

A Hmong Birth and Authoritative Knowledge: A Case study of choice, control, and the reproductive consequences of refugee status in American childbirth

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Abstract

One area in which anthropologists are concerned is in examining what the state of good health consists of from society to society, and what happens when practitioners of western medicine intersect with people who hold other explanations of well being. This paper explores how the western medical practices of childbirth in America are forced on Hmong refugee childbirth, and therefore, used as a continuation of governmentality, or refugee objectification. Ethnographic data is drawn from a case study of Hmong experiences with the birth process in an American hospital setting. Parallels are drawn between refugee resettlement programs which ultimately produce bodies that are objects of the state; and authoritative medical knowledge in childbirth which produces bodies that are objects of medicine. This research suggests that the American birth process becomes yet another site of refugee reprogramming and a struggle between western medicine and the refugee's understanding of experience.

Key Words: South-East Asia, Hmong, refugee, governmentality, authoritative knowledge, reproduction

In focusing on the art of governing, Michel Foucault (1991) originated the concept 'governmentality' which he defined as the use of resources such as schooling, family life, the labor market, and mass media by the government to steer its citizenry into specific values and "good" behaviors. In an analysis of the strategies and techniques utilized in this form of control, Nikolas Rose (1999) described these institutions as "technologies power" used in governing and directing individuals to certain ends. Aihwa Ong (2003) extended this concept to the treatment of refugees examining how cultural categories were encoded in the technologies of government embedded in the refugee resettlement process of Californian Cambodians, suggesting that refugee incorporation is a series of lessons in what it means to be a "good" citizen. This psychosocial process of transformation begins in the liminal spaces of the refugee camps, where

migrants fleeing violence are prepared for their destination of ultimate freedom (Mortland, 1987).

For a refugee fleeing from violence, UN camps are set up to be a city of refuge. The controls of the nation-state the refugee has flown from are soon replaced by the camps regime whose objective has been argued, among others, to “adjust the physical and social body of the normalized values and hierarchies of their ultimate destination” (Ong, 2003:91). A sign posted at the Bataan refugee processing center in the mid 1980’s read, “The primary goal of our operations is achieved through a psycho-social recuperative process involving the critical phases of adaptation, capability building, and disengagement which result in changing a displaced person into an individual well equipped for life in his country of final destination” (Mortland, 1987).¹ As Foucault (1991) suggests that modern medicine is a prime mover in transformations that define and promote normative attitudes of subjects of the state, the body becomes a space for political transformation. On this line, Ong (2003) has detailed how the refuge body itself goes through a process of medical socialization that continues through their first years of citizen incorporation.

The physical aspects of stripping and re-building identity in the refugee begin when a country for resettlement chooses them. This process could be categorized as a form of machinery or governmentality that Foucault (1979) called creating docile bodies. He introduced the idea to explain policies of coercion that act on the body. For those coming to the US, that “machinery” begins with a three-day process of CDC screening of family member’s health (Mortland, 1987). Everyone over the age two is further screened for infectious tuberculosis, and those with active infections or suspected to be active are placed in quarantine and denied departure to the United

¹ This processing center was closed by the UNHCR in the late 1980s when post –Vietnam war refugee migration of Southeast Asians dramatically declined

States (Kemp & Rasbridge, 2004). Ong suggests this process not only acclimatizes the refugee to intercultural status hierarchies but presupposes them to a medical image as “the contagious other to the American body politic,” that is, biological categories of deviance and normalcy (94).

The machine continues upon arrival in America where a weeklong stay at a health-processing center schools refugees in the bureaucratic and medical definition of the modern subject. Their histories are taken, and they are given a physical examination and some blood tests. Every adult is given a test for syphilis, for TB and anemia. Children receive urine tests and audiograms to make sure their hearing is intact. Everyone gets a stool parasite check coming from Southeast Asia. Subsequent visits include pelvic exams for the women and dental screening for everyone. They are given hygienic items such as a toothbrush and toothpaste, deodorant and taught how to use them (Mortland, 1987). By the end of the this period, the refugee, who immigration authorities have read as a diseased and deviant bodies in need of control, have taken their first step toward citizenry. They have learned the crucial importance of yielding information and submitting to tests in order to generate a health record, and understand important daily rituals like brushing one’s teeth (Ong, 94). Their objectification is an important first step toward their transformation into docile bodies and, as a body of the state, important preparation for the American medical system, or biomedicine, as a whole.

The production of docile bodies has also been examined by medical anthropologists, specifically surrounding the use of western medical practices deployed in clinical child birth (Jordan, 1993; Sargent 1996; Davis-Floyd at al., 1997; Ketler 2000). This body of research suggests that authoritative knowledge, defined by Jordan as the knowledge which counts, in any given situation, produces bodies that are objects of medicine. She argues that this is produced in Western societies, by a structural inequality that is instituted as childbirth takes place under the

control of medical management from pregnancy through birth. As a result, biomedical technology and expertise is considered authoritative and a women's own knowledge of her body is delegitimated. In this process, women may lose confidence in their own bodies as they are encouraged to rely on biomedically-institutionalized authority.

Drawing on these concepts, my research on Hmong refugee incorporation assessed if parallels could be drawn between refugee resettlement medical programs which ultimately produce docile bodies that are objects of the state and authoritative medical knowledge in childbirth which produces docile bodies that are objects of medicine. Are the biomedical practices of childbirth in America that are forced upon newly arriving refugees in childbirth a continuation of governmentality, or refugee objectification? In the case where a woman enters prenatal care directly after encountering the medical system of refugee intake, are the biomedical practices associated with childbirth seen as a continuation of this process? And if so, in what context does it attempt to produce "good" citizens and what kind of agency do refugees show in the process? In an effort to understand how people in different cultures with different understandings of well being experience U.S. incorporation, this case study of a Hmong refugee expectant mother seeks to examine the use of authoritative knowledge in childbirth as a domain of "good" citizen-making.

Methodology

My research was conducted in 2005 in a town in the Dallas/Ft. Worth area of Texas where most of the 1200 Texan Hmong live (Nibbs, 2007). I gained entry into the Hmong community through the director of the Hmong American Planning and Development Center whom I had met in an interview. I have done ethnographic research with 40 families from this community over a six year period of time as the basis for my dissertation research in cultural

anthropology that examined the paths that refugee populations take in the course of belonging. The woman from whom this particular case study is drawn was introduced to me in 2005 when she and her family arrived from the Wat Tham Krabok refugee camp. I began this study on the week of her arrival in the U.S. and have continued in a research relationship with her family for the last six years. The reason I focused on this particular woman was a matter of timing. She had a child in the refugee camp less than a year before leaving Thailand and became pregnant again shortly after she arrived in the U.S. while already an informant in my broader research. Her circumstances situated her squarely between worlds and experiences of traditional forms of knowledge and western medicine surrounding childbirth.

This paper is based on a triangulation of information generated through participant observation, in-depth interviews, and research covering a number of issues concerning Hmong and American reproduction. Informants utilized outside of this family included the obstetrician, prenatal nurses, refugee service personnel, four male Hmong clan leaders, and a variety of Hmong women from the ethnic community. Interviews were conducted in English in the presence of a Hmong translator, a local Hmong college student hired as my research assistant, and all visits and interviews were either tape-recorded or video recorded for further analyses. The names, ages, and place of residence have been altered to prevent recognition.

I lived within a few miles of the informants and in an effort to establish a relationship with them, provided much of their initial transportation around town. Subsequently, I had taken the woman to the doctor appointment where she found out she was pregnant. I discussed the possibility of this research with her, and obtained signed releases to be with her at all doctor visits. I was also with the informant at the time she went into labor and provided her transportation to the hospital. Because of her lack of familiarity with the hospital system,

inability to communicate with the medical staff, and the lengthy time it took for other Hmong to get to the hospital (almost three hours), she asked if I would stay with her in the birthing room. The physician, whom I had established a relationship with over the course of her nine month pregnancy, allowed my presence through the entire birthing process, and granted interviews with me and allowed the same with her staff. During this time I operated as a true anthropological 'participant observer' recording notes, interviewing staff and physicians, offering comfort and assurance to both my informant and her husband who were nervous and unsure in their new surroundings, and held her hand in the birthing room as she welcomed her new baby.

Background

The case study revolves around a woman, who we will call Chua, who is one of the hundreds of thousands of Hmong Americans who currently reside in the U.S. namely, in California, Wisconsin, and Minnesota. She and her husband arrived in U.S. with one of the most recent waves of Hmong immigrants between 2004-2005 from the Wat Tham Krabok monastery in Thailand. Her family was the only one sent from Wat Tham Krabok to the small, roughly 1,200 member, Hmong community in Dallas/Ft. Worth Texas. The parents and other siblings of Choua and her husband were resettled far from them in the state of Wisconsin. Since her husband was able to find work in Texas right away, they decided to stay there. This income afforded them the opportunity to live alone in an apartment secured for them by the local refugee agency. Unfortunately, their residence was twenty-five minutes away from any other Hmong. At the time of this study Choua, who was born and raised in the refugee camp, was seventeen years old, married to a Hmong man a few years older than her, and they already had one child, a two year old daughter. Her experiences were of particular interest to me as her entire life, including

the birth of her first child, had taken place in the liminality of camp life. She found out that she was expecting another child within months of in Texas.

Findings: Perceptions of prenatal care/labor and birth/hospital stay

Three months after undergoing this process, Choua, my informant, became pregnant. Given a choice of providers, she requested a female physician and chose one recommended to her by human services for her cultural sensitivity.

Like her experiences with refugee camp medicine, her monthly encounters with American prenatal health workers were ongoing lessons in new bodily regimes relevant to the cultivation of behavioral traits such as checkups, vitamins, routine urine and blood tests. The process begins with a breast check, a pap smear, and various other tests for bacteria that require drawing a blood sample, and asking the women to collect some urine. Monthly to bi-weekly follow up visits routinely begin with asking her to get out of her own clothing and donning a generic paper gown, setting her on a paper covered table, measuring her stomach, checking her weight, taking her blood pressure, spreading her legs on stirrups for an invasive vaginal exam, asking her to urinate in a cup, and then drawing more blood. While clinicians focused on disciplining Choua's body to regulate her childbirth, they became unwitting players in the temporal structuring of refugee life. Not only were they socializing her to the expected norms of patient behavior, but also teaching her their own interpretation of the signs and symptoms she would experience as the pregnancy proceeds (Browner & Press, 1995:316). This, in essence, devalued her own experiences in deference to biomedical authority.

Choua thought the monthly prenatal visits were excessive, a constant invasion of her body, and inferred that something must be wrong with her baby. The biomedical reasons for these procedures was never quite understood as the facility had no Hmong translators and did not

offer to utilize the medical translation phone service on her behalf. She had given birth to a healthy child before in the refugee camp where this constant regulation of her body was not necessary. She especially bemoaned the routine taking of blood, as the Hmong believe that some soul resides in it. She often had trouble finding a ride to her appointments and missed or had to reschedule many of them. She was told by the nurse not to bring her two-year-old daughter with her to the appointments, but had no babysitter and did so anyway. Choua found the prenatal vitamins big and difficult to swallow, and in the absence of any understandable explanation for their use, chose not to take them. After the baby was born she disclosed to me that she had been uncomfortable with the vaginal exams but never voiced objections in fear that she would be seen as noncompliant. Always in the back of her mind, as was the case in most refugees I talked to, was the idea that if she didn't comply with these, or any American rules, she might be sent back to Laos. It was clear that the physician and nurse recommendations carried the all too familiar force of the medical processing she had just endured coming out of the refugee camp.

As the time to have the baby neared, the doctor voiced concerns to me that she hadn't communicated what labor pains were well enough and that Choua might not be able to recognize when to go to the hospital, find a ride, or a sitter for her daughter. This was in spite of the fact that Choua had already experienced labor with her first pregnancy. Since Choua had already begun to dilate, to avoid these potential problems, the doctor decided that she would induce her labor at Choua's next visit. The Hmong woman was told in rudimentary English "The baby coming Monday." Although Choua hadn't had any such crystal ball to predict the birth of her first child, she was excited that the American doctor was able to tell such things.

On the morning preceding the birth, the Hmong community threw Choua a baby shower. At some point during the party she mentioned that she had been having pains since the morning.

A group of relatives gathered to discuss whether she should go to the hospital now or wait like the doctor said for the baby to come on Monday. Since I had driven Choua and her family to the baby shower, I was brought into the discussion. Even though Choua was in labor, the husband repeatedly insisted that no action was necessary as the doctor knew, decisively, that the child would arrive on Monday. I intervened explaining that although all the technological use and testing they had undergone might appear to determine precision; the arrival of child was still somewhat ambiguous. They were not convinced. I was no doctor. Even though his wife described her pains as similar to the ones that preceded the birth of their first child, such knowledge conflicted with their rationality for why his wife had endured all those invasive prenatal visits – that they were a path to such certainty. After nearly an hour of negotiation between the husband and relatives, he decided that an English-speaking relative and I should accompany his wife to the hospital to get evaluated.

Bridgette Jordan (1993:152) in her explanation of the concept of authoritative knowledge explains how the overwhelming use of technology leads women away from embodied knowledge and legitimizes this alternate way of knowing. In just nine months, although Choua had already had a child, she clearly doubted her own ability to determine if she was in labor. Thinking, in essence, “If the doctor said Monday, my body must be wrong.” The rapidity in which she abandoned her own embodied knowledge suggests that refugee women might be particularly vulnerable to medical objectification.

Immediately upon arriving, the hospital staff connected Choua to multiple machines, drew blood, and gave her an IV. When I asked how this differed from her first birth she said, “We didn’t have all these machines. I don’t know what’s wrong.” The husband looked at all the equipment and told the Nurse that he had once worked with a doctor in Thailand, hoping this

would privilege him to some information about what was happening to his wife. After an examination, the nurse told me that Choua was not really in labor, nor had her cervix dilated any more since her last visit. The doctor, however, was going to induce the labor to insure the baby was born in what she referred to as a “controlled” environment. The nurse then went into the room with the Hmong couple and told them none of this information. She simply smiled and said. “We are going to have a baby!” The husband was relieved that he had decided to rush his wife to the hospital, albeit sad that he hadn’t time to go home and perform a traditional ritual to prepare the arrival of new souls, which he explained as his need to ask the blessing of his ancestors on the new arrival and a healthy outcome for the child and his wife.

Up in the labor room Choua was attached to more equipment. The husband stood by them and stared. After the birth they confided in me that they were scared because of not knowing what to expect. Choua asked for something to help her with the pain. Within minutes an anesthesiologist entered the room rolling a large machine with him. Seeing that Choua and her husband were visibly frightened, I asked the nurse to wait to perform this procedure until the interpreter was back from her break. “It’s just an epidural for her pain. She’ll be OK.” The nurse said, pointing out that they had signed release forms when they arrived.

When the translator returned, the nurse asked Choua if there was anything special she needed or wanted done differently because of their culture. Unaware of what was going to be different in the upcoming moments from their “culture.” they just nodded no. After the birth Choua told me that the refugee camp stressed that they should do whatever the physicians tell them. She equated this blind obedience with good citizenship. In this way I could see how the refugee regime and obstetrician had become unwitting partners in the production of both authoritative knowledge and forms of citizenship.

Obstetric intervention continued throughout the birth. When having difficulty pushing the baby out, Choua asked for help, to which the doctor interpreted as a request for vacuum suction, a procedure she had never even heard of. In a later interview Choua said that she thought they were just going to stand her up so the baby could “come out.” She was also given an episiotomy without her knowledge, something she later resented because she hadn’t needed one with her first child.

After the baby was born their new daughter was brought to Choua’s room. Upon instinct and centuries of tradition she removed the baby from the bassinet and placed it in the bed next to her. She was saddened that the nurse kept removing her daughter and telling her “You’ll suffocate the baby. Baby die!” In the hospital she also experienced a sense of intrusion, helplessness, and shame every time the nurse would pull back the blankets and change her sanitary napkins for her. “I can do it.” She said. “I can do it.”

When asked to articulate her satisfaction with her birthing care, I was surprised that although many aspects of it were intimidating and uncomfortable or its usefulness undefined, Choua believed that the hospital with all its equipment must have been safer than a homebirth and that as long as she could bring home a healthy baby, the means had been justified. The intrusive biomedical authority in their new home of resettlement now seemed reasonable and right.

Discussion and Conclusion

Although these health providers were well-meaning and sympathetic to the fact that Choua was a violence-induced migrant, “doing something” to help her acclimate to life in America meant “the use of the trappings of cultural sensitivity in a limited, strategic fashion to win her cooperation, facilitate diagnosis, and buttress the doctors’ authority, rather than to give

equal time to relative biomedical knowledge” (Ong, 2003:102). As a result, the childbirth that was once a natural process for the refugee, under Western medicinization, became yet another pathology they didn’t know they had. Like brushing one’s teeth or using deodorant, authoritative knowledge socializes the refugee into how this aspect of life should be conducted. Medical objectification, especially as experienced in childcare, is not limited to refugees, indeed, there is much discussion of how this is experienced by many women across the U.S. However, coming directly from the experiences of medical reprogramming in refugee processing to the routine medicalization of the prenatal and childbirth process, such systematic medicalization has an increased potential to be absorbed as a continuation of the schooling for what it means to be an American. Therefore, in the same way that refugee resettlement programs produce docile bodies that are objects of the state, authoritative knowledge in childbirth produces docile bodies that are objects of medicine.

In this way, Authoritative knowledge in birthing care may become yet another site of refugee reprogramming, or governmentality, and a struggle between biomedicine and the refugee’s understanding of experience. As a case study, this research is limited in its ability to determine how the understanding of authoritative knowledge differs in refugees with longer pauses of time between in-processing and childbirth, or the ways in which refugees begin to exert agency against such processes in subsequent child births, or what effects these processes might have on cultures at large. However, there has been enough correlation demonstrated between the refugee medical intake process and American childbirth practices to suggest that it can be experienced by new arrivals as an additional domain of good citizen making, and therefore, warrants further research in our understanding of the refugee experience.

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