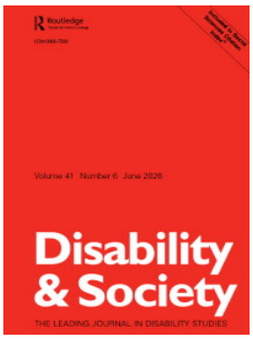

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Becoming mothers: reproductive experiences and agency of women with physical disabilities

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ABSTRACT

This qualitative study draws on in-depth interviews with six women with physical disabilities in Taiwan who gave birth within the past decade. Despite societal misconceptions and traditional gender expectations that often discourage their reproductive choices, these women, usually portrayed as 'misfits', negotiated institutional barriers and opportunities and built support networks tailored to their needs. Their narratives reveal mixed emotions around pregnancy, including concerns about genetic risk and difficulties accessing inclusive healthcare. Although Taiwan has incorporated international disability rights norms into domestic law, significant gaps remain in ensuring reproductive justice for women with disabilities. Informed by feminist disability theory's critique of the 'normate', this study highlights how women with disabilities navigate, reclaim, and practise motherhood as a site of empowerment, shaping a transformative politics attentive to the intersecting oppressions of sexism and ableism.

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Convention on the elimination of all forms of discrimination against women; convention on the rights of persons with disabilities; disabled motherhood; enabling motherhood; feminist disability studies; reproductive health and rights

Points of Interest

- This article examines the reproductive experiences of women with physical disabilities in Taiwan, drawing on in-depth interviews with those who have recently become mothers.
- Challenging ableist assumptions about fertility and caregiving, participants articulated a strong desire for motherhood and a belief in their capacity to parent.
- Pregnancy was shaped by ambivalence, including concerns about health risks, family pressure, limited access to care, and the possibility of passing on genetic conditions.
- Participants encountered structural barriers in healthcare settings, including inaccessible equipment and limited professional support, yet actively negotiated these constraints in everyday practice.
- While motherhood was experienced as empowering, the findings highlight persistent gaps between rights frameworks and lived realities, pointing to the need for more inclusive reproductive healthcare systems.

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Introduction

Ensuring equal access to maternal healthcare for marginalised groups, including women with disabilities, is recognised as a core state obligation in fulfilling sexual and reproductive health and rights (CRPD 2016; CESCR 2016). By the end of 2022, around 1.2 million people in Taiwan (approximately 5.14% of the population) were registered as having disabilities. Women with disabilities made up about 4.54% of the female population. Among all disability types, physical disabilities accounted for 28.36%, second only to neurological and mental impairments (Ministry of Health and Welfare [MOHW] 2023). Women with physical disabilities comprised 26.06% of all women with disabilities, with an estimated 15.34% of women of reproductive age (15–49 years) living with physical disabilities (MOHW 2023). Advances in biomedical technology and prenatal interventions have reduced the number of people born with disabilities, while the number of those acquiring disabilities over the lifespan has increased (Mosher et al. 2017; WHO and WB 2011).

Since 1980, Taiwan has enacted several laws to protect the rights of people with disabilities, including the People with Disabilities Rights Protection Act (originally enacted as the Handicapped Persons Welfare Act in 1980 and subsequently renamed the Physically and Mentally Disabled Citizens Protection Act in 1997). Though not a member state of the United Nations and therefore unable to become a State Party to the Convention on the Rights of Persons with Disabilities (CRPD), the Taiwanese government adopted the CRPD Implementation Act in 2014 to incorporate global disability rights norms into domestic law (Chang 2019; Ministry of Justice 2014). In line with the CRPD, the Act also stipulates that the government shall conduct periodic reviews by independent international experts, which began in 2017.

Despite significant improvements, violations of disability rights persist. This reflects the tension between the globalisation of disability rights norms and Taiwan's enduring paternalistic culture (Lin and Chang 2024) and the continued neglect of disability experiences, particularly concerning sexual and reproductive health (Chou, Lu, et al. 2020). Notably, in disability studies, 'person-first' terms (e.g. people/women with disabilities) highlight shared humanity; 'identity-first' terms (e.g. disabled people/women) recognise disability as an integral part of identity and align with the social model of disability, which holds that "disability" arises from interactions with unjust social arrangements rather than being a necessary result of individual impairments (Campbell, Löfgren-Mårtenson, and Martino 2020; Shakespeare 2017). There is no consensus on usage, as preferences vary by political and theoretical stance (Lee and Torres Celis 2024). In this article, we use both terms, guided by context and sensitivity to how individuals are disabled or live with a disability.

Reproductive oppression and legal-policy barriers

Questioned by ableist assumptions embedded in medico-societal norms, people with disabilities are often labelled as 'incompetent', which impedes their ability to exercise rights and express opinions despite the legal recognition of their right to self-determination (Shakespeare 2006; Thomas 2017). In particular, women with disabilities face intersectional marginalisation due to their subjective positions within gendered and able-bodied social orders, where heteropatriarchy and dis/ableism reinforce one another (Garland-Thomson 2005; Hall 2011).

In Taiwan, women with disabilities are often caught between professional and welfare agencies that overlook the complex realities limiting their autonomy in decisions about their bodies, pregnancy, abortion, and sterilisation (Chou and Lu 2011; Lin 2020). The 1984 Genetic Health Act, for instance, has been criticised for its eugenic underpinnings and for excluding disabled women's perspectives during its drafting (Tai 2024). During Taiwan's CRPD state report reviews in 2017 and 2022, disability rights organisations (DROs) and International Review Committees (IRCs – ad hoc expert panels reviewing state and civil society submissions) scrutinised laws related to health and bodily autonomy (Article 25) and family life (Article 23), urging reforms to bring domestic policies in line with the CRPD standards (Su 2023; Su and Lee 2026).

The Control Yuan, Taiwan's constitutional oversight body, has also criticised delayed reforms by both central and municipal governments. In its 2019 report, it reproached the MOHW for continuing to neglect the rights of people with disabilities to form families and for failing to address their needs concerning pregnancy and childcare support (Control Yuan 2019). In 2021, a public outcry emerged in response to the Taipei City Government's promotion of subsidies for birth control and sterilisation measures targeting women with disabilities – a decision that reflected a continued emphasis on birth-control governance rather than a commitment to inclusive reproductive health services (Chou 2021).

Disabled motherhood and the 'normate' discourse

A recent study adopts a life history approach to examine the reproductive experiences of Taiwanese women living with polio born between 1955 and 1965, revealing the profound influence of non-disabled 'good mother' figures on these women (Kuo 2020b). Another study explores the reproductive decision-making of women living with albinism, who perceive and experience discrimination throughout their childhood and womanhood, continually concerned about the potential genetic transmission of their condition (Huang et al. 2022). These examples align with Garland-Thomson's depiction of the

role of the 'normate' in defining whose bodies are deemed usable and capable of realising their 'full potential':

> [T]he veiled subject position of the cultural self, the figure outlined by the array of deviant others whose marked bodies shore up the normate's boundaries. The term normate usefully designates the social figure through which people can represent themselves as *definitive human beings*. Normate, then, is the constructed identity of those who, by way of the bodily configurations and cultural capital they assume, can step into a position of authority and wield the power it grants them (Garland-Thomson 1997, 8).

'Normate' standards, against which 'non-normates' are measured, embed biomedical judgments about disabled women's bodies into Taiwan's ableist reproductive culture, both in policy and public perception (Kuo 2020a). Reproductive health policies often conflate medical (impairment) and social (disablement) models of disability (Huang et al. 2022; Nguyen et al. 2018), reinforcing the perception of women with physical disabilities as 'misfits' – marked by vulnerability and dependence, and seen as out of place in social and material contexts (Garland-Thomson 2011). This discursive framing legitimises or excuses policy and infrastructural inaccessibility, in direct conflict with the reproductive rights of women with disabilities as recognised in international human rights law, including both disability and women's rights norms (Hallgarten 2021; OHCHR, UNFPA, and DIHR 2014).

Medical discourse emphasises links between pregnancy in women with disabilities and health risks for both mother and foetus (Deierlein et al. 2021). This creates psychosocial pressure on these women and deprives them of mainstream conceptions of motherhood (Grue and Lærum 2002). Their ability to provide care as mothers is often doubted, and they are assumed to require more attention than others, overlooking their capacity to form bodily connections with their child and the human rights-based approach to care support (Horner-Johnson 2019; Long-Bellil, Valentine, and Mitra 2021; Long-Bellil et al. 2017; Silvers, Francis, and Badesch 2016).

Some women are considered 'disabled' from becoming mothers due to prejudicial attitudes and assumptions about their perceived 'lack' of capacity. As a result, women with disabilities often receive limited education and information about reproductive health (Mitra et al. 2017; Powell et al. 2017; Streur et al. 2020) and are seldom provided with care services tailored to their specific needs and characteristics (Heideveld-Gerritsen et al. 2021). To meet societal expectations of the 'perfect mother', women with physical disabilities frequently experience anxiety and depression, often prioritising the needs of their children over their own (Becker et al. 2021).

Inaccessibility, such as physical barriers within hospitals and the lack of barrier-free equipment (e.g. height-adjustable examination tables, seated scales, assistive devices), constitutes a form of disability discrimination under the CRPD. Yet such discrimination is often rationalised by citing insufficient

knowledge, skills, or resources. For instance, in response to inaccessible mobile cervical screening units, the Taiwanese government advised women with disabilities to seek care at hospitals with accessible facilities, rather than committing to upgrading existing services (Executive Yuan 2022b). These systemic inadequacies have continued to undermine disabled women's access to sexual and reproductive health, despite their clear desire to become mothers.

As previous studies have shown, although becoming a mother may involve various barriers, reproductive and parenting experiences can empower women with disabilities to achieve a sense of womanhood and further enhance their agency, responsibility, and capability (Grue and Lærum 2002; O'Connor-Terry and Harris 2022; Prilleltensky 2004; Shpigelman and Karlinski Argi 2024). Yet, the reproductive journeys of disabled women, from pre-pregnancy decisions to childbirth, remain largely underrepresented. This study draws on qualitative accounts from women with physical disabilities in Taiwan to explore how they navigate pregnancy, childbirth, and parenthood. It examines the practices that empower disabled people in their social and sexual lives (Lee and Torres Celis 2024; Yau 2019) and affirms their reproductive health rights (Chang and Chou 2023; Chou, Kuo, et al. 2020).

Research methods and process

We conducted semi-structured, in-depth interviews with women with physical disabilities to explore their experiences before and during pregnancy and childbirth over the past decade, and how they envision 'motherhood' in terms of being 'enabled to' or 'disabled from' guaranteed reproductive rights. Understanding their perspectives helps us identify the need for tailored care and support infrastructure, informing policy recommendations aligned with the CRPD and grounded in Taiwan's local context. This study was reviewed by the National Taiwan University Research Ethics Committee (NTU-REC No. 202109HS016).

We employed purposive and snowball sampling methods. Recruitment information was shared *via* social media (e.g. Facebook, Instagram, Line [a popular social networking application in Taiwan]) and circulated through DROs, including the Taiwan Disabled Women's Alliance for Equal Rights, the New Taipei City Spinal Cord Injury Association and the Taiwan Disability-Free Association, from December 2021 to March 2022.

We recruited interviewees who held Taiwanese nationality, were over the age of 20, were fluent in Mandarin, and possessed a disability identification manual for 'neuromusculoskeletal and movement-related functions and structures' (Malfunction Category 7 under Article 5 of the People with Disabilities Rights Protection Act) during pregnancy. While we remain critically aware of the medico-bureaucratic nature of such assessments, in Taiwan, disability identification is a prerequisite for accessing disability-related benefits and

support services. This requirement underscores the tension between Taiwan's eligibility-based system and the CRPD's social model and universalist approach to disability rights (Chang 2007, 2015).

Six women (Chung, Douma, Mei, Sugar, Yaa, and Yu) were interviewed, with an average age of 38. All participants had been officially assessed as having a moderate or severe disability; two had congenital disorders, one had hand injuries, and three had spinal cord injuries. Except for Yu, all interviewees used wheelchairs as assistive devices. Most participants held a college degree or higher, except for Yaa, who had completed high school. All were employed. Most had given birth to at least one child, with caesarean section being the primary mode of delivery in hospital settings; only Douma had vaginal deliveries for both of her children.

This topic remains underexplored in Taiwan; our recruitment was limited to women with physical disabilities who had given birth between 2011 and 2021. As a result, participant recruitment proved to be challenging. However, the rarity of such narratives also underscores the value of these six participants' experiences, offering important insight into how reproductive health and rights have been practised and experienced by disabled women in Taiwan. Informed by critical reflections on the situated and subjective nature of 'data saturation' (Braun and Clarke 2021a, 2021b), we prioritised analytical depth and interpretive meaning-making over a fixed sample size.

As the COVID-19 pandemic was ongoing during the data collection period, all interviews were conducted online by the first author *via* Google Meet. No interviewees requested specific accommodation. The interviewer kept the camera on throughout, while participants could choose whether to have theirs on. Each interview lasted between 60 and 90 min. Where clarification was needed, a follow-up interview was conducted with the participant's consent. The interviews covered topics such as reproductive intentions, pregnancy experiences, and the use of supportive resources during pregnancy. These topics were not addressed in a fixed order; instead, participants were encouraged to decide what and how they wished to share, helping maintain a balanced and respectful power dynamic.

With participants' informed consent and assurance of privacy and confidentiality, all the interviews were audio-recorded and transcribed verbatim, then edited for readability and comprehensibility (Mondada 2007). Thematic codes and subcodes were identified through the first author's iterative readings, familiarity with the narrative data, and in-depth discussions with the second author. Both transcripts and our analysis at different stages were shared with our interviewees, allowing them to participate in our interpretative process and seek agreement with our interpretations. Narrative information was quoted, and our dissemination plan for the research results was discussed (Chen et al. 2023).

Our analysis centred on how participants interpreted their experiences of pregnancy, childbirth, and motherhood, which were shaped by emotions such as worry, anxiety, and fear (Badakhsh et al. 2020; Walsh-Gallagher, Sinclair, and Mc Conkey 2012). These narratives were grounded in a broader rights-based context, where the sexual and reproductive health of women with disabilities in Taiwan remains marginalised by stigma and structural neglect (Control Yuan 2019; Kuo 2020a). Recruitment challenges underscored this marginalisation and the limited societal recognition of disabled women's reproductive experiences. Nevertheless, the voices of those who participated help address a critical gap in advancing the rights enshrined in the CRPD.

Our positionalities

This study draws on intersectional feminism and feminist disability studies to amplify the voices of women with disabilities and advocate for a more inclusive environment for pregnancy and child-rearing (Garland-Thomson 2005). As non-disabled, cisgender queer men with long-standing engagement in research and activism for sexual and reproductive health and rights, we have sought to remain attentive to our positionality throughout the research process. To bridge the experiential gap, we spoke with friends and colleagues at DROs and extensively reviewed literature on the reproductive health of disabled women to ground our understanding of key debates. Before data collection in 2021, we consulted members of the Taiwan Disabled Women's Alliance for Equal Rights, whose insights helped shape our research design.

Throughout the interview and analysis processes, we remained transparent about our position as 'allies' and critically self-reflexive about the limits of our lived experience, fostering a research process grounded in reciprocity and mutual knowledge production (Lee et al., 2026). While we initially questioned our suitability to undertake this work, we came to recognise that the 'insider-outsider' binary often oversimplifies the complexities of researchers' and participants' social identities (Bourke 2014; Jacobson and Mustafa 2019; Mohler and Rudman 2022). Instead, we embraced a shared sense of inequality as a point of entry into disability studies, while remaining careful about the responsibilities our position entails (Beauchamp-Pryor 2011; Bourke 2014; Su 2026). This awareness guided us in approaching our research, participants, and ourselves with care.

Study results

Our interview questions covered four parts: background and life-story information; reproductive intentions and decisions; experiences of pregnancy and care; and experiences of exploring or utilising publicly funded assistance and resources. Based on participants' recollections of their reproductive

experiences, the narratives can be summarised into four themes: (1) ambivalence toward having a child (the paradox of becoming a mother or not), (2) experiencing and embodying 'motherhood' (during and after pregnancy), (3) seeking, utilising and refusing maternal and childcare support services, and (4) empowerment through becoming a mother.

To be or not to be a mom, that is the question

Our participants had always wanted to have a child. However, influenced by the the traditional and familial expectation that one should marry before having children, most of them – except Yu – worried that starting a family would be impossible. They all reported being dissuaded or discouraged by family members and friends who doubted their ability to care for others. 'Their negative attitudes are out of a sense of overprotection, I think. They might think they were out of good intentions, although it was prejudicial and hurtful,' stated Mei. She continued:

> Many stereotypical statements keep appearing in my ears. In fact, they wanted to protect me and did not want me to be mistreated or abused. My relatives thought that if I couldn't even take care of myself, how could I serve my parents-in-law and care for a child?

It is indeed difficult for women with disabilities to practise women's 'traditional social roles'; that is, according to Chung, 'The reason why I had never thought about having children was that boys generally do not seem to be able to "embrace" my wheelchair situation'. In this context, 'embracing' (or 'accepting,' as literally translated from Chinese) reflects the subjective position where a woman is discouraged from taking the initiative in marriage and childbirth and can only be passively chosen by a man. When a disability is acquired, concerns about the uncertainty of pregnancy following a physical injury can alter one's intention to have children. For example, as Douma shared with us:

> Before the car accident, I always wanted to have three kids. After the accident, to be honest, I didn't even want to get married anymore. I didn't know what it'd be like to be pregnant in a wheelchair. Can I still be a mother?

While traditional notions of family and motherhood and prejudice against people with disabilities persist, ideas about family formation among women with disabilities have evolved. Two participants viewed 'marriage' and 'childbirth' as independent events in their life course, not necessarily related to each other. As Yaa told us:

> Initially, I thought we could raise the kid together, but did not have to get married, but everyone told me that my children need 'a complete family', so we got married…However, since my situation [physical disability] is involved, the man, knowing

> it, should try to handle the complicated situation, and he should communicate with others who are worried.

Most interviewees did not question their fertility, but Yaa's experience differed slightly. She 'almost believed' that her menstrual irregularities might make it difficult for her to conceive. She was 'denied by family members for a long time due to "that situation" [spinal cord injury]', convincing herself that she did not 'deserve the same life path as normal people, including giving birth,' Yaa recalled. Internalising such a belief (or 'misbelief', as Mei put it) that equates disability with infertility, some interviewees had been seriously concerned about 'the future without a kid' before they became mothers. Mei stated:

> After I went to Japan for training about disability rights, I saw girls in wheelchairs like me getting married, having children and living a very normal life. I was super surprised. In Taiwan, everyone says no, so why is it possible here? I felt that the problem lay in the discrepancy between social expectations and knowledge, so at that time, I finally came to realise that there was nothing wrong with being a mother.

As these women got older, they gradually accepted their desire for motherhood and tended to embrace pregnancy. Mei told us, 'I was already 30-ish years old, and I planned to get married when I got pregnant anyway, so I was like partially prepared for the pregnancy in my mind.' Most of our participants were not under pressure to have children, except Yu. She was constantly 'asked with a caring voice' by her parents and her husband's family (family-in-law) to 'continue the family line after marriage', especially when, according to Yu, 'my sisters-in-law and friends were all getting pregnant one after another, so we [my husband and I] had to plan for pregnancy actively'. She also mentioned:

> My mother-in-law was the pushiest one. She introduced me to all her 'secret recipes' because she thought I was infertile. She also took me to get checked for infertility at the same clinic where my sister-in-law had her prenatal checkups, and the clinic's website said, 'specialising in treating infertility'.

Some participants felt that their families and friends did not support their decision to get married and have children. Consequently, when they discovered they were pregnant, many chose to inform their 'important others' of the news over time. For example, although Sugar announced her pregnancy on social media when she found out, she did not inform her aunt until she was about four months pregnant. Her mother was not informed until she was nearly eight months along. 'I concealed the news because I knew she wouldn't be happy. She was mad, I fully understand, out of worry about my health. I finally told her when an abortion was not possible anymore.' When Douma found out about her pregnancy, she didn't tell her parents immediately; she said:

> I dared not tell my mother until I accidentally bled. She thought I was menstruating, so I had no choice but to tell her…She was very angry with me for having to live a pregnant life in a wheelchair. But very soon, she told me that's fine: 'Let's take good care of your body…if the kid wants you to be their mom, we should do our best to protect them' [in Chinese, he and she read and pronounce the same (*tā* [他/她]), so we rendered *tā* as 'they/them' for convenience].

It wasn't just about me during the pregnancy

With the underrepresentation of disabled women's pregnancy in personal networks, the internet and social media were crucial sources of information about maternal health and maternity services. Yet much of the information online was not tailored to individual situations, making it very challenging to find a suitable clinic or hospital. For instance, Chung chose a regional hospital primarily for transportation convenience, while Sugar and Yaa relied on word of mouth to assess the pros and cons of nearby institutions, though not all of these were physically accessible to people with disabilities. About the first doctor Yaa visited, 'he wasn't confident to help me or deliver my baby due to my condition'. On this matter, Douma shared with us:

> We [my husband and I] thought about going to a 5-star OGC (obstetrics and gynaecology clinic)…and we had to see the doctor, but some of them said stuff that made me feel uncomfortable. I also preferred a female doctor who understands better…At that time, the doctor, who later became my regular obstetrician, saw me sitting in a wheelchair, acted normal and showed no negative responses. I told my husband, 'She is very special; let's stay here.' Also, the clinic has wheelchair ramps.

All participants expressed concerns about pregnancy and childbirth complications after finding a suitable space for prenatal and maternal care. Those with congenital conditions, such as Chung and Sugar, were stressed out by genetic disorders. Chung has experienced mobility disability since childhood, but she was not diagnosed with spinal muscular atrophy (SMA) type III until she took a blood test after discovering her pregnancy. She became paranoid and uneasy throughout pregnancy, even though the amniocentesis test results confirmed that the child did not carry the SMA gene. Chung recalled:

> The doctor told me the test was not completely accurate…The SMA diagnosis was a shocker because I knew that some patients around me had passed away with a cold and were unable to cough up the phlegm. The attending physician who treats SMA explained the chances that a child might be like me, or they could be just 'normal'. I couldn't accept it, so I didn't even listen to what the doctor said. I just kept crying.

Chung and her doctor highlighted the concept of being 'normal' in contrast to her own condition, emphasising a rejection of SMA and the suffering it has brought to her. Similarly, Sugar, who lived with congenital spinal disease, was also under significant pressure, saying, 'I don't want my children to

suffer the same "tragedy" that happened to me'. Therefore, 'it was a very painful time whenever I was waiting for the results of a prenatal checkup'.

For those whose condition is not genetic, Douma, for instance, also experienced significant pregnancy-related anxiety. She consistently tested for high blood pressure at the hospital, leading her to worry that pregnancy-induced hypertension might affect her foetus's health or result in postpartum hypertension and other negative outcomes. Choosing a C-section rather than vaginal delivery also stemmed from the same worry. For example, Yu mentioned that her mother had gestational diabetes during pregnancy, resulting in her being a large foetus and damaging her right arm during the labour process, so 'I was afraid my child would be like this; after all, I think my life was quite hard when I was a child…so I didn't want "natural childbirth"'.

In addition to publicly funded prenatal checkups under the National Health Insurance, most interviewees also opted for self-funded tests, such as rare disease screenings and high-level ultrasounds, to further assess foetal health. However, Mei and her husband, both disability rights advocates, saw prenatal screening as a form of 'examination to give up the child' and chose to forgo all such tests. Sugar and Douma faced difficulties providing urine samples due to incontinence and therefore did not complete routine urine testing. While the Health Promotion Administration offers gestational diabetes screening (24–28 wk) and routine blood pressure checks, Sugar, who missed some of these, noted: 'We might have missed important health information, but we were offered no alternative or any help.'

Participants mentioned the difficulty of getting on the examination table for checkups, and only Sugar and Chung had used an examination table with a lifting function. Chung noted, 'After my husband forcefully carried me onto the examination table, the nurse said it could be lowered.' This indicates that even with relevant equipment available, medical staff may still be unable to provide timely assistance. When it came to weight measurement, many participants had to do it at home or be weighed while being held by their husbands, after which the husband's weight was subtracted. This practice was risky for both parties and often led to inaccurate measurements. Mei knew there were seated scales at haemodialysis centres, so 'I normally went to measure my weight before going to the OGC on the checkup day,' she said.

We mentioned that Yu chose to have a C-section out of her concern about 'hurting' the baby. Still, most of them did so based on attending physicians' advice, who tended to believe that their lower body was weak or that it was difficult to give birth naturally due to changes in body structure. However, as Douma shared with us:

> I was told to have a C-section initially, but I gave birth to my eldest daughter naturally and successfully within 2 hours after her first labour pain. After that, I started to advocate for vaginal delivery because, first, I was worried about the complications associated with a C-section, and secondly, I didn't need to have extra surgery to worry my family.

Four participants mentioned that pregnancy made mobility more difficult. Douma and Chung, for instance, struggled to reposition their bodies due to weight gain and enlarged bellies. Douma experienced uterine contractions triggered by forceful movement, while Chung relied on her husband and mother for daily support, yet still fell twice during her second and third trimesters. Mei's customised wheelchair also became unsuitable for her changing body, and she shared that:

> Changing a wheelchair is like wearing shoes that don't fit. It became inconvenient to do anything. On a slope, leaning forward would hit your stomach and cause pain, making climbing difficult. Ultimately, the problem was solved using an electric wheelchair instead.

Among our participants, Yaa chose to undergo sterilisation after her second child, believing two children would be enough company for each other. In Douma's case, her husband took the initiative to have a vasectomy. At 21 wk pregnant, Sugar experienced a premature rupture of membranes, and her doctor warned she might not carry the baby to term. Family and friends urged her to consider termination, leaving her 'between myself and my baby', as she recalled. However, guided by her Catholic faith, she rejected abortion: 'I decided to continue my treatment, and I felt and was inspired by the foetus's vitality… Fortunately, the pregnancy and childbirth process were completed successfully.'

Family members, especially those providing direct care, play an important role in disabled women's decision-making. When Sugar was 18, her mother suggested a hysterectomy, yet 'fortunately', she said, 'my mom's friends were against the idea…I also said no because I felt that I wouldn't be a complete woman without a uterus, and I didn't want to take hormone drugs.' Conversely, when Douma was rehabilitating from her injury, an unknown caregiver once suggested to her mother that she should undergo sterilisation because, as Douma recalled the conversation, 'it would be easier to take care of me without menstruation, and it would be better for me not to have children.' But Douma told us with relief:

> My mom refused the idea; she told the care worker that my daughter didn't hurt her uterus. My mom didn't tell me this until recently, and she said it was the correct decision to make so she could have two lovely grandchildren. If she really listened to the carer worker and did something for me in secret, I wouldn't know. I was young then, so I might have obeyed because I didn't want to worry my mom.

Yes, I can do it, but I also need some support

Although the Health Promotion Administration in Taiwan provides prenatal healthcare instruction services for pregnant women during two key stages (before 17 wk and after 29 wk), our participants mainly received parental information and education from private actors and companies. Three participants attended 'Baby and Mommy Expos' and so-called 'mommy's classrooms' run by

milk powder companies and postnatal care centres. They were primarily motivated by gifts and souvenirs (such as towels, baby carriers, and nursery sets) and only secondarily by the opportunity to learn parenting skills such as breastfeeding and baby care. Some places offered yoga classes for mothers-to-be; however, Chung was politely rejected because 'they had never met any mom *like me*', and Douma knew she would not be accepted even if she wanted to.

Perceiving potential hostility based on past experiences, mothers with disabilities need mental support and representation of successful motherhood despite their impairments to handle social expectations and uninvited comments. Observing disabled women around her, Douma emphasises the importance of psychosocial support, stating that:

> There is a mother in our group chat. She is always afraid to pick up her child from school. She fears her kid will get bullied once his classmates see her. We told her to step out, but she couldn't get over it. I always wonder if there's any space or organisation for us to talk about our needs and feelings…some of us need a model to look up to, a successful example to break through. Our feelings…will affect the children and the atmosphere at home.

All interviewees received maternity subsidies from local governments, ranging from TWD 6,000 to TWD 8,000 (approximately USD 200–267), which were typically applied for at the same time as household registration for their newborns. Yu also used New Taipei City's 'Taxis-for-Pregnancy' programme, which subsidises 28 prenatal and postnatal check-ups (TWD 200 [USD 6.67] per round trip, totalling TWD 5,600 [USD 187]) *via* contracted taxi services. While accessible taxis are in place, they must be booked well in advance due to limited availability. The Health Promotion Administration offers additional subsidies for amniocentesis and certain health checkups under the Regulations Governing the Expense Reduction, Exemption, or Subsidy of Genetic Health Measures; however, the application process is reportedly complex, as Chung noted.

Indeed, as highlighted by our participants, physical changes during pregnancy can create additional challenges for women with physical disabilities, particularly affecting mobility and bodily function. Chung shared that while she had been able to move independently before pregnancy, this became harder as her abdomen grew. After slipping from her bed in the second trimester, she and her husband invited her mother to live with them to help with daily tasks. She later fell again while bathing in the final trimester. Although Chung was uninjured, her mother sustained a foot injury while helping her. Douma also reported worsening mobility as her body changed; the effort required to move often triggered uterine contractions, forcing her to rest frequently. Douma recalled that:

> Every time I moved, I had to exert force, and since I drive myself to and from work, I had to pause quite often…I used a manual wheelchair at school, and pushing it also required abdominal strength. So, I would sometimes stop by the roadside to

> rest due to contractions. If they occurred while I was driving, I had to pull over. Maybe it's the seatbelt pressing my belly – I still don't know. I'd…wait for my belly to 'soften' before setting off again.

Thus, informed by our participants' experiences, a support network that offers both complementary and substitute caretaking roles is highly helpful, and a platform that coordinates all relevant information and support for pregnant women with disabilities is necessary. Most interviewees received support from their spouses, relatives, or friends during pregnancy and childbirth. However, two participants felt there was substantial room for improvement in the existing home service assessments, particularly when human resources were scarce at home. For example, Mei completed a home service assessment before becoming pregnant; as her body changed throughout the pregnancy, the services based on the initial evaluation no longer met her needs. Mei commented that:

> During pregnancy, it would be better if I could have a hand to provide services according to my needs, which vary along with my body's changes. Prioritising these mothers' safety and preventing them from being helpless, we would get human power support in line with our demands at different stages of pregnancy. The support costs can be lessened when the child is older and when I recover. The system should be more flexible. However, the current assessment system has not evolved in this direction.

Being a mom made me nervous but stronger

The intersection of the two positions where our participants, as mothers-to-be with disabilities, were located revealed that they faced doubts, uncertainty and helplessness, yet felt empowered throughout the journey. 'Requiring and relying on lots of help from others, like getting someone to help me get off the bed…feels like falling into a black hole of depression, just because I was having childbirth,' Chung told us. For Chung, childbirth was difficult yet, surprisingly, rewarding – it showed her that she was cared for while caring for her children. Chung continued:

> My emotional state improved after a period of psychological adjustment, and I believe that there is a strong connection between mother and child. Such psychological bonding and the imagining that our bodies and fates are interconnected were important drivers and supports for me to walk out of the darkness.

It seems that having a child is not only about fulfilling the desire to form a family and meet their needs but also about fostering disabled women's capabilities, resilience and awareness of their rights, particularly concerning reproductive and child rights. As Chung shared, she experienced prejudice and mistreatment in various aspects of everyday life during her pregnancy. However, she no longer accepts such treatment after giving birth. Chung continued:

> I am now more courageous in resisting unfairness. As a mom, I should not fear; I fight. I am no longer afraid of being a mother. I will fight. If I have a second child, I will be a 'difficult customer' and won't be as obedient as before. Being experienced now, I don't think I should accept their so-called 'standard' services and play along.

When Mei took her child to the health service centre for vaccination, the staff asked her to wait on the ground floor while others took their child to the second floor for shots, where no elevator was available. Mei wanted to stay with her baby and be part of the important moment, so she wrote to the mayor's office requesting that vaccination services be provided on the ground floor. Although she received a positive response, she continued to encounter the same situation until she showed the staff the message from the mayor's office. This shows her persistence and highlights how a mother with disabilities must 'patiently' yet 'exhaustedly' advocate for something basic to be a fit, as Mei recounted.

Sugar also reflected on the Chinese proverb, that 'one becoming a mother becomes strong' (*wèi mǔ zé qiáng* [為母則強]). She deeply appreciates her mother's courage and strength, understanding the challenges she had faced 'raising a daughter like me, who was born with deformities,' Sugar said. Similarly, Douma shared how she actively and happily participates in her children's school life, sometimes volunteering on campus. She shares her life experiences with school children to help them understand and appreciate people with disabilities better, hoping to change society's perceptions of disability and overturn the images of misery and pity. Accepting her 'imperfect body' as part of her identity but not as a 'disabled woman', Douma said:

> As a 'mommy volunteer', the kids have become used to seeing and talking to me. Then, they are not afraid anymore and won't make a big deal about or tease a person in a wheelchair. They think I just changed my way of walking after the car accident. We don't have to look as sick as they find in a hospital; people like me also make jokes and are fun to be with.

Motherhood affects a woman, whether she has a disability or not, but perhaps in different ways. While pregnancy often makes people feel markedly different from their former selves, what moved Mei most was witnessing the birth of her daughter, the moment she realised she truly could become a mother – 'It was transformative,' she reflected. Mei shared the ups and downs of her life, noting that she had been committed to independent living initiatives before becoming pregnant, including those related to illness, medicine and surgical issues, which made reproduction seem less terrifying and impactful. Mei said:

> I didn't feel much about it [pregnancy]. It was more like another issue with my movement. It was only when the child was born and alive in front of me that I slowly realised that I have the responsibility as a mother. In the past, I even went

> for surgery alone, not because my parents didn't care, but because I didn't need anyone else to take care of me just for that. Since my husband had been in Japan, I had mostly gone to prenatal checkups alone, so I'd got used to it. Nothing could really surprise me, but a baby hugely changed my life!

Interestingly, Mei believes that pregnant women with physical disabilities may have several 'unexpected advantages' over those who have never used a wheelchair or assistive devices. 'When we couldn't move easily during pregnancy…at least we sat in a wheelchair, so we didn't need to bear all the weight,' Mei explained. Disabled people are also more familiar with mapping where to find barrier-free facilities and accessible routes, knowledge that non-disabled women may lack until they encounter mobility challenges. Finally, Mei noted, 'we are used to seeking and asking for help from others, but many people can feel embarrassed or be too shy to do so if they have never had to'; on this matter, she recounted:

> A good friend of mine, who had severe 'morning sickness' [nausea and vomiting of pregnancy], even had to eat, drink, defecate, and stay in bed for a while…She said, 'I finally understand how hard you've been going through – physically and psychologically.' Her husband looked upset when asked for help. It wouldn't concern me. I'm used to asking for support. I don't ask for more than I need, but I must, especially if necessary.

Discussion and conclusions

This study conducted in-depth interviews with six women with physical disabilities who had given birth in the past decade. All expressed a desire to become mothers and believed they were both entitled and capable, despite dominant social perceptions linking disability with infertility and incompetence. Those presumptions stem from traditional gender norms that define women primarily as caregivers rather than care recipients (Huang 2021). Such ableist beliefs undermined these women's capacity to envision motherhood and created barriers to pursuing parenthood (O'Connor-Terry and Harris 2022). As Garland-Thomson argues, the 'normate' figure not only governs the lives and bodies of disabled women but also constrains 'the imaginations of those who think of themselves as non-disabled' (Garland-Thomson 2005, 1567):

> Stereotypical, often unexamined narratives ultimately undergird exclusionary environments, employment discrimination and social marginalization. Women with disabilities, even more intensely than women in general, have been cast in the collective cultural imagination as inferior, lacking, excessive, incapable, unfit, and useless (*ibid.*)

Paradoxically, when women with disabilities in Taiwan choose to marry or have children, they may still encounter patriarchal expectations such as continuing the family line or bearing sons. These pressures often stem from

their husbands' families (Kuo 2020b), particularly through power dynamics involving mothers-in-law (Lin 2005). This reflects the persistent influence of patriarchal norms, including the expectation that daughters-in-law assume caregiving responsibilities for extended family members – especially parents-in-law – a pattern common across East Asia (Chou and Lu 2011; Liang 2023; Lung et al. 2021).

Indeed, our interviewees' pursuit of pregnancy reflects broader social change among people with disabilities, shaped by the rights discourse of independent living and the realities of everyday co-dependence (Chou, Chen, and Lin 2023). Sometimes, they employ 'disidentification' as a strategy – disowning the subject position of 'disabled woman' and actively rejecting imposed expectations (Egner 2018; Lee 2022; Thorneycroft 2024). This, however, does not imply a rejection of their embodied physicality or its relation to the world (Watermeyer and McKinney 2022). Their bodily boundaries (mapped and remapped), capacities, and limitations shape their feelings, needs, perceptions of time and space, and identities – not always joyfully, but as part of who they are (Garland-Thomson 2014).

Our participants were pleasantly surprised and simultaneously anxious after learning of their pregnancy. Echoing previous studies, participants expressed concern about anticipated – and at times actual – hostility and doubt from others, which demanded additional emotional labour and self-justification (Kuo 2020a). For those with congenital conditions, the fear of passing on genetic disorders was especially pronounced (Kuo 2020b). Even when conditions like SMA type III are recessive and detectable through prenatal testing (D'Amico et al. 2011), anxiety persists during and after the testing process. This enduring, though perhaps ungrounded, worry reflects the burden of 'genetic responsibility' placed on women with disabilities. Such concerns focus on the possibility of transmitting a condition and any health-related uncertainty that might affect the child (Raspberry and Skinner 2011).

Taking genetic factors into account is always seen as a responsible and moral act to prevent the birth of children with diseases or impairments. The emphasis on risk management implicitly reflects internalised eugenic and ableist ideologies – namely, the belief that it is better not to have a condition leading to disability. It denies the dignity of disabled people and reinforces their marginalisation (Boardman and Hale 2018; Mintz, Stramondo, and Tabor 2024). Differing attitudes towards prenatal screening among Mei, Chung, and Sugar illustrate that decisions about disability and pregnancy are not purely rational. Rather, they are shaped by complex emotions and moral dilemmas, grounded in each woman's relationship to disability identity and their lived experiences of stigma and social exclusion (Boardman and Hale 2018).

The omission of certain prenatal examinations, such as urine tests reported by our interviewees, can jeopardise the reproductive health of women with physical disabilities. Urine testing is a routine component of prenatal care,

used to detect conditions such as gestational hypertension, preeclampsia, and urinary tract infections (UTIs) (ACOG 2020, 2023). While hypertension can be identified through other means, urine culture remains vital for diagnosing UTIs, particularly asymptomatic bacteriuria. These omissions underscore the urgent need for clinical guidelines in obstetrics and gynaecology to ensure equitable prenatal care for women with disabilities (Long-Bellil, Valentine, and Mitra 2021; Long-Bellil et al. 2017). Such guidelines should include clear explanations and health education on necessary adaptations to standard procedures, reducing uncertainty during pregnancy.

Inadequate infrastructural support during pregnancy was a common experience among our interviewees, aligning with the conclusions and recommendations of Taiwan's second CRPD review and the fourth CEDAW (Convention on the Elimination of All Forms of Discrimination Against Women) state report review. While IRCs acknowledged government efforts, such as incentivising hospitals to improve facilities, significant gaps remain, including limited access to appropriate equipment and information and a shortage of trained personnel for sexual and reproductive healthcare for women with disabilities (Executive Yuan 2022a, 2022c). Even where adjustable equipment is available, health professionals may lack the knowledge to operate it, highlighting the need for reasonable accommodations and targeted training to ensure accessible, equitable care – a need also identified by Camilleri Zahra (2023) in the Maltese context.

Difficulty in body repositioning is another commonly shared experience; therefore, capacity-building for assistive/supportive workers, as well as the provision of relevant devices and technologies, is crucial for creating safer clinical and home environments to prevent falls. That is, as Garland-Thomson (2014) eloquently argues, 'a misfit occurs when the environment does not sustain the shape and function of the body that enters it', the moment when one's bodymind encounters the world, which is built and arranged to *fit* the majority's 'normate' bodyminds, and feels its limits both physically and tempo-spatially (Garland-Thomson 2011).

Compared to a decade ago (Kuo 2020b), online resources have expanded, and the quality of information has improved. Although health professionals often lack understanding of disability experiences, contributing to anxiety and discomfort in healthcare settings (Tarasoff 2017), our interviewees noted improvements in doctor-patient communication. Professionals have become more willing to respect their self-assessments and preferences regarding prenatal care. Decision-making, however, remained heavily influenced by parents and caregivers, who, consistent with Horner-Johnson et al. (2022), sometimes acted as gatekeepers, restricting what disabled women were 'allowed' to want, yet also helped negotiate with medical staff or assisted with childcare. While sterilisation was not central to our participants' experiences, its legal framework remains problematic (Su and Lee 2025). Overall, healthcare appears to have become more inclusive in some respects, but systemic barriers persist.

Bodily changes during pregnancy compel mothers-to-be to confront both environmental barriers and internal psychological struggles – the 'devil from within' (*xīn mó* [心魔], Lee 2023). Prior studies highlight the lack of adequate psychosocial support for pregnant individuals with disabilities (Iezzoni et al. 2017; O'Connor-Terry and Harris 2022). Our findings highlight the significance of peer support in promoting self-confidence and mental well-being. Networks built on trust and shared strategies for negotiation and coping remain valuable even after childbirth (Becker et al. 2021). Yet such support often depends on personal connections and access to more accommodating private-sector reproductive health services, indicating the inadequacy of publicly funded programmes and the urgent need for policy and infrastructural reform.

Remarkably, the idea of becoming a mother and the reality of being a mother have made women with disabilities tougher and more resilient to the challenges faced by them and their children. Motherhood has empowered these women to integrate further into society and to contest and oppose stereotypes and prejudices against themselves and their children. As mentioned previously, mothers with disabilities redefine the concept of independent living beyond an individualistic focus (Chou, Chen, and Lin 2023) by relationally, unabashedly inconveniencing and being inconvenienced by others – namely, by accepting the mutual inconveniences out of care (Berlant 2022). Acknowledging interdependence with other individuals and things allows for the emergence of a support and care network that, paradoxically, might not be available or accessible to 'non-disabled' mothers-to-be and mothers.

Although the small sample size limits the generalisability of this study, our interviewees' stories reveal their desire for lives with children and how they navigated opportunities and removed obstacles, offering insights for disability-gender activism (Wilde and Fish 2025). Moreover, inaccessible maternity-related healthcare and support, along with ableist and patriarchal ideologies, hindered their exercise of reproductive health and rights. This highlights the urgency of transforming unjust reproductive health arrangements and ensuring meaningful participation of women with disabilities in policy-making to express their needs and challenge discriminatory environments (Chou, Kuo, et al. 2020). As Taiwan has integrated global women's and disability rights norms into its legal and policy frameworks, reproductive rights should be exercisable and realised in practice, particularly when informed by the realities lived by women with disabilities, to ensure that no one is left behind.

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Author contributions

CRediT: **Chong-Min Su**: Conceptualization, Data curation, Formal analysis, Investigation, Methodology, Project administration, Validation, Writing – original draft, Writing – review & editing; **Po-Han Lee**: Conceptualization, Data curation, Formal analysis, Funding acquisition, Methodology, Resources, Supervision, Validation, Writing – original draft, Writing – review & editing.

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