‘We all decided’: The variations of Hmong Family-Based Decision-Making about Maternity Care in Thailand

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Abstract

Objective: A recent survey in Northern Thailand found that pregnant Hmong women use maternity services less than Thailand’s national statistics. Our objective was to identify which Hmong family members participated in maternity care decisions in order to include appropriate family members in interventions that might increase use of maternity services.

Design: We conducted in-depth qualitative case-studies of 16 families in one Hmong village in Northern Thailand. We chose 16 women with and without maternity services, and interviewed them, 12 husbands, and 17 elders about decisions for all pregnancies.

Results: There is a continuum of family-based decision-making, which ranges from elders alone, to elders with couples, to couples by themselves, to women alone without their husbands or husbands’ family. This continuum illustrates that no one family-based decision-making pattern exists, different family members participate at different times, particularly over the life-cycle, and pregnant women are embedded in dynamic social processes where women may have little or no influence, considerable influence, or act independently of husbands and husbands’ families. No one pattern chose maternity services more than another; some elders and husbands were as supportive of modern maternity services as were pregnant women; and some pregnant women were against maternity services, regardless of husbands and elders’ opinions. Women’s ideal is to be supported by their husbands and husbands’ family members.

Conclusion: Educational programs designed to increase use of maternity services should recognize the diversity of decision-making patterns found to exist in Hmong families and offer involvement to all family decision-makers, including women, their husbands, or family elders.

Keywords: Pregnant women; Husbands; Mothers-in-law; Births; Maternity

Introduction

While global progress has been made to provide quality maternity services to all pregnant women, including antenatal care (ANC) and deliveries with skilled birth attendants (SBA), significant challenges remain [1]. To improve women’s accessing services, studies and programs have examined women and family members’ roles in making decisions to obtain maternity services. Some researchers have focused on pregnant women’s independence, showing that empowered autonomous women with education and economic resources make more decisions about maternity services [2-5]. Other researchers have focused on women’s dependence or inter-dependence, finding that family members (particularly husbands and mothers-in-law) are involved in decisions about women’s maternity services [6-12], joint husband-wife decision making increases use of services [13-15], and increased women’s autonomy decreases male involvement while joint decision making increases male involvement [15,16]. Whether or not interventions aimed at increasing women’s use of maternity services must attempt to increase women’s autonomy, economics, or education [2-5], involve other family members in decision making [7,8,10,12,15,17,18], include husbands in services [6,9,13], or improve intra-spousal communication and joint decision making [15,16], is uncertain. Research results about who makes decisions can be difficult to generalize because specific local contexts--social, cultural, economic, and political--significantly influence processes [19].

Thailand appears to have reached near universal ANC and SBA (98.9% one ANC visit and 99.7% SBA), through its universal primary care public health system that promotes four ANC visits starting at first trimester ANC for women and their partners, and births at health centers and hospitals with SBA [20]. However, a recent community-based study in Northern Thailand revealed that Hmong women used ANC and had hospital births less often than these national statistics for Thai women -- no ANC at 8% versus 1.1% and no SBA at 12.7% versus 0.3% [21]. In a subsequent qualitative study, we identified that Hmong families assessed three major decision-making arenas about maternity services: perceived health risks; preferred experiences of delivering at home with supportive family or delivering in a hospital with obstetrical procedures; and structural issues such as money and transportation [22]. The villager’s choices of maternity services have changed over time with more choosing ANC and hospital births. Little is known about who makes decisions about maternity services for pregnant Hmong women. Before designing and implementing interventions to increase use of maternity services, it is necessary to elucidate which Hmong families participate in decisions about using maternity healthcare.
services. Our research objective was to identify which Hmong family members participate in decisions about maternity care services.

Setting

The study was conducted in a rural Hmong village in Northern Thailand, one hour from urban maternity care. The traditional Hmong kinship structure is patrilocal, patrilocal, and patriarchal. Newlywed women move in with their husband’s parents and siblings, in multi-generation households until the couples gains financial independence and moves out, leaving the youngest son and his wife taking care of his aging parents. Generally, middle-aged elders have more influence on household decisions than younger adults, and with men as household heads make the majority of family decisions (particularly in the public arena and between families [23]). Historically, younger Hmong women did not participate in most household decision, but more recent studies about gender roles in Thailand have found that women do participate to varying degrees in household decision making in areas such as the number of desired children and childcare [24]. Historically, there were no traditional midwives who routinely assessed pregnancy progress and attended births; rather, families took care of pregnant and delivering women, helped by knowledgeable healers when problems arose [25].

Methods

We conducted in-depth qualitative case-studies in one Hmong village in Northern Thailand from February 2013- July 2013 focusing on 16 women with and without ANC and hospital deliveries in the previous five years [25]. Two researchers (KACP and RT, who speak, read and write Hmong) conducted open-ended interviews with the 16 women, their 12 husbands, and 17 involved relatives, in their homes, in Hmong. The interview guide contained open-ended questions about women’s life history of each pregnancy and elicited who made maternity care decisions for each pregnancy. Women’s interviews lasted 1-2.5 hours and interviews with husbands and relatives lasted 15-60 minutes. The two interviewers took detailed notes and typed up the notes for analysis in English; they were not audio-taped because community advisors cautioned that families would not honestly share their critiques of the Thai health care system if they were audio-taped. After three researchers (KACP, SS, RT) finished preliminary analysis, we held a focus group with 12 case study participants (7 women and 5 men) and 2 female community advisors to obtain their feedback about the analysis and gain input into potential interventions. In addition, we discussed pregnancy issues with villagers, interviewed key informants about traditional practices, and visited six post-partum women (4 in the hospital and 2 at home).

Data Analysis

Our qualitative analysis team consisted of the two researchers who conducted the interviews (KACP and RT), and a qualitative researcher (SS) who read the English notes. Guided by grounded theory [26,27] two researchers (KACP and SS) worked together on the first five cases, inductively coding events about each pregnancy, organizing codes into categories, and creating the coding tree. We then used the coding tree to separately code and organize the pregnancy events in the remaining 11 case studies. Subsequently, all three researchers discussed the coded and organized case study notes until we agreed about codes and categories, which we then used to create matrices to display decision-making factors about each pregnancy.

The Ethics Committee of Faculty of Associated Medical Sciences, Chiang Mai University, Chiang Mai Thailand approved this study. Each participant signed a consent form, and received 200 Thai baht (about US$6.50) to compensate for their time.

Results

The 16 case study participants’ demographic characteristics are described in Table 1. All 16 women had been married when pregnant, 2 were divorced before the study period; all 14 husbands participated in demographic questionnaire and 12 participated in the qualitative interviews. The women’s 50 pregnancies in the previous 18 years are listed in Table 2. The four main patterns about who made which decisions about ANC and birth location are in Table 3. The four patterns of family-based decision making are placed along a continuum from elder-based to interactive family-based to women-based decisions in Figure 1.

Pattern #1: Elders made decisions

In this traditional pattern, husbands’ elders were responsible for the young couple. The man’s elders educated them about practices to embrace and avoid during pregnancy, interpreted signs and symptoms that might indicate a need for healing ceremonies, decided if a healer or a doctor visit was necessary, sought a traditional healer, provided funds for doctors and healers, arranged transportation for clinic and hospital visits, and supported them through the birth process. In the case studies, these aspects of the inter-generational relationship were vividly present for the first pregnancy, and became less active over time with ensuing pregnancies, as the couple became more responsible for their own decisions and became more independent with their own money and ultimately with their own household.

Table 1: Socio-demographic characteristics of case study participants.

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>16 women</th>
<th>14 husbands*</th>
<th>17 elders</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ages, years Mean (range)</td>
<td>28.4 years (20-27)</td>
<td>31.8 years (27-39)</td>
<td>49.2 years (48-65)</td>
</tr>
<tr>
<td>Marital status, current</td>
<td>Married 14 (88%)</td>
<td>2 (12%)</td>
<td>14 (100%)</td>
</tr>
<tr>
<td>Divorced</td>
<td>2 (12%)</td>
<td>13 (76%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Widowed</td>
<td>0 (0%)</td>
<td>4 (24%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Religion</td>
<td>Christianity 15 (94%)</td>
<td>1 (6%)</td>
<td>11 (92%)</td>
</tr>
<tr>
<td>Animism/Buddhism</td>
<td>6 (44%)</td>
<td>1 (8%)</td>
<td>15 (88%)</td>
</tr>
<tr>
<td>Formal education</td>
<td>None 5 (31%)</td>
<td>1 (7%)</td>
<td>10 (71%)</td>
</tr>
<tr>
<td>Primary education</td>
<td>4 (25%)</td>
<td>3 (21%)</td>
<td>15 (88%)</td>
</tr>
<tr>
<td>Secondary education</td>
<td>0 (0%)</td>
<td>2 (12%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Thai language skills</td>
<td>Understand, not speak 0 (0%)</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Speak, not read or write</td>
<td>5 (31%)</td>
<td>1 (7%)</td>
<td>13 (93%)</td>
</tr>
<tr>
<td>Thai, read and write</td>
<td>11 (69%)</td>
<td>8 (57%)</td>
<td>16 (94%)</td>
</tr>
<tr>
<td>Primary occupation</td>
<td>Farmer 13 (81%)</td>
<td>8 (57%)</td>
<td>16 (94%)</td>
</tr>
<tr>
<td>Merchant</td>
<td>2 (13%)</td>
<td>0 (0%)</td>
<td>1 (6%)</td>
</tr>
<tr>
<td>Wage laborer</td>
<td>1 (6%)</td>
<td>6 (43%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>*14 husbands completed initial questionnaire, and 12 husbands participated in qualitative study</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Home delivery</th>
<th>No ANC 16 (32%)</th>
<th>Yes ANC 10 (20%)</th>
<th>Total rows 26 (52%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital delivery</td>
<td>17 (34%)</td>
<td>24 (48%)</td>
<td></td>
</tr>
<tr>
<td>Total columns</td>
<td>23 (46%)</td>
<td>27 (54%)</td>
<td>50 (100%)</td>
</tr>
</tbody>
</table>

Table 2: Maternity healthcare services for 50 pregnancies over previous 18 years.
Patterns | Decisions – antenatal care | Decisions – birth locations
--- | --- | ---
Pattern #1: Elders made decisions | No ANC 10 couples 23 pregnancies | Yes ANC 14 couples 27 pregnancies | Home birth 12 couples 26 pregnancies | Hospital birth 11 couples 24 pregnancies
Pattern #2: Elders, women, husbands made decisions. | 1 couple 2 pregnancies | 2 couples 2 pregnancies | 4 couples 5 pregnancies

Pattern #3: Women and husbands decided together | 1 couple 1 pregnancy | 1 couples 3 pregnancies | 1 couple 1 pregnancy | 1 couples 2 pregnancies

Pattern #4: Women made decisions | 1 woman 1 pregnancy | 4 women 6 pregnancies | 1 woman 2 pregnancies | 4 women 5 pregnancies

Note: Couples do not add up to the total in each column or row, as any couple with more than one pregnancy could be in more than one column or row

Table 3: Patterns of who made maternity care decisions for 50 pregnancies.

Elder-based \ Interactive family-based \ Women-based

1 | 2a | 2b | 2c | 3a | 3b | 3c | 4

Elders | Elders+W+W | Elders+W+H | Couple+elders | H+H | W+H | W+H | W

Key:
W = women
H = husbands
> = more than
+ = with

Figure 1

(For my first two babies) I went for ANC and delivered in the hospital. His family decided, which was fine with me. (Woman) Delivering at the hospital is good. .. It is good to deliver at home also. It is up to the elder decide, as they are the ones who have to help.... At the hospital, the doctors help. Up the mountain, the elders help. (Husband)

Pattern #2: Elders, women, and husbands made decisions

For some pregnancies, families made decisions with equal input from the couple and the husband’s elders (2c), while in others, elders had more influence, whether they influenced their son and his wife together (2a) or influenced the wife who then convinced the husband (2b).

For ANC choices, most elders stated they held no opinions, as they had no knowledge of ANC and deferred to their educated children to make an informed decision. Some elders expressed encouragement for ANC, stating the doctors could help diagnose problems and the vaccinations could make the fetus stronger, and a few elders expressed discouragement for ANC, stating the care practices were not necessary or were harmful; but in both situations they said their children should decide.

We don’t know why they (our son and his wife) didn’t go for ANC for the first 4 babies.

It was up to them to decide. (Husband’s father)

My mother said: ‘You can go for ANC or not go’. I decided it was good to go....(Husband)

For birth location choices, elders’ opinions were influential. Some elders strongly supported home births, stating that home births could happen easily and safely. Many of these elders had positive home birth experiences themselves and some had assisted women during home births. In contrast, other elders strongly opposed home births. Some of these elders had experienced fetal and infant losses themselves, and several had witnessed fetal distress after a difficult birth process. In general these elders wanted their family members to be safe; they did not want to witness challenging births; and they did not want to be responsible for assisting when they felt they did not know how to assist a difficult birth. In this decision-making pattern, the elders, sons and daughters-in-law concurred with these perspectives about delivery location.

She wanted to deliver at home, so I supported her, but I thought it was better to go to the hospital. I asked several elders, and they said she was fine, she can deliver at home. So we did, and everything went well. (Husband)

We are glad they are going to go to the hospital. This makes us parents happy that they will go to the hospital, and then it is not our responsibility to help them. (Husband’s parents)

Pattern #3: Women and husbands decided together

While the first two patterns were described as being the traditional ideal, this third pattern was the most frequent and was described as the current ideal by the younger generation. In this pattern the couple decided together so they could share their parental responsibility for their newborn child and share the consequences of their decisions. They either had equal input, or one spouse had a stronger opinion than the other spouse. These couples made their decisions without sharing the decision making process with their elders. While the married couple would have been aware of the elders’ opinions, and they may have taken the elders’ preferences into account, they stated they were deciding for themselves.
It is up to the couple to decide (about ANC). I don’t know. She knows her body.

I believe my wife. If she goes, and there is a problem, then it is better if both people agreed together.... I have never discussed ANC with my mother. It is really up to my wife, the daughter-in-law. (Husband)

Some of the couples even made decisions against their elders’ wishes. For an ANC example, one set of parents told their two sons and daughters-in-law to avoid ANC, stating that the vaccinations harmed the fetus; their two sons and daughters-in-law made two different decisions, with one couple not obtaining ANC or vaccinations and the other couple obtaining ANC and vaccinations. For a birth location example, four couples chose home births against their elders’ expressed preferences of hospital births, because they wanted to avoid doctor’s insisting on interventions such as repeat C-sections and/or tubal ligations.

I planned to deliver at home. I was the one who decided, and my husband agreed. His parents wanted us to deliver at the hospital, but we decided. We didn’t want another C-section or a tubal ligation, because we want another son; we only have one and I love my husband. (Woman)

If the woman and her husband disagreed, the optimal approach was that they needed to agree on the decision, with the stronger person’s opinion influencing the other person. Generally the older generation said that ultimately the husband must decide because he is the superior one in the relationship and he is (or will be) the household head. In contrast, generally the younger generation said that ultimately the husband has to agree with the wife, because it is her body. If he disagrees with her, he can try to change her mind, but if he cannot change her mind, then he must support her.

Usually the wife listens to the husband more than the husband listens to the wife. But for ANC, I am the one to decide. If the woman says: Let’s go ANC, then they go, then he listens to her..... (The husband won’t say "We don’t have money for ANC" when the wife wants to go for ANC. (Woman)

Both men and women have to decide together. I was afraid for her, but I couldn’t decide for her. She is the one with the pains. She was braver and I was more scared, but we supported each other. I was brave for her; she was brave for me. I trusted her; she trusted me. (Husband)

Most couples expressed deferring to the wife’s opinion. For ANC choices, the husband could neither refuse to spend time and money to take her to the hospital, or take her against her will. For birth location choices, he could neither refuse to take her to the hospital, or take her against her will. And if she chose a home birth, he must support her, while waiting to drive the truck and take her to the hospital in case she later changed her mind.

I have told her to go (for ANC). If she doesn’t want to go, she doesn’t go. I don’t know what else I can do. I can’t argue about it. ... I said she should go to the hospital but she didn’t want to. ... It is up to the women. ...Women know their labor pains. I don’t know. Husbands are not the ones who are short of breath. (Husband)

**Pattern #4: Women decided without husbands and husbands’ families**

All five women in this category explained that they made their own decisions without their husband or their husband’s family because their husbands didn’t care about them, or their husbands weren’t actively involved in “women’s matters”. Sometimes they asked their own parents, family, or other villagers for help. Participants described this fourth pattern as appropriate, but not ideal. It was appropriate for a woman to decide what she needed to do, and necessary when her husband was not supportive, but ideally she and her husband should agree together. These women had similar demographic characteristics to the women in the other categories.

I knew that my husband couldn’t take care of me, so I had to go see the doctor/nurses as they could take care of me. I decided by myself to go to the hospital. (Woman)

I went to help myself because we two lived by ourselves---we didn’t live with his parents -and if I delivered in the mountains, no one would be there to help me. (Woman)

**Spectrum of Family-based Decisions**

These eight descriptive categories of family-based decision making can be placed along a continuum (Figure 1), from elder-based (the traditional pattern of elders making decisions especially with couples’ first pregnancies), to interactive family-based with and without elders (the more common pattern of couples deciding together without elders), to women-based decisions (when women felt they were not supported by their husbands or husbands’ family). Patterns #1 and #2a-c were seen as ideal by the elders and acknowledged as traditional patterns by both the older and younger participants. Elders made decisions for couples with first pregnancies, and then the family members made decisions together for subsequent pregnancies, with couples gaining more influence over time; most of the decisions in these patterns were towards ANC and towards hospital births. Patterns #3a-c were the most common and were described as ideal by the younger participants; about half chose ANC, and more chose home births than chose hospital births. The traditional idealized gender structure where husbands as male household heads had power over wives was tempered during pregnancy. Pregnant women and their husbands were supposed to agree, with women having more power to affect decisions about maternity care and having more influence over their husbands than in other areas of their lives. When couples disagreed, husbands yielded to their wives’ desires more than they insisted on their own views. The last pattern (#4) was the least common and only occurred when women felt unsupported by husbands and husbands’ families; most chose ANC and hospital birth, while one woman chose no ANC and home birth.

Over time, the first 3 categories occurred throughout the previous 18 years, influenced by changes over the lifecycle. When newlyweds lived with the man’s families and parents, his elders decided, or the elders influenced the married couple. Over time, as married couples gained more independence, whether moving out of the house or still living at home, they made their own decisions. More recently married couples experienced this phenomenon as well as more distantly married couples. In contrast, the fourth category only occurred in the previous 5 years; no case study women had been divorced, or separated, or expressed feeling unsupported by their husbands while pregnant during the first 13 years.

- While participants expressed one dominant decision making pattern per pregnancy, people were aware of other family members’ opinions, and the patterns were undoubtedly intertwined. A middle-aged man, living with his wife and 3 children and close by his mother, expressed the intertwined nature of the family-based decision patterns from his vantage point as the recognized male household head:

  - I, as the husband, I am the one to decide where my wife and I will go to deliver. for the people to help us. If I tell her we’ll go to the hospital, and she is willing to go, then we go. If I tell her, and she doesn’t
was a retrospective study about pregnancies over the past 18 years, taped interviews limited our analysis to the intensive notes, and did appropriate sample selection and statistical analysis. The lack of audio-
other ethnic groups in Thailand, as it is not a quantitative study with
not yield generalizable results to other Hmong villagers in Thailand, or
members' assessments, interactions, and decisions. In addition, it does
tify and account for multiple variables that could be influencing family
this study of one ethnic group in one village is not designed to iden

Limitations
Our study supports their analysis.

The study has several limitations. As with all qualitative studies,

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