# A STUDY OF THE BIRTHING PRACTICES OF A GROUP OF RECENTLY IMMIGRATED HMONG WOMEN

by

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e. b. l.

For Bob

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# CHAPTER I

## Introduction

This study will address the knowledge gap faced by American nurses who are providing nursing care to the child-bearing families of recently immigrated Hmong refugees. The Hmong, a hilltribe people of Laos, are part of the larger influx of Southeast Asian refugees; yet their culture is sufficiently distinct that they have not yet been accurately assessed in the literature addressing the nursing care needs of the Southeast Asian client. This examination of Hmong childbearing practices will be directed primarily at the needs of nurses working in labor, delivery, and post partum.

The nursing process takes place within a culturally defined setting. In order to provide the best possible nursing care, and care that is acceptable to the client, something of the cultural milieu from which the client comes must be understood. It is then necessary to cross, at least intellectually, from our culture to a frequently very different one. This intercultural bridging is often called transcultural nursing.

It is the culture from which one comes that determines one's approach to life, goals, expectations, and fears. And it is anthropological information that enables the transcultural nurse to assess care needs in light of these

factors. Therefore, it is appropriate for those who will be caring for the Hmong families to know something of the history and the cultural background of this group.

In 1975, in a series of parallel political events, the U.S. backed governments of Vietnam, Cambodia, and Laos fell to the Communist backed Viet Cong, Khmer Rouge and Pathet Lao respectively. Refugees by the hundreds of thousands poured across the borders, and even the open seas, to take refuge in Thailand and Malaysia. Unwelcome in the countries into which they fled, they were collected into camps and are now gradually being accepted as immigrants by various Western nations.

Currently, the United States receives approximately 7,300 refugees a month. Of those, the State of Oregon receives 300-400. There are now approximately 17,000 Indo-Chinese or Southeast Asian immigrants in Oregon. More than 3,000 of these immigrants to Oregon have been of the ethnic group called Hmong, though recently many have left the state because of adverse economic conditions. The Hmong in the U.S. have almost all come from Laos, Vang Tou-Fu (1978) states, and so they may also be considered to be Lao Hmong.

These people now living in the United States are turning to a new and, to them, strange health care system. They appear faithfully at pre-natal clinics for obstetrical care, and at hospitals for delivery, at least in part, it is said, because they believe this is expected of a responsible and law-abiding U.S. citizen. It may be that they come also because they believe ours is a good health care system which

as already noticeably lowered their infant mortality rate.

In the "old country," where satisfaction in life was btained by watching one's children and grandchildren grow p (Barney, 1957), and where the ideal was to be blessed ith as many children as possible (Bernatzik, 1947), the irthrate was very high. In keeping with that tradition, nd because one element in setting down roots here seems to e to have an American-born child or children, it is xpected that a significant number of births will be seen ithin this community in the coming years. These births ccurring now in American hospitals present an unique hallenge to the obstetrical care team.

The goals of obstetrical nursing are to provide comfort, upport and safety to the childbearing family. If more is earned about the Hmong childbearing customs, practices and esires, then it should be possible to increase the ffectiveness of the American nurse in providing the comfort nd support desired while adding the dimension of increased afety in the birthing process.

There is a range of good health practices which the bstetrical team attempts to teach to all childbearing amilies from nutrition during pregnancy to immunization of ell babies. In order to teach these things the nurse needs apport and credibility with her clients. If her behavior s in sharp contrast to what the clients experienced in the ast and seems to them to violate common sense, it is nlikely that she will achieve either the rapport or

redibility she desires. If, on the other hand, she can do er caring and teaching with an understanding of the lients' past experiences, she can incorporate those xperiences where appropriate and explain contradictions hen necessary.

A final reason for conducting this factor-seeking study s the observation made both historically and locally (Le ar, Hickey and Musgrave, 1964; Lees, 1981) that the Hmong omen have very easy, rapid and uneventful labors. If this s so, there may be traditional factors or practices that ccount for this. In addition, therefore, this study will ttempt to record from the practical wisdom of their older omen and traditional birth attendants those things which hey believe have led to a better pregnancy outcome, such as asier labors or stronger babies.

## Review of the Literature

The anthropology literature makes only very general eferences to the childbearing practices of the Hmong. The etails of those practices remain to be described and an ttempt will be made to do so in the course of this study. hat will be reviewed in this section are descriptions of he Hmong culture as a whole, Hmong childbearing practices s far as they are known, and then the literature pertaining o labor and delivery support and the role of the nurse in ffecting that support.

Yang See Koumarn, himself a Hmong, in an article written o help Americans understand the history of the Hmong

efugees states: "A complete anthropological study of the mong has never been made..." (Yang See, 1978, p. 3). The ost comprehensive material available about these people was athered and written by G. L. Barney, a missionary, nthropologist and linguist who worked in the early 1950's ith the Hmong in Xieng Khouang Province, Laos and Hugo ernatzik who, with his wife, studied the Thailand Meau Hmong) in 1936-1937. Most descriptions of the Hmong in aos after 1957 refer to Barney's work.

rigins of the Hmong

The name Hmong means "free men" and that is the name by hich these people have always referred to themselves. owever, they are called by several different names. The aotians referred to them as "Meo," a derogatory term ranslating literally as "rice shoot" and implying much the ame thing as the American term "hayseed" for a country erson. The Chinese refer to them as "Maio" - barbarians; nd most of the older literature uses some variation of this erm (Barney, 1957; Bernatzik, 1947; Garrett, 1974; Le Bar, t al., 1964; Roberts, Carroll, Kaplan, Matthews, McMorris nd Townsend, 1967; Yang See, 1978). In the United States hey are known as Hmong, a term that the most recent iterature utilizes also.

The Hmong are divided into a number of groups which are amed on the basis of a characteristic color or design of he women's costume. They are thus referred to as White, Black, Red, Striped, Flowered, and so forth, Hmong. The

ost prevalent groups in Laos were the White and the Black mong (Le Bar, 1964; Roberts, 1967).

The earliest known reference to the Hmong people occurs n a Chinese text dating from some forty-two centuries ago 2223 B.C.). The Hmong are believed to have originated in hina and approximately two and a half million of them emain in the Peoples Republic of China today (Garrett, 974; Le Bar et al., 1964). Over the centuries they moved outh through Yunnan, China where many remained and into aos and other Southeast Asian countries, always settling in he mountains between 3,000 and 6,000 feet (Roberts et al., 967; Vang Tou-fu, no date). They first appeared in Laos nly about one hundred fifty years ago and have maintained uch closer cultural links with China than with the ndigenous Laotians (Roberts et al., 1967; Yang See, 1978).

The number of Hmong who actually lived in Laos is nknown since a census was never taken. It is estimated, owever, that 350,000 lived there in the mid 1960's (Yang ee, 1978). Their numbers were greatly reduced by both ombat and the effects of relocation during the war (White & arrett, 1968; Yang See, 1978).

ife in Indo China

Living high in the mountains the Hmong practiced a form f slash-burn agriculture (swidden-farming) growing ubsistance food crops and, as a cash crop, opium (Roberts, t al., 1967). The growing of opium was legal and ncouraged under both the French and Royal Laotian

overnments until 1971 (Garrett 1974). The Hmong remained fiercely independent of Laotian influence, holding the Laotians in no higher esteem than the Laotians held them (Barney, 1957; Halpern & Kunstadter, 1967).

Traditional Hmong society is usually described as non-literate or pre-literate. Roberts et al. (p. 60) state:

> They are said to have writing systems that are based on Chinese characters, limited in use to religious texts, and known only by priests.

A very few Hmong, however, did learn to read and write in Lao and occasionally in French (Yang See, 1978).

The war that ultimately drove the Hmong from Laos lasted from about 1955 to 1975. The majority of the Hmong, recruited and armed by the American CIA, backed the Royal Laotian forces against the Pathet Lao. Even with peace in 1975, there was no relief since the pro-American Hmong were apparently singled out by the Pathet Lao for annihilation (Yang See, 1978). There was literally no place to hide and thousands more were killed. Fleeing for their lives, some actually swimming across the Mekong River border, they made their way into Thailand and from there to such unlikely places as Missoula, Montana and Portland, Oregon.

Prior to the relocations caused by the war, the Hmong lived in small scattered villages on the mountain sides, above 3,000 feet elevation. They moved the village every few years because the type of agriculture they practiced required that new land be found, the forest cut down and burned to provide the nutrients for the soil, and then the

rops planted in this clearing (Barney, 1957; Garrett, 1974; Bar et al., 1964; Roberts et. al., 1967).

Food crops planted included corn, buckwheat, and y-land rice supplemented by several different vegetables dabie, 1924; Roberts et al., 1967). Domestic animals, ich were usually only eaten in conjunction with a ritual religious sacrifice, included poultry, goats, cows, ffalo and pigs (Barney, 1957; Garrett, 1974). Horses, hich were much finer than the usual Southeast Asian ones, ere also raised but never eaten (Aradie, 1924).

ocial Organizations

More than any other of the minority tribespeople of outheast Asia, the Hmong developed a system of political rganization that enabled them to have representation and he beginnings of power in the country as a whole (Barney, 957; Garrett, 1974; Roberts et al., 1967; White & Garrett, 968). The basic and strongest unit was the household made o of an extended family under the leadership of the senior ale householder. The village was the next division and was ade up of one to twenty households, usually of one clan, nder a senior householder. The clans were spread over ifferent villages and occasionally more than one clan would hare a village. Some time after 1945, these village chiefs ere organized and led by a man named Toubey Lyfond who irst rose to prominence as a leader of Hmong militia gainst the Japanese in World War II. He was generally onsidered to be the paramount chief and was the first of

.s people to hold a seat on the Council of the Royal Lao )vernment (Barney, 1957; Yang See, 1978). This propensity )r organization was evidenced even in crowded refugee camps iere the shelters were arranged by households, clans and )rmer villages.

Parallel to this civilian organization has been the ecruitment and support of guerilla armies. These armies ere led by Faydang Lor on the side of the Pathet Lao and eneral Vang Pao on the side of the Royal Laotians (Barney, 957; Roberts et al., 1967; Yang See, 1978). Vang Pao is iving in the United States today where he retains much of is former influence in the Hmong Community (Woody, 1981). ne Hmong economist, Dr. Yang Dao, attributes this military nvolvement with ". . . more progress in 14 years . . . than e could have had in 50 years of peace" (Garrett, 1974, . 86).

The religion of these people is animistic in that there re numerous spirits, each of which is involved with a pecific aspect of daily life such as the rice field, the rail, the sleeping quarters, and the like. The degree to hich an individual believes in these spirits varies reatly. There was also a Supreme Being, the creating pirit called Fua Tai who initially created all things but ecame disgusted with man and abandoned him to the spirit orld (Barney, 1957). Related to this spirit world is the onoring of the spirits of the families' ancestors. A hrine within each home is reserved for this purpose. Not

eing able to erect a proper shrine in the refugee shelters is a source of some distress to these people (Barney, 1957; ing See, 1978).

Barney observed that:

> with the Hmongs, life is conceived of as one long series of events with no great traumatic experiences leading from one stage to another. Birth and death are considered the major crises, while marriage is an important event that assures the continuance of Hmong society and culture. The household functions throughout the life of the Hmongs, and serves as the mold in which life is lived (1957, p. 42).

amily Life

Marriage must be with someone from outside the clan and he marriage partners make their own choices. The age for arriage is variously set at 20-21 for girls and 16-17 for oys by Bernatzik (1947); at 14-18 for girls and 15-30 for oys by Bessac & Rainbolt (no date) and beginning at 14 for irls by the Indo Chinese Mental Health Project (no date). arney and others state that sexual adventures and trial arriage are the norm and that virginity at the time of arriage has no particular value (Adabie, 1924; Barney, 957; Bernatzik, 1947; Garrett, 1974). Hmong writers, owever, dispute this and Yang See adds that unwed pregnancy s a family disgrace (Truong-Quang Reed & Tou Fu-vang, 1978; ang See, 1978).

When a couple determined that they wanted to be married, go-between was chosen who would negotiate with the bride's arents for the "bride price" which would be paid by the

)tential husband. Elopements occurred when negotiations
:oke down and the arrangements were then made after the
ıct by a neutral panel (Abadie, 1924; Barney, 1957;
:rnatzik, 1947). The society is patrilocal and so the
)ung woman leaves her father's household and joins the
)usehold and clan of her husband (Barney, 1957; Bernatzik,
947).

Polygamy was traditionally allowed and was most often
:acticed when a man married his brother's widow (Barney,
957). Second and subsequent wives occupy a lower status
ıd must answer to the first wife (Bernatzik, 1947).
:casionally a second wife might be sought by the first wife
) help with an increasing load of household duties
Garrett, 1974), although, the consent of the first wife is
)t required (Bernatzik, 1947; Indo Chinese Mental Health
roject, no date). In general the members of this household
:t along well and unhappy wives are rare (Bernatzik,
947). With the war, a tremendous number of men were killed
ıd so polygamy, which was beginning to die out, increased
:yond that formerly seen (Yang See, 1978; Garrett, 1974).
ıe staff of the Indo Chinese Mental Health Project in
:nnsylvania state: "In coming to the U.S., only one spouse
ay remain to the husband. Second, third, etc., marriages
ıst be dissolved. Wives are still informally accepted as
amily." (p. 42).

Divorce, initiated only by the wife, was possible, but
as unusual (Bernatzik, 1947). More commonly, a neutral

ınel with a village headman and representatives of both ts of in-laws would arbitrate a dispute (Barney, 1957).

By way of emphasizing the importance of the family in s essay for Americans on Hmong culture, Vang Tou-fu states:

> By tradition the Hmong usually have big families... In a world where people have not learned to trust police, banks or insurance, the happiness, prosperity and security of the individuals are centered in the family. Thus the larger the family, the better and more secure it is (no date, pp. 94-95).

ealth-Illness Caring System

Bernatzik describes the Hmong as having a very highly veloped talent for observation and diagnosis of illness. heir knowledge of herbal medicine was so great that he ecommends a serious investigation by western pharmacology f the many medicinal plants which they utilized. They are ost skillful at treating fractured bones which are arefully set with splints and bound with bandages. He tates that only in those cases of illness for which there s no known remedy do the Hmong turn to the ancestors and pirits for help. And, even then, some of the shamen who e called in are also skilled at medicine (Bernatzik, 1947).

Several authors describe the appropriate use of opium to reat pain, the discomforts of old age and diarrhea (Barney, 957; Bernatzik, 1947; Garrett, 1974). In contrast to that, owever, both Barney and Garrett report that illness is tributed to spiritual factors. Usually blame is placed on he spirit trying to leave the body of the ill individual,

us the job of the shamen is to entice the spirit to return d remain where it belongs (Barney, 1957, Garrett, 1974).

ildbearing Practices

Barney states that when childbirth occurs the father sists his wife during the birth and receives the child. cuts the cord and bathes the child with warm water. That thor did not observe any taboos that the father was pposed to observe but it was clear that he was expected to present at the delivery. An informant is quoted who ated that a pregnancy lasts nine months if it is a girl d ten months if it is a boy. Shortly after a birth takes ace, the village shaman will place fetishes on the child's ck and limbs to guard against evil spirits and to courage the soul to remain in the body (Barney, 1957).

Bernatzik similarly describes the participation of the sband who when the time for delivery comes supports his fe who is squatting on the ground next to the bed, catches e child, ties the cord and cuts it with scissors and then shes the baby. If this is the husband's first experience e parents will assist him. A mat or leaves will have been aced underneath the delivering women. The placenta and bilical cord are placed in a bamboo and buried -- the irl's under the bed of the parents and a boy's next to the iddle post of the house. After delivery the mother remains her bed and her busband cares for her and tries to elieve her of all work. Length of confinement varies ccording to economic circumstances from a few to 30 days.

: is always prolonged as long as possible in the belief
iat it will make the women healthier and stronger and thus
)le to bear future children. The birth of twins, he found,
; considered an especially happy and lucky occasion.

In his discussion of medicinal practices Bernatzik
1947) reports the use of an herb as an uterine tonic. He
lso cited Meau (Hmong) obstetrical skill where "... even in
ransverse presentation they are able to turn the child in
ie uterus by reaching in through the vagina with the hand
id assisting the work of the hand through massage from the
utside (p. 319).

Le Bar et al., (1964) offer a very comprehensive
thnography of the different "Meo" groups, yet they have
nly two references to birthing practices. First the Miao
f Yunnan, China are reported to have easy births, sometimes
iattended in the fields. Birth is reported to be in:

> ...upright position, legs apart and slightly bent while grasping a stationary object with a lined basket or receptacle on the ground to receive the baby. The mother is back in the fields in three or four days (p. 72).

iey also report the possession of an herb which makes
)thers strong and able to give birth easily.

These authors' descriptions of the Laos "Meo" in part
uote from the French work of Abadie in 1924 wherein they
tate that the "Meo" have no food taboos for the mothers but
ie husband must observe a vegetarian diet and remain near
ie house. If a boy is born, his placenta is buried before

the entrance to the house; if a girl, hers is buried underneath the hearth. The child is named at thirty-three days of age and at that time friends bring gifts (LeBar et al., 1964).

Bessac and Reinbolt (no date) who investigated Hmong culture among recent immigrants in Missoula, Montana, confirmed earlier observations about the husband's role. They state that "Even in Montana the husband tries to stay at the hospital until his wife can safely come home with the baby" (p. 34). Their informants also recall "...wild plants which when eaten assure the birth of a son, increase fertility or cause abortion" (p. 25). Like other Southeast Asians these new or expectant mothers avoid drinking cold things in order to keep their bodies strong both now and in old age. Chicken and rice prepared with healthful herbs are recommended for new mothers.

The staff study by the Indo Chinese Mental Health Project in Pennsylvania (no date) reported that the husband traditionally delivered the baby with the help of a midwife, a statement that contradicts to Bernatzik's observation that "Midwives are unknown" (p. 75). Further, they alone report a strict confinement to the house for one month of all newly delivered women.

Garrett in 1974 reported that the necklace placed on every baby right after birth, in addition to encouraging the soul to remain is also to show the spirits that the child is not a slave and belongs to a family.

Some Hmong, Barney relates, believe that the soul of a cently deceased family member will remain in the house and en inhabit the body of the next newborn.

One of the few published articles to date which address e issue of providing obstetrical nursing care to Southeast ian families considers all of the ethnic groups who have ed that region to have similar cultural backgrounds. cusing on the Vietnamese who make up the largest number, e article is quite misleading. For example, the question whether the woman's husband would expect to play a part the labor and delivery is answered in the negative. ile this would be correct in the case of Vietnamese, otians or Cambodians it would not be correct in the case Hmong families (Hollingsworth, Brown, and Brooten, 1980).

Todd (1982) writing for the publication of the ternational Childbirth Education Association, on the other nd, recognizes the cultural differences among Southeast ians and goes on to say that even within the ethnic group is not possible to altogether generalize. She presents a ief ethnography and recommendations based on information thered by Barbara Huff-Bloomer, a public health nurse who terviewed 10 Hmong women who had had at least one child in os and one in the United States, and published in a sconsin regional perinatal journal.

Todd reports that Hmong women in Laos would have sociated clinics and hospitals only with severe illness d death and thus may be quite fearful about a hospital

xperience. She predicts that Hmong fathers might only take
heir wives to the hospital for delivery but not wish to be
n the hospital themselves. She states that Hmong may be
ery anxious about blood tests believing that blood loss
eakens the individual. There may, she found, be a tendency
lso to want to avoid taking vitamins and iron because
edicine should be used only by the sick.

The Hmong women's special post partum diet is described
s chicken, rice, eggs, salt, black pepper, hot herbs and
pices for one month with all fruits and vegetables
orbidden in the belief that they would cause lifelong
llness. It is expected, she reports, that the baby would
tay with the mother after birth and she refers to the
pecial significance of the placenta to the Hmong people.
n Laos, the boy's placenta was buried outside the door of
he home and the girl's in the floor under the place of
irth, so in this country she recommends that the
isposition of the placenta be discussed with the parents.

he Role of the American Nurse

In contrast to the dearth of literature describing the
hildbearing practices of the Hmong family, there is a wide
ange of literature about the role of the American nurse in
ssisting the childbearing family in general.

During the course of labor, Affonso describes two major
oals:

1. To nurture the woman and significant other during labor and delivery so that they can cope optimally during the experience.

2. To stimulate the woman and significant other so that they will emerge from the labor experience with a strengthened self esteem and family unity.

(Affonso, 1976, p. 355).

e nursing actions to accomplish this are those which velop a sense of trust, meet informational needs, promote mfort and relaxation, provide the support system of rself and significant others, facilitate the immediate ternal-infant claiming process and help to integrate the bor experience into a meaningful whole.

Similarly, Chassie (1976) sees the role of the nurse in pporting the laboring couple as that of advocate and the als as:

(1) to identify and reinforce strengths that already exist within the family,

(2) to augment those strengths for the future, and

(3) to prevent events that weaken such strengths.

(p. 100).

Muecke (1976) believes that the health care system, if can attract clients by its obvious reduced risk in livery, can act as an agent for social change. She sees proved nutrition, environmental sanitation and fertility ntrol attitudes all arising from teaching during e-natal and delivery care. At the same time, she visions traditional (Thai) practices incorporated into

stern hospitals, thus salvaging the rich human intimacy at was the strength of those older ways.

Addressing the issue that American nurses need to opt a transcultural nursing model, Leininger urges rses to systematically study and classify the nursing re beliefs, values and practices of other cultures. sed on her own anthropological and nursing research she pothesizes that:

> Professional people working in strange cultures with different values about nursing care or caring behaviors can create obvious cultural conflicts and problems unless they are willing to recognize and adapt to indigenous caring values and expectations.
>
> The greater the differences between indigenous...cultural caring values and modern professional nursing care values, the greater the signs of cultural conflict and stresses in care-giving and care-receiving contexts.
>
> Professional caring behaviors which are congruent with the social structure and the values of a particular culture will show greater client satisfaction and acceptance than those caring behaviors which show incongruencies with the values and social structure of a given culture.
>
> (Leininger, 1978, p. 37)

ımmary

In summary, then, the literature provides us with a :neral background of the life style of the Hmong people ı their Laotian homeland and a history of their .slocation. The desirability of children is evidenced, ıt there are scanty references to childbearing practices

and those that are found scarcely treat such areas as the husband's role, the traditional birth attendents, treatment of the mother in labor or the immediate care of the newborn. Nursing literature recommends a number nursing actions which facilitate healthy childbearing in general and Leininger (1978) warns of the consequences of a failure to provide culturally sensitive care. There does not seem to be a published work on the American nurse's role in meeting the particular nursing care needs of the Hmong families in labor and delivery.

Conceptual Framework

If it is accepted that nurses who are going to be caring for laboring women need to understand them within their cultural context, then the conceptual and theory-generating model of Leininger can be used. Within this model the major sources of transcultural information are:

1. A general ethnography of the lifeways of the particular culture.
2. The major social structure features (political, kinship).
3. Cultural values.
4. The health-illness caring system.

From these sources, the researcher looks for those caring "constructs" such as comfort, nurturance and protection "which reflect the culture's own caring practices" (p. 22). Analysis and utilization of this data

enable us to determine appropriate nursing interventions (Leininger, 1979).

In the case of the Hmong the literature has provided a basic ethnographic, social structure and cultural value orientation. Within the health-illness caring system, however, there is an inadequate information base in the area of childbirth. This basic information can be gathered in such a way as to yield details illustrating the culture's approach to comfort measures, support measures, helping behaviors, coping behaviors, health maintenance acts and stress alleviation measures. Following Leininger's model, these, constructs can be identified and analyzed for use in nurses' decision making.

The data collected in this study will be used to describe some aspects of the health illness caring system relating to childbirth. The data analysis will then utilize the classification of those details for the development of factor-isolating theory.

Problem Statement

There is a need for nursing to determine the child birth practices that are valued by the Hmong clients. This information can be analyzed and used to prescribe the nursing interventions which will ensure maximum benefit from Western obstetrical care while providing comfort and support that is sensitive to Hmong desires and customs.

search Questions

To address the gap in knowledge regarding the ildbearing health-illness system, the following research estions are asked:

1. What were the caring constructs of the birthing practices of the Hmong women in their homeland?
2. What were the caring constructs of the birthing practices in their American deliveries?
3. Which of the traditional caring constructs do they continue to value?
4. What can an American nurse do to facilitate the continuation of those valued caring constructs, thereby providing the support desired and enhancing her effectiveness as a health care provider?

# CHAPTER II

## Methods

troduction

This chapter will deal with the setting and why it was osen for the study; the subjects and how they were cruited into the study; the design of the study including e procedure; the type of analysis it was subjected to. mitations of the methods used and of the study data will nclude the chapter.

tting

The setting chosen for the study was the Indochinese ltural and Service Center. This center is a private, n-profit, social service agency dedicated to aiding fugees from Southeast Asia in achieving self-sufficiency d productivity in American life. This service center erates in the classic tradition of the settlement house d is in fact located in The Neighborhood House which was ilt as a settlement house in 1911.

Among the many programs offered by this center is the men's Cultural Skills Program. This program enrolls adult men in a course of study which includes such basic rvival skills as: telling time, shopping for groceries, undry, and taking prescribed medications. The women rolled range in age from 15-80 and most of them are e-literate.

This setting, which also had available records of their st students, was chosen because it provided a source for lecting the desired number of participants, all of whom e recently immigrated to this country. The surroundings re familiar to them and the interpreter was someone they ew.

Secondly this setting was chosen because it is not a alth care provider. Under the National Institute of alth guidelines effective June 1, 1981, therefore, this rvey/interview procedure was exempt from human subjects view requirements and as a result, some of the fficulties associated with the necessity of obtaining formed consent were avoided.

bjects

Seventeen Hmong women from Laos were recruited as a nvenience sample from the Women's Program at the dochinese Cultural and Service Center. The identification d recruitment of these women was done by the Hmong terpreter of the Women's Program from their list of rrent and former students. The women had to have had at ast two births in Laos and one hospital birth in the ited States (During the course of the interview it was scovered that one women had delivered precipitously at me and was only admitted to the hospital post partum.). rths which occurred in the refugee camps in Thailand ither disqualified a candidate nor counted as part of the nimum requirement because of the disruption and atypical ature of the situation. At least two births in Laos were

ipulated to allow for the difference between the first
oor and delivery a mother has and any subsequent ones.
ving had experiences delivering in both countries, it was
oed that these women would be able to identify those "old
untry" practices which they missed in this country.

An attempt was also made to identify traditional birth
tendants or midwives but finding none, a group of four
ltiparous women over 50 years of age were selected. These
men were recruited to act as critical informants providing
ckground information regarding reasons for specific
actices and details. Additionally they had all had their
bies prior to the severe physical and cultural disruption
used by the war. The same question technique used with
e 17 initial subjects was used except that they were asked
ly about their Laotian experiences.

sign and Procedure

The study is a descriptive one using the results of a
ructured interview to outline the past, present and
sired birthing practices of the target population.
estions were developed with input from nursing staff of
anuel Hospital. These questions were further refined with
e help of the Emanuel staff Hmong interpreter so that
estions were culturally sensitive enough to obtain the
quired information without causing discomfort to the
rticipants. The interpreter at the Indochinese Center
so reviewed the questions for appropriateness. Finally, a
t of nine specific questions and one open-ended question

was adopted for use. The questions can be seen in Appendix A.

The Indochinese Center interpreter, herself a Laotian born Hmong, contacted the potential subjects by telephone or at the center and asked them to participate. The purpose of the study, a general description of the questions' content and an assurance of privacy was given to potential subjects. A written and signed statement of informed consent was not obtained for the following reasons: there was no risk of physical or psychological discomfort involved (all questions were tested for possible causes of psychological/emotional discomfort); the concept of a written informed consent form would have been extremely difficult to explain adequately and so it was unlikely that it would have validly served its purpose; and the act of obtaining informed consent could in itself have constituted a discomfort to these people.

Subjects were interviewed in groups of two to four to save interpreter time, to minimize the amount of direct confrontation which might be threatening, and in the hopes of decreasing their characteristic shyness. A cover letter was read to the participants before beginning the interview and the opportunity to ask questions was offered. (See Appendix B.) The interpreter asked the questions and provided immediate translation. A tape recording was made of each interview with the permission of the participants.

a question seemed to cause discomfort to either the )jects or the interpreter, it was not pursued. Subjects 'e reimbursed for travel expenses to and from the )ochinese Center with two Tri-Met bus tickets.

Background data was gathered from each participant )arding the Hmong group they belong to, i.e. White, Black, )e, etc., age, number of children, age at first birth, and )rs in the U.S.

Data sheets (Appendix C) were prepared to code formation received from each participant. There was one )et per question and the individuals' responses were )ed. The sheets were divided to allow for answers in )ms of the Laotian experience, the U.S. experience, and ) desired experience.

)alysis

Analysis of the raw data entailed examination of the )wers received in the course of the interviews for themes )ich could then be categorized within Leininger's caring )nstructs. These were examined for elements which pointed a discrepancy between birthing practices the Hmong women )member, continue to desire, and those currently employed local obstetrical facilities with Hmong clients. These )emes were not subjected to statistical analysis and are )esented in descriptive, narrative form.

)mitations

The study subjects were a convenience sample taken from )rticipants in the Women's Program and, while it is )lieved by the Indochinese Center that most newly arrived

fugee women enroll in the program, it is possible that ere are childbearing Hmong women who have not taken this urse and who represent a group with a different mind set.

Because the family and clan relationships are so portant in Hmong culture, the Portland Hmong community may present a specific group who intentionally settled in the me area. Evidence which supports this is the finding that early all of the subjects were White Hmong, there were two ue Hmong and no other groups; and that several of the men were related to each other by either blood or marriage.

The interpreter provided by the Indochinese Center was killful and patient, however, an interview done through an nterpreter is difficult at best. The process is tedious nd in the end exhausting for the interpreter. Thus, the nterpreter tries to keep the exchange to an efficient endering of the facts and some of the background nformation is lost. Particularly sad was the nvestigator's inability to understand the frequent bursts f humor within the groups.

The study design contained too many questions so that nterviews took much longer than had been anticipated. Most f the subject women were accompanied by infants and/or mall children and both were tired before the session was oncluded. Thus, it seems that answers to the later uestions were less complete than the earlier ones.

Interviewed in a group, the women often reached a onsensus before answering and it can be assumed that the

inions of the more assertive ones were reported. There s disagreement within groups so this was certainly not the se each time. Additionally, a topic might come up in one oup which triggered the memory of the participants of that oup but not come up in another group although they might so have experienced the same thing.

Finally there seemed to be a tendency among these women be agreeable and perhaps to avoid criticism of American ys. Because an effort was made to encourage criticism, at ast some of the women did do so, but it is very difficult know whether there may have been others who had mplaints they did not feel free to voice.

# CHAPTER III

## Results

This chapter will present the biographical data obtained from the seventeen subject women and the four critical informants, the answers received to the ten research questions, and the supplementary information provided by the critical informants.

### Sample

Initially, 20 women who had had at least two births in Laos and one birth in the United States were sought as subjects for this study. Only 17 women, however, could be identified by the staff at the Indochinese Center who met the sample criteria and who were willing and able to meet at the center for the required interview.

The subjects' biographical data can be seen summarized in Table 1. The majority identified themselves as white Hmong, with only two women identifying themselves as Blue Hmong. The mean age of these women, who ranged from 20 to 46 years of age, was 30.06. One women, who seemed older than most, did not know how old she was. Their ages at their first birth are difficult to determine, since several participants did not know and others were unsure. Most could estimate their ages at that time, nevertheless, and the range was from 16 to 19 years with a mean of 16.93. The

nber of children each had had ranged from 3 to 12 with a an of 5.58. They had had from 1 to 11 children in Laos th a mean of 3 and had had 1 to 2 children in this country th a mean of 1.12. Fourteen of them had had at least one by in a Thai refugee camp and three had not. These women d lived in the United States from 11 to 24 months with a an residence time of 19 months.

An unsuccessful attempt was made to determine their llage of origin in Laos. No one knew how the village mes were spelled and it was impossible for this writer to cord the tonal Hmong language phonetically. It should be ted, however, that several of the participants were from e same town.

The subject women were identified alphabetically from A Q and will be referred to in the text by their letter.

TABLE 1

Subjects' Biographic Data

| | | | | Births | | | | |
|---|---|---|---|---|---|---|---|---|
| Subject | Hmong Group | Age | Age @ 1st Birth | Total Births | Laos | Thailand | U.S. | Months in U.S. |
| A | White | 41 | ?[b] | 5 | 2 | 2 | 1 | 24 |
| B | White | 33 | 17[b] | 6 | 4 | 1 | 1 | 15 |
| C | White | 33 | 16 | 6 | 3 | 2 | 1 | 20 |
| D | White | 34 | 19[b] | 7 | 4 | 2 | 1 | 24 |
| E | White | 46 | 17 | 11 | 8 | 2 | 1 | 24 |
| F | White | 28 | 16 | 4 | 2 | 1 | 1 | 24 |
| G | White | 24 | 19 | 4 | 2 | 0 | 2 | 20 |
| H | White | 37 | 18 | 4 | 2 | 1 | 1 | 24 |
| I | White | 26 | 17 | 5 | 3 | 1 | 1 | 12 |
| J | White | 28 | 16 | 4 | 2 | 1 | 1 | 18 |
| K | White | 20 | 16 | 3 | 1 | 1 | 1 | 12 |
| L | White | 20 | 16 | 3 | 1 | 1 | 1 | 17 |
| M | White | 26 | 19 | 5 | 4 | 0 | 1 | 11 |
| N | Blue | 26 | 17 | 5 | 3 | 1 | 1 | 12 |
| O | White | 31 | 15 | 6 | 3 | 1 | 2 | 24 |
| P | Blue | ?[ab] | ?[c] | 12 | 11 | 0 | 1 | 18 |
| Q | White | 28 | 16 | 5 | 1 | 3 | 1 | 24 |

[a]seemed older than most subjects
[b]unsure
[c]said she was very young

In addition, four older women were recruited as critical informants. These women were all white Hmong and ranged in age from 56 to 64 years, with one being unsure of her age. They had borne from 3 to 15 children each and had been between 15 and 25 years old when their first child was born. They had lived in the United States from 10 to 36 months.

## Findings

The research questions were asked in three forms: first, how these women remembered an issue or situation in Laos; secondly, how they experienced it in their U.S. hospital deliveries; and, lastly, how they would wish for it to be. A summary of the seventeen subjects' views will be followed by specific comments by them and the critical informants. Not every women answered every question and so the numbers do not always total seventeen.

### Birth Attendants

As can be seen in Table 2, there was a variety of responses to the question: "Who was with you during your labor and delivery in Laos?" Furthermore, because there was more than one birth for each women, it was not necessarily the same person each time and so the numbers of the attendants total more than 17.

Table 2

Attendants During Labor

and Delivery in Laos

| tendant | Number Reporting Attendant in Labor | Number Reporting Attendant During Delivery |
|---|---|---|
| sband | 10 | 13 |
| ther-in-law | 1 | 2 |
| andmother-in-law | 1 | 1 |
| ther | 0 | 1 |
| cle's wife | 0 | 1 |
| one | 7 | 2 |

Only two women, N and O, reported being totally alone r the whole birth process, although others noted that the tendant merely cut the umbilical cord rather than oviding any particular companionship or support. One men, P, related that her husband was not always home at e time of the birth and had to be summoned afterward. other, Q, remarked that older people don't like the sband to see his wife's first birth because he is then too ung.

The experience of the critical informants also varied, t their attendants included: husbands, mothers-in-law, e mother, and one husband's first wife. One women had no e with her. They all agreed that it was important for the sband to be there for a birth, but that there were no rious consequences if he was not.

Answers to the question: "Who was with you during your bor and delivery in the United States?" are shown in ble 3 below:

Table 3

Attendants During Labor and Delivery in the U.S.

| tendant | Labor | Delivery |
|---|---|---|
| sband | 13 | 11 |
| ctor | 10 | 12 |
| rse | 5 | 7 |
| onsor | 2 | 2 |
| ster-in-law | 1 | 1 |
| one | 1 | 0 |
| delivery | 0 | 2a |

usband not in OR

Two deliveries occurred accidentally at home. One was sisted by her husband and the other by her husband and ster-in-law. Another delivery occurred in the hospital evator with her husband standing by.

Subjects E and P, both of whom were grand multipara's, d Cesarean births and were distressed that they had been le to deliver their babies with ease in the old country, t had to be delivered surgically here. P still seemed ite angry and stated that her husband, rather than rself, had signed the consent for the Cesarean delivery, well as, a bilateral tubal ligation.

Also notable is the fact that only seven mentioned ving had nurses with them during their U.S. labors mpared to 12 who mentioned the doctor. It may have been, wever, that they were unable to distinquish the nurse from e physician in a setting where both are dressed alike, rform similar functions and are, in many instances, both male.

The next question asked about birth attendants was: ho would you like to have with you during labor and livery?" Responses are summarized in Table 4.

Table 4

Attendants Desired During

Labor and Delivery

| Attendant | Number |
|---|---|
| Doctor | 12a |
| Husband | 10 |
| Nurse | 6 |
| No family | 4 |
| Alone in labor | 3 |
| Delivery at home | 2 |
| Friend | 1 |

[a]Two mentioned women doctors

Additional comments included those of A and B who stated
at they preferred not to have relatives with them since
e relatives don't know what to do. D, E, and F wanted the
ctor to stay with them, but not to touch them; and
other, Q, so feared having the doctor touch her that she
uld prefer to remain at home for her next birth. J
quested that there not be too many people in the room
cause that makes her uncomfortable. K, on the other hand,
ated that she needs support people because she has a hard
me having a baby. Though P had been sterilized and knew
e would have no more children, she said that if she were
have another baby it would be at home with her husband.

tendants' Functions at Birth

The question asked was: "What did those with you do to
lp during labor and delivery in Laos?" While many of the
spondents (6) answered that the helper did nothing or only
t the cord (3) after the birth, they also indicated that
eir labors were short and no help was expected or
quired. For example, L started having pains while working
the fields and ran to the house where she delivered
mediately without help, although her husband and
ther-in-law were present. C recalls that her husband
ied to help by bringing a lamp, but she sent him away. At
subsequent birth in Thailand, he really wanted to help her
t only succeeded in being distracting and annoying,

hough she did allow him to cut the cord. Similar mples include N's husband, who just watched and made her k around the fire, and O's husband, who went to sleep and ke in time to cut the cord.

J said that her husband was there and she could hold o him when the pain was bad. Three others also said that y were held up by their support persons. Another kind of sistance included that rendered by M's husband who took ter and performed a ceremony to the spirits to hasten the rth. By contrast, K who had had 5-6 days of labor pains ported that nothing was done by anyone to help her.

It should be noted that question number two was designed determine what was done by way of support by the laboring men's companion/attendant rather than to determine additional obstetrical aids or techniques which are dressed in question number three. The answers largely erlap, however, since there was no "professional" birth tendant for these primitive hill women and whatever might ve been done was done by whichever family member happened be nearby.

By contrast to the minimal intervention or assistance ring their Laotian deliveries, the subjects reported a mber of measures taken during their U.S. deliveries. swers to the questions: "What did the support person(s) to help during your labor and delivery in the United

ates?" are summarized in Table 5. The answers to this estion seem to apply to the assistance given by hospital rsonnel even though most of the women had had their sbands with them at least up to delivery.

Table 5

Attendants' Functions at Birth in the U.S.

| Activity | Number |
|---|---|
| Nothing | 5 |
| I.V.'s | 5 |
| Shot | 2 |
| Blood | 2 |
| Sent home | 2 |
| Made to lie still | 1 |
| Held hand and wiped brow | 1 |
| Belt placed on stomach | 1 |
| Doctor caught the baby | 1 |

C and G diagnosed as not being in labor, were sent home ere they then delivered, so do not perceive that they were ven any assistance. One who indicated that nothing was ne to help was L whose baby arrived in the hospital evator while her husband stood by.

O's American sponsor held her hand and wiped sweat from r forehead. O was given what seems to have been spinal esthesia and subsequently did not feel anything. Others re given I.V.'s, blood, and shots which they report as

ving been done to help, but were unable to report whether, not these did any good. P was very frightened by the ood transfusion given her. Both G and J were made to lie ill which they found most distressing. J stated that ing still makes you feel like you are going to die. Also, s bag of waters was broken by someone who did not tell her at they were going to do.

The women were then asked the question: "What would you ke those with you to do to help you during your labor and livery?" N and O both volunteered that whatever they did st time was all right and would be what they would want ain. In fact, a majority of the women appeared relatively tisfied with the support that was given.

Three of the women, A, I, and J, were adamant in their quest that the bag of waters not be broken. H stated that the bag of waters breaks three or four hours before livery, a difficult labor will ensue. J remains very much raid that her bag of waters will be broken by someone in a ture delivery.

Ten of the 17 subjects mentioned the need for a high llow or the wish not to lie down flat during labor and/or livery. H explained that if the mother is lying down the by can become stuck and not come out. Furthermore, I ated that lying down causes pain to be felt in the back.

While three requested that they not be bothered and one at she not be touched, three others asked that someone ld their hands and another that someone hold her when she d a hard pain. One requested that she not have to walk or lk in labor. Another asked for help to get up as cessary. Among those with minimal requests were two who nted only that the doctor cut the cord, one who wanted ter to drink and one who asked that her husband and the rse remain with her.

asures to Ease or Speed Labor

The question first asked was: "Was anything done to ke labor shorter or the pain less during your labor and livery in Laos?" The majority (14) of the women stated at nothing was done to speed or ease their labors but veral were able to report things that were sometimes done en labor was difficult.

As a group G, H, I, and J explained that they worked rd so it was easy to have a baby. I stated that in Laos bor was usually only twenty or thirty minutes long. This lief was confirmed by the critical informants whose planation of that was:

> Hmong people work very hard and so have easier labors. Americans lie down too much. During labor pains but when the birth is not imminent, they stayed up working around the house. They still had to do their farming chores even in labor and would run home when they knew it was time. Young people were told that the harder they work and the more they carry, the easier the labor will be. Americans take it easy during pregnancy, the Hmong do not.

D and F described a massage and pressure technique that s used by older women to help bring the baby down in bor. E remarked that that was used on her to help with e-labor (Braxton-Hicks?) contractions.

Q's mother-in-law was knowledgeable in Hmong medicine d had a very heavy stone that she boiled in water. The ter was then drunk by the laboring women. Q still has the one, but does not use it in this country because the baby uld come too fast for the mother to get to the hospital. stated that she had helped others with an herbal remedy. e also said that ginger and egg can be given for prolonged bor without delivery. M's father-in-law could, by feeling ntractions, predict the exact time of delivery and this s seen as helpful. He also turned the baby so that it me easily.

Most fascinating were the reports of the older women ritical informants) who were recalling both their own rthing experiences and those of others they had tnessed. One confirmed the use of a special plant to help

or, while another related that soot from the ceiling ld be rubbed on the stomach of the laboring women. When y were asked how malpresentations were handled, one women alled that there was a woman from the village who could in her hands and deliver the baby, however, she charged lot. This was the only reference made to any sort of fessional birth attendant or midwife. If a first baby es easily, the cord is saved and dried. Then if another an has a hard labor, the cord is put into a cup and an usion is made and drunk by the distressed woman. Tribute honor to the spirits during pregnancy, however, is lieved to prevent trouble.

One of these older women related that while nothing was er done to help her, she had helped her rude ghter-in-law. Trouble with delivery of the placenta, she blained, can be due to having spoken rudely to one's ther-in-law, sister-in-law or grandmother. She was the cipient of this kind of behavior yet when her ughter-in-law experienced the resultant difficulty she was le to help her deliver the placenta by ritually washing r and putting her husband's shirt over her head.

The next question asked: "Was anything done during your bor and delivery in the United States to make labor orter or the pain less?" Four of the women stated that ey found their U.S. deliveries to be a better experience

ın their previous deliveries, but were not specific about ıt it was that was better. D had less afterpains and ɔught that something may have been given that helped is. Six women said that nothing had been done and three d not know if anything had. Two had Cesarean births, ile three were given shots and one a spinal for their ginal births.

There were two women who said that things had been made rse. Subject I felt that her labor here was prolonged cause she was held down; when she got up and squatted the by came at once. J felt labor was prolonged by artificial pture of her bag of waters.

The third question on this subject asked was: "What uld you like to have done to make labor shorter or the in less in future labors and deliveries?" The largest mber (7) answered that they wanted nothing done. Two men would like to have a shot and one women each asked r: massage pressure, help only if the baby is slow in ming, to be able to move about at will, an abdominal nder, a home delivery, a shot to make the baby come fast, I.V. and spinal anesthetic, and a spinal if the doctor nts to give it to her.

sition for Delivery

Answers to the question: "What position did you use for livery in Laos?" were nearly unanimous. All but one woman

had squatted for all deliveries. The woman who had not squatted, knelt and another woman related that her sister-in-law had knelt. It was asked if they had had any support to maintain the delivery position. Six of the women had been held up by their husbands, three had held onto the bed, two said they had needed no support, and one demonstrated how she was supported from behind. The woman who had knelt had done so holding onto the bed.

There was also a consensus among the critical informants that only if labor was so long that one became exhausted, would one lie down.

The question was then asked "What position did you use for delivery in the United States?" Table 6 summarizes these answers.

Table 6

Position for Delivery

in the U.S.

| Position | Number of Responses |
|---|---|
| Lying | 9 |
| Squatting | 4 |
| Lithotomy | 2 |
| Cesarean Delivery | 2 |
| Standing | 1[a] |

[a]Precipitous delivery in elevator

Of the four women who delivered squatting, two of them out of hospital births. It is not clear whether any of nine who described their position as lying were in the ndard hospital lithotomy position. The one standing ivery was that of L who delivered in the hospital vator. Q, who delivered squatting said that the nurse up on the bed with her.

J described being tied up in such a way that would not her move and P who had 11 babies squatting in the old untry was made to lie down here and ultimately had a sarean delivery which she attributes to being made to lie wn.

Then the question was asked: "What position would you ke to deliver in in the future?" Responses to this estion are summarized in Table 7. Two of the women were lling to assume whatever position the doctor wanted. Q, ose nurse had gotten onto the bed with her, wanted to hold to the nurse, while M definitely wanted to hold onto her sband.

Table 7

Desired Position for Future Deliveries in the U.S.

| Position | Number of Responses |
|---|---|
| Squat | 10 |
| Lithotomy | 2 |
| At home | 2 |
| Lying | 1 |
| Lying with high pillows | 2 |
| Kneel | 1 |
| No Preference | 2 |

H did not like having a mirror to see the baby coming t. She explained that "We are shy for ourselves." kewise, one of the older women was shocked when the thotomy position was described to her because of the posure involved.

re of the Mother After Childbirth

The question was first asked: "Immediately after ildbirth, what was done for you in Laos?" The majority of men reported changing clothes (13) and lying down by the re (12), but three also mentioned a tradition of lying wn on a bed of leaves. F added that the leaves are a ecial kind that are cut one month before the expected rth. Four women said that they lay down with a high llow and one said that she had bathed in a few hours.

All of the critical informants agreed that the new ther would change her clothes and lie down by the fire.

Response concerning the amount of time that a new mother ɔuld rest varied among the subjects from 2 days to 30 ys. A believed that the women should remain lying down r three days, while M, N, and O thought two days was fficient. C recommended that no work be done for 30 days st partum, if possible, and at least 10 to 20 days if ere was no help available. The amount of rest they tually had after delivery seemed to be dependent on how ch help was available to take over their sponsibilities. It does seem clear that rest post partum s considered more important than during the antepartum riod.

This question elicited the first mention of ritual ods. Q said that the first food eaten was egg cooked in ter and served with the cooking water. She explained that ting egg and water with pepper causes blood to be pressed out. Three others mentioned the exclusive post rtum diet of chicken, rice, warm water, and black pepper r 30 days after delivery. E said that if chicken and rice re not available then rice and rice water would be served.

The critical informants were in agreement that the first od should be egg, though three said that the egg should be oked on the sooty side of the pan and one agreed with Q's adition of an egg cooked in water. Egg cooked with soot s to prevent afterpains and one informant said it could so bring on a delayed period. One of these women

lained that they planned for the thirty day chicken and e diet by raising a lot of chickens during their gnancy so they would have enough after the baby was n. She said that a special plant was also grown and ked with the chicken.

The next question asked was: "Immediately after the th in the U.S., what was done for you?" Three of the ien spontaneously expressed the opinion that they were y well taken care of. D said that care of a women who just had a baby is better here. A majority (10) embered being put to bed, four said they were helped to wer, four mentioned the sanitary pad being placed and/or nged and two that their clothes were changed.

The food that was served to them was mentioned by four ien, one of whom said that the hospital saw the food that husband was bringing in and prepared the same thing for . B related with much amusement how a large piece of icken and a small bowl of rice were served to her when it uld be the other way around. F also mentioned how small rice serving was explaining that "when you live on rice, have to eat a lot of rice." O agreed to her sponsor's commendation that she add fruit to her chicken and rice t. N was given rice and rice water to eat (probably a ll-meaning attempt by the staff who were aware that other dochinese groups do prefer that), but she did not like

t. Q was given the chicken and rice meal but needed to egg and water first, so she waited until her husband ld bring it in along with some chicken and rice.

Two women remarked that the baby was taken away and one ld remember only the I.V.'s and transfusion. K embered being left lying flat which she felt caused her mach to become hot and the afterpains to be worse than ore. Three women also mentioned that their husbands had ped out at home.

The third question asked on this subject was: "What ld you like to have done for you immediately after a th?" The issue of having the appropriate foods to eat er a delivery came up both in response to this question l responses) and as comments when other points were being scussed. Three women stated that the wrong foods eaten er birth can cause the mother trouble all her life. The sire for a first meal of egg and water was not expressed the majority, but a virtual litany of requests came for exclusive diet of rice, chicken, chicken cooking broth d black pepper. The critical informants stated that those re the only foods which should be eaten for one month llowing childbirth. The pepper used, they said, must be ack and not like the fine ground pepper usually served in spitals which has white specks throughout it. (One woman ecifically requested that no fruit be served.)

Next to having the right foods to eat, the desire to stay warm brought the most responses (7). Five women said they would like to have a shower and one women volunteered that it is all right to bathe as long as it is in hot water. Five women additionally noted that no cold food should be served. The critical informants as a group agreed that socks and head covering should be worn always at this critical time, or else one would have headaches when one got older.

The amount of rest desirable following delivery varied considerably. M would like to go home from the hospital as soon as the paperwork was done, while O stated emphatically that if it were not for the cost, she would like to stay in the hospital for a full month post partum. No one, she said, would take care of her when she went home. Two women again noted the need for high pillows to rest against.

Three of the four critical informants agreed that if you have enough help you should rest one month at home or, lacking that, return to work as soon as you are strong enough. One of these women advised seven days of rest.

An abdominal binder described as four or five yards of fabric wound tightly around the abdomen was recommended by Q to increase strength post partum. In Laos, she said, wearing a fabric binder would enable one to get up and wash

thes or walk long distances three or four hours after th.

L felt that her hospital care had been good and so was ling to follow hospital routine stating "they know what I d." In a similar vein, F volunteered that she certainly not want the leaf bed they had used in Laos and that she ds the idea funny in retrospect.

e of the Infant

The question first posed on this subject was: "What was e with the baby immediately after birth in Laos?" Nearly of the subjects responded that the baby was washed (15) wrapped or clothed (17). Three, in contrast, said that baby was not washed until later. Eight said the baby then put down to sleep; six said it was nursed when it ed; one said it was nursed after it was washed; and ther said it was only nursed after it had urinated. Two en mentioned that it was nursed by someone else.

If the cord was wrapped aroung the baby's neck, then the ditional necklace was put on immediately before the cord cut. Otherwise, this necklace was placed on at the ditional birthday celebration. Two women described the thday celebration which took place three days after th. P remembered that three chickens were killed, the y was named, and the baby's head was shaved. Q differed that she remembered that the boys' heads were shaved

pletely while girls had only a small amount shaved off, they also had their ears pierced. One women said that pregnant women were allowed to visit the baby.

Two of the critical informants said that if a baby was n in the evening it was just wrapped and put down to ep, waiting until morning to be washed because of a blem with the spirits; the other two did not recall this blem. They were evenly divided as to whether they nursed baby initially themselves or had someone else do it. n asked specifically how the cord was cut, one explained t it was measured to the baby's knee and cut there. ing was used to tie off the cord. One 63 year old women had borne 11 babies said that she did not want to pick baby up immediately because she had carried it for nine ths and it was her husband's turn.

The question then asked was: "What was done with your by immediately after birth in the United States?" The jority (10) responded that it was taken away and so they not know what was done. While most mothers did not press having had great fears when the baby was taken to nursery, A worried when she heard babies crying for fear was hers. Babies she said were taken to their mothers in der regardless of whether they were crying or not. One men said that she visited with it for awhile before it was ken away and another said that it was taken away and

ther said that it was first taken away and then brought
k to visit. Two said they saw it only twice a day while
women said that they had to wear masks when they saw
Two women recalled that an I.D. bracelet had been put
and one that it had been weighed and measured.

When they were asked the question: "How would you like
have your baby cared for immediately after birth?" the
ority (11) responded that nursery care was all right.
eral women expressed the opinion that they would be far
tired to take responsibility for caring for the baby
mselves. There were different opinions expressed on
ming-in with one women wanting the baby in the room all
time, one wanting the baby away all the time and another
ing it should be in the room all the time only if she was
astfeeding. Again, one women simply said she was
eeable to hospital routine. K and L said that people
y at how soon the milk comes in so a friend who is
sing may be asked to nurse initially.

K is very much afraid that a baby boy would be
cumcised which she does not want to have done.

sposal of the Placenta

The answer to the question: "What was done with the
terbirth in Laos?" was nearly unanimous with the only
ception being one of the two women who identified
emselves as Blue Hmong. Sixteen of the respondents said

t the placenta of a girl was buried under the bed and the centa of a boy under the center post of the house. The dissenter said that her family buried both boys' and ls' placentas under the bed. Three women mentioned that placentas were covered with cloth before burying.

Nearly all of the groups expressed curiosity about how ricans handle the placenta. The reason for this concern in part be due to the belief expressed by M that the centa must be handled right or the baby will have uble. L and Q explained the belief that if an ant or ething similar gets into the placenta, the baby will get ash and they felt that babies in the U.S. have had rashes t may have been due to how the placenta was handled. Q d that in Laos if a baby developed a rash then water was led and poured over the placenta burial site to kill tever had gotten into it. P, on the other hand, believed t anything getting into the placenta would cause eye blems.

The critical informants explained why the boys' and ls' placentas were buried in different places. The boy's s buried under the center post because, like his father, will take care of the house. The girl's was buried under e bed because when she marries she will go away.

The question then asked was: "What was done with the terbirth following your United States' delivery?" None of

subjects knew what had been done with the babies' placentas in the hospital, but most were curious. One women observed that the doctor spent some time carefully examining and her group was quite interested in the investigator's explanation of why this was done. One family had been offered the placenta in a plastic bag to take home, but they declined to do so.

Thirdly, the question: "What would you like to have done with the afterbirth?" was asked. All of the subjects stated that they did not want to take the placenta home. Reasons given for this were that it just was not practical because there are no dirt floors here and it is not possible to bury anything in the concrete floors of American houses. Another problem expressed was that they did not own the house and so would not want to bury anything there.

The investigator, when asked what American hospitals did with placentas, answered that she believed most hospitals incinerated them. This seemed to be a satisfying solution, since it got rid of the placenta once and for all so there is no need to worry about anything improper getting into it.

<u>Food and Drink During Labor</u>

The question first asked was: "Did you eat or drink anything while you were in labor in Laos?" While most of the subjects (9) had had nothing at all to eat or drink during labor or nothing if the labor was short (3), they

nowledged the need for water if labor went on for some
e. Three mentioned having had water in prolonged labor;
apparently drank as they wished; and one women ate some
e. K, who had experienced a five or six day labor, said
t she drank at will throughout it. E remembered that
re was a special medicine boiled in water and eaten if
re was a problem with the labor, but she did not describe
further.

The opinion of the critical informants was that Hmong
en have babies so fast that there is no need for food or
er during labor.

Secondly, the subjects were asked: "Did you eat or
nk anything during your labor in the United States?"
rteen of the women had had nothing to eat or drink. Two
en who were given I.V.'s recognized that this was given
a substitute for drinking water. K stated that she was
rsty, but was not given any water to drink. One women
given ice water and another water and 7 UP.

The third question asked was: "What would you like to
e to eat or drink during labor?" Eleven women wanted
er as necessary; three wanted nothing; two mentioned
ting warm liquids; and one would like to have tea. G,
said that she would ask for water if she was thirsty,
d that there should be no ice.

ds, Medicines, and Herbs Eaten/Avoided During Pregnancy

The questions was asked: "Were there any foods, icines or herbs which you ate or avoided eating during gnancy in Laos?" Fourteen of the subject women said that re were no particular things which were eaten or ided. Two women said that they stayed away from medicine n they were pregnant, while one women said that medicine ld be used only if there was a problem. A stated that if baby did not move by five months gestation, there was a icine that was taken. Q mentioned the use of water led with a special stone as has been described above. P d that a person would eat whatever she wanted.

One critical informant said that the foods sought in gnancy depend on the individuals' tastes where some like thing and others hate it. Another of these older women d that she always like sour things when pregnant and she emed to enjoy hearing from the investigator about the erican lore that considers a craving for sour things, pecially pickles, a sign of pregnancy.

The question was then asked: "Were there any foods, dicines or herbs which you ate or avoided eating during ur pregnancy in the United States?" Fifteen of the women swered that there was nothing special eaten or avoided. ly one of the subjects volunteered that she had taken tamins and none of them mentioned iron supplements. This

surprising in light of the fact that probably all of the
en had received pre-natal care. D volunteered that she
not understood the pre-natal instructions she had been
en because there was no interpreter at the clinic. One
en said she had eaten foods from the WIC program.

Thirdly, the question was asked: "Are there any foods,
licines or herbs that you would like to eat or avoid
ing during pregnancy?" Fourteen women said there was
hing they would particularly eat or avoid, while two said
y would like something sour and one wanted something to
e her stronger. This lack of desire for any special
ds during pregnancy contrasts sharply with the exclusive
t desired in the post partum period.

nal Thoughts on the Subject of Childbirth

The last question that was asked was: "Is there
thing else about childbirth that you think it would be
d for me to know?" There were only a few responses to
is question, which may in part be due to the fact that the
men were tiring and anxious to leave.

D thought that having a home delivery would be less
pensive, but she worried about obtaining a birth
rtificate in that case. She wondered about finding an
tendant to help with a home birth.

J stated that in Laos the bag of waters remains intact
til just before delivery when it breaks spontaneously. To

s H added that in the American hospital her bag of waters
artificially broken at 5 p.m. and so the baby did not
e until 11 p.m. Another issue that troubled both J and H
their observation that in the American hospital there
e too many people involved in the delivery. J remembered
t there were seven or eight people with her in the
ivery room.

L, who had in response to different earlier questions
ut desired practices answered to the effect that the
rican hospital routine was fine with her, stated that she
too young when she had her babies in Laos to really know
h about it.

Because so many women had described very short labors in
s, the investigator further asked the group consisting of
H, I and J when they considered labor to start. Their
sensus was that it began when the pains started or the
of waters broke.

mary

From the ten questions that were asked, it was possible
obtain a description of how things were generally done in
old country, how these women perceived certain aspects
their American deliveries and, to a great extent, how
y would like to be treated in future deliveries. There
re clearly individual differences throughout (except on

one issue of disposal of the placenta), but there were
nds which can well be utilized in prescribing nursing
erventions.

# CHAPTER IV

## Discussion

In order to classify a culture's own caring constructs, eininger (1979) has identified seventeen major segregates see Appendix E). These segregates or specific ways of aring will be used to identify elements of traditional mong birthing practices. There were no studies found in he review of the literature which dealt specifically with he issues investigated in this study, hence there will not enerally be comparisons made with the findings of other tudies.

### omfort

Traditional Hmong life seems to have been a hard one herein little attention was given to providing for the omfort of the childbearing women. Such comfort measures as ave been mentioned by the subjects and informants of this tudy are essentially permissive. For example, the women as allowed to assume for herself a position of comfort for abor and delivery. She changed her clothes after delivery nd reclined by the fireplace on a bed with high pillows hat had been prepared for her. One exception was the ccasional mention of a massage/pressure technique that was sed in labor and to ease pre-labor contractions. The merican practice which caused distress to many of these

omen was that of restricting them to lying in a bed for abor and delivery. During labor and post partum they would ave welcomed a high pillow to recline against.

upport

In all but two cases the Hmong women reported having had someone (usually the husband) with them during delivery if not always during the labor. The support rendered by this person was, however, minimal. Some mentioned that they were physically supported during hard pains or delivery while others mentioned that the umbilical cord was cut for them and the largest number said that the attendant did nothing. These women expected little in the way of labor support in the old country and continue to prefer to be largely left alone. Acceptable supportive nursing behaviors are simply being there and, for some, offering a hand to hold or water to drink. During delivery some women would welcome physical support in the squatting position by their husband or by the nurse while others would rather hold onto something like a siderail.

Helping Behaviors

Known helping behaviors were usually described as something that could be done when things were not going well such as the old woman's technique of ritual washing and covering the parturient's head with her husband's shirt to bring about the delivery of a retained placenta. A special stone boiled in the laborer's drinking water was thought by

women to shorten labor, but most women felt that there nothing that could or should be done to speed or ease ir labors. While most had experienced some sort of ervention in this country in the way of I.V.'s, lgesics, anesthesia or surgical intervention, they were gely skeptical that it had done any good. The common rican practice of artificially rupturing the bag of ers was not interpreted as a helping behavior.

cific Stress Alleviation

Being free to move about during the pains of labor was expectation in the old country as was being able to isfy one's thirst at will. There is real dissonance seen e between what was the former practice and the American uation where women are frequently tied to fetal monitors ch restrict movement and allowed nothing by mouth oughout labor.

ching

Several of the women stated emphatically that they did want to be touched or bothered during labor. This may e been in part a reaction to the vaginal exams that were e during their American births and which were of course known in their homeland. There seemed to be a desire to ncentrate or focus on the work to be done by contrast to popular Western Lamaze technique which emphasizes straction from the labor. Since some welcomed being held

having someone to hold onto during hard contractions re may also be individual preferences shown here.

turance

The mother was not responsible for care of her newborn iediately after delivery. This responsibility was most en taken by the father, who washed and wrapped the baby. nsequently, nursery care for the baby was acceptable to st of these women. In their homeland, if a mother's milk s not in, a friend or relative might nurse for her. This y in part account for why many of these women bottle feed eir babies in the hospital here. Most of the women breast d infants and toddlers during the course of the interviews it is unclear if these women were continuing to pplement with bottle feedings. The desirability of a pplemental nutrition source for these women who had seen many babies die during the war years is obvious.

ccorance

Traditionally, babies were nursed whenever they cried d so one should not be surprised to hear that at least one men was distressed by the American hospital practice of inging the babies out at a specific time and in order gardless of whether they were crying or not. Additionally the extended family home babies were immediately sponded to by someone and it may not have been clear that e nursery could do the same thing.

ection

In this animistic society the protection and goodwill of spirits was sought in different ways. This was essed, however, as an issue only infrequently in the se of the interviews. Two women recalled that a emony was performed over water calling on the spirits ing their labors. Others recalled the traditional celet which is placed on every child and which the erature states is a message to the spirits. Breast milk, women warned, should not be expressed or spilt for fear t it would attract spirits (a not unwise fear in a mate and situation where saved milk would rapidly become taminated). Placentas were carefully buried to keep thing from getting into them and causing rashes or other blems for the infant. Our practice of placenta disposal, ess it is explained to the family, is a potential source distress. There was some fear of hospital procedures. ther these women saw hospitalization as a protection inst the perils of childbirth or not is hard to say; they ressed fear over certain procedures but not necessarily hospitalization per se that Todd (1982) reports.

toration

The restoration of strength after childbirth was one of most important issues to come up in this study. If the per things were not done, the women could expect to have

trouble later in life. While there were no injunctions for the pregnant women concerning the antenatal diet, the post delivery diet was strictly prescribed. The exclusive diet of chicken, chicken broth, black pepper and rice was for some women preceded by a first meal of egg cooked in water. These foods may have constituted an important source of protein, calcium, and iron for the nursing mother in a land where dairy products were not used and meat consumption was rare. The woman was expected to lie down by the fire immediately after childbirth and to keep warm. Rest after having had a baby was considered important for future health, but the time allotted for this varied with the woman's circumstances. Here there may not be much discordance with the desired practice since the recovery period in bed with a nurse watching over them was noted as an improvement. None of the women articulated the reason for keeping warm post partum, but authors describing other Southeast Asians state that this stems from a belief that heat is lost in the course of childbirth (Stringfellow, 1978). In sharp contrast with this are such American nursing measures as a cool cloth on the head, an ice bag on the perineum and cold or iced drinks.

Stimulation

In keeping with their general practice of leaving the parturient largely alone, little in the way of stimulation was done. One exception to this is the stone described by

ne women which could be used to speed labor to such an xtent that while she still has it, she does not use it in his country because, if she did, the mother would not make t to the hospital in time. Attempts at stimulation of abor such as amniotomy, vaginal examination with stripping f membranes and operative deliveries that are widely made n this country would have been extremely dangerous had they een used in the unsanitary circumstances surrounding home irths in Laos. Consequently, the common wisdom of keeping ne's hands out of the birth canal continues to prevail among these people and violation of that causes great fear.

Health Maintenance

The post partum regimen seems most closely tied to health maintenance, in addition to its restorative function, since a violation of its principles was considered to have a long-term effect on the woman's health. Furthermore, while there were no foods especially eaten or avoided during pregnancy, some women reported that the pregnant woman was enjoined to stay away from all medicines. This essentially wise practice may present a point of conflict when a Hmong women in this country is prescribed pre-natal vitamins and iron, and it may in part account for why only one woman volunteered that she had taken vitamins during her American pregnancy.

ealth Instruction

The lively group of older women who told why Hmong women ave an easier time in childbearing described the nstruction given young women thusly: if they worked hard n the fields and continued lifting and carrying things, hey would experience a short and easy labor. iven this eady source of aerobic excercise, cardio pulmonary fitness nd suppleness was probably well maintained. The estrictions of urban life these women now experience make t difficult to comply with that traditional instruction. he only form of health instruction that the Hmong women epeatedly asked of this investigator was how Americans handle disposal of the placenta.

ealth Consultation

According to the literature (Barney, 1957; Bernatzik, 1947; Garrett, 1974) a shaman would be consulted should a health problem arise. The fact that none of the women mentioned this kind of consultation may indicate that childbirth was considered a natural function and not one connected with illness. There is disagreement in the literature about whether there was a midwife position or role in this culture and within the sample surveyed the only mention made was of the woman who could deliver a mal presentation and who charged highly for her services. The father-in-law of one young women was apparently experienced

both turned the baby and predicted the exact time of ivery. By contrast, the American system is one of ular health consultation during the pre-natal period and tiple invasive procedures by the consultant during labor delivery. That the Hmong women have largely acquiesced this system may be due to several factors: the ervations that maternal and infant mortality rates are er here, a desire to adapt to American ways, and a desire be law abiding in the face of a wide spread rumor within community that it is illegal to have a home birth.

er Ethnocare Constructs

The upright position for labor and delivery, which is an ortant issue for these people is difficult to egorize. There is clearly an element of comfort involved ch may derive from the physiologic and mechanical ropriateness of this position and also from the fact that s is a customary resting posture. The mechanical iciency of that position was probably observed over the s and so became relatively standard. The fact that ceptions (kneeling or lying if exhausted) to this were orted indicates that the woman was not forced to use the sition.

Of the seventeen major segregates that Leininger ggests for classifying a culture's own caring constructs, urteen can be demonstrated in the caring behaviors

orted as valued by the subject women. There are surely
nts which overlap and so the designation into one or
ther segregate was arbitrarily made. The important issue
position did not clearly fit into any named segregate and
was added as an "Other Care Construct."

# CHAPTER V

This chapter includes a summary of the study and the lications for nursing practice. Implications for future sing research conclude the chapter.

## Summary

Professional nurses working in cultures with values ferent from their own can create conflicts and stress ess they are willing to identify and adapt to the fering cultures' values and expectations. Yet the rican nurse working with childbearing Hmong families es an information gap about that culture's preferences, ues, and caring beliefs during and immediately after ldbirth.

This study was designed to address that informational d. It surveyed a sample group of recently immigrated ng women regarding their birthing practices in their tian homeland and their birth experiences in an American spital to determine which practices were preferred. A venience sample of 17 women who had had at least two ths in Laos and one birth in the United States was ruited from the Indochinese Cultural and Service Center's en's Program. An additional group of four elderly

tigravidas was recruited from the same program as tical informants. A structured interview consisting of biographic questions, nine research questions and one n-ended question was used to identify the traditional thing practices which these women continued to value.

The answers to these questions indicate that the Hmong en were surprisingly accepting of most American hospital ctices and pointed out those several areas where nursing e can be adapted to provide a more culturally sensitive thing situation.

## Conclusions and Recommendations for Nursing Practice

Although ten different questions were asked of these en, the answers tended to overlap and the results seem to ter around six major issues: support persons, care ing labor and delivery, position for labor and delivery, sposition of the placenta, post partum care of the mother care of the newborn infant. These issues will be marized here and implications drawn for nursing practice.

### pport Persons

The most frequently referenced support person for labor delivery in the old country was the woman's husband, who ntinues to be the major preference here also. There are table exceptions to this, however, and some Hmong women be satisfied with hospital personnel only. The role of

support person was largely simply to be present; thus
ted interaction between the parturient and support
son should be accepted as normal. The husband might be
ered the opportunity to cut the cord as is sometimes done
other family-centered deliveries and should probably be
ded the infant after delivery. To meet the complaint of
women that there were too many people in the delivery
m, the number of personnel in attendance might well be
t to a minimum.

e During Labor and Delivery

Care given during labor and delivery in Laos was minimal
these women continue to believe that little needs to be
vided here. Little in the way of analgesics or
sthesia should be needed, since even the women who did
eive them during their U.S. births were not convinced
t it did any good. Some women appreciate having a hand
hold during labor though generally they would prefer to
touched as little as possible. They should be allowed to
e about freely during labor and never made to lie down
t. Most would like warm water offered to drink as
essary. Artificial rupture of the bag of waters may be
n as something approaching assault and this invasive
cedure should not be undertaken without obtaining
formed consent.

ition for Labor and Delivery

During labor in their homeland the women were at liberty move about, usually remaining upright and occasionally lining with high pillow support. The traditional ition for delivery was squatting and either holding onto ething or someone or being supported in that position by ther. The majority of women continue to prefer that hod of delivery and so, unless there are strong tetrical contraindications, delivery should be allowed in t position.

position of the Placenta

Proper burial of the placenta was important in the Hmong eland. The women in the study continue to be concerned t it be handled so that nothing improper gets into it. le it is unlikely that any of the families will want to e the placenta home, they should be informed as to how it l be disposed of. Incinerating the placenta seems to be acceptable way of disposing of it.

t-partum Care of the Mother

Immediate post-partum care for the mother traditionally cluded a change of clothes and rest in a warm place. e, too, they preferred to have support with high pillows so initial care of the Hmong woman should include eping the head of the bed up and teaching her how to use bed's controls. She should be kept warm and offered ly warm liquids to drink. A warm shower would be

eptable to most. Rest following delivery continues to be ued. It should be remembered that many of these women l return home to heavy responsibilities with little help. The hospital care in this country would have pleased the prity of the women had it not been for the difficulty y had getting acceptable foods to eat. The proper diet er childbirth continues to be a significant value. There no point at all in offering the usual varied house diet ce it causes distress and will only be refused. Because all Hmong women want the egg and water first meal before inning the exclusive chicken and rice diet, it might be ctical to have pictures of each so that a choice can be ered. The chicken and rice diet should have portionately more rice than chicken, the chicken should served with the cooking broth, and the pepper should be cked or in a grinder since the fine ground type usually ved is filled with white specks.

e of the Newborn

After birth in Laos the infant was taken care of by neone else. Several women expressed the idea that they e far too tired to care for the baby themselves. Thus, e in the newborn nursery is acceptable to most Hmong thers. If rooming-in is available, it should be offered r those who want it. Traditionally, babies were nursed enever they cried; thus sticking to an established feeding

edule may be cause of distress to the mothers. Pumping expressing breast milk is totally unacceptable to most of se people. Consequently, other remedies for engorged asts should be used. Often the mother will combine ast and bottle feeding, and an occasional mother would e to have a friend help with the initial nursing. The ual necklace may be placed on the child at any time, but the case of a baby with a nuccal cord, or who is erwise compromised, the mother may want to have it placed immediately.

Looking at the conclusions drawn in these six areas, one s that those caring behaviors which the Hmong continue to ue are all ones which can safely and easily be orporated into standard hospital practice for those who ire them. To make the Hmong families' American ldbearing experiences ones which are satisfying rather n fear-filled, and ones which increase their faith in ern Western health care require only cultural sensitivity the part of the nurse who is willing to learn their kways and incorporate them into her care.

## Implications for Nursing Research

The following implications for future nursing research e been identified.

1. This study could be replicated using recently immigrated Hmong women in different parts of the U.S. to determine whether there are differences which might be due to homogeneity within the population in Portland, Oregon.
2. Childbirth practices might be studied using other Hmong groups such as Black Hmong as subjects.
3. Childbirth practices might be studied in five or ten years to see whether a number of years spent in this country has a significant effect on desired birthing practices.
4. A study could be done comparing birthing practices of other Southeast Asian cultures with an attempt to draw general conclusions and to point out specific differences. Reasons for specific differences should be analyzed in light of that culture so that generalizations could be made on the basis of cultural characteristics.
5. Other aspects of childbearing within this culture should be investigated such as pregnancy, maternal-infant bonding patterns, infant care, child spacing, etc.

6. Childbirth practices of other cultures could be analyzed using the caring constructs used in this study to determine:
   a) which constructs are valued and applicable cross culturally
   b) which constructs are most highly valued by most cultures
   c) which constructs are more likely to be acculturated
7. The effectiveness of the suggested nursing interventions could be tested and evaluated.

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# Appendix A

The following questions were asked of each participant.

Demographic:

1. Hmong Group
2. Name of village/town in Laos
3. Age
4. Age at first birth
5. Number of births
6. Number of months in the U.S.

Research:

1. Who was with you during your labor and delivery? Which part?
2. What did that person do to help during labor? during delivery?
3. Was anything done to make labor shorter or the pain less?
4. What position did you use for delivery -- stand? squat? lie? other?
5. What was done for you immediately after birth?
6. What was done with the baby immediately after birth?
7. What was done with the afterbirth?
8. Did you take anything to eat or drink during labor?
9. Were there any foods, herbs or medicines that you tried to eat during pregnancy? -- any that you tried to avoid?

10. Is there anything else you can tell me about childbirth that you think would be good for me to know?

The research questions were asked three times; first erring to births experienced in Laos, second referring to ths in the U.S., and third referring to what would be ferred.

# Appendix B

YOU ARE INVITED TO JOIN IN A STUDY ABOUT HMONG WOMEN WHO E HAD BABIES BOTH IN LAOS AND IN THE UNITED STATES. THIS DY WILL HELP AMERICAN NURSES TO TAKE CARE OF HMONG WOMEN LABOR IN THE WAY THEY WOULD LIKE. LIZ LA DU, WHO IS A SE AT OHSU, WILL BE ASKING YOU QUESTIONS THROUGH YOUR ERPRETER ABOUT HOW YOU WERE TAKEN CARE OF IN LAOS, AND YOU WERE TAKEN CARE OF IN THE UNITED STATES, AND HOW YOU LD LIKE TO BE TAKEN CARE OF HERE. YOU WILL BE ERVIEWED IN A SMALL GROUP.

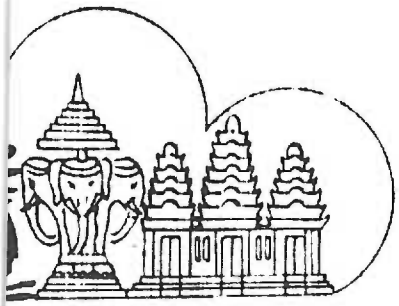
THE QUESTIONS WILL TAKE ABOUT ONE HOUR TO ANSWER. THERE L NOT BE ANYTHING ASKED THAT IS LIKELY TO CAUSE YOU ARRASSMENT OR DISCOMFORT. THERE ARE NO OTHER RISKS. LIZ L USE A TAPE RECORDER AND ALSO WRITE DOWN YOUR ANSWERS. WILL NOT USE YOUR NAME ON ANYTHING THAT ANOTHER PERSON HT SEE. YOUR NAME WILL NOT BE ON THE TAPE.

LIZ WILL PROVIDE YOU WITH BUS TICKETS TO COVER YOUR ENSES FOR TRANSPORTATION TO AND FROM THE INDO CHINESE NTER.

YOU DO NOT HAVE TO JOIN THIS STUDY AND MAY SAY "NO" AT Y TIME WITHOUT HURTING YOUR RELATIONSHIP WITH THE INDO INESE CENTER OR THE OREGON HEALTH SCIENCES UNIVERSITY. Z WILL ANSWER ANY QUESTIONS YOU MAY HAVE ABOUT THE STUDY.

QUESTION: (Example) Who was with you during your labor and delivery? Which part?

| Participant | A | B | C | D | E |
|---|---|---|---|---|---|
| Laos | | | | | |
| U.S. | | | | | |
| Desired | | | | | |



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September 23, 1981

Elizabeth LaDu
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Portland, OR 97227

Dear Liz:

The Indochinese Cultural and Service Center is pleased to assist you in a study of the Birthing Practices of the Hmong. It is our understanding that you are pursuing this as part of your work toward a Master's Degree, but that you also hope that it can help to make the medical service delivery system more sensitive to the needs of this group and open to adjusting services to accommodate their practices.

We have agreed to let you contact a group of approximately 20 refugee women who meet the specifications of your project design and to provide interpreter service for interviews of these women, with their consent and understanding of your purpose. We will assist you in the contact and in the group discussions with them. For this consultation, you can provide us $150; you will also provide us with a bound copy of your finished work for our library and we understand that if articles are presented to professional journals about this work, the Center may share in authorship of these articles. We would also be interested in pursuing possible publication rights with you in the future if the study proves as valuable as it appears now.

Tentative interview dates will be Wednesday, Oct. 14; Friday, Oct. 23; Wednesday, Oct. 28; Friday, Nov. 6, and Wednesday Nov. 11. You should make contact with Carrie Wilson to firm this for times, etc.

We look forward to the project and any good impact it may have for refugee women.

Sincerely,

[redacted]

Carol Law
Associate Director

I am in agreement

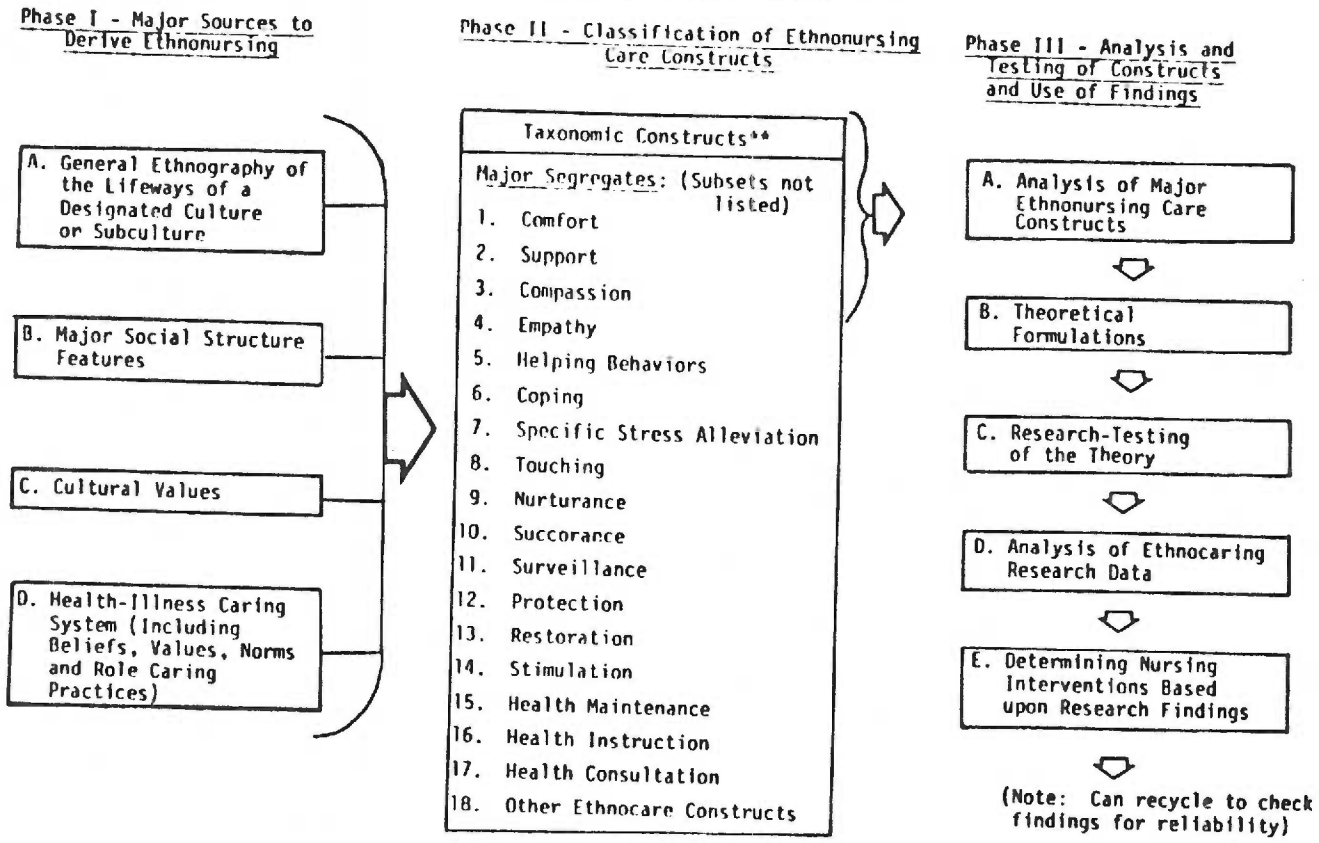
[redacted]

cc: Carrie Wilson

FIGURE 1

A Conceptual and Theory-Generating Model to Study Transcultural (or Ethnonursing) Constructs*

(Developed by M. Leininger)




*Developed in 1968 with revision and additions in 1972, 1975, and 1976.
**Constructs derived from 30 cultures using ethnoscience and literature studies.

AN ABSTRACT OF THE THESIS OF

Elizabeth Bjorkman La Du

)r the MASTER OF NURSING

ite of Receiving this Degree: June 11, 1982

itle: A STUDY OF THE BIRTHING PRACTICES OF A GROUP OF RE[redacted]

)proved: _____
Mary Ann Curry, D.N.S., Thesis Advisor

A Study of the Birthing Practices of a Group of Recently mmigrated Hmong Women is designed to provide information eeded by nurses working in ante partal, intra partal and ost partal settings where Hmong clients are served. eventeen subjects were surveyed regarding their birthing ractices in their Laotian homeland and their birth xperience in an American hospital to determine which ractices are preferred. In addition four elderly ultiparous women were recruited as critical informants to rovide background information on "old country" practices.

Subjects were recruited from the Indo Chinese cultural nd Service Center's Women's Program. They were women who ad had at least two births in Laos and one birth in an U.S. ospital. A structured interview consisting of six iographic questions, nine research questions and one pen-ended question were used to identify the traditional

irthing practices valued by these women. The results hould provide American nurses with information that will elp them provide more culturally sensitive care to hildbearing Hmong women.

The results of the interviews revealed that these women ere in large part agreeable to American hospital deliveries ith a few notable exceptions.

They prefer to be left largely alone during labor, being llowed to move about at will and resting with high upporting pillows. The bag of waters was traditionally eft intact until delivery and many are very fearful of an rtificial rupture of membranes. A squatting position is esired for delivery. After delivery they want to be kept arm, allowed to rest, supported by pillows, and provided ith an exclusive diet including only: eggs, chicken, hicken broth, rice and black pepper. Nursery care of the aby is acceptable.

All of the changes desired by these women are ones which an be easily and safely made in any American hospital esiring to do so.