Reflections on "Crossing Borders in Birthing Practices": Hmong in Northern Thailand and Saint Paul, Minnesota

By

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Abstract

As a family physician and medical anthropologist, I have interacted with pregnant women and their families in Minnesota since 1983 and in one Hmong village in Northern Thailand since 1988. In the previous article I describe our recent research about Hmong families' pregnancy and birth practices in Thailand. In this article, I reflect upon the differences in Minnesota and Thailand, consider what socio-cultural factors may be influencing people's experiences, and speculate that Minnesota Hmong experiences could be helpful to Thai Hmong.

Keywords: Hmong Culture and Childbirth, Hmong in Thailand

Reflection

Hmong in Northern Thailand have "crossed borders" about birth practices slowly. During the last several decades, the borders were brought to them, as Western obstetrical practices arrived in the country. Over time, Hmong families have faced the differences between traditional Hmong birthing practices and Thai biomedical obstetrical systems, have made care choices for each pregnancy, and have been caught in the contest for supremacy of authoritative knowledge. (See study in one Hmong village by Culhane-Pera et al 2014, this volume.) In contrast, Hmong in the diaspora crossed borders quickly when they lived in refugee camps, and were re-settled into Western countries such as the United States (US) and Australia, immediately facing a hegemony of biomedical birth practices. Through these immersions, Hmong families abruptly experienced the differences between their cultural practices of pregnancy and birth (Cha 2003; Symonds 2005) and the biomedical concepts and practices of antenatal care, hospital births, and postpartum care, with the attendant hierarchical system of control based on biomedical knowledge, technology, and surgical practices (Bengiamin et al 2011; Bruce and Xiong 2003; Erwin 2005; Faller 1987; Halvorsen 2012; Jambunathan and Stewart 1995; Morrow 1986; Nibbs 2010; Potter and Whiren. 1982; Rice 1997, 1999, 2000a, 2000b; Spring et al 1995).

Upon their arrival in Minnesota, many Hmong families resisted and refused an array of biomedical maternity practices (i.e., pelvic exams during antenatal care, dorsal

lithotomy positions during birth, post-delivery uterine massage, and C-sections), while holding onto traditional birthing practices (i.e., external cephalic version by Hmong elders, squatting position, and post-partum prohibitions) (Bruce and Xiong 2003; Erwin 2005; Halvorsen 2012; Jambunathan and Stewart 1995; Morrow 1986; Rice 1997, 1999, 2000a, 2000b; Potter and Whiren 1982; Spring et al 1995). The ensuing conflicts were based on differences in authoritative knowledge, and were contests between traditional social, cultural, physical, and spiritual aspects of birth and the biomedical focus on physical aspects of birth. Families' experiences in the refugee camps and their concurrent experiences with the medical system about disease management that included conflicts and disagreements with biomedical personnel (Cha 2003; Culhane-Pera et al 2003; Kirton 1985) were also based on similar differences in authoritative knowledge that are grounded in larger social systems of power and control.

Over the past four decades in Minnesota, both the medical system and the Hmong have undergone changes that have lessened these conflicts. The American medical system has responded to movements that advocate for empowering women during birth (MacDonald 2011; Matthews and Zadak 1991; Gaskin 1997 and 2003), respecting cultural differences (USDHHS 2001 and 2012), focusing on patients' preferences (Epstein and Street 2011; Stewart et al 2013), and providing women-centered care (Culhane-Pera and Rothenberg 2010; Shields and Candib 2010). These changes have meant that doctors, nurses, and medical institutions have become more willing to adjust processes and procedures to women and families' desires. (Nonetheless, women and women's advocates want to see additional changes—see ACNM 2013 and Hadjigeorgiou et al 2012).

Concurrently, the Minnesota Hmong community faced dramatic culture changes from many fronts, which have undoubtedly influenced their interpretation, expectations, and reactions to biomedical birth. Over time, as Hmong adjust to American society—obtained formal education, acquired language skills, gained experience in medical institutions and became healthcare professionals—they have become more accepting of biomedical concepts, more responsive to institutional hierarchical decision making by doctors and nurses, and more accustomed to medical procedures and results. In addition, people's familiarity and expertise with Hmong traditional birth knowledge and skills has waned, as family members lost experience and comfort with supporting home births, and as healers had less experience to deliver and adjust fetal positions. Given these changes in Hmong and American society, the vast majority of women now give birth at hospitals that have accommodated some cultural practices. This is not to say that the contests have completely resolved, as some women continue to give birth at home rather than be subjected to institutional pressures for hospital procedures and some healthcare personnel continue to expect women to accept their biomedical assessments and orders without adjustment for families' cultural needs. But change has occurred nonetheless.

Both Hmong in Minnesota and Hmong in Northern Thailand have experienced similar pressures and conflicts that have influenced their affording authoritative knowledge to biomedicine rather than traditional birthing. Through societal systems of education, governance, politics, religion, as well as medicine, both are being socialized into citizens of their respective societies. Both are being instructed to defer to majority societal ways about biomedical knowledge for all health issues, and relinquish their connections with traditional healing knowledge and skills. Both are being pressured specifically about pregnancy and birth, to confer authoritative knowledge on biomedical systems and turn away from Hmong traditional birth knowledge.

Differences in societal contexts between Minnesota and Thailand could be contributing to different Hmong experiences (and each of these generalizations about major societal differences is not absolute). Certainly, the transition for Hmong in Minnesota started earlier, was quicker, and was more comprehensive, encompassed all aspects of life, and now the majority of the reproductive generation was born and raised in the US and have had no or limited personal exposures to traditional home births. The nature of the education systems is different, with the Thai system emphasizing memorization and respect for teachers and the American system encouraging problem solving and questioning authority. The nature of social class is different. Thailand has a more formal social class structure, with highland ethnic groups generally at the bottom of the hierarchical class structure. The American social system has a more flexible social hierarchy classes, such that people may feel less vulnerable than they do in Thailand, although Hmong in St. Paul still express their experiences of discrimination. The emphasis on religious authority is different, with Thailand teaching respect for Buddhist monks in schools, and the US having a history of tolerating religious differences. While both biomedical systems are hierarchical and Hmong are minorities in both societies, this confluence of societal factors may render Hmong in Thailand to be less powerful in the healthcare arena than Hmong in Minnesota.

Given that Hmong families in *Up the Mountain Village* (Culhane-Pera et al 2014) (both those who choose home births and those who choose hospital births) object to harmful and denigrating hospital processes and procedures, the Thai public health hospital system could make adjustments to improve care and relationships. They could adjust institutional processes that could accommodate Hmong cultural practices (i.e, family support, squatting, hot water and hot food after birth), and adjust procedures that also fit with evidence-based obstetrical care (i.e., family support, no routine episiotomies, and patient-centered care). I have seen family-friendly hospital birthing processes occurring in some Northern Thailand hospitals, particularly private hospitals that are advertising to people with financial means as well as some public hospitals that require additional fees. For these changes to occur in other public health hospitals, such as the one that serves the Hmong in *Up the Mountain Village*, two concurrent forces might have to emerge. Women and families will have to express their desires for change—Hmong alone or with other people, as individuals or as collective groups, before or during labor and delivery,

and expressed to individual health care personnel or to provincial public health authorities. Concurrently, Thai health care professionals will have to listen, be willing to make changes, and prioritize those changes with their other planned improvements. While these significant changes require tremendous effort, the process of engaged and empowered communities improving maternity services to be culturally respectful is occurring throughout the world (CARE USA 2012; UNFPA 2014). The experience of Hmong in Saint Paul Minnesota could also be helpful, as they have travelled similar paths.

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