國立台灣大學公共衛生學院全球衛生碩士學位學程

碩士論文

Global Health Program

College of Public Health

National Taiwan University

Master Thesis

跨文化視角的台灣女性生產知識與經驗

Women's Childbirth Knowledge and Experiences in Taiwan: A Cross-Cultural Perspective

林黛希

Donielle Allen

指導教師：官晨怡博士

Advisor: Chen-I Kuan, Ph.D

中華民國 112 年 7 月

July, 2023

doi:10.6342/NTU202303847

國立臺灣大學碩士學位論文
口試委員會審定書
National Taiwan University
Verification Letter from the Oral Examination Committee for Master's Students
論文中文題目 跨文化視角的台灣女性生產知識與經驗

(Thesis Chinese Title)

論文英文題目 Women's Childbirth Knowledge and Experiences in Taiwan: A Cross-cultural Perspective

(Thesis English Title)

本論文係 君（學號 ）在國立臺灣大學全球衛生碩士學位學程完成之碩士學位論文，於民國 年 月 日承下列考試委員審查通過及口試及格，特此證明。

This Thesis is written by Donielle Allen R10853006 studying in the graduate program in the Global Health Program. The author of this thesis is qualified for a master's degree through the verification of the committee.

_____（指導教授簽名 Advisor Signature）

口試委員 Committee Members:

doi:10.6342/NTU202303847

Acknowledgements

If not for Fulbright, I would not have the opportunity to attend school in Taiwan and conduct research; therefore, I am obliged to offer the first thanks to Fulbright Taiwan.

I am extremely grateful for Dr. Kuan's and my defense committee members, Rita Jhang and Po-Yao Huang's support, guidance, and feedback throughout this entire process.

I would like to thank the professors and faculty of the Global Health Program who have fostered a deep love for global health in my heart and a foundation for research as a scholar.

I also thank all of my participants who were vulnerable, yet excited and willing to share their personal stories with me to complete this project.

Finally, I am forever indebted to my family, church family, and friends who encouraged me and helped me triumph over all of the challenges that I faced through these two years abroad.

doi:10.6342/NTU202303847

摘要

過去 20 年來，台灣一直實行醫療化懷孕和生產，導致極高的醫療介入其中，包含剖腹產和會陰切開術。雖然剖腹產比率仍居高不下，2021 年為 37.9%，但會陰切開術比率已從 2020 年的 99.9%下降至 2023 年的 73.4%。目前，約有 414,794 名外國女性居住在台灣。一些在台外國女性和男性透過撰寫部落格闡述他們痛苦的生產經驗，包括幾乎沒有隱私保障，丈夫在嬰兒快出生時才被允許進入產房，以及與醫生和護士的不愉快經歷。台灣人也對自身的生產經驗感到不滿。為了反對醫療化生產，並為婦女創造更正面的生產體驗，台灣的第一個改變是引入溫柔生產。溫柔生產促進了生產教育，進而提高了生產自主性。

本研究透過深入、半結構式訪談，訪問並比較外國和台灣女性的生產知識和經驗。研究結果發現，文化差異影響著人們對生產的概念和認知。此外，文化也會影響蒐集資訊的行為和生育決策。最後，外國女性的經驗可凸顯台灣健保系統的獨特之處。台灣還需要強化性教育和生產教育，以賦能婦女和其支持者更多信心和正面的生產經歷。

關鍵字：跨文化、分娩，生產、居家生產、溫柔生產、質性研究

doi:10.6342/NTU202303847

Abstract

For the past 20 years, Taiwan has had a history of having medicalized pregnancy and childbirth which led to extremely high rates of medical interventions, including cesarean sections (c -sections) and episiotomies. Although cesarean sections have remained high, 37.9% in 2021, the episiotomy rate has lowered from 99.9% in 2020 to 73.4% in 2023. Currently, there are about 414,794 foreign women living in Taiwan. Some foreign women and men in Taiwan have written blogs detailing their traumatizing birth experiences where sometimes there was little privacy, the husband was not allowed in the delivery room until the baby was almost born, and had unpleasant experiences with healthcare providers. Taiwanese too were unhappy about their experiences, and one change that the Taiwanese have incorporated to counter medicalized childbirth and create more positive experiences for women was the introduction of gentle birthing. Gentle birthing promotes childbirth education and increased birthing autonomy.

This study used in-depth, semi-structured interviews with both foreign and Taiwanese women to understand and compare their childbirth knowledge and experiences. The study findings suggest that cultural differences impact the way childbirth is conceptualized and perceived. Furthermore, culture also has an impact on knowledge seeking behaviors and childbirth decision making. Ultimately, the experiences of foreign women can highlight the uniqueness of the Taiwanese healthcare system. In Taiwan, there is a need for better sex and childbirth education to empower women and their supporters to have more confidence and positive childbirth experiences.

Keywords: cross-cultural, childbirth, home birth, gentle birth, qualitative research

doi:10.6342/NTU202303847

Table of Contents

doi:10.6342/NTU202303847

doi:10.6342/NTU202303847

List of Tables

doi:10.6342/NTU202303847

Chapter 1 Introduction

1.1 Original Study and Objectives

Originally, this study sough to explore the knowledge and attitudes of women in Taiwan on planned home birth. I visited the librarian to find literature in Chinese language; however, the first librarian had not heard of home birth or gentle birth. I had to handwrite the Chinese characters, show the paper to her, and explain what they meant before she told me that maybe another librarian would be able to offer more help. The second librarian, before searching on her computer, expressed that home birth was associated with poor people or people older than her grandparents who could not access the hospital. She described it using words such as “painful” and “dangerous.” On the contrary, she considered gentle birthing as a safer, modern-day practice that included a midwife or nurses at the birthing clinic. After consulting the internet, this librarian found that home birth could be considered a gentle birthing method as well.

In my classes with Taiwanese students, at church, and during the beginning rounds of interviews, some of them had never heard about home birth. There was a subset that knew of it but considered it an option for rich people that posted their experiences on social media. They did not think is was accessible or possible for themselves. I wanted to understand why home birth was so misunderstood in Taiwan but realized that there was a bigger question about women’s childbirth knowledge and how their knowledge impacted their childbirth experiences, which are often negative. For this purpose, my study particularly focuses birthing experience of women from different countries currently living in Taiwan.

doi:10.6342/NTU202303847

1.2 Background

According to the Ministry of the Interior National Immigration Agency Republic of China (Taiwan), as of May 2023, the total number of foreign residents living in Taiwan was 822,319 and over half at 414,794 are women. Although statistics were not found on how many foreign women have give birth in Taiwan, studies show that foreign women are at a high risk of experiencing pregnancy and childbirth complications due to the cultural, social, psychological, and physiological natures of pregnancy and childbirth (Behboudi-Gandevani et al., 2022). For these reasons, it is imperative to include foreign women's experiences in this study, as they contribute to the comprehensive assessment of the impacts of Taiwan's healthcare system. Including foreign women's experiences in the study can be used to ensure and create positive birth experiences for all women, both foreigners and locals alike in the future.

Some foreign women and men in Taiwan have shared their experiences through blogs detailing traumatizing birth experiences in hospitals where they were required to undergo pubic shaving (for episiotomy), made to accept enema to prevent pooping during birth, forced to lie on the bed while fasting from food and water, and were required to use a bedpan or catheter for urination from the time they entered the hospital until they gave birth (*Taiwanonymous*, n.d.). Some women discussed how their doctors needlessly recommended induction or planned c-sections (*To give birth in a new country/culture*, 2022). Some fathers even discussed how they were not allowed to enter the delivery room until the baby was coming out (Blogpost, 2021). All of this coupled with low privacy and

doi:10.6342/NTU202303847

the profundity of power imbalances between the doctors, nurses, and the patients, many women leave the hospitals feeling guilty, ashamed, and humiliated.

There is a larger context that shapes birthing experiences in Taiwan: over-medicalization of pregnancy and childbirth. From the early 2000's, Taiwan recognized the extremely high rates of cesarean sections (c-sections), well above the World Health Organization's (WHO) recommendation to keep the procedure at 10%-15% of birth to reduce maternal and neonatal mortality rates (*WHO Statement on Caesarean Section Rates*, 2015). C-sections were originally a surgical procedure to terminate pregnancy to save the life of the mother or neonate because vaginal birth risks outweighed the risk of c-sections (Jafarzadeh et al. 2019). WHO also suggests that c-sections should not be performed unless medically necessary because the operation poses unnecessary risks to both the mother and the child's safety (*WHO Statement on Caesarean Section Rates*, 2015). The latest rate in Taiwan in 2021 was 37.9%, exceeding the WHO suggestions nearly three times over (Guoneizhibiao-pofuchanlu, 2021). Surprisingly, there have been no effective means to lower this rate in the past 20 years. In fact, it has increased. Studies in Taiwan show that the likelihood of c-sections increases with the age of the couple as well as having had prior c-sections among other factors, and this is of particular interest as women in Taiwan today are getting married and having children later in life (Guoneizhibiao-pofuchanlu-yinianlingbie, 2021).

Furthermore, c-sections are not Taiwanese women's only concern. As of 2023, almost 99.9% of Taiwanese women give birth in hospitals where nearly 73.4% of women receive episiotomy, often without their knowledge beforehand (Goueslard et al., 2018). Importantly, this number has decreased from figures take in 2020 where the rates of the

doi:10.6342/NTU202303847

procedure were at 99.9%. This surgical procedure cuts the perineum to prevent vaginal tears and decrease time in labor; however, the results of this intervention have left many women suffering with third- and fourth-degree lacerations, which are more painful than spontaneous tears, and contribute to pelvic floor dysfunction and incontinence (Goer and Romano, 2012). The WHO reports that episiotomy should no longer be a routine procedure as only about 10% of women actually have cases that evidence-based medicine supports the use for this surgical procedure (World Health Organization, 2018).

The medicalization of pregnancy and childbirth occurs when women are seen as sick people in need of a medical doctors' intervention versus them going through a natural process that may or may not need medical intervention. When so many interventions take place, women, their needs, and their desires are considered low ranking priorities, and are devalued because the concepts of pregnancy and childbirth are viewed through the lens of medicine, not humanity. Therefore, it is no surprise that some women can encounter negative and traumatizing birth experiences. In response, women in the United States are opting for home birth to have less traumatizing birth experiences, more voice and control in decision-making processes, more autonomy, and the option to trust their intuition (Freeze, 2010). Taiwanese women too are also choosing home birth, or what is more often referred to as gentle birthing.

Gentle birthing in Taiwan, according to the Birth Empowerment Alliance of Taiwan (BEAT), is a human rights advocacy group that pushes for a more friendly space for women to give birth with adequate childbirth knowledge, increased awareness of autonomy, and the ability to have midwifery support. BEAT seeks to change the thoughts and perceptions of childbirth from negative to positive and gentle. This organization

doi:10.6342/NTU202303847

supports only going to obstetricians when medically necessary. Gentle birth can be done at home, in a midwife unit, at a birthing center, or in a hospital, and the intention is to reduce the risks for medical intervention and increase maternal autonomy, comfort, and safety (Birth Empowerment Alliance of Taiwan, 2023).

Home birth can fall under the category of gentle birthing, but in some cases, especially in underdeveloped regions, it can also be outside of the scope of gentle birthing especially when considering women who give birth without the assistance of a midwife. Home birth comes with benefits and pitfalls, and throughout the literature, having a beneficial home birth experience can depend on the location of birth and available resources. Some studies done in high resource countries where home birth and birth centers are common and where midwives are accessible, suggest that perinatal morbidity and other outcomes between hospital and home births are similar (Caughey and Cheyney, 2019). Others studies discuss medical intervention rates such as epidural, episiotomy, caesarean sections and show that they were substantially lower in home birth than low risk women who gave births in hospitals while intrapartum and neonatal mortality for low-risk women were similar among low-risk women who gave birth at home and in hospitals (Johnson and Daviss, 2005).

In conclusion, the background discusses various aspects of childbirth in Taiwan, revealing the experiences of foreign women and the medicalization of pregnancy and childbirth. These experiences, coupled with a power imbalance between healthcare providers and patients, leave many women feeling guilty, ashamed, and humiliated. The over-medicalization of pregnancy and childbirth in Taiwan is evident in the high rates of unnecessary c-sections and episiotomies. Taiwan's c-section rate exceeds the WHO’s

doi:10.6342/NTU202303847

recommendations, and the prevalence of episiotomy has been decreasing but still remains high. These interventions can lead to long-term complications and discomfort for women. Overall, the background highlights the importance of considering foreign women's experiences and the effects of medicalization in understanding and improving childbirth practices in Taiwan. The promotion of gentle birthing approaches, including home birth, can offer a more positive and empowering experience for women during childbirth.

1.3 Literature Review

The Medicalization of Pregnancy and Childbirth

Natural childbirth is a significant event that encompasses physiological, cultural, and emotional processes for birthing mom's, partners, and families, and it has the potential to be a positive experience for all parties involved. Natural childbirth is the safest childbirth method for low-risk pregnancies, and it involves the birthing parties' satisfaction, improved maternal and fetal outcomes, and immediate bonding and breastfeeding between birthing mom and newborn. Over the years, scientific and medical advancements have no doubt decreased maternal and infant mortality; however, these interventions shifted attention away from the birthing mom childbirth experiences. Even after the advancement of medicine and technology, natural births remain the safest option and offer more autonomy for low-risk pregnancies. One major issue is that pregnancy and childbirth are overmedicalized, and this has the potential to lead to negative childbirth experiences.

Medicalization first emerged in sociology in the 1970s. Zola stated that physicians were replacing the law and church's roles as the authors and judges of truth in society through "medicalizing daily living" (Zola, 1976). By doing so, physicians have control over

doi:10.6342/NTU202303847

anything that can be labelled as a sickness. Later, in the early 1990s, Peter Conrad's definition focused on medical social control and discussed how medicine makes society adhere to social norms by "minimizing, eliminating, or normalizing unacceptable behaviors (Conrad, 1992)." He stated that medical social control at its core is when the medical perspective defines a certain phenomenon and medical advice and information are the sole source of knowledge (Conrad, 1992)." When researching the medicalization of pregnancy and childbirth, many researchers use Conrad's definition of medicalization. Examples of medicalization are obesity, menopause, social anxiety, sleep disorders, and erectile dysfunction. These were once social phenomena that became medical issues that need medical intervention to adhere to social norms. Medicalization is considered to be sought after or resisted by patients and medical professionals, and it can be costly and work towards disempowering individuals while empowering medical professionals as they have more knowledge and skills in treating medical disorders.

Over the years, researchers have seen medicalization, not always clearly defined, as diverse, conceptualized, and context-driven. Because of the complexities of medicalization, other terms were brought forth such as biomedicalization and pharmaceuticalization. Critiques of medicalization include overmedicalization as well as restraints placed because of medicalization. Following this further, feminists have long critiqued the medicalization of childbirth. Feminist's critiques of medicalized childbirth made great contributions to understanding the gendered aspects of childbirth and how professionals, mostly men, have gained power and agency over women's health and reproduction. While some researchers view these critiques as "shifts" in defining medicalization, I see them as building blocks

doi:10.6342/NTU202303847

that recognizes these various contributions as stacking definitions to better comprehend medicalization in the context of pregnancy and childbirth (van Dijk et al., 2019).

The medicalization of pregnancy and childbirth has evolved over time. First, pregnancy became medicalized, and the medical lens was used to describe pregnancy and childbirth. Then, the source of knowledge and information stemmed from medicine. In the USA, by the 1900s, physicians had taken over the majority of childbirths, implementing highly medicalized practices, such as sedation, c-sections, episiotomy, forceps delivery, and blood transfusions (Johanson et al., 2002). Through this process, physicians stripped the role of childbirth from the hands of midwives, and the physicians themselves, mostly men, gained power and agency over women's health and reproduction. The medicalization of pregnancy and childbirth is evident in various levels, including how pregnancy is perceived, how the medical system manages pregnancy and childbirth, and how doctors interact with pregnant women (Conrad, 1992). During pregnancy, biomedicalization occurs through the use of ultrasounds and fetal heart rate monitors, and pharmaceuticalization taking place both during pregnancy and childbirth where these processes are targeting for pharmaceutical intervention. These stacking definitions holistically explain how pregnancy and childbirth are medicalized.

The medicalization of pregnancy and childbirth is not inherently bad. Some medical interventions do save lives, but it has been acknowledged for decades that sometimes, certain decisions and techniques are unnecessary and potentially harmful. For instance, there are times when constant monitoring throughout pregnancy, c-section, episiotomy, 24-hour fetal heart rate monitoring, and labor induction are medically necessary. However, much research has been done to show that outside of select circumstances, these procedures

doi:10.6342/NTU202303847

can be unnecessary and do more harm than good. Furthermore, there have been reports of women being mistreated, not being able to participate in the decision-making or negotiation process, or not being allowed to have their desired childbirth experience due to the medicalized childbirth system. The process of medicalizing pregnancy and childbirth has shifted attention and control from birthing women to OBGYNs which negatively impacts women's health and childbirth experiences by diminishing autonomy, confidence, and self-worth (Oladapo et al., 2018). Thus, it is not proper to treat every childbirth as high-risk and in need of medical intervention. When this does happen, positive and healthy birthing experiences are abdicated for quick, predictable, and strictly controlled labor.

During pregnancy and childbirth, medicalization can happen at any stage. The medicalization of childbirth is often exemplified by the image of an OBGYN assisting delivery with the woman lying on her back in a hospital bed, a practice that continues throughout pregnancy with constant monitoring and over-testing, contributing to a perception of childbirth in terms of fear and risk (Espinosa et al., 2022). Consequently, many women may prefer medical intervention, believing it to be the safest option. Research indicates that women with low education, poor self-assessed health, and negative prior childbirth experiences tend to favor medical intervention in childbirth, while those with a high locus of control and effective coping strategies do not (Espinosa et al., 2022). Overall, the medicalization of pregnancy childbirths has led to increased rates of c-sections, epidurals, episiotomy, and the disempowerment of birthing women that often result in long-term morbidity.

doi:10.6342/NTU202303847

Process of Childbirth:

Labor and delivery, also known as childbirth, is divided into three stages. The first stage is known as labor, and it includes early, active, and transitional labor. The second stage is delivery of the baby, and the third stage is delivery of the placenta. Every woman's experience can be quite unique. One woman's experiences can differ with different pregnancies. Labor can last from several hours to several days. With each stage of labor, women experience longer and stronger contractions along with other symptoms (*Labor and Birth | Office on Women's Health*, 2021). During this process, women undergo many physiological, psychological, emotional, and physical changes, and in the hospital, the medical model sees childbirth as a potential risk. Thus, medical intervention can happen at any point, even to start labor which is known as induction. Induction includes the use of medications as well as physically breaking the amniotic sac. Other medical interventions during childbirth are fetal heart monitoring, c-section, and episiotomy. All of which the WHO has stated are only necessary in some cases and can do more harm than good if used outside of those medically necessary scenarios. C-sections were initially designed as an emergency life-saving technique to quickly and safely deliver the fetus. Common reasons for c-sections are when either the birthing person or fetus are having heart issues, the fetus is in a breech position, labor stops, or there are multiple gestations. Research shows that c-sections come with risks as with any other surgery, including side effects from anesthesia, loss of blood, infection, and more. There are also risks to the fetus. Episiotomy, on the other hand, is typically used if the birth is lasting too long, if the baby needs more space, or if tools such as forceps or vacuums will be used to assist the delivery (Verma et al, 2021). Episiotomy does not reduce the likelihood of further tearing. Before the early 2000s, it was

doi:10.6342/NTU202303847

thought that episiotomy would prevent pelvic floor dysfunction and urinary and bowel dysfunction; however, the latest research has proven that to be false (Barjon & Mahdy, 2023). But this was not new or groundbreaking. In 2006, the American College of Obstetrics and Gynecology released guidelines that restricted the use of episiotomy in response to a systematic review that found episiotomy to have no immediate or long-term benefit, and episiotomy negatively impacts women long-term.

After the baby is delivered, a very important process happens known as the golden hour where the newborn and the birthing mom have uninterrupted skin-to-skin contact and initiate breastfeeding (Neczypor & Holley, 2017). This skin-to-skin has been shown to support thermoregulation for the infant, decrease stress for the birthing mom and infant, increase bonding between the birthing mom and baby, and lead to better and longer breastfeeding experiences. Breastfeeding early can also speed up delivery of the placenta as well minimize postpartum hemorrhage and increase postpartum weight loss (Neczypor et al., 2017). Also, during this phase, doctors have realized that their practices of immediately clamping and cutting the cord was harmful for the newborn; therefore, delayed cord clamping and cutting are now standard practices and recommended by the WHO (Zhao et al., 2019). Common problems that occur during this phase are women not being allowed the opportunity to participate in the golden hour, uninterrupted and not being allowed to delay cord clamping by medical professionals or hospital protocol.

Delivery of the placenta is the last stage of childbirth. Birth attendants can also use medical interventions at this time to help deliver the placenta and control postpartum hemorrhage (World Health Organization, 2018).

doi:10.6342/NTU202303847

Childbirth is experienced differently for every woman and does come with some risks; however, that does not negate the fact that childbirth is natural and involves human beings with emotions, expectations, and desires that have to live with the experiences that unfold before, during, and after childbirth. Medical interventions can happen at any stage of birth, and can have positive or negative impacts on women's health and childbirth experiences. Additionally, there is a complex relationship between medicalized pregnancy and childbirth and fear.

Fear:

Fear, sometimes separated into general fear and fear of pain, is one of the most researched emotions related to childbirth. The fear of childbirth can be debilitating and affect women's decision to become pregnant and give birth, and the impact can unfold through postpartum period and the rest of a woman's life. Fear can also be a deciding factor to the choice of birth method and intervention (O'Connell et al., 2021). For instance, higher rates of obstetric intervention and c-section are experienced in fearful women (Fenwick et al., 2015).

Studies have shown that culture impacts the way that childbirth is conceptualized which in turn impacts fear, expectations, and decision making (Preis et al., 2018). For example, there was a study that compared fear between Norwegian and Israeli women. In Norway, the researchers noted that births are midwife-led and patient-centered, and Norwegian women consider birth a natural process. For low-risk pregnancies, they received one ultrasound during pregnancy, and feared less self-efficacy and positive anticipation. In contrast, Israel's culture considers childbirth to be an obligation to give birth to what the researcher quotes as "perfect" babies. Israel's birth care system is more medicalized which

doi:10.6342/NTU202303847

induced monthly check ups and an ultrasound and blood tests for each visit. The researchers referred to this as a "risk instilling environment" that leads women to fear the risks and pain of childbirth along with the safety of the child (Preis et al., 2018).

The childbirth system in Taiwan is similar to Israel's in that the system is overmedicalized. There are ultrasounds and blood tests at every monthly check-up. A study done by Hui-rong found that there is a general fear of childbirth in Taiwan. Continuing, 50.3% of women in the study rated their highest fear as the fear of pain. Women who were more fearful of childbirth commonly used anesthesia pain relief during labor (Tu, 2016).

In conclusion, fear of childbirth can significantly influence women's decisions and experiences during pregnancy and childbirth. Cultural perspectives and medicalization of childbirth play a vital role in shaping women's fears and perceptions of childbirth, underscoring the need for more patient-centered and woman-friendly approaches to improve birthing experiences.

Trauma and Negative Birth Experiences:

Negative childbirth experiences unfortunately do occur for some women. Some research has stated that "negative childbirth experiences refer to the birthing mom's perception which means that a normal birth can still be perceived as negative or traumatic" (Viirman et al., 2022). Negative childbirth experiences can stem from pre-pregnancy issues such as common stressors, psychological issues, socio-economic circumstances, intimate partner violence, poor self-rated health, and fear of childbirth all the way through childbirth and postpartum experiences (Ayers et al., 2016). Some traumatic childbirth experiences include women not being allowed the space to ask their doctors questions and voice

doi:10.6342/NTU202303847

concerns, the lack of social support, a sense of helplessness, and other physical and emotional distress such as losing a lot of blood or losing a child. It is imperative that women have adequate support to meet their needs and desires in order to prevent these negative and traumatic experiences as they can lead to ill mental health, post-traumatic stress disorder, and the lack of bonding, attachment, and breastfeeding between birthing mom and baby, and more (Viirman et al., 2022).

Positive Birth Experiences:

The WHO defines a positive birth experience as, “to meet a woman’s personal and sociocultural beliefs and expectations in every setting. This includes giving birth to a healthy baby in a clinically and psychologically safe environment, assisted by a kind and technically competent health care provider (World Health Organization, 2018). There are many studies on interventions and methods that women and families can use to have positive birth experiences. Some suggestions are to have doula, create a stress-free warm and dark environment to maximize oxytocin production, facilitate openness and positive communication with the family and healthcare providers (Pascali-Bonaro, 2003). Other studies suggestions include providing evidence-based childbirth education which do include birth plans. Some of these studies noted that while doctors agree with the positive impact of childbirth education, they were not always supportive of birth plans (Afshar et al., 2019). Studies also show that childbirth education prepares women on what to expect during childbirth and reduces medical intervention. For instance, in one study, women that attended midwifery-childbirth classes had less induction, less epidurals, and used pain relief techniques and birth postures. Their pain scores were lower, and they had more positive

doi:10.6342/NTU202303847

attitudes, less fear, and felt more confident during birth. They were also less afraid for themselves and the safety of their baby (Chen et al., 2021). This shows that childbirth education can have a positive impact on women's choice, confidence, attitudes, and fear thus leading to more positive birth experiences.

Human Rights in Childbirth and Patient-provider Relationships:

The medicalization of childbirth has been a major contributing factor to the mistreatment of women, obstetric violence, and a highly polarized medical care system that leads to power struggles between women and doctors, midwives and doctors, women and system, feminists and system, and more. Researchers are saying that human rights in childbirth rises above changing birthing locations and arguing for body integrity and autonomy (Lokugamage & Pathberiya, 2017).

To help women achieve their human rights in childbirth, researchers suggest that patient-centered care should be the cornerstone in which healthcare providers offer the knowledge while the patients make the decision. Both compassion and evidence-based medicine are both essential, and healthcare providers should not lose sight of compassion (Lokugamage & Pathberiya, 2017). Furthermore, other researchers have made the bold statement that "bioethical principles are not sufficient to care for pregnant and birthing women. Kate Buchanan and along with a few colleagues suggest that there are two fields of ethics, "women-centered ethics" and "authoritarian ethics." Women-centered ethics is defined by women's perceived care on the basis of relationship, knowledge, and mannerisms (Buchanan et al., 2023).

doi:10.6342/NTU202303847

Taiwan Specific Research:

Research has been done in Taiwan on childbirth and factors that impact women's childbirth experience; however, many of these studies were done almost solely with Taiwanese women. Furthermore, the studies that were done on women's childbirth-related knowledge and childbirth experiences were either done almost 20 years ago, or more recently have focused on Southeast Asian immigrant wives. Not very much attention has been given to western women nor has there been much comparisons of foreign women and Taiwanese women's childbirth-related knowledge and experiences. For these reasons, this study seeks to explore both foreign and Taiwanese women's childbirth-related knowledge and childbirth experiences.

doi:10.6342/NTU202303847

Chapter 2 Methods

Chapter two explains the methods used to respond to the research objectives presented in chapter one, which are to investigate the childbirth-related knowledge and experiences of diverse women in Taiwan to add to the growing body of research around childbirth and the impact of medicalization and culture on women's childbirth experiences. To do this, qualitative interviews were used to build rapport and trust with participants and allow the researcher to gain rich, quality details about participants' lived pregnancy and childbirth experiences. Purposive, convenience, and snowball sampling methods were used to recruit participants. There were 15 total participants which included one doctor and two doulas. Six Taiwanese locals and one non-Taiwanese shared their knowledge and experiences with me to increase my cultural understanding. Interviews were supported with field observations in an OBGYN clinic that allowed the researcher to prove participants experiences and write the section presented later titled, "Setting the Scene with Sally." The other field observation was completed through attending a childbirth class taught by one of the doulas in the study.

2.1 Setting

The setting took place at National Taiwan University (NTU) where the research was approved by NTU's Research Ethics Committee with validity dates from March 10, 2023 to December 31, 2023. NTU-REC No.: 202212HS037.

doi:10.6342/NTU202303847

2.2 Participants

Participant inclusion criteria were women in Taiwan (both foreign and Taiwanese) who were ages 20 to 65 who have given birth or want to give birth in the future. Exclusion criteria were men and those who did not speak English or Mandarin. Women's ages ranged from 23 to 51 (mean 32). Twelve women had given birth from 2 months to 15 years ago with the exception of three women who did not have children but want to in the future. As a researcher from another culture, in order to seek more understanding of childbirth and related aspects in Taiwan, I had informal discussions with seven friends whose background information was not captured. The process will be detailed in the following thesis. Each participant was given a pseudonym in English or Chinese to protect their identities and help with clarity for readers. Below are two separate tables of the participants to separate the formal and informal interviewees.

Table 1

Formal Interview Participants' Background Information

Pseudonym	**Age**	**Education**	**# of kids**	**Childbirth method**	**Nationality**	**Age when had 1st child**	**Location of birth**
Sandy	23	Masters	0	N/A	Taiwanese American	N/A	N/A
淑芬 Shu-fen	25	Masters	0	N/A	Taiwanese	N/A	N/A
Jill	23	Masters	0	N/A	American	N/A	N/A
Lily	30	BA	3	Vaginal and 2 waterbirth	Korean American	25	1-USA 2-Taiwan Lovingcare in Xinzhuang
Harper	40	MD	2	Induced Vaginal birth with epidural	Hong Kong-American	35	Taiwan Veterans General

doi:10.6342/NTU202303847

							Hospital (VGH)
雅婷 Ya-ting	43	BA	2	1- Vaginal, no epidural 1- Vaginal, epidural, vacuum assisted	Taiwanese	29	USA
Pemala	34	Vocational	2	1-Vaginal, no epidural 1-Vaginal, epidural	Myanmar	31	Malaysia and Taiwan NTUH
美玲 Mei-ling	51	Vocational	4	C-section 3 times, (1 set of twins)	Taiwanese	31	Taiwan-Taizhong City Hospital
怡君 Yi-jun	29	BA	1	Vaginal, no epidural	Taiwanese	29	Taiwan-Weifubu Taoyuan Hospital
Eun- Jung	25	BA	1	Vaginal, epidural	Korean	25	Taiwan
淑華 Shu-hua	28	BA	1	Vaginal, epidural	Born in American but Raised in Taiwan	28	Taiwan
美惠- Mei-hui	27	BA	1	Vaginal, epidural	Taiwanese	27	Taiwan-Lovingcare in Xinzhuang
Cassie	NA	MA	1	Vaginal	German		Taiwan
Doula 1	NA	NA	1	Vaginal, no epidural	Taiwanese		Germany Birthing clinic
Doula 2	NA		3	Vaginal epidural, 3rd baby no epidural	Canadian		Taiwan: 3rd baby at Lovingcare in Xinzhuang

doi:10.6342/NTU202303847

Table 2

Informal Cultural Informants

Informal Interview Participant pseudonyms and connection to researcher	Topic of Informal Interview
Xiu-mei (Taiwanese Classmate)	Taiwanese culture's influence on childbirth
Ming-yue (Taiwanese Classmate)	Taiwanese culture's influence on childbirth
Peizhen (Taiwanese friend)	Doctor-patient relationship
Ruiqi (Taiwanese friend)	Doctor-patient relationship
Yawen (Taiwanese friend)	Doctor-patient relationship
Syndey (Paraguayan friend)	Doctor-patient relationship
Ruyi (Taiwanese friend)	Doctor-patient relationship

2.3 Data collection

Interviews:

I, a bilingual (Mandarin and English) interviewer, conducted fifteen semi-structured, in-depth, interviews. The semi-structured interview method was adopted to allow for two-way communication and diverges into topics. I wanted interviewers to have the freedom to discuss the matters that were important to them that might not have been in my list of questions. The bulk of these interviews were one on one; however, there were two interviews with two interviewees present. This was not my original idea. These two interviews were set up through snowball sampling. A previous interviewee, although her interview was one-on-one, contacted her friends, and set up the interviews in a two-on-one fashion. Six interviews were conducted in Mandarin with English support when necessary for understanding while others were in English and supplemented with Mandarin when needed. One of the two-on-one interviews was bilingual as one person spoke English while the other spoke Chinese. Each interview was recorded and lasted 45-90 minutes with

doi:10.6342/NTU202303847

participant informed consent to discuss their childbirth knowledge and experiences. Interviews took place wherever the participant was most comfortable; thus, the setting was in various locations including homes, coffee shops, restaurants, and virtually. During these interviews, participants were asked to draw what came to their minds when they thought about childbirth. Only three participants agreed to do so.

Three of the interviews were expert interviews with one internal medicine doctor and two bilingual doulas. Doulas provide evidence and experience-based childbirth education to families and walk with them and their healthcare providers from pregnancy to postpartum. They have first-hand accounts on what the literature says as well as what actually happens during childbirth with many women, including their own. There were also 7 short, informal discussions in this study on aspects of Taiwanese culture and the doctor-patient relationship in Taiwan to better understand participant responses.

Field Observation:

The interviews were supplemented by ethnographic field observations. These observations included attending Doula 2's (as referred to in the study) birthing class, and observing an OBGYN waiting room at a local hospital in Taipei. The birthing class consisted of two four-hour-long sessions and included topics that were not limited to stages of labor, what to expect, pain management, partner support, how to choose a birthing location and physician, questions to ask the physician, women's rights, doula support, birthing methods and risks, the golden hour and breastfeeding, mom guilt, diaper changing for dads, and birthing mom and partner communication methods to achieve desired outcomes.

doi:10.6342/NTU202303847

Analysis:

Interviews were recorded and transcribed in English, and the transcripts were stored on the researcher's password-protected device and stored in a folder titled "Interview Data" named "Interview #" in the order that the interviews were conducted. The transcripts were typed semi-verbatim as some audible and verbal aspects and pauses in between words were not captured to increase clarity. Filler words, broken sentences, and repetitions remain in place. An inductive approach to reflexive thematic analysis was used. Validity was achieved through data saturation where no new information was found, expert interviews with a medical doctor and two doulas, data triangulation, and field observations and notes. Reliability was achieved through rapport building with interviewees and participants using their own experiences unless they were experts. Thematic analysis was used to develop three themes and five subthemes.

doi:10.6342/NTU202303847

Chapter 3 Results

Precursor to Results:

3.1 Setting the scene with Sally: What it looks like to visit an OBGYN in Taiwan

During each interview and field observation in this study, women detailed their encounters with the healthcare system in Taiwan. Women choose their hospital, clinic, or doctor from three main ways: friends' recommendation, convenience, or they want a specific birth experience such as water birth which is only offered in 2 known locations in Taiwan: Dianthus and Loving Care clinics. Many foreigners referred to the next steps as an assembly line and commended its efficiency. Based on an attempt to introduce the audience to the uniqueness of the scene that birthing women usually encounter in Taiwan, I integrated all of the interviewees' experiences in the clinical setting in Taiwan into a story. In the following part, I will introduce Sally, a fictional character, to walk us through this "assembly line" of real people's experiences.

First, upon arrival at her chosen hospital or clinic, Sally will pick up a number from a queue machine. When the number is called, she goes to the front desk to set up an appointment with whichever doctor she wants to see, in this case, an OBGYN. The person at the front desk requests Sally's National Health Insurance Card (NHI) and slides it into a card reader. Then, the person at the desk asks, "do you have a specific doctor in mind or would like a male or female." Many Taiwanese women in this study mentioned that they preferred females but noted that there are very few female doctors in Taiwan, especially in the OBGYN specialty. Some Taiwanese women in the study had a specific doctor in mind from a friend's suggestions, but the westerners in the study only had their choice of hospital

doi:10.6342/NTU202303847

or clinic in mind, not a doctor. Next, Sally is given a sheet of paper with the doctor's name, clinic room number, and a number in queue and told to visit during the morning or evening clinic hours. Clinic hours vary slightly at each location, but generally there are two sessions a day, a morning session from 8am-12pm and an afternoon session 2pm-5pm. During her scheduled clinic time, Sally puts the NHI card into the machine plastered on the wall outside the designated clinic room to let the nurse know that she is present.

Wait time can vary tremendously. For instance, I will introduce participant Harper, and tell you about her experience with wait times. Harper was an internal medicine doctor before moving to Taiwan. She is a mom of two, both born in Taiwan. One of her proudest accomplishments was not being able to speak any Chinese during her first pregnancy, but during the second pregnancy, she mentioned how elated she was that she no longer needed her husband to translate as much. Harper describes her wait times in Taiwan. "It was a private clinic. I didn't have to wait. I went straight in." Harper said that each consecutive visit was very similar in that she could see the doctor shortly after arrival without waiting a long time. Participant Lily on the other hand had a different experience. Lily is a mom of three. Two of her births occurred in Taiwan where she had waterbirth. Lily was a teacher before moving to Taiwan, and in Taiwan she educates women in her church about all the information she learned in childbirth classes because she is passionate about women having positive birth experiences. When describing wait times, she stated, "It wasn't just in and out. But at the same time, it wasn't like in America. The line was so long. It was a big public hospital." Lily went to a larger public hospital that had a longer wait time but stated that the waiting time was still shorter than she experienced in the USA.

doi:10.6342/NTU202303847

Back to Sally, in the clinic room, Sally notices there are two desks back-to-back. One side belongs to the nurse and the other side is where the doctor sits. The patient will sit perpendicular to where the desks meet. The doctor asks Sally if she speaks Mandarin or prefers them to speak in English while the nurse swiftly grabs the NHI card to schedule tests and order prescriptions per the doctor's instruction. Sally has about 3 minutes to see the doctor because the doctors in Taiwan have to see many patients a day to get paid a good enough salary. During this visit, if patients not currently seeing the doctor want to speak to the nurse or have questions, they will sometimes barge into the room or knock and simultaneously barge into the room without permission. The nurse either answers their question while sitting, tells the patient to wait a moment, or meets the patient at the door and has a discussion standing in the doorway while Sally is talking to her doctor. For Sally, after about 3 minutes, the nurse instructs her to wait out in the waiting room as she prints paperwork. In the waiting room, where others are sitting or bustling back and forth, the nurse calls Sally's name and hands her the paperwork and her NHI card. The nurse tells Sally to go to the payment desk where oftentimes the patient will have to guahao again, then instructs her to go to the bloodwork station to get blood drawn and to the pharmacy to pick up medicine. Also, while in the waiting room, the nurse will teach Sally how to take her medicine. This entire encounter is what most foreigners refer to when they mention the efficiency of Taiwan's healthcare system; the patient can cover all the bases in one location just at different departments. Privacy; however, is not a matter of concern in this system which can make some foreigners feel uncomfortable. To Taiwanese, this is the social norm.

Here, I will briefly introduce participant Mei-ling. She is the mom of four children with a set of twins. Her first pregnancy ended in miscarriage of a set of twins. During the

doi:10.6342/NTU202303847

interview, she mentioned having a grave fear of childbirth, so much so to the point of being put to sleep during her c-sections because even the sound of the doctors and nurses talking over her was frightening. She was kind and vulnerable enough to openly share her thoughts and experiences with me. Mei-ling says that during this first visit, after confirming her pregnancy, Sally, will receive a booklet with "next appointment dates throughout the duration of her pregnancy and different tests to run at each visit, including amniocentesis."

Pemala is another interview participant. She is from Myanmar, and she sees childbirth as being a natural occurrence that women just have to go through. She is intrigued by her mother's strength who gave birth at home with the help of a midwife where she witnessed fundal pressure. She went to school in Taiwan, and married a Malaysian man. She moved back to Malaysia with him and gave birth there before moving back to Taiwan giving birth to a second child. Below, she describes the stark differences in pregnancy care between Myanmar, Malaysia, and Taiwan. She says that at consecutive doctor visits in Taiwan, Sally will undergo many of the tests that Mei-ling mentioned.

> "In Taiwan, at each appointment, women also receive blood tests and sonograms. In Malaysia, I did not specifically do any tests. In Myanmar, they can't do these sorts of tests. They just listen to the heartbeat, so when the child has problems, they have no way of knowing. In Taiwan, it's not the same. At 6 months, they will tell you to do a lot of tests, for example, stick a needle down to the baby to see if they have certain health issues."

doi:10.6342/NTU202303847

Here, Pemala was referring to amniocentesis. In Taiwan, she mentioned being told by doctors that two of her children would not be healthy after several tests were completed; therefore, she was encouraged to abort the babies. The doctors told her the same thing for her third pregnancy in Taiwan; however, because the baby had a heartbeat, she decided to keep the baby against the doctor's recommendation that led her doctor to suggest a specialist to deliver the baby instead of him. Through her story, we can see the impact of medicalization of pregnancy through constant monitoring and doctor authority.

To some women, having many tests and being monitored throughout the pregnancy is reassuring. Interviewee Harper says, "I'm just too risk-averse. I'm a medical doctor, so I just know all the possible sadness that can happen, and I prefer the feeling of control. It's all a false sense of control, but there's a greater sense of being monitored and having a sonogram. I'm over 35. I have gestational diabetes. The risk for me just felt like it was too high."

Ya-ting, unlike other Taiwanese in the study, gave birth in the USA, and she was able to share her experiences of pregnancy differences in Taiwan and the USA. It seemed as if she had been waiting to tell her story for many years; however, because I am American, she became quieter and timid when she mentioned liking aspects of Taiwanese care better than the USA, for instance getting blood drawn is more simple and less painful in Taiwan. Ya-ting seconds Harpers concern.

"In Taiwan, they use the sonogram every time, whether in the clinic or the hospital. You will feel very safe and reliable because you can check the situation all the time.

doi:10.6342/NTU202303847

> But in the US, you cannot do that. They only offer 1-2 times for the whole pregnancy. But since I have diabetes during the period, they will try to add one or two more to check my baby's situation."

Other women, like Pemala, do not really lean heavily for or against monitoring throughout the entire pregnancy. She says, "it was standard procedure and you just do what the doctor says." She continues with a shoulder shrug, "I don't question it or have thoughts about it." Yet, a third subset of women, including the two doulas who were interviewed say that some of this may be medically unnecessary considering in other countries, women do not receive this much intervention.

3.2 Addressing the East-West Dichotomy

The OBGYN clinic setting in Taiwan is set, but there is another important topic to discuss before diving into the themes. In this study, I used the broad terms "Asian" and "Western." For the purposes of clarifying the results of this study, Asians are defined as women who was raised in Asian. Likewise, Westerners refer to those who were raised in the western world. I acknowledge that these broad terms lack the ability to fully define how people identity; however, there were clear cultural distinctions between women, in this study, who were raised in Asian versus the West in how they conceptualized childbirth. For this reason, I will use these terms throughout the study unless a particular point is referring to a certain subgroup such as Taiwanese or American.

Theme 1 is Culture and Medicalization of Pregnancy and Childbirth Impacts on Birthing Mom's Relationships and Childbirth Experiences. Theme 1 has two subthemes: Birthing Mom's Relationships Impact on Childbirth Experience and Strict Adherence to

doi:10.6342/NTU202303847

Protocols Impact on Childbirth. Theme 2 is Birthing Mom Sate and Mom Guilt. Theme 3 is Cross-cultural Conceptualization of Childbirth with 3 subthemes: Different Knowledge Seeking Behaviors Among Women Cross-culturally, Childbirth-related Knowledge, and Ideal Birth Experience.

Results:

3.3 Theme 1: Birthing Mom's Struggle for Power Caused by Culture and Medicalization

Birthing Mom Relationships (Family, Partner, and Doctor) Impact on Childbirth Experiences

Family:

In some cases, the role of birthing mom's family members, particularly the mom or mother-in law in Taiwan, could be either detrimental or supportive to the birthing mom's decisions and experiences. Three stories used here will explain this interaction. First, Mei-hui's mother has a friend who is a traditional Chinese medicine (TCM) doctor that told her that a birthing woman should not touch water. Even after birth, she should not shower, wash her hair, or touch water for a 30-40 days. Mei-hui's testimony is below.

> "I want to try waterbirth. My friend told me it's really good for you. So, I think I will try that. But then a few weeks before he comes out a traditional Chinese medicine doctor, she knows me, even when I'm not born yet. She and my mom are really good friends. She said, 'waterbirth is good for a baby, but it's not good for moms. Pregnant

doi:10.6342/NTU202303847

woman should not touch water or give birth in water.' Then, I tried to argue with her, but then because she is a good friend with my mom, I said OK. I told my mom what this doctor told me and my mom said, 'just follow what she says'."

Taiwanese culture played a large role in Mei-hui's decision to obey her mom. Hence, even though she wanted a waterbirth, she listened and obeyed regardless of her preference. She did not want to cause discord in her family. My Taiwanese classmates, Ming-yue and Xiu-mei, commented on her experience by saying, "Taiwanese consider how others would think of them if they choose water birth or home birth." Their comment speaks to more cultural nuances about potential social stigmas around not going to the hospital or clinic to give birth. People will think that they are irresponsible.

Some westerners in the study reported very different experiences with their family member's roles in their decision making about childbirth options. When Lily told her family about waterbirth, she just explained the situation to their parents and in-laws to put their minds at ease, knowing the option that she and her husband were going to take was not up for negotiation. Her story is below.

"My family did not impact my decision to do waterbirth. I get what I want. They asked questions in the beginning. They asked, 'why would you have a non-medicated birth?' My mom did not want me to go through that much pain. They knew I would ultimately do what I wanted to do. They respected my decision. I never felt pressure or influence or resistance for this method. I explained how water is a smoother way for a baby to

doi:10.6342/NTU202303847

enter the world. Other things are healing and recovery is quicker without epidural. I never received any push backs."

Another American woman in the study, Jill, although she has not had kids yet, reported, "well my dad is a doctor and may have different views, but I would want to choose home birth. If he disagrees, I will try to convince him especially by telling him if a problem occurs, I will go to the hospital."

Here we see how family, culturally, can have an impact on the birthing mom's childbirth experience. Mei-hui's mom had authority over her, and in this instance, caused Mei-hui to have negative emotions. She also ended up having a traumatic birth experience which led to her wondering if the situation would have gone the same way had she chosen waterbirth. Lily, on the other hand, had family who did not force her hand one way or the other and who was quite adamant about what she wanted. She described her waterbirth experience as being so much better than her previous hospital delivery that she did waterbirth again for her third child. Doula 1 responds to this cultural difference below by sharing that the parents who are giving birth should be making their own decision and others, especially mothers and mother in-laws, should be unconditionally respectful and supportive of core family's decision. Her statement is below.

"I feel like in Taiwan it's especially strong that your mother or your mother-in-law has a lot to say about your childbirth and how you're gonna raise your kid. In Taiwan, everybody feel that they're entitled to give you advice when you're

doi:10.6342/NTU202303847

pregnant or when you have a baby. And I feel like the family's role would be nice if it is just supporting. No matter how much you know, the actual core family, the family that is giving birth, are the ones deciding. Other people should take a deep breath, even though they might not agree with the birthing person."

Partners:

The most common complaint that was expressed by the participants in the study was the concern of loneliness when their partners were not present at different stages of labor and delivery. This highlights that partners play a significant role in childbirth. Below, participants comment on their partner's role and impact on their overall birth experience. Then, I will discuss what Doula 1 suggests and Doula 2 teaches in her childbirth classes tailored for partners.

Both Ya-ting and Shu-hua, respectively, given as account of their personal stories, emphasizing the safety and security that having their partner by their side brought to the childbirth experience.

"Well, because my English was so poor at that time, I let my husband manage and handle everything. During the epidural, I feel lonely, to be honest, because who can I count on, only the nurse and the doctor. And then because I have no family or friends next to me, I asked the nurse to let me hold her hand. So, I think if I hold her hand, I will feel more safe. And she said, of course you can do that. It's like a

doi:10.6342/NTU202303847

complaint. My husband didn't stay there with me all the time, so sometimes I will feel there's something not satisfying in my heart" (Ya-ting).

"My husband, my mom, and my dad tested positive for COVID, so it was my mother-in-law who went to the hospital with me. I think that it's different when my husband is not beside me. It made me actually more anxious about what is going to happen even though my mother-in-law takes good care of me. It just feels like I have to face this myself" (Shu-hua).

These are two experiences where the birthing moms expressed the need for their partners next to them. These women lost a source of power when their spouses were not around. Now, I will share some experiences where the husbands had a very active role during childbirth, sometimes more active than anticipated. Lily's husband was in the tub with her as she gave birth, and Harper's poor husband had to suddenly become a nurse and measure excretion and urine output. They shared this information with me below.

Lily and her husband decided that waterbirth was right for them. When mentioning her husband's role, she excitedly says, "My husband was very supportive. He loved this idea, and he was in the tub with me." Harper's story was quite the shocker for her family and me too.

"My husband became like the nurse. They made him take the bedpan and record how much I peed or pooped. I needed more support than I thought or imagined. In the USA, the nurses would do that or their medical assistance. But he was basically

doi:10.6342/NTU202303847

my nurse. The nurse came in to show me, like this is how you gotta push, count to five. So, they did it with me for like three to five times, and then they left. My poor husband was then trying get me through this," says Harper.

Harper empathized with her husband; however, she never imagined that she would need that kind of support from him. She also talked about how during the first pregnancy, her husband had to take off work to go to doctor appointments with her as he was the translator. At the time, she did not speak Mandarin Chinese, only Cantonese and English. This just emphasizes the empowering role that partners play during pregnancy and childbirth.

Doula 1 experienced something that she called quite odd with her partner during making a decision on the childbirth location. Her husband knew that she was a doula, but he thought it was strange that she wanted to give birth at home. The couple compromised for clinic birth with doula support. She shares her experience below.

"I wanted to do a home birth, but I think my husband was a little bit too afraid because it was the first pregnancy, first baby. But I told him that I definitely don't want to do a hospital birth, so he kind of at the beginning he was really suspicious or having doubts. But now, my husband is very happy about it. And at the end, he said that even though I had to be transferred to the hospital, he doesn't regret using the birth center. Then he thinks it's really a wonderful experience that he would still

doi:10.6342/NTU202303847

pick the birthing center. If we do it again next one, maybe I'll suggest home birth again."

Doulas are a rarity Taiwan, with an even lower level of recognition and understanding than midwives. They provide comprehensive support from pregnancy through a year after childbirth. Their support provides several benefits, including increased paternal support during labor, improved maternal and infant outcomes, decreased likelihood of low birth weight, remarkably increased rates in breastfeeding initiation, heightened self-efficacy, and greater childbirth satisfaction. Doulas understand the significance of having a partner present during childbirth. As a matter of fact, according to Doula 1, their role in childbirth is consistent with that of a partner. Although she is Taiwanese, most of her work as a doula has been done in Germany where she works with the English-speaking population. She describes what this partnership is like in the passage below.

"We are like partners-relationship instead of a doctor-patient relationship. We don't give medical advice. We only share experiences and information. The clients will ultimately make decisions themselves. We're only there to support their decision. So, it's also very important that doulas and clients or families are picking each other. They should see if their values and beliefs are aligned with each other politically and in personality. All that has to be put into consideration whether it's a good fit or not. Because the labor and childbirth process is also very private, very intimate, and you don't want someone that is making you uncomfortable to be part of it. So, we always do interviews, and then we have to of course establish a

doi:10.6342/NTU202303847

relationship and trust before the labor actually starts. We also have to talk a lot about wishes and how a doula can support the family."

Both doulas in the study emphasized the importance of partner participation during childbirth. Doula 1 revealed that there is an increasing trend of dads getting engaging and searching for insight even more than moms. She notes active involvement from the dads not only strengthens the bond with their child, but it also acts as a safety net for the birthing mom in the case that she cannot make a decision. He could step in to help. For this reason, she stressed the necessity for partners communicating their desires to one another "before going into childbirth because there's no time, no room, nor energy for arguments during this time." To meet the need for active partner participation, Doula 2 has integrated sections into her childbirth class to empower partners and help spark discussion among the couples. Section topics include partner communication on their desires (with emphasis on not attempting discussion during contractions), techniques aimed to help birthing mom ease pain by applying pressure to nerves in the lower back and hips, guidance to support the mom in certain birthing positions, reminders for the mom to use breathing techniques, and lastly, how to help set the external environment for the birthing mom's safety and comfort which includes providing music, cold towels, and popsicles.

The accounts shared by the participants above shed light on the fact that birthing mom's experience disempowerment when their partners are not present during childbirth or are not in agreement with expectations. Partners' roles span a spectrum from having no defined roles to assuming nurse-like duties. Their presence and support empowers the birthing mom to advocate for her desired birth experience; however, partners could also

doi:10.6342/NTU202303847

undermine the birthing mom's desires, especially in cases where they are uncertain about the birthing mom's preference, lack understanding on how to assist her during labor, or are not present at all.

Doctors:

This section will be discussed in three parts. The first part is on the cross-cultural OBGYN- Birthing Mom Interaction. The second part details doctor's decision-making impact on women's childbirth experiences. Lastly, there will be a discussion on broad views of relationships with other kinds of specialists in Taiwan.

Part 1: Cross-cultural OBGYN-Birthing Mom Interaction

> Donielle: "Why are more Westerners mentioning how doctors make them feel while Taiwanese talk about the doctor having a degree and many patients?"
> Doula 1: "Cultural differences. I lived in the US for three years and what I have noticed that is very different is about the culture of speaking and expressing feelings and emotions, and in Taiwan people don't talk about that. People don't care about it also. So, if you're not used to having it, then when you have to make decisions about your childbirth, you also don't just suddenly have that kind of ability to speak up for yourself, ask questions, and express and to notice and be aware of your own feelings."

The scenario being discussed between the interviewer and interviewee is the disparities in the perceptions of the OBGYN-birthing mom relationship. Throughout my

doi:10.6342/NTU202303847

interviews, consistent patterns emerged in how Asians and Westerners defined trusting their doctors and described their willingness to ask their doctors questions. In the above context, Doula 1 focuses on Americans capacity to care for and express their emotions; however, she missed the fact that some Americans view their interactions with their doctors as a relationship that is more emotionally involved. For some, that relationship is a partnership where they collaborate to have a healthy and ultimately an ideal childbirth experience. Harper's interview scripts exemplifies this partnership when she reflects on her time in medical school. She says, "During medical school rotations, I saw that the relationship between OB and the patient is really special. You get to walk with them through a beautiful time in their life." As the interview progressed, she delved into how cultural differences made her feel uncomfortable, and resulted in her to finding a different doctor.

> "This doctor in Tianmu did an ultrasound, and the whole time, he was telling me about all this, like academic achievements, diplomas from Harvard or whatever on the wall. And I was turned off by that. I was just like, I'm not really here for your accomplishments. So, I ended up going to a different OBGYN, who is really nice. In Taiwan, I was told that the doctors are going to listen to you for like 3 minutes and then kick you out basically. But he actually listens to me, spent more time with me than I thought, and actually answered all my questions. And that gave me a lot of confidence in having him as my OBGYN."

During the interview, when Harper was describing her delivery, she reveals that the openness of the OBGYN and healthy communication with the OBGYN helped her build

doi:10.6342/NTU202303847

trust. She says, “the doctor's said ‘because of the way the baby is, we need to use forceps.’ That's another thing that my husband and I tried not to use, but then I thought, you know, I trust him.”

Above, we see that this participant defined the interaction between the OBGYN and the patient as a “special relationship” where the OBGYN spends time listening to and answering the patient’s questions. The participant explained being “turned off” by the doctor bragging on his accomplishments and degrees which I later learned would help built trust for Taiwanese counterparts but not for Americans. Communication and openness built a foundation of trust for this participant. Because she trusted her provider, later during childbirth, when the doctor suggested the use of forceps that she and her husband did not want, she agreed and still had a positive birth experience despite using an intervention that was not in her birth plan.

Another participant, Lily describes her process of switching doctors in Taiwan until she found the one that was right for her. Popular clinics did not trump her needs to feel taken care of, and that feeling of being taken care of stemmed from her ability to communicate with and negotiate with her doctors. Because this section is very long, I will use “…” to indicate the gaps where information was deleted to get the full effect of how Lily defines the OBGYN- birthing mom interaction.

> “I went to a popular clinic that had state of the art facility and was very new and modern. But I didn’t feel like it was compared to American standard of care because I didn’t feel taken care of. I didn’t feel like there was a personal relationship that I

doi:10.6342/NTU202303847

had with my PC (primary care doctor) back in America. It felt more like a business transaction, very quick… Then, I went to a public hospital that I liked a little better because it felt a little bit more personal. They would ask me a little bit more questions. The reason I left that place was because the baby was still head up and the doctor immediately suggested c-section. Intervention. Immediately, a huge red flag to me. Thankfully it's not weird for ppl to go from hospital to hospital in Taiwan... At the new hospital, I told the doctor right away that he was still head up and asked for her thoughts. She was understanding. I stuck with that hospital for the 2nd and 3rd babies. I don't think it's common for big public hospitals in Taiwan to receive birth plans from others, but this clinic that I go to received birth plans."

This participant detailed several critical cultural differences between the USA and Taiwan. First among these differences are in the healthcare systems where in the USA, people have a primary care doctor where the relationship is based on a personal connection. Secondly, she mentioned having a doctor that was willing and able to negotiate and accommodate her needs of low interventions and waterbirth. Lastly, her comfort and needs were held to a higher esteem than the popularity of a clinic or doctor. Ultimately, what we see with both of these participants is that they kept searching for options until their desires of a "special relationship" with their OBGYNs were met.

Now let's assess the perceptions of OBGYN-patient interactions from a few Taiwanese participants. In this first scenario, I asked the participant, Mei-ling, how she decided on her birthing location and doctor, to which she responded that her friends recommended the hospital and male doctor to her. I then asked her about her relationship

doi:10.6342/NTU202303847

with her doctor. She seemed confused by the question, and after she didn't respond for a while, I asked more questions. Among those questions were, "did you like your doctor, and was your doctor trustworthy?" Her response was that they blindly trust in doctors, and the definition of a good doctor was not related to the birthing mom's experience with the doctor. Her statement is below.

> "When friends tell you this is a good doctor, he already has a lot of patients. He is busy. He doesn't have time to explain things to you. So, he will do a check up and tell you if there is or isn't a problem. Does the baby have hands and feet with 5 fingers and toes, or another doctor will tell you the baby is moving. They are all different. We trust the doctor. We trust the doctor will look for us. So, no other questions. If a lot of people say he is good, then he is good. If he goes and says the baby doesn't have a problem, then we just trust him"

Towards the end of the interview, on the topic of home birth, I asked her, "of the people who know about home birth, but still choose hospital birth, why do you think they do it?" Her response was as follows. "They don't trust themselves, just trust the doctors. In Taiwan, we think the doctors know what's best, and we don't know. We don't understand this knowledge."

With this example and many others in the transcript, we can infer that some Taiwanese, particularly, do not view their interaction with their doctor as a partnership, and they trust their doctors because doctors have a set of knowledge regarding maternal and

doi:10.6342/NTU202303847

infant health that they themselves lack. Although the pregnancy and childbirth is happening with the woman's body, it seems as though the entire process belonged to the doctor. It was the doctor's job to oversee this process alone with no questions asked by the birthing mom. With her response, it seems that childbirth knowledge alone could shift some of the power in decision making back into the hands of the birthing mom.

Another example is where Shu-hua describes what Mei-ling mentioned in her last quote about women trusting the doctor, not themselves.

> "I went to the clinic twice because I also have some questions for the doctors, but they just give me very short responses. They would say, 'oh, if you want to choose a, that's OK, but B also is OK and C also is OK.' So, I cannot think. I was asking for your professional advice, but I think I don't know what to do. Maybe the doctor is nice. But I don't know what is good for me and you said 'everything is OK, it depends on you.' It made me feel like, so what's what? What should I do? I don't know what to do. I cannot have the more specific advice and more professional advice from the doctors. So, they even tell me 'you can go home and google.' They say because it depends on many different situations. So, you can decide for yourself."

> "But when I go to the hospital, I asked the female doctor the question. She can just tell me 'Oh, you're still young, so you don't have to do this. This you don't have to do. This you don't have to do. This it's just a waste of money.' So, after she gave me

doi:10.6342/NTU202303847

the advice, then I know I can do this. I cannot do that. I don't have to do that, so it's more specific for me. But I think it's a trade-off like having the doctors like this. She gave you a very specific advice, but she's also very direct about things. So maybe she will be lack of empathy."

Here, Shu-hua describes the kind of doctor that she trusts is not the one who gives her choices but the "professional" one who is direct and tells her what their suggestions are to which she gladly follows. She did mention a trade-off with these kinds of doctors lacking in empathy which she later describes as she gave birth, the doctor was very nonchalant and gave her orders to stop shivering after being given a drug that has a side effect of causing women to shiver following childbirth. In the previous two scenarios, both women did not trust themselves because they were lacking in pregnancy and childbirth-related knowledge. This explains why some women do not have questions, are not able to trust themselves to make a decision for themselves and their baby, and why some blindly accept what the doctor says.

There is also a third example of a woman, Mei-hui, wanting to ask her doctor questions but being too afraid because of the power dynamic between women and their OBGYNs.

"I like the doctor to tell me what causes this problem or to show more empathy, but not go too far into his or her own experiences with another patient. If it's too short then I would still have a lot of questions. Actually, every time I go to see the doctor, I can collect my questions and make a list. But when I sit there, my brain is blank. I

doi:10.6342/NTU202303847

don't know what to ask because some doctors look really busy. And I know they have a lot of patients waiting outside. So, I might think to myself, 'you might ask too many questions that will take their time.' It just makes you feel like you shouldn't ask this much questions because they will get upset. I need to be brave to ask questions. If their face is more serious and they answer questions really short and get on their computers, or when they look like they want me to stop, I do stop."

Here Mei-hui's experiences were much different from Shu-hua's. Both are Taiwanese, but I think here is a good example of why there is a need for patient-centered care. Like Shu-hua, Mei-hui wanted to ask questions and understand what was going on, but she felt like if she did, it would make other people wait longer or the doctor would get angry. She felt the need to be "brave" to ask the doctor questions about her health. This describes the difference in relationship between some Americans with their doctors and some Taiwanese with their doctors. The Americans above believed that their relationship with their doctor was a partnership while some Taiwanese in the study saw that interaction as doctors as more one-sided where the doctors were the decision makers. This power dynamic extended to the act of asking questions, with the decision of whether to inquire or not hinged on the doctor's authority. Another occurrence that is clear and needs to be mentioned is that it appears that some doctors may treat their foreign patients with a bit more openness and empathy than the Taiwanese patients. Harper above stated that her doula told her that doctors would not spend much time with her answering her questions, but her doctor did.

doi:10.6342/NTU202303847

Part 2: Doctor's Decision-Making Impact on Women's Childbirth Experiences

There is research that supports empathy and openness in doctor-patient relationships. Below are three women's testimonies about how their doctors positively or negatively impacted their birth experiences with or without these character traits.

First, Shu-hua describes her doctor encouraging her to ask questions during her visits.

> "Sometimes I have a lot of questions. I have the list and I ask, and my husband says, 'You ask too much. You ask too much.' He was thinking about the people outside, and the doctor said, 'Don't worry, keep asking'."

It was very rare in the study where Taiwanese women said that they asked their doctors questions, let alone many questions. Shu-hua stood out in this aspect. Her husband even intervened to tell her to stop asking so many questions; however, the doctor, in her openness, encouraged Shu-hua to continue asking her questions. This encounter does have some significant considerations in that, it could be that it is not just Taiwanese women who sometimes lack the courage to ask doctors questions, but it could also exist with the men as well. There should be more research done on the patient-OBGYN-partner relationship.

Next, Pemala describes her encounters with the doctor not being empathetic with her that revealed some insight into the extent to which childbirth is medicalized in Taiwan.

doi:10.6342/NTU202303847

> "Giving birth in Taiwan was more friendly. In Malaysia, because everyone was on the beds in the same room, they will tell you 'stop screaming!'. In Taiwan, most people were not in pain. Once you have the epidural, you won't have any feelings and there isn't this kind of problem."

Her doctor's words toward her and other women were unkind; however, as she compares the situation in Taiwan, it reveals the acceptance of excessive usage of medical interventions that take place in Taiwan.

Lastly, Doula 1 accounts to the experiences of some women. She said, "A few doctors in Taipei know that the expats like to hire doulas, and they specifically say, 'OK, if you want to give birth with me, you cannot hire a doula.' So that for me is quite extreme." It is quite extreme and surprising to know that doctors feel that it is okay to control who a birthing mom wants to be present during such critical times as she undergoes labor and delivery. Through these women's experiences, it is evident that doctors' who possess the qualities of openness, flexiblility, and empathy can favorably impact a woman's birth experiences and vice versa.

Part 3: Doctor-patient Interaction Across Specialties

As an American who also possesses some similarities with the American women above in thoughts and expectations towards the OBGYN-patient interaction, I wanted to seek more clarity and understanding about this phenomenon in Taiwan. Below is a chart of what others had to say about their interactions with their doctors in Taiwan. This chart details three different informal discussions with Taiwanese friends and one friend from Paraguay. The first session, with Pei-zhen and Rui-qi, happened at an ice cream shop. We

doi:10.6342/NTU202303847

meet weekly and discuss life, so they already knew about my research project. I grasped the opportunity to share and ask for their thoughts and opinions. The second session was with Ya-wen and Sydney at the Student Activity Center on campus. We took graduation pictures on a hot sunny day on campus and went to the Student Activities Center to chat and cool off. I took that opportunity to introduce my research and ask what they thought about childbirth and their interactions with their doctors. Lastly, Ru-yi and I ran into each other on campus, and walked together as our destinations were on a similar side of campus. My research was one of the topics we discussed. When I asked these participants about their doctor-patient interaction, I did make it clear that I was not asking about their interactions with their solely with OBGYNs but with any kind of doctor.

Although some of the information in the table was consistent across specialties, their responses provided me a greater understanding of the dynamics within the field OBGYNs in Taiwan. Doctors' holding higher authority than patients was similar across different specialties; however, it is clear that OBGYNs have a higher degree of authority over their patients when compared with other specialists due to the knowledge gap of the patients. Interestingly, with other health issues, Taiwanese will seek information, even through google, but they typically do not seek information related to pregnancy and childbirth. This gives rise to a very unique relationship dynamic between OBGYNs and birthing moms that needs to be carefully considered.

Table 3

Informants on Childbirth and the Doctor-patient Interactions in Taiwan

doi:10.6342/NTU202303847

Name and Nationality	Thoughts on childbirth	Interactions with and thoughts on doctors in Taiwan
Pei-zhen Taiwanese	Pain, I don't really think about it	"Doctors should observe patients and use more time and better communication when needed. They should have higher EQ-emotional intelligence. The IQ is high but the EQ is low. Doctors also get frustrated when people keep coming back saying something is wrong but maybe they are just mentally ill. Also, patients do not know what questions to ask. The doctor gives them medicine and send them away without explanation."
Rui-qi Taiwanese	Pain	"Patients do not know what to ask. The doctor just gives them medicine and send them on their way with no explanations. If the doctor refuses to acknowledge you, then you cannot ask him/her questions. They are nonchalant. Doctors should have more patience, but they are so busy, tired, and burnt out. I understand that they cannot spend time with me."
Ya-wen Taiwanese	Pain, knives, tubes, sweating, c-section, scary. Older generation says you should give vaginal birth because that's the way god designed it, so c-sections are not common	Sometimes the way they ask questions seems disrespectful. Doctor asks questions, gives medicine, and sends you away. They do not care about your life. They are busy. As long as he has a good reputation, then he is a good doctor. There aren't many female doctors, and they aren't well respected. But, I feel more comfortable with females. Only rich, highly educated people can become doctors. Also, a few politicians were once doctors. Under Japanese rule, a doctor fought for us. Patients also do not know what to ask."
Sydney Paraguay	Legs up, placenta, procedure, something coming out of a small place, so many people in the room looking	"There are three types of doctors I have seen in Taiwan, and I kept changing until I found a good one. The first one was a young man who was afraid to touch me when I said my neck was hurting. The second kind is the one that doesn't make eye contact. He asks you what the problem is, doesn't listen to you, and kicks you out as soon as possible. I was very uncomfortable. Then there is the kind that I feel like are my grandpas. They ask a lot of questions. How are you? Also, some doctors, if you ask them why, they will say 'I don't know'."

doi:10.6342/NTU202303847

	down there, nauseous, pass really quickly	
Ru-yi Taiwanese		"Physicians have a high social status and authority, and many politicians (last mayor of Taipei) like to brag about once being a physician to show that he is superior to others. Maybe if the patients ask the doctor a significant question, the doctor will think the patient is questioning their authority and ability. Doctors have to study really hard to get the highest score on exams. Doctors are results oriented while women care about the process. Doctors study hard and get good results on the exam. The end goal is what's important. Maybe it's similar in childbirth. They only focus on the end result. The child is born. We should change the definition of patient care in Taiwan and have courage to face an unknown future by challenging the authority. Culture says respect the older man, but it's not reasonable sometimes. We should have more independent thinking"

Regarding thoughts on childbirth, I was very shocked to learn that even though Pei-zhen does not think about nor consider childbirth, her first response to it was the word, "pain." Others comments consist of medicalized views of childbirth, and no one had any positive thoughts about childbirth. Overall, I think this chart with their comments about their experiences with doctors in Taiwan paints a picture of a system falling short in patient-centered care, doctor's with empathy, and patient education. However, there are doctors, OBGYNs, that offer patient-centered care, and Doula 2 in her childbirth class instructs women on how to find them. Asian and Westerners alike take her classes.

She teaches, "the most important thing is finding a provider and a birthplace that match your expectations. For example, here's 20 expectations. Choose the three that are the most important to you. And if your doctor can't meet you on those 3, then

doi:10.6342/NTU202303847

maybe you can find another provider. If they're willing to accept those 3, then the other things you can be more lenient with."

In other words, what she means to say is that women should lower their expectations. Also, I think one important point to know is that lacking in knowledge can sometimes lead to not having many expectations.

Strict Adherence to Protocols Impact on Childbirth

In the study, a few women described how the health insurance system and hospital protocol impacted their pregnancy and childbirth experiences. This section is small, yet it reveals how these outside factors can play a significant role in the pregnancy and childbirth experiences of women.

Story 1

During pregnancy, Harper got pneumonia and was hospitalized for 5 days. After 48 hours with no fever and blood culture results that were within normal range, the doctors still wanted to keep her in the hospital for 5 more days due to hospital protocol to wait on another culture from the lab. She, an internal medicine doctor herself, began to advocate for herself and ask for evidence as to why she needed to stay in the hospital for more days. Her comments on the matter are below.

"In Taiwan, strict adherence to guidelines is a big thing, and I see it at my job too, just working with our medical students. The way we approach guidelines in

doi:10.6342/NTU202303847

> America I think there's a little more wiggle room. You can do clinical assessments and decide against protocol. Like, in America, you're not just like a statistic, you're not based on some sort of data set. There's a need in Taiwan to have more personalized care."

Here, Harper describes that as a doctor herself, she did not see the need to be held in the hospital any longer. She had to go back and forth with a resident, then speak to her doctor several times to advocate for herself. She said that she is not a statistic but a human being whose test results were normal. In Taiwan, this strict adherence to protocol was a barrier to her being a part of informed decision making and being back in the safety and comfort of her home with family.

Story 2

Doula 1 describes the impact that the National Health Insurance has on the doctor-patient interaction, the quality of care that pregnant women receive, and why it is difficult for women to access the knowledge and resources they need to have autonomy in the decision-making process.

> "The National Health Insurance kind of leaves very little room for hospitals or doctors to budget themselves. So that's why you see in Taiwan that hospitals and doctor's practices are always full. Some doctors are seeing 100 patients in one morning. That's so not healthy for the doctors themselves, too. And so, for them to kind of make sure that they could have a good outcome is that they're providing a

doi:10.6342/NTU202303847

lot of services, so they could get the insurance coverage. They have to see so many patients. And with that you could see they don't have time. And the service quality is not good. And you're not allowed to ask more than one question, for example. So, I think that is contributing to the reason why doctors' authorities are so strong in Taiwan. It's a big systematic issue, and it's not very easy to resolve.

The NHI system in Taiwan is shockingly convenient with low costs and short wait times to see the doctor; however, this comes at the expense of building solid OBGYN-patient relationships and providing patients with adequate health knowledge because there is not enough time during each visit. This section is under strict adherence to protocol because doctors are typically very strict in rushing patients in and out of the room.

Story 3

Pemala describes her childbirth experience in Malaysia and details how the government or hospital dictates care.

"In Malaysia, the government decides which day to go, which day to get tests. You must go that day. Malaysia is very strict. Taiwan is very special. Every time you see the doctor, you have to get blood tests. There (Malaysia), you go to the hospital and they pick the doctor for you. It's not like in Taiwan where you get a number. In Malaysia, you just sit in the hospital. Everyone is in one room, and the doctor will go sit face to face with you. There is sometimes a curtain, but there is a rule that you cannot close the curtain. Everyone can see you. I can see everyone's pain. When

doi:10.6342/NTU202303847

someone gives birth, they make me afraid to give birth because I can see their struggle." She continues to explain that "In Malaysia, it is mandatory to go to the hospital for your first birth. Home birth is not an option."

It was appalling to find out that the Malaysian government gives people a list of requirements in order to be eligible to give birth at home and mandates the days to go to the hospital for tests. Such protocols oppose patient autonomy. Being able to select a doctor and choose privacy in the labor and delivery room in Taiwan is seen as a luxury to some.

Story 4:

In her childbirth class, Doula 2 mentions hospital protocols in the section that teaches parents how to choose the birthing location or doctor that suits their needs. She tells clients that select protocol are important to know before labor because "labor is not the time to fight and advocate for needs." Sometimes doctor's decisions are based on hospital protocol, not necessarily the state or condition of the mom and fetus. A few of the questions that she gives her clients to ask their doctors are below.

1) Will there be continuous, 24- hour fetal heart rate monitoring or will it be intermittent?
    a. If its continuous, the birthing mom will be required to stay in bed from the time she enters the hospital until she delivers the baby.
2) If labor is induced, how long will doctors wait for the baby to come until they require a cesarean section.

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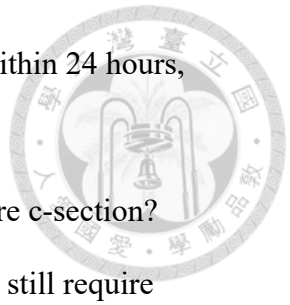

    a. Some doctors will automatically require a c-section within 24 hours, even if the mom and fetus are still in stable condition.

3) How long will the doctor wait after 40 weeks until they require c-section?
    a. If the birthing mom and fetus are still stable, will they still require medical intervention or will they be willing to wait a until natural onset of labor?
4) How long will the doctor wait from the time of hospital admission until proceeding with induction or c-section?
5) Are you allowed to change birthing positions?
    a. Will the woman be able to use intuition to choose a birthing position, or do the doctors dictate this aspect as well?
6) Will the birthing mom's doctor be called if she goes into labor or will a random doctor that she is unfamiliar take on her case?
    a. Some women chose their doctors and may want to keep the doctor who is familiar with them and their desires to proceed with them through delivery.
7) Can the birthing mom and baby spend 1 hour after birth together?
    a. Some hospitals in Taiwan do not allow the golden hour and will take the baby immediately after birth for testing.
8) Are partners allowed in the birthing delivery room?
    a. The presence of partners has a profound impact of the childbirth experience.

doi:10.6342/NTU202303847

When doctors strictly follow the protocols of their institution, negotiation against the protocols to achieve desired expectations can be difficult for the birthing mom. Doula 2 suggestions negotiation before labor and even before a birthing location and doctor are officially selected because these decisions have the potential to positively or negatively impact the birthing mom's childbirth experiences.

From details shared through these interviews, it is clear that protocols hold more weight in the decision making process than birthing moms. Protocols can impact how birthing moms conceptualize and experience childbirth. Most Asians in the study accepted these protocols as totality while Western women in the study saw themselves at the center of care and sought to negotiation for their expected outcomes. It is also apparent that the NHI system as is, is constraining doctors to spend less time with patients, and this impacts the quality of care, services, and openness that they can provide to their patients. Thus, there is room for improvement. Lastly, certain protocols can restrict women from having the ability to choose the services that they desire. Childbirth, although it happens within a woman's body, there are many outside influences that have some control over how this process unfolds, and strict adherence to government and hospital protocols are included in these factors. For this reason, protocols should be flexible to allow for more empathetic and patient-centered care where the patient's voice, knowledge, and opinions matter.

In sum, if the birthing mom's relationships with her family, partners, and doctors along with government and hospital protocols oppose her desires for childbirth, this list can fall under the category of power struggle. This struggle for power appears to result from both the medical model of childbirth and culture. The medical model of childbirth dictates

doi:10.6342/NTU202303847

who has authority to decide if and what information is taught along with the steps taken through pregnancy and childbirth. There are also cultural implications in the power struggle in terms of relationships styles between the birthing mom and her family, partners, and with doctors. Many Westerners have taken power or been empowered through knowledge, having a partnership with their doctor, and playing an active role in decision making. Conversely, some Asians are unknowingly allowing other people and other factors to control their path and experiences.

3.4 Theme 2: Birthing Mom State and Mom Guilt

First, I will introduce Doula 2. Doula 2 married a Taiwanese man and gave birth to her children in Taiwan. She detailed the proactive steps she took to seek knowledge and prepare for childbirth; however, she did not foresee the challenges that she would face in the birth care system in Taiwan. She recognized a need for doula services and became a doula to prepare the women who would give birth after her in Taiwan. She also teaches a childbirth class where she teaches women and their partners from many countries and cultural backgrounds the process of childbirth along with cultural facets of giving birth in Taiwan.

I attended one of her childbirth classes which consists of 2 four-hour-sessions where she teaches evidence and experience-based birthing knowledge to her clients. I really enjoyed how innovative and interactive her classes were. She prepared flashcards, fake babies, cloth placentas, handouts, breakout sessions, and real-life exercises that women, partners, or the couples could do together. She was able to teach in an authoritative manner

doi:10.6342/NTU202303847

that expressed her wisdom but also in a way that helped the expecting parents relate to her and enjoy her course.

During my interview with Doula 2, she told me that "labor is not the time to fight and assert rights. You should do this prenatally with your doctor." Doula 2 is expressing that during birth, the birthing mom may not have the energy, will power, or be in a state well enough to express needs that differ from the doctors' actions or other situations taking place in her environment. Women, while giving birth, are in a vulnerable state. While in labor, delivery, and immediately following delivery, women's state can consist of being in pain, exhausted, embarrassed, sweaty, numb, shivering, afraid, feeling disrespected, and more, and oftentimes, they are desperate to just make it through the process. Here are some of the women's explanations of the state they were in during the phases of childbirth.

The first testimony is from Harper. Before coming to Taiwan, she was an Internal Medicine Doctor. She shared with me that her highest test scores were actually in OBGYN; however, due to the poor work hours that OBGYNs have to endure, she chose Internal Medicine. Currently, she partners with an American medical institution and a Taiwanese medical institution to train Taiwanese resident doctors. She describes the residents here as being accustomed to the right or wrong answer, but when she asks them why the answer or treatment is right or wrong, they have difficulties answering. She is the mother of two, both born in Taiwan, and she and her husband speak three languages: English, Cantonese, and Mandarin. She was very happy to share her testimony and frequently asks for updates on my project to see if I have learned something new. Harper explains the state she was in while giving birth and immediately after as numb, cold, and painful.

doi:10.6342/NTU202303847

> “Because of the epidural, I couldn't feel my legs. I couldn't get into position. I just couldn't feel anything. Then after delivering the placenta, I was still bleeding. So, they had to give me misoprostol, and they told me I’d feel cold. I couldn’t stop shivering, and later on they tried to take out the epidural. They kept saying, ‘you need to lay still.’ I told them it's not physically possible. But what hurts more than anything was massaging the abdomen afterwards. It feels like they're punching you.”

The second testimony is from Ya-ting.

> Ya-ting says, “I was already inside the room and my child was born, but the doctor needs to leave. I didn't expect that the suture would be arranged by another doctor that I didn't know. My doctor is a woman, but actually the one who is doing the sutures is a man. So, I was quite surprised at that moment, but I didn't complain. I think maybe it's because I don't know how to complain about that, since I feel so shocked. So, I think that will be the only time I feel not being respected.”

Even through this vulnerable time where birthing moms are experiencing drastic changes in state, they still might have to make decisions regarding the unexpected events that could transpire during this time. These drastic changes in state can cause some women to change their minds about previous desires such as not getting an epidural or breastfeeding immediately after birth and can sometimes contribute to what is known as mom guilt. Any time that an event or action does not reach the mom’s desired, decided, or perceived acceptable result, it can lead to mom guilt. For example, after birth, because

doi:10.6342/NTU202303847

Harper's labor was induced, she felt that her body was not ready to begin producing milk and felt guilt that she could not breastfeed her baby.

> "The decision was made for me. I felt really bad about the formula. I felt guilty. You know, even though they say don't feel guilty because the baby is a happy baby, but as a mom, you're just left asking 'why can't I provide'?"

Another example of mom guilt is shared through Ya-ting's story.

> "So in the beginning, I felt very guilty. She (her baby) was sucked by something from her head. And then they told me, 'oh, maybe because we used the tool, so the shape of her head will be a little longer than usual.' When I went through childbirth, I may not have known how to breathe in the right way to push effectively."

Here, Ya-ting says that maybe because she lacked knowledge on how to breathe properly during childbirth, it led to her not having the energy and strength to push the baby out. Because of that, she feels guilty as she could not deliver the baby using her own strength. That the doctor had to assist the delivery with a vacuum that caused the shape of her baby's head to be longer than normal.

Many women in the study experienced mom guilt. One exception was Doula 1. Doula 1 became a doula in 2019 and currently practices in Germany where she gave birth to her first child with a doula by her side. She emphasizes the importance of having a doula to provide knowledge and walk through the intimate process of childbirth. She describes

doi:10.6342/NTU202303847

the doula-birthing family interaction as a partnership where personalities and even political views are important factors in the relationship. Doula 1 explains the state that she was in after giving birth as having uncontrolled bleeding postpartum and being transported to the hospital. Unlike moms, she did not experience mom guilt.

> "Even though I had to be transported to the hospital, the imperfect part of my childbirth experience, I did not experience guilt because I did all I could to prepare... I have no fear, no regret. There is not something that I feel that I could have done better. And so for me, it's very satisfying."

Doula 1 chose to give birth at a birthing clinic where after childbirth, she lost over a pint of blood and had to be transported to the hospital. The birthing clinic was run by midwives and did not have doctors nor the necessary medical equipment to stop the bleeding. She stopped bleeding in the ambulance; however, she and her husband decided to stay in the hospital for one night just to be safe. She explained why why she did not want to give birth in the hospital. She says, "even though the people are nice, it's just the setting that's not comfortable. The physical space affects our emotions, and emotion has a lot to do with hormones, childbirth, and postpartum." Having birth knowledge, being involved in the decision making, and having individual agency, or power to fulfill her wishes, directly opposed guilt in Doula 1's case.

Hence, Doula 2, in her childbirth class, involves parents in healthy communication amongst themselves, their family members, and their doctors. She says, "a positive childbirth experience is not about all natural and low intervention. It's about agency and

doi:10.6342/NTU202303847

having the knowledge and power to be able to advocate for their desired experience." When the birthing parents have the necessary knowledge to make informed decisions and are in agreement with their expectations, the partner or family members can even help advocate for the birthing woman. Then, the birthing mom may be less likely to experience mom guilt even if her expected desires are not met as shown in Doula 1's experience.

There were instances that seemed to contradict this notion. Sometimes, women prepared as best as they could yet still experienced mom guilt. For example, before becoming a doula, Doula 2 reported experiencing mom guilt when she was not allowed by nurses to breastfeed her baby. The nurses kept her baby under observation for a week post birth for breathing difficulties. Cassie, another mom in the study, is a journalist who once wrote an article on childbirth and interviewed key players in positive childbirth advocacy. She and her partner relocated to Taiwan for his job; hence, she gave birth in Taiwan. Cassie, reported mom guilt because she wanted to feed her baby breastmilk, but when the baby had to be taken for jaundice treatment, the nurse persuaded her that giving formula and nutritional supplements would be best. Because these women were exhausted and had lost a lot of blood, they did not have the strength to advocate for themselves against the nurses. Cassie said if at that moment, she could think properly, she would have requested the baby be fed pumped breastmilk; instead, she agreed with the nurse and signed the paperwork. I do wonder if these two women's partners had advocated for them, would they still feel mom guilt even if they were not able to feed their baby breastmilk as Doula 2 mentioned in her childbirth class.

doi:10.6342/NTU202303847

3.5 Theme 3: Cross-cultural Conceptualization of Childbirth

Cultural norms impact the conceptualization of childbirth which in turn influences childbirth perceptions, fears, expectations, and preferences. For the Taiwanese in this study, three key factors seemed to determine how women conceptualized childbirth: OBGYN, medical protocol, and family. In contrast, for the westerners, particularly those from the USA, I found that knowledge, doctor trust, and control in decision making defined how women conceptualized childbirth. This section has three subthemes: Cross-cultural Knowledge Seeking Behaviors, Childbirth-related Knowledge, and Ideal Childbirth.

While discussing study research findings with my Taiwanese classmates, Xiu-mei and Ming-yue, to better understand how childbirth is conceptualized, Xiu-mei said that "Childbirth in Taiwan is a family decision where others opinions are considered. They worry about how others perceive them while many westerners have the privilege to make decisions based on the individual and how they feel." Ming-yue shared, "In the western mind, people may think, 'it is my child, my experience, and my life'." Although there can be outliers, culturally and through study findings, there is truth to both of their statements.

Different Knowledge Seeking Behaviors Among Women Cross-culturally

Recent studies in Taiwan show that over 60% of Taiwanese parents do not seek prenatal education (Birth Empowerment Alliance of Taiwan, 2023). This study found similar results. As a matter of fact, there was a stark difference in the knowledge seeking behaviors between the Asians and the Westerners in the study. For instance, all of the Westerners who had given birth sought childbirth classes, while only three Asians, all

doi:10.6342/NTU202303847

Taiwanese, did. Of the Westerners who had not given birth, they also reported actively learning information about childbirth through google, social media, YouTube, and Biology class in college. Of the Taiwanese who sought knowledge, one sought knowledge from someone who had taken childbirth classes. The second took a midwife's childbirth class, and the third one is a doula. Some westerners expressed that they only found one English taught childbirth classes in Taiwan, yet more still utilized this service when compared with Taiwanese who have more options. In the study, women reported that outside of childbirth classes, other sources of childbirth-related knowledge came from friends, blogs, Facebook groups for foreigners, google, pastor's wives, and middle school education for girls which was not enough nor was it effective. Of the ones who reported using google, they all said they would tell new moms not to do so. It was very rare that their knowledge came from their doctor which is not shocking considering that most patients spend about 3 minutes per visit with their doctor in Taiwan; that is not enough time to focus on knowledge acquisition. When participants reported seeking knowledge from their friends, there was also a difference in the types of questions that Taiwanese, specifically, and Westerners would ask. Taiwanese asked their friends questions relating to which is the best hospital or the right doctor. Some even mentioned tolerating waiting for long times just to see a famous doctor. There was only one Taiwanese in the study, Mei-hui, who asked her friends questions similar to those of Westerners. Those questions were related to what happens during pregnancy and childbirth, how to prepare, what should they know about giving birth in Taiwan, or what kinds of questions should they ask their doctor.

It is also important to note that Americans might have more experience seeking knowledge because of healthcare costs in the USA. It is very convenient for Taiwanese to

doi:10.6342/NTU202303847

revisit the doctor for recurring issues; however, some American women have longer wait times at the doctor which results in a loss in working hours as well as higher fees to pay with each visit to the doctor and each medical exam. They are more likely to get information on how to self-treat at home rather than go back to the doctor. Doula 2 explains more about knowledge seeking behaviors below.

> "I think Western women are pretty good about searching for information. They read a lot. A lot of information is out there. It's all easily accessible. So, I think they do read a lot. I think that they have quite a bit of knowledge. In Taiwan in general, I'm going to say that there's a lot less child birthing classes. I think it is a pretty accepted practice in the West that you would go through childbirth class. Then here (in Taiwan) it's like no you just go to the doctor. The doctor tells you what to do. And there's actually a lot of trust with the doctor in Taiwan because the doctor knows better."

Most Taiwanese women in the study did not seek any information at all and put complete trust in their doctors to take care of everything. Doula 1 said that some Taiwanese women have an attitude of, "I see nothing, know nothing, and do not have to worry about anything." There were a few instances where a mother-in law who was a nurse or a husband did the knowledge seeking on the pregnant mom's behalf and handled finding a hospital and doctor that was suitable for her as in the cases of Eun-Jung and Shu-hua. As for why some women did not seek knowledge, they reported not knowing who to ask

doi:10.6342/NTU202303847

questions to without feeling awkward, not knowing what questions to ask, and not knowing their doctors well enough to ask questions.

I would like to introduce more background information on Mei-hui, Shu-hua, Eun-Jung's and Yi-jun. Mei-hui connected me to the other ladies, and even welcomed all of us into her home for us to have the interviews. Her hospitality, kindness, and translation skills were amazing. These interviewees are friends, training to become missionaries to spread the love and kindness of God throughout the nations; hence, it is no surprise that Mei-hui helped me set up the interviews, opened her home, and welcomed me with so much compassion all while caring for her 2-month-old baby.

Eun-Jung's is the child of missionaries; therefore, she spent her childhood traveling. She speaks a few languages, but only a few words in Chinese. The most funny yet shocking line from her interview was when she mentioned telling her husband that she would die and go see Jesus before him because she was afraid to death of childbirth. During the interview though, I felt her get discouraged after her baby was the only one needing to be fed, changed, soothed, and put to sleep throughout the process, compiled with the fact that she was the only one who could not speak Chinese. I tried my best to console her by telling her it's okay to experience this, and we can work with her and the baby. I even joked with the baby saying, "Are we taking up all your mom's attention," to which she chuckled a little. I and Mei-hui also translate what the other participant was sharing during the interview.

Yi-jun is Taiwanese with a 4-month-old baby, at the time of the interview. While pregnant, her friend recommended a doctor and childbirth classes to her that were run by a midwife. She mentioned that the only skill she learned in the childbirth class was how to breathe during labor, not even different birth positions. She also stayed home to labor, went

doi:10.6342/NTU202303847

to the hospital on three different occasions in two days with the doctor telling her that it was not time to give birth yet. Yi-jun's story is interesting because she found out that warm showers relieved pain from wanting to take a shower before entering the hospital. She did not learn this information in her childbirth class.

Out of all of the friends, Shu-hua had the oldest baby at 6 months and the only girl. She was also quite different from other Asian participants in the study in that she asked her doctors many questions which her husband tried to discourage in front of the doctor. She also reported not feeling any pain from induction to labor, even though she reported that pain was what she was most afraid of about childbirth. To my astonishment, her mom did not know what an epidural was, so she thought her daughter would be in so much pain. While Shu-hua was in labor, her mom called on the phone crying to her saying, "my poor child. I know you're in pain. You don't have to pretend not to be in pain." Shu-hua laughed almost to the point of crying as she told us the story.

Because their time was precious as students and new moms, I traveled a long way to see them, and Mei-hui set up the interviews this way, I interviewed them two at a time. I encountered a bit of a struggle when the first interview had one Chinese speaker and one English speaker, but I found a way to work through this. This experience, though unplanned, was valuable and instrumental because during the interview, the women were able to share thoughts, opinions, and experiences, and the conversations led into other important matters that were not in my list of interview questions. One example of this is sex education. It naturally came up during the other interviews; however, these interviews highlighted the significance of sex education. They helped me realize that quality sex

doi:10.6342/NTU202303847

education has the potential to powerfully induce healthy conversations amongst parents and sex partners and increase positive childbirth emotions and experiences.

Childbirth-related Knowledge

Sex Education

Sex education was something that all participants in the study had an opinion about, and the consensus was that no one really remembered anything from the classes that helped them in real life. During sex education classes, several American participants mentioned watching movies where the teachers covered certain parts of the film. The kids, thinking the movie was inappropriate, did not pay close attention. However, many Taiwanese mentioned just having one class that only the girls went to around the age of puberty. The key takeaway points that many women in the study learned from sex education about pregnancy and childbirth is that sperm and egg connect to form a baby, and after pregnancy, abortion was an option. In my opinion, this was a missed opportunity for teachers and women.

Shu-hua made a fantastic observation on a topic that was missing in her sex education class. She says, “When I look at that, it’s just some knowledge, but I think people should tell more about not just the knowledge, but your emotional exchange.” What she means is that outside of the science and medicine of sex, people should be taught about emotions that happen as a result of sex and the events that follow, including childbirth. To support Shu-hua’s point, Mei-hui told a story about a couple that she saw who appeared to be in high school. They went to the hospital to get an abortion. She said, in response to Shu-hua’s story, maybe in sex education class, they learned about options if you get pregnant such as having an abortion, but maybe they did not tell the young girl about how

doi:10.6342/NTU202303847

that would impact her feelings. Mei-hui says, “I think to that young girl, that must not be that easy because I think she can also feel a little life is in her womb.” From these women’s experiences, it is obvious that sex education is not comprehensive, and this could be one of the results of medicalization of human bodies, sex, pregnancy, and childbirth. Other interesting points that were mentioned is that parents do not discuss sex or childbirth in the household either.

> “For Chinese, that’s too personal and many adults are afraid that the kid is asking them questions. I think they just don’t know how to tell them the whole process or their own feelings and experiences. Maybe because adults are afraid, so they just make it really like textbook knowledge,” says Mei-hui.

It’s quite surprising that in Taiwan, family plays such a huge role in deciding how the woman will give birth, but it is taboo for the parents to engage in conversation about sex and what to expect with childbirth with their children. Both Shu-hua and Mei-hui reported that after marriage, they did not know how to have sex or what to expect, so they went to their respective pastor and wife instead of their parents to have this discussion. Mei-hui shared her experiences a few days before her wedding, her pastor and wife told her and her husband “where to buy condoms, how to put them on, and how to relax.” She even mentioned that sex is something you need to learn with your spouse. With deep sadness she says, “Why did no one tell us about what was gonna happen after marriage? Many young people think sex is interesting, or they’re curious about having sex with someone. They think it’s really fun, but it actually hurts a lot.” Mei-hui’s concern is not just related to sex;

doi:10.6342/NTU202303847

it is also related to childbirth. Sex education classes did not teach these women what to expect during pregnancy and childbirth. Their experiences detail that sex education, as they were growing up, was not sufficient in providing necessary knowledge, nor was it expressed in its fullest capacity expanding outside of schools and into homes and marriages.

Home birth and Gentle Birth

Lastly, as an effort to maintain some aspects of the original research topic, and dive into childbirth knowledge, I still asked participants about home birth and gentle birth. I learned that home birth and gentle birth knowledge is very limited and unheard of in some, even in the year 2023 as in Eun-Jung's case.

> "Ever since I thought about it, I wanted a hospital birth. I didn't know about home birth. I never heard of people doing water birth or home birth. It's not like I'm against it. I just didn't know about it. I do now. In my church, there are two women that gave waterbirth at home."

Ya-ting, although she gave birth almost 10 years ago in the USA, had the same experience as Eun-Jung.

> "To be honest, because when I was 30 or 34, I didn't hear a lot of things about that. Maybe I even never heard about that at that time. So, I never thought about that. But after giving birth, I have seen some news, or maybe it's about some artist. They

doi:10.6342/NTU202303847

choose to have water birth or home birth. But before that, actually because of my friends or my family, they didn't do that. So, what we know we have to do is go to the clinic or go to the hospital to have childbirth. I never thought about that or imagined that."

A few Westerners reported wanting to try home birth, but they were not able to find the necessary resources such as a midwife in Taiwan who spoke English or space for a bathtub in their apartment. Lily states, "I think it's the access to midwives or just knowing people who have gone through it because you're looking for somebody who you can really trust."

In terms of gentle birth, I had to explain it in all of my interviews except with Doula 1, Doula 2, and Cassie. After learning about it, Lily stated that she actually experienced gentle birth in the USA and Taiwan, and Mei-ling said that it sounds nice, but she stands firm in being put to sleep during c-sections.

Demonstrations of the Lack of Knowledge

The lack of childbirth knowledge demonstrated in this study was quite alarming. Here are two statement below from Ya-ting and Pemala.

"So, I woke up and I told myself, oh, I need to go to the restroom. Then when I got to the restroom, I couldn't stand up anymore. It's because I cannot stop

doi:10.6342/NTU202303847

peeing. I tried to run to my husband who was in bed sleeping, but I was too big… I tried to fight the pee." (Ya-ting)

"This baby's head was bigger, so the doctor cut all the way to my anus." (Pemala)

Pemala also later says, "I would advise new moms, don't take too many vitamins. You should first talk to your doctor. Because I didn't know that after your 6th month, you're not supposed to take those. I kept taking them and found out that my baby has 6 fingers and 6 toes. I do not fully know if it's because of the vitamins, but with the first child, I didn't take too much. He is normal."

Here, we see the lack of knowledge about the water breaking causing unnecessary worry. We also see how the lack of knowledge about episiotomy can cause negative birth experiences; she reported taking almost two months to heal. Also, lack of knowledge about how babies could form 6 fingers and toes and proper vitamin education caused Pemala to feel guilty about her baby's condition. These are just a few examples of how the lack of knowledge leads to negative emotions or negative birth experiences.

Ideal birth Experience

Most women in the study detailed their ideal childbirth as something that encompasses the security of having the life-saving capacity of a hospital and the

doi:10.6342/NTU202303847

comfortable environment of home birth. There were a few other ideal experiences and expectations that stood out, and some of them have cultural implications.

Ya-ting shares two very interesting ideal experiences. The first one is “生得過雞酒香、生不過四塊板.” It is a common proverb in Taiwan that means, if you give birth successfully, you get to smell the chicken soup with black sesame oil and ginger. If you do not give birth successfully, you only get four boards, or a casket. Ya-ting says that she loves this soup and wants to live through childbirth and taste it. The second experience that she shared is the importance of having family in the labor and delivery room to give her strength to not give up.

> “I really want my family to stay with me in the same room. That’s quite important because if I can feel them, I will feel more reliable. It will make me feel like I can do that. I think that will be different because when there’s no one with you, you can only do that by yourself. So, I think that it will be easy to give up. If I can do that and also not only with the family, also with the medical support in case there’s any accident.”

Cassie also shared her ideal birth situation. Even though she planned for her ideal childbirth well, she still did not achieve it.

> “I really wanted to succeed with breastfeeding and the golden hour was not what I imagined. I was on a gynecological chair, and there were still like 5-6 people in the room because I hadn’t even filed my paperwork yet, because obviously we’re

doi:10.6342/NTU202303847

arriving at the last minute. Looking back, I was in that rush of fear and excitement that I didn't get to spend it with her (newborn). I didn't get to welcome her. And the fact that I was being stitched up while she was on me and I was under like a surgical lamp, so that they do the stitches properly, it just wasn't that intimate moment that I had in my head. Ninety minutes later, it felt like only minutes had passed, but she's already being whisked away. So, I would say the breastfeeding issue and me paradoxically staying at home too long are the two things where I would say my ideal wasn't met."

Here, Cassie was explaining that her ideal situation was to stay at home and labor, but to be able to make it to the hospital around 5-6 centimeters dilated, so that she could have time to fill out paperwork and give birth in the hospital bed. Instead, she got there late and was whisked into the delivery room. She was required to finish the paperwork in bed with her newborn during the golden hour window while they were stitching her perineum. During the golden hour, she was not able to bond with her baby in peace, and the baby was not able to latch on and breastfeed.

Lastly, Lily had a wonderful comment that is important to bring to the discussion on ideal births and a good summation in my opinion. She argues that there is no right or wrong decision, there is just access to accurate information, options, and informed decision making. Her statement is below.

"There are so many different ways and it's not a right or wrong thing. The ideal situation is when you're not limiting your choice when. You have all the resources

doi:10.6342/NTU202303847

to make the decision that's right for you. I think that's the ideal scenario. Whether that means home birth or hospital birth. The greatest blessing is to not be constrained in your choice and to have access to accurate information to know what you need to know about each one option to make that decision. I think that's a big role of public health to inform, to educate people, and then ultimately to have the mom, or the parents to have the freedom of choice."

doi:10.6342/NTU202303847

Chapter 4 Discussion

This study is a qualitative research study about women's childbirth knowledge and experiences. Several key trends were discussed in the literature review. First, pregnancy and childbirth are medicalized, and medical intervention can occur at any stage of pregnancy and childbirth. Next, fear and medicalization have a positive feedback loop type of relationship where women's fear promotes medicalized childbirths and medicalized childbirth amplifies fear in women. Then, culture and medicalization both play a role in conceptualizing childbirth and determining whether a woman perceives her childbirth negatively or positively. Lastly, to counter the negative effects of medicalization of pregnancy and childbirth, doctors should be more empathetic and provide patient-centered care. Very little research on the medicalization of childbirth and women's childbirth knowledge and experiences have been done in Taiwan. Furthermore, this research dates back to the early 2000s or only focuses on southeast Asian women, thus there is a need for more up-to-date and inclusive research in these areas.

In this study, fifteen women from different cultural backgrounds were interviewed, and all but three had some sort of childbirth experience from pregnancy to delivery in Taiwan. Seven additional women provided cultural understanding through informal discussion. There were many factors that were found in this study that revealed women's childbirth-related knowledge and experiences. Three themes and five sub themes were revealed through thematic analysis. Theme 1 is Culture and Medicalization of Pregnancy and Childbirth Impacts on Birthing Mom's Relationships and Childbirth Experiences. Theme 1 has two subthemes: Birthing Mom's Relationships Impact on Childbirth

doi:10.6342/NTU202303847

Experience and Strict Adherence to Protocols Impact on Childbirth. Theme 2 is Birthing Mom Sate and Mom Guilt. Theme 3 is Cross-cultural Conceptualization of Childbirth with 3 subthemes: Different Knowledge Seeking Behaviors Among Women Cross-culturally, Childbirth-related Knowledge, and Ideal Birth Experience.

The first theme is Culture and Medicalization of Pregnancy and Childbirth Impacts on Birthing Mom's Relationships and Childbirth Experiences. The medicalization of pregnancy and childbirth has been a source of disempowerment of women over what happens to their own bodies. This lack of control is shown from many angles including but not limited to knowledge control, imbalanced OBGYN- birthing mom relationships, protocols, and even defining that childbirth looks like a woman giving birth on her back in a hospital bed. In "Negotiating Patient-Provider Power Dynamics in Distinct Childbirth Settings: Insights from Black American Mothers," Rachel West and John P. Bartkowski talk about the power asymmetries in hospitals and birth centers. They described both open and secretive "domination, exploitation, subordination, and resistance" from healthcare professionals. They said, "power can both restrain and mobilize," (West & Bartkowski, 2019). Women in my study reported similar findings on the power dynamics between the birthing mom and her healthcare team, hospital protocols, and the conceptualization of childbirth. They can all either participate in restraining or mobilizing care for the birthing mom.

In the matter of the relationships in a birthing mom's life, this study found that they can either support or oppose the birthing mom's wishes and help contribute to positive or negative birth experiences and emotions. In some cases, this was culturally dependent. In this study we saw that the main relationships that women mentioned were with family

doi:10.6342/NTU202303847

members, partners, and doctors. One study done by Petronellah Lunda and colleagues supports this theme and found that a woman's perception of her childbirth depended largely on her support person as it provided means of control during childbirth and individualized support. The types of relationships or "support persons" in this study were husbands, family, friends, midwives, and doulas, very similar to those in my study.

Following this further, on the birthing mom-OBGYN interactions, the Americans and other westerners in this study saw their relationship with their doctor as a partnership. On the contrary, the Taiwanese and other Asians in the study saw this relationship in a paternalistic fashion where there is clearly a figure with higher authority that makes the decisions on the patients' behalf. In this study, Western women reported that trusting their doctor came from experience with the doctor, how open the doctor was for questions, how the doctor made them feel, and more. Moreover, most Asians in the study trusted doctors because they have a medical degree. Mostly though, they preferred a famous doctor with many patients, and that is how they defined trust. In Matthew Ridd and colleagues research titled, "The Patient-doctor Relationship: A Synthesis of the Qualitative Literature on Patients' Perspectives," although the findings were not divided culturally, they were quite similar to those in my study. In examining doctor-patient relationships, they found four groups: "knowledge, trust, regard, and loyalty." Trust included general, blind trust of doctors which was relevant in my study with Asians. In addition, they defined trust in the context of the experience, openness, honesty, and feelings of the patient (Ridd et al., 2009). The latter findings were closely related to what the westerners reported in this study.

With respect to the strict adherence to protocols and policies, we saw that they can positively or negatively impact women's pregnancy and childbirth experiences. In the

doi:10.6342/NTU202303847

study, government and hospital protocols did leave women having more negative experiences; however, that does not negate the possibility for policy and protocol to positively impact women's experiences. As a matter of fact, many of them were created with good intentions.

Clinical practice guidelines are created from evidence-based medicine and are utilized to optimize patient care. They have been known to empower patients, influence policy, and contribute to care consistency; however, they are not perfect and come with some drawbacks. One good side of clinical practice guidelines is that doctors can use them to make evidence-based suggestions for patients while one negative aspect of these guidelines is that sometimes, guidelines are not updated as often as they should. (Guerra-Farfan et al., 2023). Although in my study, I used the word "protocol" because that is the term that the participants used, both guidelines and protocols can both positively and negatively affect patients in similar fashions. Also, regarding the protocols that negatively impacted some women in this study, it was likely due to the protocols not being updated as often as they should. Some current protocols in Taiwan were discouraged in the USA in the early 2000s. Such is the case with the episiotomy which is still widely practiced in Taiwan.

The second theme is Birthing Mom State and Mom Guilt. Pregnant women and women who are going through and have recently gone through childbirth are vulnerable groups, and that can negatively impact their decision-making ability and lead to feelings of guilt. This theme was seen in other research on mom guilt that labeled their theme as the "motherhood myth" where the researchers discussed women feeling inadequate, labeling themselves as a failure for not living up to their breastfeeding expectations, and having feelings of depletion while trying to tend to themselves and their child (Constantinou et al.,

doi:10.6342/NTU202303847

2021). This is consistent with what women reported in my study when they felt inadequate for not breastfeeding or too exhausted after childbirth to advocate for their needs and their desires for their baby.

The third theme introduces Cross-cultural Conceptualization of Childbirth. I mentioned how cultural norms impact conceptualization which influences childbirth perceptions, fears, and expectations. For Asians, these cultural norms were their interactions with their OBGYN, medical protocol, and family. For the Westerners in the study, these cultural norms were knowledge, having trust in their relationship with their OBGYNs, and having control in decision making. These factors lead to different knowledge seeking behaviors, different preferences on childbirth methods, and differences in their levels of fear and how they interacted with their healthcare providers. There was a related study done on the conceptualization of the fear of childbirth that was cited in the literature review, and it discusses a similar theme. The study compared Norwegian and Israeli women, and researchers showed how culture led to the conceptualization of fear of childbirth and how this created women's fears and preferences as a result. Norwegian women consider birth as a natural process while Israel's culture considers childbirth to be an obligation to make "perfect" babies. Norwegian women only received one ultrasound throughout their pregnancy. On the contrary, Israel's birth care system included more intense monitoring throughout the pregnancy that researchers called, " a risk instilling environment" that led women to fear the risks and pain of childbirth. Here, we see how culture influenced medical practices that then impacted the woman's level of fear and birth preferences as one group favored c-sections while the other preferred epidurals (Preis et al., 2018).

doi:10.6342/NTU202303847

This study also found that women from different cultural backgrounds have different knowledge seeking behaviors. Western women find it more natural and common to seek their own knowledge and resources such as taking a childbirth course before giving birth because it is normalized in the culture. Conversely, the Asian women relied heavily on their doctors to make sure they were healthy and make important decisions on their behalf. A study, although they used the term "help seeking," detailed how the social environment tells people the aspects of health that need attention, and when to ignore or take action (Arnault, 2009). This is consistent with my research findings on different knowledge seeking behaviors because in Western countries, seeking childbirth knowledge is accepted and even encouraged by physicians and society while that is not the case in Taiwan.

Childbirth related knowledge in this study included the knowledge that women had or did not have regarding sex, pregnancy, and childbirth both before and after childbirth. This knowledge varied exceedingly. We see in an article written by Neamin Berhe and associates that lacking knowledge about COVID-19 was significantly associated with fear (Berhe et al., 2022). With this information, it explains that one reason why many Taiwanese are fearful and lacking self-confidence in childbirth is because they are lacking in sufficient childbirth-related knowledge. While all of the Westerners in the study sought childbirth knowledge, very few Asians in the study did.

Although childbirth is different for every woman and can seem quite unpredictable, many women in the study still had ideal childbirth experiences that they would like to have. Sometimes these ideal experiences reflected the culture that they were raised in. Women's ideal birth experiences reported in the study were synonymous with what researchers call "positive birth experiences." There is a lot of research on what makes up a positive birth

doi:10.6342/NTU202303847

experience, but one study broke down the positive birth experience into internal and external factors. Internal factors included women's own strength while external factors included trusting relationships, support from the father, the feeling of safety and control. All of these support this study's findings (Karlström et al., 2015).

In conclusion, women's experiences that were shared in this study were consistent with the experiences of others in the broader academic discourse. This study also revealed a complex interplay between culture and medicalization and the impact of that relationship on women's childbirth experiences in Taiwan. Lastly, in future research in Taiwan, this relationship should be explored more in-depth.

doi:10.6342/NTU202303847

Chapter 5 Conclusion

In this study, the childbirth-related knowledge and experiences of 15 women have been highlighted. Three themes and five sub themes were found. First, this study found that where a woman is raised may have a larger impact than where she gives birth on her childbirth experiences. Medicalization and culture both impact how pregnancy and childbirth are conceptualized and experienced. Next, we learned that both medicalization and culture also influence birthing mom's knowledge seeking behaviors and how they view their relationship with their OBGYN. Then, an overarching power struggle for control between birthing moms and outside factors was explored. These outside factors include the OBGYN, family members, partners, and medical protocols during pregnancy and childbirth that may have roots in both culture and medicalization. Lastly, in Taiwan specifically, sufficient childbirth education is not sought after by women and families to adequately prepare them for autonomy in childbirth. Overall, based on patterns in women's experiences, we see that Taiwan's healthcare system fails to administer patient-centered care in the area of women's health and childbirth.

5.1 Policy suggestions:

Research has been performed explaining how women's empowerment through knowledge, birthing support, and informed decision-making leads to positive birth experiences, and this study showed that Taiwanese women have been stripped of their power. In fact, many are even quite fearful of childbirth, a natural human process. It is time to take women's mental and physical health seriously and implement measures to ensure

doi:10.6342/NTU202303847

safe and positive childbirth experiences in Taiwan. These measures include but are not limited to increasing childbirth education campaigns as well as the option for doula and/or midwifery support for every woman. Another policy suggestion is to reevaluate approaches to taboo topics such as sex education. Poor sex education has the power to take away a woman's opportunity to learn about sex, pregnancy, and childbirth and become empowered to make decisions for themselves and their families. Sex and childbirth education should include the hard sciences as well as psychological components. Science is important; however, it is imperative that this education includes more personalized and humanized knowledge that is readily available in multiple languages to serve many populations in Taiwan. Lastly, in Taiwan, with the current healthcare system and only being able to see a doctor for a short period of time, giving doctors the role of patient education is nearly impossible. Instead, I suggest involving community health workers whom doctors refer their patients to. Community healthcare workers can help perform knowledge assessments, provide patients more information, and serve as a point of contact whenever questions arise.

5.2 Limitations:

This study was unique in its cross-cultural perspectives to understanding and comparing foreign and Taiwanese women's childbirth- related knowledge and experiences to highlight the uniqueness of Taiwan's healthcare system. However, there were some limitations to this study. First, childbirth knowledge was highly dynamic and varied throughout the women in the study making it difficult to gauge knowledge through interviews. Survey questionnaires would have offered a more robust method for

doi:10.6342/NTU202303847

understanding this aspect of the study. Second, there were limitations in sampling and recruitment. As an American with mostly American and Taiwanese contacts, purposive, convenience, and snowball sampling were used to recruit study participants. These methods are non-probability sampling methods; therefore, the results are not generalizable. With that being said, the purpose of this study was not to generalize but to explore in depth into the phenomenon of women's childbirth in Taiwan. Next, I also realize that the majority of Americans in the study were Asian or white American, and they came from higher socioeconomic backgrounds. Their knowledge and experiences could be vastly different from other Americans and other nationalities in general due to their resources and experiences.

Additionally, there was also a limited sample size (15); however, considering the exploratory nature of the study, a smaller sample size was enough to reach thematic saturation and is thus appropriate. A larger study with more diverse participants from diverse socioeconomic backgrounds could make way for a better insight. Also, the majority of the participants were living or working in Taipei, and seeking participants in more diverse locations could find regional differences' impact on women's experiences as well. Lastly, another limitation was the lack of midwives and OBGYN doctor interviews. Their input could serve as a significant point for understanding childbirth experiences from professional angles, especially in the areas of healthcare provider and birthing-mom relationships.

doi:10.6342/NTU202303847

5.3 Future Research Suggestions:

One critical aspect of the research study was that as I listened to the women's experiences, I realized that it is just as important to know the childbirth knowledge and experiences of their partners. I learned that husbands or partners play a critical role and strongly impacts pregnancy, childbirth, and afterwards for both the mom and the baby; therefore, their knowledge and experiences matter. We need to understand their knowledge and experiences so that in the future, they can be targeted for improved education and awareness around the childbirth experience.

doi:10.6342/NTU202303847

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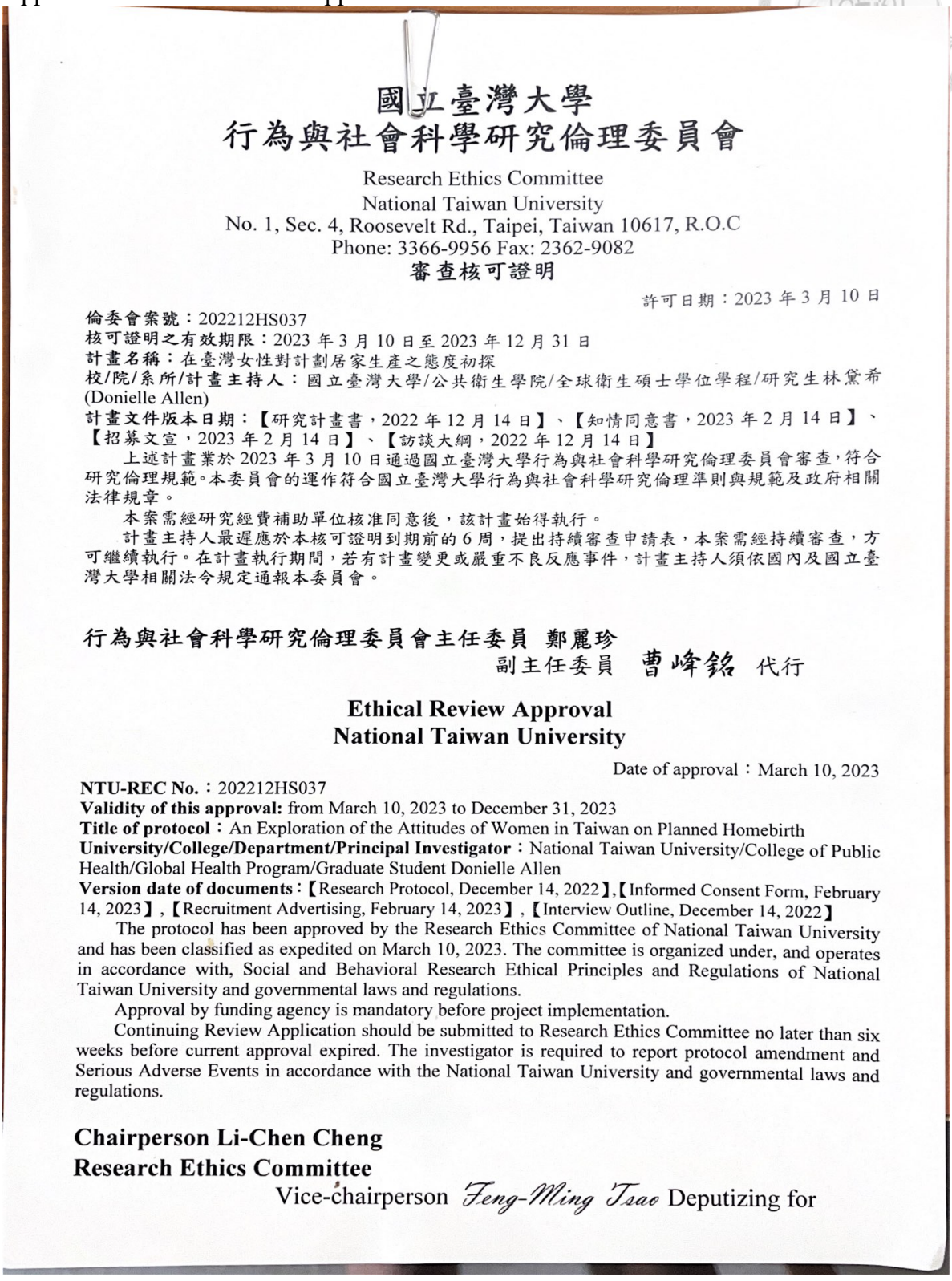
Appendixes

Appendix A: Ethical Review Approval



國立臺灣大學
行為與社會科學研究倫理委員會

Research Ethics Committee
National Taiwan University
No. 1, Sec. 4, Roosevelt Rd., Taipei, Taiwan 10617, R.O.C
Phone: 3366-9956 Fax: 2362-9082
審查核可證明

許可日期：2023 年 3 月 10 日

倫委會案號：202212HS037
核可證明之有效期限：2023 年 3 月 10 日至 2023 年 12 月 31 日
計畫名稱：在臺灣女性對計劃居家生產之態度初探
校/院/系所/計畫主持人：國立臺灣大學/公共衛生學院/全球衛生碩士學位學程/研究生林黛希(Donielle Allen)
計畫文件版本日期：【研究計畫書，2022 年 12 月 14 日】、【知情同意書，2023 年 2 月 14 日】、【招募文宣，2023 年 2 月 14 日】、【訪談大綱，2022 年 12 月 14 日】

上述計畫業於 2023 年 3 月 10 日通過國立臺灣大學行為與社會科學研究倫理委員會審查，符合研究倫理規範。本委員會的運作符合國立臺灣大學行為與社會科學研究倫理準則與規範及政府相關法律規章。

本案需經研究經費補助單位核准同意後，該計畫始得執行。

計畫主持人最遲應於本核可證明到期前的 6 周，提出持續審查申請表，本案需經持續審查，方可繼續執行。在計畫執行期間，若有計畫變更或嚴重不良反應事件，計畫主持人須依國內及國立臺灣大學相關法令規定通報本委員會。

行為與社會科學研究倫理委員會主任委員 鄭麗珍
副主任委員 曹峰銘 代行

Ethical Review Approval
National Taiwan University

Date of approval：March 10, 2023

NTU-REC No.：202212HS037
Validity of this approval: from March 10, 2023 to December 31, 2023
Title of protocol：An Exploration of the Attitudes of Women in Taiwan on Planned Homebirth
University/College/Department/Principal Investigator：National Taiwan University/College of Public Health/Global Health Program/Graduate Student Donielle Allen
Version date of documents：【Research Protocol, December 14, 2022】,【Informed Consent Form, February 14, 2023】,【Recruitment Advertising, February 14, 2023】,【Interview Outline, December 14, 2022】

The protocol has been approved by the Research Ethics Committee of National Taiwan University and has been classified as expedited on March 10, 2023. The committee is organized under, and operates in accordance with, Social and Behavioral Research Ethical Principles and Regulations of National Taiwan University and governmental laws and regulations.

Approval by funding agency is mandatory before project implementation.

Continuing Review Application should be submitted to Research Ethics Committee no later than six weeks before current approval expired. The investigator is required to report protocol amendment and Serious Adverse Events in accordance with the National Taiwan University and governmental laws and regulations.

Chairperson Li-Chen Cheng
Research Ethics Committee
Vice-chairperson *Feng-Ming Tsao* Deputizing for

doi:10.6342/NTU202303847

Appendix B: Recruitment Flyer for original study

An Exploration of the Knowledge and Attitudes of Women in Taiwan on Planned Home birth

在台湾女性对计划居家生产之态度初探

My name is Donielle Allen, and I am a student in the College of Public Health's International Global Health Master's Degree program. For my thesis project, I will conduct in-person interviews with women in Taiwan to understand their knowledge and attitudes towards planned home birth. Interviews will be in Chinese or English, whichever the participant prefers, with English to support interviews done in Chinese to foster understanding.

我叫林黛希。我是公共衛生學院國際全球衛生碩士學位項目的學生。為了我的論文項目，我將對台灣女性進行親自訪談，以了解她們對居家生產的知識和態度。訪談將以中文或英文進行，視視參與者的喜好而定，必要時將必要時將以英文支持用中文進行的訪談，以促進理解。

Location	Are you eligible?	If you're unsure if you meet the requirements, call or email me
• In-person （實體進行） • At National Taiwan University Main Campus or College of Public Health classroom or seminar room, NTU Cafeteria, participant's home, wherever the participant feels is convenient and comfortable（地點可能為台大本校或公共衛生學院教室或研討室，咖啡廳，參與者家中等參與者覺得方便和舒服的地點）	• Women, both foreigners and Taiwanese （外國和台灣的婦女） • Women in reproductive ages 20-65 （20 歲到 65 歲的婦女） • Women who have given birth or want to give birth in the future （已經生育還是未來想生育孩子的婦女）	• Donielle Allen, 林黛希 • Master's student in the International Global Health Program • Dda126@msstate.edu • Line ID: dda126

doi:10.6342/NTU202303847

Appendix C: Interview Guide

1) General background info: where is she from, age, and education background
2) Current job and salary
3) Do you have children?
   a) If yes, what did you know about childbirth before becoming pregnant?
      i) Where did you find this information?
      ii) What were your experiences from pregnancy through childbirth?
      iii) How did your relationship with your physician, nurses, partner, and family impact your birth plan and method?
   b) If no, what do you know about childbirth?
      i) Where did you learn this information?
4) Have you heard about home birth?
   a) If yes, what do you know about home birth?
      i) If you have experienced home birth, why did you choose it?
      ii) Did you ever consider this birth method?
   b) If no, tell them and ask for their thoughts.
5) What thoughts come to your mind when you hear “home birth” versus “gentle birth” versus “planned home birth”? Do you think they are the same or different?
6) If participant has not experienced home birth, would she consider home birth?
7) Why do you think others choose home birth?
8) What do you think are some reasons why women who give birth in Taiwan do not choose home birth?

doi:10.6342/NTU202303847

Appendix D: Informed Consent English and Chinese

Interview Letter of Consent

Hi,

I am Donielle Allen, a master's student in the Master's Degree Program in Global Health at National Taiwan University. The title of this research is " An Exploration of the Knowledge and Attitudes of Women in Taiwan on Planned Home birth." This project analyzes how women make decisions about delivery methods and seeks to understand their experiences, observations, and thoughts regarding home birth and gentle birth. People who meet the following criteria are expected to be interviewed: (1) women, (2) between ages of 20-65, (3) have experienced or want to experience childbirth in the future, and (4) can use Chinese and simple English for conversations. Five to ten people are expected to be interviewed.

To thank you for participating in the research, I will offer 200NTD gift card. I will ask you about your childbirth experience or ideas and ask you to share your thoughts and opinions. This interview is expected to be from 60 to 90 minutes long. During this process, if there are any questions that make you uncomfortable, you have the right to refuse to answer or stop the interview at any time. If you choose to stop the interview, the amount on the gift card will be prorated based on the time spent in the interview, and your interview responses and recording will be deleted immediately. With your consent, our conversation will also be recorded. This recording and the subsequent transcribed text will be properly stored on my password-protected personal computer, and only my advisor and I can access it. The data will also be destroyed within three years after the research is published. In the writing of follow-up reports and papers, I will protect your privacy. If I quote your interview, I will also process it anonymously and avoid disclosing other details that can be associated with you. Except for psychological pressure and privacy exposure, participation in this study will not cause other damages, so compensation and insurance measures are not provided. If there is any updated information related to the research which may affect your willingness to continue participating in the research, you will be notified immediately.

Through your opinions, this study will gain an in-depth understanding of women's reproductive knowledge and experience and will be transformed into knowledge that will help improve public health policies and practices in the future. I look forward to your contribution. There will be no commercial interest derived from this research.

This study has been reviewed by the Behavioral and Social Science Research Ethics Committee of National Taiwan University. The review content includes benefit and risk assessment as well as research participant care and privacy protection. It has been approved. If you have any questions during the research process or think that your rights have been affected or harmed, you can directly contact the Research Ethics Center of National Taiwan University at (02) 3366-9956, (02) 3366-9980. The researcher will give you one of the two signed consent forms for your records.

I (name) _____have read the above description and through the interviewer's description, I have a detailed understanding of the above research method and its possible benefits and risks. I agree to be a voluntary research participant in this research project, and I also agree that the interview content will be recorded and written into text

doi:10.6342/NTU202303847

(verbatim draft) and cited in publications of this research project and other related publications.

□ I agree to be recorded
□ I do not agree to be recorded

Participant	Researcher
_____	_____
Signature/ Date	Signature/ Date
	Contact Information: dda126@msstate.edu Line ID: dda126 Phone #: 0970630615

doi:10.6342/NTU202303847

訪談知情同意書

您好，

我是林黛希，台灣大學全球衛生碩士學位的碩士生，本研究題目是「在臺灣女性對計劃居家生產之態度初探」，這個研究計畫探究臺灣女性對計劃居家生產與溫柔生產方法的知識和態度，並對女性如何決策生產方式進行分析，了解他們在居家生產或溫柔生產上的經驗與觀察。本研究預計訪談符合以下條件之民眾：(1)女性 (2)介於 20-65 歲之間 (3)曾經有生產經驗或有計畫要生產 (4)可以使用中文和簡易英文進行對談，預計訪談 5-10 人。

為感謝您參與研究，您將獲得新台幣 200 元的禮券。我將請教您生產經驗或者想法，並請您分享想法和觀點，這次訪談約為 60 至 90 分鐘，如果這過程有任何讓您不舒服的問題，您有權拒答，或者隨時停止訪談. 如果您選擇停止訪談，您的訪談和錄音將被立即刪除，禮捲金額也將根據時間比例計算。為了完整紀錄訪談內容，若您同意，我們的對話也將會錄音。 這份錄音與後續謄打之文字資料，將會妥善存放於主持人的個人電腦裡，唯有主持人得以接觸，該份資料亦將於研究發表完成後的三年內銷毀。 我在後續報告與論文的撰寫中，會盡力保護您的隱私，若是引用您的訪談，也會匿名處理，並避免洩漏其他可供聯想之細節。 除心理壓力與隱私曝光等疑慮外，參與本研究不會造成其他損害，故未提供賠償與保險措施。 若有與研究相關的最新資訊，可能影響您繼續參與研究之意願，亦會立即告知。

藉由您所表達的意見，本研究將深入了解女性生育知識和經驗，將其轉化為有助未來公共衛生在政策與做法有所提升的知識，期待對您有所反饋。 本研究將不會衍生任何商業利益。

本研究已經過國立臺灣大學行為與社會科學研究倫理委員會審查，審查內容包含利益與風險評估、研究參與者照護及隱私保護等，並已獲得核准。 若您於研究過程中有任何疑問，或認為權利受到影響、傷害，可直接與國立臺灣大學研究倫理中心聯絡，電話號碼為：（02）3366-9956、（02）3366-9980。 計畫主持人會將您簽署之一式兩份同意書其中一份交給您留存。

我 (姓名) _____已經閱讀了上面的說明，並經由訪談者的說明，詳細瞭解上述研究方法及其可能益處與風險，本人同意成為本研究計畫的自願研究參與者，亦同意訪談內容將會被整理成文字（逐字稿），並在這個研究計畫的出版品和其他相關發表中被引用。

doi:10.6342/NTU202303847

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參與者

簽名　日期

計畫主持人

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