

Pregnancy as an Embodied Experience: Cultural Construction, Body Politics, and a Cross-Cultural Autoethnography of China and Canada

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Abstract

Pregnancy is commonly understood as a biological and medical process, yet women's lived experiences of pregnancy are profoundly shaped by institutional arrangements, social relations, and cultural discourses. This article adopts a cross-cultural and reflexive autoethnographic approach to examine how pregnancy is socially and communicatively constructed in China and Canada. Focusing on medical systems, family practices, and discourses of motherhood, the study analyzes how different governance logics shape pregnant women's embodied experiences and gendered subjectivities.

The analysis shows that pregnancy in China is embedded in a highly medicalized and family-centered framework that emphasizes risk prevention and collective responsibility. Pregnant

bodies are simultaneously positioned as objects of protection and regulation through intensive

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prenatal surveillance and everyday familial interventions. In contrast, pregnancy in Canada is shaped by a model of limited medical intervention and individualized responsibility, which foregrounds bodily autonomy and emotional well-being while governing through self-management and uncertainty. From the perspective of body politics and gendered health communication, this study argues that pregnancy is not a purely physiological condition but a culturally mediated and politically situated embodied experience. By foregrounding pregnancy as a site of everyday body politics, the article contributes to feminist health communication and medical humanities scholarship on gender, care, and subjectivity.

Keywords: pregnancy; embodiment; body politics; discourses of motherhood; gender and health communication; cross-cultural comparison

1. Introduction

Over the past two decades, global maternal and child health governance has gradually shifted from a biomedical paradigm focused primarily on reducing mortality rates toward a more comprehensive framework that emphasizes maternal mental health, subjectivity, and quality of life (World Health Organization, 2016). Yet the pregnant body—how it is understood, managed, and experienced—is never determined by biology alone. Rather, it is deeply embedded in institutional logics, family structures, cultural discourses, and patterns of resource distribution within specific societies.

Based on the author's lived experiences of pregnancy and childbirth in Canada, combined with long-term observation and comparison of prenatal care practices in China, this article adopts an ethnographic and autoethnographic approach to explore the *cultural construction of embodied experience*. It asks why the same pregnant body may be associated with markedly different perceptions of risk, reassurance, and agency across social contexts.

In China, pregnancy is commonly situated within a governance structure characterized by institutionalization, high-frequency monitoring, and conservative risk thresholds. From the establishment of the Maternal and Child Health Handbook to dense regimes of imaging and laboratory testing, and to the intensive involvement of family members—especially older generations—in everyday care and regulation, pregnant women are both carefully protected and

continuously reminded of potential risks. A typical metaphor circulating in online discourse is that “prenatal checkups are like exams,” with results framed as “passing” or receiving a “green light.”

In contrast, medical practice in Canada places greater emphasis on limited intervention, individual choice, and emotional care. Clinicians often encourage pregnant women to “be yourself,” and pregnancy is not automatically treated as a special or fragile condition in everyday social life. Pregnancy tends to retain continuity with ordinary life as that of a “normal person.” At the same time, this model may expose new forms of uncertainty when medical resources are constrained or when family support is limited.

This article advances the central argument that pregnancy is not a singular biological process, but a form of body politics and gendered practice repeatedly encoded by different institutional and cultural arrangements.

Core research question: How is the pregnant body culturally constructed?

To address this question, the article develops its analysis along three interrelated dimensions. First, at the medical and institutional level, it examines how prenatal care systems—through examination frequency, risk thresholds, and the allocation of medical resources—define and regulate bodily “normality” and “abnormality.” Second, at the social and relational level, it explores how families, intergenerational care practices, social discourse, and doctor–patient interactions shape pregnant women’s self-understanding and everyday practices. Third, at the cultural and discursive level, it analyzes how pregnancy-related metaphors, such as “passing

checkpoints” or “be yourself,” together with broader gendered discourses, contribute to the production and circulation of meanings and values attached to women’s bodies.

2. Theoretical Framework

Pregnancy as an embodied experience is not merely a biological process, but a *culturalized body* shaped by institutions, cultural norms, and social relations (Van Teijlingen & Hundley, 2002). To understand differences between pregnancy experiences in China and Canada, this study draws on theories from the sociology of the body, medical anthropology, and gender studies to construct the following analytical framework.

2.1 The Social Construction of the Body

The body is not a purely natural entity; it is continuously constructed through medical discourse, social norms, and cultural practices. Foucault (1978) provides a critical lens for understanding how medical systems shape pregnant bodies through surveillance, discipline, and risk management. In the Chinese context, frequent prenatal examinations and strict diagnostic thresholds exemplify the operation of biopolitics in the field of reproduction.

At the same time, sociological approaches to the body emphasize that the body is a key site of social control and cultural meaning. During pregnancy, women’s diets, physical activities, and everyday behaviors are often subjected to normative scrutiny. Thomas Csordas’s concept of *embodiment* further reminds us that pregnant women are not passive recipients of cultural regulation. Through perception, practice, negotiation, and occasional resistance, they actively experience and reproduce bodily meanings in everyday life.

2.2 Medical Ethnography and Cross-Cultural Comparison

This study adopts autoethnography as its primary methodological approach. By documenting lived experiences of pregnancy and childbirth in Canada and juxtaposing them with medical practices and social experiences in China, the article develops a thick description of pregnancy as an embodied and communicative process.

Medical ethnography emphasizes the observation of bodily experience as it is generated through everyday interactions and micro-level practices. For example, prenatal checkups may be metaphorically framed as “passing checkpoints,” while clinicians may use expressions such as “be yourself” to alleviate anxiety. These communicative moments reveal how medical knowledge and care are translated into lived experience (Csordas, 1990).

Cross-cultural comparison enables the study to reveal how the same physiological processes acquire different meanings across cultural contexts. In China, the body is often defined as fragile and in need of close monitoring; in Canada, the body is more commonly treated as capable and trustworthy. Such contrasts illuminate how cultural assumptions shape perceptions of risk, safety, and bodily competence.

2.3 Gender and Body Politics

Pregnancy is inseparable from gender politics. Judith Butler’s theory of *gender performativity* suggests that behaviors during pregnancy—such as passively accepting care or actively maintaining physical activity—are not merely health-related choices, but performances through which gender identities are enacted and reproduced (Butler, 1990). Foucault’s concept of *body*

politics further reveals that the pregnant body does not belong solely to the individual, but is also claimed by the state, medical institutions, and the family, becoming embedded in the intersection of population policy, risk governance, and family ethics (Foucault, 1978).

Discourses of motherhood refer to a normative system of meanings surrounding what constitutes a “good mother,” a concept widely discussed in feminist and body studies. The focus of such discourses lies not in what mothers are, but in how they are expected to act, feel, and manage their bodies. Research has shown that motherhood is not a natural outcome, but a gendered role continuously produced through the interaction of medical knowledge, family ethics, and social values. By emphasizing responsibility, sacrifice, emotional investment, and bodily regulation, discourses of motherhood bind women’s bodies to moral evaluation, making pregnancy a critical moment when maternal norms intervene in advance (Hays, 1996).

From this perspective, discourses of motherhood take different forms in China and Canada. In the Chinese context, motherhood discourse emphasizes sacrifice, caution, and protection, framing the pregnant body as an object requiring strict management and regulation. In Canada, motherhood discourse is more closely associated with self-care, mental health, and subjectivity, emphasizing the legitimacy of women’s bodily perceptions and agency. These discursive differences shape how pregnant women interpret bodily discomfort, risk, and emotional experience, and position pregnancy as a key site where gender identities are continuously performed and reproduced.

Through this framework, the article seeks to answer its central question:

How is the pregnant body culturally constructed in China and Canada?

3. Methodology

3.1 Research Design

This study adopts a research design that combines autoethnography with cross-cultural comparison. Autoethnography enables the researcher to situate her own pregnancy experience within the field of inquiry and to examine how pregnant bodies are constructed at the intersection of medical systems and cultural norms through embodied and reflexive analysis. Cross-cultural comparison, in turn, makes visible the differences produced by distinct institutional and cultural arrangements, preventing the experience of any single system from being treated as universal.

By integrating these two approaches, the study seeks to illuminate how pregnancy is differently experienced, governed, and interpreted across social contexts, while remaining attentive to both structural conditions and lived bodily experience.

3.2 Autoethnography

Autoethnography is an extension of ethnographic methodology that treats the researcher's own lived experience as a source of data. Through narrative and reflexive writing, autoethnography reveals cultural meanings embedded in everyday life (Ellis & Bochner, 2000). In this approach, personal experience itself constitutes the field site: the researcher is simultaneously the subject of narration and the object of analysis. Autoethnography values detailed, ordinary experiences while examining how they reflect and are shaped by broader cultural contexts.

3.2.1 Researcher Positionality

In this study, the researcher experienced pregnancy and childbirth in Canada while maintaining long-term familiarity with pregnancy-related practices and discourses in China. This dual positionality provides a natural vantage point for cross-cultural comparison.

It is important to note that the researcher's role is not that of a neutral observer, but of a situated subject with a clearly defined positionality. The researcher occupies three intersecting positions. First, as an individual who has lived extensively within the Chinese cultural context and is deeply familiar with local prenatal systems, she possesses an internalized understanding of medical regulation and family-based discipline in China. Second, as a woman who experienced pregnancy and childbirth within the Canadian public healthcare system, her embodied experience is shaped by North American medical practices and Western discourses of motherhood. Third, as a researcher, she seeks to translate embodied experience into an analyzable cultural text.

This layered positionality offers a distinctive perspective for cross-cultural analysis, enabling the researcher to apprehend how both discipline and empowerment operate differently across contexts. At the same time, it also means that the researcher's perceptions are inevitably influenced by cultural expectations, emotional states, and identity transitions associated with pregnancy. Accordingly, this study does not treat the researcher's experience as a representative sample. Rather, it is understood as a culturally charged slice of experience through which institutional and cultural forces can be traced as they are perceived, negotiated, and internalized at the bodily level. Reflexive awareness of positionality is therefore central to the analytical strategy of this article.

3.2.2 Data Sources

The primary data sources for this study include:

- a. Personal pregnancy journals and daily records documenting prenatal checkups, medical encounters, travel, dietary practices, and emotional fluctuations.
- b. Records of interactions with family members, physicians, and nurses, including verbal communication, nonverbal cues, and patterns of interaction within doctor–patient relationships.
- c. AI-assisted consultation records (e.g., ChatGPT), used only as a reflective and linguistic support tool during the research process rather than as primary data for analysis, which reflect the researcher’s ongoing concerns and reflections regarding risk, emotional well-being, and cross-cultural differences in medical practice during pregnancy.

3.3 Cross-Cultural Comparison

Cross-cultural comparison is employed to examine how pregnancy is structured and experienced differently across institutional and cultural settings. The analysis focuses on three key dimensions: differences in medical systems, including prenatal examination frequency, diagnostic thresholds, and the allocation of medical resources; variations in doctor–patient relationships, particularly in terms of interaction styles, information delivery, and emotional support; and the role of social and family environments, encompassing intergenerational care practices, social discourse, and expectations surrounding the role of pregnant women.

The comparative analysis draws on multiple sources of data. These include prenatal care guidelines and regulations issued by the National Health Commission of China, as well as *Baby’s*

Best Chance, the official prenatal and postnatal health guide published by the Government of British Columbia in Canada. In addition, materials from online pregnancy communities and experience-sharing platforms in both countries are incorporated, together with existing academic literature and findings from medical anthropology and related fields, in order to provide a more comprehensive and contextually grounded analysis.

3.4 Data Collection and Analytical Methods

The study employs the following analytical methods:

a. **Thick description:** Drawing on Clifford Geertz’s methodological approach, detailed contextual descriptions are used to reveal the cultural meanings embedded in embodied pregnancy experiences.

b. **Discourse analysis:** Pregnancy-related discourses—such as the metaphors of “green lights” or “passing checkpoints” in China, and encouragements like “be yourself” in Canada—are analyzed to examine how perceptions of risk and subjectivity are constructed.

c. **Comparative analysis:** Institutional norms and personal experiences in China and Canada are placed side by side to illuminate how culture and governance shape bodily experience.

3.5 Research Ethics

All cases discussed in this study are based on the researcher’s own experiences and publicly accessible policy documents and online texts. No private or sensitive information concerning other individuals is involved.

4. The Embodied Construction of Pregnancy in China

4.1 Prenatal Medical Systems and Institutionalized Management

In China, pregnancy is commonly embedded within a highly institutionalized and medicalized system of management. From early pregnancy onward, women typically establish a *Maternal and Child Health Handbook* through community clinics or hospitals. This handbook not only records examination indicators but also serves as the basis for prenatal risk stratification and referral. According to guidelines issued by the National Health Commission, pregnant women are required to complete at least 8–11 systematic prenatal examinations throughout pregnancy, including routine physical assessments, blood and urine tests, infectious disease screening, and multiple ultrasound examinations. For those identified as high-risk, additional follow-up visits and case-based management are implemented (National Health Commission of the People’s Republic of China, 2018).

This institution-centered model of continuous care produces a management logic characterized by “full coverage” and “zero omission.” From the moment pregnancy is confirmed, women enter a dense network of medical surveillance, and the prenatal examination schedule becomes a key temporal reference structuring everyday life during pregnancy.

4.2 Imaging Practices and Visualized Reassurance

Imaging practices constitute a particularly salient aspect of pregnancy experience in China. Early pregnancy ultrasounds are typically conducted at 6–8 weeks to confirm intrauterine pregnancy and fetal heartbeat, followed by nuchal translucency (NT) screening at 11–14 weeks. The

mid-pregnancy anatomical ultrasound at 20–24 weeks is widely regarded as a critical milestone, while additional scans assessing fetal growth, amniotic fluid volume, and fetal position are often recommended after 28 weeks. In practice, many large hospitals and families voluntarily increase the number of ultrasound examinations to obtain psychological reassurance.

In urban obstetric clinics, long queues outside ultrasound rooms are a common sight. Family members often accompany pregnant women, hoping that physicians will “take another look” or “double-check.” Women frequently share ultrasound images and the physician’s notation of “normal” immediately within family chat groups or social media platforms. Within this cultural context, ultrasound functions not only as a diagnostic tool but also as a form of *visualized reassurance*. Repeated imaging confirmations help mitigate uncertainty and anxiety during pregnancy.

4.3 Laboratory Indicators and Risk Management Practices

Heightened sensitivity to risk is also evident in the management of laboratory indicators. Gestational diabetes mellitus (GDM) screening offers a representative example. Chinese guidelines commonly adopt a one-step 75-gram oral glucose tolerance test (OGTT), conducted between 24 and 28 weeks of gestation. Diagnostic thresholds are relatively conservative: GDM is diagnosed if any one of the following criteria is met—fasting plasma glucose ≥ 5.1 mmol/L, 1-hour glucose ≥ 10.0 mmol/L, or 2-hour glucose ≥ 8.5 mmol/L.

Once diagnosed, pregnant women are typically enrolled immediately in dietary regulation and exercise management programs, with insulin therapy prescribed in more severe cases. This

means that even mild deviations in laboratory values are incorporated into a clearly defined framework of risk management. In obstetric laboratory areas, women hold time cards and undergo repeated blood draws according to the “0-minute, 1-hour, and 2-hour” sequence. In waiting areas, they exchange dietary strategies for glucose control and scroll through short-video platforms and online forums offering advice on “how to pass the glucose test.”

In this process, numerical thresholds cease to function merely as medical standards and become embedded in everyday life, shaping dietary records, exercise routines, and emotional self-regulation. Risk management thus extends from clinical spaces into daily practices.

4.4 Family Involvement and Everyday Life during Pregnancy

Parallel to the intensive management of the medical system is the significant role played by family and society in pregnancy. In China, pregnancy is rarely understood as an exclusively individual experience; rather, it is commonly treated as a “family-wide” event. For many women, this translates into enhanced support during pregnancy, including shared household labor, preparation of specialized meals, accompaniment to prenatal appointments, and, to some extent, restrictions on physically demanding work and travel.

Mothers or mothers-in-law often assume the roles of “nutritionists” and “supervisors.” They formulate dietary plans, emphasize avoiding “cold” foods, encourage soup consumption, and advocate reduced salt and spice intake. They repeatedly caution against lifting heavy objects, climbing stairs, or leaving home frequently. Emotional regulation is also emphasized, with reminders such as “don’t get angry—it’s bad for the baby.” These forms of guidance are typically

justified in the name of fetal well-being, making them difficult to refuse emotionally. Many women recall being placed at the center of family attention during pregnancy, experiencing an intensified form of care and concern.

4.5 Role Transitions and Social Expectations during Pregnancy

Such care, however, is accompanied by ongoing regulation. Ethnographic accounts and lived experiences indicate that pregnant women are often encouraged to relinquish previous social roles and daily rhythms, gradually reorganizing life around pregnancy. Some women are advised to reduce work or social engagement during early pregnancy, while in later stages they may be discouraged from going out alone and increasingly treated as requiring assistance.

Within this context, notions such as “full-time pregnancy” or “quitting work to focus on pregnancy” evolve from individual choices into normative social expectations. These ideas are repeatedly reproduced through family persuasion, online experience sharing, and maternal platforms, often justified through discourses of “being responsible for the child,” “safety first,” and “better safe than sorry.” For some families, such arrangements are taken for granted; in contexts of limited resources, however, they may have long-term implications for women’s career continuity and economic autonomy.

4.6 Summary

Overall, pregnancy experience in China unfolds through the intersection of highly institutionalized medical management, intensive risk monitoring, and deep family involvement in everyday life. From early registration onward, pregnant women enter a system structured around examination

schedules, diagnostic thresholds, and risk stratification. Ultrasound images, laboratory data, and follow-up records not only serve as the basis for medical judgment but also become central reference points through which women understand their bodily states. Pregnancy is thus segmented into a series of checkpoints requiring timely completion and repeated confirmation, with progress validated through assessments of “normality” and “compliance.”

Within this process, the pregnant body is first constructed as an object requiring protection. Dense prenatal schedules, repeated imaging confirmations, and family accompaniment provide reassurance and support, enabling women to feel valued and emotionally sustained. Family involvement in meal preparation, household labor, and emotional care transforms pregnancy into a collectively supported experience rather than an isolated individual condition.

At the same time, such protection is not neutral. As medical institutions and family care increasingly intervene, the pregnant body also becomes an object of regulation. Under discursive frameworks emphasizing “fetal safety,” dietary choices, mobility, emotional expression, and social participation are continuously regulated. Everyday life is gradually reorganized around risk prevention and safety considerations, while prior routines and social roles are partially suspended. Protection and regulation thus operate simultaneously, intersecting in lived experience.

As a result, pregnancy experience in China is characterized by an internal tension. Women receive careful attention and concentrated care, while also adapting to behavior expectations centered on safety and risk avoidance. They experience emotional recognition alongside the internalization of bodily restraint and self-management. Pregnancy becomes a highly socialized

embodied experience in which the pregnant body both carries familial hopes for the future and remains subject to ongoing normative regulation.

It is within this dual structure of *being protected and being regulated* that the bodily experience and identity of pregnant women in China take shape. This experiential configuration provides a clear empirical reference for the subsequent comparison with pregnancy experiences in the Canadian context and lays the groundwork for further discussion of how embodied experience is culturally constructed across societies.

5. The Embodied Construction of Pregnancy in Canada

In my experience of pregnancy in Canada, the most striking difference lies in the fact that neither the medical system nor the broader social environment automatically equates pregnancy with “risk” or “fragility.” Instead, pregnancy is framed through a logic that emphasizes women’s subjectivity and continuity of everyday life (Government of British Columbia, 2020). As a result, my embodied experience took on a form markedly different from what I had imagined based on pregnancy practices in China.

5.1 Medical Resources and Prenatal Care Systems

In Canada, the frequency of ultrasound examinations is remarkably low. Throughout my entire pregnancy, I underwent only one anatomical survey ultrasound at 20 weeks. This stands in sharp contrast to the Chinese context, where ultrasound imaging is often arranged at nearly every prenatal visit. In late pregnancy, when my physician suspected at 36 weeks that fetal growth had

stalled for two weeks and expressed concern about reduced amniotic fluid, she immediately issued a referral for an ultrasound. However, the appointment was not scheduled until 39 weeks.

During those three weeks, I repeatedly questioned whether fetal growth had indeed ceased and whether amniotic fluid levels were dangerously low, yet I was unable to obtain reassurance through imaging as I might have in China. When the ultrasound was finally performed at 39 weeks, it revealed that the fetal head size corresponded to more than 41 weeks of gestation. Nevertheless, the physician responded calmly, saying, “It’s okay.” Only after delivery did I fully grasp the practical consequences of this “unattended risk.” Labor progressed for over two and a half hours without descent of the fetal head, and delivery was ultimately completed using forceps. The infant weighed over eight pounds, a substantial discrepancy from the physician’s earlier manual estimate.

This experience made me acutely aware that the Canadian healthcare system oscillates between avoiding excessive medicalization and being constrained by limited medical resources. My embodied experience was shaped precisely within this tension.

5.2 Prenatal Procedures and Risk Management

Differences in risk management were particularly evident in glucose monitoring practices. Following standard Canadian procedures, I underwent a 50-gram oral glucose challenge test (GCT) at 24 weeks. After receiving a normal result, my physician informed me that there was no need to proceed with a 75-gram oral glucose tolerance test (OGTT) or to engage in further monitoring.

From the medical perspective, my body was considered capable of maintaining metabolic balance naturally.

However, informed by my familiarity with the strict blood glucose management protocols common in China, I chose to continue self-monitoring of blood glucose (SMBG) at home. When repeated measurements showed fasting glucose levels between 5.2 and 5.6 mmol/L, anxiety quickly followed. In the Chinese context, such values might prompt a diagnosis of gestational diabetes and the imposition of dietary restrictions. In the eyes of Canadian physicians, by contrast, these fluctuations were considered normal. They reassured me by saying, “You are fine—be yourself.”

At that moment, I realized that the same numerical value carries radically different interpretive power across cultural contexts. In China, it signals potential danger; in Canada, it affirms bodily self-regulation and trust.

5.3 Doctor–Patient Relationships and Emotional Support

Prenatal care in Canada operates within an appointment-based system, where long queues are rare and healthcare providers remain relatively consistent throughout pregnancy. This institutional design avoids the overcrowding commonly seen in Chinese hospitals and fosters a sense of calm and predictability. More importantly, doctor–patient relationships extend beyond the management of clinical indicators.

At approximately 30 weeks of pregnancy, I experienced emotional distress and expressed a desire to travel. Expecting cautionary advice, I was surprised when my physician encouraged me,

saying that I should do things that made me happy. I subsequently drove eight hours to Banff National Park and even visited a glacier. Upon returning to the clinic, both the physician and the nurses were aware of my trip and asked enthusiastically about my experience. For the first time, I felt that medical professionals were not merely monitoring my bodily indicators, but were engaging with me as a whole person living a concrete, meaningful life.

Postpartum, the healthcare system even initiated follow-up through letters and phone calls to conduct postpartum depression screening. This institutionalized attention to psychological well-being reinforced my sense that pregnancy in Canada is treated not only as a biological process, but also as a social and emotional event requiring sustained care.

5.4 Family and Social Environment

Existing studies on pregnancy and early parenthood in Canada suggest that while intergenerational involvement tends to be less intensive, support is often reconfigured through partner-based care and broader community and healthcare resources. Research has shown that expectant fathers and partners play an increasingly important role in providing emotional and practical support during pregnancy, reflecting a shift toward more egalitarian and individualized family structures (Deave et al., 2008; Plantin et al., 2011). At the same time, large-scale national data indicate that Canadian maternal care is embedded within a system of distributed support, in which public healthcare services, prenatal education programs, and community-based resources partially substitute for intensive family involvement (Public Health Agency of Canada, 2009).

Within this context, pregnancy is less likely to be organized as an intergenerationally managed family event and more often unfolds as a combination of partner-supported care and institutionally mediated assistance. This configuration reflects a broader socio-cultural orientation toward individual responsibility, self-management, and the normalization of pregnancy as part of everyday life, rather than a condition requiring continuous collective supervision.

Within the Canadian social environment, I was not treated as someone requiring special protection. I maintained a routine of walking 10,000 steps daily, participating in prenatal fitness classes two to three times per week, and continuing to work and study. People around me rarely expressed excessive concern. Apart from one encounter at 40 weeks—when a mother walking with her newborn in a park remarked with surprise, “You are the fastest pregnant woman I’ve ever seen”—I encountered little social special treatment.

This social atmosphere enabled me to sustain a self-perception of “non-specialization”: pregnancy did not equate to weakness, nor did it necessitate exceptional protection. At the same time, because both sets of parents lived in China, my husband and I managed pregnancy almost entirely independently, free from intergenerational supervision and intervention. This distance allowed me to construct my pregnancy experience based on personal perception and judgment rather than traditional taboos or familial regulation.

In contrast, I was keenly aware that pregnancy in China often unfolds under continuous guidance from older family members, where diet, exercise, and even emotional expression are subject to ongoing commentary. In Canada, my pregnancy experience unfolded primarily as a form of *self-narrative*; in China, pregnancy is more commonly written as a *family narrative*.

However, the absence of intergenerational care also brought challenges. Without parental support, my husband and I assumed full responsibility for daily management of pregnancy. While this granted freedom from traditional restrictions and allowed flexible lifestyle choices, it also meant a lack of routine nutritional guidance and care. During early and mid-pregnancy, I continued to cook for myself and often did not strictly adhere to pregnancy-specific dietary recommendations, frequently consuming high-fat, high-sodium foods, including instant noodles and other convenience foods.

By contrast, had I been pregnant in China, older family members would likely have intervened extensively in my diet, emphasizing reduced salt and spice intake, increased protein consumption, and avoidance of “cold” foods. In this sense, dietary flexibility in the Canadian context also reveals another side of dimension of autonomy and responsibility: pregnant women must assume greater responsibility for their own health management rather than relying on collective family regulation.

Thus, pregnancy experience in Canada can be understood as a double-edged sword. On the one hand, women gain autonomy and ease, avoiding excessive protection and regulation; on the other hand, the absence of intergenerational care may reduce certain forms of health safeguarding. This contrast highlights how cultural norms and family structures profoundly shape everyday life and the embodied construction of pregnancy.

5.5 Summary

Overall, my pregnancy experience in Canada reflects a logic centered on limited intervention, emotional care, social equality, and individual autonomy. The medical system relies less on intensive monitoring and places greater trust in the body's capacity for natural regulation. Physicians function not only as risk managers, but also as sources of emotional support and companions in everyday life. Within the broader social environment, pregnancy is not excessively special-marked, allowing women to retain the social role of "normal persons." Meanwhile, the physical distance from extended family creates conditions for the emergence of self-authored pregnancy narratives.

Together, these factors construct an experiential model in which pregnancy is integrated into life rather than set apart from it. The body is understood as capable, trustworthy, and autonomous.

At the same time, this model is not without limitations. Limited access to ultrasound examinations and constrained medical resources may delay the identification of potential risks, while understated attention to danger can increase uncertainty during labor. Pregnancy experience in Canada thus continually oscillates between empowerment and autonomy on the one hand, and delay and risk on the other.

This logic stands in clear contrast to the Chinese pregnancy experience characterized by intensive risk management, family regulation, and social special-marking. It is precisely this contrast that provides a distinctive comparative lens for understanding the cultural construction of embodied pregnancy and lays the foundation for the deeper comparative discussion that follows.

6. Comparative Analysis of Pregnancy Experiences in China and Canada

6.1 Medical Systems and Prenatal Guidelines: Two Modes of Bodily Governance

The differences between prenatal medical systems in China and Canada are not merely matters of technical procedures or guideline details; rather, they reflect two fundamentally distinct modes of bodily governance. Chinese prenatal guidelines are organized around the principles of continuous monitoring and risk prevention (National Health Commission of the People's Republic of China, 2018). Through high-frequency examinations and relatively conservative diagnostic thresholds, pregnant bodies are systematically incorporated into a framework of risk management. Within this system, the pregnant body is understood as a potential risk carrier requiring constant assessment and timely intervention. The density of medical examinations serves the goal of safety while simultaneously reinforcing expectations of possible bodily abnormality.

In contrast, Canadian prenatal guidelines embody a governance orientation centered on limited intervention and bodily trust. By adopting stepwise screening procedures, strictly limiting indications for testing, and controlling examination frequency, the medical system places greater reliance on the body's capacity for self-regulation, initiating further intervention only when clear deviations from normality occur (Government of British Columbia, 2020). As a result, the pregnant body is not primarily defined as a site of risk, but as a subject endowed with relative stability and competence. This divergence should not be understood as a simple difference in medical technology, but as the outcome of broader configurations involving public healthcare resource allocation, societal risk tolerance, and cultural values.

6.2 Logics of Risk Management: Preemptive Control and Risk Tolerance

At the level of risk governance, prenatal management in China and Canada exhibits a structural contrast between preemptive control and delayed intervention. In China, risk management prioritizes early identification and minimization of uncertainty. Through low-threshold alerts and intensive monitoring, potential risks are brought forward into a controllable domain. Certainty functions as a core value within this model, such that pregnant women are simultaneously protected and continually reminded of bodily vulnerability.

By contrast, Canadian risk management is grounded in risk tolerance and delayed intervention. The medical system assumes that a certain degree of uncertainty is acceptable and that the body does not require constant correction. This approach reduces the intrusion of medical intervention into everyday life, allowing pregnancy to more closely resemble a “normal life process.” At the same time, it leaves certain risks unresolved until later stages. Risk, therefore, does not disappear but is redistributed and borne differently.

These two approaches do not reflect differences in scientific validity, but rather divergent societal judgments about the relationship between safety, efficiency, and autonomy.

6.3 Doctor–Patient Relationships: Technical Authority and Emotional Empowerment

Differences in medical systems also directly shape the fundamental form of doctor–patient relationships. In China, clinical interactions are highly structured around indicators, data, and diagnoses. Physicians primarily assume the role of technical authorities responsible for identifying risk and making intervention decisions. Within this relationship, pregnant women are positioned

largely as managed subjects, and emotional experience tends to be secondary. While this structure supports technical efficiency, it may also amplify anxiety.

In Canada, doctor–patient relationships place greater emphasis on communicative equality and emotional support. Physicians are not only technical decision-makers, but are institutionally expected to attend to patients’ psychological states and lived experiences. This form of “accompaniment-oriented care” weakens the framing of the body as a risk object, enabling pregnant women to maintain a sense of subjectivity. However, it may also appear conservative in terms of the intensity of technical intervention.

Accordingly, differences in doctor–patient relationships should be understood not as matters of individual clinical style, but as reflections of contrasting institutional definitions of what constitutes “good care.”

6.4 Family and Social Structures: Specialization and Normalization

If medical systems constitute the institutional dimension of bodily governance, family and social structures extend this governance into everyday life. In China, pregnant women are often embedded within highly participatory family networks, where pregnancy is treated as a collective family matter. Intergenerational care provides substantial support, while simultaneously further specializing the pregnant body through regulation of diet, mobility, and emotional expression.

In Canada, family and social structures demonstrate a pronounced orientation toward normalization. Pregnant women are less likely to be socially marked as requiring special treatment, and their everyday activities and social participation are not systematically interrupted. This

structural arrangement reinforces women's autonomy, but also shifts greater responsibility for risk management and daily life onto the individual.

These two patterns are not simply oppositional; rather, they reflect different roles assigned to the family within broader systems of social support—one in which the family substitutes for institutional provision, and another in which institutions partially substitute for family involvement.

6.5 Cultural Construction of Embodied Experience: Riskification and Autonomization

Taken together, differences in pregnancy experience between China and Canada can be understood as reflecting two distinct logics of cultural construction of embodied experience. In China, the pregnant body is continuously riskified. Through the combined effects of medical surveillance, family regulation, and public discourse, it is shaped as a body requiring heightened protection. In Canada, the pregnant body is more often autonomized, understood as capable of self-regulation and deserving of trust.

The former reduces uncertainty in exchange for a sense of security, but tends to internalize anxiety as a normalized feature of pregnancy. The latter grants autonomy through reduced intervention, but transfers uncertainty to the individual level. Pregnancy thus emerges not as a singular biological event, but as an embodied experience deeply embedded in medical systems, family structures, and cultural value regimes.

Recognizing pregnancy as culturally constructed in this way enables a departure from purely biomedical perspectives and invites reconsideration of prenatal health and care practices through the lenses of body politics and cultural governance.

7. Discussion: Body Politics, Gender, and Cross-Cultural Pregnancy Experiences

7.1 Body Politics: From Risk Management to Subject-Oriented Governance

Building on the comparative analysis above, pregnancy can be understood not merely as an object of medical intervention, but as a highly institutionalized field of body politics. In Foucauldian terms, biopolitics is not limited to the surveillance of bodies; rather, it operates through institutional arrangements, professional discourses, and everyday practices to produce particular forms of bodily subjects. In the context of pregnancy, risk governance does not function solely as external control, but works through repeated examinations, assessments, and reminders that encourage pregnant women to internalize risk awareness and actively participate in the management of their own bodies(Lupton, 1999).

In the Chinese context, risk is not treated as an occasional contingency, but is structurally positioned as a constant premise of pregnancy. Once pregnancy begins, the body is re-coded as a “potential assemblage of risks,” requiring continuous validation through test results and medical confirmation. This mode of governance does not rely on overt coercion; instead, it operates through a logic of compliance secured by promises of safety. While being disciplined, pregnant women simultaneously gain social recognition as subjects worthy of care, attention, and collective investment.

In contrast, pregnancy governance in Canada does not negate body politics, but rather transforms it into a different modality. Limited intervention and bodily trust do not signal a withdrawal of power; instead, governance is relocated through concepts such as “self-management” and “risk tolerance,” embedding responsibility more deeply within the individual subject. Pregnant women are constructed as self-regulating and self-assessing agents, whose autonomy itself becomes a mechanism of governance (Davis-Floyd, 2003). The contrast between China and Canada, therefore, is not one of “strong control” versus “no control,” but of two distinct rationalities of governmentality.

7.2 The Production of Gendered Subjects: From Care Recipients to Responsibility Bearers

Pregnancy, as a profoundly gendered life experience, constitutes a critical moment in the reproduction of gendered subjectivity. It is not merely a phase of physiological change, but a process through which women’s social identities are reordered and redefined.

In China, pregnant women are often positioned within a dual framework of being both cared for and disciplined. Through an emphasis on vulnerability, family structures and medical institutions construct pregnant women as subjects in need of protection. Yet this protection is not neutral benevolence; it comes at the cost of concentrated responsibility. Women are expected to assume primary—if not exclusive—responsibility for fetal health. As a result, gender identity during pregnancy becomes heavily maternalized, tightly binding women’s social value to reproductive function.

In Canada, pregnant women are more likely to be maintained as “normal social members,” ostensibly reducing gender-based exceptionalism. However, normalization does not equate to gender neutrality. Rather, through an emphasis on independence, autonomy, and self-responsibility, risk and decision-making burdens are redistributed to individual women. In the absence of strong family or community support, pregnant women must simultaneously manage bodily regulation, emotional adjustment, and risk assessment. Gendered responsibility is not eliminated, but re-coded in the form of the “autonomous subject.”

Thus, gender formation in these two contexts does not reflect a linear transition from “traditional” to “modern,” but rather two distinct mechanisms through which gendered responsibility is produced and sustained.

7.3 Discourses of Motherhood: Moralized Responsibility and Emotional Governance

As the starting point of motherhood, pregnancy marks a critical phase in which maternal discourses begin to exert normative force. In China, “successfully passing prenatal checkups” is not merely a medical outcome, but a moral practice. Pregnant women’s bodily behaviors—diet, routine, emotional regulation—are placed within a moral evaluative framework, continuously assessed in relation to standards of responsibility and competence. Motherhood is thus pre-emptively embedded in pregnancy, shifting future caregiving obligations into the domain of bodily self-management.

In Canada, maternal discourse more often appears in the language of emotional well-being and self-care. While this framing seems to soften the logic of sacrifice, it does not eliminate

normativity. The emphasis on emotional stability and positive affect may, paradoxically, generate self-doubt and self-blame when pregnant women experience anxiety, exhaustion, or discomfort. This happiness-centered maternal discourse constitutes a subtler form of emotional governance, regulating not only behavior but also feeling.

Across cultural contexts, maternal discourses differ not in whether they discipline, but in the moral frameworks through which acceptable maternal subjectivity is defined and enacted.

7.4 Theoretical Implications from a Cross-Cultural Perspective

The comparison of pregnancy experiences in China and Canada demonstrates that pregnant bodies are consistently situated at the intersection of multiple forces: medical institutions, family structures, gender norms, and cultural values jointly shape the meaning of pregnancy.

The Chinese model, through concentrated risk management and family involvement, constructs a collective governance logic centered on safety. The Canadian model, through normalization and autonomy, embeds governance responsibility more deeply within individual subjects. These models are not hierarchically opposed, but reveal the diverse ways body politics operates across social contexts.

Theoretically, pregnancy experience underscores that body politics is not limited to direct institutional control. Rather, it is continuously produced through “soft mechanisms” such as gender roles, maternal discourses, and emotional norms that permeate everyday life.

7.5 Summary: Pregnancy as a Gendered Practice of Body Politics

In sum, pregnancy experience should not be understood as a natural, purely biological, or private event, but as a deeply gendered practice of body politics. Whether protection is achieved through risk management or autonomy is articulated through empowerment, pregnant bodies remain embedded within structures of responsibility allocation and value judgment.

Cross-regional patterns in maternal mental health further illustrate that when women are expected to bear bodily and emotional management responsibilities alone, isolation and psychological risk may increase; conversely, when family and institutional interventions become overly intensive, women's subjectivity may be constrained. The presence or absence of family support itself constitutes a critical dimension of body politics (World Health Organization, 2014).

Understanding pregnancy experience therefore requires moving beyond technical debates about the adequacy of medical intervention. Instead, pregnancy should be approached as a social issue concerning gender, responsibility, and modes of governance. It is not a singular natural process, but a social practice continually produced at the intersection of body, culture, and power.

8. Conclusion: Pregnancy as a Governed Embodied Experience

This article has examined pregnancy as a culturally and institutionally governed embodied experience through a comparative analysis of pregnancy in China and Canada. Drawing on autoethnography combined with cross-cultural analysis, the study demonstrates that pregnancy cannot be reduced to a medical process driven solely by physiological change. Rather, it is a form of embodied experience continuously shaped through the interaction of medical systems, cultural

norms, family structures, and gendered expectations. Pregnancy thus emerges as a site where biological reproduction and body politics intersect with particular intensity.

The comparative findings show that medical systems do more than provide technical care; they play a constitutive role in shaping how pregnant women understand, evaluate, and manage their own bodies. In China, pregnancy management characterized by risk preemption and dense monitoring situates the pregnant body within ongoing processes of assessment and verification. Safety is achieved through heightened sensitivity to potential risk and an implicit acceptance of bodily vulnerability. In contrast, the Canadian model, emphasizing limited intervention and bodily trust, foregrounds self-regulation and autonomous judgment, thereby embedding governance responsibility more deeply within individual subjects. Despite their apparent divergence, both approaches reveal a shared condition: the pregnant body is never outside governance, but is governed through different rationalities, techniques, and moral frameworks.

This perspective suggests that pregnancy should be understood beyond surface-level debates about whether medical intervention is excessive or insufficient. Pregnancy constitutes a concrete site in which governance rationalities become embodied. Body politics operates not only through explicit regulation or institutional authority, but through everyday routines, professional discourses, and affective expectations that gradually shape how women come to perceive and manage their bodies. In this process, pregnant women are not passive recipients of control, but active participants who negotiate institutional logics and internalize norms in lived, embodied ways.

The analysis further highlights pregnancy as a critical moment in the production of gendered subjectivity. Rather than simply extending preexisting gender roles, pregnancy reorganizes women's social positions through the combined effects of institutional arrangements and cultural expectations. In the Chinese context, pregnant women tend to be highly maternalized, with their bodies imbued with collective responsibility and moral significance. In the Canadian context, women are more often maintained as "normal subjects," yet this normalization carries implicit expectations of independence, self-responsibility, and emotional regulation. Gendered responsibility does not disappear across contexts; instead, it is redistributed and legitimized through different cultural narratives.

Building on this insight, the article argues that maternal norms do not originate only in postnatal caregiving, but are institutionalized during pregnancy through bodily management, risk assessment, and emotional regulation. Whether articulated through discourses of safety and responsibility or through narratives of happiness and self-care, motherhood acquires a moral form well before childbirth. As a result, the pregnant body becomes not only a biological entity but also a site of moral evaluation and social expectation.

Methodologically, this study demonstrates the interpretive value of autoethnography for cross-cultural health research, particularly when combined with reflexive attention to researcher positionality. Compared with approaches centered on aggregated data, autoethnography allows for close examination of how institutional logics are perceived, internalized, and enacted at the level of embodied experience. Pregnancy, as a deeply corporeal, emotional, and institutionally dense

experience, provides a particularly revealing lens through which to examine the everyday operation of body politics.

At the same time, the conclusions of this study should be understood in relation to its scope and limitations. The analysis is grounded primarily in the researcher's embodied experience and in selected policy texts, and does not claim to represent the full diversity of pregnancy experiences within either China or Canada. Differences related to region, socioeconomic status, ethnicity, and access to medical resources are likely to shape pregnancy in ways that extend beyond the present discussion. Moreover, while autoethnography offers rich insight into the cultural mechanisms through which pregnancy is governed, its value lies in interpretive depth rather than statistical generalizability. Future research incorporating multi-sited ethnography or comparative interviews could further extend and complicate the patterns identified here.

Overall, this article argues that pregnancy is neither a natural nor a purely private life event, but a deeply socialized, gendered, and political embodied experience. Attending to the cultural construction of pregnancy makes it possible to move beyond narrowly technical perspectives in medicine, public policy, and health communication, and to engage more attentively with the complex realities faced by pregnant women as social subjects navigating multiple regimes of care, responsibility, and governance.

9. Limitations

This study is grounded in the pregnancy experience of a single researcher. While the experience carries analytical relevance, it does not claim representativeness. The comparison between China

and Canada is based on a limited set of policy documents, academic literature, and shared experiences, and therefore cannot fully capture the diversity of medical practices within either country.

From a methodological perspective, autoethnography itself constitutes an important limitation. On the one hand, it allows for rich, nuanced accounts of bodily experience and emotional change; on the other hand, its analytical depth depends heavily on the researcher's capacity for reflexive interpretation and theoretical translation, making complete avoidance of subjectivity and selective narration impossible. Moreover, the cross-cultural comparison relies primarily on the researcher's experiences within specific contexts in China and Canada, without incorporating broader interview data or multi-sited ethnographic materials. Differences related to social class, ethnicity, or regional variation are therefore only partially addressed.

In addition, the researcher's pregnancy experience in Canada occurred within a particular province and under specific conditions of medical resource availability, and should not be uncritically equated with "the Canadian experience" as a whole. Given these limitations, this article emphasizes autoethnography as a method for *revealing cultural mechanisms* rather than for producing statistically generalizable conclusions. The findings are intended to contribute to interpretive understanding of the cultural construction of embodied pregnancy, rather than to offer normative or universal claims.

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