Iu Mien Practices Surrounding The Events of Pregnancy and Childbirth: East and West

By

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Summary

The following pages present findings of a yearlong study which looked at the Iu Mien traditions surrounding the events of pregnancy and childbirth. The research involved an extensive review of the literature as well as numerous interviews. The interviews were conducted with Iu Mien women in Thailand (four), as well as eleven Iu Mien women in the Bay Area. Most of the local women were interviewed on two to four occasions.

The literature review provides background information which sets the stage for interpreting the results of the interviews. Information is then presented from the interviews which details the pregnancy and birthing behaviors of Iu Mien women in their homeland, followed by their behavior in the Western milieu.

It was discovered that although Iu Mien women living in the Bay Area appear to have made a transition to practices consistent with the Western protocol for pregnancy and delivery, they have continued to practice their own traditions concurrently. They have managed to allow the two practices to exist side by side in their new lives in the West.

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Introduction

The Iu Mien are a group of tribal people that originated in the Chinese province of Kweichow. Over the last hundred years, many have migrated to Southeast Asia, specifically to Vietnam, Laos, Burma (now called Myanmar), and Thailand. During the late 1970's, many Mien fled Laos and sought refuge in camps in Thailand. Since 1978, when the United States opened its doors to these refugees, many have entered this country. Currently, there are an estimated 10-12,000 Iu Mien living in the US. Three thousand live in the Bay Area.

With the influx of these refugees, the differences between Mien and Western cultures have become evident to westerners in a number of situations. These differences are striking in the health care setting, and in particular, around the highly significant event of pregnancy. Women in all cultures tend to have a tremendous interest in ensuring that their pregnancies are managed in ways that they feel are acceptable. Prompt reliance on longstanding cultural norms and rituals serves as a comfortable means of ensuring an optimal birth outcome. A conscientious adherence to traditions limits a pregnant woman's feelings of

vulnerability. Mien refugee women in the US find themselves in a new health care delivery system which impacts their ability to practice their traditions. The Western system demands that these women manage their pregnancies in ways very different from those to which they are accustomed. However, because of their strong beliefs in traditional methods of pregnancy management, the Mien strive to continue to accommodate their own traditions. I have sought in this study to define the differences in the Mien practices in their homeland, and here in the US. Examining the different practices has allowed me to come to an understanding of the extent to which Western methods of pregnancy management permit Mien women to continue the practice of their own traditions.

Methods

The goal in this study has been to identify Mien traditions around pregnancy and delivery, and determine the extent to which these traditions are being practiced in the US. In order to meet this goal, it was first necessary to do an extensive review of the literature. Four bodies of

literature were examined. The first group of literature described the Iu Mien culture, specifically. This background study was necessary in order to gain better insight into the culture as a whole. The second area of review focused on gaining a broad understanding of the challenges that often meet refugees in general, with their adaptation to American culture. Third, I looked at studies of Indochinese refugees and their adaptations to the Western health care system. Lastly, a literature review was done on the anthropology of pregnancy.

After reviewing the literature, I conducted multiple open-ended interviews with 15 Iu Mien women ranging from age 18 to 58. As very little has been written about Mien traditions around pregnancy and childbirth, the interviews were a vital step in acquiring information. The interviews allowed me to learn not only about Mien traditions as they were practiced in Laos, but also the extent to which the traditions were practiced in the US. The first four of the interviews took place in a Mien village in Northern Thailand during the summer of 1989. The women volunteered to talk with me when I was visiting their village with a Mien contact I had met in the town of Chiang Kham. The contact person was also able to provide translation. These interviews took place at the center of the village in the evenings, with a great deal of interjections from others in the community.

From September, 1989 to March, 1990, interviews were conducted in Richmond, Oakland and San Francisco with eleven Iu Mien women who had given birth in Laos and or Thailand only (five), four that gave birth only in the US, and two that gave birth in both locations. All of the women were married, and all of them had children. Four were unemployed and were supported by their husbands or other family members. Four were employed part-time as store clerks (each of these women had other jobs in addition to their work at the store), two worked as full-time translators in local hospitals, and one was a social worker. Most of these women were interviewed more than once (two to four occasions on average). Multiple interviews allowed a rapport to be established which made the sharing of information much more comfortable than a one-time interview would permit. The interviews took place in the homes of the women, in coffee shops, hospitals and at the Laotian Handicraft Center in Berkeley. The interviews lasted about one hour and a half on average.

The interviews were directed at defining the traditional practices of Mien women, including dietary and behavioral requirements during pregnancy, labor and post-partum. Questions were also asked about complications and their perceived etiologies as well as treatment. For the women with pregnancy experiences in this country, I asked them to define some of the fears they had in attending

prenatal care and undergoing hospital delivery, in an attempt to ultimately define the perceived appropriate role of the physician or midwife in the process from pregnancy through delivery. I also attempted to define the extent to which traditions practiced in Laos were being incorporated into the Mien experiences in this country.

Three midwives and 2 nurse practitioners were interviewed to obtain information on the perceptions of members of the Western medical establishment. This input was helpful in gaining insight into areas of conflict that arise in the health care setting with pregnant or post-partum Mien women and health care delivery personnel. Two Mien public health translators were interviewed and they provided particularly valuable information on this subject. Questions were also aimed at determining when and why non-compliance occurs and how this non-compliance affected the doctor-patient or midwife-patient relationship.

In the pages that follow I will present the results of these interviews. First, I provide a review of the literature is presented to give a theoretical framework for examining the intersection of Mien refugees and their culture, Western culture and the protocols for pregnancy and

delivery. Then, I offer a description of Mien traditions as they were and are practiced in Laos around pregnancy, delivery and post-partum. This will be followed by a discussion centered on how these traditions are practiced in the West, with attention paid to the kinds of conflicts that arise concomitantly.

Review of the Literature

In conducting this research, four bodies of literature were used to gain an appropriate knowledge base.

1) ethnographic writings on the Iu Mien, with particular emphasis on those that include descriptions of beliefs associated with pregnancy and health care;
2) literature describing refugee adaptation to American culture;
3) studies of Indochinese adaptations to the Western health care system; and
4) the anthropology of pregnancy.

The pages that follow contain a review of the literature on the above four topics. The review is not

exhaustive, particularly on the second and fourth topics, as endless accounts exist of the Western challenges faced by migrants and refugees, and there is an enormous body of literature detailing examples of cross-cultural birthing practices and the associated belief systems. However, these readings do provide a broad understanding of the complexity of the issues at hand, and the groundwork is thus established for studying the behavior of Iu Mien refugees in this particular context.

The literature provided some direct information on issues involving traditional Mien pregnancy management and how the traditions are incorporated into Mien life in the West. However, more important than the data, were the questions that were raised on the subject. The answers to the questions became the goals in my interviews.

In conducting this review, books, articles and reports were examined for the period 1967 to 1989. The key words used were Iu Mien, Yao, Indochinese refugees, Southeast Asian refugees, anthropology of pregnancy, and pregnancy management. The Social Science Citation Index, the Tribal Research Institute in Chiang Mai, Thailand, a Medline search and personal contacts were used to locate the appropriate literature.

Literature on the Iu Mien

Few ethnographies have been completed on the Iu Mien. Tan Chee Beng wrote 5 brief chapters on the Mien in Anthony Walker's Farmers in the Hills. In his "Introduction to the Yao," he provides a summary of the Mien (or Yao) population and its distribution, language, costume, swidden agriculture and settlement patterns, religion, and social, economic and political organization all in 9 pages. In the few chapters that follow (each is no more than 6 pages long), he describes various activities which took place in the Thai Mien village that he studied, including the election of a headman and the religious bridge building ceremony, which is done as therapy to cure one who is ill. Although brief, Chee Beng's chapters provide a good introduction to Mien culture.

A similar account of Mien culture was provided in the Ethnographic Study Series. Although this account does not provide details on activities in a specific village, it does provide a broader description of the Mien and includes a more lengthy description of the Mien social structure, including traditions relating to clans, class and family structures, marriage, death and burial.

Peter Kandre has published two particularly informative pieces on ethnic characteristics of the Iu Mien. In the first (1967), Kandre described a group of Mien that emigrated from Laos to Thailand throughout the mid-20th century. He observed this population as they adapted to the new political and economic conditions that faced them in Thailand. The strongest motivator to their adaptation appears to be related to the commitment the Mien have to their ancestors. In order to fulfill the needs of the powerful ancestral spirits, the Mien strive to be in positions where they can acquire wealth (which allows for numerous and plentiful spirit offerings), provide frequent large group rituals, and have the necessary ritual specialists available to them. If they are without these necessities, their ancestors are not adequately placated or lauded, and the descendants suffer illness and bad fortune. Kandre details the elaborate system of ancestor worship, which has created a system of social control and has reinforced the value of harmonious interpersonal relationships and strong communities. The Iu Mien have a long history of immigration and settlement in communities across China, Laos, Vietnam, Burma and Thailand. Adaptation to the local environment has been a practical means of maintaining their basic productive and ritual capabilities. This system has allowed the Mien to make a stable transition to their new home in Thailand. There, supportive

communities have been readily established which allow for the uninterrupted practice of traditions. Impediments to these practices are reduced in a number of ways, including maintaining cohesive communities, and electing village headmen who acquire the political savvy to function as leaders of these communities, as well as mediators between their communities and the local government.

In a 1976 publication, Kandre picks up on the idea of ethnic maintenance and focuses primarily on the function of language and supernatural ritual as a means of maintaining cultural solidarity and preventing cultural dissolution by "supernatural pollution" from other belief systems. He emphasizes the growing importance of ritual and language maintenance as the Mien experience continued cultural and residential interpenetration.

Jacques Lemoine also studied the Mien in Thailand, and in a 1983 publication he described the resilience of the Mien culture as it has faced centuries of repression, migration, and segmentation. Many Mien feel that they would have never survived the dangers and obstacles that confronted their people had they not been empowered by their ancestors and the Taoist Pantheon. As the culture has been somewhat preserved for over ten centuries, confidence in the traditions is a pervasive feature of Mien communities in Thailand today.

Little has been written about the Iu Mien refugees that

have been arriving in the US since 1979. Dennis Rockstroh published an article in the San Jose Mercury News in 1988 which gave a concise description of the journey that the Mien took from Laos to refugee camps in Thailand, and then finally to a neighborhood in Oakland, where they currently struggle to adapt to Western culture. In particular he notes the reticence that many Mien feel about giving up their traditions. This, coupled with the wide-spread ignorance regarding the significance of Mien traditions, creates an alienating situation for the refugees. A 1987 article published in The Express discusses the added problem of racism that the Mien face, which heightens their already peaked sense of alienation.

Jonathan Habarad (1987) completed his PhD dissertation on the Iu Mien and the role of religion in creating social order in changing environments (i.e. from China to Laos to Thailand to Oakland). A central theme in the study, was the use of the supernatural world as a means of coping with deficiencies perceived in the material world. Examples were given which showed how the Mien have adapted to difficult situations by prescribing to a highly flexible belief system which accommodates seemingly extraneous, uncontrollable events, and puts them into a context which gives them meaning and justification.

In a published article, Habarad (1987) provided an historical account of the Iu Mien which illustrated a

pattern of dependency seen in Mien culture for a number of years. In 1968 the Mien were recruited by the US government to fight against the Pathet Lao regime in the Laotian civil war. Many fought for and were supported by the US until 1975, when the US backed out of Laos. At that time, many Mien fled Laos and sought refuge in camps in Thailand, waiting placement in the US. Once in the US, they were placed on public assistance and provided language and job training. Employment (typically at a low wage) often resulted in discontinuation of public assistance, and was therefore perceived as risky and not worth the marginal increase in income. Thus, many of the Iu Mien have never been in a position which fully encourages autonomy and self-reliance.

Sarah Hsia (1985) completed a Master's thesis on the Iu Mien refugees in the East Bay and focused specifically on the changes that the refugees have made in selecting health care since coming to this country. Of particular interest was her observation that Mien believe that Western practitioners have the ability to treat <u>some</u> illnesses, but that the illnesses caused by "soul loss" can be made worse by Western treatments.

Kacha-Ananda's (1986) Mien ethnography is remarkable for its inclusion of a description of the relationship between the human body and the spirit world. Each part of the body is believed to be managed by a specific spirit,

which can wander away, resulting in disease. Bodies of the newborn are particularly vulnerable to soul loss and sickness can easily come about.

Paul and Elaine Lewis (1984) devoted a chapter of Peoples of the Golden Triangle to the Iu Mien. This ethnographic account is particularly noteworthy for its description of Mien beliefs about pregnancy and childbirth. A description is included of some of the precautionary measures women traditionally take to ensure the safety of their unborn children, including respecting different areas of the house depending on the month of the gestation and where the soul of the fetus resides during that month. It is believed that if the soul of the fetus is harmed, the child will be born malformed or perhaps dead. Although the description is brief, it is one of the only accounts available on this belief.

Douglas Miles also provided a description of pregnancy and birthing practices in his Field Reports. He included some of the dietary restrictions that are practiced by the mother during pregnancy and the month following the birth of a child. These restrictions are based largely on the humoral theory of disease, but in addition, some of the practices are designed to prevent soul loss of the fetus and newborn.

Literature on Refugee Adaptation to Western Culture

For as long as civilization has existed there have been migrant populations which have moved from the environments in which traditions were borne, to new locales, which challenge cultural survival. Anthropologists have studies these groups extensively, and have focused on a number of issues related to migrations and settlement. Graves and Graves outlined many of these issues in their 1974 publication. They defined 3 major patterns of migration which explain why groups migrate. These are foraging, circular and permanent. Next they discuss the conditions which result in individual migration. These include the migrant's position in the social network, as well as the psychological attributes of the migrant. The psychological attributes are broken down into variables which include cognitive, motivational, and personality factors which determine whether or not a person becomes a refugee. Cognitive variables include knowledge of beliefs about and expectations for the new settings and their opportunities. Motivational variables refer to a response to needs such as achievement or the aspiration for the migrants' children to prosper. Personality variables include flexibility, risk

taking, and level of optimism. In establishing the refugees' previous group migration patterns, as well as the individual social and psychological factors, one can arrive at a better understanding of the refugee's expectations and needs in the new community.

The transition from a traditional, rural community to an urban setting is laden with challenges. The mass of new problems to cope with spans widely, and includes such tasks as learning how to effectively work with government bureaucracies, mastering the transportation system, and learning how to use electric stoves.

Strand and Jones looked specifically at the difficulties refugees have in assimilating the life in the West (1983; 1985; 1986). They found that these difficulties include language, money and employment problems, which, along with racism, contribute to downward social mobility. These and additional problem areas were ranked and discussed extensively in their 1985 publication, Indochinese Refugees in America. It was interesting to note that the hill tribe refugees placed "difficulty in understanding American life" number 4 out of 20 problem areas. This difficulty in understanding has resulted in a tremendous sense of alienation and disorientation and has limited the refugees integration into American society.

One problem which underlies these difficulties is the lack of control that many refugees feel. Events are often

unanticipated, and go on to have unpredictable outcomes. In adapting to new environments, migrants strive to gain control over their new, seemingly chaotic surroundings.

The present difficulties that refugees are faced with has compounded the already widespread incidence of depression in this population. As James Curtis Alley has pointed out in his 1982 article, depression is exceedingly prevalent and accounts for the high suicide rate among Indochinese refugees. He believes that this depression is due largely to the chaotic past the refugees have experienced, which has included war, poverty, and separation from their families and homelands. A new chapter to the tumultuous journey has been added with their move to the US, and a relationship has developed between the level of understanding and integration into American culture, and depression among refugees.

Nicassio (1983) found that refugees with greater income, better English language skills and more American friends suffered less alienation and depression than those without. Beiser's (1988; 1989) work, showed that those refugees without social support from their own ethnic groups were at the highest risk for depression. This was true for refugees within one year after arrival, as well as nearly a decade later, when he found that refugees with support from within their ethnic communities had an "enhanced sense of identity and belongingness." Westermeyer, et al. (1989)

brought these seemingly disparate views together when he provided a more complete picture of factors that contribute to depression. According to him, the depressed include those who are unemployed, older, socially isolated, and non-English speaking. In other words, it appears that the ideal situation is one in which refugees can maintain their ethnic attachments and identities, and at the same time, function well enough in American culture to gain employment and command of the language.

Graves and Graves cite different adaptive strategies employed by refugees in their new, urban communities. A balance is struck between self-reliance and reliance on other members of the migrant group. Interdependence is prominent in coping with employment, housing, and social interaction. To quote the authors, "urban life, far from attenuating primary relationships within the ethnic community, may actually reinforce and strengthen them." (p.132)

Christine Finnan referred to this interdependence when she described the functions of the refugee community (Finnan, 1983). In her observations, the community contained within it a system of social, emotional, cultural, spiritual and political support. Refugees are able to look to their communities for validation of the difficulties they encounter in assimilation in these various arenas. At the same time, they can be comforted by others regarding the

extent to which they have adapted to western ways. This support is facilitated by maximal social contact, which is heightened with the formation of tight-knit communities as well as with the location of homes nearby or with kin or coethnic members.

Eleanor Rogg provides an explanation for migrant interdependence in her article on Cuban exiles (Rogg, 1974). "The ethnic community acts as a prism through which the new values of the absorbing society are refracted in such a way as to make them more acceptable to the immigrant and more compatible with his cultural heritage...Little by little, new elements of American culture filter in through the community and slowly the immigrant becomes gradually assimilated without the shock of cultural collision," (1974:14).

This process may be prolonged by what Scudder and Colson refer to as "cultural involution," (1982). This involves a period of "clinging to the familiar," in which refugees attempt to change no more than is absolutely necessary and avoid practicing any new, seemingly high-risk behavior. They attempt to recreate the same community that they left at home. Cultural involution can buffer changes which would otherwise seem too rapid. It can become problematic if it is sustained, as the refugees may neglect focussing on development of new skills and the understanding of Western culture, which is closely associated with

assimilation and the ability to create reciprocal ties with the host community.

It is interesting to note here, that US policy for refugees has reinforced, rather than discouraged cultural involution. The policies have focused on dispersing groups in order to minimize the economic and social conflicts which may arise in any one particular area. In doing this, the refugees are drawn to one another even more, as they feel such an overwhelming loss of cultural identity upon arrival at resettlement sites (Colson 1987).

Jonathan Habarad (1987) referred to the Iu Mien specifically when he argued that the training programs for the refugees also reinforce cultural involution. The Mien were encouraged to undergo drastic alterations of the values which go hand in hand with the acquisition of the new skills needed to be qualified for certain types of employment. These shifts were so great, that given the alternative or remaining on the guaranteed public assistance dole (at least for the first three years), refugees opted out of acquiring new job skills.

Christine Finnan (1983) made a distinction between men and women in their adaptive roles. She concurs with Habarad and Colson in their assessments that men with non-transferable skills tend not to find employment readily in the US. However, Finnan notes that women tend to be quite employable as they are generally more willing to take lower

status jobs.

In addition to pointing out this exception to the observations made by Habarad and Colson, Finnan also reported on an adaptive aspect of cultural involution. She described a group of elderly Vietnamese who lived in an isolated community in New Orleans. In this community, Vietnamese is the only language that is spoken, Vietnamese shops are within walking distance from residences, and the refugees are able to walk to the houses of their friends and relatives. Among these elderly, the mental health problems were discovered to be markedly fewer compared to those in other, more integrated communities. However, for the younger generations, the isolation and seemingly rigid traditionalism was perceived as oppressive, and an impediment to turning outward and integrating into American culture.

Scudder and Colson (1982) cited other reasons which motivate migrants to turn outward from the closed refugee community. With the movement into a new culture, migrants experience a loss of their own cultural identity, as they see their traditional practices limiting their ability to integrate. They experience a loss of confidence in the traditions, as well as in the leaders of the community. They are further discouraged by outside ridicule and misunderstanding of their traditions. According to these authors, this can lead to a suppression and ultimate

abandonment of practices which were formerly central to dealing with life's crises.

Literature on Indochinese Adaptation to Western Health Care

Many authors have written about the traditional beliefs held by Southeast Asian refugees in the US, and special attention has been given to those beliefs which influence perceptions of health care delivery. In addition to outlining some of the basic models of health and disease in Southeast Asian cultures, these authors urge physicians to be sensitive to the specific beliefs held by these refugees (Finck, 1984; Goldfield, 1982; Hoang, 1982, 1985; Olness, 1979; and Schultz, 1982).

Tung (1980) has provided a framework for understanding the dilemma faced by Indochinese refugees in the health care setting. He noted that in order to provide appropriate and acceptable health care, a match must be made between the perceptions of the doctor and patient in what the problem is, whether or not there is a demand for need, and what the appropriate service consists of. As is described extensively by the Indochinese Cultural Center (1982), the

Eastern and Western understandings of pathology are widely divergent. Consequently the treatment that is given as well as the function of the physician are often mysterious to the refugee.

In addition to simply not understanding the need for and the logic behind Western treatment, many refugees fear the hospital and medical regimens (Finck [1984] explains the fears behind taking medications, having blood drawn, and allowing surgery and autopsies). Thus many refugees are resistant to seeking Western health care. Van Esterik provided an example of this resistance when she observed that refugees often think of hospitals as places where one goes to die, and that the only way to survive hospitalization is to have family members in attendance at all times. Egawa and Tashima (1982) noted that many refugees would prefer to stay home and suffer rather than see a western medical doctor.

Even though the fears and misunderstandings are heightened when Indochinese patients visit their physicians, several authors have noted that the patients rarely voice their concerns. The typical Southeast Asian stoic and agreeable nature often prevents these individuals from verbalizing any complaints or fears (Indochinese Cultural Center, Muecke, Tung). As William Liu (1979) posited, the refugees have learned that in order to be successful, they must be passive recipients of whatever services are provided

them. Although they do not understand the practices, and sometimes do not desire the treatment, many refugees are uncertain of what other options they have. Thus they continue to find themselves in the Western health care setting.

Many refugee women will have contact with American hospitals. Rumbaut and Weeks (1986; see also Weeks, et al., 1989) observed that despite knowledge of contraceptive methods, the fertility levels have remained high among the Indochinese refugee population. This is due largely to the language barrier and lack of information on where to obtain contractive devices. As long as the fertility level remains high, we can expect that many women will face the task of coping with the Western medical system.

Along with high fertility rates among the Indochinese refugees, a disproportionate number of suboptimal birth outcomes has been discovered in this population. Swenson, et al (1986) observed that babies born within 10-12 months after arrival had better Apgar and height-weight status than non-refugee babies, and she attributed this to the absence of alcohol and tobacco consumption in the population. However, Hopkins et. al (1983) observed the same phenomenon in children born within one year after arrival and attributed the favorable outcome to the fact that all refugees are screened and provided medical care upon arrival, thus increasing the likelihood of obtaining

prenatal care. They noted that children born to refugees after one year of residence in the US had suboptimal birth outcomes. It is important to note here, that as acculturation proceeds, the drug and alcohol consumption may not remain at a minimum, and birth outcomes may become even less favorable. In any event, it is likely that they will remain suboptimal.

Davis, et al. (1982) followed a group of recently arriving Southeast Asian refugees who suffered more complications than non-refugees and gave birth to a disproportionate number of low birth weight infants. They attributed the poor outcomes to low socioeconomic status and concluded that these outcomes are likely to occur in any population experiencing low SES and downward social mobility.

The above examples provide reason to suspect that refugee women will have frequent and challenging contacts with physicians, not only during birth, but for possibly lengthy periods of time after the births of their children.

Literature on the Anthropology of Pregnancy

Several books have been written which are devoted entirely to the anthropology of pregnancy (Artschwager, 1982; MacCormack, 1982; Michaelson, 1988). They contain examples of birthing practices in different cultures, and are prefaced by introductions which point out the significance of the variations among cultures, how these variations reflect cultural norms (see also, Newman, 1972), the richness of beliefs and rituals associated with childbirth, and why it is important for health care practitioners to be aware of these beliefs and associated needs.

Michaelson made several important introductory remarks in Childbirth in America. Of particular interest was her observation that in many cultural traditions, pregnancy is not managed by applications of science and technology (see also MacCormack, 1982), which is the Western cultural construct of appropriate pregnancy management. Because of this, conflicts arise between health care workers and patients in defining the appropriate care, pre-natally, as

well as ante-natally.

The provision of ante-natal care may create more anxiety, and thus elicit more cultural conflicts within the hospital setting than many other "medical" events. In any culture it is common for pregnant women to feel tremendous anxiety about the health of themselves as well as their unborn children. Many authors have discussed the stresses invariably experienced by individuals who take part in the Western birthing system (Arms, 1975; Bauens and Anderson, 1978; MacCormack,1982; and Shaw, 1974). They provide examples which show how the health care delivery process can actually aggravate these feelings of anxiety. A central point in many of these writings, is how alienating and unfamiliar the hospital environment can be. Obviously, for the refugees, it must be much more mysterious. It may also be very awkward, as it includes such requirements as having several parties - including males - present during labor (Jordan, 1978; Spencer, 1977). These examples make it clear that the birthing process is particularly stressful for refugees.

As a result of the increased anxiety experienced by the refugees, they are likely to diverge even more from practices which are unfamiliar to them. Clarissa Scott (1978) addressed this issue when she noted that one way that refugees manage stressful events (such as the birth of a child in an unfamiliar setting), is to turn more

aggressively to traditional rituals, which give them a greater sense of control and well-being. As ritual gives the refugees greater control, it often frustrates health care workers who view the "superstitious" rituals as impediments to "proper" health care delivery. Snow (1978) observed that while many patients may believe that they are behaving very reasonably by adhering to appropriate rituals, health care practitioners see them as being hopelessly noncompliant.

The perceived "noncompliance" is very damaging to the doctor-patient relationship. Judith Lorber (1979) discussed the repercussions this situation, in which the patient is considered "difficult," and concluded that these patients are more likely to be stigmatized and neglected.

A possible solution to this problem, is for both doctor and patient to realize that each party has differing concepts of the patient's physiological and spiritual needs. Numerous authors have addressed the idea of reality as a social construct that is necessarily defined differently in different cultures. They explain that it is essential for the doctor and patient to partake in a "reality negotiation" in which both parties are working together to meet the agreed upon needs of the patient (Anderson, 1979; Clark ,1978; Helman, 1984; Katon and Kleinman, 1981; Kleinman, 1980). Katon and Kleinman argue that simply showing an interest in the patient's perceptions of reality and of

their expectations for treatment will result in a more therapeutic doctor-patient relationship.

A number of cases were reported by Irwin and Jordan (1987) in which no attempts were made to come to an agreement with the patients regarding the appropriate course in managing their pregnancies. Instead, the physicians used court orders to bypass the negotiation process and proceed with their therapeutic plans without regard for the desires of the patients. The authors used these as examples of medical hegemony, pointing out the existence of "the ethno-obstetrics of biomedicine, compared to which all other birthing traditions are found wanting" (1987:320).

Conclusion of the Literature Review

It is clear from these writings that Mien refugees face innumerable challenges in finding comfort in their new cultural setting. The transition from East to West is a tremendous one. The event of pregnancy, which is stressful under any circumstances, presents refugees with many added challenges. They are forced to cope with a dominating, new, often frightening and unfamiliar process. Perhaps the greatest challenge, is the struggle that the Mien make to

understand and fit into the overall mechanics of the Western birthing system. This struggle provides a good model for examining how the Mien refugees adapt to Western culture in general.

Research Findings

The information in the next three sections was obtained from the interviews which were conducted in Thailand and the Bay Area. In the first two sections, Iu Mien traditions are presented as they are practiced in Laos and Thailand. The final section provides a discussion of how these practices are woven into the new lives of the Mien in the West.

The women who were interviewed in Thailand were members of a Mien village which was located about 30 Km from the town of Chiang Kham. These interviews were held in a group setting, with a number of villagers present. Most of the information obtained during these interviews had to do with dietary constraints during pregnancy. Some information was also elicited regarding post-partum ritual.

After returning from Thailand, eleven Iu Mien women were interviewed in the Bay Area. Each of these women had lived in the US for at least five years, with most having lived her for nearly ten years. They were all married and

had given birth to children in the US, in Laos or Thailand, or in both locations. Seven of these women were employed as store clerks or translators, and one was employed as a social worker. The four who were unemployed were being supported by their husbands and/or children.

The Bay Area interviews provided verification of the information obtained in Thailand. In addition, data was gathered regarding the rituals surrounding pregnancy and post-partum in Laos and Thailand, as well as the extent to which the rituals were practiced in the US. The interviews were open-ended, each one building on data obtained from the previous interviews, as well as from the literature.

Iu Mien Traditions: Pregnancy

In this section, a description is provided of the traditional Iu Mien practices which surround pregnancy. In order to fully appreciate these traditions, it is necessary first to look at the spiritual beliefs held by these people. The Mien believe very strongly in the power of the spirits that surround them. This belief stems from a combination of animistic and Taoist tradition. The supernatural universe

is believed to be administered by three members of the Pham Ching Trinity. Each one of these gods is assisted by various emperors, and the emperors are assisted by troops, generals, knights, marshals and governors. Aside from these "ruling" spirits, there are spirits of nature, such as spirits of the sky, water and earth, as well as random, evil spirits and ghosts. The latter forms of spirits are particularly adept at harming humans. Spirits of ancestors are also omnipresent, and, when neglected, are quite capable of harming humans as well. In addition to the spirits which are "outside" of the body, each person is thought to have 7 souls of his own. These souls can be lost, scared or taken away, resulting in illness.

The ancestor spirits have played a particularly significant role, as it is believed that they depend on their survivors for sustenance. Once a person dies and his soul goes to the spirit world, he has no money, food or shelter there. It is the responsibility of the survivors to provide those needs via sacrifices and ceremonies, in which paper houses and money are burned and sent up to the spirits, a large meal is served, and at times opium is smoked (the latter does not typically occur in the US). These commodities are consumed so that they may be "shared" with the spirits. If the ancestors are not sufficiently provided for, they will become angry, and lash out at their survivors. This anger can result in outcomes such as a

suboptimal crop, ill-health or "bad luck."

The Mien are further motivated to appease the spirits by their beliefs about reincarnation. The ultimate goal of all people is a standing in the afterlife. This can only be obtained by careful adherence to the needs of the Holy Trinity as well as all of the other spirits that surround people in daily life. Thus, there is great incentive to appease the spirits, including those of the ancestors. In order to appease them, it is important that people keep a record of all of their ancestors. Traditionally, families contain written records of all of their ancestors, dating back as many as 12 generations. Most refugees in this country have kept these records or have kept track of who has the records.

Another requirement in providing for the ancestors is sufficient resources for the necessary ceremonies. Clearly, in order to provide the lavishes prescribed by traditional rituals, the Mien must stand in fairly good stead financially. Indeed, they are known among hill tribe groups as being relatively prosperous. This reputation has been earned by their fruitful efforts to provide for their ancestors.

As with a number of other facets of daily life, many of the traditions associated with pregnancy focus on protection of spirits. If a pregnant woman becomes ill, she will usually consult an herbalist before seeking any other help.

Herbalists are used to cure illnesses with "natural" etiologies, i.e. those caused by polluted air, weather change, wind, excess hot or cold, and dietary imbalance. If the prescribed herbs do not help her regain a healthy balance of humors, she will consult a shaman, as the next most likely cause of her illness is one of animistic etiology. The shaman will converse with the spirits to find out the source of her malady, and then will ask the woman for the necessary offerings so that the angry spirit can be appeased. In some cases, this will ultimately result in the return of one of the woman's wayward spirits to her body.

Prophylactic measures are taken in regard to the safety of the unborn child, by protecting the soul that belongs to the fetus. This soul is present in various locations in the household, depending on the month of the pregnancy. It is dangerous to disrupt the particular space that it occupies, as the soul may be injured or scared away. A scared or injured soul can result in an injured or dead child. The soul is a roaming one, but it roams along a well-established path. During the first and second months of the pregnancy, the soul is at the doorstep. It is important that the children of the family keep their horseplay away from there, as they may accidentally cut something, which will result in a harmed baby. During the third and fourth months, the soul is in the stove. During this period, it is important not to let the water boil over or the roof leak water onto the

stove. This can lead to miscarriage. It is also important not to remove the ashes from the stove during these months, as it is possible to remove the fetus' soul along with them. During the fifth and sixth months, the soul resides in the living room. There is to be no cutting, repairing or moving of furniture. These activities will confuse the development of the fetus and may result in severe harm to it. During the seventh month, the soul is in the rice pounder and throughout the eighth month it is in the mother's bed. Again, it is unsafe to make repairs on these items or to cut anything around them. During the ninth month, the soul is in the mother's body. Although the soul has definite resting places depending on the month of the pregnancy, the spirit may wander temporarily from its usual location, and at any given moment, there is a chance that it will be in any of the aforementioned locations. Therefore, many Mien people will take precautions in all areas of the household in order to minimize any chance of conflict with the spirit.

One informant recalled a time in the refugee camp when a man did not know his wife was pregnant and went out to chop wood on the stairs. He accidentally chopped the stairs themselves, and his wife gave birth to a dead child. The chopping of the stairs was believed to be the direct cause of the death of the child. Aside from direct contact with the part of the house in question, it is also considered dangerous to cut anything in the vicinity. When one cuts

anything, the soul may get in the way, and this may result, for example, in a baby with no ear. It is for this reason, that women are reluctant to clip their toenails, fingernails, or hair while they are pregnant.

Sewing is also considered unsafe behavior in the presence of the fetus' soul. One Bay Area woman reported that one of her friends did not abide by the rules. People told her that it was unsafe to sew in bed, but "she did not want to believe them." As a result, my informant reported, "her baby was born with no ass!" indicating that the mother had sewn her baby's anus shut by taking part in this activity when the soul of the fetus was present.

At some point during a woman's pregnancy, a shaman conducts a ceremony in which the 36 most diabolical spirits of the universe are honored. In this ceremony, a shaman brings to the woman's home 36 paper figures, cut in the shapes of small humans. These figures represent each of the most feared spirits. The pregnant woman, with help from sisters, mothers or aunts, makes 6 animal figurines out of material extracted from banana root. These clay-like figures, believed to be of great substance in the spirit world, sit before the shaman, as he drops onto them the blood from a sacrificed chick. This act represents a sacrifice to the spirits, and is done as a precautionary measure, in hopes that the evil spirits will not be tempted to harm the child as it develops inside the woman.

Other methods of protecting the unborn child involve certain dietary restraints on pregnant women that originate from beliefs about causes of "bad luck." There are several creatures which are thought to bring bad luck to a pregnant or nursing woman. This bad luck can be passed along if a food is consumed that was bitten or killed by one of these diabolical animals. Tiger, fox, cock roaches, and snake are all placed in this "bad" category. Any type of bird that may have feasted on other animals is also considered unsafe cuisine. This includes hawks, ducks and eagles. Many women believe that if any food is consumed which has been tainted by the unsafe creatures, their children will be born ill. Many said specifically that the child would be born "yellow" and the child will have a higher likelihood of suffering seizures. If this does occur, embroidery threads are warmed and rubbed all over the body of the child. This works only some of the time, but it is one of the few things that can be done to cure the baby with this illness.

One informant reported that her sister had become pregnant although she was not married. She was afraid to tell anyone in her family for fear her father would find out about this out of wedlock pregnancy and become angry. Typically, women are very "embarrassed" about being pregnant, and tell only their close family members, as it is important for members of the household to know. However, in this case, no one was informed. A ceremony was held and the

woman went to the feast and consumed some of the pork that was served. No one told her that the pig had been killed by a tiger. Once she found out, it was too late, she had already consumed her portion of the ceremonial feast. The baby was born healthy, but at three months of age, the baby became ill. He could not bend his neck and he cried a lot. Within a couple of months, he died. The cause was linked directly to the bad luck imparted by the tiger when it killed the pig.

These dietary restrictions extend beyond pregnancy and through the 30 days following labor. The mother's body is perceived to be still connected to the child, in that the child is still relying on her for its sustenance. This reliance is less strong that during pregnancy, but more than the reliance after "the month after," even though the mother may breast feed the child for several months after it is born.

It is clear that there are a number of precautionary measures that Mien women take during their pregnancies. It is also evident that members of a pregnant woman's household also have guidelines to adhere to. It is interesting to note that despite the perceived gravity of adherence by members of her community to certain guidelines, pregnant women are very reluctant to tell those around them that they are pregnant. I tried repeatedly to obtain an explanation for the reluctance to share news of a pregnancy, but all of

the informants responded simply that they were embarrassed to tell anyone they were pregnant, and they provided no other insight. The informants that were living in a hill tribe in Thailand asked if it was any different in the US. When I explained that the women I knew in the US were very open and often excited to share about their pregnancies, the group erupted into peels of laughter.

This reluctance to discuss pregnancy results in very little prenatal consultation with others. When women living in the hilltribe were asked whether or not they seek help from others during their pregnancies, one responded, "we get ourselves pregnant without any help, so why ask for help once we're pregnant?"

This reluctance to talk was also present around the subject of menstruation. Women tended to be embarrassed about revealing anything about their menstrual histories and their beliefs about menstruation. One informant reported that she was very frightened when she first menstruated because she thought that her hemorrhaging was the result of leech bites. Her mother had not told her anything about menstruation so she did not know to expect it. She told a trusted aunt about her problem and the aunt explained to her that it was not the result of leech bites, but something inside of her that she should expect every month or so, and that she would need to wear several layers of clothing every time it happened. She received no explanations beyond

that, and felt that it was just something that she needed to hide from others.

Iu Mien Traditions: Delivery and Post-Partum

The following pages contain a description of the traditional Iu Mien practices immediately before and after the birth of a child.

When a woman is ready to go into labor in Laos, she usually disappears into her house along with someone who provides assistance. This helper is usually a mother, sister or aunt. She provides help not only during labor, but she (or some other helper) is present for up to 7 days after birth, at which time the other family members take over. Outside help is needed because, according to belief, the post-partum woman is not permitted to carry anything for the first month after delivery, and her abilities to prepare meals are substantially curtailed.

During labor, the delivering woman usually squats and holds onto a cord which is hung from the ceiling. The assistant pushes on the woman's abdomen. Throughout labor, the mother is careful not to utter sounds. Acknowledging the severity of the event tends to scare and possibly anger the spirits. The anger of spirits will manifest itself

accordingly in prolonged labor and greater pain in childbirth.

Once the baby is born, the umbilical cord is tied off with embroidery thread and then cut with a sharpened piece of bamboo. The placenta is placed in a basket and then taken out into the forest and suspended from a tree, far from the house. As it is packaged in a basket, it is safe for the men to handle it (as I explain later, men are typically protected from any direct contact with the delivery). Usually the husband is charged with the task of taking the placenta to some outside location. He must be careful not to hang it too high in the trees, or the baby will grow up being afraid to climb trees or walk over bridges. However, it must be off of the ground, so that no one can see it. It is hidden in this way so that none of the outside spirits will come into contact with it and realize it is from the birth of the child. The placenta is considered offensive, and if the spirits see it and realize from whence it came, they may exert their wrath on the child or the family of the child. This wrath may take the form of illness, death or just bad luck.

The newborn baby is cleaned in a warm, herb bath and then returned to the mother. The herb bath is believed to make the newborn strong. The mother also receives her first bath. She continues to receive them for several days as often her helper can boil water for her (up to 3 times per

day). As childbirth is perceived as a "dirty" event, the woman is typically highly motivated to take as many baths as she is afforded.

The concept of childbirth as a "dirty" event explains a great deal of the behavior in the post-partum household. Because the woman is in an unclean state, she is capable of offending many of the spirits present in her household, or in the households of others. Thus, she does not enter any other household during "the month after." In her own house, she avoids any activity in close proximity to the spirit altar (located in the main room of the house). She also avoids exposing her husband to any of the uncleanliness, and he avoids it by steering clear of her at the time of delivery.

Men are endowed with a large number of spirits because of their central role in the family. Men are the heads of household and are responsible for the most vital function in Mien culture: the passing on of traditions. For this reason, they are given the most protection not only by a large number of spirits, but also by spirits who are very temperamental, and in need of tremendous respect. This ensures that men will be respected and listened to, and in a position most conducive to carrying out their role of passing on traditions and providing for the spirits of their ancestors. As labor is considered a "dirty" and "offensive" act, men stay away, so that their spirits will not be scared

off or angered.

Not only are the men protected from the "dirty" event of delivery, they are also protected from the uncleanliness of the post-partum woman for the 3 days that follow delivery. During this period, the woman sleeps by the cooking stove. This serves a dual function as it allows her to avoid offending her husband's spirits, and also helps her stay warm, which is believed to be therapeutic for a woman recovering from labor (many women reported sleeping out by the stove for as many as 30 nights).

One other strategy employed for "returning the mother's body back to normal," involves sitting upright for the first several hours after delivery. Women will sit up for anywhere from 12 hours to several days in order to return their "insides" to their original positions.

The central focus for women in post-partum recovery is on dietary restrictions. A post-partum woman is believed to be very fertile and capable of nurturing anything that can grow. For this reason, it is considered dangerous for her to eat anything which may be dirty and contain insects or other small organisms. Consuming very "clean" foods is also a way to cleanse the mother after she has gone through the "dirty" event of delivery. A post-partum mother is always careful to eat only rice taken from the middle of the pot. There is a great danger that rice taken from the top or the bottom may be burned and/or "dirty," and capable of

growing inside the mother.

It is also important that she avoid foods which may take root or grow inside of her. A number of foods fall into this category. First, anything with roots or stems is considered unsafe. Pumpkin and bamboo are particularly dangerous, as they take root and grow to a large size so quickly. Fruits with seeds are unsafe because the seeds may germinate. Cucumbers can be eaten only if the seeds are removed and the ends cut off. There is only one type of fish that is permitted during pregnancy. It is a freshwater fish, found only in Southeast Asia, that does not typically grow very large, and it is safe for consumption as long as the head and tail are removed. If they are not removed and the mother eats the fish, it may grow in her stomach.

It is also very important that the mother eat only very well cooked foods. Raw foods not only may grow inside of the mother, they are also considered "too rough," and may cause the mother to hemorrhage.

The concept of hot and cold as a function of wellness is invoked during the post-natal period, and also serves as a determinant of the mother's diet. In the hot/cold theory of diseases, health is considered a state in which the two opposing elements of the body, yin (male, hot) and yang (female, cold) are at equilibrium. An excess of either means deranged physiology, discomfort and illness. Foods, herbs and other natural elements are used to regain the

vital balance. The amount of each element required depends on a number of variables, such as the time of year (fewer hot substances are needed in the summer and fewer cold substances are needed in the winter), and the stage of life cycle (an older person has a more disruptable balance).

A post-partum woman is thought to be in a "warm" state, but this warm state is appropriate, as it helps her heal from the trauma of childbirth. A careful balance is sought which will prolong the mother's "warm" state without making her too hot, as an excess of heat may cause a host of problems, such as headache, constipation and fever. Thus, very hot foods are avoided, such as oily, deep fried and spicy foods, while very cold substances such as raw vegetables and cold water are also avoided. An excess of cold causes stomach pain, leg pain, diarrhea, and may cause prolonged hemorrhage following childbirth. On the balance, more hot foods are consumed than cold.

Another factor contributing to the need for hot foods, is the belief that the body lacks hot substances when it has lost blood. (This is not the case in the instance of a nose bleed. This loss of blood is thought to be the release of excess heat that must be dissipated from the body.) Clearly, there is a substantial amount of blood loss in childbirth, and hot foods are called for. Hot foods are also consumed in many ceremonies, as they represent strength, and adding to resources.

A woman routinely drinks a special tea which is believed to be very strengthening after the event of childbirth. It is made of ginger and pepper. It is important that this be the first thing consumed after delivery, as it is the most efficacious in healing the post-partum mother. It also protects her from cooling down too rapidly.

Rapid cooling of the body is not only believed to be threatening to the mother's current health status, it is also thought to be damaging to the future health of the mother. There is a notion that the rapid cooling initiates a slow, malignant process which gradually weakens the body, making it more susceptible to illnesses later in life. In particular, women who do not stay warm during "the month after" tend to suffer more "aches and pains" as they age.

Other precautions against future ill-health involve management of the fireplace coals. It is considered very unsafe for a post-partum woman to handle coals from the fire. If she does this, she can expect to suffer something which resembles some sort of premature neurological dysfunction. In the words of one informant, "a woman's hands will lose feeling and become numb and tingly by the time she reaches her forties and fifties."

The protocol for the event of childbirth is extensive in terms of the rituals that are necessary to avoid offending the spirits. Immediately following the birth of a

child, a chicken is sacrificed for the ancestor spirits so that they will welcome the newcomer to the family. The chicken is cooked with sweet rice, and after it is done, the mother eats only a little. She eats a small portion because of her limited ability to digest, which is assumed to be the result of her shrunken liver and stomach, both of which were squashed by her pregnancy. If there are any women in the community who are having difficulty getting pregnant, they will have a small share of the chicken as well.

A few days after the child is born, a shaman will conduct the most important ceremony following the birth of the child. The day that this ceremony is conducted depends on the family name, and usually occurs 3 to 5 days after the child is born. Although the child may have been presented to the ancestor spirits at birth with the sacrifice of a chicken (usually performed by the child's father), at this time, the child is presented to the spirits of the household and outside environment by a shaman. The ceremony lasts from 30 minutes to 2 hours. The shaman begins by chanting steadily to the ancestor spirits, and then moves on to communicate with other spirits governing the household. Finally, the shaman takes the child outside to present it to the sky and other outdoor spirits. The spirit of the sky is considered one of the most powerful and feared spirits. With the introduction by the shaman, the "dirty" child can meet the sky spirit without fear of offending it.

This introduction to the spirits is the beginning of the child's preparation for life-long exposure to powerful spirits. Up until this point, the child is very likely to frighten or offend the spirits, which can result in these spirits frightening his personal spirits out of his body. The absence of one's personal spirits leads to illness or sometimes death.

One component of the ceremony involves extracting the tongue of a chicken, which has been sacrificed for the spirits. This tongue is placed in the child's mouth. It endows the child with three new powers: 1) the child may now eat any food that it wishes; 2) the child is given the tools it will need in learning how to speak; and 3) the child will be able to awake every morning when it hears the rooster crow.

Up until the time of this ceremony, the child is thought to be very vulnerable to harm. His or her spirits can be easily scared away by outsiders. One woman recalls a time in Laos when women did not even allow others to look at their children for the first few months of its life (i.e., even after the "month after"), for fear that the child's own spirits would be ultimately scared away and the child would die. Now, she says, it is only important that visitors not enter the house for the first thirty days following birth.

The first person to enter the house after the ceremony, is named as the baby's godparent, and is asked to tie a

string around the child's neck for good luck. From that point until the child is 15 years old, the god parent may be very involved with maintaining the well-being of that child. If at anytime the child is ill, or cries a lot, or is not growing adequately, the shaman will be consulted. Often, he will find that the spirits are in need of a specific offering, and often it is up to the god parent to provide that offering. This can involve merely sacrificing a chicken, but it often includes additional gifts, such as silver ankle bracelets or an egg, both of which are believed to bring back the skiddish spirits of the infant, or pay off any malevolent spirits which may be causing harm.

The shaman elicits this information by direct consultation. He speaks with the spirits, in a language only shamans and spirits can comprehend, to find out what upset the spirits, and what kind of compensation is called for. As he asks these questions, he tosses sticks onto the floor. Their landing positions reveal the answers to the questions. He may also use a stone which he suspends from a string. Any movement of the stone corresponds to an affirmative answer from the spirits.

One other method of conversing involves placing sesame seeds in a cup with cloth stretched over the top. The shaman asks the spirits questions and then shakes the cup over the head of the child. He then peers down into the cup to examine the distribution of the seeds. This distribution

reflects the voice of the spirits.

On some occasions a shaman will discover that the spirit which brought the child into the world is in need of attention. Specifically, the spirit may be in need of a bridge, which is believed to help the wayward spirit find its way back to the spirit world. The shaman actually constructs a bridge out of bamboo and places offerings on the bridge which the spirit can take with it back to the spirit world. This not only helps guide the spirit home, it serves as compensation for the spirit's assistance. This ritual may also be performed on numerous other occasions throughout life, particularly in the event of illness.

Spirits may also need attention if they are made jealous. In Mien culture, people are very careful not to lavish praise on infants, as any eavesdropping spirit may hear these praises and become jealous. In this event, the spirit may wish harm on the attention-getting child, and the child may become ill.

An excess of either hot or cold can, as with adults, cause illness in children. An excess of air, or "wind" is also potentially dangerous. After birth, it is possible for wind to enter the soft spot on the baby's head. If this occurs, the child will suffer bouts of vomiting and diarrhea. For this reason, it is important that infants wear hats for at least the first 30 days after birth. Traditional Mien children's hats serve a dual function of

protecting the soft spot from wind, as well as disguising the child from the sky spirits above (the hats resemble flowers when viewed from the top). If the child is not wearing a hat, and the wind enters the soft spot, he can be cured by eating ginger, hard boiled eggs, and green onions. In addition, a coin edge is rubbed all over the baby's head, arms, and the bottoms of his feet. A silver earring is placed in the baby's ear. Once this turns black, the wind is no longer inside the child.

It is clear from the above examples that traditional Mien behavior around the events of pregnancy and child birth are governed not by a biomedical model, but instead by a universe in which powerful spirits and natural elements determine the state of individual health and well-being. In the following pages, Mien pregnancy and birthing behaviors in the West will be examined. This behavior will be looked at in terms of the extent to which it reflects a change in the belief systems of these refugees.

Iu Mien Traditions in the West: Pregnancy, Delivery and Post-Partum

Many of the Iu Mien refugees have experienced alterations in their belief systems, but these alterations manifest themselves only as changes in behavior, and not necessarily changes in their beliefs about basic truths. Specifically, the role of the spirits is still believed to be fundamental to the Iu Mien living in the West. As Jonathan Habarad explained, many Mien joined Christian churches because they felt that relying on ceremonies, and the shamans necessary to conduct them was going to be impractical in this new setting. Many decided that if they paid respect to Jesus Christ, he would help protect them from angry spirits. And going to church on Sundays proved to be quite convenient for many Mien, particularly those living in neighborhoods where recruitment efforts were strong. Thus, although their ceremonial behavior changed, and appeared as "religious conversion," it was not very complete, as many joined the church in order to more effectively continue their animistic practices (Habarad

1987). This is also the case for many Iu Mien who are moving to urbanized areas in Thailand. Many are "becoming" Buddhist, as it is a more practical means of worshipping their ancestors and other spirits. Honoring monks, and worshipping at Wats are more practical means of paying homage than locating shamans who will carry out expensive ceremonies.

The Iu Mien have adapted their practices around pregnancy and childbirth in similar ways since coming to the West. Although their beliefs about the importance of honoring spirits, and paying attention to the balance of hot and cold are still present, they are manifested in slightly different forms of behavior.

For the first few years of the Mien migration to the West, the refugees were bombarded by a large array of new and uncomfortable challenges. Visits to the doctor were included in this category. As Mien women typically do not undress in front of their husbands, they were horrified when health care workers would ask them to take off their clothes. Most complied anyway, although they appeared very pained, and furrowed their brows as they were examined. They were also horrified by the requests for blood samples, as they believed that this blood would never be replenished. This fear was also swallowed, and most complied with the requests. The most troubling aspect of going to the hospital was having no idea what was being done to them, why

it was being done, and the extent to which it may harm them. These fears were ample, as very few translators were available to assist in any degree of clarification.

One other fear was associated with the possibility of an unwanted tubal ligation. Many doctors have impressed upon the Mien their views about contraception and a limited family size. There were some reports of physicians using fear tactics in order to convince refugees to use birth control. Doctors were telling women that they may not be able to survive any additional pregnancies. Despite these and other efforts to encourage Mien people to reduce their family sizes many have been reluctant to do so. Many believe that it is optimal to have as many children as possible. A large brood is not only assurance of being taken care of in old age, it is also helpful in the afterlife. The spirits of the parents (like the spirits of all people) will inevitably move onto the spirit world after death. There, they depend upon their descendants for provisions. Thus, the more offspring, the better the chances are for survival and comfort in the spirit world (this concern is particularly prominent in the male population, as they are endowed with more spirits).

Aside from the conflict arising from a fundamental desire to have a large family, contraceptive devices are feared by many Mien people. Rumors abound in the Mien community that use of any contraceptive device may cause

cancer or some other incurable illness of non-animistic etiology. Tubal ligation is feared to cause an entity called "the sickness." This refers to the deep depression that women feel once they are rendered infertile. Women with this "sickness" tend to retreat into their homes and become isolated and very unhappy. As one informant explained, "their major purpose in life has been to provide children. When this ability is gone, they feel completely worthless."

Cesarian sections are also widely feared in the Mien population. One reason for this fear is the belief that once a woman is anesthetized, and an incision has been made, the surgeon will be free to perform a tubal ligation. In addition, surgery of any kind is viewed as excessively violent and unnecessary. Mien women fear it to such an extent, that they limit their food intake during pregnancy to protect against an "overly-large baby," which, they fear, will require a cesarian section (the nurses and midwives reported that this limited caloric intake has not, for the most part, resulted in low birth weight babies). Again, it was reported that doctors have used fear tactics to coerce reluctant women into agreeing to cesarian sections. One informant reported a doctor telling a woman that she would die unless she had a Cesarian. She delivered vaginally and neither she nor the child suffered any complications.

If given a clear choice, many refugees would never have

put themselves in these often excruciating hospital-centered situations. However, upon arrival to the US, the refugees were told that if they wanted to receive full AFDC support, they would need to deliver their children in the hospital. They also learned about WIC, the Federally subsidized nutrition program for Women, Infants and Children. WIC provides relatively valuable food vouchers for low income women who are pregnant and those with small children. In order to receive the vouchers, the women must come to a clinic for nutrition counseling once every month, and she must bring with her evidence that she is receiving prenatal care. These economic factors were sufficient to motivate Mien women to participate in prenatal care and in-hospital delivery, despite their discomfort with the process.

As more women used the system, it became less frightening to them. More translators became available, and as time passed, more women were conversant in English, and could understand the health care workers on their own. New refugees to the community were informed by their co-ethnic friends and family members about what to expect when they went to the hospital, and those that returned repeatedly to the hospital were no longer surprised by what was required of them. In fact, many women began to find that it was comforting to go to the hospital, because never before had they received reassurance from someone that indeed their baby was alive and healthy inside of them. They also

appreciated the comfort of being able to lay in a soft bed around the time of delivery. As they saw themselves and others go through the system and come out unharmed (usually), very often with healthy children, most began to believe that seeking prenatal care and hospital-assisted delivery was more beneficial than it was harmful, and family and community members began expecting pregnant women to seek medical advice.

Now, Mien women are considered the most compliant of all ethnic groups. They tend to come in earliest for prenatal care, and as one nurse practitioner put it, "if you ask them to stand on their heads, they ask you, 'for how long?'" This does not mean that the women have looked forward to going to the hospital, but certainly their participation in the medical system became less motivated by economic gain, which was coupled with trepidation, and more motivated by a desire to ensure an optimal pregnancy outcome.

Although Mien women have recognized some value in medical assistance, they do not believe that it is of primary importance. They seek medical assistance because it is available, and it is one more thing that they can do to prevent a poor pregnancy outcome. However, animistic etiologies are still viewed as the most powerful, and the traditions associated with this belief have been imported as well. When a pregnant Mien woman becomes ill in Oakland,

her first choice is typically not to call a doctor, but instead to call a shaman. If, after the shaman has performed all of the necessary rituals, she is still not feeling well, she may consider calling a doctor. The shaman is routinely called by pregnant women to perform the ceremony for the 36 spirits (see earlier discussion), still viewed as a significant means of preventing harm to the developing child.

Many of the traditional precautionary measures are adhered to in the West, as they are in Laos. For example, the spirit of the fetus is believed to be present in the downtown Oakland apartment during pregnancy, just as it is in the bamboo house in the Laotian hills. When asked specifically where the soul of the fetus resides during the months that it is supposed to be in the rice pounder (as Western homes are not usually equipped with rice pounders), the informants reported that it was "somewhere in the kitchen." One building manager who leases to a large number of Mien families reported that he was not allowed to make repairs of any kind on apartments in which pregnant Mien women were dwelling.

Traditional dietary precautions are also adhered to. Although tigers are not known to be present in the East Bay, Mien women are skeptical about eating any type of food which may have been tainted by them. With the exception of duck, most of the dangerous foods are not available here anyway.

The setting for child birth in the West is obviously extremely different from the setting in the hills of Laos. Rather than retreating to their homes along with a woman helper, Mien women typically arrive at the hospital by themselves, and are ready to give birth at any moment. As was explained earlier, they are hesitant to express their feelings of any pain, as this may only intensify it, as well as prolong labor. One nurse reported that, "often the only way you can tell when a Mien woman is about to deliver, is when you see her face turn a little pink."

At times men will assist their wives to the hospital, but, as in Laos, the men stay away from the delivery room. One male Mien translator is often required to assist in deliveries. He avoids offending his spirits by not speaking during the actual delivery. As long as he does not speak, the spirits do not believe he is acknowledging the event, and they are not offended. "Fortunately," he said, "this hospital has a policy of not speaking during delivery. So I am safe in there."

After the child has been delivered, the placenta is taken away by a nurse. This procedure is acceptable, as it is felt that the nurses are capable of hiding the placenta from the spirits. Some Mien women are careful to ask the nurses not to elevate the placenta above the bed, as this may lead to the child's fear of heights, as described earlier.

As in Laos, the mother is given her child to hold after it is born. However, in the hospital, she may only hold it for up to 2 hours. After that, the child is taken to the nursery to receive any necessary injections or tests, and is returned to the mother after an additional 2 hours. It would seem that this procedure could be quite upsetting to a woman who in her homeland was afraid to let any outsider look at her child, let alone inject the child before a shaman has prepared it for such events. However, the Mien have expanded their definition of a household to include the hospital in the cases of a newborn and post-partum woman. Thus, it is considered safe for anyone in the hospital to see or handle the child, but the child must be taken directly from the hospital to its home, where it can safely await the day that the shaman comes over to conduct the birth ritual. The injections also do not seem to disturb the Mien. Surely most of the early-arriving refugees were unaware that their children were being injected when they were taken away to the nursery. Now that many of them understand English, and those that do not have access to translators, they are aware of the procedures that are integral to the standard protocol for newborns. And with this knowledge, they are not opposed to the procedures. Again, this seems to be the result of seeing numerous healthy children emerge from the hospital, and feeling confident that it is generally beneficial to adhere to

medical advice that is given regarding pregnancy and childbirth.

One significant factor which has allowed Mien to adhere to much of the medical advice that is given them, is that often it does not necessarily involve going against traditions - at least not in the hospital. The reason for this, is that the Mien have shifted their behaviors in such a way that they can accommodate the requests of the medical establishment as well as their own needs. The two sets of requirements seem to exist side by side while the woman is in the hospital. She gives birth in a delivery room, and then sits up in her hospital bed for the first several hours, so that her "insides return to normal." The nurses request that the post-partum woman eat a meal at some point after her delivery. The husband typically delivers this meal, but first he prepares the pepper and ginger tea, which the woman drinks before her small meal, composed of chicken, rice and greens. The baby is returned from the nursery with a cap on its head (at Highland Hospital in Oakland this cap used to be white, until it was discovered that in Mien culture, white symbolizes death. Now the caps are blue and pink-striped). Although many health care workers may not be aware of it, the cap is preventing wind from blowing into the baby's soft spot. While in the hospital, women are careful to avoid allowing anyone to praise her child, and many health care workers are aware of this taboo.

Once the mother returns home with her child, the hospital rules no longer apply, and she and her family are responsible for delivering proper care to the newborn, as well as to herself. This means that someone is there to help her, as she is not able to cook (in Laos she must stay away from the coals, but in the US, she is to stay away from the electric stove. Contact with either of these results in illness later in life). Although in the hospital she was told not to take baths, but only showers, she takes as many as 3 baths per day. She places herbs in these baths which are similar to those found in Laos. She was also told at the hospital not to bathe her child more than once or twice in the first week, but she bathes the child at least 3 times every day.

The shaman is called on the telephone, and an appointment is made for him to come to the house to perform the first big ceremony for the child. A live chicken is purchased for the ceremony, and the ritual proceeds, just as it does in Laos.

The post-partum Western Mien woman usually cannot sleep by the fire, as most Mien homes do not have fireplaces. Instead, she sleeps in her room and an electric heater is placed at her bedside. Her husband sleeps on a separate mattress, on the floor.

Visitors are discouraged from entering the house for the first 30 days, and the first visitor to contact the baby

at home is named as its godparent. Again, if the baby is sick, or cries excessively or fails to grow, a shaman consults the spirits in order to find out how the godparent may satisfy their wishes. Bridge-building ceremonies are conducted in the West and rather than finding wood in the jungle, the materials are purchased at a hardware store. The ceremony for the 36 spirits is also performed in the West, but all-purpose white flour is used to construct the animal figures, rather than banana root.

Conclusion

The adaptation of Mien women to Western methods of pregnancy management and delivery corresponds to models of refugee adaptive behavior outlined by Scudder and Colson (1982). In particular, the concept of cultural involution is relevant to this set of events. However, unlike the problematic situation in which cultural involution has prevented integration into the new community, surprisingly, the Iu Mien have found ways to continue their traditions without excluding themselves entirely from the outside community. This ability to maintain traditions has buffered

the newness of the procedures in which they are called upon to participate. In addition, it has provided them a way to maintain and pass on cultural norms and the beliefs that correspond with them. Their ideas about reality are founded on strong animistic explanations, yet they are interacting in a functional manner with members and institutions of the outside community which have a very different constellation of basic truths that guide them.

The Iu Mien have arrived at this strategy for coping with the outside world which enables them to abide by their own traditions as they begin the practice of the "new traditions" of the West. As the generations pass it is unlikely that these differences in belief systems will be maintained. Certainly, the power of the outside community will grow in strength as more Mien children become exposed to it in schools, the work place and social settings. For the time being, it is comforting to see this group of relatively new refugees maintain its cultural tenets despite forces of the new community which seem to threaten them.

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