

Understanding the Dynamics Between Thai Culture and Reproductive Health Across Generations of Thai Women

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Background

Health outcomes are the product of culture and social change. These constructs shape how people perceive their bodies, interact with doctors, and can liberate or hinder health autonomy. Social pressures influence health behavior and perceived barriers, like stigma impacting engagement with care.^{1,2} Thailand provides a compelling example through “greng jai,” a cultural concept involving avoidance of causing others inconvenience or confrontation.³ This qualitative study explores how Thai women across three age groups – young (18–34 years), middle-aged (35–59 years), and elderly (60+ years) – understand and interface with their reproductive health, particularly how sociocultural factors shape their experiences in health systems.

Methods

In-depth interviews were conducted with 21 participants across three age groups. Sampling was purposive with snowball recruitment.⁴ Using NVivo 15,⁵ we implemented inductive analysis with generational comparisons, following the reflexive thematic analysis approach.^{6,7}

Results

Three themes emerged: intergenerational knowledge transmission, generational disagreement in reproductive health autonomy, and perpetuation of social standards and stigma. Younger women were the predominant abortion supporters; middle-aged and elderly women objected on religious grounds. Across all age groups, contraception initiation was linked to committal relationships. Female family members play a vital role in preparatory and reactive teaching about menstruation. Subjects prioritized modesty and frugality when seeking healthcare.

Discussion

The impact of social conventions and stigma on reproductive health is ubiquitous in Thai culture, and it appears to persist through generations. Stigma might hinder information dissemination and engagement, yet Thai traditional medicine and familial wisdom may uplift health and holistic care. Intergenerational communication reinforces privacy around sensitive information, but it is still education which otherwise may never be delivered.

Conclusion

Reproductive health attitudes are likely the product of push-and-pull forces between cultural tradition and novelty. Assessing social and behavioral climates is vital for health promotion at the individual, community, and population levels.

INTRODUCTION

Health outcomes are the product of dynamic forces: culture and social change. These constructs shape how people perceive their bodies, interact with doctors, and can liberate or hinder health autonomy.

The Theory of Planned Behavior (TPB) model postulates that social pressures influence behavior which then guide health engagement.¹ Similarly, the Health Belief Model highlights how perceived barriers – such as stigma – can impact behavior.² Both models apply to this study, connecting sociocultural considerations with reproductive health.

Thailand provides a compelling example of the models' relationships, especially through "greng jai," a Thai cultural concept regarding avoidance of imposing inconvenience or discomfort.^{3,4} Greng jai influences Thai patients to question physician authority less, potentially hindering autonomy in their care due to fear of displeasure or confrontation. Cultural constructs, like greng jai, may manifest in reproductive health engagement, as decreased autonomy is associated with lower likelihood of prenatal and postnatal care and contraception use.⁵ Women's hesitancy to assert themselves appears to lead to unmet healthcare needs, namely cervical cancer screenings.

Although cervical cancer incidence in Thailand has decreased from 18.1 to 10.3 per 100,000 (2001–2021), mortality has risen from 5.9 to 6.8 deaths per 100,000 (2012–2021).⁶ This underscores the need to address upstream socio-behavioral influences in primary care promotion. Similarly, understanding how adolescents view contraception initiation can protect against unplanned pregnancy and substantial downstream consequences for education and financial stability.⁷

Thai culture has experienced ongoing negotiations between cultural continuity and change.⁸ Older generations emphasize values such as hard work, family loyalty, and adherence to tradition while younger generations are described as individualistic, technologically savvy, and open to new social ideas.⁹ As Thai culture becomes more liberal and individualistic, this may influence how women of different ages perceive and engage with reproductive health, especially since media and internet catalyze cultural exchange, ideological progression, and social change.¹⁰

This qualitative study explores how Thai women across three age groups – young (18–34 years), middle-aged (35–59 years), and elderly (60+ years) – understand and interface with their reproductive health, particularly how sociocultural factors shape their experiences in health systems.

METHODS

A qualitative approach with individual in-depth interviews was conducted by the Principal Investigator of this study. A Thai-to-English interpreter was used for non-English speaking participants. Remote and in-person interviews were recorded in real-time and transcribed afterwards in English.

The subject population consisted of 21 women: 6 elderly (60+ years), 8 middle-aged (35–59 years), and 7 young (18–34 years). Participants must have been born and raised in Thailand with active Thai citizenship at the time of interview. Of the 21 interviews, 10 were conducted in-person in Bangkok and the remaining were completed over the phone from the United States. The sampling was purposive, selecting participants whose experiences were relevant to the phenomenon of interest.¹¹ The snowball sampling method allowed for subjects to refer members of their personal network to participate in the study. Demographic variables were not systematically collected across the full sample, but partial information was recorded. Participants came from a range of occupations (education, healthcare-

adjacent roles, administrative positions, retirees) and living situations (urban, rural, and rural-to-urban migration patterns).

The interview guide was sectioned by topic (ref. [Table 1](#)). Questions were designed for participant introspection with follow-up questions to elicit more detail. Lifestyle and comorbidity questions contextualized findings and informed researchers' broader understanding, yet they were outside the thematic scope and did not contribute to the reported results. Coding was conducted in two iterative cycles three months apart. Cycle 1 focused on trialing codes and identifying preliminary themes, while cycle 2 allowed for further reflection, refinement of interpretations, and increased analytic consistency. Thematic patterns were identified through inductive analysis with generational comparisons, following the reflexive thematic analysis approach.^{12,13} All analysis was performed on NVivo 15.¹⁴ This study was reviewed by the Tulane University Institutional Review Board and deemed to be exempt.

RESULTS

Among the 21 subjects, 9 women had never been pregnant before and 12 had been pregnant and birthed at least one child.

Three major themes emerged: intergenerational knowledge transmission, generational disagreement in reproductive health autonomy, and perpetuation of social standards and stigma.

THEME 1: INTERGENERATIONAL KNOWLEDGE TRANSMISSION

Female family members (FFM) play a vital role in preparatory and reactive menstruation teaching. The results demonstrate this point, as approximately 50% of the subjects mentioned family involvement in their menstrual health education. Otherwise, women learned basic knowledge from school, including how to clean menstrual blood. FFM frequently responded reactively, offering advice only after menarche. One subject assumed the process was pathologic:

"I was really scared – I thought there was something wrong with me because I didn't know what it was. Just saw the blood. I had it for the first time at 11... I was so scared. I cried and ran to my mom." [ID #072224, young]

Thai traditional medicine (TTM) was another channel for informal education. Multiple generations cited TTM-aligned dietary changes to optimize breastfeeding, like avoiding certain temperature foods to maintain milk quality. However, women who birthed at home were all elderly subjects; they did so out of necessity, utilizing traditional medical practices. Both elderly women lived in rural areas and prolonged travel to a hospital would have threatened both maternal and fetal life. Both women were assisted by a *maw thum yae* (หมอตำแย): village women trained by prior generations of practitioners. Notably, one subject's mother was their village's *maw thum yae*:

Table 1. Interview Guide Categories and Representative Questions

Category	Representative Questions
Rapport and general health perceptions	1. How are you feeling about the health of Thai women nowadays? 2. Do you have children? If so, how old is the oldest? How old is the youngest child?
OB/GYN visits	1. Have you ever visited an OB/GYN doctor? 2. How important is it to you to regularly visit an OB/GYN? Please explain why.
Menstruation	1. Could you please explain to me what menstruation is? 2. Please describe how you felt when you had your first period. 3. How did you learn about menstruation? Did anyone teach you about what to expect? 4. What kinds of period products do you (or did you) use? 5. Have you ever used a tampon?
Pregnancy and childbirth	1. When you were pregnant with your youngest child, did you receive care from an OB/GYN? 2. What advice did you receive when you were pregnant? 3. What kinds of things do you think you should do before, during, and after a pregnancy? 4. Have you heard of a doula? If so, what do you know about them?
Contraceptive knowledge and use	1. What are contraceptives? 2. What types of contraceptives do you know of? 3. Have you used contraceptives or do you currently use contraceptives? 4. Do you talk to your friends, or have you ever talked to your friends, about contraceptives? Why or why not? 5. At what age should a Thai woman should start using contraceptives? 6. Do you think older and younger generations of Thai women would agree with you?
Abortion and generational perspectives	1. Do you support women who get abortions? Why or why not? 2. Thailand recently made abortions legal. Could you share your thoughts on this? 3. Do you think that older and younger generations of Thai women share your opinions on abortion?
Lifestyle choices and health conditions	1. What do you eat in a typical day? 2. Do you exercise? 3. Do you believe that eating and exercise impact your health as a woman? 4. Do you have a history of high blood pressure, high cholesterol, or diabetes?

Table 1. Follow-up probes are omitted for conciseness.

"They don't even have a sharp knife to cut the umbilical cord, they used a ceramic bowl. They broke it and used that to cut the umbilical cord. Because you don't want [infection]...the ceramic bowl is clean and you use it one time then toss it... they had a plastic container that the [maw thum yae] put [the placenta] in. And then the [maw thum yae] put ash from burning wood to get rid of the odor." [ID #0510242, elderly]

TTM remains an important fixture in Thai culture and reproductive health education, leaning on intergenerational knowledge transmission. Generational knowledge inheritance shapes the way Thai women perceive, understand, and manage health over their lifetimes.

THEME 2: GENERATIONAL PATTERNS IN REPRODUCTIVE HEALTH AUTONOMY

General patterns emerged in 2 main categories: abortion and contraception. Abortion supporters reported increased strain on society if the mother decides to forfeit their newborn. Younger women were the predominant, unanimous abortion supporters; they emphasized quality of life, readiness, and the mother's financial status, rather than religiosity. Middle-age women constituted the majority of abortion objectors that cited Buddhism. Elderly women condemned abortion for religious reasons, associating the act with sin and taking of life.

"I disagree with abortion because it is a big sin to take life. It's an unborn child – if you made it happen, you should take responsibility...personally, I think it is such a sin that I do not support it." [ID #051024, elderly]

Young and middle-aged women expressed comfort in discussing contraception with peers. In contrast, elderly women were uncomfortable with addressing the topic publicly; they felt Thai culture is not yet supportive of contraception as a nonchalant conversation topic. Across all age-groups, the majority of participants stated commitment to a serious relationship should prompt contraception use rather than menarche.

Cross-generationally, women associated serious relationships with sexual activity (Table 1). Although family planning is seemingly becoming more autonomous, for one subject, autonomy was entirely absent.

"The doctor didn't tell me anything during pregnancy, no advice whatsoever... after birth, I got my tubes tied. The doctor did it without asking me." [ID 0512242, elderly]

THEME 3: PERPETUATION OF SOCIAL STANDARDS AND STIGMA

Social conventions and reproductive health stigma persist in Thai culture as evidenced by tampon use. Despite 3 of the 21 subjects trying them, all promptly discontinued their use. Overall, no participants currently use them, repeatedly



Figure 1. Word frequency for menarche experiences across all participants (n = 21)

Figure 1. Bars visualize 11 words' frequency (black) derived from interview transcripts with the "menstruation" code. Percentages (gray) are displayed on the horizontal axis, reflecting each word's proportional contribution to total word count across all transcripts.

remarking concerns about "getting them stuck," the penetrative mechanism, hygiene, and infection risk.

"I'm afraid to use it because it might get stuck in there, I also think it is very dirty. You can get an infection from using the tampon because it stays inside – I don't know what's going on in there."[ID #020124, middle-age]

Formal menstruation education is generally not standardized or mandated in Thailand; therefore, informal education through mothers, sisters, aunts, and friends is typical. Menarche experiences are faced with mixed-emotions due to varying familiarity and preparation beforehand (Figure 1).

Results showed subjects had either a neutral or negative experience with menarche. Although some subjects were taught about menstruation before menarche, menstruation symptoms still provoked emotional reactions. The women who were not taught about menstruation beforehand were equally confused and scared:

"I was told about how it happened and what to do when it happened. I had it when I was 15. I was scared...what is going on with my body? Suddenly the blood came out. In the past... no media to show you what's going on." [ID 0514232, middle-age]

Observed generational consistencies in healthcare experiences demonstrate that Thai women continue to share values around bodily modesty and frugality in healthcare

engagement. When asked about visiting a doctor regularly, women were hesitant, mentioning busy schedules, shyness, or lack of illness or symptoms. For many, their first experience interacting with an OB/GYN was due to health changes such as pregnancy or menopause. All generations generally preferred having female physicians or would have liked a female chaperone for male doctors; they were more shy around male doctors, specifically during vulnerable procedures, such as pelvic exams and pap smears. Modesty remains a poignant cultural value as participants preferred female OB/GYNs or a chaperone present. Overall, subjects utilized care through a problem-based lens rather than preventative or maintenance-based approaches.

DISCUSSION

Culture sets the tone for reproductive health and sexual health engagement. The three major themes outline how this manifests cross-generationally:

1. Intergenerational knowledge transmission
2. Generational disagreement in reproductive health autonomy
3. Perpetuation of social standards and stigma

Themes 1 and 3 are intertwined because intergenerational knowledge transmission privatizes discussion around stigmatized topics and sensitive information (Figure 2). However, it is still education which otherwise may never be

Table 2. Cross-generational comparison of reproductive health domains among Thai women (n = 21)

Domain	Young (18–34) (n = 7)	Middle-aged (35–59) (n = 8)	Elderly (60+) (n = 6)	Generational pattern
Menstrual education	School & family; preparatory and reactive teaching	School & family; preparatory and reactive teaching	Family only; reactive teaching	Increased school involvement; reactive channel persists
Menarche experience	Emotional distress common	Emotional distress common	Emotional distress common	Stable across cohorts; distress persists regardless of generation
Childbirth practices	Hospital births	Hospital births	Hospital & home births (maw thum yae)	Progressive shift; traditional birthing practices dissipated
Abortion attitudes	Supportive; autonomy- and quality-of-life framing	Mostly opposed; religion-based objection	Strongly opposed; sin framing	Generational liberalization; Buddhist influence moderates change
Contraception discussion	Open with peers	Open with peers	Mostly private; discomfort with public discussion	Increasing openness among younger cohorts
Contraception initiation	Linked to committed relationship	Linked to committed relationship	Linked to committed relationship	Norm remains stable; relationship status as prerequisite across all cohorts
Tampon use	Rare; concerns regarding insertion & hygiene	Rare; concerns regarding insertion & hygiene	Rare; concerns regarding insertion & hygiene	Persistent purity norms; no generational change observed

Table 2. TTM = Thai Traditional Medicine

delivered. Despite stigma hindering information dissemination and engagement, TTM and familial wisdom may uplift health and holistic care.^{15,16} Theme 3 confirms Thai cultural conventions and stigma remain a constant. When subjects were asked about tampon aversion, they drew reflexive connections between tampons and societal notions on sexual purity. These principles align with previous research on Thai and other Asian women's ideals around preserving virginity.¹⁷

In comparing our findings to the literature, the results differ: Research among vocational school participants in Northern Thailand showed adolescents with casual partners were 7.7 times more likely to use contraception than those in committed relationships; sex workers showed similar patterns at 7.4 times more likely.¹⁸ This quantitative divergence from our study captures an intriguing dissonance between Thai women's ideation and actuality. Although they may idealize contraception initiation within serious relationships, behavioral data suggests younger women are initiating sooner in practice.^{18,19}

Generational differences in abortion demonstrated conservative beliefs from the middle-aged while young women were progressive, indicating a shift towards more liberal views. However, opposing Buddhist ideals could delay progression since Buddhism is a fixture of Thai culture as evidenced by surveys from young medical graduates and nurses who hesitate to offer abortion services.^{20,21} In contrast, a study evaluating attitude change in abortion training demonstrated optimism in shifting providers' perceptions.^{22,23}

Theme 3 presented in approaches to healthcare; the observed norm for Thai women is seeking healthcare more

for illness than for prevention. Likewise, embarrassment or asymptomatic status contributes to decreased health maintenance visits.²⁴ It is plausible that these sentiments reinforce the deferential behavior seen in greng jai by fostering concern about imposing on physicians. Clinical medicine and public health play integral roles in building consistent educational and social programming to encourage routine doctor visits. Furthermore, physicians should be aware of sensitivities around penetrative products and procedures, and they should be prepared to field patients' doubts to initiate contraception, including beliefs about relationship status and sexual activity.

Theme 2 exemplifies how greng jai can influence health autonomy and potentially dictate healthcare engagement. It advises physicians on navigating broader power dynamics and healthcare patterns; for example, the experience of the subject who underwent a non-consensual tubal ligation aligns with prior research. One study found statistical significance between Caesarean deliveries and immediate postpartum sterilization, situating the practice in Thailand's efforts to curb population growth in the 1970s; notably, 17% of Thai women were reported to have been sterilized within their first postpartum month.^{25,26} These patterns may reflect systems' prioritization of procedural efficiency, however, this study's findings and literature raise questions about how patient-centered decision-making fits into these contexts.

Overall, study insights can be situated within Ross and Solinger's reproductive justice framework, which equally upholds the right to end a pregnancy and the right to motherhood. This study complements the tenets of the framework through centrality of storytelling and how social in-

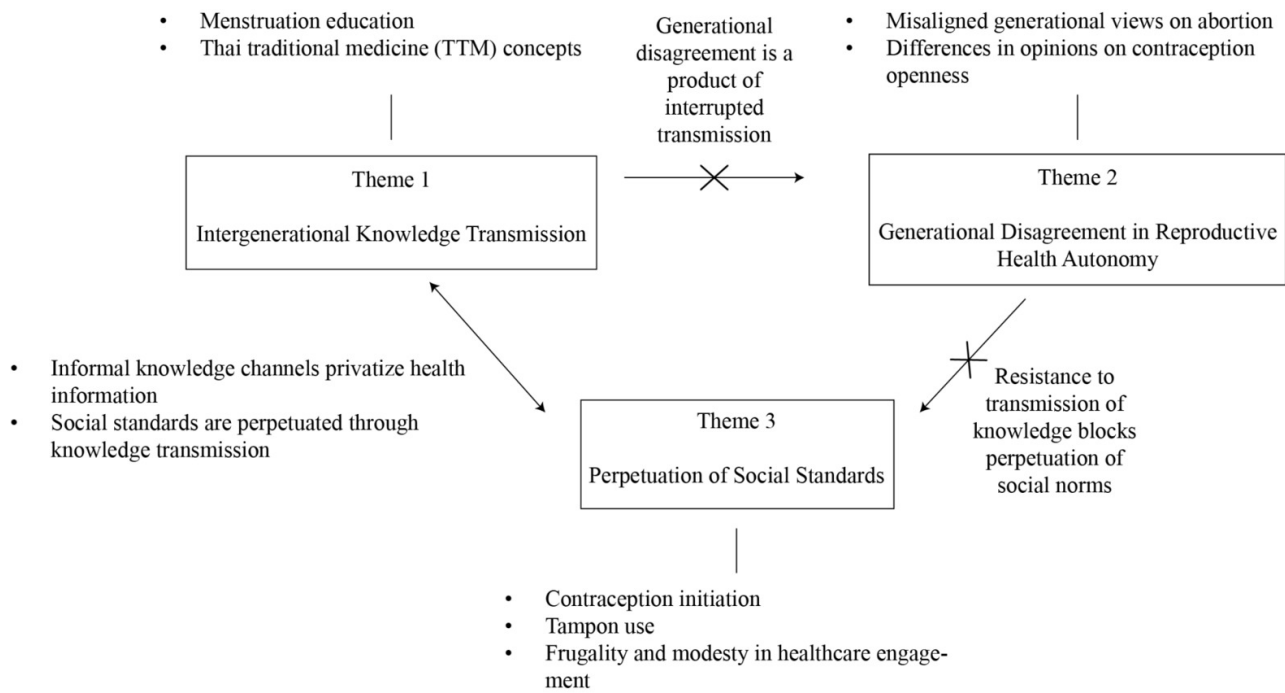


Figure 2. Conceptual mapping of themes

Figure 2: Boxes contain major themes. Bidirectional arrows represent reciprocal relationships between themes, while arrows with an "X" demonstrate a blocked relationship. Bullet points expand on respective themes.

stitutions and culture affect women's reproductive lives.²⁷ The account of an elderly subject who received a non-consensual tubal ligation illustrates a violation of her right to motherhood, one that reflects wider patterns of diminished patient autonomy in her culture. Similarly, the two elderly women who had to give birth at home – due to hospital distance – points to disparities in healthcare access on a geographic level.

While this study was not designed to examine geographic disparities, these women's stories serve as platforms for future reproductive health equity research in Thailand. This analysis motivates the need for research and interventions that address interpersonal stigma, geographic disparities in healthcare access, and promote primary care utilization.

This study's potential limitations include small sample size, mixed interview formats, and presence of an interpreter. Considering the smaller sample, cross-generation comparisons were less reliable. The interpreter was a middle-aged Thai native, and their presence may have impacted interviewees' responses. Iterative coding, reflexivity, and structured coding and analysis strengthened methodological rigor.

CONCLUSION

The goal of this research was to examine the effects of culture on health across time through interviews with three generations of Thai women. Findings showed that younger women were more progressive than middle-aged and elderly women, particularly regarding abortion, with no young women identifying as objectors. Middle-aged women

yielded mixed results: they aligned with the younger generation in discussing contraception openly, but sided with the elderly in religious beliefs on abortion. Elderly women were the only group to have experienced home births as predicted; however, they were outnumbered by middle-aged women in abortion objection, an unanticipated finding. Despite this, elderly women continued to preserve traditional conventions.

Thai adolescents often adopt Western culture, but it is frequently curbed by cultural values bestowed by older generations who value Thai tradition, thereby creating tension and a "dual identity".¹⁵ This strain was evident in young women's opinions regarding tampon use and contraception initiation as perspectives aligned with traditional values, rather than progressive cultural exchange.

Traditionalism was not uniform: although contraception initiation was linked to relationship status, *greng jai* appears to shape comfort level in peer discussion. Avoiding candid discussion of contraception may reflect an effort to prevent imposing discomfort on others in social exchange, consistent with *greng jai*'s underlying logic. Middle-aged and young women's candor might suggest a weakening of *greng jai*, whereas elderly women's preference for privacy may reinforce it. In contrast, *greng jai* did not account for purity concerns, suggesting that purity-based modesty operates as a distinct cultural construct rather than an expression of imposition avoidance.

Women aged 45-59 tended to reject premarital sex, which has been found in the literature on Thai sexual attitudes.²⁴ Similarly in this study, the majority of elderly women supported contraception initiation with committal relationships. Overall, research indicates that reproductive

health attitudes are likely the product of push-and-pull forces between cultural tradition and novelty.

Thai people are attuned to identity, valuing dignity and pride highly. This is applicable to our study and to global audiences. The data establishes range in generational trends, and although shifts in norms have been observed, social change is deliberately paced to conserve cultural identity.¹ Assessing the fixity of a social convention can guide cultural sensitivities when interacting with Thai patients, as persistence of norms may be a proxy for higher social value. The speed of social change in areas of women's health – contraception, abortion, menstruation, etc. – are seemingly impacted accordingly.

Future research should further examine how shifting societal norms shape health behaviors and engagement across public health and medical contexts. This research reinforces the idea that culture is intertwined with health, and that assessing social and behavioral climates are vital for health promotion at the individual, community, and population levels.

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DISCLOSURE STATEMENT

The authors used Claude 1.8555.2 (a476c3) 2026-05-22T23:04:37.000Z for formatting of tables 1 and 2, and for grammar and language editing of the manuscript. All of Claude's outputs were reviewed and accepted by the corresponding author. No substantive content was generated by AI.

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