

## **Seeking a connection: Women's lived experience of the woman–midwife relationship in mainstream maternity services in Japan**

Keiko Doering, Judith McAra-Couper, and Andrea Gilkison

### **Abstract**

**Problem:** In Japan, women continue to suffer from mental health and other postpartum issues despite good clinical outcomes of maternity care.

**Background:** As key care providers, midwives potentially affect women's overall birth experience. Most women in Japan give birth in hospitals or obstetric clinics where different midwives and nurses provide one woman with fragmented care. Women's lived experiences of the woman–midwife in these birth facilities are not well known in Japan.

**Aim:** To understand women's birth experience and relationship with midwives in the mainstream maternity care system in Japan to improve maternity care and women's birth experience.

**Methods:** Face-to-face individual interviews with 14 mothers were conducted. The data were analysed using van Manen's hermeneutic phenomenological approach, which reveals the meaning of human experience in the everyday world.

**Findings:** Four themes were derived from the hermeneutic phenomenological analysis; 1) Closed hearts and bodies in insecure relationships, 2) Alienation, 3) Hopelessness and helplessness, and 4) Women's vulnerability and desire for positive relationships.

**Discussion:** In institutionalised and fragmented maternity care settings, it is difficult for women and midwives to develop a relationship. In such a care environment, women's birth experience with midwives is negative or even traumatic; yet, women still need and seek the midwife relationship. Respectful care—necessary for women's positive birth experience—requires positive relationship between women and midwives.

**Conclusion:** Women's negative birth experience may affect their mental health and parenting. Maternity and midwifery care in Japan needs to develop relationship-based care to improve women's birth experience.

## 1. Introduction

The World Health Organization (WHO) [1] has maintained that simply surviving a birth is not the goal of childbirth for women, and women need to have a positive birth experience to fully thrive and achieve their potential through the childbirth experience. Japan holds one of the lowest maternal and neonatal mortality rates [2,3], and is recognised internationally as the safest country in which to give birth [4, 5]. However, pregnant women and mothers in Japan have struggled with anxiety and depression [6]. In Japan, the number of women committing suicide during pregnancy and within 1-year after birth (which is not included in the maternal mortality rate) is double that of the number of women who lost their lives at birth [7,8]. Further, in Japan, death caused by child abuse primarily among babies under 1-year mostly occurs at the hands of their mothers [9]. While it is recognised that Japan is a safe country in which to give birth, the relationship between these issues and women's birth experience is often overlooked in maternity service provision.

More recently, the Japanese government and stakeholders have tackled issues around childbirth by focusing on postpartum care but not labour and birth care [10]. The government launched a national project called 'seamless maternity care,' wherein the government and health care professionals attempt to provide seamless care throughout the pregnancy and postpartum period to solve women's postpartum issues [11]. However, the project does not indicate any care during labour and birth. In Japan, it is assumed that care and women's experience at birth have few problems because of Japan's advanced medicine and good clinical outcomes. Good statistical outcomes are not always equivalent to positive birth experience. Even if women survive birth, the experience can be negative. Negative birth experience affects women's mental health, attachment with their babies, and their parenting [12–15]. In Japan, more than 99 % of women give birth in hospitals or obstetric clinics, and those birth facilities commonly provide fragmented care—care intermittently provided by many different midwives and nurses during pregnancy, birth, and postpartum periods [16]. Moreover, Nakayama [17] argued that those birth facilities tend to manage delivery rather than caring for birthing women. Research exploring women's birth experience and care at Japan's midwifery homes run by self-employed midwives, where only 0.5 % of the women give birth, revealed high quality of care and women's positive birth experience [18–21]. However, there is dearth of research about women's birth experience in Japan's mainstream birth facilities.

Over the past two decades no studies have specifically focused upon the woman–midwife relationship in Japan. Hunter et al. [22] maintained that the woman–midwife relationship is the foundation of quality maternity care. As key care providers of maternity care, midwives naturally shape women's experience of birth. Exploring women's experience with midwives is significant for understanding women's birth experience. The current study explored women's lived

experience with a focus on the relationship with their midwives in institutionalised and fragmented maternity care settings. The study aimed to understand women's birth experience and relationship with midwives in the mainstream maternity care system in Japan. The findings of the current study will contribute to improving maternity care and women's birth experience in Japan. Further, the study findings have potential to add insights to international discussions on this topic. The study research question was 'What is woman's lived experience of the woman-midwife relationship in mainstream maternity care settings in Japan?' This paper reports findings from one study of a broader research project conducted to understand the meaning of the woman-midwife relationship in Japan.

## **2. Methodology and methods**

Ethics approval for the research was granted by Auckland University of Technology Ethics Committee (AUTEC 16/429).

The study drew on van Manen's hermeneutic phenomenological approach in order to reveal the meaning of human experience in the everyday world [23]. The phenomenological approach seeks to uncover how a person sees and experiences the world. Phenomenology deals with the lifeworld in which the person is living, and the reality in the lifeworld is described as lived experience [23]. A phenomenological stance is that the essence of the lived experience is concealed within one's experiences. van Manen [23] introduced methodological theory with a practical approach to develop a hermeneutic phenomenological inquiry to human science research based on the phenomenology of Heidegger [24], Gadamer [25], and other philosophers. His methodological structure differs from technical procedures of other qualitative research, such as coding and methods comprised of a step-by-step procedure. In the methodology, the phenomenon itself appears to consciousness, and language is the tool to access that world [23]. Therefore, this study chose to collect lived experience spoken by women.

Participants were required to have met midwives during their childbearing period and have children under 6-years of age (before primary school). No other factors (e.g., places and modes of birth) were used as inclusion criteria as all pregnant women in Japan go to hospitals or obstetric clinics to see doctors and midwives at least three times during their pregnancy, even if they plan to give birth at home or birth centres. Participants were recruited by email advertisements sent to mothers' groups and a midwives' network. The adequate sample sizes are not specified for phenomenological studies, but Bartholomew et al. [26] argued that smaller sample sizes resulted higher quality research within 200 phenomenological studies. For the current study, 10–15 participants were recruited to ensure quality in-depth interviews for participants' full experience and analyse each one more carefully within the feasibility of the study.

Interviews were conducted in Japanese, took between 50 and 120 minutes, and were digitally audio-recorded with participant consent. Field notes were taken after each interview capturing women's facial expressions and key points from the interview. The interviewer was a Japanese midwife and the study's primary researcher. Phenomenological reflection and exploration requires lived experience descriptions but not perceptions, views, beliefs, or interpretations [27]. Therefore, the interviewer asked questions such as, '(When/Where) did you meet midwives?' and 'Could you tell me what it was like (what happen) at the time?'. Without asking many questions, the participants naturally discussed what midwives did and said, and what the women did in their birth stories.

Following data collection, the interviews were transcribed, edited, and interpreted using van Manen's hermeneutic phenomenology. Writing is considered the most critical component of the analytic method in van Manen's approach [23]. The text was produced through writing and rewriting of the interview transcripts and further interpreted to bring clarity and seek depth of the lived experience of the study participants. The study also used the approach of crafting text in order to form a condensed story that captures meaningfulness of the experience [28]. The transcription and earlier interpretations were returned to each participant to confirm the interview contents and the researchers' understandings and interpretations. One woman asked to delete a part of her interview because she felt she was blaming a midwife, but all participants agreed with the interpretations. The interpretations, put all together, were rewritten, reinterpreted, and rethought until adequate convincing interpretations, which are explicit, rigorous, and comprehensive, were achieved.

The analysis was mainly conducted by the primary researcher. Two other researchers, New Zealand midwives, supervised and discussed the interpretations with the primary researcher. Prior to conducting this study, the primary researcher wrote down and discussed with other researchers her personal and professional background experiences and how her pre-understandings potentially affected the study.

### **3. Findings**

Fourteen Japanese women participated in individual face-to-face interviews in 5 prefectures across Japan. They were aged between 33 and 43 years. Each woman had her last baby within 6 years in hospitals (6 women), obstetric clinics (1 woman), at midwifery homes (5 women), and at their own home (2 women). Three women had Caesarean sections; one had spontaneous labour and a Caesarean section after the use of epidural and arrest of labour, one had induction and high blood pressure before emergency Caesarean section, and another had a rupture of the membrane around the 23rd week of her pregnancy and a Caesarean section four weeks later. A brief overview

of participants can be found in Table 1.

Four themes were derived from the hermeneutic phenomenological analysis; 1) Closed hearts and bodies in insecure relationships, 2) Alienation, 3) Hopelessness and helplessness, and 4) Women's vulnerability and desire for positive relationships.

**Table 1**  
Participants' Information.

| Name  | Age (years) | Age of children (years) | Place of birth          | Mode of birth                |
|-------|-------------|-------------------------|-------------------------|------------------------------|
| Shizu | 38          | 3                       | Hospital                | Vaginal birth                |
| Juri  | 38          | 1                       | Hospital                | Epidural, Caesarean section  |
| Aki   | 34          | 3 and 6                 | Midwifery home          | Vaginal birth                |
| Tae   | 35          | 4                       | Hospital                | Caesarean section (27 weeks) |
| Kumi  | 38          | 1 and 3                 | Midwifery home          | Vaginal birth                |
| Chika | 38          | 1                       | Hospital                | Induction, Caesarean section |
| Waka  | 39          | 1                       | Midwifery home          | Vaginal birth                |
| Maya  | 39          | 3                       | Obstetric clinic        | Vaginal birth                |
| Ema   | 43          | 1                       | Midwifery home          | Vaginal birth                |
| Orie  | 36          | 5, 7, and 10            | Hospitals               | Vaginal birth                |
| Naomi | 33          | 1                       | Midwifery home          | Vaginal birth                |
| Hana  | 35          | 6, 9, and 14            | Obstetric clinics, home | Vaginal birth                |
| Uta   | 40          | 4 months                | Hospital                | Vaginal birth                |
| Rena  | 41          | 5, 8, and 9             | Midwifery home          | Vaginal birth                |

### 3.1. Closed hearts and bodies in insecure relationships

In maternity care settings, women desire to meet midwives who can provide care and support that offers comfort. However, for the participants, the encounters with midwives were defined by insecurity. Shizu illustrated how she felt when meeting a midwife during labour.

*When the midwife greeted to me, my legs were left opened [because it was just after she gave me an internal examination]. Then she came to check on me [during labour]. I saw her again when I was on the birthing bed. I might have been a bit more relaxed if I had a chance to meet her before. I felt like they might have taken me away somewhere. I wouldn't say that everyone was an enemy, but it was difficult when a stranger came into my room. I wanted to be friendly, but I was nervous to meet someone new in such a situation. I remember I recoiled when I suddenly heard the door opening. I felt my tummy got stiff in pain when the midwife came into the room. I was told to lie on my back, but I wanted to be on my hands and knees. I could say something, but I just followed what she said.*

Midwives often existed as strangers to the women of this study. In this case, ‘strangers’ refers to a sense of detachment in the relationship. It implies an emotional distance between the woman and her midwife that did not allow them to feel a connection. Other participants also stated, ‘Meeting a midwife suddenly during labour was huge pressure on me’; ‘I got nervous, and I was not open up to the midwife’; and ‘I could not talk to anyone.’ The women were nervous, embarrassed, and hesitant in their relationship with their midwives. Correspondingly, such relationships became filled with insecurity for the women. Every relationship has a first encounter but, in this instance, women experienced the pressure of building a new relationship during an intense period of childbirth. Establishing a relationship often requires time and ongoing interaction to understand each other [29]. Building a new relationship in the limited time of labour placed strain on the women, and this experience became a significant part of their birth experiences. The sense of insecurity in the midwife relationship came to represent the overall tone and mood of the women’s birth experience.

The atmosphere of insecurity was also felt corporeally. Encountering someone who seemed enemy-like made the women scared and they physically closed-off to the relationship. Shizu’s recoiled body expressed her nervousness and anxiety about the new relationship with the midwife. Such an encounter was a disruption in her labour. Another woman described her first meeting with a midwife: ‘I turned my eyes away from her instantly’ due to fear. Their bodies instantly rejected the midwives before they rationally understood the situation. In these instances, the lived body became a corporeal expression of the tension felt with respect to the phenomenon [30]. Participants found, through their own physical responses, that their hearts were closed as much as their bodies in the relationship. The midwife relationship emotionally and corporeally co-produced a sense of fear and insecurity. van Manen [30] claimed the body and mind influence each other’s state. Likewise, the women could not feel safe and secure with their closed bodies. It is difficult for women to trust their bodies to their midwives or to the flow of the birth in such a situation.

### **3.2. Alienation**

The women felt isolated and alienated in their relationships with their midwives. The experience of alienation was traumatic insofar as it negatively characterised their entire experience of pregnancy or childbirth. Juri spoke of her experience.

*The pain was unbelievably intense [during labour]. I may be selfish, but no one came around to check on me. I suffered for probably 3-hours. I really put up with the pain and it was awful. I should probably have called someone, but I didn’t know how much pain I was supposed to endure. A midwife came and apologised, ‘I am sorry to leave you*

*alone. We had births back to back. 'She also told me, 'Good. Your labour is proceeding.' But I could not do anymore. I was by myself. So, I asked to have an epidural. It was too hard. That was not because of the midwife. I think many situations piled up. It was also Sunday morning, and I was just unlucky. I saw many midwives while in hospital, and I recognised that the midwife assisting me was young. She was kind but when I realised that there were many other midwives, I was kind of disappointed. To be honest, I drew a losing lottery ticket. I don't feel I met a midwife at my birth.*

In this isolated situation, Juri did not feel she was important enough to be cared for and she wondered if she even existed in her care environment which brought about a deep sense of alienation. Juri's relationship with the midwife was one of disappointment, frustration, and sorrow. Her words 'I drew a losing lottery ticket' and her sense that she had 'not met a midwife' imply that she did not get what she had expected from the midwife. She likely expected to be warmly cared for and supported in her struggle to overcome her labour pains. Contrary to her expectations, her experience with the midwife was that of being left alone and not feeling connected to anyone. Human beings seek to experience the other; that is, they seek meaningfulness in their relationship to others [23]. Consciously or subconsciously, Juri was anticipating a meaningful relationship with her midwives during her labour and struggled with the gap between her expectation and the reality of her situation. This relationship made her feel abandoned and alienated in her birthing care. Uta also described her alienated experience during labour and following birth.

*I had not met the midwife before. She was nice, but I was scared when she left. She was not always there. I was in pain and felt insecure, so I wished she had been there all the time. I didn't have chance to talk about my birth with her later. I saw her, but I wondered that she might not have remembered me. That was sad. While I stayed in the hospital for 5-days, midwives came one after another, but she didn't come to my room. She came to see my baby and took care of him in the nursing room, but still her reactions made me think she didn't remember me.*

Irrespective of how nice or helpful the midwife might have been in practice, the resulting relationship Uta experienced was one of insecurity and alienation. She desired to feel a connection with the midwife, but it was difficult as the midwife could not always stay with her. Further, not being remembered made Uta feel that she was just one of many women. Uta only had the one midwife who attended her birth and birthed her baby. Nonetheless, Uta's reality was that her special experience of childbirth was not shared, to the same extent, by the midwife, and she felt that she was not really the focus of the midwife's attention. Uta was disconnected and alienated from the relationship with the midwife. Lack of recognition as an individual enhances feelings of anxiety, isolation, and alienation. It seemed Uta's desire to make a connection with the midwife

was not reciprocal, and that broke her heart. Uta further expressed:

*I was afraid of the midwives for some reason. I didn't know what kind of people midwives were, so I didn't know what they could do for me. I wanted them to give me comfort. One midwife showed me only her back during the antenatal care. She looked like she was really just doing her job. Where could I find someone to comfort me in person and give full attention to me? If doctors could do it, I didn't need to expect that from midwives. I didn't know the difference between nurses and midwives, either. There were many midwives there. I didn't care who would come for care during my hospital stay as long as they helped me. I really wanted someone to speak to me.*

Midwives were among the professionals who would have occupied this role of caring for a childbearing woman; but Uta was at a loss to meet even one midwife who engaged with her in a convincing manner. She was confused about who they were, and felt devastated by those who did not possess any substantial being as midwives. It was a natural consequence that Uta did not obtain any meaningful relationships in this situation. The midwives made little of their occupational ability for her, and Uta felt hopeless as a result. Therefore, it seemed of no value to have a relationship with midwives who hurt, rather than helped her. Yet, Uta still expected their help. She needed caring support in the transition of becoming a mother. Unable to find anyone to care for her in that way, she was left alone without help, without the empowerment needed to be a confident mother in this experience.

The absence of the midwives in the relationship—physically and psychologically—left the women alone in the care environment. They might have felt as if they were invisible in the eyes of the people at the hospital or the clinic and as if they did not deserve to be cared for. The lack of relationality with midwives meant a lack of humanity in the care. Such negative experiences caused their deep sense of alienation in the relationship and, thus, in their own maternity care.

### ***3.3. Hopelessness and helplessness***

The women wanted to be recognised as individuals and to feel connected to their midwives in the relationship. When this feeling was not forthcoming, a sense of hopelessness and helplessness started to emerge. In this case, hopelessness means the women felt they could not receive supportive care from their midwives. Helplessness refers to a sense of feeling powerless in the midwife relationship. The women also came to feel useless as a mother through the interactions with their midwives. Orie, as an anxious first-time mother, had a 'shocking' experience with a midwife.

*[After birth] I received a paper with the instructions about how to take care of babies.*

*It said to breastfeed the baby and check on the nappy when the baby cried, but I couldn't ask about how to do that at first. I breastfed and changed the nappies, but my baby was crying. I held him, but he was still crying, and I didn't know what to do. Then a midwife ran into my room. I had tried everything written on the paper, and his nappy was not wet when I checked it. But when she checked, it was wet, and she said, 'The nappy!' I felt scolded. I could never ask her anything again. I didn't even want to see her. I was afraid of who will come when I had to call them. That was an experience that froze my heart. I was unsure of myself with whatever I did while taking care of my first baby because I had this shocking experience.*

Like Orie, some participants began developing feelings of hopelessness through their interactions with midwives. They felt no one was there to help them in their care environment at the starting point of their parenting. Being scolded by midwives, who were supposed to help women, deeply hurt them and produced a sense of loneliness. The women were disappointed in the midwives and, at times, even felt they were unworthy of being cared for and undeserving of being treated kindly.

Consequently, they could not help becoming passive recipients of care. Even when the women needed help, they were too timid and frightened to request it. After meeting many midwives, a participant stated, 'I did not see anyone I could talk to'; the women lost hope and trust in their midwives and felt helpless in the relationship. It was an inevitable consequence that they could not feel a connection with their midwives. The midwife relationship even disempowered the women. The midwife experience made the women feel as if they could not do anything right for their babies. The women lost confidence in their abilities as mothers. This sense of helplessness and loss of self-confidence could have adverse impacts on maternal self-esteem and self-efficacy.

Similar to Orie, Hana felt helpless at the very beginning of her mothering experience.

*I was the only mother giving birth on the day, but I was left alone right after the birth. A midwife told me, 'Wait a minute.' I was on the birthing bed, and my baby just born was sleeping in a basket next to me. Suddenly there were no midwives or doctors in the room. I was left with my legs opened. I was really in such a posture. Then my baby started crying. I thought, 'Should I wait till they come back?' But he was crying. I immediately wanted to go hold him, but I didn't know if I could get off the bed and hold him while my legs were spread apart and fixed [on leg stands of the birthing bed]. Even if there was no one there, I wanted to hold him. It was probably several minutes, but I felt it was really long. That was devastating. I never want to have the feeling again.*

Being left alone with her legs apart and unable to hold her crying baby was Hana's first experience as a mother. Sudden feelings of insecurity, frustration, and sadness, just after her baby's birth,

devastated her. She felt helpless that as a mother she could not do anything for her baby in that situation. Hana felt she was not even allowed to close her legs on the birthing bed. Her own body felt controlled, as if it belonged to the midwife or doctor. She was disciplined to the extent that she could not move or do anything for herself and her baby at that moment. Her feeling of helplessness was exacerbated by the fact that her body was frozen in a humiliating posture. This situation caused by the existing relationship deprived Hana of her autonomy. Her words imply just how traumatic she found the experience. Nonetheless, it is possible that the midwife meant no harm when she left Hana alone in this way. 'Wait a minute' are common words spoken by midwives in busy maternity care settings; yet, for Hana, these words left an emotional gap between her and the midwife. At the very least, Hana's dignity was damaged by this experience.

The women described the sense of helplessness and hopelessness that marked the beginning of their motherhood due to their negative experiences with midwives. The midwives and their care were not only helpless and hopeless; rather, they were described as being harmful for the women's mental well-being. In their hopeless and helpless experiences, the women used thermal expressions, such as 'no warmth,' 'frozen heart,' and 'cold feeling,' that clearly captured the atmosphere they were in and the state of their feelings. Atmosphere or mood envelops and affects everything, and it is the way people experience the world [31]. Atmosphere is also how one is present to another [31]. The midwives were present to these women in a way that gave them a sense of coldness, helplessness, and deprivation. Giving birth, being or not being cared for, and caring for babies in such a cold atmosphere are antithetical to having hope. The women perceived through their experiences that they were deprived of hope in their early parenting.

### ***3.4. Women's vulnerability and desire for positive relationships***

In this study, the resulting relationships the women experienced were often unsatisfactory, but they all had hope and tried to develop a good midwife relationship. They struggled because they wanted better experiences with their midwives, even if it could not be achieved. Shizu illustrated the actual relationship she experienced and what kind of relationship she wants to have with midwives the next time she gives birth.

*The midwives look after you and everyone else in the same manner like an assembly line work. I did not have a choice. They looked busy. So I tried not to talk to them [not to disturb busy midwives]. The contact with midwives for me was only at the moment of birth, but it sounds as if midwives could look after us longer from pregnancy until lactation period. So, if I had another baby, I would like to have a longer relationship with a midwife.*

Other participants also used the term 'assembly line work'. They felt they were treated like things

on the conveyer-belt of a factory. Regardless, they still tried to be modest and patient. They recognised their vulnerability in terms of their relationship with midwives and in their maternity care. For example, one woman wanted to complain about a midwife's rude attitude at antenatal care but did not 'because the midwife might take care of me at birth.' Wanting midwives' help in the hospitals, meant the women felt that they should be silent and obedient. They were vulnerable under such conditions; and, as a recipient of care, they perceived how they should act in the presence of the midwives in the relationship. Perhaps their attempts to be a nice person stemmed from unconscious pressure from the midwives they encountered. They understood that good care emerges from good relationships with care providers. However, even if the relationship looked smooth on the surface, their experiences of the relationship was negative.

While the women were resigned to their situations, they expressed their desire to have a longer relationship and continuity of care with the same midwife. They longed for connection with midwives, saying, for example, 'If I see a midwife from pregnancy and I can communicate well with her, I will be able to talk about anything. I will feel close to the midwife.' Furthermore, Maya, a first-time mother, stated, 'I saw the midwife's professionalism and she did her job properly, but it was not like I felt at ease.' What the women desired was a direct and deeper connection with a midwife, more than just midwives' safe practice. They wanted to be understood and supported in a warm atmosphere that would enable them to be close and talk to a midwife freely and easily. Their aspiration was to belong or connect to one caregiver with whom they could truly feel free, close, and trust.

#### **4. Discussion**

This study revealed women's experiences of the midwife relationship in Japan's mainstream maternity care system. Although birth is an extremely important experience for every woman to become a mother, the participants' experiences were traumatic and involved anxiety, alienation, and neglect from care providers. The WHO [1] recommended respectful maternity care as a human rights-based approach. In Japan, disrespectful care is often seen as an issue pertaining to foreign countries, especially low-income countries [32]. In those countries, disrespectful and undignified care might be more serious than in Japan. It may also look like Japanese women have choices and give birth in fortunate circumstance because of good clinical outcomes. However, this study found that respectful maternity care is not always ensured in Japan. Women's traumatic experience of childbirth affects their postnatal mental health [33]. Some of the difficulties, such as anxiety and depression, experienced by Japanese women during the postnatal period are probably related to disrespectful care as experienced by the participants.

The study findings resonate with other research regarding women's negative birth experiences in

care settings where institutional rules and professional expertise control birthing women and place them under professional authority [33–38]. In Kuipers et al.'s study [35], women in 7 European countries experienced disconnected and disembodied feelings with uncaring, impersonal, and discriminative health care professionals, and their birth space were described as scenes of horror. The relationship with health care professionals were also described as 'dominance, power, authority, and control.' Reed et al. [33] identified that in addition to threats and violence, institutionally prioritising the care providers' agenda over the women's needs and disregarding embodied knowledge are also considered part of the traumatic birth experience among women. In the present study, women's experiences were caused by midwives prioritising institutional demands in the task-oriented environment. In order to deliver 'efficient' care, the facilities follow many procedures and rules before considering individual needs [35,39,40].

Women's negative birth experiences have also been observed in the medicalised care system emphasising risk management [34]. The care mechanism controls professional behaviours, and women's own knowledge and autonomy are ignored in such a care environment [41]. The medicalised care system affects the power balance both between professionals and women, and among professionals [34,35,42]. Medical hierarchy, as well as organisational rules and limited time, restricts midwives' ability to respect and care for women [43,44]. In Japan, midwives cannot provide total maternity care, even for low-risk women, without the obstetrician's agreement and regular consultations; a law many women and midwives struggle with [45]. Thus, the obstetric-led structure of the maternity care implies that the Japanese maternity care system does not trust or value midwife-led care; and thereby cannot provide woman-centred care. In Japan, midwives need to strengthen their professional autonomy to prioritise individual woman's needs in practice [43,44]. Eliminating the various barriers to midwives' autonomy, such as patriarchy and hierarchy, in the care system and environment is important to develop a positive woman–midwife relationship and to provide woman-centred care [35].

To improve women's participation to their own maternity care requires mutually respectful relationship with their carers [41]. Through humanistic relationship, midwives can focus on the woman, and women feel valued and respected [46]. Such woman-centred care will bring more opportunities for women to be empowered and gain confidence in themselves as mothers [47]. For women, the midwife relationship is, first and foremost, a human relationship before it is a relationship with a health professional. The women in this study wanted to connect with their midwives through knowing, understanding, and remembering each other. Having such a reciprocal relationship with a midwife enhances woman-centred care, an important element necessary for women to have a positive birth experience [43,48,49].

Shakibazadeh et al. [50] discussed how effective communication, the physical environment,

competent and motivated human resources, and continuity of care help to ensure respectful maternity care. The WHO [1] also recommended the midwife-led continuity of care (MLCC) for women's positive birth experience, and MLCC is now recognised as the gold standard based on global scientific evidence [51–55]. MLCC promotes developing a relationship between women and midwives through knowing each other, and a positive woman–midwife relationship is an inseparable part of respectful care. If the women in this study had the opportunity to develop their relationships with their midwives over a prolonged period, they might have understood the midwives differently, developed different relationships of power, and fostered new perspectives of their birth experiences.

One limitation of this study is that while women's experiences were collected from many different birth facilities across Japan, the number of participants was restricted. Also, women's negative experiences were focused on as a result of the analysis, while some participants' stories involved positive birth experiences (mostly at homebirth and birth centres run by midwives). However, the choice of methodology enabled gathering of rich data from participants that contributed to understanding what women actually experience in Japanese mainstream maternity care settings. Another limitation is that the data involved only women's and not midwives' experience, although the woman–midwife relationship is an integrated phenomenon between women and midwives. It is difficult for midwives to treasure their relationship with women and, subsequently, women's birth experience in busy, hierarchical, and fragmented care settings. As future research, midwives' lived experience in such care settings in Japan needs to be explored to understand what midwives are experiencing behind women's negative birth experiences and why the midwives allow themselves to be in circumstances which seem difficult to provide woman-centred care.

This is the first study examining women's experience of the midwife relationship in Japanese mainstream care settings. The study showed that women suffer in their maternity care in the country recognised as the safest country for childbirth. Safe at birth cannot be measured only with clinical outcomes, and care based on human rights needs to be incorporated into maternal care service provision [56]. This study contributes to understanding the relationship between women and midwives, and to begin the discussion and implementation of relationship-based care in Japan with the aim of improving the quality of care and women's birth experience.

## **5. Conclusion**

Although Japan has one of the world's lowest maternal and neonatal mortality rates, women still have negative birth experiences in maternity care settings. In particular, women face insecurity, alienation, hopelessness, helplessness, and even devastation in their relationships with midwives. Fragmented care in birth facilities makes it difficult for women and midwives to share time and

space and feel connected. Such experiences affect women's mental health, parenting, and future life. Maternity and midwifery care needs an environment and system that allows women and midwives to build the woman–midwife relationship for a positive birth experience. The Japanese maternity care system needs a radical shift to relationship-based care, such as MLCC, for women's positive birth experience and long-term well-being.

## **Funding**

The research was supported by the Auckland University of Technology (AUT) Vice-Chancellor's Doctoral Scholarship and the AUT Doctoral grant, New Zealand. There has been no significant financial support for this work that could have influenced its outcome.

## **Ethical Statement**

Ethics approval (16/429) for the study was granted by Auckland University of Technology Ethics committee (AUTEC) on 17th November 2016.

## **Conflict of Interest**

We know of no conflicts of interest associated with this publication.

## **Acknowledgements**

We express our gratitude to all the women who generously gave their time and shared their experience for this research. We thank our colleagues who have supported us to complete this research. The research was supported by the Auckland University of Technology (AUT) Vice-Chancellor's Doctoral Scholarship and the AUT Doctoral grant. Special thanks to Shoba Nayar, who provided editing assistance.

## **References**

- [1] World Health Organization, WHO recommendations: Intrapartum care for a positive childbirth experience, Author, Geneva, 2018.
- [2] Neonatal mortality [Internet]. United Nations Children's Fund. 2023 [cited 2023 Feb 2]. Available from: <https://data.unicef.org/topic/child-survival/neonatal-mortality/>.
- [3] Maternal mortality [Internet]. United Nations Children's Fund. 2021 [cited 2022 Nov 22]. Available from: <https://data.unicef.org/topic/maternal-health/maternal-mortality/>.

[4] UNICEF. Japan is the safest place to be born according to our new report [Tweet]. In: UNICEF, editor. 2018, March 16.

[5] King A. Japan the safest place to give birth: UNICEF. Nikkei Asian Review. 2018 February 21st.

[6] Japan Association of Obstetricians and Gynecologists, Ninsanpu mentaru herusu kea manyuaru: Sango kea eno kireme no nai sien ni mukete [Expectant and nursing mothers' mental health care manual: Towards seamless support of postpartum care], Author, Tokyo, 2017.

[7] Takeda S. Ninsanpu no jisatsu: sono jittai [Suicide of expectant and nursing mothers: the actual situation]: Japan Association of Obstetricians and Gynecologists; 2017 [2022 Nov 22]. Available from: <http://www.jaog.or.jp/wp/wp-content/uploads/2017/11/11643745157d48555ead55ae19d42a0a.pdf>.

[8] National Center for Child Health and Development. Jinko dotai tokei (shibo•shusse•shizan)

kara miru ninshin-chu•sango no shibo no genjyo [The state of deaths during pregnancy and after

birth based on the vital statistics (deaths•births•stillbirths)]: National Center for Child Health and

Development; 2018 [2022 Nov 22]. Available from: <https://www.ncchd.go.jp/press/2018/maternal-deaths.html>.

[9] Ministry of Health Labour and Welfare, Kodomo gyakutai ni yoru shibou jirei tou no kensyou kekka tou ni tsuite [Results of verification of cases of child abuse deaths], Ministry of Health, Labour and Welfare, Tokyo, 2021.

[10] Ministry of Health Labour and Welfare, Sanzen sango sapoto jigyo gaidorain, sangokea jigyo gaidorain [Service guidelines for antenatal and postnatal support, and service guidelines for postnatal care], Ministry of Health, Labour and Welfare of Japan, Tokyo, 2020.

[11] Cabinet Office, Annual report on the declining birthrate 2022, Cabinet Office of Japan, Tokyo, 2022.

[12] A.F. Bell, E. Andersson, The birth experience and women's postnatal depression: a systematic review, Epub 20160507, Midwifery 39 (2016) 112–123, <https://doi.org/10.1016/j.midw.2016.04.014>. PubMed PMID: 27321728.

[13] S. McGowan, Does the maternal experience of childbirth affect mother–infant attachment and bonding? J. Health Visit. 2 (11) (2014) 606–616, <https://doi.org/10.12968/johv.2014.2.11.606>.

- [14] A.F. Bell, L.H. Rubin, J.M. Davis, J. Golding, O.A. Adejumo, C.S. Carter, The birth experience and subsequent maternal caregiving attitudes and behavior: a birth cohort study, *Arch. Women's Ment. Health* 22 (5) (2019) 613–620, <https://doi.org/10.1007/s00737-018-0921-3>.
- [15] A. Holopainen, M.L. Verhage, M. Oosterman, Childbirth experience associated with maternal and paternal stress during the first year, but not child attachment, *Epub* 20200908, *Front Psychiatry* 11 (2020), 562394, <https://doi.org/10.3389/fpsy.2020.562394>.
- [16] Jinko dotai tokei: shusseki [Digest of vital statistics: birth] [Internet]. Ministry of Health, Labour and Welfare of Japan. 2022 [cited 2022 Nov 22]. Available from: [https://www.e-stat.go.jp/stat-search/files?page=1&query=出生の場所&layout=dataset&bunya\\_l=02&stat\\_infid=000032235774&metadata=1&data=1](https://www.e-stat.go.jp/stat-search/files?page=1&query=出生の場所&layout=dataset&bunya_l=02&stat_infid=000032235774&metadata=1&data=1).
- [17] M. Nakayama, *Shussan shisetsu wa naze hihei shitanoka: nichibo sanko kangogakuin, iryoho kaisei, kosei shoseisaku no ayumi* [Why did birth facilities get impoverished: history of Nichibo obstetric nursing schools, amendment of the medical service law, and political strategies set by Ministry of Health], Nihon Hyoronsha, Tokyo, 2015.
- [18] C. Misago, T. Umenai, M. Noguchi, T. Mori, T. Mori, Satisfying birthing experiences in Japan, *Lancet* 355 (9222) (2000) 2256, [https://doi.org/10.1016/S0140-6736\(05\)72759-8](https://doi.org/10.1016/S0140-6736(05)72759-8).
- [19] T. Igarashi, M. Wakita, K. Miyazaki, T. Nakayama, Birth environment facilitation by midwives assisting in non-hospital births: a qualitative interview study, *Midwifery* 30 (7) (2014) 877–884, <https://doi.org/10.1016/j.midw.2014.02.004>.
- [20] K. Takehara, N. Okamoto, K. Yoshida, C. Misago, Y. Osanai, K. Okamoto, et al., A qualitative study of care provided for pregnant women at birth houses in Japan: what is the essence of midwifery care at birth houses? *Bosei Eisei*. 50 (1) (2009) 190–198.
- [21] M. Noguchi, Women's positive childbirth experience at a birthing home and knowledge by acquaintance, *Nihon Josan Gakkaishi* 15 (2) (2002) 7–14.
- [22] B. Hunter, M. Berg, I. Lundgren, O.A. Olafsdóttir, M. Kirkham, Relationships: The hidden threads in the tapestry of maternity care, *Midwifery* 24 (2) (2008) 132–137, <https://doi.org/10.1016/j.midw.2008.02.003>. PubMed PMID: 18378051.
- [23] M. van Manen. *Researching lived experience*, 2nd ed., Routledge, New York, 2016.
- [24] M. Heidegger, *Being and time: A revised edition of the Stambaugh translation*, State University of New York Press, Albany, 1927/2010.

- [25] H.-G. Gadamer, *Truth and method*, Bloomsbury Academic, London, 1960/2013.
- [26] T.T. Bartholomew, E.E. Joy, E. Kang, J. Brown, A choir or cacophony? Sample sizes and quality of conveying participants' voices in phenomenological research, 20597991211040063, *Methodol. Innov.* 14 (2) (2021), <https://doi.org/10.1177/20597991211040063>.
- [27] P.J. Hall, J.W. Foster, K.M. Yount, B.M. Jennings, Keeping it together and falling apart: women's dynamic experience of birth, *Midwifery* 58 (2018) 130–136, <https://doi.org/10.1016/j.midw.2017.12.006>.
- [28] S. Crowther, P. Ironside, D. Spence, L. Smythe, Crafting stories in hermeneutic phenomenology research: a methodological device, Epub 20160626, *Qual. Health Res.* 27 (6) (2017) 826–835, <https://doi.org/10.1177/1049732316656161>.
- [29] S. Crowther, E. Smythe, Open, trusting relationships underpin safety in rural maternity a hermeneutic phenomenology study, Epub 20161124, *BMC Pregnancy Childbirth* 16 (1) (2016) 370, <https://doi.org/10.1186/s12884-016-1164-9>.
- [30] M. van Manen, *Phenomenology of practice: Meaning-giving methods in phenomenological research and writing*, Left Coast Press, Walnut Creek, 2014. [31] M. van Manen. *The tone of teaching*, 2nd ed., Routledge, Abingdon, 2016.
- [32] Japan International Cooperation Agency, *Ningenteki na osan [Humanised birth]*, Japan International Cooperation Agency, Tokyo, 2018.
- [33] R. Reed, R. Sharman, C. Inglis, Women's descriptions of childbirth trauma relating to care provider actions and interactions, Epub 20170110, *BMC Pregnancy Childbirth* 17 (1) (2017) 21, <https://doi.org/10.1186/s12884-016-1197-0>.
- [34] L. Goldkuhl, L. Dellenborg, M. Berg, H. Wijk, C. Nilsson, The influence and meaning of the birth environment for nulliparous women at a hospital-based labour ward in Sweden: an ethnographic study, e337-e47. Epub 20210726, *Women Birth* 35 (4) (2022), <https://doi.org/10.1016/j.wombi.2021.07.005>.
- [35] Y.J. Kuipers, G. Thomson, J. Goberna-Tricas, A. Zurera, E. Hresanova, N. Temesgenova, et al., The social conception of space of birth narrated by women with negative and traumatic birth experiences, Epub 20220502, *Women Birth* 36 (1) (2023) e78–e85, <https://doi.org/10.1016/j.wombi.2022.04.013>.
- [36] E. Hrešánov'a, 'Nobody in a maternity hospital really talks to you': socialist legacies and consumerism in Czech women's childbirth narratives, *Czech Sociol. Rev.* 50 (6) (2014) 961–986, <https://doi.org/10.13060/00380288.2014.50.6.150>.

- [37] D. Koster, C. Romijn, E. Sakko, C. Stam, N. Steenhuis, D. de Vries, et al., Traumatic childbirth experiences: practice-based implications for maternity care professionals from the woman's perspective, *Scand. J. Caring Sci.* 34 (3) (2020) 792–799, <https://doi.org/10.1111/scs.12786>.
- [38] E. Newnham, M. Kirkham, Beyond autonomy: care ethics for midwifery and the humanization of birth, *Nurs. Ethics* 26 (7–8) (2019) 2147–2157, <https://doi.org/10.1177/0969733018819119>.
- [39] F. Dykes, 'No time to care': Midwifery work on postnatal wards in England, in: B. Hunter, R. Deery (Eds.), *Emotions in midwifery and reproduction*, Bloomsbury, London, 2009, pp. 90–104.
- [40] S. Boyle, H. Thomas, F. Brooks, Women's views on partnership working with midwives during pregnancy and childbirth, *Midwifery* 32 (2016) 21–29, <https://doi.org/10.1016/j.midw.2015.09.001>.
- [41] M. Lopez-Toribio, P. Bravo, A. Llupia, Exploring women's experiences of participation in shared decision-making during childbirth: a qualitative study at a reference hospital in Spain, Epub 20210917, *BMC Pregnancy Childbirth* 21 (1) (2021) 631, <https://doi.org/10.1186/s12884-021-04070-3>.
- [42] Y. Fontein-Kuipers, Hd.H.-v Veen, L. Klop, Zondag L. Conflicting values experienced by Dutch midwives: dilemmas of loyalty, responsibility and selfhood, *Clin. Res. Obstet. Gynecol.* 1 (1) (2018) 1–12.
- [43] K. Guilliland, S. Pairman. *The midwifery partnership: a model for practice*, 2<sup>nd</sup> ed., New Zealand College of Midwives, Christchurch, 2010.
- [44] J.H. Clemons, A. Gilkison, T.L. Mharapara, L. Dixon, J. McAra-Couper, Midwifery job autonomy in New Zealand: I do it all the time, Epub 20200919, *Women Birth.* 34 (1) (2021) 30–37, <https://doi.org/10.1016/j.wombi.2020.09.004>.
- [45] Asahi Shimbun. Kaigyo josanzo, san wari pinchi shokutakui gimuka ni kakuho kibishiku [30% of midwifery homes in a crisis, hard to find backup doctors]. Asahi Shimbun. 2007 February 10th.
- [46] Z. Bradfield, Y. Hauck, M. Kelly, R. Duggan, "It's what midwifery is all about": Western Australian midwives' experiences of being 'with woman' during labour and birth in the known midwife model, in: *BMC Pregnancy Childbirth*, 19, 2019, p. 29, <https://doi.org/10.1186/s12884-018-2144-z>.

- [47] D. O'Brien, M.M. Butler, M. Casey, The importance of nurturing trusting relationships to embed shared decision-making during pregnancy and childbirth, *Epub* 20210311, *Midwifery* 98 (2021), 102987, <https://doi.org/10.1016/j.midw.2021.102987>.
- [48] Y. Fontein-Kuipers, R. de Groot, A. van Staa, Woman-centered care 2.0: Bringing the concept into focus, *Epub* 20180530, *Eur. J. Midwifery* 2 (5) (2018), <https://doi.org/10.18332/ejm/91492>.
- [49] D.L. Davis, D.K. Creedy, Z. Bradfield, E. Newnham, M. Atchan, L. Davie, et al., Development of the woman-centred care scale- midwife self report (WCCS-MSR), *Epub* 20210723, *BMC Pregnancy Childbirth* 21 (1) (2021) 523, <https://doi.org/10.1186/s12884-021-03987-z>.
- [50] E. Shakibazadeh, M. Namadian, M.A. Bohren, J.P. Vogel, A. Rashidian, V. Nogueira Pileggi, et al., Respectful care during childbirth in health facilities globally: a qualitative evidence synthesis, *Epub* 20171208, *BJOG* 125 (8) (2018) 932–942, <https://doi.org/10.1111/1471-0528.15015>.
- [51] J. Sandall, H. Soltani, S. Gates, A. Shennan, D. Devane, Midwife-led continuity models versus other models of care for childbearing women, *Cochrane Database Syst. Rev.* 4 (2016), <https://doi.org/10.1002/14651858.CD004667.pub5>.
- [52] C. Axcell, Continuity of carer, *Br. J. Midwifery* 26 (2) (2018) 134, <https://doi.org/10.12968/bjom.2018.26.2.134>.
- [53] J. Allen, S. Kildea, M.B. Tracy, D.L. Hartz, A.W. Welsh, S.K. Tracy, The impact of caseload midwifery, compared with standard care, on women's perceptions of antenatal care quality: survey results from the M@NGO randomized controlled trial for women of any risk, *Epub* 2019/06/25, *Birth* 46 (3) (2019) 439–449, <https://doi.org/10.1111/birt.12436>.
- [54] F. D'Haenens, B. Van Rompaey, E. Swinnen, T. Dilles, K. Beeckman, The effects of continuity of care on the health of mother and child in the postnatal period: a systematic review, *Eur. J. Public Health* 30 (4) (2020) 749–760, <https://doi.org/10.1093/eurpub/ckz082>.
- [55] H. Perdok, C.J. Verhoeven, J. van Dillen, T.J. Schuitmaker, K. Hoogendoorn, J. Colli, et al., Continuity of care is an important and distinct aspect of childbirth experience: findings of a survey evaluating experienced continuity of care, experienced quality of care and women's perception of labor, *Epub* 20180108, *BMC Pregnancy Childbirth* 18 (1) (2018) 13, <https://doi.org/10.1186/s12884-017-1615-y>.
- [56] A.S. Miltenburg, F. Lambermon, C. Hamelink, T. Meguid, Maternity care and human rights: what do women think?, *Epub* 20160702, *BMC Int Health Hum. Rights* 16 (1) (2016) 17,

<https://doi.org/10.1186/s12914-016-0091-1>.