

**“No Matter What Goodness Women Do, Women Are Not Their Husband’s People”:
A Qualitative Analysis of Hmong Women’s Reproductive Health in Rural Northern
Thailand**

By

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Abstract

Hmong women in northern Thailand face unique reproductive health challenges shaped by socio-cultural and gendered expectations. Despite global health disparities, limited research has examined how these factors influence Hmong women’s reproductive health experiences in rural Thai settings. This qualitative study draws on participant observation, in-depth, semi-structured interviews with married Hmong women in Ban Mae Sa, Chiang Mai, Thailand. Thematic analysis was guided by socio-ecological, life course, gendered, and grounded theory frameworks to explore how Hmong women navigate reproductive roles, marriage dynamics, and healthcare access. Five key themes emerged: (1) Traditional Hmong Way of Life, (2) Gendered Expectations of Marriage: Pregnancy and Motherhood, (3) Health Care Accessibility, (4) Family Planning, and (5) Economic and Social Support. Findings show that reproductive health among Hmong women is shaped by deeply rooted patriarchal norms and structural barriers. Addressing these challenges require culturally responsive efforts to shift norms, engage Hmong men and women, and improve healthcare access.

Keywords: Hmong women, northern Thailand, reproductive health, marriage, pregnancy, family planning, healthcare access

Introduction

This article is a qualitative research study focusing on reproductive health among Hmong women in Ban Mae Sa, located in Pong Yaeng Sub-District, Mae Rim District, Chiang Mai Province, Thailand and is in collaboration with Southeast Asian Study Abroad (SEASA), a non-governmental, community-based organization based in Ban Mae Sa. SEASA is committed to supporting the well-being of Hmong women and children (SEASA, 2023). As both collaborators and community members, SEASA identified concerns related to marriage and pregnancy, particularly early marriage and early pregnancy, among Hmong women. In response, SEASA

invited the research team to collaborate on addressing Hmong women’s health, with the goal of informing future program development through evidence-based and community-reflective recommendations. Given that this community is understudied, with limited existing research and literature, a qualitative approach was implemented to capture the depth and complexity of Hmong women’s lived experiences. In alignment with SEASA’s mission and through a collaborative, community-engaged process, this study explores the socio-cultural factors that shape reproductive health experiences among Hmong women in Ban Mae Sa.

Background

Reproductive Health

The World Health Organization (WHO) defines reproductive health as a state of complete physical, mental, and social well-being in all matters related to the reproductive system, throughout the life course (Ara et al., 2022). This includes the right to a safe and satisfying sexual life, access to family planning services, the ability to make informed reproductive decisions, maintain healthy relationships, and prevent reproductive health-related diseases, with the freedom to decide if, when, and how often to have children (Ara et al., 2022). Globally, reproductive health challenges remain pressing. An estimated 295,000 maternal deaths occur each year, primarily in low- and middle-income countries (Antsaklis et al., 2022). In Southeast Asia, ethnic minority communities experience significant barriers to accessing reproductive health services, which increase risks such as maternal mortality, preterm birth, and untreated complications during pregnancy and childbirth (Jones et al., 2014).

The Hmong Diaspora

The Hmong are an ethnic group with a “unique culture and language with some dialectic differences” (Vang & Flores, 1999, p. 9). ‘Hmong’ is commonly interpreted to mean ‘free’ or

‘free people,’ reflecting their cultural emphasis on independence and freedom (Hmong American Center, 2018). Historically, the Hmong can be traced back to China as early as 2700 B.C., and then to various regions of Southeast Asia during the 1800s (Thao, 2021; Vang, 2007). In the early 1960s, the United States (U.S.) feared that “communist control of Laos would lead to the ‘loss’ of all Southeast Asia” (Benson, 2015, p. 34). In response, the U.S. recruited the Hmong to fight in the Secret War against communism in Laos (Hillmer, 2011). Between 1975 and 1997, approximately 138,000 Hmong people escaped Laos by crossing the Mekong River into Thailand due to persecution. Many found temporary refuge in camps supported by the United Nations High Commissioner for Refugees (UNHCR), the Thai government, and international humanitarian organizations. While over 100,000 Hmong eventually resettled in countries such as the U.S., France, and Australia, others remained in Thailand (Stanford Medicine, n.d.). Today, the global Hmong population is estimated to be between 4 and 5 million across Southeast Asia and Western countries (Zhang, 2023).

The Hmong in Northern Thailand

While many Hmong resettled in Thailand after the Secret War, others migrated to the mountains of northern Thailand much earlier, around 1885, and are recognized as the second-largest hill tribe group in the country (Xuefang, n.d.; Wirunsakunphiban et al., 2022). Among their settlements is Ban Mae Sa, a Hmong village located within the boundaries of Doi Suthep-Pui National Park in Chiang Mai, Thailand (Green Trails, 2024). Founded in 1922 at an elevation of 1,300 meters above sea level, Ban Mae Sa was later relocated to its current location at 1,000 meters in the early 1960s due to deforestation (Chazdon, 2022).

Ban Mae Sa is the largest Hmong community in northern Thailand, with approximately 1,800 individuals, 90% of whom speak the Hmong Green dialect and 10% the Hmong White

dialect (Chazdon, 2022; Green Trails, 2024). The village is uniquely known for its role in cultural tourism, where community members perform traditional Hmong shows for tourists. These performances, which include music, storytelling, and rituals, offer an immersive experience of the “authentic” Hmong way of life. However, many of the featured traditions, such as courting songs and hunting calls, are no longer part of everyday life and have been revived specifically for tourism. While community members take pride in preserving these traditions, adaptations like shortened show times, mixed costumes, and blended cultural gestures reflect the tension between preservation and commercialization (Wirunsakunphiban et al., 2022).

Reproductive Health Across the Hmong Diaspora

Marriage and childbearing are central to Hmong cultural identity and social structure, where the ability to bear multiple children, particularly sons who inherit family clans, is widely regarded as a measure of success and respect (Kamdee & Nuntaboot, 2021). As a result, early marriage remains common across the Hmong diaspora. In Vietnam, some girls marry between ages 13 and 16 and some boys as young as 14 (Jordana, 2016; Triet, 2024); in the U.S., some girls marry between 13 and 18 (Vang, 2013; Vang & Her, 2014); in Laos, some girls marry between 12 and 15 (Redfern & Joyce, 2018; Toutou, 2023); and in China and Thailand, some girls marry at ages 14 or 15 (Xuefang, n.d.). Some early marriages have been reported to occur through arranged marriage (Toutou, 2023; Vang, 2013), bride kidnapping (Lan, 2024; Toutou, 2023; Triet, 2024), and forced marriage (Vang, 2013). These practices, driven by cultural expectations to improve Hmong boys’ social status and continue the family lineage, often come at the expense of Hmong girls’ education, autonomy, and reproductive health (Kamdee & Nuntaboot, 2021; Jordana, 2016). Moreover, early and repeated childbearing increase Hmong women’s risk of complications such as anemia, postpartum hemorrhage, and infections, which

are often exacerbated by delayed access to healthcare and preference for traditional remedies (Culhane-Pera et al., 2015).

Reproductive Health among the Hmong in Northern Thailand

Earlier research documents that Hmong communities in northern Thailand sustain high fertility and relatively low use of healthcare, shaped by rural residence, reliance on self-employed farming, and low levels of formal education among Hmong women (Kunstadter et al., 1993). Similarly, the 2011–2012 Northern Thailand Access to Care in Communities survey finds that Hmong women use maternity services at significantly lower rates than Thai women, with higher proportions not obtaining antenatal care (8% compared to 1.1%) or delivering in a hospital (12.7% compared to 0.3%) (Culhane-Pera et al., 2015). Hmong women often view pregnancy as a natural event requiring little to no medical intervention, supported by beliefs that physical labor promotes easier deliveries (Culhane-Pera et al., 2015; Kamdee & Nuntaboot, 2021). At the same time, Hmong families perceive hospital births as “unnecessary, harmful, abusive, or inadequate” (Culhane-Pera et al., 2014, p. 1). Discrimination and disrespect in healthcare encounters are frequently reported by Hmong women, particularly as members of minority hill tribe groups in northern Thailand, including experiences of episiotomies, cesarean sections, tubal ligations, and other procedures performed without adequate explanation or informed consent (Culhane-Pera et al., 2014), which further discourages them from seeking healthcare.

Reproductive Health among the Hmong in Ban Mae Sa

While previous research has explored marriage, pregnancy, and social structures among Hmong communities in Thailand and across the Hmong diaspora, very little research specifically examines the reproductive health experiences of Hmong women in Ban Mae Sa. To date, only

one identifiable study appears to directly examine Ban Mae Sa, although its publication date is unclear. This study describes deeply rooted cultural beliefs that frame early marriage, early childbearing, and high fertility as social and spiritual blessings (Xuefang, n.d.). Conventional ideas that “marrying early, bearing early, and having many children are blessings” remain influential, with many Hmong girls leaving school between the ages of 13 and 18 for marriage and bearing multiple children, especially sons, before the age of 20, as fertility and child survival are closely tied to social respect and status (Xuefang, n.d., p. 10).

Ban Mae Sa is a particularly significant setting for this study because it is the largest Hmong community in northern Thailand and continues to be shaped by geographic marginalization, strong cultural traditions, and complex relationships with Thailand’s healthcare system. Although research has examined reproductive health among Hmong women in northern Thailand, very few studies have focused specifically on Ban Mae Sa or explored how village-level dynamics influence Hmong women’s reproductive autonomy and healthcare decision-making. Broader studies document persistent barriers to care, discrimination in healthcare settings, and reliance on traditional remedies and reproductive practices. However, these patterns have not been thoroughly examined within this specific community. As a result, Ban Mae Sa offers a critical opportunity to understand how these socio-cultural factors are experienced and how they shape Hmong women’s reproductive health.

Theoretical and Methodological Frameworks

This study uses four guiding frameworks: (1) the Socio-Ecological Model, which examines how individual, interpersonal, community, institutional, and policy-level factors interact to shape Hmong women’s health behaviors and outcomes (Tebb & Brindis, 2022); (2) the Life Course Approach, which considers how early life experiences, critical transitions, and

cumulative exposures across time influence Hmong women’s health and well-being throughout their lives (Stephenson et al., 2023); (3) a Gendered Perspective, which analyzes how gender norms, power dynamics, and socially constructed roles affect Hmong women’s access to resources, autonomy, and health outcomes (UN Women Training Centre, 2025); and (4) Grounded Theory, which collects and analyzes qualitative data to develop theories grounded in Hmong women’s lived experiences (Eddy & Fife, 2021). Together, these frameworks provide a comprehensive lens to understand the multi-layered factors influencing Hmong women’s reproductive health. In partnership with SEASA, this study explores how socio-cultural factors shape reproductive health experiences, particularly around marriage, motherhood, and family planning, among Hmong women in Ban Mae Sa.

Methods

Ethical Considerations

Ethical approval for the study was obtained from the Institutional Review Board at St. Catherine University (Protocol #2065). Audio recordings and transcripts were securely stored in Google Drive, with restricted access limited to the research team. Additionally, Ban Mae Sa’s representative granted permission for the research team to conduct research within the village.

Design

This qualitative research was led by Dr. Susi Keefe, Director of St. Catherine University’s Masters of Public Health Program in Global Health and Associate Professor and included three additional researchers; Gao Sheng Yang, lead graduate student researcher, Lee Lor, second graduate student researcher, and Connie Vang, Visiting Assistant Instructor. Three members of the research team identify as Hmong and are fluent in the Hmong language, which enriched both the scope and the process of the research.

This study used a qualitative research design to explore reproductive health knowledge, beliefs, and practices among Hmong women in Ban Mae Sa. Primary data collection was conducted over a 5-week period from June to July 2024, in partnership with SEASA, using qualitative methodologies to capture participants' narratives, revealing socio-cultural factors and personal experiences often overlooked by quantitative methods. Storytelling, a practice deeply rooted in Hmong culture, supports the use of qualitative methodologies by preserving and conveying Hmong traditions, values, and beliefs for generations (Xiong et al., 2012). This cultural form of narrative allows for a richer, more nuanced understanding of the socio-cultural factors shaping reproductive health experiences among Hmong women, making qualitative research the most suitable method for capturing this community and their lived experiences.

Participants

A total of 20 Hmong women participated and recruitment was facilitated by SEASA using convenience and snowball sampling. To be eligible for participation participants were required to meet the following criteria: (1) be a Hmong woman currently residing in the community; (2) be currently or previously married and have at least one child; and (3) fall into one of the following marriage duration groups: 0–5 years, 5–10 years, 10–20 years, or over 20 years. Each marriage duration group included 5 participants. Participants were informed of the study's purpose, procedures, and voluntary nature, with verbal consent obtained prior to participation. As an incentive, SEASA partners recommended participants receive 300 Thai baht (approximately 8.84 U.S. dollars), and a bag of locally grown fruits and chicken eggs upon completing their interviews, in recognition of their time and expertise.

Characteristics	N	%
Age		

20 – 29	7	35
30 – 39	6	30
40 – 49	3	15
50 – 59	2	10
60+	2	10
Age at Marriage		
14 – 16	5	25
17 – 19	6	30
20 – 22	2	10
23 – 25	2	10
26 – 28	5	25
Marital Status		
Married	18	90
Widowed	2	10

Table 1. Characteristics of participants by age, age at marriage and marital status

Data Collection

Data collection was primarily conducted through in-person, semi-structured interviews. The interview guide included three sections with a total of 33 questions focused on reproductive health, marriage, pregnancy, family planning, and antenatal care. The development of the semi-structured interview protocol was informed by a review of relevant literature on reproductive health, with a focus on Hmong cultural beliefs and traditions, antenatal care utilization, and gender norms among Hmong and rural Thai communities. Additionally, the interview guide was reviewed by the research team and SEASA, which refined the clarity, cultural appropriateness, and sequencing of the interview questions and Hmong language translation.

The interview questions were open-ended to allow participants to share their experiences in their own words, with additional probes to encourage elaboration. Interviews lasted between 1 and 3 hours and were scheduled at times and locations convenient for participants to minimize disruption to daily activities. Participants were allowed to respond in Hmong, Thai, or a combination of both languages throughout the interviews.

In addition to semi-structured interviews, the research team engaged in participant observation and attended daily activities and cultural events within the community. These observations provided additional context to the interview data, enriching the understanding of socio-cultural influences on reproductive health experiences.

Data Analysis

The interviews were transcribed into English by the lead researcher. Audio recordings and transcripts were reviewed multiple times to immerse in the data and understand the nuances of participants' experiences. Data analysis followed a Grounded Theory approach, guided by four steps: (1) tagging, (2) coding, (3) categorizing, and (4) grouping data into themes that captured key insights from participants’ experiences (Eddy & Fife, 2021). This process was complemented by participant observation, community engagement, a review of relevant literature, and recurrent research team discussions. Data were analyzed manually using Google Docs, Google Sheets, and Google Slides.

Results

The data analysis revealed five key themes drawn from participants' shared experiences. These themes capture the lived realities, cultural traditions, and challenges that Hmong women navigate in relation to reproductive health. The identified themes are: (1) Traditional Hmong

Way of Life, (2) Gendered Expectations of Marriage: Pregnancy and Motherhood, (3) Health Care Accessibility, (4) Family Planning, and (5) Economic and Social Support.

Traditional Hmong Way of Life

Across all interviews, participants described the challenges they face with family dynamics, with special attention to patrilocal living, bridenapping, and pressures from in-laws.

Family and Community Roles

Participants shared the pressures of being a good *nyab* (daughter/sister-in-law), describing the high expectations and responsibilities placed upon them to fulfill household duties, respect elders, and maintain harmony.

From what I hear, I am not a good *nyab*. They say that a good *nyab* must listen and do whatever a grandmother and grandfather say, and must not argue back ... (2.1.5, NHY06, age 30–39)

If they have good in-laws, then their in-laws will not say much. But if they do not have good in-laws, if they make boiled greens, they will be lectured (2.1.8, TYX20, age 40–49)

Participants expressed both the benefits and challenges of relationships with in-laws, with supportive in-laws easing the transition into married life, but critical in-laws imposing restrictions on independence.

Everyone has their own way of finding and earning income, so I do not want in-laws to always hold us to stay together when married. I want in-laws to let us go find and earn our own income so that there are no arguments ... As daughters, we marry husbands, so if we give a lot to our biological parents, our in-laws will not like us ... This is something that we are afraid of when we marry husbands, it makes us sad. (2.1.13, NL13, age 20–29)

Participants shared that when family conflicts arise, they often turn to clan leaders for mediation and guidance.

If *kwv tij* (husband’s side of the family) does not help, then go tell the clan leaders ... they will help mediate ... They address problems equally. After lectures, clan leaders see if it gets better. If it does not get better, it is up to the wives and husbands. (2.1.11, NL13, age 20–29)

Participants highlighted the important role of friends as sources of emotional and practical support, particularly when familial relationships are strained.

I have friends so when I am sad, I have a place to express my feelings. But those who do not have friends, they are depressed and do not know who or how to express it ... (2.4.1, MTH07, age 30–39)

These narratives illustrate how traditional Hmong family structures and social expectations, especially patrilocal living, hierarchical in-law dynamics, and the role of the *nyab*, deeply influence Hmong women's daily lives, emotional well-being, and access to support, both within and outside the household.

Traditional Practices

Though now less frequently occurring, a few of the older participants described their personal experiences with bridenapping, a practice of kidnapping girls to be brides.

I was 17 years old. My husband was 22 years old ... I did not want to marry so they bridenapped me. I told them, “I do not want to marry yet” but they did not listen. So, they dragged me ... My mother had already gone outside to speak to them, but they said, “No matter what, we will marry her. If we do not marry, then the others will come and marry her.” Anyone’s heart would hurt ... But nothing could be done ... (1.1.7, PYX19, age 50–59)

When they told us that they were going to marry us, we said to them, “I do not want to marry.” But they still bridenapped us all the way to their homes. We could not do anything, so we just stayed here until now, all old (2.1.6, KYX11, age 60+)

Back then, they bridenapped so I was bridenapped. They bridenapped women a lot ... Right now, they do not bridenap anymore ... (1.1.7, NTX04, age 60+)

The practice of bridenapping did not only occur in previous generations, but was also facilitated by the groom's parents and relatives who believed it was an acceptable way to secure a marriage for their sons.

Participants also expressed the pain of being unable to return to their biological families after divorce or during times of need, a reflection of traditional beliefs that Hmong daughters

lose their value after marriage. Participants voiced their hopes for cultural changes that would allow them to seek refuge and support from their parents without judgment or rejection.

Hmong has a tradition that if women do not have a marriage that lasts, we cannot return ... It is difficult ... I want there to be a change ... (2.1.13, MTH07, age 30–39)

As a woman, when we marry, why are we not able to go to our parents? We cannot be sick or pass away in our parent’s home. As a Hmong daughter, our *neej tsa* (women’s side of the family) does not see value in their daughters. (2.1.13, YHX08, age 30–39)

These challenges, unsupported by biological families, have led some Hmong women to contemplate or die from suicide, feeling trapped with no place to turn for help or understanding.

Even if I went to my mother and father, they would say, “You already went, so endure it.” So I would return and endure what my mother-in-law lectured ... Number one is thinking, “I went good, but lived badly, so I will die.” Making the way of dying first ... (2.1.8, TYX20, age 40–49)

Either leave or die [suicide]. I have seen women die because they could not have children or their in-laws did not like or support them. (2.1.12, CHX12, age 50–59)

These narratives underscore how deeply rooted traditional practices, such as bridenapping and post-marriage exclusion, continue to shape the emotional and social landscapes of Hmong women’s lives. While some of these traditional practices are fading with time, their lasting effects, particularly on Hmong women’s autonomy, sense of belonging, and mental health, remain a significant concern voiced by many participants.

Gendered Expectations of Marriage: Pregnancy and Motherhood

Across all interviews, participants described the common expectations placed on Hmong women regarding marriage, pregnancy, and motherhood.

Wife's Sacrifice, Daughter's Endurance

Participants discussed the expectations for Hmong wives to take on all household duties, leading to overwhelming responsibility if not shared with others in the family.

Hmong think and say that when a man marries a wife, the wife must make meals and do everything ... Whoever can do it can do it. If everyone waits for one person, that one person cannot do it all. (2.1.13, TNVY15, age 30–39)

Participants emphasized a common sentiment that Hmong daughters must silently endure hardships, leading to a cycle of unacknowledged suffering.

They must endure it. Endure it alone. Even with my life, I just endure it. (2.1.12, YLX03, age 30–39)

If there is no one to help, then there is nothing that we can do. We just have to go along with our fate. (2.1.12, MTH07, age 30–39)

To leave, it is difficult. Myself, when I go back to my mother and father, they tell me, “Daughter, endure it.” ... If one decides to leave, they must cut off ties. To change is just to leave. If one returns, they will have to endure it again. (2.1.13, YLX03, age 30–39)

These narratives reveal how deeply ingrained gendered expectations place a heavy burden on Hmong women, who often silently endure hardship and prioritize family responsibilities above their own well-being, with little support or opportunity to seek change.

Early Marriage and Pregnancy

Participants observed that early marriage and pregnancy, sometimes as young as 12, occurred in the village, but that this has changed in recent years.

There are girls who marry and have children early in this village ... They are 12 years old, 14 years old, 15 years old, ages like this. Girls who marry at these ages go and not too long after, they come back. (2.1.1, MTH07, age 30–39)

Back then, there were some who were 15 to 16 years old and married. Those who were able to stay longer married at 16 to 17 years old. Back then, they said, “Women who are 20 to 30 years old are too old.” (2.1.1, NTX04, age 60+)

Challenges with Early Marriage and Pregnancy

Participants shared that insufficient preparation often leaves Hmong women feeling unprepared for life, regretful of their decisions, and unable to foresee future challenges.

... “We like each other so let us just marry.” I just thought about this, I did not know to think about anything else ... I regret that back then, why did I not wait until I was older? I married when I was soft and young, and he did not like me, he did not love me ... I am sad that I married and he did not love me, my heart was broken. (2.1.5, KYX11, age 60+)

... It is a mistake in the way of love. We do not see what is ahead of us ... I did not see what problems would occur ahead of myself. (2.1.5, TYX20, age 40–49)

Therefore, participants expressed a desire for resources to help unmarried Hmong women build their lives before marriage.

To start a life together, what to prepare ahead of time. The program should tell them the way of starting a life, what mindset to have to, to help them move forward, before marrying a wife or a husband. (2.1.14, ZHY18, age 20–29)

Participants noted that young Hmong women often lack the skills, maturity, and experience to manage marital and financial responsibilities.

Women right now, who marry early like us, do not have the abilities compared to us back then. They do not know where to earn and find income, they do not know how to do anything ... (2.1.1, MTH07, age 30–39)

Nyabs work hard, so if they marry young, it will be hard work. If they do not know how to talk and mothers and fathers talk about them, then they will get into arguments. It makes living together challenging ... So if they marry young and are not able to find and earn income with others, others will not like them. (2.1.5, NLH13, age 20–29)

A participant mentioned that “the life of being Hmong, is scolding women and the wife. Most of the time, people will scold the wife.” (2.1.12, MVX17, age 20–29) These narratives reveal how early marriage and pregnancy often leave young Hmong women unprepared for the demands of family life, where participants voice for better resources and support to build skills, maturity, and financial independence before entering marriage.

Delayed Marriage and Pregnancy Advocacy

Participants advocated for delaying marriage until 20 or older to allow for Hmong women to complete their education, secure employment, and develop the maturity necessary for a stable and healthy marriage.

I want my daughter to stay longer with me then marry. Until she is at least 20 years old ... So she knows how to prepare for her life. If she marries at a young age, even if I provide her with things, she will not know how to prepare for her life. (2.1.2, ALX02, age 20–29)

... Truly in my heart, with all of my sons and daughters, I do not want them to garden, I want them to attend school. (2.1.2, CHX12, age 50–59)

... I have seen with my eyes that women who are not old enough ... They divorce their husbands and return ... They do not know how to find and provide meals ... They only go for a while, when it is fun to do so, but when they have 2 to 3 children, they divorce and return ... (2.1.3, YMLX16, age 40–49)

... 25 years old and over ... They already completed school ... They already have jobs and know people, so they know who would be good or not good partners, how to prepare for their life moving forward, what meals to make, things like that. (2.1.3, NHY06, age 30–39)

Furthermore, participants shared that delaying pregnancy until 20 or older provides physical, emotional, and practical skills necessary to care for children.

... So they know how to think, love their children ... They have at least basic knowledge of how to raise and care for their children. (2.1.3, NXL14, age 20–29)

... They must be 22 years old and above. Their bodies will be big enough, so when they birth their children, it will not tire them out as much ... They will know how to raise and care for their children. Some women, like my granddaughter who is young and 13 years old, when raising and caring for her child, she does not know how ... (2.1.3, YMLX16, age 40–49)

Motherhood and Responsibility

Participants revealed that pregnancy was an expected consequence of marriage, often not consciously planned, leaving many feeling unprepared and regretful.

I did not know that marrying meant to have children. I did not know what to do, so that is why I am living a sad life. (2.1.10, KYX11, age 60+)

There was no decision-making in having children. We just stayed together so eventually, we had children and kept them. (2.1.2, MTH07, age 30–39)

Even if the wife does not want to, they will still have children. (2.1.2, HQXH09, age 30–39)

Participants shared an understanding that raising and caring for children is a fundamental responsibility that young Hmong mothers must take on, sometimes without preparation or the opportunity to pursue other goals.

If they go and have children and are able to care for their children, then it is good. (2.1.5, ZHY18, age 20–29)

Back then, I continued to care and raise children and was not able to do anything else. I was only a girl who played like a child, then suddenly married. (2.1.1, KYX11, age 60+)

These narratives highlight how motherhood is seen as an expected and central role for Hmong women, often embraced with dedication despite limited choice or preparation.

Spousal Support and Marital Conflict

Participants shared experiences of limited autonomy in healthcare and childcare, expressing a lack of spousal support that isolates them and creates barriers to healthcare services.

With my first child, my in-laws did not let my husband take me to the clinic. So I had to wait for the bus alone. (2.3.3, YHX08, age 30–39)

When my husband does not have time to take me to seek healthcare. Going alone is difficult because I do not know how to drive, therefore, I cannot go. (2.3.3, PHY05, age 20–29)

I married and with my first child, my husband ... was still with his friends, at night too ... (2.1.8, ZHY18, age 20–29)

Participants shared that disagreements in marriage often arise from different perspectives, especially regarding household responsibilities and communication.

If husbands understand their wives ... If husbands help their wives fulfill responsibilities, then there will not be many arguments. And if mothers and fathers do not scold wives, then it will be okay. (2.1.10, NLH13, age 20–29)

Usual problems ... is the way of thinking ... If she understands him and if he understands her, then it will be good. But if she goes her own way and he goes a different way, then it will not be good. (2.1.9, ZHY18, age 20–29)

Conditional Love and Infidelity

Participants revealed that love in marriage is sometimes conditional. They expressed that without financial stability or mutual respect, relationships often lack genuine affection, especially from both spouses and extended family.

They love you if you have money. With me, he is able to love me because I have money. If I did not have money, then he would not love me as much and we would argue. (2.1.9, ALX02, age 20–29)

If the husband does not respect the wife and keeps scolding and keeps telling others about the wife, then *kwv tij* [husband’s side of the family] will not love or like her as much. (2.1.13, MVX17, age 20–29)

Participants observed that older Hmong men tend to prefer younger Hmong women.

Husbands are usually older by 1 to 2 years or 4 to 5 years ... Men like women who are younger [because] they are soft and young ... They are beautiful and do not know anything ... If women are older, they already know how to be mature, so then men cannot say anything to them. (2.1.7, HQXH09, age 30–39)

Participants shared experiences of infidelity in their marriages, including instances occurring shortly after childbirth.

When married early, husbands still like to be boyfriends. Like myself, I just had my first child, and my husband already went to be a boyfriend. (2.1.9, YHX08, age 30–39)

Participants expressed frustration when such affairs involved the misuse of their financial contributions, often earned through significant personal effort

It is not difficult when husbands want to be boyfriends, but it is difficult when they go, they use their money and help and love others. Wives work so hard to find and earn income, and husbands just take it out. (2.1.9, TYX20, age 40–49)

Divorce

Participants shared that a lack of mutual understanding and neglect of marital responsibilities often leads to divorce, with Hmong women enduring these challenges until the situation becomes unbearable.

Maybe both the wife and husband do not understand each other, which causes problems. It makes wives and husbands divorce each other ... Men like to find and be with many girls, and do not know to be, work, earn income with their wives. (2.1.5, MVX17, age 20–29)

Women must endure and if they cannot endure any longer, then divorce. (2.1.12, TYX20, age 40–49)

These overlapping challenges, ranging from a lack of spousal support and communication to conditional love, infidelity, and age-based power imbalances, illustrate how deeply embedded gender dynamics and societal expectations contribute to marital conflict.

Health Care Accessibility

Across all interviews, participants shared about the challenges with access to healthcare, with special attention to reproductive health, contraception, and abortion.

Government Healthcare

Participants expressed their desire for improved access to health care, expressing a preference for free healthcare services. Furthermore, they expressed dissatisfaction with government healthcare services, policies, and inconsistent government assistance.

Some things are free and some things are out-of-pocket, so we must borrow money. It depends on the government to decide what is free and out-of-pocket. (2.3.3, NLH13, age 20–29)

Furthermore, participants found the services at government-run clinics to be slow, overcrowded, and inadequate. They referenced the experience at private hospitals as better.

Anything that would make it easier would be having money and going to private hospitals ... it will be easier, quicker. They will medically treat people well, then people return home easily. (2.3.4, MTH07, age 30–39)

I heard that healthcare staff do not speak nicely to Hmong. They lecture at Hmong. But myself, healthcare staff speak to me and care for me well. (2.3.5, NLX14, age 20–29)

Distance, Road Conditions, and Transportation

Distance to healthcare services is a large barrier that participants identified, highlighting distance, road conditions, and lack of adequate transportation.

Distance is too far. When there was no car, I could not go because it was too far. (2.3.3, YMLX16, age 40–49)

The roads are not good and it is far, so even with a vehicle, it will be slow. (2.3.3, TYX20, age 40–49)

It is not easy. Women will just have to walk on foot. Women are given due dates, so no matter what, they will have to go. (2.3.4, PYX19, age 50–59)

Reproductive Health

Participants shared that today’s educational curriculum adequately covers reproductive health and hygiene, providing school-aged children with education on topics, such as menstrual cycles and childbearing.

Schools educate everything about bodies and the way of having children. They teach children who are 9 to 10 years old in primary school, grade 3 to 4. So teachers do teach about it, as well as menstrual cycles. (2.2.3, NLH13, age 20–29)

A participant mentioned that this is a difference from their own past experiences: “Back then, schools did not teach about pregnancy, but schools taught to not have sex to prevent pregnancy.”

(2.2.3, CHX12, age 50–59) Participants also expressed the unequal burden of pregnancy, shouldering the physical, emotional, and social challenges of parenthood on their own.

When women have children, they face problems alone. Men do not face the same problems as women. (2.2.6, PHY05, age 20–29)

Abortions

Participants noted the prevalence of abortions among young and unmarried Hmong women that has led to fertility issues and a reliance on traditional remedies.

Before girls are married, they talk to many boyfriends and have many abortions. After three abortions, it is difficult to have children again. Right now, elders find herbs for girls to have children, but their bodies are not good anymore. Either the womb has problems or they had too many abortions. (2.1.9, YMLX16, age 40–49)

Family Planning

Participants consistently described challenges with family planning, especially pressures to have children and difficulty advocating for contraception.

Significance of Children

Participants emphasized that cultural norms place significant importance on having children shortly after marriage.

Hmong say “If married, please have children.” Hmong do not think about whether couples are ready, or if couples have money, a house, land, or a garden, before having children. Usually, Hmong say “If married, please have children to continue the bloodline and prepare for your lives”, so most have children. (2.1.2, NXL14, age 20–29)

Participants revealed pressures tied to marital security and concerns about fertility, fearing husbands may seek relationships with other Hmong women to meet these expectations

Hmong say and think that if women marry their husbands and do not have children within 2 to 3 years, then their husbands will marry another wife ... (2.1.2, CHX12, age 50–59)

Usually, it is the mothers-in-law who tell the wives to have children. “You already married a husband, so just have children. Don’t wait too long. If you wait too long, you won’t be able to have children anymore.” (2.1.2, NLH13, age 20–29)

When they do not love you, you will be sad. I already have one or two children, so why do they not love me? (2.1.9, ALX02, age 20–29)

Contraceptive Refusal Among Men

Participants shared that Hmong men often do not use contraceptives despite being aware of their importance, making it difficult for Hmong women to advocate for contraceptive use.

Men know, but in that moment (during sex), men are too close and before we know it, men do not use it. I want men to know, but we are not able to tell them because they do not listen. (2.2.6 PYX19, age 50–59)

Even if men know, men will not use it. (2.2.6 CHX12, age 50–59)

Those who do not use it are embarrassed or their boyfriends do not allow them to use it. If they use it, it will not satisfy their boyfriends. (2.2.2 NLH13, age 20–29)

Participants described how Hmong men’s refusal to use contraceptives compels Hmong women to take responsibility for contraception themselves.

Men do not use it, only women ... It makes women have many children and that is a lot on women. We are women so we must care for ourselves. If we do not care for ourselves well, then we will have a poor life ... (2.2.2, MTH07, age 30–39)

Participants suggested that if Hmong men were more involved, such as through vasectomies, it would be less physically demanding for Hmong women.

I want for husbands to understand. To get vasectomies. We are women and get our tubes tied, but it is difficult for women. For our husbands, it will be easier. (2.2.6, MTH07, age 30–39)

Participants also expressed a strong desire for Hmong men to take responsibility for preventing both STIs and unintended pregnancies.

I want men to know that when they sleep with women, to wear condoms ... To not have infections and children, which can cause problems for women. (2.2.6, MXV17, age 20–29)

Economic and Social Support

Across all interviews, participants shared the desire and need for economic and social support for Hmong women and children, with special attention to economic, educational, and shelter programs.

Support for Women

Participants shared that financial constraints make marriage and having children difficult, stressing the need for financial support, especially during childbirth, to alleviate such challenges.

What makes the way of having children and marriage difficult is money. In this time, right now, everything costs money. (2.1.9, TNVY15, age 30–39)

... If there is no money, everything is difficult to do. If there is money, everything is easy to do ... Money is influential. (2.1.9, MVX17, age 20–29)

Participants expressed their desire for economic programs that provide support in finding and earning income, particularly for Hmong mothers with childcare responsibilities.

I want there to be help on how to find and earn income because when women have children, they cannot do anything outside the home. (2.1.14, TNVY15, age 30–39)

To teach how to find and earn income. If they do not teach, those who marry and have children young will be disrespected and live poorly. (2.2.9, KYX11, age 60+)

... To help Hmong women because Hmong men still think that Hmong men are leaders and Hmong women are followers ... (2.1.14, NXL14, age 20–29)

A participant mentioned educational programs, so Hmong women can “be educated and intelligent, to have the abilities to stand and speak alongside men.” (2.1.14, CHX12, age 50–59)

Additionally, participants expressed a desire for shelter programs to support Hmong women without husbands or divorced, as cultural traditions often prevent them from returning to their biological parents' homes, leaving them in difficult situations.

For daughters who are divorced, for daughters who are not able to stay with their parents because of traditions and practices, I want there to be a program that provides shelter ... (2.1.14, PHY05, age 20–29)

Support for Children

Participants expressed the need for support programs that provide shelter and educational opportunities for Hmong children, particularly in situations of divorce.

I want there to be help when children’s parents are divorced, like having an education and being healthy ... To have a place to stay, attend school ... (2.1.14, NLH13, age 20–29)

Discussion

Five themes emerged from participants’ shared experiences, reflecting the socio-cultural influences shaping reproductive health among Hmong women. While several findings align with existing studies of Hmong communities in the U.S., East Asia, and Southeast Asia, this study makes a unique contribution by centering the lived reproductive health experiences of women in Ban Mae Sa, an understudied community and the largest Hmong village in northern Thailand.

Importantly, this study extends prior work by documenting intergenerational patterns of continuity and change, revealing how reproductive norms are both sustained and transformed over time. Older participants described early marriage (Jordana, 2016; Redfern & Joyce, 2018; Toutou, 2023; Triet, 2024; Vang, 2013; Vang & Her, 2014; Xuefang, n.d.), bride kidnapping (Lan, 2024; Toutou, 2023; Triet, 2024), limited healthcare access (Kunstadter et al., 1993), and traditional gender roles (Nuntaboot, 2021; Jordana, 2016), while younger participants reported later marriage, greater educational attainment, increased desire to use and actual use of clinic- and hospital-based services, and evolving attitudes toward family planning.

By capturing both generational shifts and the persistence of structural and cultural constraints, this study expands current understandings of how reproductive health is negotiated within a rapidly changing Hmong community. In the discussion that follows, each theme is analyzed through the Socio-Ecological Model, the Life Course Approach, a Gendered Perspective, and Grounded Theory to deepen understanding of the complex factors influencing reproductive health experiences among Hmong women in Ban Mae Sa.

Theme 1: Traditional Hmong Way of Life

Traditional Hmong gender roles and kinship expectations, including the practice of patrilocality, the *nyab* role, and post-marriage disconnection from biological families, create persistent pressures for Hmong women that shape their daily lives, restrict autonomy, and heighten vulnerability to abuse and mental health issues. These roles are deeply embedded in social norms and cultural beliefs, and reinforced by familial structures and clan leadership, illustrating how Hmong women’s well-being is shaped by complex interactions across multiple levels of the Socio-Ecological Model. This mirrors findings in the Hmong diaspora, where the structure of extended family (Jones et al., 2014) and male-dominant lineage systems (Xuefang, n.d.) reinforce Hmong women’s social obligations and limit recourse in cases of mistreatment or conflict (Asian Pacific Institute on Gender-Based Violence, 2019).

Across interviews, participants shared stories of emotional exhaustion from trying to meet the high expectations of being a “good *nyab*,” and the difficulties of being financially or physically dependent on in-laws. Many felt they had no place to express dissatisfaction or make decisions for themselves. This is consistent with research by Thao (2013), who found that Hmong women often experience poor mental and physical health due to their roles as mediators between households, childbearers, and caregivers. Thai studies have similarly found that Thai

women living in extended households with in-laws experience higher levels of depression and anxiety, particularly when they have limited economic autonomy or social support (Phoosuwan et al., 2020). These dynamics demonstrate how cultural and familial expectations, particularly within in-law and marital relationships, intersect at the individual and relationship levels, impacting Hmong women’s agency, emotional well-being, and access to support.

While less common today, older participants’ testimonies of bridenapping reveal how marriage could begin without consent, a traumatic experience that undermines autonomy from the very beginning. Additionally, many participants emphasized that even after divorce or mistreatment, cultural beliefs prevent them from returning to their biological parents' homes, leaving them isolated and without support. This aligns with findings from Hmong populations in the U.S. and Vietnam, where bridenapping was historically tolerated within Hmong communities as a traditional customary practice, despite the emotional and physical consequences for Hmong girls (Jones et al. 2014; Yang, 2004). More recently, Hmong women in the U.S. often face pressure to endure harmful marriages due to stigma around divorce and the belief that returning home would bring shame or rejection (Vang, 2019).

Theme 2: Gendered Expectations of Marriage: Pregnancy and Motherhood

Hmong women’s experiences within marriage are shaped by gendered expectations that limit their autonomy and define their roles through constructs of obedience, endurance, and self-sacrifice. Participants described a cultural expectation that Hmong daughters and wives are socialized to endure hardships in silence, often with little to no emotional or social support. Participants shared sentiments such as having to “endure it alone,” reflecting deeply entrenched norms of resilience and self-sacrifice. This aligns with findings from Hmong populations in the U.S., where Hmong women report being introduced early in life to the widely used phrase in the

Hmong community, *ua siab ntev* (be patient), which underscores their lifelong expectation to persevere through hardships and personal sufferings (Vang, 2019).

Early marriage, sometimes as young as 12 or 13, was historically common and culturally normalized, rooted in gendered marital expectations within Hmong communities. However, many participants expressed a growing awareness of the consequences of early marriage, including emotional unpreparedness, marital instability, and regret. They advocated for marriage at age 20 or older as more appropriate, aligning with greater emotional, social, and economic readiness. This shift reflects evolving values across the life course, shaped by lived experiences and aspirations to break the cycle of early marriage for their children. This aligns with research across Hmong populations worldwide, which shows that early marriage often compromises Hmong girls’ education, economic opportunities, and long-term well-being (Jones et al., 2014; Nguyen et al., 2011). These findings illustrate how norms at the individual, relationship, and community levels are transforming, in response to changing social and economic conditions.

Pregnancy was often perceived by participants as a natural or inevitable consequence of marriage, rather than a mutually negotiated decision. Many participants revealed how decisions about childbearing were rarely planned, but instead assumed as a Hmong woman’s responsibility upon entering marriage. The lack of reproductive autonomy mirrors patterns observed among other Hmong women in Australia, Laos, and Vietnam, where cultural expectations override Hmong women’s agency in family planning. Hmong women are expected to bear many children (Liamputtong & Spitzer, 2007; Rice, 2000), ideally within the first year of marriage (Jones et al., 2014; Rice, 1997), and suffer the blame that accompanies infertility (Corbett et al., 2017). These expectations are instilled early in life, reinforced by families and communities, and shape both reproductive trajectories and Hmong women’s sense of worth and agency.

Motherhood was described as an extension of the gendered expectations and burdens placed on Hmong women within marriage. Participants shared recurring experiences of navigating pregnancy, childcare, and illness largely on their own, due to a lack of emotional and practical support from spouses. Marital conflicts, often stemming from Hmong men’s absence of shared responsibility, reveal how women’s roles within the family are frequently undervalued. Similar patterns have been documented among Hmong women in the U.S., where patriarchal norms restrict women’s decision-making autonomy (Xiong, 2018) and emotional well-being (Khang, 2010). These tensions reflect not only interpersonal struggles, but also systemic expectations that normalize male disengagement and reinforce gendered divisions of labor.

Participants highlighted the normalization of conditional love within marriage, closely tied to men’s preference for younger women and traditional ideals of beauty, submissiveness, and male authority. Infidelity and emotional betrayal were common sources of distress, with participants describing how husbands redirected their affection and resources outside the marriage, while participants shouldered caregiving and financial responsibilities. These dynamics mirror global reproductive health findings, where inequitable gender norms, financial dependency, and normalization of male infidelity within marriage increase women’s vulnerability in marriage (Alsemgeest & Grobbelaar, 2015). Importantly, participants voiced a growing desire for change, including mutual respect, shared responsibility, and equitable partnership, challenging cultural expectations that expect Hmong women to endure suffering until divorce becomes the only option.

Theme 3: Health Care Accessibility

Participants highlighted systemic barriers that affect their ability to seek and receive care, particularly reproductive care, contraception, and abortion. Many expressed dissatisfaction with

the public healthcare system, including long wait times, inconsistent services, and discrimination. Participants voiced a clear preference for private healthcare, which they described as faster and more respectful, though often financially inaccessible. These challenges are exacerbated by distance, poor road conditions, and lack of reliable transportation, issues that disproportionately impact and mirror patterns seen in other minority hill tribe groups in northern Thailand (Mulikaburt et al., 2022; Thummapol, 2018). These barriers reflect both institutional and policy gaps in healthcare and structural inequalities tied to geography, ethnicity, and class.

Participants also spoke about reproductive health education and abortion with a mix of hope and concern. Older participants recognized improved reproductive health education in schools compared to their own youth. Participants reflected on the ongoing burden of pregnancy and parenting as women often bear alone, and emphasized that men are largely absent from this sphere. Additionally, abortion, especially among unmarried Hmong women, was discussed as both a common and deeply consequential experience, leading to fertility complications and a reliance on traditional remedies. These conversations reveal the need for comprehensive, culturally sensitive reproductive health services that extend beyond education to include equitable access, emotional support, and informed care. As shown in similar studies, improving healthcare access for minority women requires addressing both logistical and cultural barriers embedded at multiple levels of society (Mulikaburt et al., 2022).

Theme 4: Family Planning

Family planning was a deeply personal and culturally complex topic for participants, who shared their struggles with societal pressure to have children shortly after marriage and the emotional toll that comes with it. Many described how expectations from family and community, especially in-laws, reinforce the belief that motherhood should begin immediately to prove

marital worth and continue the bloodline. This pressure is intensified by fears that failure to conceive quickly could jeopardize the marriage, prompting Hmong husbands to seek other partners. These gendered expectations remain consistent across generations, shaping Hmong women’s roles and limiting their reproductive autonomy from marriage through adulthood.

Participants also voiced frustration with male resistance to contraceptive use, describing how Hmong men’s refusal or disregard for protection often forces Hmong women to take on the entire burden of contraception. While some Hmong men are aware of reproductive health, Hmong women explained that in intimate moments, Hmong men often ignore contraceptive use or discourage it due to embarrassment or dissatisfaction. As a result, Hmong women bear the physical, emotional, and financial responsibility of managing their reproductive health, often through long-term methods like tubal ligation. Participants advocated for more equitable involvement from Hmong men, including condom use and vasectomies, to reduce Hmong women’s health risks and improve family wellbeing. Further, community and societal efforts are needed to provide resources, opportunities, and educational programming that include and address Hmong men’s involvement and reluctance in reproductive and sexual health care.

Theme 5: Economic and Social Support

Economic insecurity intersects with social norms to limit Hmong women’s autonomy and access to supportive systems, particularly in the areas of childbirth, childcare, and post-divorce stability. This finding aligns with research on Hmong women in Thailand, where gendered expectations confine women’s roles largely to domestic duties and agricultural labor after marriage. Women are often expected to stay home, raise children, and work in the fields, leaving little opportunity to sustain friendships, access social support, or pursue entrepreneurial goals (Langill, 2025). This reflects how cultural norms not only isolate women but also heighten

emotional and financial vulnerability. From individual to broader policy levels, such intersecting barriers undermine Hmong women’s ability to seek support, maintain economic independence, and care for their children after separation.

Participants revealed that patriarchal cultural norms prevent divorced Hmong women from returning to their biological family, underscoring a structural gap in available support services. This aligns with findings in northern Thailand, where divorced Hmong women face resistance from clan leaders when attempting to return to their biological home, often treated as outcasts. As a result, some Hmong women have turned to Christianity as a source of refuge and belonging in the absence of clan-based support (Baird & Yangcheepsutjarit, 2022). These gendered expectations, which determine Hmong women’s value and restrict their options post-divorce, reflect community and institutional factors that shape life trajectories and limit autonomy, prompting some Hmong women to seek refuge in religion as a path to reclaim belonging and agency.

Recommendations

To address the socio-cultural factors that influence the reproductive health experiences of Hmong women in Mae Sa, it requires a multi-faceted approach. The following recommendations are proposed to improve gender equity, improve healthcare access, and empower Hmong women at individual, relationship, community, and institutional levels: (1) facilitate open family dialogues about reproductive health and shared responsibility in family planning, specifically engaging Hmong men in conversations about contraception and reproductive roles; (2) conduct community-based campaigns on gender equity and women’s rights, recognizing Hmong women’s roles and values beyond motherhood and marriage and challenging restrictive gender norms; (3) establish community-based programs that provide financial education, including

microfinance or microlending opportunities and cash transfer programs to support Hmong women’s entrepreneurship, promote self-autonomy, and offer shelter services; and (4) advocate for and improve the availability of local health facilities that offer culturally sensitive, affordable, and high-quality care, and/or develop transportation services to support Hmong women in accessing both local and distant health facilities more easily.

Conclusion

This study offers critical insight into the socio-cultural factors shaping Hmong women’s reproductive health experiences in Ban Mae Sa, Chiang Mai, Thailand. Participants’ narratives demonstrate that reproductive health is influenced not only by individual choices, but by the intersection of gendered expectations, economic hardship, marriage dynamics, and structural barriers, which are reinforced across the life course and embedded within family, clan, and community systems. Interventions must go beyond targeting individual behaviors to address relational, community, institutional, and policy-level challenges. Engaging both Hmong women and men is crucial to reshaping patriarchal norms and fostering more equitable, supportive environments for reproductive decision-making. Ultimately, meaningful progress in Hmong women’s reproductive health and gender equity will require sustainable and holistic strategies that respect cultural context, while challenging the structures that limit Hmong women’s voices and choices.

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