

HMONG PREGNANCY PLANNING GRANT

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PURPOSE OF PROJECT AND RELATIONSHIP TO SSA TITLE V MATERNAL AND CHILD HEALTH PROGRAMS

The data related to adolescent pregnancy reflect great health disparities. In 2000 Asian American/Pacific Islander [AA/PI] teens of Ramsey County, Minnesota accounted for less than 15% (14.3%) of 15-19 year old females in 2000. Yet this demographic group accounted for over 28% of all births to teens and 38.0% of all repeat teen births in the same year. By comparison, almost 70% of females in this age group are white, however, they accounted for less than 30% of teen births in 2000. It has been a long held belief by adolescent pregnancy prevention professionals in Minnesota that with the Asian American population, the Hmong experience an even higher rate of teen births. Given the current measurement strategies of the Minnesota Birth data it is not possible to easily assess births in the Hmong community. This population is simply collapsed into the Asian American population. Yet the Hmong are quite unique among Asian American/Pacific Islander population.

By origin, Hmong are an indigenous hill tribe native to Southern China and Southeast Asia. Battles between the Chinese and the Hmong forced the Hmong people to migrate into Laos in the early 1800's.ⁱ From 1961 to 1973, thousands of Hmong soldiers aided the Central Intelligence Agency and were involved in a secret war. In 1975, when American forces withdrew from Indochina and the Lao coalition government fell, the communist party initiated a plan to eliminate the Hmong from Laos. Many Hmong were forced to flee to refugee camps in Thailand.ⁱⁱ

Since the end of the Vietnam War in 1975, Hmong began resettling from refugee camps to various Western countries. The majority of Hmong refugees were able to resettle in the United States — particularly in California, Wisconsin and Minnesota.ⁱⁱⁱ

According to the 2000 US census, the Hmong population in Minnesota has increased by about 150% in the past ten years.^{iv} Nearly 45,000 Hmong live in the state. More than 92% of the Hmong population lives in the two most populous counties in the state, Hennepin and Ramsey. With approximately 26,000 Hmong inhabitants, the city of St Paul has the largest Hmong concentration of any U.S. city.

Challenges of Hmong Youth. The Hmong have faced numerous challenges that play a unique role in adolescent sexual health. Formerly in Laos, the Hmong did not socially recognize the period of adolescence. In Laos, puberty served as an indicator of adulthood for the Hmong. Youth were not considered adults in the Hmong community until they were married and had children.^v Thus early adolescents, especially girls, might marry as young as eleven years old and bore children shortly thereafter.^{vi}

By necessity, Hmong youth live between two worlds. They often find themselves caught between the traditions of Hmong elders and the American adolescent experience. Many of the adults continue to speak only Hmong and observe many traditional practices that can influence the youth, including early marriage and childbearing. The majority of Hmong youth have adopted Western ways of speaking, thinking, and behaving more quickly than their parents. This often results in loss of parental influence and control. Increasingly these stresses can also contribute to alienation in Hmong youth, breakdown in Hmong families, early marriage, and ill-timed pregnancies.

Little has been written about how adolescent development and parental involvement is confounded within an immigrant family.^{vii} Parents who grow up in one culture and raise their children in a completely different setting have added pressures of acculturation and assimilation. Immigrant parents often want to raise their children

according to their traditional ways and customs, but these traditions may conflict with the dominant society's cultural norms. Such is the case of the Hmong.

Bronfenbrenner's ecological model^{viii} encourages the examination of several different layers of influence when attempting to understand phenomena. Lao Family Community [LFC] strove to understand individual, peer, familial, and community factors related to adolescent sexual health, particularly as it relates to adolescent pregnancy. This multi-faceted study served to examine Hmong perspectives on adolescent sexual health in hopes of developing an effective adolescent pregnancy prevention program for this community.

This work informs our understanding of the health of child-bearing women in the Hmong community. Given the prevalence of adolescent childbearing in this community, the findings should promote the efficacy of various programs designed for the Hmong in states such as Minnesota, Wisconsin, and California. Findings will be publicized through presentations and publications.

GOALS AND OBJECTIVES

Given the lack of information in the literature regarding Hmong adolescent pregnancy, it was beneficial to collect a variety of data to examine the issue from different perspectives. Three primary goals were addressed through LFC efforts: (1) Conduct a thorough and accurate needs assessment in the area of Hmong adolescent sexuality, pregnancy, and marriage and establish baseline data; (2) Develop abstinence education approaches that are culturally sensitive and age-appropriate to meet the needs of Hmong adolescents, ages 10 to 18; (3) Develop a more effective abstinence-only

education program that targets the prevention of Hmong teen pregnancy and premature sexual activity.

To reach these goals, the objectives for the grant period included the following:

(1) Increased understanding of the attitudes and behaviors regarding teen sexuality among youth, parents, and leaders in the Hmong population in Ramsey County; (2) Increased understanding of attitudes and behaviors regarding abstinence-only education for Hmong teens among youth, parents and leaders in the Hmong population in Ramsey County; and (3) An improved abstinence education curriculum for Hmong youth.

METHODOLOGY

The majority of the work was undertaken to address objective one: Increase understanding of the attitudes and behaviors regarding adolescent sexuality among youth, parents, and leaders in the Hmong population in Ramsey County. The breadth of this study required multiple methods to be used. A multi-pronged approach was taken to address the goals and objectives related to this grant.

Literature review. Search engines were used at the University of Minnesota. Key words in the search included words such as Hmong, Asian Americans, pregnancy, adolescence, and parenting. Each of the articles was copied to insure that they were on hand for the remainder of the study. The literature was summarized into a thirty page paper with 52 references. A graduate student worked on this project for 432 hours and received \$15.00 per hour for her time. Editing and supervision were included in the \$1,400.00 per month fee of the research consultant.

Birth record data. In order to understand the prevalence of Hmong adolescent births, birth record data from the seven-county metro area were reviewed for the years

1990 to 2000. The Hmong were discerned from other Asian Americans by name — either the mother or father having a Hmong first or last name. Marline Spring of the University of Minnesota completed this task after receiving special permission from the Department of Health. Spring required 31 hours to complete this project and charged \$100.00 per hour. The report writing was included in the \$1,400 per month fee of the research consultant.

Interview data. A semi-structured interview was developed based on the current literature available on the Hmong community and adolescent sexual health. The questions were reviewed by the project advisory board and the staff at Lao Family. Revisions to the questions were made after the first five interviews to enhance the young women's comprehension of the questions.

Forty-four young Hmong mothers were recruited in the Ramsey County area in Minnesota. Recruitment was done through word of mouth, flyers, and newspaper ads in the two local Hmong papers. All young women interviewed met the following criteria: (1) age 20 or younger; (2) pregnancy before the age of 20; and (3) a member of the Hmong community. Attempts were made to recruit both mothers who are currently in school and those who are not.

Prior to the interviews the mothers were provided the list of questions to be discussed. The young women were informed to respond only when they were comfortable doing so. A \$50 honorarium was provided to each of the respondents for their time. The interviews were taped and then transcribed to allow for analyses. Nine of the interviews (20.5%) were conducted in Hmong and the remaining 36 (79.5%) were

conducted in English. The interviewers included three Hmong females ($M_{age} = 23.5$) and two Caucasian females ($M_{age} = 37.5$).

The Hmong interviewers worked for 89 hours and received \$15.00 per hour. The Caucasian interviewers did not receive an hourly rate, and their hours were factored into their salary time (\$1400 per month and \$1200 per month). All interviews were completed between April and September 2002. The transcriber charged \$15.00 per hour and invested 168 hours in transcription. Preliminary analyses of the interviews were included in the \$1,400 per month fee of the research consultant.

Focus groups. Hmong staff received training in focus group facilitation. The staff included two males and four females. All focus group participants signed a written consent and were provided \$25.00 for their time and effort. The focus groups were taped and transcribed. The six youth focus groups were conducted in English. The three focus groups with fathers and the one with mothers were conducted in Hmong. The recordings of the focus groups conducted in Hmong were translated by the Lao Family staff. Focus groups with the social service providers and the community leaders proved to be difficult to organize. Thus, social service providers were surveyed instead. Only one of the focus groups occurred and this was attended by six persons. Thus in addition to the focus groups, fourteen Hmong leaders completed surveys. All respondents received \$10.00 for their time and efforts. It also is hoped that the opinions of Hmong leaders are included in the surveys data from the parents of adolescents described below. Focus group facilitators were paid \$15.00 per hour and the groups required approximately 3 hours of time. The cost of summarizing the focus group data was included in the \$1,400 per month fee to the research consultant.

Survey data. Three surveys were developed based on the focus group and interview data. The surveys were designed for three specific groups: Hmong youth, parents of Hmong adolescents, and social service providers. LFC staff members were responsible for the administration of the youth and parents surveys that were completed at a two day Hmong soccer tournament. This event was estimated to have 50,000 Hmong in attendance in July 2002. Both youth and parents received two dollars in appreciation for filling out the survey. Both surveys were written in English. These were completed quite easily by the youth, but in the case of the parents, it was necessary for the LFC staff to read the survey to the parents in Hmong to enhance comprehension. Seven hundred and eleven youth (ages 10 to 19) and 194 parents completed the surveys.

The social service provider survey was administered at a meeting at Lao Family. This meeting was attended by Ramsey County social service providers who work with the Hmong community. Survey respondents received \$10 for completing the survey. Fifty-one persons completed the social service provider survey.

Healthy Hmong Teens, an abstinence-only curriculum. The development of this curriculum was based on the adolescent development literature and the findings from the data collection efforts affiliated with this project. Goals and objectives were first drafted. Activities were then formed to the programmatic objectives. The curriculum was reviewed by Hmong staff from Lao Family Community. A pilot of the program will begin in 2003 with funding from the Minnesota Department of Health.

EVALUATION

In order to assist in evaluating whether the activities at hand were accomplished in a timely fashion, a timeline was established for each of the necessary activities (see

Table 1). This also served as punch list and kept the focus on the most pressing tasks at hand. In general, each of the necessary activities was a bit behind schedule in one or more the prescribed steps. However, most of the tasks were completed in their entirety. Exceptions included focus groups with clan leaders, mothers of adolescents, and social service providers. For these populations, survey methods were used to gather similar information.

Table 1.
Timeline for SPRANS grant

	Nov 01	Dec 01	Jan 02	Feb 02	Mar 02	Apr 02	May 02	Jun 02	Jul 02	Aug 02	Sept 02
Act I	1a			1b	1c						
Act II	2a	2b, 2c	2c	2d	2e						
Act III		3a	3b, 3c	3c	3c	3d					
Act IV		4a	4b, 4c	4d	4d	4d	4e				
Act V		5a	5b, 5c	5d	5d	5e					
Act VI						6a, 6b	6a, 6c	6c, 6d	6c, 6d	6e	6e, 6f
Act VII						7a	7a	7b, 7c, 7e	7d	7d	
Act VIII	8a, 8b, 8c	8d									
Act IX											9a

Activity 1: Lit review

- a. Hire grad student
- b. Complete lit summaries
- c. Complete lit review

Activity 2: Vital stats on Hmong births and STIs

- a. Contact person who did this before
- b. Gain data access
- c. Data entry
- d. Data analyses
- e. Complete report

Activity 3: In depth interviews with teenage 40
Hmong mothers

- a. Formulate questions
- b. Recruit and train interviewers
- c. Complete interviews
- d. Complete report

Activity 4: 10 focus groups with youth and
parents

- a. Formulate questions
- b. Recruit and train facilitators
- c. Recruit focus group participants
- d. Complete focus groups
- e. Complete report

Activity 5: 5 focus groups with Hmong leaders

- a. Formulate questions
- b. Recruit and train facilitators
- c. Recruit focus group participants
- d. Complete focus groups
- e. Complete report

Activity 6: Survey data collection

- a. Develop survey based on qualitative data and lit review
- b. Develop sampling strategy
- c. Print and distribute surveys
- d. Enter data
- e. Analyze data
- f. Complete report

Activity 7: Curriculum development

- a. Organize applicable research findings for application to curriculum development
- b. Determine target audience
- c. Develop goals and objectives
- d. Develop activities
- e. Develop evaluation tools

Activity 8: Form an advisory group

- a. Create list of advisory group objectives
- b. Create list of 10 members to form knowledge base
- c. Recruit board members
- d. Set meeting dates

Literature review. A University of Minnesota graduate student was hired November 2001, however the complete draft of the literature review was not completed until June 2002, three months behind schedule. Several drafts were provided prior to June and this information was used to inform the development of survey and interview questions.

Birth record data. The application for approval from Human Subjects at the University of Minnesota was obtained in February 2002. The analyses were finished in May 2002, two months behind schedule. The report was completed in September 2002, yet the data were used to inform the surveys and curriculum development.

Interview data. The structured interview questions were finalized in April 2002, three months later than scheduled. The interviewers were also trained in this month and recruitment began. The interviews were completed in September 2002. The first report on the interview data was completed in November 2002. This was seven months behind schedule. A total of 44 interviews were completed, exceeding the pre-determined forty.

Youth and parent focus groups. Focus group questions were formulized in April 2002. Four focus groups were held with youth (two with youth who had completed the LFC abstinence program and two groups who had not). One group was mixed gender, two included only females and one included only males. Six to ten youth attended each of the groups. All participants received \$25 for their time and effort.

All of the scheduled three groups with fathers were completed and included 18 fathers. Mothers were much more difficult to recruit so only one focus group was conducted. This group included 9 mothers of adolescents between the ages of 31 and 50. All groups were conducted and transcribed by June 2002. All focus group participants received \$25 in compensation for their time and effort.

Five focus groups with Hmong leaders. For the purpose of this study, Hmong leaders refer to clan leaders and social service providers who work in the Hmong community. Recruitment of clan leaders was very difficult. Hence only one of the focus groups occurred and this was attended by six persons. Thus in addition to the focus groups, fourteen Hmong leaders completed surveys. All respondents received \$25.00 for their time and efforts. It also is hoped that the opinions of Hmong leaders are included in the surveys data from the parents of adolescents described below. Recruitment of social service providers for focus groups also proved difficult. Thus surveys were developed and administered for this group as well.

Survey data. The surveys for youth and parents were developed in June 2002 and administered in July 2002. The reports were completed in September 2002 as prescribed by the timeline.

Healthy Hmong Teens, an abstinence-only curriculum. An extension was requested and granted by MCHB. The 15-session curriculum was completed in November 2002. Evaluation tools related to the curriculum were also developed by November 2002. Thus the development process was two months behind schedule. The program will be piloted in 2003.

Advisory group. The advisory group was initiated late in relation to the timeline. The group of 18 persons was developed in February 2002 to assist in reviewing interview and focus group questions, as opposed to November 2001. The group included professionals who are working with the Hmong community in the area of adolescent pregnancy prevention (both Hmong and non-Hmong) and young women who have experienced adolescent pregnancy and/or parenting. The group met once in February 2002. Ten of the 18 members attended. Individual feedback was requested from members on various issues throughout the project, but no further meetings were held.

RESULTS AND OUTCOMES

Given the extensive nature of the data collection associated with this project, the following summary of results and outcomes is but a cursory glance at the overall data and the findings that emerged.

Literature review. The literature was summarized into a thirty page paper with 52 references. Subtopics within the literature review include: (1) History of the Hmong; (2) Marriage patterns and childbearing; (3) Risk factors for HIV and STIs in the Hmong community, (4) Socioeconomic factors related to teen pregnancy, and (5) Parenting in the Hmong community.

Birth record data. Birth record data for the seven-county metro area were reviewed for the years 1990 to 2000 with a focus on the Hmong community. Trends were analyzed for Ramsey County, Hennepin County, and the seven-county metro area. The majority of adolescent births (about 65%) consistently occurred in Ramsey County and less than 5% of the births occurred outside of Hennepin or Ramsey Counties. Thus to exemplify the results, the focus is placed on Ramsey County.

Within the eleven year period the number of Hmong births increased from 726 births in 1990 to 857 births in 2000. At the same time the percentage of Hmong births born to adolescents between the ages of 15 and 19 also increased. In 1990 127 or 17.5% of Hmong births in Ramsey County were to adolescents. In 2000 229 or 25.4% of births were to adolescents. This is a 31.1% increase. Based on U.S. Census data, 1,904 Hmong females between the ages of 15 and 19 resided in Ramsey County in the year 2000. Of the 1,409 Hmong births in 2000, 24.8% (229 births) were to mothers less than 20 years of age. This is a rate of 116.6 per 1,000! This is more than four times greater than the Ramsey County Caucasian teen birth rate of 26.2 per thousand.

The birth data also allow characteristics of adolescent birth mothers to be examined. Some hypothesized that a factor driving the high number of adolescent births was the issue of arranged marriages to much older men. The likelihood of this phenomenon appears to have decreased within the decade under consideration. A dramatic increase in the percentage of births fathered by adolescents is detected. In 1990 15.8% of births to adolescent mothers were fathered by teens, compared to 26.8% in 2000. The percentage of births fathered by men age 30 or older remained quite constant from 5% in 1990 to 7.9% in 2000. However, the percentage of 25 to 29 year-old fathers has decreased from 36.6% to 20.5%.

Another hypothesis regarding Hmong adolescent pregnancy is that teens who become pregnant are likely to already be married or will marry shortly after the pregnancy is detected. The data actually depict a decrease in the percentage of married young women who give birth. In 1990 57.5% of teen birth mothers reported themselves as married, compared to only 38.4% in 2000. In the interviews discussed below, some of

the interviewees shared that they were married in the Hmong tradition and not by Minnesota law due to their age (too young) or eligibility for social service benefits. The issue of age is supported by the data in that 23% of birth mothers under the age of 17 were married in 2000 whereas 42.3% of teen mothers, ages 17-19 were married. This is down from 30.2% and 71.4% respectively, as found in 1990 data.

Finally the number of prior pregnancies has decreased for teen birth mothers over the past decade. In 1990 54% of the adolescent birth mothers reported having one or more prior pregnancies. In 2000 43.2% of the adolescent birth mothers had experienced more than one pregnancy prior to the target birth.

Interview data. The interviewees were between the ages of 14 and 20 ($M = 17.55$; $SD = 1.62$). Thirty-two of the respondents (72.7%) were married either in Hmong tradition or by Minnesota law. Thirteen (29.5%) of the young women were currently pregnant. Thirty-five (79.5%) had one or more children with most having one child (54.5%) and one person had four children. Most ($N=38$; 86.4%) of the young women were enrolled in school and just over one in five (22.87%) were employed. Almost 60% (59.1%) of the women hoped to complete a four-year college degree or more. Only two were interested in completing their education with high school graduation.

Following marriage, it is quite typical for Hmong women to live in the home of their husband's parents. This was true for the women in this study. Over half (52.3%) lived with their in-laws. Just over a quarter (27.3%) lived with their biological parents. Eight of the young women (18.2%) were living with their partner and their child(ren). Given the birthrate among the Hmong (over 70% of the respondents had 5 or more siblings) and their commitment to extended family, it is not uncommon to find more than

ten persons in a household. Nearly a third of the women (31.8%) lived with five or fewer persons. Another third (34.1%) lived with ten or more people. Two of the young women resided in households with twenty people.

The results of this study indicate that over a third of young women who are pregnant or parenting report a close relationship with their parents both before and after their pregnancy or marriage. The family of origin typically serves as the most significant source of support for the adolescent mothers, including financial aid and childcare.^{ix} Indeed, compared to older mothers, teen mothers rely more on their own mother for support.^x In general, young, Hmong women report relatively healthy relationships with their parents. A third of the young women considered their parent(s) as their closest family relationship prior to pregnancy. After the young women's first pregnancy, they were more likely to report their husbands as being their closest family member (24.4%). Nearly one in five of the young women reported parents as their closest relationship after pregnancy or marriage.

Mothers remained especially important in providing support to the young women. Previous research has indicated that the support of grandparents for adolescent parents and their offspring is very important. The grandmother's support of her adolescent daughter and grandchildren has been associated with reduced stress for the young mother^{xi} and reduced risk of maternal rejection for the children of an adolescent mother.^{xii} Responsive grandparent may also buffer the effects of an unresponsive mother.^{xiii}

The young mothers were also asked to describe their relationship with their parents in junior or high school, depending on the age of the mother and the timing of her pregnancy. Nearly half of the young women revealed that their relationships with their

parents during this time were negative. A third reported the relationship as positive and the remainder described the relationship as a bit of both. When asked to reflect on their current relationship with their parents, nearly seven in ten of the young women reported a good relationship with their parents. Twenty percent reported a negative relationship with their parents with the remaining ten percent reporting a mixed relationship.

Given the scant research that has occurred in the Hmong community, it is difficult to determine whether perceptions of parental support differ between the young women and the larger population. Biannually the Minnesota Department of Children, Families, and Learning surveys students across the state on a variety of developmental issues, including family life and sexual health. A subset of these data allow us to make comparisons between the data of this current study and the responses of female, Asian-American students (grades 6, 9, and 12) in Ramsey County. Of this sample, four in ten of the girls reported a less than optimal relationship (score less than 3) with their parents on the five item family cohesion scale (e.g., family respects your privacy, family understands you, your parents care about you). A quarter of these respondents reported a good or excellent level of family cohesion (score of 4 or greater).

Compared to the MSS 2001 data, the quality of the respondents' relationships with their parents can be considered healthier or less healthy, depending on the time of reference. Prior to the pregnancy and/or marriage, the interview respondents (45.5%) were a bit more likely than the MSS sample to report negative parent-adolescent relationships (40%). However, following pregnancy and/or marriage, the percentage of young women who reported their relationship as positive (70%) was higher than that of the greater population (25%).

Family discussions about sexuality occurred for a third of the young women. However, the information was not always accurate and often very limited. Mothers were the more typical source of information. Again, we turn to the MSS 2001 data for Asian American girls in Ramsey County (n=686) to see how the interview respondents compared to the larger population. The survey students were asked, “Where have you received most of your information about sex?” Respondents could choose as many categories as they wished. Over a quarter (25.7%) of the students (n=176) selected their parents as a major source of information about sex. This is slightly lower than the third of interviewees who shared that sex was discussed to some degree in their home.

A variety of reasons were shared as to why parents were not discussing sexuality with their daughters. A third of the young women believed that their parents were afraid of the potential consequences of such discussions — including that it might encourage their daughters to be sexually active. Much evidence exists that disputes this belief. For example, the Kaiser Family Foundation and Seventeen magazine recently conducted a survey of 15-17 year olds about their perceptions about various sexual health topics. Respondents who said they were sexually active were asked the reasons behind their sexual activity. Various reasons were shared, including meeting the right person (51%), other person wanted to (45%), and just curious (32%), however, because “parents discussed sexuality with me” was NOT listed as one of the reasons.

In a recent survey conducted by LFC, less than half of Hmong parents of adolescents did not believe Hmong parents had the knowledge to discuss sexual health with their children.^{xiv} Interestingly, this explanation was not suggested by the young

women of the interviews. Perhaps they are of the notion that if persons have sex they must be able to educate somebody else about it.

Youth focus groups. The youth shared their views regarding sexual behavior and marriage for Hmong adolescents, including the consequences and benefits of early sexual behavior. Consequences included STIs, pregnancy and parenthood, shame from the community (particularly for girls), and marriage. Benefits of early sexual behavior included social status, happiness, and a child. The members of one group failed to come up with any benefits of early sexual behavior.

Clear gender differences emerged throughout the discussions. Regarding early sexual behavior, girls were viewed as receiving the brunt of their behavior whereas boys could avoid any obligations related to impregnating a girl. Girls would also be likely to receive more shame from the Hmong community and boys might be viewed as “just being boys.” Given this perceived standard, it did not seem odd to find that in general the youth reported that more family conversations about abstaining from sexual behavior occurred with daughters than with sons. One boy’s parents told him that they didn’t want him to raise any girls, and that was the extent of their disclosure about sexuality.

Most of the youth shared that teens begin to face more pressure to have sex by age 14 and 15 — one person said that 12 year old girls often experienced pressure too. Youth were asked to share what they would tell a 13 year-old youth who was thinking about having sex in order to change his or her mind. The messages were quite simple — “Wait,” “You will regret it,” “Raising a child would be difficult,” “May lose your childhood to marriage,” and “I will tell your parents.”

Parent focus groups. The fathers involved in the groups had been married an average of 19.9 years, ranging from 10 to 39 years. The mothers had been married from 21 to 33 years (Mean = 22.6 years) and had five to 13 children (Mean = 7.5). The fathers had two to eighteen children with an average of eight. The fathers believed that parents should talk to their kids about sexual issues. The age of initiating such discussions ranged from nine to eighteen (Mean = 13.7 years). Mothers emphasized early adolescence for such discussions (ages 10-14). Most mothers believed the direct approach was best however one mother believed that the use of Hmong metaphors was still effective. The other mothers said it was better to be straightforward as the metaphors were difficult for the youth to understand. However the fathers acknowledged that such discussions were difficult or very difficult. Reasons for this difficulty included culture and embarrassment. Mothers also reported embarrassment as a barrier to such discussions.

Fathers stated that boys and girls should not have sex until they are eighteen or older. All fathers agreed that it was important or very important for parents to discuss marriage with their teens. The two most cited reasons for delaying marriage until 20 years or older were completion of education and maturity. This was true for both boys and girls. All of the mothers agreed that marriage before age 18 was too young. Most of the mothers indicated that marriage after age 22 (finish college) was beneficial for their children. Fathers listed a number of ideas about how to prevent unmarried children from having sex at an early age. These included no contact between boys and girls (58%), scare youth about AIDS, and tell kids not to do it. The fathers shared that the importance of education, goals, hopes for the future, the hardship experienced by parents and the

burden of children should be emphasized in a program designed to encourage Hmong youth to postpone sexual activity.

Mothers shared that comprehensive sexual education was the ideal for their youth. Parents as teachers was advocated but given the issues of embarrassment and knowledge level, the efforts of schools were also appreciated. They advocated abstinence before marriage (encouraging kids to wait before having sex) but they also said that it was fine for teachers to share information about protection, specifically condom use. The mothers were more supportive of teaching the consequences associated with early sexual behavior than issues of contraception and abortion, but emphasized that the former should be addressed first — not that the latter should be excluded from educational programs.

The fathers shared their opinions about potential programs for parents of adolescents. Topics for such a program included general information on parent-adolescent relationship, social resources, sexual education, and guidelines for effective parenting. The majority of the fathers (47%) thought mothers and fathers should attend the sessions together, as they viewed a united front or co-parenting as more effective than a single parent approach. Slightly fewer (41%) thought the sessions should be held separately for mothers and fathers. Mothers were viewed as responsible for daughters and fathers were viewed as responsible for sons. Another father shared that he would not be comfortable discussing sexual health issues in front of his wife. Early evening, between 5 and 6 p.m. were cited as the most favorable times for such programs. Finally fathers shared that participants would most likely be recruited via phone calls (41%) or radio advertisements (29%).

Hmong leader and surveys. The survey was completed by fourteen Hmong community leaders. All of the leaders were male and born in Laos. Half were older than 50 years old. Two out of three had less than a high school education and one was a college graduate. Nine of the fourteen respondents (64%) chose pregnancy as a top priority issue for Hmong youth. A similar number selected alcohol use prevention and English language skills.

All of the leaders believed it was important to teach Hmong teens about sexual health. On average they recommended that males marry at age 21 and that females should marry at age 20. Eight of the fourteen (57%) thought it was the parents' responsibility to educate their teens about sexual health. Five were not sure and one person disagreed. Similar to the parents themselves, of which less than half thought that parents had the knowledge to teach their youth, only two of the Hmong leaders (14%) believed the parents had necessary knowledge. The other 86% disagreed or were not sure.

On average the leaders reported less than 2 benefits of teen pregnancy. The most common benefit cited was that the adolescents stay out of trouble (43%). The second most cited benefit was that the children bring joy to the parents (36%). In contrast, on average nearly seven consequences (6.7) of teen pregnancy were shared. Difficulty in completing education was the most frequent response (100%) and financial difficulties was the second most common (93%). A third of the leaders selected all ten of the suggested responses. Lack of knowledge about contraception was by far the most common reason cited for the reason behind teen pregnancy (64%) with the second most common response being spontaneity (38%).

On average the leaders cited nearly four ways the Hmong community has tried to promote later childbearing and sexual intercourse. The top two responses, each selected by 64% of the respondents, were the “encouraging sexual abstinence until marriage” and “role model.” The third top response was “youth classes” (50%). Barriers to involvement by the Hmong community included lack of financial support and lack of educational activities (e.g., posters, videos, guest speakers, etc.) — each were selected by 57% of the men. In general over three issues that might motivate community involvement in teen pregnancy prevention efforts were selected. The most popular response was community outreach (86%). Of the respondents 71% selected educational advancement for youth. In sum it is clear that Hmong leaders view adolescent pregnancy as a problem for the community and if the resources were available, they can see the community rallying around the issue.

Social service provider survey. Providers shared a variety of experiences regarding their work with the Hmong community. Providers were asked which programs their organization currently provides to parents of Hmong adolescents. Respondents most frequently indicated that their organization offers one-to-one counseling (43%), the Positive Parenting of Teens program (41%), family counseling (39%), social support (39%) and youth counseling (35%). A little less than a quarter (24%) of provider respondents indicated that they offer living skills training to parents of Hmong adolescents. Less of the social service organizations offer a self-manufactured parenting program (12%) or the Can We Talk? program (6%).

Survey respondents were asked to share about their most useful recruitment strategies both for Hmong parents of adolescents and for Hmong youth. According to the

providers, using word of mouth is the most useful recruitment strategy for both parents (53%) and youth (63%). A personal phone call was the second most highly rated strategy for both parents (37%) and youth (35%), however distributing flyers (37%) and making announcements at related events (37%) were deemed just as useful for recruiting parents. Flyers (33%) and announcements (26%) were also important strategies to recruit youth, but not as highly rated as phone calls.

Provider respondents were asked what they view as the greatest successes of the Hmong community in America, as well as what they view as the greatest barriers to success for this population. The most frequently noted success for the Hmong community was making the transition to American life (57%) followed by developing English language skills (51%) and maintaining the Hmong culture in America (47%). A third of the respondents rated commitment to family as a great success (33%) and over a quarter noted surviving the trip to America (28%). Less of the respondents felt that entrepreneurship was one of the greatest successes (24%).

English language ability (55%) and mental health issues (51%) ranked highest in terms of barriers to success that providers felt the Hmong community faced in America. Providers also frequently felt that the Hmong community was hindered by the great contrast between American life and life in Laos (45%) as well as by the occurrence of domestic violence (45%). Societal issues such as racism and discrimination (41%) as well as gender roles (29%) were other frequently noted barriers to success.

Social service providers overwhelmingly felt that it was important to teach Hmong teens about sexual health. Ninety-four percent believed this type of education was either somewhat important or very important; 80% felt it was very important. The

majority of provider respondents did not believe that teen marriage or teen pregnancy were advantageous to Hmong youth or the Hmong community, respectively. When presented with the statement that it is advantageous for Hmong youth to marry before 18 years of age, 70% either disagreed or strongly disagreed. Respondents were less adamant about the statement that teen pregnancy is advantageous in the Hmong community; while more than half (57%) still either disagreed or strongly disagreed with this statement, more than a quarter (27%) either agreed or strongly agreed that teen pregnancy did benefit the community.

Almost all (94%) the provider respondents either agreed or strongly agreed that Hmong adults should be involved in promoting the prevention of teen pregnancy. When questioned about the influence that Hmong parents have in their teenagers' lives, 68% of providers agreed or strongly agreed that parents have a lot of influence, while 18% were not sure and 14% disagreed with this statement.

Providers overwhelmingly believed that Hmong parents have a responsibility to educate their teens about sexual health. Eighty-three percent of providers either agreed or strongly agreed with this statement, while only 6% disagreed or strongly disagreed. Providers were less confident, however, that Hmong parents had the knowledge to educate their teens about sexual health or had the desire to do so. Only 46% of providers thought parents had adequate knowledge to educate their teens, while 22% were not sure and 32% did not think they had the knowledge. Again only 46% of providers agreed or strongly agreed that parents would like to educate their teens about sexual health; a large percentage (38%) were not sure and 16% did not think parents would like to do this type of education with their teens.

Youth survey data. Several interesting findings emerged from the youth survey data. Youth respondents were asked to rank their level of agreement with statements concerning sexual health education for Hmong teens. In general, youth overwhelmingly agreed or strongly agreed that sexual health knowledge was important for Hmong teens and that parents and community leaders could and should have a role in this type of education. On the other hand, youth were much less likely to report that their parents had told them everything they needed to know about sex and romantic relationships.

Of all the statements given, adolescents most strongly agreed (44%) that it is important for Hmong teens to know about sexual health; eighty-one percent of youth either agreed or strongly agreed with this statement. Youth also frequently either agreed or strongly agreed that adults should be involved in promoting the prevention of teen pregnancy (72%) and that parents have a responsibility to educate their teens about sexual health (60%); however more than 20% of youth were not sure about whether adults and parents should be involved in these issues.

In addition to questions about parent responsibility, youth were asked about the role of Hmong community leaders in the prevention of teen pregnancy. Sixty-two percent of respondents agreed or strongly agreed that community leaders should be involved in the promotion of teen pregnancy prevention. However a full 25% of teen respondents were not sure about this statement and 13% disagreed or strongly disagreed that community leaders should be involved.

While over half (54%) of the respondents felt that Hmong parents have a lot of influence in their teenagers' lives, 30% were not sure about this statement and 16% disagreed or strongly disagreed altogether. Youth frequently revealed that Hmong

parents have a responsibility to educate their teens about sexual health, but less than half (47%) agreed or strongly agreed that Hmong parents have the knowledge to deliver this type of education; almost a third (32%) were not sure and 21% did not think parents had the knowledge.

Although a majority of youth agreed that parents should be involved in issues of teen sexual health education, less than a third agreed or strongly agreed that their parents had told them all they need to know about sex (30%) and about romantic relationships (33%). Forty-four percent of youth either disagreed or strongly disagreed that their parents disclosed all they needed to know about sex and 40% disagreed or strongly disagreed that their parents shared all they need to know about romantic relationships. Over a quarter were not sure about each of these statements.

Consequences of sexual behavior. Youth most frequently responded that a benefit of having sex as a teen is that it shows your girlfriend or boyfriend that you love them (51%). Other frequently reported benefits included that sex is fun (41%) and that friends will think you are cool (35%). Some noted benefits of having sex as a teen were related to roles as an adult, parent or spouse. Twenty-seven percent believed that a benefit of teen sex was that it made you more like an adult. Twenty-percent or more reported that having sex as a teen is a benefit because it can: (a) help one get married sooner; (b) can lead to a pregnancy; and (c) can allow one to be a parent. Only 12% reported that teen sex could benefit youth by making them more like people seen on TV and in movies.

The most frequently reported consequence of having sex as a teen was the risk of contracting HIV/AIDS (70%) or other sexually transmitted infections (63%). Youth respondents also frequently noted new responsibilities as consequences including that one

may get pregnant or get a partner pregnant (58%); one might become a parent (61%) or one might get married sooner (55%) as a result of having sex as a teen. One's reputation being put in jeopardy was another consequence noted by the youth; fifty-eight percent reported that friends might think you are "bad" or a "slut" if you have sex as a teen and 55% noted that this behavior could bring shame to your family. Seventeen percent of youth believed that a consequence of having sex as a teen was that one would be more like people on TV and in movies.

Resistance. Youth respondents were asked about factors that might make it difficult to say "no" to sex. The most frequently reported factor was peer pressure (61%), followed by not wanting to reject one's girlfriend or boyfriend (55%). Hormones (42%) were another factor commonly noting for making saying "no" difficult. Respondents also believed that it might be hard to say "no" to sex because it is a way to make your boyfriend or girlfriend love you more (41%) or because your boyfriend or girlfriend is very good looking (37%).

Respondents answered that it may also be difficult for them to say "no" to sex because they want to have experience and lose their virginity (37%) and that sex is fun (33%) and a way to look cool (29%). Less common answers were that sex makes you more like an adult (21%) and that saying "no" may be difficult if you want to have children (18%).

Motivators of teen pregnancy. When asked what factors may motivate a Hmong teen girl to become pregnant, the most frequent answer given was that she desired to have someone to love (73%). Respondents almost equally noted that lack of knowledge about contraception could be a factor for a teen girl becoming pregnant (73%). Other

motivators of pregnancy included a means to marry the child's father (48%) or to avoid an arranged marriage (38%). Many respondents felt that a teen pregnancy could be the result of spontaneity (38%).

The adolescent respondents also noted that a Hmong teen girl might be motivated to become pregnant because of the expectations within her marriage (32%) or from her parents (25%), or that pregnancy may be seen as a rite of passage to adulthood (30%) or as a way to achieve elevated status within the Hmong community (15%). In addition, some youth responded that a teen girl might be motivated to become pregnant because of a lack of alternate roles for young women (23%).

Parent survey data. Parents shared the ideal age of marriage for Hmong males and Hmong females in America. Parents reported most frequently that 24 years or older would be the ideal age for a Hmong male to be married (29%); the second most frequent answer given was 18 years of age (19%). For females, these two ages were also most frequently given, however in reverse order. Parents most frequently answered that 18 would be the ideal age for a Hmong female to be married (27%), while 24 or older was the second most common answer (18%). In general, parents more often reported younger ages of marriage for females than males.

Beliefs about teen sexual health education. Parents were asked to rank their level of agreement with statements concerning sexual health education for Hmong teens. In general, parents overwhelmingly agreed or strongly agreed with the need for sexual health education. Parents most strongly agreed (46%) that it is important for Hmong teens to know about sexual health; overall eighty-nine percent of parents either agreed or strongly agreed with this statement. Parents also highly ranked their responsibility

concerning this issue. Of the parents, 76% agreed or strongly agreed that parents have a responsibility to educate their teens about sexual health.

Although parents were advocates of the importance of and parental responsibility for teen sexual health education, they were less confident about Hmong parents' ability to deliver this type of education. Of all the statements, parents disagreed most frequently with the statement that Hmong parents have the knowledge to educate their teens about sexual health. Twenty-seven percent of parents either disagreed or strongly disagreed that parents had adequate knowledge to educate their teens. In addition, while 62% of parents agreed or strongly agreed that parents would like to educate their teens about sexual health, a quarter (25%) of respondents said they were unsure about this statement and 13% felt that parents would not like this responsibility.

Teen pregnancy. The most frequently reported benefit of teen pregnancy in the Hmong community was that it helped teenagers to stay out of trouble (47%). Parents also commonly responded that teen pregnancy increased the responsibility of young parents (38%); provided an opportunity for the community to look down on or shaming the mother (38%); and prompted youth to become adults (34%). Secondary to the benefit of promoting maturity in teens, teenage pregnancy is seen as enhancing relationships between the teens and their parents (29%), securing a marriage (25%) and bringing joy to the parents (22%). Thirteen percent reported that there was no benefit to teen pregnancy.

The most frequently reported consequence of teen pregnancy was that it made completing one's education difficult (84%). The second most frequent consequence reported was financial difficulties (79%). Parents also commonly felt that teen pregnancy resulted in stress on the marriage between young parents (55%); that youth would be

faced with too much responsibility (54%); and that daycare would be difficult to find or afford (52%). Other quality of life issues were noted. Parents believed teen pregnancy would increase difficulties with the teen's parents (49%); that it could increase depression (41%) and feelings of burden (43%) for the teen mother; and that it would result in less free time for the teen parents (41%). In addition, some parent responders believed that young parents are less capable than older parents (43%).

When asked what factors may motivate a Hmong teen girl to become pregnant, the most frequent answer given was that she desired to have someone to love (61%). Respondents also quite frequently noted that lack of knowledge about contraception could be a common reason why a teen girl would become pregnant (43%). Other motivators included using a pregnancy as a means to marry the child's father (39%) or to avoid an arranged marriage (31%). Many respondents felt that a teen pregnancy could be the result of spontaneity (37%). Parents also noted that a Hmong teen girl might be motivated to become pregnant because of the expectations within her marriage (27%) or from her parents (25%). Pregnancy may also serve as a rite of passage to adulthood (20%) or as a way to achieve elevated status within the Hmong community (17%). Some parents thought that a teen girl might be motivated to become pregnant because of a lack of alternate roles for young women (25%).

Healthy Hmong Teens, an abstinence-only curriculum. The development of the curriculum as based on adolescent development research and the information gathered in the Hmong community in 2002. The pilot of the program will begin in February 2003. The fifteen session curriculum was structured around the following goals and objectives.

- I. Validate the participants' experience as an adolescent in the United States and a member of the Hmong community.
 - a. Identify the negative myths about adolescence and Hmong culture in a society where adults and Euro-American culture are dominant.
 - b. Present the facts that contradict the myths; encourage group members to find experiences and events in their lives that contradict the myths.
 - c. Explore the aspects of Hmong culture that enhance adolescents' experiences in American and those aspects that complicate adolescent life.
 - d. Address the biological, psychological and social development related to adolescence

- II. Encourage the exploration and enhancement of the adolescents' self efficacy
 - a. Identify their contributions that are currently working well in their lives
 - b. Assist adolescent in realizing that although their family experiences are personal and valued, that many of their peers can and do relate to many of their experiences
 - c. Promote participants' understanding of the responsibilities that they may face given their increasing autonomy as adolescents
 - d. Identify and encourage the use of personal strengths
 - e. Identify and explore how to capitalize on the experiences of other Hmong-American adolescents
 - f. Identify and encourage the use of available social resources
 - g. Identify and encourage the use of various coping strategies
 - h. Assist adolescents in identifying stressors in their lives

- III. Encourage adolescents to explore and develop their personal aspirations (e.g., family composition, personal relationships, work, and education) and acknowledge societal expectations (e.g., government, community, school, parents, and peers).
 - a. Identify present standards and future expectations of adolescents
 - b. Identify how to prioritize non-congruent or competitive goals.
 - c. Identify constraints (societal, school, and family) to meeting the adolescents' expectations and standards without undermining the potential for achieving them.
 - d. Discuss strategies to achieve future plans.
 - e. Address the importance of increased responsibilities (positive and negative) in relation to immediate and long-term outcomes specific to the Hmong families in America
 - f. Enhance ability to apply the decision making model to short- and long-term goals
- IV. Explore and enhance the adolescents' communication strategies in relating to their parents and peers
 - a. Explore where appropriate problem solving and negotiation strategies.
 - b. Discuss effective strategies for adolescents' self-disclosure with their romantic partners, and clarify what the adolescent's comfort level
 - c. Discuss the changing nature of adolescent communication in various relationships during the transition from childhood to adolescence
 - d. Present constructive communication strategies to use during conflict.

Advisory group. Ten of the eighteen advisory group members attended the first and only meeting of the group. Although no subsequent meetings were scheduled, the members remained available for individual consultation on project development issues. Primarily the Hmong members of the group were sought out for later work, including the review of survey measures, data presentation, and also input into the development of the Healthy Hmong Teens curriculum.

PUBLICATIONS & PRODUCTS

To date no publications have been created based on the efforts affiliated with this grant. However, one manuscript is in its final draft form and will be submitted to the *Journal of Adolescent Research* in January 2004.

A fifteen session, culturally appropriate abstinence-only education program was created for 10-14 year-old Hmong students. This curriculum is currently available only to the LFC staff. After piloting and appropriate revisions, LFC may sell the curriculum to other interested parties.

DISSEMINATION OF RESULTS

Interview data were presented at the annual conference of the National Council on Family Relations in Houston, Texas in November 2002. The title of the presentation was *Hmong adolescent mothers: Their chosen path and undetermined future*. The presentation was authored by Laurie L. Meschke of Good Reason Consulting and Kim Dettmer of LFC.

A proposal to present at the annual conference of the Minnesota Organization on Adolescent Pregnancy, Parenting, and Prevention was submitted in December 2002.

Notification of acceptance status should be received in January 2003. The conference will occur in May 2003.

FUTURE PLANS & FOLLOWUP

Several funding options are being considered or pursued in the area of data analyses and implementation of the Healthy Hmong Teens curriculum. First an implementation proposal was submitted to MCHB in 2002. This proposal was rejected. LFC will submit a revised proposal in January 2003.

LFC received some implementation funding from the Minnesota Department of Health in Spring 2002. This will allow the curriculum to be implemented in four schools for a two year period. A second implementation grant was submitted to the Minnesota Department of Health in Fall 2002. This funding stream would also allow a parent component to be implemented. LFC has not yet received notification of these funds.

Finally LFC intends to pursue more funding for data analyses. Emphasis will be given to the interview data. To date only a handful of questions have been considered in the analyses. The time commitment required of qualitative data analyses necessitates more funding for thorough examination.

**TYPE & AMOUNT OF SUPPORT
AND RESOURCES NEEDED TO REPLICATE**

The research completed with the MCHB funding for this project is actually quite phenomenal. The study included secondary data analyses, qualitative data collection and analyses and quantitative data collection and analyses. The work could not have been performed within the prescribed budget without the commitment of the associated parties and their willingness to work for reduced wages for the purpose of the project. Hence the table below summarizes the actual budget breakdown and also the budget that might be followed within the typical academic setting.

Budget Item	LFC Cost	Replication Budget Item	
Project Manager (10% time @ \$25 per hour)	\$20,741	25% of faculty time (based on \$75,000 salary and 33% benefits)	\$24,937.50
Research Consultant — 25% time (\$1,400 per month for 14 months)	\$19,600	Not applicable; covered within faculty time	\$0
Data collection staff (345 hours @ \$15.00 per hour, 48 hours @\$10/hr, 28 hours @\$25/hr)	\$6,355	Four - .25 graduate students for two quarters	\$37,500.00
Literature review (432 hours @ \$15.00 per hour)	\$6,480	One - .5 graduate student for one quarter	\$18,750.00
Data entry (350 hours @ \$10.00 per hour)	\$3,500		
Data transcription (189 hours @	\$3,585		

\$15.00 per hour), 30 hours @\$25			
Curriculum development contractor (148 hours @ \$23 per hour)	\$3,404	Curriculum development contractor (150 hours @ \$25 per hour)	\$3,750
Game design contractor (40 hours @ \$23 per hour)	\$920 (Alternative Budget)	Game design contractor (40 hours @ \$25 per hour)	\$1,000
Focus group participant compensation 62 individuals X \$25/person	\$1,550	Focus group participant compensation	\$2,000
Interviewee compensation 44 individuals X \$50/individual	\$2,200	Interviewee compensation	\$2,500
Survey respondent compensation 905 individuals X \$2, 65 individuals X \$10	\$2,460	Survey respondent compensation	\$2,500
Copies and supplies	\$1,546	Copies and supplies	\$1,600
Indirects Staff development	\$3,499	Indirects based on U of MN School of Public Health requirements (48%)	\$45,378
TOTAL	\$74,920		\$139,915.50

ANNOTATION

This study was designed to assess the behavior and attitudes of the Hmong community regarding the issue of adolescent pregnancy. The study included: (1) a review of the literature on Hmong culture and sexual behavior; (2) a review of Minnesota birth record data from 1990 to 2000; (3) focus groups with youth, parents, and Hmong community leaders; (4) the collection of survey data from youth, parents, and social service providers; (5) interviews with 44 pregnant or parenting adolescents; and (6) the development of an abstinence-only curriculum for early adolescents in the Hmong community. Data revealed that the 2000 Hmong teen birth rate (116.6 per 1,000) was 6.2 times greater than that of the Caucasian population. Both youth and parents shared their belief in the importance of sexual health information for adolescents. However, less than 50% of parents surveyed believed that parents had the knowledge to be involved in such education.

KEY WORDS

Hmong

Adolescence

Pregnancy

Prevention Program

Assessment

Parents

Minnesota

Ramsey County

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