changing.
   D. correct for the older people but not the youth.
   E. correct but is not widely admitted.
2. The statement is partially true. Please write changes or additions to make the statement correct.
3. I don't know enough about this subject to respond.
4. I believe this statement is not true.

Statements	Response	Important?	Comments
Fertility and Adoption			
1. Infertility is a common problem among the Yiu-Mien.			
2. The Yiu-Mien have a method of worship for infertile couples where ancestors mediate for a child.			
3. At least 1 in 10 of the Yiu-Mien population have been adopted.			
4. The Yiu-Mien traditional practice of adoption was related to infertility.			
5. There is no sense of shame or inferiority attached to adoption.			
6. Yiu-Mien believe that one can be a true Yiu-Mien without being born of the tribe.			

Question: Have you noticed high rates of infertility among the Yiu-Mien? If so, what do you consider the cause? If Yiu-Mien infertile couples were aware of possible remedies, would they consider Western care?

Cultural Factors and Components
of Prenatal Care for the Hmong and Yiu-Mien

Response Options: Write as many of the number and letter codes as you think apply under the column labelled "Response". If you think this statement is important for health providers to know put a check mark under the column labelled "Important?"

1. I believe this statement is often
   A. correct.
   B. correct in Laos but not in the U.S..
   C. correct for the majority but is changing.
   D. correct for the older people but not the youth.
   E. correct but is not widely admitted.
2. The statement is partially true. Please write changes or additions to make the statement correct.
3. I don't know enough about this subject to respond.
4. I believe this statement is not true.

Statements	Response	Important?	Comments
Marriage and Pregnancy			
1. A Yiu-Mien girl is considered an "old maid" if she is not married by age 18.			
2. Yiu-Mien women who have a baby before marriage may bring a higher bride price.			
3. Whether the young Yiu-Mien bride and her husband would live with his or her parents, depends in part on whether the bride price has been paid in full.			
4. Having a baby before age 15 is preferred and desired by the Yiu-Mien.			
5. The reason many Yiu-Mien women have been classified as "unmarried" is because many are "culturally married" and not registered with the state.			
6. "Cultural marriage" is common among the Yiu-Mien.			
7. Young Yiu-Mien women who are neither culturally nor legally married are encouraged to become pregnant in the Yiu-Mien community.			

Question: Are there reasons for young Yiu-Mien women to delay pregnancy? What are they? Who are the young neither culturally nor legally married Yiu-Mien woman's most important advisors?

Cultural Factors and Components of Prenatal Care for the Hmong and Yiu-Mien

The previous statements are only some factors which may or may not be important in prenatal care. Can you tell us what in your opinion are the important factors? What might increase Western prenatal care use by pregnant Yiu-Mien women?

APPENDIX F

Non-culture Member Key Informants

Biographical Information

NON-CULTURE MEMBER KEY INFORMANTS BIOGRAPHICAL INFORMATION

Beverly Aiello
Homemaker / Missionary
Has lived in a Yiu-Mien Community for 3 years.
Halsey Square in Portland, Oregon

Nick Aiello, BA
Truck washer / Missionary
Has lived in Halsy Square for 3 years.
Portland, Oregon

Susan L. Clark, MA
Director of Indochinese Family Planning Project
Linda Vista Health Care Center, San Diego,
California. has worked with Hmong for 7 years in a
community health center and with the family planning
education project.

Eric Crystal, PhD
Program Coordinator, Center for South and S.E. Asia
Studies. University of California at Berkeley,
Berkeley, California.
Author: has written 30 articles, films and videos.

Nancy Donnally, PhC
Assistant Director of the Northwest Consortium for
S.E. Asian Studies
Anthropologist, University of Washington in Seattle,
Washington. Research related to gender roles of
Hmong women.

Bruce Downing, PhD
Associate Professor of Linguistics University of
Minnisota Minneapolis, Minnisota.
Co-editor of The Hmong in the West and The Hmong in
Transition: additional research and publications on
language contact, bilingualism and language learning
in Vietnamese and Hmong refugee communities.

Helen Faller, EdD
Associate Professor at East Carolina University, School of Nursing. Greenville, North Carolina
Publication: Perinatal Needs of Immigrant Hmong Women and Health Care Providers. Public Health Report, 1985.

Marshall G. Hurlich, PhD in anthropology, 1976 and MPH Epidemiology, 1988
Reserch Associate, University of Washington, Seattle, Washington. 8 years working with Hmong on resettlement issues, nutrition, demography, growth and development

Sylvia Lombard, LPN
Lived and worked as a missionary in Laos, Thailand, and Portland with Yiu-Mien people.
Published Yao-English/English-Yao Dictionary, (Southeast Asia Program, Cornell University, 1968).
Worked as bilingual aide and "community agent" Portland Public Schools and taught ESL at Portland Community College.

Jeff Mac Donald, BA, MA, PhC
Research Fellow in Anthropology, New School for Social Research. New York:NY. Previous research: Chinese Americans in the Pacific Northwest. Has been associated with Yiu-Mien people as a researcher for three years. Currently lives in Halsey Square, Portland, Oregon.

Grace Merchant, M.A.
Program Coordinator, International Refugee Center of Oregon. Director of Hmong, Mien and Lao Family Research Project.

Laurie Moore, M.D.
Indochinese Psychiatric Clinic,
Oregon Health Sciences University Portland, Oregon.
Plans to write about the Yiu-Mien.

Kathleen Morrow, RN, CNM, MA
Certified Nurse Midwife, Isla Vista Medical Center
Pulication: Transcultural Midwifery: Adapting to Hmong Birthing Practices in California. Journal of

Nurse-Midwifery, 1986. University of California at Santa Barbara, California.
Presently seeking a midwife position in Thailand Refugee Camps through the American Refugee Committee

Debra Richman, BSN, MPH, MSN
Certified Nurse Midwife, San Diego, California
Publications: Comparative study of Cambodian, Hmong and Caucasian Infant and Maternal Perinatal Profiles. Journal of Nurse Midwifery, 1985. Masters thesis for MSN was on identifying and treating iron deficiency anemia in Southeast Asian Refugees.

Kimberly Gay Rilette, RN
Has worked in OB-GYN perinatal nursing for 8 years at the Oregon Health Sciences University Hospital. Kim has lived in Halsey Square for 2 1/2 years in Portland, Oregon and is currently seeking a nursing position in a Thai camp.

APPENDIX G

Consent Form A

Cover Letter

Oregon Health Sciences University

CONSENT FORM A
For Those Responding to Written Instrument

According to a recent study by the Oregon State Health Division, there has been an increase in the proportion of low birthweight infants born to the Hmong and the Yiu-Mien. And the rate of inadequate prenatal care, according to State standards based on time of initiation and number of visits, is much higher for Hmong and Yiu-Mien women in Oregon than for all childbearing Oregon women. This data prompted the proposal of a research study by two graduate nursing students, Dawn Doutrich, BSRN and Lydia Metje, BSRN. As principle investigators they titled this descriptive study "Cultural Factors and Components of Prenatal Care for the Hmong and Yiu-Mien." The study uses an instrument based on a literature review, community needs assessments, and personal communications to determine the validity of information about the cultures. The primary objective of the study is to confirm and expand upon descriptions of Hmong and Yiu-Mien ways of life in order to describe to the community aspects of the Hmong and Yiu-Mien social worlds. The ultimate purpose is to provide a more complete body of knowledge so that cultural barriers to prenatal care can be reduced and health services can be more appropriately matched to cultural expectations.

As a participant, I am asked to read the statements on the instrument. From a list of responses I am asked to select the ones that most accurately represent my opinion. I am asked to place a check mark in the appropriate column if I think this statement is important for health providers to know. My comments, examples and elaborations are encouraged to help illustrate that opinion. Suggestions regarding culturally acceptable means of solving problems related to health issues of childbearing women are also elicited. I will return the completed form in a pre-addressed, stamped envelope that has been provided. Should I choose not to participate, I will return the unanswered form.

It is my understanding that there are no physical risks associated with my participation in this study, however I may experience feelings of discomfort in discussing cultural beliefs and values, particularly if my opinions are controversial. I do understand that my name will <u>not</u> be identified with my opinions or comments.

The potential benefits of my participating include a sense of personal satisfaction in contributing to research that could improve understanding across cultures and health care for the Hmong and Yiu-Mien. In addition, there may be benefit as information about the cultures and potentially relevant approaches to health issues are identified and made available to the communities and health professionals.

I have been asked to describe my qualifications, and the cultural group(s) to which I belong and with which I am familiar (see Addendum to Consent Form A). I understand that I will be named as a study participant and the report of the study will contain my description. I understand however, that my name will not be attached to my opinions and I will not be quoted by name.

I understand the Oregon Health Sciences University, as an agency of the State, is covered by the State Liability Fund. If I suffer any injury from the research project, compensation will be available to me only if I establish that the injury occurred through the fault of the University, its officers or employees. If I have further questions, I can call Dr. Michael Baird at (503) 279-8014.

Both investigators Dawn Doutrich, BSRN, (503) 236-0998 and Lydia Metje, BSRN, (503) 684-5165, and/or their faculty advisor, Caroline White, DrPH., (503) 279-7709 would be pleased to answer any questions I might have.

I understand that I may refuse to participate or withdraw from this study at any time without affecting my relationship with or treatment at the Oregon Health Sciences University.

I have read the foregoing and agree to participate in this study. And, I am enclosing this form with the completed instrument in the envelope provided.

_____	_____	_____
Date	Signature	Witness

Retain a copy of this form for your records.

Should you decide not to participate, please return the instrument so that the investigators might know that this mailing to you did not get lost.

Addendum to Consent Form A

Oregon Health Sciences University

Dear (Respondent's Name):

You have read the consent form and are aware of the purpose of our research. The attached instrument contains statements about information on the cultures. It is our hope now to validate and expand on these statements and to elicit suggestions for culturally acceptable solutions to the problems. The Hmong-American Association of Oregon, Inc. and the Yiu-Mien Association of Oregon have both agreed to support this research study.

Dr. Ruben Rumbaut suggested you might be a person with the information we seek. We have included an abstract of our study to describe the nature of our work to you. We would like to invite you to contribute as a key informant professional who has worked closely or lived with either the Hmong, the Yiu-Mien, or both. We will be naming and describing our key informants to increase credibility of the study and would like to include you.

Please indicate in the space below.

Your name _____

Please circle your age range (20-24, 25-29, 30-34, 35-39, 40-44, 45-49, 50-54, 55-59, 60 or over).

Your work title._____

Years of school/ Degree(s) if applicable_____

Your previous research and publications if applicable _____

What else would you like us to know about you?_____

We would like to thank you for your participation in this study. It is our sincere hope that this research will be useful to the Hmong and Yiu-Mien and that their health care will improve through a better understanding of their cultures.

Dawn Doutrich, BSRN

Lydia Metje, BSRN

APPENDIX H

Consent Form B

Oregon Health Sciences University

CONSENT FORM B
For Those Respondents Being Interviewed

I have been asked by two graduate nursing students, Dawn Doutrich and Lydia Metje, under the direction of Caroline White, DrPH, to participate in a research study entitled, "Cultural Factors and Components of Prenatal Care for the Hmong and Yiu-Mien."

The study uses an instrument based on a literature review, community needs assessments, and personal communications to determine the validity of information about the cultures.

The primary objective of the study is to confirm and expand upon descriptions of Hmong and Yiu-Mien ways of life in order to describe to the community aspects of the Hmong and Yiu-Mien social worlds. The ultimate purpose is to provide a more complete body of knowledge so that cultural barriers to prenatal care can be reduced and health services can be more appropriately matched to cultural expectations.

Lydia and Dawn telephoned and it was then I agreed to this meeting. Now I am asked to listen to the statements they read from the instrument. They will also read me a list of responses and I am asked to select the ones that most accurately represent my opinion about the statement. My comments, examples and elaborations are encouraged to help illustrate that opinion and will be written on the instrument by Lydia or Dawn. They will ask me for suggestions regarding culturally acceptable means of solving problems related to health issues of childbearing women. They may be recording my responses on a cassette tape recorder in addition to writing them on the instrument.

It is my understanding that there are no physical risks associated with my participation in this study, however if I experience feelings of discomfort during the interview I may choose not to continue. I need only to say that I would prefer not to participate and the interview will end.

The potential benefits of my participating include a sense of personal satisfaction in contributing to research that could improve understanding across cultures and health care for my people.

Personal information such as my name, age, or address will not be transmitted outside the Oregon Health Sciences University. This information will be kept strictly confidential by the researchers. Tape recordings of my voice will be destroyed and the instrument will identify me only be number, not by name. Neither my name nor my identity will be used for publication or publicity purposes.

I understand the Oregon Health Sciences University, as an agency of the State, is covered by the State Liability Fund. If I suffer any injury from the research project, compensation will be available to me only if I establish that the injury occurred through the fault of the University, its officers or employees. If I have further questions, I can call Dr. Michael Baird at (503) 279-8014.

Both investigators Dawn Doutrich, BSRN, (503) 236-0998 and Lydia Metje, BSRN, (503) 684-5165, and/or their faculty advisor, Caroline White, DrPH., (503) 279-7709 would be pleased to answer any questions I might have.

I have read the foregoing and agree to participate in this study. (I agree to the taping: yes___ no___)

_____	_____	_____
Date	Signature	Witness

Retain a copy of this form for your records.

ABSTRACT

MASTERS RESEARCH PROJECT

Dawn Doutrich and Lydia Metje

Cultural Factors and Components of Prenatal Care for the Hmong and Yiu-Mien

Approved: [redacted]

Caroline White, R.N., Dr.PH., Project Advisor

High rates of low birthweight infants and inadequate prenatal care are problems for the Hmong and Yiu-Mien of Oregon. Cultural factors and perceptions of Western prenatal care were thought to contribute to the high rates of inadequate prenatal care for these two groups. Using two instruments, one for the Hmong culture and one for the Yiu-Mien, this ethnographic, descriptive study examined cultural factors and perceptions of Western prenatal care of the Hmong and Yiu-Mien.

Three groups of key informants were asked to comment on statements which described cultural factors and to identify culturally appropriate solutions to problems encountered when culture members access Western health care. One group of key informants, fifteen non-culture members who have lived or worked with one or both cultures, were mailed the semi-structured instrument(s). The second group of key informants were ten Hmong culture members. The third group of key informants were nine Yiu-Mien culture members. Culture member key informants were interviewed using the instruments as interview schedules.

Major concepts of importance for the cultures in relation to prenatal care were identified. Ones common to both cultures include: (a) a reluctance to discuss pregnancy, (b) "shyness" influences the divulgence of pregnancy, (c) modesty affects culture members desire to seek prenatal care, (d) children are highly valued, and (e) concern over early marriage and childbearing and high school incompletion are common to both cultures.

Implications for health providers were also identified by Hmong and Yiu-Mien culture members. Some of these are: (a) a request for sensitivity to modesty with less intrusive exams, (b) a desire to be served by one consistent female (in the prenatal context) provider, (c) health providers need to be aware that culture members depend on the leaders and elders to help in decision-making, and (d) culture members want to have control over their bodies, to have the choice implied by informed consent.