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The Meaning of Giving Birth
Voices of Hmong Women Living in Vietnam

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ABSTRACT
Increasing knowledge about the sociocultural context of birth is essential to promote culturally sensitive nursing care. This qualitative study provides an ethnographic view of the perspectives on birthing of Hmong mothers living in the highlands of Vietnam. Unique cultural beliefs exist in Hmong culture about the spiritual and physical world as well as ritual practices associated with childbearing. This includes variations of ancestor worship, reincarnation, and healing practices by shamans. Traditionally, Hmong families take an active role in childbirth with birth frequently occurring in the home. Situated within a large collaborative anthropology project, a convenience sample of 8 Hmong women, who had recently given birth, were interviewed regarding the perinatal experience. In addition, ethnic traditional birth attendants (midwives) and other village women contributed perspectives providing richly descriptive data. This ethnographic study was conducted during 6 weeks of immersed participant observation with primary data collection carried out through fieldwork. Data were analyzed to derive cultural themes from interviews and observations. Significant themes included (1) valuing motherhood, (2) laboring and giving birth silently, (3) giving birth within the comfort of home and family, (4) feeling capable of birthing well, (5) feeling anxiety to provide for another child, and (6) embracing cultural traditions. Listening to the voices of Hmong women enhances understanding of the meaning of childbirth. Gaining greater understanding of Hmong cultural beliefs and practices can ensure childbearing women receive respectful, safe, and quality care.

Key Words: childbirth, culturally competent healthcare, Hmong women

Women’s childbearing practices are inevitably underpinned by culturally distinct values and beliefs. Understanding cultural perspectives on childbearing is essential to guide nursing practice, recognizing that cultural differences exist both within and between societies. The purpose of this study is to gain an understanding of the meaning of childbirth among Hmong women living in Vietnam. This research provides an ethnographic view of Hmong ethnic minorities whose perspectives on birthing lead to clinical insights as to how to provide quality care for women in the context of culturally varying health ideologies.

BACKGROUND
In the community in Vietnam where this research was conducted, Hmong are considered an ethnic minority group. Hmong are dispersed across Southwest China and Southeast Asia and generally practice subsistence rice farming. More recently, Hmong women have become involved as trek guides, in addition to selling handicrafts for economic support.

Hmong religious practice is based on an oral animist tradition (ie, in which the world is understood to be “animated” by multiple spirits) with a rich repertoire of ancestral rituals. Hmong concepts of the person are rooted in this ancestral tradition, and Hmong ritual practices revolve around maintaining positive relationships with ambient and ancestral spirits.
Childbearing and childrearing play an essential role for Hmong women. Upon marrying, a Hmong woman usually leaves the birth home and the nuclear family to join the husband's clan. Healthcare and decisionmaking may be determined by family and clan, especially respected elders.

Development over the life course is marked by significant ritual from birth and receiving a soul to becoming a venerated ancestor. There are many beliefs about the physical and spiritual world, as well as rituals and practices associated with childbearing. Traditionally, Hmong families take an active role in childbirth, with birth frequently occurring in the home when feasible. The continued prevalence of home births varies from country to country. Hmong traditional midwives may also be utilized to attend women giving birth at home. Other traditional healthcare practices include a range of healing practices that span spiritual and herbal cures treating both the body and the spirit.

The global Hmong community has spread across 5 continents over the past 40 years secondary to wars, conflict, and refugee resettlement. From 1975 to 1997, approximately 150,000 Hmong refugees from Laos were resettled in the United States, with a second wave of 15,000 in 2004 to 2006. According to the 2010 United States census, 260,073 people of Hmong descent reside in the United States. These figures are broadly understood to undercount the population, which Hmong studies scholars often estimate is closer to 350,000. There are Hmong living in all 50 states, with the largest populations in California, Minnesota, and Wisconsin. Between 1990 and 2010, the Hmong population in the United States increased a remarkable 175%. Inevitably, there are variations in beliefs and practices across individuals and communities, but striking similarities exist in religious and ritual practices across these now distant communities—including birthing practices such as placenta burial and the most common meanings of such practices. The commonalities in cultural practice across Hmong communities are worth noting for nurses who care for Hmong women and families. While healthcare practice and related ideologies are certainly changing as Hmong interact with new types of healthcare, traditional Hmong health beliefs are also being perpetuated in these resettlement communities.

LITERATURE REVIEW

There is a paucity of literature on the meanings of childbirth among Hmong living in their country of origin, with few exceptions, focusing on Hmong in Thailand. The majority of literature on childbirth among the Hmong population was published greater than 10 years ago, with most reported research focusing specifically on Hmong women who have migrated to the United States. Against this backdrop of literature dealing primarily with Hmong health beliefs and practices in the United States and Thailand, this research provides ethnographic data on Hmong childbearing experiences in the northern highlands of Vietnam.

Some studies with Hmong refugee women document that conflicts may arise between western approaches to giving birth and traditional Hmong childbearing beliefs. A history of legally imposed healthcare (court-ordered Cesarean births and court-mandated child healthcare against the will of parents) in the United States has led to distrust and other problems for Hmong in American healthcare settings. These problems could be dramatically overcome by a more grounded cultural understanding of Hmong women.

Studies focusing on Hmong childbearing conducted in participant's countries of origin include 2 in Thailand describing family decisionmaking surrounding perinatal healthcare and Hmong birthing practices. Research with Hmong in Australia includes women experiencing a perinatal loss and Hmong perceptions of giving birth. Research conducted in the United States with Hmong refugee women included healthcare decisions describing the tension of authoritative knowledge between Hmong traditions and western medicine; placental disposal; postpartum health constraints; and a comparative study contrasting Hmong childbearing women’s birth practices in Thailand and Minnesota.

METHODS

Following institutional review board approval and informed consent, data collection took place in 6 rural Hmong villages in the area surrounding Sapa, near the border of northern Vietnam and China. Situated within a large collaborative medical anthropology project, a convenience sample of 8 Hmong women (n = 8) who had given birth within the past 17 months participated in the study. Snowball sampling was utilized, as women referred the investigators to other Hmong women who had recently given birth. Following completion of demographic information, interviews were conducted using a 22-question, semistructured interview guide. The guide has been utilized with diverse cross-cultural groups of women in North, Central, and South America; Asia; the Middle East; Eastern Europe; the Pacific Islands; and Scandinavia. Interview questions were adapted from a guide suggested originally by Nichols, including “What did you do during your pregnancy to prepare to have your baby?” and “What words describe how you felt when you first saw your baby?” This ethnographic study was conducted during 6 weeks of immersed participant observation. Women specifically on Hmong women who have migrated to the United States. Against this backdrop of literature dealing primarily with Hmong health beliefs and practices in the United States and Thailand, this research provides ethnographic data on Hmong childbearing experiences in the northern highlands of Vietnam.
were asked to respond to interview questions on the basis of their most recent birth experience. Several interviews took place during one interaction and others with return encounters, determined by participant preference.

Field notes were kept capturing inflection, emotion, and other nonverbal responses to incorporate into data analysis and generation of themes. In addition to the 8 Hmong mothers, ethnic traditional birth attendants (midwives) and other village women contributed their perspectives providing richly descriptive data. Observations, impressions, and insights were carefully recorded. Saturation occurred when information became repetitive and data were fully explored. It was not feasible to contact study participants to conduct member checks. Each woman’s birth experience was uniquely hers, but similarities emerged from the data. Interviews were conducted in both Hmong and English, depending on the languages spoken by participants. Interviews conducted primarily in Hmong were interpreted by fluent Hmong-speaking team members. Demographic data and interviews were digitally recorded and transcribed or translated when needed.

Gathering qualitative data from participants thinking and communicating in another language offered unique challenges, although some of the participants spoke English as a second language. The researchers attempted to convey the attitude, “Teach me” or “Tell me about your birth.” Gaining rapport that crossed cultural boundaries with a sense of connectedness and sharing was an important part of ensuring trustworthiness of the data. Engaging in “small talk,” particularly about their infant and the details of the study participants’ lives helped facilitate communication. Simple and clear grammatical sentence construction enhanced understanding, with some questions rephrased for this specific cultural group of childbearing women. Changes were made in the questions to help overcome linguistic differences in how emotion is expressed. For example, in place of asking the question “how did you feel when you saw your newborn for the first time?” researchers found it more effective to ask, “what did you think in your heart when you saw your baby?”

As appropriate in ethnographic studies, primary data collection was carried out through fieldwork. The first and third authors conducted the interviews in Vietnam in June 2015 and were engaged participant observers, participating in face-to-face, day-by-day contact with Hmong women. They consulted electronically with the second author who is an experienced global nurse researcher. The investigators also consulted in country with the fourth author, an ethnographic research consultant and anthropologist who has conducted years of research with the Hmong people. This prolonged engagement contributed to the trustworthiness of the data. Researchers reflected on the sociocultural context of the study participants and attempted to represent the perspectives of the study participants when analyzing the data.

Trustworthiness of the ethnographic data was ensured by establishing credibility, transferability, dependability, and confirmability. Methods to ensure trustworthiness included establishing credibility through prolonged engagement, persistent observation triangulation, and peer debriefing and establishing transferability through thick, rich description.

Dependability was established through frequent consultation with members of the research team. Members of the research team analyzed the data independently and concurrently with data collection, engaging in reflection. Data analysis consisted of a cultural discourse analysis, in which transcripts and field notes were analyzed to inductively derive cultural schemas—or themes—from interviews and observations, as well as to explicate the cultural meanings behind these themes. Data were evaluated and iterations of preliminary themes were developed into the final themes, using guidelines appropriate to ethnographic inquiry about the meaning of lived experiences. Confirmability was established by triangulation of data sources including Hmong childbearing women, birth attendants, and village women.

RESULTS
As noted in Table 1, 8 women participated in the study, ranging in age from 20 to 38 years. Four of the study participants had no formal schooling; the others had 5 to 9 years of schooling. Two were not employed outside the home; others were street vendors, farmers, shop owners, and trek guides. The number of pregnancies ranged from 1 to 12; the number of living children ranged from 1 to 12. Five gave birth at home and 3 in the hospital. Those assisting with the birth included husbands, mothers, mothers-in-law, other extended female family members, and physicians.

This research provides insights into the perceptions of childbirth in Hmong women living in the highlands of Vietnam. Significant themes were identified and include valuing motherhood, laboring and giving birth silently, giving birth within the comfort of home and family, feeling capable of birthing well feeling anxiety to provide for another child, and embracing cultural beliefs and rituals.

Valuing motherhood
Bearing a child is spiritually significant in that it represents the entry of multiple spirits into the body
of the newborn. Responses to inquiries about not having children help illuminate the value of children to Hmong women in Sapa, Vietnam. Infertility is considered a tragedy, since motherhood is the primary role for women. Hmong women are concerned about being infertile until one actually gives birth to a child. One mother spoke of being without children, saying, “the whole family won’t have joy . . . . It looks [to others] like she isn’t liked by her husband. Other people have joy [xyiv fab], but she is sad.” The social value of appearing publicly desirable to one’s husband was a common theme. On a more personal level, this response shows the private sorrow a woman might have if unable to give birth to a child and subsequently seems to equate having joy with having children.

A study participant reported, “if you can’t have a baby, the husband will yell at the woman saying, ‘Why can’t you have a baby? If that’s the case, I’ll marry another woman.’ Then [she] will be sad.” Often times, “marrying another woman” means having another woman enter into the house in a polygamous union. While polygamy has been historically practiced by a significant minority of families in Hmong society and is commonly seen as acceptable, polygamous relationships are linked to the private stress of permanently sharing home and responsibilities with another woman. This may result in de facto separations between the husband and an older wife, even if the couple remains formally married.

While polygamy is a possibility looming in a woman’s mind if unable to have children, adoption may help relieve the stress of infertility, There’s only a few cases where the husband will only stay with the one . . . . There’s a few men who think it over and just adopt children instead of marrying a second wife . . . . That couple over there, they just adopted two children . . . . That couple is one of the happiest couples because he didn’t marry a second wife.

Given that adoption often includes a monetary transaction and can drain household resources, this woman’s comments reinforce the value of having children.

Some of this valuing of children may be seen as a long-term investment, including help with farming, providing care in old age, and performing rituals to provide for the parents, who will themselves become ancestors, after death. Gender is crucial to fulfilling ritual roles, because only sons carry the clan name and do rituals for the lineage. A mother said, “it is very important to have at least one boy.” A participant, who gave birth to 12 daughters, said that her husband was unhappy that he did not have a son. Another woman explained that “boys . . . have to take care of the parents when they are old.” If no one can provide for the parents in the afterlife, the parents may become wandering, vagrant spirits, begging or stealing in order to survive. This may include ransoming or tormenting the spirits of living people—often a person’s own descendants—and causing illness in the process.

### Laboring and giving birth silently

Hmong women describe a tradition of laboring and giving birth stoically, since crying out may cause the child to fear being born. A mother said that during her birth, “I no screaming.” Another woman said, “You just stay
quiet. If you scream and cry, then the baby goes backwards. Our Hmong traditions are to just be quiet and the children won’t think anything and will come out quickly.” This is consistent with the common broader idea that loud sounds, sudden jolts, or other sharp discomforts can disorient spirits or even cause a spirit to separate from the body, thus resulting in significant health problems. A study participant expounded on this link between mother and child during labor, “If you cry, then the child is scared and they go backwards and they won’t go out.” A new mother further reported that for home births, women take Hmong herbal medicine, including the roots of the indigo plant, which are boiled and mashed with water.

**Giving birth within the comfort of home and family**

Home birth was most often preferred among study participants. Women cited the desire to give birth at home because the costs of hospitalization were prohibitive. Another barrier is unreliable transportation. Some homes require as much as a 40-minute drive on a motorcycle on a rough road to travel to the nearest hospital. Study participants felt comfort and control could be maximized in the woman’s own home as demonstrated by this comment,

> I think mostly Hmong [are] born at home. [At the] hospital, we need to pay much. So most people, they don’t want to go to the hospital. If [labor is] too difficult for two or three days then they have to go to hospital. But mostly they do it at home.

Another barrier to seeking hospital care includes a perceived lack of control of the birth experience. Hmong in Vietnam, Thailand, and the United States commonly perceive that once one decides to go to a hospital, one cedes control over decisionmaking process to the hospital staff. A participant describing the difference between home and hospital births said that a home birth was preferred, but the husband was worried about complications, “So we had to go to [the] hospital because he wanted baby and me both to be safe.” The participant stated that the husband had learned in school that a hospital was safer. Further explanation was given that a hospital birth is not as comfortable as giving birth at home. “When you [are] at home, everyone’s like a friend or family, so you feel more comfortable … When you go [to the] hospital, the doctor [tells] you how to do—[then] you have to do—You can say nothing.” This mother explained that subsequent births would be at home as a result of this experience at the hospital.

A participant said that birth could be handled well in the home and that sometimes giving birth in the hospital led to a longer recovery. The comment was made that some women were afraid to give birth at home, but this woman’s response was that it was more frightening to give birth in the hospital. Some study participants noted that only in the case of prematurity or obstructed labor would hospital services be accessed. Others did not trust giving birth in the hospital because of the potential of unwanted interventions such as episiotomies and Cesarean births. As one participant noted, “they cut you without asking.” Women were also concerned about the inability to take the placenta home for ritual burial.

Family presence is essential to Hmong women. One woman noted that what was most helpful during labor and birth was “to have someone who loves you there. If you don’t have support you really don’t want to give birth.” Another mother described a typical home birth saying that the husband must stay nearby when a wife is in labor. The husband is expected to be present when the infant is born. Sometimes, a woman keeps working and does not tell other people. This mother continued by stating that she was in labor all day in the fields and did not say anything until the contractions got stronger that evening. The husband was quietly told but not the others working in the field until the pains were very strong. This participant noted that the husband usually holds the woman from behind during the birth. The mother-in-law catches the infant and cuts the cord. Women are advised not to make sounds because it will either scare the infant and it will not come out or it will think that the mother is singing a song and will wait to come until the song is over. This participant commented that when the child was born, it hurt so much that she made lots of noise and cried out. The woman expressed feelings of joy and happiness when holding the child for the first time.

**Feeling capable of birthing well**

A study participant said that she prepared her heart to be strong for the birth. Discussion of birth with Hmong women in the streets and fields lends itself to such comments as, “It’s easier for us to birth [than other women] because we are stronger” or “we walk all day long, and don’t take rest before the baby comes, so it’s not so hard to have the baby.” When giving advice to her daughters about pregnancy, one woman said, “Hmong are hardworking. Even if we have children, we still worked hard like gathering firewood … and housekeeping. Having children should not interfere with your duties … You will be able to have the child quickly.” This mother expounded further,

> In a day you carry a basket/firewood rack then you go to cut a rack full to make food. You won’t have time to
One of the participants who led a group of trekkers to her home while at term and then gave birth silently in the home that night said that working in the mountains makes giving birth easy. Another mother said that it was the Hmong way to work right up until giving birth. Some women expressed fears of giving birth and being tired during pregnancy, but more commonly women told of having innate strength during labor and birth, attributing it to a physically demanding lifestyle. One woman said, “hard work helps the baby to be born.”

Feeling anxiety to provide for another child
While having a desire to have many children, some Hmong women also felt conflicted because of economic challenges. As a highland ethnic minority that is in the midst of a dramatic economic change, Hmong in Sapa live in relative poverty. A woman spoke of the challenge of poverty when having another child, “Going to work is hard so I worried about not being able to care for and feed my children.” Another mother spoke of being afraid that there would not be enough money to get clothes and take care of her children, saying, “I have a lot of children so when I make food I worried about not having enough for everyone. That’s one of the hardest things.”

A study participant stated, “when I am done having children I am able to be free.” While pregnant, this woman worried that the children would be born healthy. She described hopes after bearing children to fulfill a vision of buying land and building a guest home to receive trekking tourists for “village homestays.”

Embracing cultural traditions
Hmong in China, Vietnam, Laos, Thailand, and other countries commonly practice a set of postpartum taboos and dietary restrictions designed to help a woman recover from the depletion of birth. The Hmong term for this period, “nyob nrub hlis” literally translates as “to be in the middle of a month.” Study participants described this period as one in which the new mother is on bed rest for the first week and then has minimum activity for the remaining month, taking care only of herself and her newborn. Given the physical and psychological stress, as well as the fact that birth is a moment of transition where spirits and bodies are in transition, it is seen as a particularly vulnerable time for the mother. The concern is that, in a postpartum woman’s weakened state, one of her spirits may flee, causing significant illness or even death. To avoid this, common taboos dictate that a woman keep as warm as possible and avoid drafts, since a significant amount of blood has been lost. An abdominal binder is worn to promote uterine involution. Dietary constraints—commonly a simple diet of chicken with herbs and rice for this entire period—are thought to cleanse the uterus and provide strength for the woman to recover from the rigors of giving birth. A mother said, “In the month, you don’t go out . . . you don’t care for your own clothes but have the husband wash them.” Often women mentioned the specialness of being cared for by the husband after the birth. Attached to the niceties of having a husband do the work was also a sense of fear. For example, one participant said:

If we don’t do it, when we get old then our limbs will get weak. We just stay home and close our doors and windows. We’re not supposed to go outside because we can get sick. We follow these rules so we won’t have weak limbs and [are] able to live life better . . . . When you go out the weather will affect you. If you’re lucky, you won’t get as sick but if you’re unlucky you can really get sick and at times won’t be able to get up. You should just stay home.

Study participants noted that chronic health problems would result from not following these postpartum requirements. One elderly woman attributed chronic body pain to washing with cold water after giving birth. Another participant further reported that if a new mother “enters [another family’s] house, their household spirits won’t accept you … when you’re about to die, you won’t die peacefully.” Similarly, some Hmong subscribe to the idea that if another pregnant woman or even the husband of a potentially pregnant woman crosses the threshold of the home, then the spirit of the mother or the infant may wander off after the newborn, causing the mother’s milk to not come in properly. To guard against this, restrictions are set in place about who may enter the home.

Not all of the women in this study fully endorsed the idea of sicknesses resulting from breaking the taboos, as a mother clarifies: “There’s people that do say, ‘We go out and do things and nothing happened’ but later they get sick. We just stay home comfortably.” One of the participants explained that after the birth women stay by the fire in the house to stay warm. A postpartum woman must be completely covered with clothes and a hat and gloves to stay well even if it is a hot time. A woman eats the boiled chicken that the husband prepares. This participant further explained that women who generally exclusively breastfeed. If the newborn does not like the mother’s milk, the mother may try a little rice or eat papaya leaves to make more milk. This woman further explained that girls who are
poor sometimes cannot rest very long and must go back to working in the fields to get the rice planted or harvested.

The placenta—literally in Hmong a “child’s jacket”—plays a central role in both birthing and funeral ritual. For women who gave birth at home, the placenta is buried in a deep hole in the house. For sons, it is commonly buried under the central column of the house—the abode of the most prominent house spirit. For daughters, the placenta is typically buried under a post of the parents’ bed. At the end of life, one of the most essential Hmong funeral rituals guides the soul of the deceased to retrace every step of one’s life, back to the place of birth in order to retrieve the placental ‘jacket,’ which is picked up and put back on for the journey to the land of the ancestors. The placenta, therefore, becomes a crucial symbol of the cycle of mortal life. However, as births move out of the home and into the hospital, this key ritual element is potentially disrupted. While perinatal staff commonly discard placenta as common biomedical waste, a participant who gave birth at the hospital, described a place adjacent to the hospital available for placental burial. However, the uncertainty of what one can or cannot do with the placenta plays a critical factor in how Hmong perceive the value of home births versus hospital births.

**DISCUSSION**

This research provides a rounded view of the diversity of Hmong beliefs about birthing that can provide key clinical insights, whether working with Hmong in Southeast Asia or in the United States. Significant problems arise when nurses fail to understand Hmong perspectives on the nature of health issues or even misinterpret different understandings of health experience as “non-adherence” or a lack of a desire to be treated. These data assist nurses to provide culturally appropriate healthcare for Hmong women that will likely lead to positive clinical interactions and ultimately more optimum health outcomes.

A meaningful issue raised in this study is decision-making regarding the access to and whether or not women choose to use professional maternal healthcare services. Results from interviews in this study demonstrate that husbands, mothers-in-law, and other extended family and community members influence decisions in a collective decisionmaking process, rather than women making these decisions individually. This is also noted in other studies and coincides with a dual autonomy and community-based ethics in Hmong communities. Implications for clinical practice are noted in Table 2.

Given the communal nature of the maternal healthcare decisionmaking process in Hmong culture, nurses need to be aware of this decisionmaking process. It is vital for providers to understand how this process can potentially conflict with Euro-American norms of medical decisionmaking and seek to accommodate how these families make decisions by adjusting the way health information is communicated and consent for care is obtained. To increase hospital births, cultural practices can be accommodated and interchange with healthcare providers must be culturally sensitive. If the Hmong model of birthing is better understood by healthcare providers, key taboos and Hmong-specific understandings of spirits can be accommodated to provide effective care that better coincides with Hmong women’s desires.

A culturally competent nurse understands the importance of sociocultural influences on women’s health beliefs and childbirth practices. Social determinants of health have a significant effect on how women access and utilize healthcare appropriately, which has an impact on ensuring positive maternal and neonatal outcomes. Learning more about the meaning of childbirth in other cultures will increase nursing knowledge and promote cultural competency. Because

<table>
<thead>
<tr>
<th>Table 2. Clinical implications for perinatal providers working with the Hmong population*</th>
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<td>Develop a relationship based on trust and mutual respect for women with cultural variations</td>
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<tr>
<td>Listen to the voices of women to guide clinical preferences and care</td>
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<tr>
<td>Acknowledge the value and importance of bearing children to Hmong women</td>
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<td>Understand the importance of cultural practices surrounding birth in Hmong women and honor those that are helpful or harmless</td>
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<td>Recognize that healthcare decisions may be influenced or determined by extended family and community leaders</td>
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<td>Support efforts for those choosing to take an active role in childbirth with family member participation</td>
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<td>Recognize the importance of food preferences and restrictions in the childbearing period and the perceived impact on a woman’s lifelong health related to the adherence of these preferences</td>
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<td>Support dietary preferences where feasible (ie, hot/cold theory)</td>
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<tr>
<td>Promote World Health Organization guidelines for perinatal/neonatal care, specifically Sustainable Development Goal #3 “Ensure healthy lives and promote well-being for all at all ages.”</td>
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*From World Health Organization Statement.
of global migration and the increasing multietnic society of the United States that has the largest number of international immigrants in the world, nurses are caring for a markedly diverse population of women.\textsuperscript{51,52} Given that the United States has the largest population of Hmong residing outside of any Asian country, it is essential for nurses to be aware of cultural variances specific to this potentially vulnerable population of childbearing women.

Cultural values, beliefs, and traditional health practices have an effect on how Hmong utilize healthcare. In the present sample, there were a minority of women who preferred hospital births, but the majority of respondents tended to prefer home birth. In the United States, some Hmong have abandoned practicing traditional childbirth lifeways, others have not. Some Hmong live within cultural enclaves and have integrated into society while maintaining traditional ritual and birthing practices. Some childbearing women engage in evolving transitional customs. Care must be individualized with a careful cultural assessment of each childbearing woman. Presence represents a significant nursing intervention. As one study participant stated regarding providing support for laboring Hmong women, “Just be with them.”

Study limitations
A limitation of this study is that it may not reflect the experiences and perspectives of all Hmong women giving birth in Vietnam or other countries. Intercultural communication issues contributed to difficulty in understanding the emotional elements of birthing experience. This same limitation was noted in research with disadvantaged East Indian and Ecuadorian women.\textsuperscript{35,34} In addition, investigators confronted obstacles in mapping common terms onto emotional dimensions of birthing in interviews. For example, one smiling participant described in English the feelings after giving birth as, “You feel—I cannot tell you—it’s like very big!” To understand the emotional dimensions of the birthing experience, more research is first needed to better map the linguistic registers of emotional experience and to understand the cultural psychology of emotion in a Hmong context.\textsuperscript{35}

CONCLUSION
This qualitative study provides an ethnographic view of the perspectives on childbirth of Hmong mothers living in the highlands of Vietnam. Listening to the voices of Hmong women enhances understanding of the meaning of childbirth. Gaining greater understanding of Hmong cultural beliefs and practices can lead to clinical insights on providing quality care for women in the context of culturally varying health ideologies. Nurses can address needs of these women regarding the integration of traditional cultural practices with evidence-based practice to ensure quality health-care and satisfying birthing experiences. When cultural beliefs and practices are taken into account, healthcare professionals can provide respectful care to Hmong women leading to more positive health outcomes.

References