Chapter 7

AN-TAI

ACTIVE MATERNAL BODY WORK

Five months after Stella's fetal reduction (from three fetuses to two), I visited her in the maternity hospital. She was practicing *an-tai,* the Chinese term for keeping the fetuses (*tai*) safe/calm (*an*). Twin pregnancy often requires bed rest in hospital to prevent premature birth, the leading complication of multiple pregnancy. Stella had started mild contractions during her thirty-first week of pregnancy. To prolong her pregnancy, she was taking medicine (an *an-tai* drug) as well as maximizing time in bed. "I should hang on until at least the thirty-sixth week," she told me. Premature birth is usually defined as birth before the thirty-seventh week, and Stella wanted to get as close as possible to that threshold. Walking slowly down the hall in her pajamas, she said that members of a lesbian social media group she belonged to discussed how "*raising* twins is like hell," but that the hardship of *carrying* twins was still seldom mentioned. The burden of child-rearing was known, but not that of childbearing.

The determined Stella did not quite reach her goal of the thirty-sixth week; she had a cesarean section in the thirty-fourth week. After the birth, the underweight twins were sent to the neonatal intensive care unit (NICU) at a nearby medical center. The same day, Stella's partner Jackie announced the birth on Facebook, posting photos of Stella and the twins in their separate beds in two different hospitals. Jackie's tagline of "the hardworking mom" for the photo of Stella with her eyes closed won countless heart emojis, including mine. The twins grew well. A couple of years later, when

I saw a video Stella posted of the twins copying their older sister doing exercises during the Covid-19 lockdown in Taiwan, I could not help but smile.

Women carrying twins and triplets undertake differing degrees of *an-tai*, including those who, like Stella adopt fetal reduction to "only" have twins. *An-tai* has a long history. The health practices of *an-tai* have been recorded in the classic Chinese medical books since the fifth century (J.-d. Lee 2008). Some traditional rituals of *an-tai* are still in practice in Taiwan to expel spirits dangerous to pregnancy (Sung 1996, 2000). Today, people still use the traditional phrase "*an-tai*" for the medication (*an-tai* drug and *an-tai* shot) given to expectant mothers who are on bed rest, for maternal or sick leave during an eventful pregnancy (*an-tai* leave), and for various activities to protect fetuses from premature birth. Women who carry multiples, whether due to IVF, IUI, fertility drugs, or spontaneous conception, have a higher chance of preterm labor, so they often need to practice *an-tai*. Since 50–60 percent of twin pregnancies result in preterm birth, Stella's situation was typical. Routine interventions to prevent preterm labor include close monitoring, anticontraction medication (tocolytic therapy) if showing symptoms presaging preterm labor, and recommendations to change the mother's activity level, such as increasing rest (Newman 2005; Medley et al. 2018). Stella went through all these precautions for more than a month.

The *an* in the term *an-tai* is a verb meaning "to remain safe/calm," and women are the subjects enacting it. In order to practice *an-tai*, women in my study took on extra tasks and responsibilities. As Stella indicated when stating her goal of "hanging on until at least the thirty-sixth week," keeping the twin fetuses in utero for a certain length of time was her main task during this stage. Medical practitioners may offer the anticontraction drug, advice, and care, but many of the tasks involved rely heavily on the expectant mothers to execute, experiment with, and then adjust accordingly. What exactly do pregnant women do to practice *an-tai*? Since some common practices, such as bed rest, sound quiet and easy, why did Stella call it a hardship? How does *an-tai* differ from other anticipatory labor decisions and actions described in chapters 5 and 6?

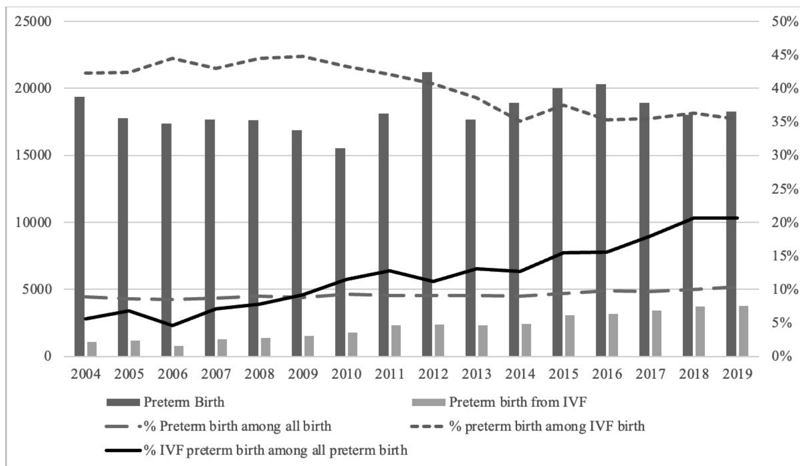
This chapter discusses women's active maternal body work during the *an-tai* period. First, I discuss the medical intervention routinely used during *an-tai*. It is stunning that most of the practices are not supported by evidence-based medicine, yet practitioners continue to prescribe them to pregnant women in many parts of the world, including Taiwan. Second, I delineate three major kinds of maternal

body work during *an-tai*: self-palpation for prediction, corporeal adjustment, and emotion work. Though a prescribed intervention such as bed rest may sound easy, I will show why it is a strenuous and disturbing task for women. Third, I present women's negotiation between reproductive labor and productive labor to maximize their efforts to prevent preterm labor. To carry out the heavy responsibility of practicing *an-tai*, some women resign from their paid jobs to become full-time mothers, which they may never have anticipated doing when they embarked upon the reproductive journey.

"No Placement in Incubator"

After the hurdles of reaching conception and deciding on fetal reduction, women carrying multiples move to a new task: prolonging the pregnancy. Stella strove to give birth to the twins as close to the thirty-seventh week as possible because sooner than that is defined as preterm. She was quite reasonable not to expect to be able to carry them to full term (such as the fortieth week). Several of my interviewees referred to their goal as "no placement in incubator" for their anticipated newborns. One concern was financial. Before the National Health Insurance (NHI) was implemented in 1995, parents told me that it cost 10,000 NT dollars a day (roughly 300–400 USD) to use the incubator for a preterm baby. This was not affordable for most of families. As Emily, the manager in a small business company who was pregnant with twins in 1993, stated, "It was impossible to pay 10,000 NT dollars per day with my salary, so I needed to do the *an-tai* well." After NHI relieved families of this financial burden, parents tended to cite the health problems of the newborns as their major concern.[1]

Once women were carrying twins or triplets, their goal of avoiding preterm birth was difficult to reach. Various studies have shown that about 50–60 percent of women carrying twins will have preterm birth. In the US, the 2021 CDC flyer "Having Healthy Babies One at a Time" states that "about 3 out of 5 twin babies are born preterm." The online advice for pregnancy care from the Health Promotion Administration in Taiwan states that while only 10 percent of singleton pregnancies have preterm birth, the rate increases to 50 percent for twins and 90 percent for triplets (M.-H. Hsu 2021; see also Hu et al. 2015). All epidemiological research, from global statistics (World Health Organization 2012) to local data (K.-H. Chen et al. 2019; Y.-K. Chang, Tseng, and Chen 2020), demonstrates that multiple



Graph 7.1. Trends in Preterm Birth in Taiwan, 2004–19. Sources: ROC Ministry of Health and Welfare 2021a, 2021b. © Chia-Ling Wu

pregnancy is one of the leading causes of preterm birth. As we have seen in chapter 6, for those doctors who advised women to continue twin and even triplet pregnancies, the high prevalence of preterm birth was not a focus of conversation.

Preterm birth has been particularly common for women who have achieved pregnancy through assisted reproductive technology in Taiwan. Graph 7.1 shows that over the fifteen years between 2004 and 2019, about twenty thousand preterm babies were born annually—roughly 10 percent of all newborns. Of these preterm babies, the percentage of IVF babies has increased from 6 percent in 2004 to 21 percent in 2019, shown in the dark horizontal line in graph 7.1. The IVF registry shows that around 35–45 percent of IVF babies are born preterm, mainly due to the high prevalence of multiple pregnancy. There are no data about the relationship between multiple pregnancy or preterm birth and the use of fertility drugs. If such data were included, the rate of ARTs leading to preterm birth would be much higher. Most women who start infertility treatment are seeking to have children through modern technology, and they seldom imagine that their babies from IVF could be preterm babies.

Babies "Born too Soon," as the title of World Health Organization (2012) report summarizes it, have become a global issue that must be tackled. The risks are clear—namely, the high morbidity and mortality of preterm babies and the great care burden this poses

for the healthcare system, community, and family. The solutions include preconception prevention of IVF multiples, good maternal care during pregnancy and childbirth, and high-quality infant care after the preterm babies are born. This chapter focuses on the available interventions *during* multiple pregnancy.

Preventing Preterm Labor *during* Multiple Pregnancy

Evidence-based medicine has cast doubt on various commonly practiced interventions during pregnancy to prevent preterm birth. These "pregnancy management" strategies for singleton and multiple pregnancies range from bed rest, home uterine monitoring, and various drug interventions to surgical interventions such as a cervical stitch (cerclage) and good nutrition. Evidence-based medicine shows that almost none of these practices is known to effectively prevent preterm birth. An overview of eighty-three Cochrane systematic reviews of interventions during pregnancy to prevent preterm labor prompted myriad question marks—the icon for "unknown harm or benefit"—on the report (Medley et al. 2018). Please note that this is a review of reviews, so eighty-three systematic reviews mean hundreds of clinical studies. Page after page of question marks are listed in most of the systematic reviews. Among the eighty-three reviews, only one shows "clear evidence of benefit" in lowering perinatal mortality and preventing preterm birth—namely, midwife-led continuity models versus other models of care (Sandall et al. 2016).

The evidence targeting multiple pregnancy specifically for preterm birth prevention is limited. The current evidence shows that "there is no conclusive evidence that any intervention prolongs gestation in multifetal pregnancies" (Biggio and Anderson 2015: 664; see also Jarde et al. 2017). Bed rest stands out as the most dramatic example. Although bed rest is the most frequently prescribed intervention for twin pregnancy, there is no evidence to support its efficacy (Newman 2005; Crowther and Han 2010; Sosa et al. 2015). Due to the lack of evidence on strict bed rest, some experts suggest that "its use to prevent preterm birth cannot be recommended" (Biggio and Anderson 2015: 659). Some doctors emphasize the harm that bed rest can cause pregnant women, from stress to common physical harm, such as a blood clot in a vein or bone demineralization, and therefore even call its prescription "unethical" (McCall et al. 2013).

Intensive Maternal Body Work

Despite the strong evidence that interventions to prevent preterm birth have almost no efficacy for multiple pregnancy, women in my study received a lot of medical advice and prescriptions to keep the fetuses safe. These women carrying twins or triplets, categorized as a high-risk group, often closely followed the advice they received from healthcare providers about ways to prolong their pregnancy. At some point in their pregnancy, most of them felt they needed to practice *an-tai*. In addition to the well-documented statistics of risk, women felt alert to signals from their own changing bodies—especially the "unruly maternal body" (Neiterman and Fox 2017)—such as evidence of bleeding found in the underwear, swelling of the feet, and tightening of the belly. As Vivian described it, the statistics about preterm birth for twin pregnancy did not ring any bells for her until "my belly was so big in the fifth month, as big as if I was close to delivery, that the doctor asked me to stay home to *an-tai* to prevent preterm labor."

The tasks of *an-tai* rely heavily on the expectant mother's body. I borrow and extend the concept "maternal body work" (Gatrell 2011, 2013) to delineate what women do during the *an-tai* period. Most of the literature on body work discusses the paid work undertaken to care for others' bodies (e.g., Wolkowitz 2006). In contrast, a woman's pregnancy is unpaid work, except in cases of commercial surrogacy, and involves practicing on her own body for the sake of another body (or bodies) inside the woman's own body. I present three major forms of maternal body work—self-palpation for prediction, corporeal adjustment, and emotion work—to analyze how women carrying multiples work to avert the threat of preterm birth.

Self-Palpation for Prediction

Predicting the onset of preterm birth is a task that pregnant women often need to share with their medical professionals. If the woman is hospitalized, medical professionals can use devices and vaginal examinations to monitor the pregnancy and make the prediction. However, most women are not hospitalized throughout their pregnancy, so learning to identify the signs of preterm labor becomes part of routine prenatal education for women with multiple pregnancy. The rationale is that if women can detect the early signs of preterm labor, they can ask medical professionals for further assessment and intervention. The signs include tightening of the belly,

abdominal cramps, lower backache, bleeding from the vagina, and lack of fetal movement.[2] The umbrella term "home uterine monitoring" includes various elements, ranging from education to the use of monitoring devices at home to detect the early signs of preterm birth. Overall, the women I interviewed were advised to observe their body keenly so as to do self-screening.

Self-palpation of one's uterine contractions and of fetal movement is most challenging. Compared with other signs, such as discharge from the vagina, which can be detected visually, contractions were a new bodily sensation for most women I interviewed. Vivian described the difficulty of identifying contractions as a first-time expectant mother:

> Many twin moms said that by the sixth or seventh month, preterm labor may happen. So I needed to pay attention to the contractions. This was my first pregnancy, so how could I know what contractions were? I asked many of my friends what they were, and they often said it was the tightening of the belly, as hard as a rock. … During the seventh month, I felt a little bit of pain in the belly, and some funny feeling during the middle of night, so later I went to see the doctor. He said that the contractions had started. Then, I finally knew what contractions meant. I started two months of *an-tai* in the hospital after that.

Monitoring the early signs requires women to observe, feel, record, judge, and then respond by consulting their doctors or midwives. Women enact their new sense of having a pregnant body (Mol and Law 2004). The verbal descriptions of what to watch for may not easily translate into bodily sense, not to mention the fact that there is a wide variation of bodily sensation. Vivian did not experience her belly feeling "hard as a rock," like her friends did, but simply noticed a "funny feeling." Instead, it was menstruation-like cramps in the lower abdomen—another preterm sign—that led Vivian to consult her doctor.

Women sometimes mobilized other resources to practice the palpation. Hsiao-Yen described vividly how feeling the "fetal movement" confused her about her twin pregnancy:

> The doctor advised me to note the fetal movement since the seventh month. He said if one of the twins did not move suddenly, then. … I felt worried hearing that. How could I know which one was moving? Was it only one moving? Or were both twins moving? I felt the kicking, but was it the two feet of one twin, or two feet from both twins? So I asked help from my sister-in-law (a nurse), and she lent me a stethoscope to figure it out. And then, when she touched my

> belly, she said that I had been contracting. I finally got to know, wow, this was a contraction. I was told that contraction meant the tightening of the belly, but I was confused. When the twins kicked, I also felt tightening of the belly. I could not figure out which meant which through the whole pregnancy.

Hsiao-Yen's confusion illustrates the difficulty in distinguishing the normal (fetal movements) from the abnormal (early contractions) and in precisely identifying the sensation (the kicking of just one or of both twins). In some countries, women have easy access to midwives to clarify such kinds of confusion (e.g., Carter et al. 2018). In Taiwan, 99.8 percent of women go to obstetrician-gynecologists for their prenatal visits; although it is free and easy to make appointments in Taiwan's maternity program, women do not regard seeing doctors as a way to seek reassurance or learn how to detect these bodily signals. This explains why Hsiao-Yen mobilized her own social network and asked a relative who was a nurse to bring medical equipment to help her denote the preterm signs more accurately. The task of self-palpation became a new worry for these women. Not only did it consume their attention, but the sensations they were looking for were not easily identified simply by following a book.

What these women never told me is that evidence-based medicine has not firmly supported the efficacy of the home-monitoring program. A systematic review of thirteen randomized trials, involving more than six thousand cases, could not determine whether or not home monitoring is effective in prolonging pregnancy and improving the infants' health outcomes (Urquhart et al. 2017). Nor has evidence-based medicine confirmed the effectiveness of predictive practices, such as cervical-length screening, that only medical professionals can perform (Biggio and Anderson 2015). Still, women often took self-palpation seriously. The self-monitoring can only be done by women themselves. If any suspicious signs appear, women need to decide whether to go to the emergency room or just take more time to rest. Hsiao-Yen, a lawyer, said that after intensive on-site legal investigations and appearances in court, she often found bleeding and needed to go home to rest. However, it is not only such symptoms that can lead to an intervention such as bed rest because carrying multiples itself may require a lot of rest.

Corporeal Adjustment

Twin and triplet pregnancy means a heavy belly—so heavy that women need to develop a lot of strategies to deal with it. When

Neiterman and Fox (2017) investigated how women control the symptoms of their "unruly maternal body," such as morning sickness, nausea, fatigue, shortness of breath, and rapid weight gain, their sample group was women pregnant with a singleton. In my study, most of the women with multiple pregnancy not only shared some typical pregnancy "symptoms" but were also literally carrying a heavier load than they ever had before. It is very common to have a full-term belly by just the fifth month of a twin pregnancy. Gaining twenty kilograms (forty-four pounds) by the eighth month is about the average. In some cases, this prevents women from moving around and doing other things they usually do in daily life. Monica told me that, during the seventh month, she almost never left the house due to her heavy body: "Walking was very tiring. I felt the distance from the living room to the kitchen was very far." She needed to use a wheelchair for her prenatal visits to the hospital. Zoe said that, by the thirty-second week, she was short of breath even when she was sitting: "My boss called me for my latest situation. He wondered whether I had walked from a long distance to pick up the phone because I sounded out of breath. I said I was sitting right next to the telephone. I was out of breath even when I was sitting."

Women needed material support to adjust to this corporeal change and continue the simplest tasks of daily life. Many women mentioned using a maternal support belt to carry the belly. Once walking became difficult, some of them relied on a wheelchair or modified their furniture to help them sit or sleep at home. Almost all mentioned the difficulty of sleeping. Mei-Hui, pregnant with triplets, described vividly how "in the beginning, the right side of the belly was compressed, and then the left side, and later the middle part sprang up." She needed to adjust her sleeping position but eventually could not sleep with the unruly body. Some women had such difficulty lying in bed that they slept in a chair. Yi-Fen, carrying twins, slept in the sitting position for three whole months. Others said that they could not sit because of being afraid their belly would drop to the floor, so they preferred lying on a bed. Women strove hard to figure out how to adjust their body to maintain the basic aspects of daily life, such as moving and sleeping.

"Rest," the common advice given to women carrying multiples, was not easy. In addition to their heavy body that made sleep difficult, some other bodily tasks interfered. During her twentieth week, Zoe started to have contractions every ten minutes, so she was prescribed medicine every two hours, including through the

night. By the thirtieth week, frequent urination made Zoe go to the restroom every hour. She often found herself short of breath and woke up gasping for air in the middle of the night, which further deprived her of sleep. Monica described terrible pains during the last few weeks of pregnancy: her belly was pressing on her stomach and sternum so that she even needed a painkiller to reduce the discomfort, but this was often in vain, "so that I could barely rest during the *an-tai* at home." If hospitalized, women were confined to bed. In Mei-Hui's words, "Eating, drinking, and bowel movements were all in bed," which she ranked as the most horrible time during the whole pregnancy. The hospital offered constant monitoring and regular drug taking, and often required strict bed rest. Women described how they endured the side effects of the *an-tai* drugs, as well as their anxiety and impatience. The term "bed rest," either at home or in the hospital, sounds quiet and inactive, but in women's descriptions it was fierce and disturbing.

Again, there is little evidence to support the efficacy of the typical practices to prevent preterm labor in Taiwan, such as taking oral tocolytics, bed rest, and restriction of some strenuous activities (Medley et al. 2018). Women nevertheless try hard to find ways to follow such medical advice, even though it may not work very well. Instead, much research has shown that these so-called prevention measures may cause more anxiety and distress than they assuage, which could increase the chances of preterm birth (MacKinnon 2006; Carter et al. 2018; H.-Y. Hung et al. 2021).

Emotional Work

Despite feeling anxious and stressed, women often engage in emotional work to foster the fetuses. Gatrell (2011: 398) defines "emotion work" as the "emotional energy expended in making decisions about, and implementing, the obligations of pregnancy carework in accordance with medical advice." This is related to how women handle the uncertainty in identifying signs of incipient preterm birth and do their best to adjust their unruly body. Women I interviewed most often used the term *cheng* (hang on) to describe what they did—an action that draws more upon mental strength than physical capacity. Women needed to lift their spirits to foreground the protection of fetuses above their own bodily discomfort. Some described how they imagined the healthy birth of their twins and triplets as powerful motivation for enduring their physical discomfort. After all, in many cases they had achieved the pregnancy only after a long and difficult journey, as described in chapter 5.

Some visualized a better future to further strengthen their determination. For example, Emily stated that "to suffer several months in exchange for healthy twins—it was highly worth doing it, wasn't it?" Hsin-Yu also imagined that child-rearing might be easier as long as she endured all the hardships of the pregnancy.

Such emotion work may intensify for women carrying multiples, due to the increased maternal-fetal conflict. Some honestly expressed how they could not bear it any more at some point in their pregnancy. Yi-Fen kept asking her ob-gyn husband when the earliest time was to deliver the twins, only to hear that she needed to wait until the thirty-sixth week for the cesarean section: "I felt so torn. I felt extremely exhausted, but I also wished they could stay longer to have better lung function." Hsiao-Mei, a cleaner, described the discomfort of the whole twin pregnancy. She recalled the contradiction: "I really wanted to give birth as soon as possible because I felt so uncomfortable. However, doctors told me that the babies were still too small, and their weights too low, so I did my best to eat as much as possible." For Hsiao-Mei, the new task of gaining weight was a way to distract herself from her own suffering. Monica would have liked to give birth to her twins sooner, for relief from various forms of bodily suffering. However, she strongly believed she needed to endure to the thirty-sixth week so that the twins would not have to be placed in incubators, which might prevent her from breastfeeding, her ideal feeding method. Again, her ideals about motherhood enabled her to put her suffering aside. Still, a few days before Monica's scheduled C-section, when she was sent to the emergency room due to contractions, she rejected the ER doctor's advice to practice *an-tai* for a few more days. Monica said that she could not bear the pain of carrying twins, and only wished to give birth as soon as possible. "I just could not hang on anymore," Monica told me. The twins were twenty-three hundred and twenty-five hundred grams when they were born, within the margin of low birthweight.

Although women clearly described how they suffered, I found almost no one who mentioned worrying about their own threatened health. In an important study of women's stress and distress about home rest in Taiwan, the leading worry was "losing baby" and "possible preterm birth" (H.-Y. Hung et al. 2021). That said, the questionnaire that was used included no item about the worry of women losing their own lives, or of possible serious physical and/or psychological harm. Research has shown that, in developed countries, maternal mortality is two to three times higher in twin

pregnancy than in singleton pregnancy (Senat et al. 1998; Conde-Agudelo, Belizan, and Lindmark 2000). It is well documented that women carrying multiples have a higher risk of hypertension, anemia, urinary tract infection, and postpartum hemorrhage. However, neither women's narratives nor questionnaire items include the issue of maternal death and health risk. *An-tai* is practiced in anticipation of the better health of fetuses, not mothers.

Negotiating Reproductive and Productive Labor

To execute active maternal body work, women carrying multiples often need to negotiate their reproductive and productive labor. Since bed rest is the key element of *an-tai*, most women need to take leave from their paid jobs. In addition, place matters for *an-tai*. Even for a singleton pregnancy, it is not easy to implement health advice or handle common discomforts such as morning sickness in the workplace (Gatrell 2011, 2013). In the case of multiple pregnancy, where the location of *an-tai* is either the home or a hospital, most women simply cannot practice *an-tai* while continuing to work in an office, shop, or market.

"You want work, or kids?" Emily recalled that her doctor had sharply asked when she was hospitalized for a short time during her second trimester. Emily's doctor created the image of a zero-sum game: women must devote themselves either to *an-tai* or to a job. This narrative places the sole and primary responsibility for the welfare of children at their mother's feet. Some women assumed that their pregnancy care work would not be compatible with their paid work, so quitting their job was part of their maternal body work. Hsiao-Yi was a marketing manager in an international car company when she became pregnant with twins by donor insemination privately arranged by a doctor. A feminist with a strong determination to become a voluntary single mother, she decided to quit her job to focus on "cultivating my belly," in her words. Monica was also reminded by her doctor to rest more and not do strenuous work. For her, "work" meant housework and childcare, so she needed to arrange helpers to take care of her first child. Carrying multiples is itself a full-time job—or more than that, necessitating twenty-four-hour maternal body work in some difficult cases. Sometimes there is no room to manage a second shift.

Maximizing time and energy for *an-tai* means rearranging women's preexisting work. For those who have paid jobs, taking

long maternal and sick leaves is most feasible for public servants, teachers, higher-ranked managers, employees of international corporations, and others whose job offers better family policies. Still, it causes much struggle. *An-tai* remained a gray area for any category of leave. In the late 1990s, Mei-Hsiang was working at a national bank that had the most generous paternity leave available at the time in Taiwan. During her *an-tai* period, she combined all her possible leaves—sick leave, annual leave, and maternity leave—to practice *an-tai* at home and in the hospital. Still, after using up all her possible days off, she had no choice but to resign and become a full-time mother and housewife. Hsiao-Yen, a partner at a law firm, used up all her leave and then received support from the firm's other partners to stay home on "special leave." In contrast, part-time workers and private-sector or service-sector employees tend to have to resign in order to practice *an-tai*.

An-tai leaves became part of the Gender Equality in Employment Act in 2010, thanks to the efforts of the feminist legislator Shu-Ying Huang. The revised act specifies that, with their doctor's request and approval, women can follow the regulation of sick leave to practice *an-tai* (Legislative Yuan 2010). If they do not need to be hospitalized, women can have up to thirty days of leave; if hospitalized, following the official rule on sick leave, they can have up to one year. Yet even though women can legally take *an-tai* leave, it can be very stressful to request it. A recent study shows that women who have home rest with threatened preterm labor have higher stress than healthy pregnant women, and "having to ask for leave from work for bed rest" was one of the most stress-inducing items in the survey (H.-Y. Hung et al. 2021). Moreover, legal disputes continue regarding employers' discrimination against women who take *an-tai* leave (e.g., C. Chang 2021).

Conclusion: *An-tai* in Vain?

This chapter reveals women's active maternal body work and reorganization of care to prevent the threat of preterm labor, the leading complication during multiple pregnancy. Unlike most literature that focuses on women's experiences and anxiety surrounding pregnancy and childbirth, this chapter makes women's work visible by highlighting what women do to practice *an-tai*. The women I interviewed were far from being the passive, vulnerable containers of their fetuses. In anticipation of giving birth to healthy newborns,

they actively developed various ways to work with the tasks recommended or prescribed for them at this stage.

By the time they practice *an-tai*, women carry the sole responsibility for the welfare of their fetuses. When these women attempted to enhance conception (chapter 5), the major point of contention was optimization of medical intervention, such as determining the best number of embryos to transfer. Here medical professionals bore at least partial responsibility in reaching success. After attaining a multiple pregnancy, fetal reduction (chapter 6) was the major dilemma that women faced, often together with their family members and doctors. In contrast, practicing *an-tai*—to keep the fetuses safe by prolonging their time in the womb—is the embodied responsibility solely of the expectant mother. Over the trajectory of anticipatory labor, from success in conception to stabilizing the pregnancy, the share of responsibility thus gradually increases until it rests on the woman alone.

Most of my interviewees still had preterm births even after all their arduous efforts. This accords with the findings of evidence-based medicine, which show little efficacy for most of the preventive measures encompassed by *an-tai*. Nevertheless, women tend to blame themselves for endangering their children by not being able to further prolong a multiple pregnancy. This sense of guilt may linger. Ya-Wen told me in tears that, "even now, I still blame myself for making him [one of her twins] so small." In contrast, I did not hear anyone mention how fetuses might have harmed their mothers. The closest case was Mei-Hui's father-in-law saying that if the lives of the mother and triplets were endangered, saving the mother's life was more important. Most other cases did not include maternal death as a possible scenario and often positioned fetal health as the priority.

This feto-centrism, as implied in the term *an-tai* ("keep fetus safe/calm") itself, needs to be corrected through policy. First of all, doctors and policymakers need to highlight the maternal health risks of multiple pregnancy rather than focus only on the danger of preterm labor. "Twin pregnancy is risky for baby and mother," as the CDC flyer mentioned earlier emphasizes in bold type. This is even more true of triplet pregnancy. Mothers' health should be part of the prevention agenda, both before and during pregnancy. Second, evidence-based medicine should be followed and become a resource for improving preventive measures. As McCall, Grimes, and Lyerly (2013: 1308) point out, "Findings of fetal harm often lead to immediate prohibitions (such as caffeine or various medica-

tion), whereas findings of maternal harm or relative fetal safety are overlooked or slowly integrated into practice." During *an-tai*, women and fetuses are not two different entities, so *an-tai* needs to abandon useless practices that are recommended in the name of protecting fetuses but can harm women's health and/or further burden them.

Finally, the strongest evidence of benefit so far in preventing preterm birth is the midwifery model (Sandall et al. 2016), which has become seriously marginalized in Taiwan (Wu 2017b). This chapter shows that women often either "hang on alone" or have to utilize support by themselves. The midwifery model offers continuity of care, with quick access to advice, judgment, and support. This midwife-led continuity model should be built into *an-tai* as one of the primary ways to safeguard the health of both expectant mothers and their fetuses.

Notes

1. The parents I met at the 2019 triplets gathering told me that they were surprised to find that the expense listed on the bill was more than 2 million NT dollars (roughly 70,000 USD) when their triplets were discharged from the medical center after a two-month stay in the NICU. Taiwan's NHI paid all the fees, and the parents only paid around 50,000 NT dollars (less than 2,000 USD).
2. See the health advice from the National Taiwan University Hospital: https://reurl.cc/o1Qad3 (accessed 8 May 2022).