The meaning of the woman–midwife relationship in Japan:

A hermeneutic phenomenological study

Keiko Doering

A thesis submitted to
Auckland University of Technology
in fulfilment of the requirements for the degree of
Doctor of Philosophy (PhD)

2020

School of Clinical Sciences
Faculty of Health and Environmental Sciences

Abstract

Maternal and neonatal mortality rates in Japan are consistently among the lowest in the world. Nevertheless, many Japanese women suffer from anxiety and depression, and commit suicide during pregnancy and postpartum periods. This indicates that, in the pursuit of saving women's and babies' lives, Japan's advanced medical system may have overlooked the importance of women's overall birth experience that includes psychological well-being. Midwives are considered key care providers of maternity care, and the relationship between women and midwives has potential to improve women's birth experience. However, the significance of such relationship has received far less attention in Japan. With the aim of improving Japanese maternity care and women's birth experience, the study examines the values of the relationship by asking, 'What is the meaning of the woman–midwife relationship in Japan?'

To address this question, hermeneutic phenomenology inspired by Max van Manen and philosophy based on the Japanese worldview provide the methodological foundation of the study. This methodological approach enables a more nuanced interpretation of women's and midwives' lived experiences. Individual interviews were conducted with 14 women and 10 midwives across Japan. The hermeneutic phenomenological analysis revealed four themes; 1) Connection, 2) Presence, 3) Having a voice, and 4) Peace of mind and trust. The women and midwives of the study in the dominant maternity care context, described it as an assembly line care, often struggled to make a connection with one another, leaving women feeling helpless and alienated. However, some women and midwives, especially in a long-term relationship, described that by sharing time, experience, and understanding, they were able to feel present to each other. Such a relationship enabled the women to have a voice, and the mutual understanding established between the women and their midwives allowed the midwives to advocate for the women for whom they cared. Furthermore, the positive relationship always embraced the women and midwives with a feeling of safety (*anshin*) and trust (*shinrai*), which were described as key emotions contributing to women's positive birth experience.

The study found the significance of the woman–midwife relationship is that it provides psychological safety for both women and midwives in maternity care. Women requires both clinical and psychological safety to have a positive birth experience, as the experience affects their lives afterward. Further, a positive relationship with a midwife instils confidence in women as mothers. Conversely, it is difficult to ensure woman-centred and respectful care without developing the relationship because the woman–midwife relationship is the foundation of midwifery care. Having a positive relationship should be considered a basic human right for all

the women in maternity care. Nevertheless, the current maternity care system in Japan limits many women and midwives from developing a relationship. The study recommends midwifery continuity of care in Japan to ensure opportunities to better develop the woman–midwife relationship. The shift from the current maternity care to the relationship-based care requires radical changes, but it is vital to improve women's birth experience and foster improved long-term social and psychological outcomes for women in Japan.

Table of Contents

Abstract ..... **i**

Table of Contents ..... **iii**

List of Figures ..... **vii**

List of Tables ..... **viii**

Attestation of Authorship ..... **ix**

Acknowledgements ..... **x**

Abbreviations ..... **xii**

Chapter One: Introduction **1**

The research question and aims of the study 1

Reasons for undertaking the study 2

The context of the research 3

My journey towards to this research 4

Justification of the research 6

Choice of methodology and research methods 6

Personal pre-understanding 8

Structure of the thesis 10

Summary 11

Chapter Two: The Context of Maternity Care and Midwifery in Japan **12**

Japan's demographic features and healthcare context 12

Maternity care in Japan 13

Maternity care system in Japan 13

Statistical features of maternity care in Japan 14

Birth places and midwifery practice in Japan 17

Changes of birth places and maternity care providers over time in Japan 17

Current situation of birth places and midwives' work style in Japan 20

The context of Japanese midwifery 24

History of Japanese midwifery 24

Educational context of Japanese midwifery 25

Midwives' status and roles in Japanese society 28

Current issues of maternity care in Japan 31

Issues of maternity care and facilities in Japan 31

Social issues faced by childbearing women in Japan 32

Summary 34

Chapter Three: Literature review 35

The meaning of relationship 37
Human relationship and humans as beings of relationship 37
Relationship in healthcare 38

Midwifery relationships in the international context 40
The significance of the woman–midwife relationship 40
Models and concepts of the woman–midwife relationship 44

The woman–midwife relationship in the Japanese context 52

Summary 55

Chapter Four: Methodology 56

Philosophers underpinning hermeneutic phenomenology 56
Husserl's phenomenology 56
Heideggerian phenomenology 57
Gadamer's phenomenology 60
van Manen and phenomenology of practice 61

Philosophical and methodological foundations of the study 62
Hermeneutic phenomenology as the research methodology 62
Meaning in hermeneutic phenomenology 64
Lifeworld existentials 66
Pre-understanding and openness 69

Japanese philosophy and worldview 71

Summary 75

Chapter Five: Methods 77

Ethical considerations 77

Participants 78
Recruitment 78
Consent, confidentiality, and anonymity 78

Gathering the data 79
Individual interviews and participants' profile 79
Hermeneutic phenomenological interview 81

Working with the data 82
Nonmethodical method 82
Interpreting the data: Hermeneutic phenomenological analysis 84

Rigour: Trustworthiness of the study 92
Credibility 93
Transferability 94
Dependability 94

Summary 95

Chapter Six: Seeking a Connection 96

Closed hearts and bodies in insecure relationships 96

Hopelessness and helplessness 100

Alienation 103

Compromising a way of being a midwife 107
Despair of a midwife 110
Women's vulnerability and desire for positive relationships 111
Summary 114

Chapter Seven: Being Present 115
Sharing time and space 115
Sharing time throughout pregnancy, birth, and postpartum 120
Listening and being listened to 122
A sense of unity 128
Timeless relationship and presence 130
Summary 134

Chapter Eight: Having a Voice 135
Voices unheard 135
Losing a voice 140
Having a voice 142
Finding an inner voice 144
Speaking for women 147
Summary 150

Chapter Nine: Sensing a Peace of Mind and Trust 151
A sense of *anshin* 151
Midwives' *anshin* and quality of care 155
Different kinds of trust—*shin'yō* and *shinrai* 156
Relying on and entrusting midwives 158
Becoming/making a mother 161
An emotional bridge 165
Summary 168

Chapter Ten: Discussion and Conclusion 169
Psychological safety and safe care 169
Midwifery continuity of care 172
Respectful care and woman-centred care 175
Shaping midwives' identity 178
Implications for practice 180
Implications for education 182
Implications for future research 183
Strengths and limitations 185
Closing thoughts 186

References **188**

Appendices **221**
Appendix A: Ethics approval 221
Appendix B: Email advertisement 222
Appendix C: Participant information sheet for women 224
Appendix D: Participant information sheet for midwives 228
Appendix E: Research safety protocol 232
Appendix F: Consent form 233
Appendix G: Protocol and conversation guide for interviews 235
Appendix H: Confidentiality agreement 236
Appendix I: An example of crafting the data 238
Appendix J: Tentative themes emerged from the participants' experiences 240
Appendix K: An example of organising themes and selected passages for thematic analysis 241

List of Figures

Figure 1: Birth facilities and birth places in Japan (2017)..... 20
Figure 2: Workplaces of midwives in Japan (2016)..... 21
Figure 3: The number of registered midwifery homes in Japan..... 23
Figure 4: Hermeneutic circle of this study 84

List of Tables

Table 1: Women participants..... 80
Table 2: Midwife participants..... 80

Attestation of Authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

Signed:

Dated: 22nd June 2020

Acknowledgements

I would like to express my gratitude to all the people whose support and encouragement enabled me to complete this thesis. I am deeply grateful to the women and midwives who generously gave their time and shared their experiences for this study. I cannot thank them enough for their enormous contribution to this study.

I would also like to show my greatest appreciation to my supervisors, Dr Andrea Gilkison and Associate Professor Judith McAra-Couper. They are my midwives who continuously supported the birth of this thesis. They have always been with me during this journey, brought out my potential with supportive and insightful advice, and given me the confidence needed to complete this thesis. Without their guidance and persistent help, this thesis would have not been possible.

Special thanks to my mentor, Professor Liz Smythe. She kindly and patiently taught me phenomenology from the introductory level to being able to apply it for this study and in practice. I would also like to offer my special thanks to Qorinah Estiningtyas Sakilah Adnani. As doctoral candidates, we have shared fun and difficult times and encouraged each other to keep going. Her positive messages always cheered me up and inspired me to carry on with this study. Dr Jean Patterson and Dr Christine Griffiths, the supervisors for my master's thesis at Otago Polytechnic, gave me a great help to obtain the Vice-Chancellor's Doctoral Scholarships and start this journey at Auckland University of Technology (AUT). My deep appreciation goes to transcribers, editors, AUT staff, the Vice-Chancellor's Doctoral Scholarships, and the institution of AUT who have supported and sustained my study.

I must thank Fumiko Hinokuma and Chie Kota who are my mentors and friends in Japan. Discussions with them has been illuminating, and they have motivated me to complete this study for our common goal; improving women's birth experience in Japan. After completing this thesis, I believe that we can make a difference in maternity care and midwifery in Japan. Heartfelt thanks also to members of Birth for the Future (BFF) and other colleagues and friends in Japan for their support.

Finally, I want to thank my husband from the bottom of my heart. Adam's enormous support is indispensable. Miyabi, Naru, and Kaede, thanks for their patience, generosity, and love. They are the real source of my positive energy. I am glad that I can submit this thesis just before my mother's 70th birthday. Literally, it was impossible to continue the study without her generous support to my entire family. ありがとう！

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

Abbreviations

GHQ	General Headquarters, referred to as the offices of the American occupation in Japan after World War II
ICM	International Confederation of Midwives
JAOG	Japan Association of Obstetricians and Gynecologists
JMA	Japanese Midwives Association
JNA	Japanese Nursing Association
MCOC	Midwifery Continuity of Care
MHLW	Ministry of Health, Labour and Welfare of Japan
MLCC	Midwife-led Continuity of Care
NICU	Neonatal Intensive Care Unit
OECD	Organisation for Economic Cooperation and Development
UNICEF	United Nations Children's Fund
WHO	World Health Organization
WWII	World War II

Chapter One: Introduction

Japan is the safest place to be born/to give birth.

(King, 2018; UNICEF, 2018)

Every time I see this statement, I feel uncomfortable. I am a Japanese midwife and yet, rather than being proud of our low neonatal and maternal mortality rates, I know this statement does not fully reflect the situation of the current Japanese maternity care. Perhaps the meaning of 'safe,' in the statement above, is too narrow; with safety of childbirth becoming synonymous with measurements and statistics of mortality rates. However, women never equate their birth experience only with outcomes and numbers. The statistics may represent the quality of medical services but not the quality of care.

Globally, midwives are expected to undertake the primary role in maternity care, and midwifery care is considered key to improving the quality of women's birth experience (Horton & Astudillo, 2014; International Confederation of Midwives [ICM], 2017b; World Health Organization [WHO], 2016). Research further shows that care and safety are sustained by human relationship between women and midwives (B. Hunter, Berg, Lundgren, Ólafsdóttir, & Kirkham, 2008; Y. Noguchi, 2002). This thesis is a journey towards seeking the meaning of the woman–midwife relationship in Japan, with the potential to help broaden the meaning of safety of childbirth. The thesis will demonstrate that a more holistic and nuanced understanding of childbirth and care is only achieved when the human's lived experience is comprehended.

The research question and aims of the study

The research question is 'What is the meaning of the relationship between women and midwives in Japan?' The study aims to improve maternity care and women's birth experiences by developing a better understanding of the relationship between women and midwives in Japan. More specifically, the study explores the lived experience of women and midwives in the Japanese context in order to:

- Reveal taken-for-granted dimensions of the day-to-day midwifery relationship in maternity care settings.
- Express the experience and meaning of the woman–midwife relationship in Japan.
- Stimulate discussion about the meanings and practices of having a 'relationship with women' in Japanese midwifery

- Enhance relationship-based maternity care in Japan
- Develop a holistic approach to understanding the meaning of safe childbirth based on women's and midwives' lived experience
- Enhance safety of childbirth in Japan, and
- Improve women's satisfaction and psychological well-being in birth experience.

Furthermore, this study has the potential to find a culture-specific concept of relationships in Japan that differs from the West, since maternity care values and systems differ among cultures and countries.

Reasons for undertaking the study

WHO (2018a) has highlighted the significance of women's birth experience, which can be enhanced by quality of care. The woman–midwife relationship affects the quality of care, and thereby women's birth experience (B. Hunter et al., 2008). Women's birth experience is important because childbirth is a significant life event, which has a life-long impact for women and their families (Dahlberg et al., 2016; Eigen, 2014). Research has shown that women's positive birth experiences bring them joy, self-confidence, personal development, and empowerment; as well as attachment with their babies (Attanasio, McPherson, & Kozhimannil, 2014; Crowther, Smythe, & Spence, 2014a; Ichikawa & Kamada, 2009; Klaus, Kennell, & Klaus, 1995; Misago et al., 2005). However, negative birth experiences can result in feeling a lack of self-control and competence, difficulties adjusting to their new role as a mother, barriers to attachment with their babies, and psychological disorders including postpartum depression and trauma (Bell & Andersson, 2016; Howarth, Swain, & Treharne, 2011; Kunikiyo, 2012; McGowan, 2014).

In Japan, a recent survey indicated that the number of pregnant women and new mothers who commit suicide is more than that of maternal death caused by childbirth (Japan Association of Obstetricians and Gynecologists [JAOG], 2017a). Suicide is not included in the maternal mortality rate but could, nevertheless, be considered as an adverse consequence of pregnancy and a negative experience of childbirth. Furthermore, a large number of childbearing women are estimated to need mental health treatment, and an increase of postpartum depression and baby abuse has been reported in Japan (S. Abe, 2016b; Iwamoto, 2015). These situations indicate that, in its pursuit to save the lives of women and infants, by medicalising childbirth, the Japanese maternity care system may have overlooked the significance of women's birth experience, including psychological aspects.

It is evident that women's birth experience and satisfaction is related to the maternity care provided (Howarth et al., 2011; Moloney & Gair, 2015). As key maternity care providers,

midwives are close to the women in their care, and their interactions with these women are significant. There is research showing that well-developed relationships between women and their midwives promote a positive birth experience (Howarth et al., 2011; Kirkham, 2010b; Leap, Sandall, Buckland, & Huber, 2010; Walsh, 1999). This means that the kind of relationship a woman has with her midwife affects the care the woman receives and, therefore, her birth experience.

The evidence suggests that the woman–midwife relationship has potential to improve the quality of care and contribute to women's well-being in maternity care context in Japan. That is, understanding the relationship between women and their midwives can be a key to make changes in maternity care. For these reasons, the present study explores the relationship between women and midwives in Japan.

The context of the research

The context of this study is Japanese maternity care settings. Japan is an East Asian country holding the world's longest average life expectancy at birth (WHO, 2018b). The neonatal and maternal mortality rates are, internationally, also at the lowest level—0.9/1,000 and 5/100,000 live births respectively (United Nations Children's Fund [UNICEF], 2018; WHO, 2019). However, the neonatal and maternal morbidity is not as good as the mortality in Japan. For example, Japan's percentage of low-birthweight infants is higher than the average of the 35 countries in the Organisation for Economic Cooperation and Development (OECD, 2017). Also, cases of obstetric complications, such as placenta previa, premature birth, and eclampsia, occur in approximately 55% of childbearing women (Nakai, 2019). This number seems high, given that childbirth is a normal life event for many women. Morbidity impacts women and babies' well-being, and possibly indicates the safety and quality of care. Hence, although Japan holds low neonatal and maternal mortality rates, the morbidity of pregnant and childbearing women and babies suggests it may be too early to celebrate in Japan.

After World War II (WWII), childbirth become rapidly institutionalised in Japan. Currently, more than 99% of women in Japan give birth in hospitals or obstetric clinics (Ministry of Health, Labour and Welfare [MHLW], 2018i). In accordance with the institutionalisation of birth, midwives' workplaces also shifted from the community to birth facilities. The autonomy of midwives was diminished by the reformation of the midwifery profession under American occupation and the rise of obstetric-based maternity care (Ohbayashi, 1989). Childbirth in Japan has also become highly medicalised, and the percentages of Caesarean section and the use of epidural have been rapidly increasing (MHLW, 2018a, 2018h).

In addition, Japan is seeing serious social issues regarding women's postnatal and mental health, including postpartum depression, suicide, and infant abuse (JAOG, 2017a). These issues indicate that there is much room for improvement in Japan's maternity care, and midwives are well positioned to play a significant role in helping overcome these issues. I will discuss the context of Japanese maternity care, midwifery, and related issues in more detail in Chapter Two.

My journey towards to this research

I qualified as a midwife in Japan. I first worked in a maternity department of a hospital for five years. While I worked in the hospital, my colleagues and I tried to improve maternity care by reconsidering routine care, promoting natural/physiological birth and breastfeeding, and introducing many care approaches, such as free birthing postures and skin-to-skin care between mothers and babies. While we saw some improvement in the quality of care and women's satisfaction, by implementing the changes, I felt we could never achieve the kinds of changes women and midwives really needed. We needed a radical reform, which was much more than simply promoting natural birth. The problem was I did not know what specific and actionable changes were needed, and how they could be achieved.

During my five years at the hospital, I provided continuity of care for eight women. After all these years, those experiences with women have remained in my mind, including both positive and negative incidents. I rarely remember the details of hundreds of other women whom I met in the hospital, but the close relationship with those eight women was different. I still reflect on my care for those women, thinking how that experience could inform better midwifery practice. I think this kind of care is a necessary thing as a midwife. Once I left the hospital, I felt I could not go back to hospital settings. I then worked for a midwifery home, which is a primary birth facility run by a small number of midwives, for nearly two years. I have a lot of memories of the women I met there, but midwifery homes were in a difficult position due to strict legal requirements and a decline in women choosing to give birth at midwifery homes. Again, I felt the Japanese maternity care system needed to be changed—not just in hospitals but across the entire system.

Between 2003 and 2005, I also worked as a delegate of the Red Cross society for Congolese refugee camps in Tanzania and with an emergency relief operation following the Indian Ocean (Sumatra) earthquake and tsunami in Indonesia. Many medical resources and aid were lacking, and there were many more cases where we could not save the lives of mothers and babies. However, I saw positive differences in people's birth and life, especially in Tanzania. In the refugee camps, I saw women moving and dancing as they liked during labour. Many mothers would take care of their babies together, and mothers who lost their babies at, or after, birth would be consoled by the others. They openly expressed their joy and grief, and they energetically moved forward. I also met many traditional birth attendants who had wisdom and skills and were

trusted in their community. Childbearing women went to see those traditional birth attendants although they were encouraged to give birth in hospitals of the camps. It might have been cultural differences in perception of birth and life, but I felt people in Tanzania were more tolerant and humane, which could be what Japanese might have lost while obtaining highly advanced medical care in a technologically advanced maternity environment.

At that time, I read an article introducing the New Zealand midwifery system which had achieved what they referred to as full autonomy for midwives. I felt that was the kind of radical change Japanese midwifery also needed. I was interested in the maternity care system and the fact that women and midwives worked together to establish the New Zealand midwifery system and education. That brought me to New Zealand. I was keen to learn about New Zealand midwifery in order to create change in Japanese midwifery and maternity care. Due to personal events, including the births of my own children and moving internationally, the journey towards this doctoral study took a while. However, the above events, including homebirths of one child in Canada and two children in New Zealand, also brought me immeasurable experiences, insights, and awareness as a midwife, mother, and woman.

There are both advantages and disadvantages for conducting this study in either New Zealand or Japan. Since this study is about Japanese midwifery, it would be reasonable to conduct this doctoral study at a university in Japan. However, researching the Japanese woman–midwife relationship outside Japan has many advantages. Firstly, the discussions regarding the woman–midwife relationship are very lively outside Japan. The theoretical concepts of midwifery and cultural care are also more developed outside Japan. Secondly, researching in New Zealand affords me greater access to literature. It is important that researchers access domestic and international literature related to the research topic. However, Japanese academic research depends largely on domestic studies because of the linguistic limitation of only using the Japanese language. Accordingly, access to international academic journals, which universities usually provide, is limited due to low demand. Restricted access to literature makes it difficult to obtain wider and deeper knowledge and discussions about related themes. Thirdly, while studying in a foreign country, I realised that things that I have taken for granted as a midwife in Japan are not common knowledge outside of Japan. I have seen many differences, expanded my views, and gained more information to develop ideas and interpretations. I needed to reconsider my taken-for-granted worldview and, through the process, deepen understandings and insights regarding my chosen topic. In this way, I may contribute to the international discussion while presenting the study findings to Japanese academia and maternity care settings.

Justification of the research

The importance of the woman–midwife relationship for maternity care is globally recognised and well documented in Western countries (Boyle, Thomas, & Brooks, 2016; Dahlberg et al., 2016; Guilliland & Pairman, 2010a; B. Hunter et al., 2008). However, there is little research that specifically focuses on the woman–midwife relationship in Japan. While this indicates less attention has been paid to the relationship in Japan, it does not mean that the relationship has less value in Japanese maternity care settings. A relationship always ought to exist in some form within Japanese maternity care settings because the interaction between women and midwives is first and foremost about *being there* together. Moreover, women and midwives in Japan might have their own unique experiences of the relationship because values of childbirth and maternity care differ among cultures. Therefore, it is important to examine what kind of relationship women and midwives are actually having in Japanese maternity care settings, and to clarify the meaning of the woman–midwife relationship in Japan. The study explores this important gap in Japanese midwifery knowledge by addressing the key question; what is the meaning of the woman–midwife relationship in Japan?

If the relationship between a woman and her midwife is seen as a positive experience in specific environments, understanding the relationship could help the Japanese birth system to introduce and adopt a more relationship-based care into other maternity care settings. This study will be an important contribution to Japanese midwifery where a mutual relationship between women and their midwives has not been previously discussed. Understanding the best suited approach to building relationship between Japanese women and midwives would help improve the maternity care and women's birth experiences in Japan. This improvement may result in better maternal mental health. The study will also contribute to international discussions regarding the cultural difference of midwifery partnership and the woman–midwife relationship in different countries.

Choice of methodology and research methods

This study is underpinned by the philosophy of hermeneutic phenomenology and informed by a Japanese worldview to understand the relationship between women and midwives in Japan. In regard to hermeneutic phenomenology, the study draws on the approach introduced by Max van Manen. van Manen (2016a) combined methodological theory with a practical approach to develop a hermeneutic phenomenological inquiry based on the phenomenology of Heidegger (1927/2010), Gadamer (1960/2013), and other philosophers as human science research concerned with pedagogy. 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 (van Manen, 2016a).

Hermeneutic phenomenology is well suited to the research questions of the study because it aims to reveal the meaning of a human experience in the everyday world (Smythe, 2011; van Manen, 2016a). The phenomenological approach seeks to uncover how a person sees the world and how she experiences it. Phenomenology deals with the lifeworld in which the person is living, and the reality in the lifeworld is described as *lived experience* (van Manen, 2016a). A phenomenological stance is that the essence of the lived experience is concealed within our experiences. Giles (2011) further claimed that the element of relationship is always already there; and, ontologically, social beings cannot exist in any other way. Such sensitivity towards relationships is, therefore, fundamental for understanding human experience.

As long as women give birth with midwives, a relationship obviously exists between them and the relationship is an integral part of woman's birth experience, no matter how much she is aware of it. The woman–midwife relationship is also a lived experience of midwives in everyday midwifery practice. Nevertheless, the experience is often taken for granted within maternity care settings, and what this relationship means for women, midwives, and women's birth experience has not been clarified in Japan. Therefore, this study attempts to understand the meaning of the relationship between Japanese women and midwives through their lived experience with a hermeneutic phenomenological approach.

Japanese philosophy and worldview also, unavoidably, underpin this phenomenological study. Heidegger claimed that the idea of philosophy is Western (Kida, 2000), and van Manen (2016a) stated that phenomenological human science is a Western research method to distinguish it from Eastern meditative techniques. Since Japanese values are discussed throughout the thesis, axiology—the study of values—was a concept worth considering (Kelly et al., 2018). Although I did consider axiology, the thesis did not want to place too much emphasis on a meta-discussion of Japanese values as doing so may have taken the interpretation away from the grounded experiences the phenomenological methodology was striving to capture. The purpose of the hermeneutic phenomenological approach to this study is to attune to and detail the lived experiences of the midwife–women relationship. I understand phenomenology to be grounded in the body, in the everyday, and in how we relate to the world around us. With this in mind, Japanese ways of thinking and being supplement the philosophical approach of this study in order to understand the experience of Japanese women and midwives, but is not the primary focus of the study.

Japanese society is frequently referred to as a form of collectivism, in contrast to the individualism of Western cultures. Guessing what another person is thinking and feeling, without asking, is also valued. In Japan, where it was a relatively homogeneous nation, it was anticipated that everyone

had same or similar ideas and values (Nakane, 1967). This means that everything they do is taken for granted as a common understanding. The same may be said in midwifery practice and philosophy in Japan. The taken-for-granted common understanding could be one reason why Japanese midwives do not discuss and document the philosophy of their practice, including the relationship with women in their care. Even if many midwives have been losing their autonomy under the dominant obstetric management of maternity care, the relationship between women and midwives should be there or hidden in any situation. Understanding the experiences and documenting them is increasingly important for current Japanese midwifery. This study will be a great opportunity and challenge to describe and interpret Japanese midwives' experiences with words.

To better understand the lived experience of the woman–midwife relationship, the study involved individual interviews with 14 mothers and 10 midwives across Japan. 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 his hermeneutic phenomenology (van Manen, 2016a). The text was produced through writing and rewriting of the interview transcript and further interpreted to bring clarity and seek the depth of the lived experience of the study participants. More specifically, the interviews were conducted in Japanese, which I then translated into English. The text was interpreted, edited, and reworked in English although I kept referring back the original Japanese text when further clarification was required. The interpretations were rewritten, reinterpreted, and rethought until adequate convincing interpretations, which are explicit, rigorous, and comprehensive, were achieved.

Personal pre-understanding

An important premise of hermeneutic phenomenology is that our pre-understandings influence our interpretations (Gadamer, 1960/2013; Heidegger, 1927/2010). Therefore, it is impossible to put the interpretation of the researcher, myself, aside when interpreting the experiences as conveyed by the women and midwives. Researchers can interpret and understand another's experience because they have prior interests and pre-understandings that influence one's understandings of the phenomenon. The pre-understandings limit what can be known about a phenomenon when we are not aware of it. Therefore, researchers need to clarify their own pre-understandings that influence interpretations beforehand, rather than ignoring them. Unless we recognise our pre-understandings, we cannot be open to understandings that differ from our own.

As a Japanese midwife and mother, who gave birth with midwives, I have experienced the relationship with women and midwives in several different contexts. Many of the relationships I experienced as a hospital midwife were short and fragmented. Others, I cared for throughout their antenatal, birth, and postnatal periods. I was able to get to know them more personally and

enjoyed close relationships with them. Particularly at midwifery homes, I saw experienced midwives developing a close and deep connection with each woman in their care. During my time in Tanzania, I observed that women and their traditional birth attendants in Congolese refugee camps were also well connected. Unfortunately, I did not have specific interests in the woman–midwife relationship during most of the events above. I was not attuned to the significance of the relationship. As a midwife, I took the relationship for granted.

Later, I chose to have a homebirth for each of my three children. I chose homebirth because I wanted to give birth at home and to be with midwives. I might have unconsciously been aware of the relationship by the time of becoming a mother. During my first birth, in Canada, my midwife was really experienced but I could not communicate with her well because of language issues and a relatively short relationship (I moved and met the midwife a few months before the birth). I had really good experiences with my midwife throughout my second and third births in New Zealand. The midwife was younger than me and her career as a midwife was shorter than mine, but she was competent and trustworthy. I was impressed by her and the New Zealand midwifery system that allowed me to experience the greatness of the relationship with her. While I was working as a midwife, especially in the hospital, I think few women had such a relationship with me. I may have lacked in understanding the experience of women giving birth in the hospital.

Another factor informing my pre-understandings is my admiration for New Zealand midwifery, especially the midwifery model (the system) and its explicit philosophy. In my eyes, New Zealand midwives appear more active, lively, positive, accountable, and professional based on shared midwifery philosophy. Yes, there are some issues; however, from this experience, I see Japanese midwifery to be inadequate, including their relationship with women. As the saying goes, the grass is always greener on the other side, but this is my honest prejudice. I believe that New Zealand midwives have more opportunities, than Japanese midwives, to establish a good relationship with women due to the maternity care system and their autonomous practice. Accordingly, I also believe that childbearing women in New Zealand potentially have better birth experiences. However, it frustrates me that the statistical outcomes are always better in Japan. Hence, my desire to undertake qualitative research and try to understand women's birth experience from a different aspect.

These experiences, pre-knowledge, and biases in regard to the relationship between women and midwives, affect my understanding and interpretation of the woman–midwife relationship in Japan, as a researcher. To interpret women and midwives' experiences for the phenomenological inquiry, I am aware that I employ all my previous knowledge and experience. In addition, due to my unique experience of being a midwife in Japan, a mother receiving midwifery care in foreign countries, and a student learning from New Zealand midwives, my own pre-understandings of the

woman–midwife relationship is different from any other Japanese midwife and midwives in other countries.

Structure of the thesis

This thesis consists of 10 chapters. They will be presented in the following manner.

Chapter Two explores the context and background of the study, specifically the Japanese context of maternity care and midwifery. My interests towards this study emerged from this contextual and historical background. The context directly and indirectly impacts on the woman–midwife relationship in Japan. This chapter details Japan's demographic features, healthcare system, and health statistics; and further focuses on the maternity care and birth culture of Japan, including the historical changes, current issues, and unique characteristics relating to Japanese midwifery practice, education, regulations, and associations.

Chapter Three examines woman–midwife relationships in both Japanese and international literature. The literature review first explores the current situation concerning the woman–midwife relationship in Japan. It then examines the meaning of human relationships in wider fields of social sciences and healthcare contexts, before focusing on the significance of the woman–midwife relationship in midwifery. The exploration also investigates the impact of the relationship on women's birth experience. Moreover, this chapter explores the concepts underpinning the woman–midwife relationship in international and cultural specific contexts and seeks to provide a potential way forward regarding the woman–midwife relationship in Japan.

Chapter Four presents the methodology underpinning this study—van Manen's hermeneutic phenomenology. This approach is supported by insights from Heidegger and Gadamer, so the chapter begins by exploring those philosophers' phenomenology. Furthermore, van Manen's phenomenology is examined in detail through key concepts and notions of his approach, including why this methodology is suited to the study and how this methodology works. Lastly, Japanese philosophy and worldview are explored in order to interpret how Japanese views impact on the study and how hermeneutic phenomenology provides new insights in combination with this Japanese centred study.

Chapter Five describes the study methods based on the philosophy and methodology of van Manen's hermeneutic phenomenology. My pre-understandings are outlined in order to clarify my background and prejudices as a researcher conducting this study. While a hermeneutic phenomenology does not have a systematic method, how the data were collected, treated, and analysed based on van Manen's approach is presented. This study was conducted in the Japanese and English languages. The process of translation and interpretation between two languages will

be illustrated. The rigour of the study is also examined in order to clarify the audit trail of this hermeneutic phenomenological study.

Chapters Six to Nine present the findings of the study, which are the four themes that emerged from the data. **Chapter Six** presents the study participants' lived experiences of 'seeking a connection' with women/midwives in maternity care settings. **Chapter seven** entitled 'being present' interprets the lived experience in which women and midwives shared time and space, had a communication, felt united, and sensed a timeless connection through the development of the relationship. **Chapter Eight**, 'having a voice,' highlights how women's voice was unheard, how they had a voice or lost their voice, and how midwives were able to speak for women through their relationship. Finally, **Chapter nine**, presents the participants' experience of 'sensing a peace of mind and trust' in the woman–midwife relationship. These experienced senses reveal the meaning of the woman–midwife relationship.

Chapter Ten discusses the meaning of the woman–midwife relationship in Japan by synthesising the findings and literature. The implications for midwifery practice, education, and future research are drawn from the discussion. This chapter also presents strengths and limitations of the study. The thesis concludes with my final thoughts on the woman–midwife relationship in Japan and this doctoral journey.

Summary

This chapter has presented the research question and the aim of this study, with the justification of the study and the contributions the study will potentially make. I have introduced the context of maternity care and midwifery in Japan where the study is conducted. My background was presented to illustrate why I am motivated to carry out this study; and my pre-understandings, regarding how I understand the woman–midwife relationship and how this influences the researcher of the study, were examined. This chapter also briefly presented how the meaning of the woman–midwife relationship will be revealed in the hermeneutic phenomenological framework and through a Japanese worldview. Lastly, the organisation of this thesis was outlined. I begin the following chapter with the background of this study.

Chapter Two: The Context of Maternity Care and Midwifery in Japan

This chapter explores the context and background of the study. First, demographic features of Japan are presented followed by an outline of Japan's current healthcare system. Next, the focus moves to the context of maternity care in Japan, including statistics of maternity care and outcomes. Third, historical changes of birth places, care and culture that occurred after WWII and the current context of birth facilities and midwifery care in Japan are explored. The fourth section examines Japanese midwifery, including the midwives' history, education and roles in society. Lastly, Japan's current issues around childbirth and maternity care are presented. The context directly and indirectly influences the relationship between women and midwives, and the woman–midwife relationship could also affect the maternity care context of Japan.

Japan's demographic features and healthcare context

Japan is an East Asian island country situated in the western Pacific Ocean. It is home to over 126 million inhabitants on a land mass of roughly 378km^2 (Statistics Bureau of Japan, 2018). The population density of 340 people/km^2 is nearly 20 times that of New Zealand (Statistics Bureau of Japan, 2018; Stats NZ Tatauranga Aotearoa, 2017). Japan's Gross Domestic Product (GDP) ranks it as the world's third-largest economy, following the United States and China (World Bank Group, 2019). Yet, the *Global Gender Gap Report* (World Economic Forum, 2019) ranks Japan 121st out of 153 countries. The political empowerment of women is also low. Tellingly, the proportion of women in Japanese national parliament ranks 158th amongst 193 countries (Inter-Parliament Union, 2018). The status of women in society could affect the state of maternity care because the care is provided based on the social system and governmental policy.

Japanese health and medical standards are perhaps the highest in the world. According to the WHO (2018b), Japan has the world's longest average life expectancy at birth—84.2 years. The 2017 numbers are 87.26 years for women and 81.09 years for men, reaching historic highs for both genders (MHLW, 2018e). Some of the presumed reasons for such long life expectancy are diet, high living standards, and medical advances. The national healthcare system is also accessible. The national health insurance system has provided comprehensive coverage of citizens and equal healthcare, including dental treatments, with patient co-payment, which is 30% of the amount of medical care used or less for low-income persons. Local governments usually provide subsidies to make the payment free of charge for children less than 15 years of age.

According to the WHO and the United Nations (UN) (as cited in Tahara, 2016), Japan faces a super-aged society, one that no other country has ever experienced. One in three to four people

(27.7% of the population) is currently over 65 years of age (Cabinet Office, 2018a). The government estimates that 30% of the population will be aged over 65 years in 2025, rising to 40% in 2065. Concurrently, the number of annual births in Japan has fallen to record lows. After WWII, there were approximately 2.7 million babies born per year in Japan; however, that number has been declining since 1973. In 2016, the number dropped to 976,978, dipping below one million for the first time on record (Cabinet Office, 2018b). In 2017, 946,060 babies were born, 30,000 fewer than in 2016. Accordingly, the total fertility rate in Japan has also declined, falling to 1.26 in 2005, although recovering to 1.43 in 2017 (which is roughly the 1.4 average that has remained constant in recent years) (MHLW, 2018d). The low birth number and birth rate are associated with a lower marriage rate, late marriage, and mothers giving birth later in life (Cabinet Office, 2018b). While financial and environmental issues related to raising children have been actively debated and targeted in the government's strategy to raise the fertility rate, the increase in the aged population has placed a massive financial burden on Japan, as have the pensions of those leaving the workforce. Due to the enormous increase in healthcare expenditures, coupled with negative population growth and a shrinking economy, the healthcare budget has tightened, and healthcare for the younger generations, including maternity services, has taken a back seat to care for the elderly (Momoi, 2003; Shibata, 2017).

Maternity care in Japan

Maternity care system in Japan

In Japan, pregnant women have antenatal care at obstetric or birth facilities where they see obstetricians or/and midwives. Antenatal visits are every four weeks until the 23rd week of pregnancy, fortnightly until the 35th week, and every week between the 36th week and birth. The number of antenatal visits is approximately 14 in total. Pregnant women begin having ultrasound scans, including transvaginal ultrasound, from their first visit to confirm their pregnancy, and at every antenatal care thereafter. After birth, women used to stay at birth facilities for more than one week, but the term is currently four to six days due to the shortage of beds (T. Shimada, Abe, & Kawamura, 2003; Tsurumachi, 2018). After leaving the facilities, Japanese women traditionally stay in bed at home for three to four weeks after birth. They go back to the birth facilities to see obstetricians, paediatricians and/or midwives for a one-month check-up. The maternity care provided by the facilities is then complete. Mothers also receive a visit from a midwife or a public health nurse within a few months after birth as a service of the local government. After the one-month check-ups, babies receive regular check-ups and immunisation at community health centres.

The Japanese national health insurance system cannot be used for normal birthing care. Payment of fees for birthing care is the responsibility of the individual, as birth is not considered an injury or a disease. However, most mothers receive a lump-sum allowance of 390,000 yen (NZ$5000)

for childbirth from the national health insurance system. If special medical treatment or assistance is needed during pregnancy or birth, such as in the case of a Caesarean section, national health insurance is applicable (with a co-payment of 30%). Epidural use in normal birth is not covered by the insurance so the women pay an extra fee on top of the birth care fees. The fees for birth care vary amongst birth facilities; they tend to be higher in private hospitals and in urban areas. According to the MHLW (2014), the national average fee for birth care is 486,376 yen—ranging from 335,607 yen in Tottori, in western Japan, to 497,872 yen in Tokyo. The difference between such fees and the lump-sum allowance is paid by the individual. Antenatal care tickets (usually 14 tickets), offered with a maternal handbook from the city or town in which the expectant mother lives, cover most of the cost of antenatal care. Sometimes the mother needs to make an extra individual payment or co-payment for certain examinations and prescribed medicines at her antenatal care.

Statistical features of maternity care in Japan

Japan's maternal mortality rate of 5/100,000 live births is among the lowest in the world; as of 2017, there were only 15 other countries holding better or similar maternal mortality rates between 2/100,000 and 5/100,000 live births (WHO, 2019). Whereas, the deaths of expectant and nursing mothers, caused by reasons indirectly related to pregnancy and birth, such as suicide, are included in the numbers of maternal deaths in most other countries; there is not the case in the reporting of Japan's maternal mortality rate figures. The reason being, is that Japan's death certificates do not require documentation of whether the deceased was pregnant or gave birth in the past year. Therefore, in Japan, the total number of deaths among expectant and nursing mothers is unknown. In 2017, Japan adopted the 10th revision of the International Classification of Diseases (ICD-10) Version 2013 which the WHO and other countries use as statistical criteria (Japan Society of Obstetrics and Gynecology, 2017). Hence, the likelihood of statistical error will be lessened, and Japan's maternal mortality rate may become visible in the near future.

Recent research revealed the number of pregnant women and new mothers who committed suicide in some areas of Japan. In the 23 wards of Tokyo, 63 women committed suicide during pregnancy and within one year from childbirth between 2005 and 2014 (JAOG, 2017a; Takeda, 2017). This number was double the number of maternal deaths caused by childbirth. Alarmingly, there were 14.1 suicides per 100,000 births in Mie prefecture, in the mid-west of Japan (Takeda, 2017). In Osaka, the number of those women's suicide accounted for 4.5% of the total number of suicides among the same age group of women (Takeda, 2017). Takeda (2017) estimated, based on the number in Osaka, that the total number of expectant and nursing mothers who commit suicide in Japan would be approximately between 60 and 80 per year. Overall, Japan has relatively high suicide rates compared to the OECD averages (MHLW, 2018c; OECD, 2017). However, the number has declined in recent years, from 33,093 in 2007 to 21,321 in 2017 (MHLW, 2018c).

Nonetheless, it is not clear whether the number of pregnant women and mothers who committed suicide has decreased or not because Japan did not collect those statistics until recently. Rather, this issue has only come to light very recently, despite the fact that suicide comprises the largest reason for maternal death in Japan.

Furthermore, research has revealed that 40,000 childbearing women annually are estimated to need mental health treatment (S. Abe, 2016b), and 80% of mothers have anxiety or difficulty in raising children (MHLW, 2015a). Approximately 60% of women who committed suicide within one year after childbirth have been diagnosed with depression, including postpartum depression (JAOG, 2017a). The implication is that childbirth may be one of the key triggers causing mental health issues and suicide for women in Japan. An increasing number of cases of child abuse, and the causal relationship between postpartum depression and child abuse, have also been reported (Iwamoto, 2015; JAOG, 2017a; Nakaita & Sano, 2012). In Japan, 65% of fatal cases of child abuse are babies under 12 months old (MHLW, 2018g), and more than half of assailants of child abuse are mothers (MHLW, 2018f). These serious issues indicate that Japanese maternity care has not heeded the significance of women's psychological well-being as much as saving childbearing women's lives.

Maternal morbidity rates also indicate the safety and quality of maternity care, but they are difficult to compare among countries because they are not standardised (Firoz et al., 2013). In Japan, cases of obstetric complications, such as anaemia, placenta previa, premature birth, and eclampsia, are reported among approximately 55% of childbearing women annually (Nakai, 2019). This number seems high, given that childbirth is a physiological life event for the majority of women (ICM, 2014a). This maternal morbidity cannot be overlooked because obstetric complications could have long-term negative impacts on women's well-being. Additionally, in Japan, 32.2% of pregnant women had underlying medical conditions or accidental complications, such as respiratory diseases and digestive system diseases (Nakai, 2019). The percentages of such complications increased 10.8% between 2001 and 2010, and Nakai (2019) maintained that this was due to the increasing age of pregnant women.

With regard to the neonatal mortality rate, the UNICEF (2018) announced "Japan is the safest place to be born" on its social media accounts; 0.9 in 1,000 babies die during the first 28 days in Japan (UNICEF, 2018). On the other hand, the number of extremely low-birthweight infants (under 1000g) has doubled, despite the number of births declining, with the proportion more than threefold in the last 35 years (MHLW, 2015c). The number of beds in the neonatal intensive care unit (NICU) has also increased; from 26/10,000 births in 2011 to 30/10,000 births in 2014 (MHLW, 2015c). Nevertheless, there is a shortage of NICU beds in perinatal medical centres, the highest level of maternity care hospitals in Japan, and they often cannot receive the transfers of

childbearing women or newborn babies from other birth facilities (Kuwaki, 2016). This is partly due to more infants being born with extremely low-birthweight and abnormalities, and the length of stay of each of these babies in NICU tends to be longer. In some areas, babies requiring medical assistance and who used to stay in hospitals are now discharged (Kido, Yoko'o, Fukuhara, Ozawa, & Fujimoto, 2012). As a result, more families are responsible to care for such babies at home; for example, one instance where a premature baby was sent home with an artificial respirator two months following birth (Sanyō Shimbun, 2014; Tamura, 2013). Needless to say, those families need additional support from professionals in the community for an extended time.

In addition, the age of childbearing women and use of assisted reproductive technology (ART) are increasing in Japan. Over the course of 50 years, the average age of women having their first baby increased by five years, reaching 30.7 in 2017 (MHLW, 2018b). The proportion of births among women over 35 years of age was 28.5% in 2017, having increased three times in two decades (MHLW, 2018d). No women over 50 years gave birth in 1995, but 62 women did so in 2017 (MHLW, 2018b). The number of babies conceived by ART, such as in vitro fertilisation (IVF) and intra-cytoplasmic sperm injection (ICSI), was more than 50,000 in 2015, which amounts to 1 in 20 newborn babies in Japan (MHLW, 2018j). According to a study by Dyer et al. (2016), although the number of ART procedures performed in Japan is the highest among 60 countries, Japan's ART success rate is the lowest.

Other birth outcomes in Japan are relatively better than in other countries. For example, the proportion of Caesarean sections carried out is 20.4%, compared with 27.9% in New Zealand during the same year (2017) (Ministry of Health, 2019; MHLW, 2018a). New Zealand's rate is based on the actual number of Caesarean sections, but Japan's official rate is based on the number of medical operations performed in September every third year; the actual number of Caesarean sections in Japan is not known. Maeda et al. (2018) investigated the annual number of Caesarean sections in 2013 from the accumulated data in Japan's National Database of health insurance claims. It is the first study to describe annual Caesarean section statistics in Japan, though a small number of Caesarean sections covered by social welfare are not included in the database. According to the study, the Caesarean section rate is 18.5% (Maeda et al., 2018). Both numbers, 20.4% and 18.5%, show that the proportion of Caesarean sections in Japan is lower than that of many developing and developed countries (OECD, 2017). However, the proportion of Caesarean sections has doubled in the past two decades despite the fact that WHO targets a rate between 10 and 15% (Vogel et al., 2015; WHO, 2015).

Japan does not have a complete survey on epidural use during labour. A study by Terui (2011), examining 42.4% of 2,455 hospitals and obstetric clinics, is the first study officially investigating the epidural use for labour in Japan. According to the study, only 2.6% of women had an epidural

in labour in 2008. Recently, accidents and maternal deaths associated with epidural anaesthesia have called for nationwide investigation. From a survey covering approximately 60% of the birth facilities in Japan, the government study group found 14 maternal deaths and other incidents, including serious sequelae, resulting from epidural procedures between 2010 and 2016 (MHLW, 2018h). According to the survey, the percentage of women having epidural pain relief in labour was 6.1% in 2016. The number is particularly low in OECD countries, but the proportion of epidurals carried out has been rapidly growing in Japan in the last decade (MHLW, 2018h). Data regarding other forms of pharmacological pain relief such as nitrous oxide and oxygen or pethidine cannot be found, and they are seldom used for labour pain in Japan (Doering, Patterson, & Griffiths, 2014).

Additionally, there are no statistics of interventions such as induction, forceps, and episiotomy in Japan. The rates of Caesarean section and epidural anaesthesia may imply that there is less intervention in childbirth or that Japanese women have given birth with lower risk. Evaluating and understanding maternity care and outcomes with comprehensive statistics and multilateral viewpoints will be important in improving the quality of care. Both maternal and perinatal mortality rates and the national data on other interventions and outcomes of maternity care need to be systematically accumulated in Japan.

Birth places and midwifery practice in Japan

Changes of birth places and maternity care providers over time in Japan

The location in which Japanese women gave birth changed dramatically in the two decades following WWII. In 1947, 97.6% of women birthed at home but, by 1967, 90.4% of women were giving birth in facilities, including 12.8% in midwifery homes (Matsuoka, 1995). This figure reached 99.9% in 1990. This dramatic change resulted from both the reformation of the healthcare system introduced under the American occupation and the industrialisation of Japanese society (Matsuoka, 1993). As part of the process, the government encouraged local governments to establish public birth centres run by midwives in the community, called a maternal and infant health centre, to reduce maternal and perinatal mortality (Nakayama, 2001, 2015). That is, the institutionalisation of childbirth in Japan began with the birth centres, not hospitals and clinics. After the implementation of the project in 1957, more than 700 centres were built across Japan, but within a decade the project shifted so that the public centres no longer offered birth care. At present, only one centre remains.

During the promotion of the project, midwives were encouraged to introduce and recommend the centres to pregnant women, and the women gave birth at the centres with midwives whom they knew and trusted in the community. The style of giving birth with known and trusted midwives was maintained at the centres, but homebirths sharply decreased during the period (Nakayama,

2001, 2015). The women, who lost the centres and the culture of homebirth in the community, started giving birth in obstetric clinics and hospitals. Alongside the public birth centres, midwives were encouraged to open private midwifery homes as part of the institutionalisation policy of childbirth. However, birth at private midwifery homes also decreased while hospitals and obstetric clinics became common birth places in society. Fujita (1988) insisted the establishment of the public birth centres completely changed Japanese birth culture. Moreover, M. Sasaki (2016) argued that, as a result, midwives inadvertently assisted in the institutionalisation of childbirth by promoting birth centres.

Childbirth in hospitals and obstetric clinics was common by the late 1950s, and became the mainstream in the 1960s. This transition occurred during a period of high economic growth in Japan. The institutionalisation of childbirth was an outgrowth of modernisation of Japanese society. In the maternity care field, modernisation of Japan comprised a combination of a national policy that endeavoured to decrease maternal and perinatal mortality, the westernisation of medicine and lifestyle, and the changes of the healthcare system (Shirai, 2016c). The changes included the implementation of national health insurance, which encourages people to go to medical facilities and to see a doctor. Kikuchi (2016b) observed that women who gave birth during the 1960s were born before or during WWII, at a time when women generally lacked the right to make decisions regarding both childbirth and their bodies as wives or daughters-in-law in the traditional patriarchal family system. Thus, for these women, giving birth in a facility outside the home represented a new freedom and a break from the traditional family system. Also, M. Sasaki (2016) argued that women were willing to trust their bodies to modern medicine and the management without any doubt. At the same time, however, this change caused a rupture in the traditional birth rituals and culture that had been handed over from mothers to daughters or daughters-in-law and within the broader community (Kikuchi, 2016b).

Funabashi (1994) contended that the institutionalisation and medicalisation of childbirth should be considered separately in Japan, since the institutionalisation started with the public birth centres and preceded the medicalisation of childbirth which occurred in hospitals and obstetric clinics. According to Nakayama (2015), by the early 1970s, the focus of Japanese maternity care had changed from birth to delivery, from midwifery (or assisting birth, using the Japanese language) to birth management, from the attention to women to an emphasis on delivery, and from a normal life event to a potentially dangerous experience. Management was emphasised and obstetricians came to form the core of the maternity care system. Consequently, comprehensive medical management and a focus on abnormalities in obstetric medicine and facilities became primary factors in the medicalisation of childbirth (Suzui, 2016a). Medical interventions such as Caesarean section, forceps, episiotomies, and labour induction began to be widely used in the 1960s; high-technology instruments such as ultrasound scans and cardiotocomonitors followed

(Funabashi, 1994). Such technology began to be used for normal births as routine procedures and normal births became characterised by obstetrics (Matsuoka, 1999).

While birthing progressively and rapidly shifted from home and birth centres to obstetric clinics and hospitals, the primary caregivers also shifted from midwives to obstetricians. In 1945, in Japan, 92.1% of births were registered with names of midwives, but in 1990 only 1.8% of the births were officially attended by midwives (Shirai, 2016a). The numbers have slightly increased and is currently 4.9% according to 2016 statistics (MHLW, 2018). In reality, more midwives attend births. According to the study investigating the actual birth attendants in Japan, 63.2% of normal births were conducted by midwives; while the national vital statistics based on the professional who officially signs the birth certificates suggests that midwives primarily attended only 2.8% of births in the same year (M. Shimada et al., 2002). This means that although midwives do deliver the babies, obstetricians sign the birth certificates. The official data are symbolic for the fact that births were carried out under the authority of obstetricians regardless of whether or not midwives delivered the babies. This also shows that midwives became invisible in society during the changes and may mean women have lost control of their own birth in obstetric based medicine and management.

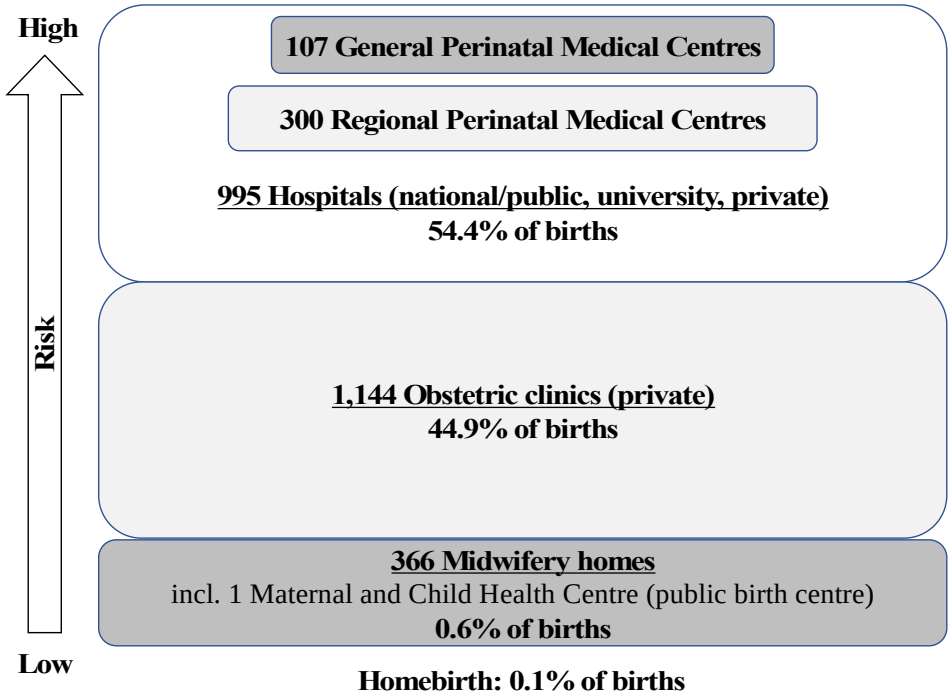
The shift in birth place meant a shift in the workplace of midwives. In Japan, midwifery had become recognised as a profession during the Edo era (1603–1868)[1] (Ogawa, 2016; M. Sasaki, 2016). When the first law concerning midwives was issued in 1899, 25,090 midwives were registered in Japan (Ogawa, 2016). The number of midwives fluctuated during the next 120 years, but most midwives were autonomously working in the community. However, along with the shift of birth places after WWII, the majority of midwives lost their jobs in the community. They did not move to birth facilities or were not hired by the facilities (Nakayama, 2015). The midwives who started working in the facilities were nurse-midwives educated under the new system. In 1951, there were 77,560 midwives but the number dropped by half in the next two decades and had reduced by one third by 1980 (Ehime Prefecture, n.d.; Kamiya & Ishiwata, 2009; Shirai, 2016b). The number of midwives dropped as low as 22,690 in 1992. The number started increasing in the late 2000s when the lack of obstetricians and midwives came to light. In 2016, there were 35,774 midwives in Japan (MHLW, 2017b).

[1] The Edo era is the period of time in Japanese history which was ruled under Tokugawa Shogun. The era was characterised by a strict social order, isolationist politics and closed borders, and the development of culture and the arts, such as Ukiyo-e.

Current situation of birth places and midwives' work style in Japan

Hospitals and obstetric clinics

Currently, in Japan, there are three main types of birth facilities; hospitals, obstetric clinics, and midwifery homes (see Figure 1, p. 20). The only distinction between hospitals and clinics is that hospitals have more than 20 beds and clinics have 19 or fewer beds under the medical law. The number of hospitals providing birthing care were 995 and, in 2017, 54.4% of women chose to give birth in hospitals (MHLW, 2018a; 2018i). Maternity departments in relatively bigger hospitals with more than 400 beds, such as national or public hospitals, university hospitals, and private medical centres, have advanced medical equipment, and a team of medical staff to provide emergency or advanced medical care for childbearing women and babies. In 2017, 107 hospitals were registered as general perinatal medical centres which are tertiary emergency hospitals having neonatological departments with more than nine beds in NICU and six beds in Maternal-Fetal Intensive Care Unit (MFICU) (MHLW, 2017e). There were also 300 regional perinatal medical centres which provide medical and emergency care for childbearing women in each area across Japan (MHLW, 2017a). There are many other small, middle, and large-scale hospitals providing obstetric care in Japan, and the types and functions vary among hospitals.



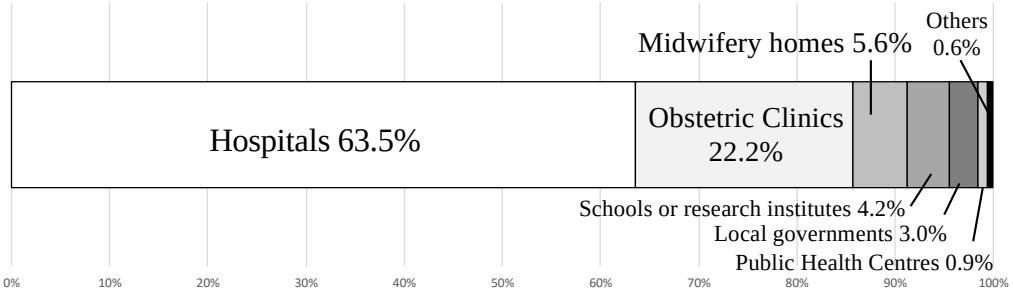
(MHLW, 2018a, 2018i)

Figure 1: Birth facilities and birth places in Japan (2017)

Obstetric clinics are usually private facilities. In 2017, 1,144 obstetric clinics provided birth care, and 44.9% of births in Japan took place there (MHLW, 2018a; 2018i). Such clinics treat low-risk pregnant women and are usually run by one obstetrician or a small number of doctors with

employed midwives and nurses. Procedures such as Caesarean section, epidural anaesthesia and instrumental deliveries can be done by obstetricians at obstetric clinics, but high-risk pregnant women and women with complications or emergency conditions are transferred to hospitals during pregnancy or delivery. Nowadays, young obstetricians do not tend to start their own business, which means new obstetric clinics are not opened. At the same time, obstetricians who are currently running obstetric clinics have an average age of 58, and are closing their clinics (Nakai, 2014). Other obstetric clinics have begun providing only antenatal care, in which case pregnant women move to hospitals before giving birth. The declining birth rate, the increase of lawsuits, the aging of obstetricians running clinics, and the centralisation of obstetricians are reasons for why the number of hospitals and obstetric clinics that provide birth care has gradually decreased. The total number of obstetric clinics and hospitals declined from 3,306 in 2002 to 2,139 in 2017 (MHLW, 2018a).

In 2016, 85.7% of midwives worked in hospitals or obstetric clinics (see Figure 2, p. 21) (MHLW, 2017b). The majority play an auxiliary role by providing care under the supervision of obstetricians or in a team led by obstetricians rather than working in co-operation (Iida, Horiuchi, & Porter, 2012; S. Suzuki, 2012). Midwife-led care is an option at 160 hospitals (15.5%) and 54 obstetric clinics (4.3%), but it is not clear how many women choose such care (MHLW, 2018a). The maternity care at many of the clinics appears to be provided primarily by obstetricians and nurses since only 22.2% of midwives work at these clinics, while nearly half of Japanese women birth there (Kobayashi & Watanabe, 2008; MHLW, 2017b).



(MHLW, 2017b)

Figure 2: Workplaces of midwives in Japan (2016)

Under the current model of care, the midwifery provided in birth facilities usually takes the form of 'fragmented' care. For example, midwives assist obstetricians at antenatal care, work only in delivery rooms or postnatal wards, or provide only care and massage for breastfeeding. In addition, it is estimated that thousands of midwives, called 'latent midwives,' work as nurses in other departments of hospitals in Japan. This occurs because of Japanese midwives' status as nurse-midwives and nursing staff, and a lack of understanding among administrators. According to

MHLW (2015b), approximately 30% of certified midwives are employed as public health nurses or nurses.

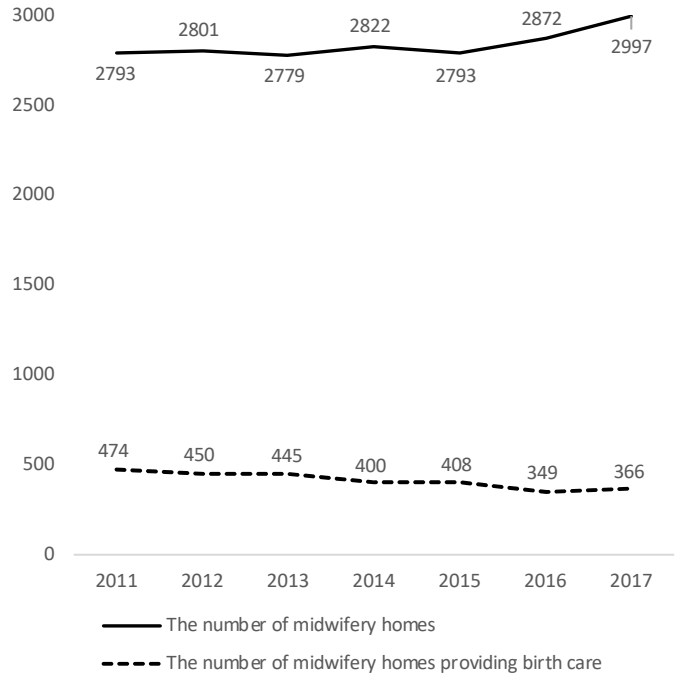
Midwifery homes

Midwifery homes are primary birth facilities with nine or fewer beds run by self-employed midwives. Such facilities often occupy one section of a midwife's house and are typically operated by a midwife who is supported by a few backup midwives or a small group of midwives. Women choosing such a facility receive continuity of care from one or a few midwives in a home-like, relaxed atmosphere. Those eligible to choose midwife-led care are pregnant women without any complications judged to be low-risk. Women and their midwives consult with backup obstetricians when there are concerns regarding the condition of the women, including medical history such as asthma, abnormal history of a previous birth, pregnancy after fertility treatment or over 35 years of age. These conditions can be the reason given for not recommending giving birth at a midwifery home. All women receiving care at midwifery homes go to hospitals or obstetric clinics at least three times during pregnancy for blood tests and obstetric consultations. This means it is compulsory that all the pregnant women in Japan see an obstetrician during pregnancy regardless where and with whom they give birth. At the time of birth, usually only midwives attend birth at a midwifery home and at the women's home.

Since Japanese midwives cannot provide medical assistance, including any prescription and episiotomy, except for emergency situations, self-employed midwives are required to conduct adequate risk assessment at an early stage and to transfer women to hospitals as necessary. Those midwives are not usually allowed to continue providing care for women transferred to hospitals and obstetric clinics. Therefore, their care often ends when women are transferred to medical facilities from midwifery homes. Sometimes, women can return to midwifery homes after giving birth in the facilities. Midwives cannot receive birth fees when they transfer women before birth. Further, self-employed midwives cannot claim the national health insurance because they provide care only for normal pregnancy and birth, while obstetricians can claim it when they provide medical interventions and care.

The number of midwifery homes has also declined. The number of such homes providing birth care was 366 in 2017, 22.8% less than in 2011 (MHLW, 2018a). In many cities and towns, women do not have the choice to give birth at midwifery homes because none exist. The number of women eligible to give birth at midwifery homes and their own homes has also been decreasing as the guidelines are prioritised over women's wishes and choices. At present, only 0.6% of women give birth at midwifery homes, and homebirths make up 0.1% of the total number of births in Japan (MHLW, 2018i). In 2016, only 5.6% of midwives ran or worked for midwifery homes (MHLW, 2017b).

Even though there are nearly 3,000 registered midwifery homes in Japan, only 12% currently provide birth care (MHLW, 2018a). While the total number of midwifery homes remains stable or has even increased: from 2,793 in 2011 to 2,997 in 2017, those providing birth care has rapidly decreased (see Figure 3, p. 23) (MHLW, 2018a). This means midwifery homes that do not provide birth care are increasing in number.



(MHLW, 2018a)

Figure 3: The number of registered midwifery homes in Japan

In Japan, midwives do not need to register their midwifery homes or themselves as self-employed midwives unless they deliver babies. Hence, the actual number of self-employed midwives who do not provide birth care is greater than the registered number. Such midwives provide antenatal classes, neonatal visits and postnatal care outsourced by local governments, breastfeeding care, infant massage classes, sex education at schools, and other forms of perinatal and reproductive care. Compared to midwives in busy hospitals, they may have more time to talk to women at each occasion, but the connection is sporadic or intermittent. Their care or services are distinguished from the perinatal care regularly provided by professionals because they do not provide antenatal and birth care. In fact, some of the services, such as infant massage, do not require a midwife certificate. In Japan, many midwives work as a 'midwife' even if they have not provided antenatal care or attended birth for decades because the qualification is permanent. Their income as professionals could be low. Moreover, self-employed midwives and midwifery homes are currently shifting their focus to postnatal care services from birth care in accordance with the

government's countermeasures against postnatal issues and falling birth rate, and the policy of Japanese Midwives Association (JMA), which strives to sustain the role of self-employed midwives in the community (MHLW, 2017d; M. Shimada, 2017, 2018; Yamamoto, Adachi, Kasai, & Okamoto, 2018).

One of the most serious issues for self-employed midwives who provide birth care is having a contract with an obstetrician and a birth facility. The contract is compulsory for those midwives. Nonetheless, the JAOG is not positive about supporting this system, and obstetricians and birth facilities are allowed to refuse the request (JAOG, 2006a). There are midwives who suffer from not having the contract and who give up practice because of it. According to a survey investigating 140 midwifery homes, nearly 30% of them answered that it is 'difficult' or 'impossible' to have the contract (Asahi Shimbun, 2007). Accordingly, Japanese women lose their choice to give birth with midwives at midwifery home or in their own home.

The context of Japanese midwifery

History of Japanese midwifery

Ohbayashi (1989) argued that the changes Japanese midwives experienced after WWII were distinctive, and the changes in the fields of other medical professions, such as doctors and nurses, were scarcely comparable to those of midwives. After WWII, the changes were directed by the United States which, at the time of the occupation, had no legal midwives. Under the American occupation policy, the fact that the majority of babies (approximately 98%) were birthed at home with midwives was regarded a problem. The reform policy of the General Headquarters (GHQ), referred to as the offices of the occupation, was 1) to abolish midwives and integrate three professions—public health nurses, midwives, and nurses—into one profession, and 2) to ensure that births were carried out in hospitals by doctors and nurses (Ohbayashi, 1989). Midwives resisted their abolishment, but the law of midwives was nevertheless integrated into a new law, the Act on Public Health Nurses, Midwives, and Nurses. The GHQ also positioned midwives as nurses in obstetric departments and made it a condition that midwives had to have a nursing certification; although midwifery had a longer history of independent regulation, education and practice than those of nurses. Under the direction of the GHQ, which lacked understanding of Japanese culture of childbirth and midwifery, Japanese traditions and care model of childbirth gradually disappeared or were changed or denied.

After American occupation, only the Japanese Nursing Association (JNA) actively promoted the integration of the three professions—midwives, nurses and public health nurses (JMA, n.d.-b). The integration of midwifery and nursing was promoted in parallel with the change of the midwife's title and the discussion about male midwives (Mitou, Ishida, Ohgushi, Kitaura, & Iseda, 2007; Okamoto, 2017; M. Sasaki, 2016). In 2002, along with the title change of nurses and public

health nurses, the title of midwife was changed to 助産師 (jo-san-shi) meaning 'a teacher/master helping birth' from 助産婦 (jo-san-pu) which means 'a woman helping birth' or '(one) helping birthing woman' (JMA, n.d.-b). This change intended to open the midwives' occupation to males and to apply the titles for both sexes because the old title indicates only women. At the time, midwives strongly opposed the introduction of male midwives and the change of title which they felt would lose the meaning of helping (being with) birthing women in their title. The title change was pushed through by the JNA's lead, but the discussion of male midwives was frozen due to strong resistance from midwives and women (Mitsui, Mori, & Kuroki, 2002; Okamoto, 2017; M. Sasaki, 2016). Today, in Japan, only women can be a midwife. The policy of JNA, which attempts to integrate midwives and nurses, has since died down, but the idea of 'We are one,' implying midwives and nurses are the same profession, is firmly rooted among nurses and some midwives (Mitou et al., 2007; A. Murakami, 2013).

At the time of reformation under the American occupation, the midwives' association was also integrated into JNA. However, midwives re-established the JMA by leaving the JNA in 1955. The JMA restarted with 60,000 members, and 100 midwives stayed in the JNA (JMA, n.d.-b). In 2018, the membership of JMA was 9,867 (JMA, 2018), and the unionisation rate was 28%, which may show the weak position of JMA as a professional organisation dedicated to uniting and representing Japanese midwives. On the other hand, 21,568 midwives (64.2%) are members of JNA (Fukui, 2013). Some midwives join both associations, but it is obvious that more join the JNA than the JMA. Midwives are often forced to first join the JNA because they belong to the nursing department of birth facilities. In fact, many of the midwives work as nurses. The confusion between nurses and midwives is at the root of many problems occurring between women and midwives. For example, midwives are too busy to be with women because they have to care for patients of other departments as nurses in hospitals.

Educational context of Japanese midwifery

Integration into the nursing profession also influenced midwifery education. Before the American occupation, midwifery education without nursing education (direct-entry programme) was the only pre-registration programme for Japanese midwives. Today, all Japanese midwives are nurse-midwives, with compulsory nursing education. In 2017, there were 214 midwifery educational institutions and at least seven types of midwifery education courses in Japan, ranging from one-year courses in nursing education or one-year vocational schools to two-year postgraduate schools (JNA, 2018b; Suzui, 2016b). The length of education is one year under the law in Japan. However, according to the *ICM Global Standards for Midwifery Education* (ICM, 2013), the minimum length for a post-nursing midwifery education programme is 18 months, with a minimum of 40% theory and 50% practice. In case of a direct-entry midwifery education programme, the minimum length is three years. In New Zealand, which has direct-entry programmes, midwifery education

requires 4,800 total hours, including at least 2,400 practice hours and 1,920 theory hours (Gilkison, Pairman, McAra-Couper, Kensington, & James, 2016). Japan's curriculum is a credit-based system and the timeframe is therefore not clear (15–30 hours per credit for theory and 45 hours per credit for practice), but the required 28 credits do not always reach 1,000 hours.

One kind of midwifery education course in Japan is integrated into the curriculum of four-year nursing education. This is contrary to the Global Standards which do not accept midwifery education integrated into nursing education (ICM, 2013). Midwifery education within nursing education is mainly provided during the last year of nursing education. This means that midwifery education is less than one year in real terms. Research has shown the low quality of such educational programmes, which has been described as too short and too busy to obtain enough knowledge and skills, as well as to accomplish the required credits and the required number of birth attendance (Mitsui, Karasawa, & Ohno, 2004; Suzui, 2016b). For instance, one third of the students delivered only six or fewer babies before graduating and sitting the national examination, according to a study of the Japan Society of Midwifery Education (as cited in Suzui, 2016b). Since that time, the programme within nursing education has attempted to improve, but as pre-registration education it is still substandard in terms of length, content, and quality (Japan Society of Midwifery Education, 2016; Mitsui et al., 2004; M. Shimada, 2009; Suzui, 2016b).

In Japan, under the law, the required number of birth attendance during midwifery education is "about 10" (MHLW, 2017c, appended table 2). However, many of the students and schools struggle with meeting this requirement. Possible reasons include decline of birth rates, increase of high risk birth, and lack of human resources of birth facilities (Fukui, Imura, & Kitagawa, 2016). However, there are nearly one million births in Japan annually and low birth rates is not an issue solely for Japan; student midwives in other countries are required to attend approximately 40–50 births (Japan Society of Midwifery Education, 2016). Moreover, student midwives sometimes have placement only during the day shift due to safety policies and the shortage of training staff at birth facilities; yet, births may occur anytime, day and night, and often last longer than one shift. A midwifery education that is defined by following the rules and time schedules of birth facilities rather than the physiological needs of each woman's birth, could affect future midwives' philosophy and attitudes towards midwifery.

The opportunities for student midwives to experience continuity of care are also few in Japan. The regulation requires each student midwife to experience continuity of care with one woman or more from the woman's second trimester (14^{th}–27th week) to one month after birth (MHLW, 2010). Imura et al. (2017) found that 95.4% of the midwifery schools in Japan offer continuity of care placements. Out of the 95.4% of schools, each student was able to experience one continuity of care in 66.3% of the schools and two or more in 28% of the schools, while 5.8% of the schools

reported they were not able to offer their students such an experience. In 42.7% of the schools, the continuity of care placement started from late pregnancy (28^{th}–39^{th} week) or even shorter. In the review meeting of midwifery education held by the Ministry of Health, the requirement to have one placement to support the learning of continuity of care in midwifery education was reviewed. The conclusion was that it was difficult to maintain the one placement experience because of the shortage of and burden to facility staff and school teachers who support students during the placement (MHLW, 2011). Also, the committee questioned whether or not it was acceptable to require students to spend weekends and summer holidays for the continuity of care placement, in part because this amount of time exceeds the required time set for the curriculum. As seen from this discussion, experiencing continuity of care in education is not a priority in Japan.

Although continuity of care is not given priority in Japan, research has demonstrated the significance of building a relationship, especially a trusting relationship, with women for students through continuity of care placement (Akita & Sasaki, 2017; Araki, Nakao, & Oishi, 2010; Fukumaru, Ochiai, & Matsuzaka, 2010; Takashima, Takatsuka, Kikuchi, Yuminamochi, & Nakashima, 2012). Some studies maintained that continuity of care is a significant opportunity for students to comprehensively learn skills, attitudes, behaviours, and/or responsibilities as a midwife (Araki et al., 2010; Fukumaru et al., 2010; Nakajima, Kunikiyo, Sakamoto, Arai, & Tokiwa, 2009). Others have unique perspectives regarding the role of continuity of care for midwifery education. For example, Y. Shimizu (2011) insisted that students obtain individualised ‘nursing’ care through the placement of continuity of care. Y. Suzuki and Shimada (2014) also found students learn to play a role of ‘doulas’ and form their identity as a midwife through the experience. Each study has recognised the importance of experiencing continuity of care for students. Yet, some claims are confusing, and the researchers’ arguments lack uniformity to indicate the goal of the continuity of care experience in Japan’s midwifery education. Overall, there is very limited discussion concerning the actual relationship or understandings of partnership between women and midwives in the stated curriculum. It is not clear how the relationship with women is specifically learned or discussed among students in Japan. The relationship between women and midwives may be considered to be taken for granted in the education. However, it is obvious that students have few opportunities to experience continuity of care and little motivational awareness towards the significance of the woman–midwife relationship. In such an education, students may focus on how they can actively and effectively ‘provide’ care for women but learn little about following women throughout their birth journey or simply being with women.

According to the survey conducted by the Japan Society of Midwifery Education (2018), only 33.7% of students answered that they can deliver babies (with a little advice) upon completion of

the pre-registration programme. Furthermore, fewer than 50% of students answered that they could independently provide care with/without a little advice (Japan Society of Midwifery Education, 2016, 2018). In Japan, it is not clear whether that is the goal of the midwifery pre-registration education or that the midwifery graduates are not competent due to insufficient education. Furthermore, the certification of midwife is permanent and there is no required post-registration training for midwives unless midwives take it on their own initiative. In addition, midwifery educators and researchers, who make up 4.2% of the midwives, do not practise midwifery in Japan (MHLW, 2017b).

The necessity of nursing education to be a midwife is controversial. Japan is the only country which does not have a direct-entry midwifery programme among Group of Seven (G7), and European Union (EU) countries (Imura, Ohta, & Takegata, 2016). According to Lopes et al. (2016), who investigated 73 low- and middle-income countries, 86% of those countries provide a direct-entry midwifery programme. Midwifery education varies internationally, but holding up the post-nursing midwifery education as a standard of ICM seems to be inconsistent with the ICM's claim emphasising the distinction between nursing and midwifery (ICM, 2011a; Pairman & Tumilty, 2016). In Japan, the boundary between maternal nursing and midwifery is vague (A. Murakami, 2013; Watanabe, 2013). Indeed, discussions about the distinction of two professions—nursing and midwifery—and the possibility of a direct-entry midwifery education are rare. A post-nursing education according to ICM Standards might have allowed Japanese Midwifery to avoid arguing these issues. Additionally, the ICM stated that education, regulation and association (ERA) are the three pillars of a strong midwifery profession, and the autonomy of each pillar is important to strengthen midwifery in each country (ICM, n.d.; Pairman & Tumilty, 2016). The reality in Japan is that none of the pillars seem to be autonomous. Poor quality midwifery education, and weakened autonomy of midwives, will certainly affect the quality of midwifery care and birth experience of women who receive such care.

Midwives' status and roles in Japanese society

While it is argued that Japan's improved maternal mortality rate is associated with the hospitalisation and medicalisation of childbirth, Matsuoka (1993) denied the interrelation of the maternity outcomes and the shift of birth places, arguing that institutional childbirth does not assure the safety of birth. In Japan, the improvement of such mortality rates had actually begun prior to WWII due to the implementation of midwifery education and the increase in educated midwives during the Meiji period (Kawai, 2009). In fact, Japan's maternal mortality rates had dropped by half since the midwife's first law was issued in 1899 (409.8/100,000) until the end of WWII in 1945 (176.9/100,000), and the maternal mortality rate was lower than that of the United States before WWII (Linder & Grove, 1947; Ohbayashi, 1989). Furthermore, between 1947 and 1957, following WWII, the rates of hospitalised birth increased from 2.4% to 28.7%, but the

maternal mortality rates were 167.5/100,000 births and 170.9/100,000 births, respectively, and the figures stayed at around 160–170/100,000 during the decade (National Institute of Population and Social Security Research, 2018; Ohbayashi, 1989). Many aspects such as hygiene, nutrition, health, socio-economy and industry developed in the Japanese society during the era, meant both the maternal mortality and the average life span of Japanese dramatically improved.

Today, in Japan, women and their families generally consider the presence of an obstetrician at birth to be important for safety reasons, suggesting that midwives alone are not seen as able to provide complete care, even for low-risk births (S. Suzuki, 2012). This may be caused by a dominant social discourse, based on a fear of childbirth, within the authoritarian structure of medical doctors and technology (McAra-Couper, 2007). Katsukawa, Sakanashi, Usui, and Mizuno (2014) studied priority matters in the maternity care of 618 pregnant women in Japan and found that the most important factor for women in the study was the presence and intervention of doctors. The majority of obstetricians seem to regard midwives' practice as dangerous within the medicalisation of childbirth and associated power structure (Nakayama, 2015). This is seen in the JAOG's document (2006b) stating that utilisation of midwives to cover the shortage of obstetricians incur higher perinatal mortality rates. Before WWII, obstetricians focused on high-risk births and midwives took care of low-risk women in Japan (Ohbayashi, 1989). Both coexisted and were responsible for a role in the system, as is now seen in other countries such as New Zealand, England, and Holland. However, obstetricians currently place midwives' practice under their supervision, including in cases of low-risk births, and deny the autonomous practice of midwives in Japan (Nakayama, 2015). In this context, midwives have become increasingly deskilled.

One of the symbolic issues of the relationship between obstetricians and midwives in Japan is the creation and training of ancillary staff called *obstetric nurses*, who work under the supervision of obstetricians but are not nationally qualified as health workers. Between 1962 and 2005, the current JAOG trained and certified approximately 25,000 women as obstetric nurses who worked in obstetric clinics and hospitals all over Japan (Nakayama, 2015). These obstetric nurses were trained and employed on the grounds of shortage of midwives, but in reality the education of midwives had been disregarded and the number of the student midwives had also been tightened after WWII (Nakayama, 2015; Ohde, 2016). They were often nurses and assistant nurses, and 20–25% of them did not have a healthcare profession license. These obstetric nurses performed internal examinations and delivered babies, which can be performed by only medical doctors and midwives in the eyes of the law in Japan. Obstetricians had replaced the role of midwives with non-qualified workers. Nakayama (2015) asserted that the creation and training of the obstetric nurses implies obstetricians' intention to eliminate midwives and to enforce obstetricians' dominant power in the field of childbirth. However, the creation and employment of the obstetric

nurses were illegal and unsafe. Medical accidents in obstetric departments, such as maternal deaths caused by the inadequate use of labour-inducing drugs, became known throughout Japan, leading to criticism against the use of obstetric nurses, specifically since the 1980s. In 2005, obstetric nurse training schools were finally abolished following repeated requests by MHLW (Nakayama, 2015).

It has been noted that Japanese women cannot always tell the difference between nurses and midwives and, in many cases, do not care whether their caregivers are midwives in hospitals (Kawai, 2007; Ohde, 2018). This may imply that women are not receiving midwifery care or they do not know what kind of care they can specifically receive from midwives because midwives in Japan are not providing care that they should provide as midwives. Moreover, it suggests that midwives are not in high demand and they have failed to demonstrate their value to Japanese society. During the past decade, the shortage of obstetricians and the increasing variety of women's needs and choices have led to predictions that midwives will take a more active part in maternity care, but the expansion of their role and activities has not happened to the extent expected (Fukui, 2015; JNA, 2018a). It was initially believed that the reasons for this were related to the resistance of obstetricians and the inadequate management of institutions. However, further research revealed that one of the main reasons was actually a lack of self-confidence and competency among Japanese midwives (Fukui, 2015). It seems that recapturing autonomous midwifery, midwife-led care, midwifery professionalism and leadership is still a distant prospect for Japanese midwives. The ability of midwives to perform as professionals is essential to ensure high-quality maternity care, regardless of how and where they work, the era they work in, and the scarcity of obstetricians (ICM, 2017c).

The situation of Japanese midwives is not all negative. While the scope of practice for Japanese midwives is relatively limited, compared to other countries (Oishi, 2015), midwifery care—especially care at midwifery homes—is rich in traditional skills, knowledge and wisdom, as well as scientific knowledge. Research has confirmed the safety of midwifery homes and midwife-led care in Japan (Iida, Horiuchi, & Nagamori, 2014; Kataoka, Eto, & Iida, 2013; S. Suzuki, 2016). A large number of qualitative and quantitative studies also show great satisfaction on the part of women who have given birth at midwifery homes (Horiuchi et al., 1997; Iida et al., 2012; Takashima, Tsukamoto, & Nakashima, 2014; Uto & Kawabata, 2015). Iida et al. (2012) compared the birth experience of women in midwifery homes, obstetric clinics, and hospitals and found that women giving birth at midwifery homes felt a greater sense of control and were significantly more satisfied with the care they received. M. Noguchi (2002) investigated 175 self-reports (diaries) of woman who gave birth at midwifery homes. She found that in 171 of the 175 cases, positive birth experiences were reported and that the women who had positive birth experiences valued the humanised care and warm environment of midwifery homes. This may include the

relationship with their midwives, though it is not specifically mentioned in the study. The fact that care at midwifery homes is highly valued by those women who have received such care has the potential to influence an improvement in women's birth experience in Japan. However, despite empirical evidence showing an increase in positive outcomes associated with midwife-led birth at midwifery homes in Japan, Japanese midwifery has not been particularly successful in educating the public regarding the significance of such care.

Current issues of maternity care in Japan

Issues of maternity care and facilities in Japan

In the last decade, the shortage and overwork of obstetricians has been normalised in Japan (JAOG, 2017b). Since around 2006, the phrase 'collapse of obstetric care' has been actively used by media, the government, professionals of maternity care and wider society because of the shortage of obstetricians, the decline of birth facilities and the increase in medical lawsuits (Jikumaru, 2009; Kawai, 2009). At the same time, the centralisation of birth care has been promoted in order to concentrate the workforce and provide 'safe' care and management for 24 hours in tertiary hospitals, called perinatal medical centres. Nakayama (2015) argued that the biggest goal of the project of centralisation, which is mainly led by obstetricians working in hospitals, is to reduce or eliminate births in obstetric clinics, which are often a solo practice of obstetricians. The opposition to birth at midwifery homes that cannot provide medical care is even stronger than that of obstetric clinics among obstetricians (Nakayama, 2015).

The closure of obstetric clinics and maternity departments of small or mid-sized hospitals has led to some women being referred to as birth refugees, meaning there is a loss of viable places to give birth in the community (JNA, 2014a). At the time of the closures, there has been little effort to save the vanishing facilities by expanding the use of midwives. It seems that, in Japan, no obstetrician means no birth facility or maternity care. Consequently, perinatal medical centres are increasingly occupied with low-risk mothers, although beds and human resources are limited. Such strategies on the part of obstetricians and the government position childbirth as a type of dangerous, emergency medicine with a great potentiality of risk, ignoring the existence of normal birth and women's choice (Nakayama, 2015). Nakayama (2015) claimed that such strategies led to the 'impoverishment,' meaning low resourcing, functioning and qualities of care, at every level of birth facilities, including any kinds of hospitals, obstetric clinics and midwifery homes, rather than coexistence and cooperation between birth facilities in Japan.

Another particular circumstance of Japan's birth facilities is the presence of patients of other departments in maternity wards. The decrease in the number of births has further pushed the admission of patients to raise occupancy rates and make profits for hospitals. These mixed-patient wards are seen in 80% of the maternity departments in Japanese obstetric clinics and hospitals

(JNA, 2014b). In such wards, elderly patients, cancer patients, terminal patients, and patients of almost any kind, both male and female, can be admitted. It is feared that the risk of infections to newborn babies increases in such a situation. Kitajima (2008) found that all 37 cases of MRSA skin infections affecting neonates within the first 28 days of life occurred only in mixed-patient wards in 8 of the 27 hospital sample which participated in a nationwide surveillance programme of nosocomial infection between 2004 and 2005. No case of MRSA infection was found in three hospitals having independent obstetric wards. Despite these findings, measures against infections in maternity mixed-patient wards have not been addressed (JNA, 2014b).

According to the JNA's report (2017a), 43.7% of midwives working on mixed-patient wards concurrently take care of women in labour and patients of other departments. On this note, Saito (2018) investigated the simultaneous care for birth and death in a maternity mixed-patient ward of a perinatal medical centre. She found that there were 22 deaths on the ward in that year, and 14 births occurred while providing care for the dying patients. Midwives also take care of postpartum mothers and babies, as well as other patients at the same time in such wards. Under such circumstances, midwives in Japan normally describe their practice as nursing and recognise themselves as nursing staff. In the *Global Standard of Midwifery Regulation*, the ICM (2011a) stated:

> Recognition that wherever a registered/qualified midwife with a midwifery practising certificate works with pregnant women during the childbearing continuum, no matter what the setting, she is practising midwifery. Therefore when a midwife holds dual registration/qualification as a nurse she cannot practise simultaneously as a midwife and a nurse. In a maternity setting a registered/qualified midwife always practises midwifery. (p. 5)

The situation of midwives in Japan clearly fails to meet this statement. In Japan, furthermore, there is no staffing standard for midwifery or perinatal care, and newborn babies are not counted as admitted people in birth facilities.

Social issues faced by childbearing women in Japan

Today, in Japan, more women give birth later in life, the number of pregnancies involving infertility treatment is rapidly rising, and the negative physiological changes in women's bodies caused by a neglect of health and transitions in lifestyle are widely reported (Iwasawa & Mita, 2007; Koba, Kashima, Moriwaki, Teraoka, & Maeomichi, 2014; Matsui, Saito, Futakawa, Sasano, & Hasegawa, 2019). These trends often render childbirth and birthing women a high-risk matter. Such a perspective regarding maternity care, including midwifery care, has led to risk-oriented screening and management rather than a respect for the uniqueness of every woman and the normal or physiological process of childbirth. The proportion of medical interventions in childbirth, including Caesarean section and epidural anaesthesia, is steadily increasing. More and

more, technologies such as prenatal diagnosis at the gene level are being introduced into maternity care.

Kikuchi (2016a) discussed childbirth and childbearing women after modernisation of Japan. She claimed that foetuses became visible thanks to technology, and that makes foetuses patients within maternity care. Furthermore, Kikuchi argued that the line separating mothers and foetuses became clear, with some women seeing their babies as 'a thing' coming out from their body, and viewing giving birth vaginally as unnatural (Kikuchi, 2016a). The embodiment of pregnancy and birth is hard to accept for these whose body image has become something they control and manage like maintaining their personal fitness (Kikuchi, 2007, 2016a). Accordingly, Caesarean section and epidural births have come to be claimed as women's needs, choices, and rights. Kikuchi suggested women's anxiety towards their bodies and birth is the fundamental cause of such claims. Nonetheless, doctors and midwives respond to their 'needs' rather than their anxiety, and recognise that an epidural is one of women's choices to control and give birth on their initiative (Hirota, 2012; E. Tanaka, Morofushi, Tokida, & Kanou, 2017). Kikuchi also argued those women who firmly hope for Caesarean section or epidural birth have little communication with healthcare providers and believe unfounded information. The women often do not know any details of the procedure and risk of their choices, though they have high education and careers, and they are well informed (Kikuchi, 2016a).

At present, reducing postnatal issues is the focus of maternity care reform in Japan because of the serious situations of anxiety, postpartum depression, suicide, and child abuse among mothers, as mentioned earlier. The countermeasures of the government and the association of obstetricians who are supposed to address these issues emphasise screening socially and mentally high-risk pregnant women and mothers for early detection of these issues and try to provide efficient care and treatment for the women identified as potentially high-risk only (JAOG, 2017a; MHLW, 2017d). The problem is that women's birth experience, childbirth care, and midwifery care are completely ignored in the strategy and discussion. In fact, the government has recently enacted laws and guidelines to solve these issues, but there is no mention about childbirth and the care at all. For the government, the low maternal and perinatal mortality may have created the perceived guarantee that birth care in Japan is safe and has few issues. Furthermore, Japanese midwives have followed such trends, public opinions, and government strategies by building postnatal care centres and providing postnatal care that is separated from the care of pregnancy and birth (Ichikawa, 2017; M. Shimada, 2018). This means that even midwives have a lack of awareness concerning the connection between pregnancy, birth, and postpartum.

The postnatal services and care enacted by the government is part of countermeasures designed to address the falling birth rate, since Japan's low birth rate is one of the most serious issues facing

modern Japanese society (Cabinet Office, 2018b). The reasons for the low birth rate are complex; but in terms of birth experience, women who have had a negative birth experience subsequently have fewer babies or wait longer before having their next baby (Gottvall & Waldenström, 2002). Kouta (2016) argued that many Japanese women suffer from a negative birth experience and trauma. Negative birth experiences have several causes, including unexpected birth outcomes and various forms of physical and emotional damages. According to Kouta (2016), childbearing women and mothers suffer particularly from isolation during pregnancy and labour, after childbirth, and while rearing their children. Childbearing women are commonly monitored by machines such as foetal monitors during labour, and often left alone after childbirth in birth facilities (Kouta, 2017). They are assumed to be healthier and less in need of care than sick or elderly patients hospitalised on the same floors, and midwives are kept busy as nurses, taking care of patients in so-called mixed-patient wards (Kaibara, 2017; Kouta, 2017; Saito, 2018). These results indicate that the Japanese maternity system may have inadvertently left the emotional care of women and their psychological well-being behind in its efforts to save the lives of women and infants by focusing on medicalising childbirth.

Summary

Japan is one of the world-leading developed countries in economy and medicine, and this has advanced the country's healthcare system and outcomes. The statistical outcomes of maternity care, such as maternal and neonatal mortality rates, are remarkably good. On the other hand, the maternity care has faced serious systematic and social issues. The changes of birth culture, especially after WWII, including the institutionalisation and medicalisation of childbirth and the shift of primary birth carers, had great impact on the roles of midwives in Japanese society. Midwives have become invisible and their autonomy has been weakened in maternity care settings. Weak education, regulation, and associations have contributed to this situation. While there are still positive evaluations of midwifery care, especially care at midwifery homes, those facilities are also decreasing. Consequently, women do not have enough opportunities to communicate with midwives in the current context. Further, governmental policies and measurements designed to tackle the issues around childbearing and childrearing have not brought positive results. Such a context must have affected the care at birth and then the birth experience of women. In such a situation, it is not clear what kind of relationship women and midwives can have. The next chapter explores the literature regarding the relationship between midwives and women in Japan and other countries, and various relationships in wider fields.

Chapter Three: Literature review

This chapter explores the literature pertaining to woman–midwife relationships. Some scholars have discussed how to approach hermeneutic phenomenology for the purposes of a literature review (Crowther et al., 2014a; Fry, Scammell, & Barker, 2017; Smythe & Spence, 2012). The main premise is that hermeneutic phenomenology requires a different way to engage with the literature than is usually practiced in academia. For researchers of hermeneutic phenomenological studies, a literature review is an important opportunity to dialogue with the work of other researchers, surfacing their prejudices, and widen their horizons by encountering different historical and cultural understandings (Gadamer, 1960/2013; van Manen, 2016a). van Manen (2016a) also stated, "the work of others turns into a conversational partnership that reveals the limits and possibilities of one's own interpretive achievements" (p. 76). For this purpose, what is considered 'literature' should not be limited and can be anything that deepens the researchers' understanding in terms of the discussion of the phenomenon which is the woman–midwife relationship in Japan.

Of course, in a traditional way, my literature search first focused on contemporary research after 2000 and used CINAHL, CiNii, ClinicalKey, Cochrane library, Google Scholar, Ichushi web, J-Stage, MEDLINE, MIDIRS, NDL Search, and Ovid databases in both English and Japanese languages. However, systematic ways of literature search may limit opportunities to 'meet and talk with' literature and thus may limit researchers' opportunities to develop the ability of interpreting the phenomenon. In fact, during the literature search on academic databases, I, a Japanese midwife and researcher, was surprised to find very few articles regarding the woman–midwife relationship and midwifery partnership in the Japanese context. There may be few studies with the primary focus on the woman–midwife relationship in Japan, but I was also able to gain an understanding of the woman–midwife relationship in research and media in which the woman–midwife relationship was mentioned in passing or could also be read as being about the relationship even if that was not the author's intention. That is, I was able to read all the literature I encountred with the relationship in mind. Therefore, depending on systematic literature search has a risk to exclude valuable literature especially in terms of the woman–midwife relationship in the Japanese context.

In addition, it has been very difficult to find high quality, primary researched, peer-reviewed research in Japanese literature relevant to the woman–midwife relationship. In Japan, many studies are published in the researcher's own university's journal, called *Kiyō*, which are usually not peer-reviewed. The quality of such research is controversial, and indeed there are large

differences among the quality of those studies and journals (Takeuchi, 2012). However, this does not mean those studies are always low quality or new insights do not emerge from them. They have proven invaluable for providing contextual insights of the phenomenon for this study. Furthermore, the two most well-known journals in Japanese midwifery and the bulletin of JMA are not peer-reviewed academic journals. These journals, approximately 40, 70, and 75 years old respectively, are the most read journals among Japanese midwives and have potential to influence Japanese midwives and midwifery. They could be considered something more akin to magazines featuring a special topic each month and aim to help readers grasp and understand the current interests in Japanese midwifery or midwifery care, what people, especially experts of the topics or leaders of Japanese midwifery, think about the issues, and how women and midwives experience the issues in some clinical settings. These are important materials for me as a researcher to immerse myself in the phenomenon I study as well as other scientific literature.

Smythe and Spence (2012) suggested an important characteristic of a hermeneutic literature review is to draw researchers and readers into thinking. For this, a wide range of materials, including biography, diaries, logs, arts, and poetry from different eras and cultures relevant to the phenomenon, can be the sources of the literature review (Smythe & Spence, 2012; van Manen, 2016a). With this in mind, I do not limit literature I explore, and I include any sources that help to provoke and deepen my thinking on the woman–midwife relationship. More specifically, I have repeatedly turned through the pages of the Japanese midwifery journals mentioned above, bulletins, newspapers, and books in my bookshelves collected over the years of being a midwife, as well as browsing through university libraries, and importantly in the library of a Japan's midwifery school.

The literature review of the current study engages with previous studies, assessing and critiquing them, attempting to determine the specific context and tensions in the texts, and striving to determine the specific roles and values of the present study in relation to these texts. At the same time, as the researcher interpreting the woman–midwife relationship, I do not focus only on the results of previous studies, and I attempt to be open to and to interpret the phenomenon seen in literature. A hermeneutic phenomenological literature review challenges my interpretation, raises questions of my role as a researcher, and by doing so influences my understanding of the lived experience of the study participants. It is also important to be aware that hermeneutic phenomenological literature review is never certain and complete. Moreover, even if the literature review did not include much mention of poetry, online blogs, and other news and social media, I have seen, heard, read and felt them and keep affecting my understanding and interpretation of this relationship. The aim of this literature journey is to stimulate my thinking and expand my understanding of the woman–midwife relationship from many angles and perspectives. This

multi-faceted and hermeneutic approach to the literature review was employed throughout the study.

I begin this chapter by examining the meaning of relationship more generally in order to understand how relationships are fundamentally or variously understood. Next, the literature review explores the international debates regarding the woman–midwife relationship to better understand the significance of the woman–midwife relationship and the cultural specificities that potentially shape woman–midwife relations in Japan. Here, I explore concepts, such as midwifery partnership, woman-centred care, and alternative cultural approaches discussed in the childbirth and maternity literature. Lastly, contextualising the woman–midwife relationship in Japan, as it relates to broader international debates, offers insights into possible or potential meanings of the woman–midwife relationship in Japan today.

The meaning of relationship

This study focuses on the specific relationship between women and midwives. However, 'relationships' also comprise the very foundation of our phenomenological experience as human beings. Therefore, this first section briefly examines what a relationship is for humans and how relationship is essentially understood. Moreover, this section attempts to understand various, unique, and possibly different kinds of relationships, other than the woman–midwife relationship, in order to expand our perspectives before returning to interpret the woman–midwife relationship. Japanese understandings of relationships are also sought throughout the literature review.

Human relationship and humans as beings of relationship

Jackson-Dwyer (1995) maintained that both our most uplifting and our darkest experiences are founded in relationships because "humans are essentially social beings" (p. 1). According to Jackson-Dwyer (1995) discussing the major theories in relationship research in the field of psychology, attachment, belonging, and affiliation are significant factors for humans in establishing emotional foundations and fundamental motivations, as well as surviving and staying strong in the social context. Also, in a study conducted by Haugan (2014), the interaction between nurses and patients in nursing homes significantly related to the patients' mental health and overall well-being, and affected their sense of meaning and purpose in life. Adversely, lack of attachment and social contact can negatively impact mental and physical health and health behaviours (Berkman, Glass, Brissette, & Seeman, 2000; Perkins, Subramanian, & Christakis, 2015; Tsai & Papachristos, 2015). These findings indicate that people live in relationships as social beings. Nevertheless, the existence or significance of relationships is often invisible and usually hidden behind the scenes in our lives. As Giles (2011) described, "While the relationship matters to the experience, the relationship lies out of sight and is largely taken for granted" (p. 80).

Japanese philosophers have also discussed the role of relationships as the fundamental ontology of being human. Watsuji (1934/2007) insisted that human beings can exist because they *are* between humans. His claim is that a human being is not only a human with body and mind but is the world/society/people itself. In Japanese language, the term human beings is written as 人間 *nin-gen* (人 means human and 間 means relation, space, or interval). Miki (1940/1976), another philosopher, also expressed a human as one with others. Japanese society is frequently referred to as a form of collectivism, in contrast to the individualism of Western cultures. Therefore, the belief that humans cannot live without others might firmly be rooted in Japanese cultural practices and societal morals. Furthermore, in Japan, especially in Shintoism, it is believed that everything has a spirit, like a spirit of a tree, river, or rock. It is said there are eight-million gods in Japan, and in this way human life exists in relation to the natural world, and not just in relation to other humans. Hashimoto (2009) described such a Japanese cosmology as co-existence with others and nature in harmony. In that case, Japanese might understand relationship in a broader sense than two people being in relation to one another; they are always already relating.

Going back to the Western discussion, Giles, Smythe, and Spence (2012) pointed out the variety of concepts regarding relationships in the context of education. For instance, some researchers have described the space, between a teacher and a student, as a gap and an opening, based on the idea that a relationship happens *between* them or occurs as exchanged transactions *from* one *to* the other (Giles et al., 2012). Metcalfe and Game (2006) described the relationship between a teacher and student as one of give-and-take. Such relationships highlight the difference between the people concerned, tending towards objectification. On the other hand, relationships can represent connectivity as a basic aspect of human nature. In this case, relationship appears as a holistic concept rather than the space or interactional exchange between people; suggesting that relationship is a uniting phenomenon (Hooks, 2003; Nakagawa, 2001). Thus, people experience and live relationships beyond the rules of engagement, and relationship is an inherent connectedness rather than functional space (Giles et al., 2012). Japanese philosophers have discussed the importance of 間 *ma* or *aida*, meaning space, arguing for the connectedness of humans through the in between space that makes the world (Miki, 1940/1976; Watsuji, 1934/2007). Such an idea is close to recognising relationship as a holistic concept. In this way, human relationship is not simply relationship between individuals, but humans appear as beings of relationship. The relationship is primary, rather than the being of individual.

Relationship in healthcare

In clinical settings, Árnason (2000) expressed concerns regarding the idea of a therapeutic relationship between caregivers and patients. He pointed out that the helping relationship is traditionally regarded as one-sided. In Árnason's argument, there are three categories of the

patient–professional relationship; paternalism, patient autonomy, and dialogical relation. He argued the first two models are not considered as inter-personal and dialogical, and they just contribute to the estrangement between professionals and their patients. Several scholars have also discussed how professional expertise often leads care providers to an authoritative status (Davis-Floyd & Sargent, 1997; Goodyear-Smith & Buetow, 2001; Larsen, 2016).

Paternalism and social hierarchy are also rooted in Japanese medical context (Ishiwata & Sakai, 1994; Sekimoto et al., 2004). Yamashita (2011) argued that doctors have monopolised decision-making and hold power over other healthcare professionals in Japan. Furthermore, healthcare professionals, such as physicians, nurses, clinical psychologists, and social workers, who participated in Sullivan's study (2017) stated that many patients are comfortable to leave decisions to their doctors. They also maintained this relational structure is a part of Japanese culture and an accepted decision-making practice, even if it appears the opposite of supporting patients' decision-making. Regardless of whether or not this is a cultural characteristic, it is still difficult to respect patients' autonomy in such relationships. That said, a better relationship and improved communication, including patients' autonomy and informed consent, have also been discussed as valuable care in the current Japanese context (Aita, 2013; Okino, 2002).

Internationally, the quality of the relationship has long been the subject in clinical settings. According to Goold and Lipkin Jr. (1999), the doctor–patient relationship has attracted attention since the time of Hippocrates, and research has actively continued. This may imply how deeply doctors' traditional attitudes are rooted, and how difficult it is to achieve the ideal relationship in complex medical contexts. For example, Delbanco (1992) discussed how to improve the doctor–patient relationship by 'inviting' the patient's perspective. Similarly, research on the doctor–patient relationship has maintained the significance of doctors' attitudes and communication skills in respecting the patients' perspectives and improving participants' satisfaction (Ha & Longnecker, 2010; Hagihara & Tarumi, 2006; Kee, Khoo, Lim, & Koh, 2018; Mahmud, 2009; Sadati, Tabei, & Lankarani, 2018; Singh, 2016). These studies indicate that there are always challenges to achieving mutual interactions, and to involving or respecting each patient as an individual in the medical context. Also, discussions on topics such as 'patients' participation,' 'patients' rights,' 'shared information,' and 'shared decision-making' indicate that patients have been excluded and their self-determination has not been taken into consideration as a matter of course in their care (Chin, 2002; Fainzang, 2016; Makoul & Dulmen, 2016). Ironically, according to Campbell et al. (2015), a lack of patient autonomy and patients' blind trust towards doctors might even contribute to better relationships where an individual appears to be 'a good patient.'

The healthcare system and organisational environment are further factors influencing the professional–patient relationship (Goold & Lipkin Jr., 1999; Safran, Miller, & Beckman, 2006).

In nursing, Bridges et al. (2013) found that the capacity of care and the relationship is greatly influenced by the organisational setting. They suggested that nurses struggle to establish relationships with patients due to inadequate conditions, such as lack of time and the managerialism of the care system. Furthermore, Coombs (2004) pointed out that paternalism and hierarchy exist among professionals, for instance, between doctors and nurses. Midwives may also be positioned in this hierarchy too because, especially in Japan, midwives are recognised as nurses. In a healthcare system where such paternalistic hierarchy among professionals exists, it is probable that this will also produce a hierarchy between professionals and patients. Both professionals and patients live in deeply enmeshed relationships, which involve various healthcare professionals and patients' family in clinical settings (Dickinson, Smythe, & Spence, 2006).

While medical science, as relating to cures, safety, and clinical outcomes, has tended to be prioritised over humanised care and patient autonomy, it is also evident that good relationships between doctors and patients lead to better clinical outcomes and patients' positive attitudes towards their treatment (Cushing, 2016; Delaney & Martin, 2016; Hefner et al., 2018; Noble, 2016; Stavropoulou, 2011; Weiner et al., 2013). The bioethics and humanisation of medicine have also contributed to enhancing relationships, including within the Japanese context (Beauchamp & Childress, 2013; McCormack, Dulmen, Eide, Skovdahl, & Eide, 2017; Todres, Galvin, & Holloway, 2009). Also, in Japan, the promotion of collaborative work among professionals, for instance, team care to support patients who require special care, have gradually been reworking the hierarchy between professionals. Also, the reflection of negative incidents, such as medical accidents and litigation, has led to enhancing trust in the relationship and better communication between patients and professionals in Japan (Nishigaki, Asai, Ohnishi, & Fukui, 2004). Kaba and Sooriakumaran (2007) suggested that, ultimately, the basic principle should be that it is a relationship between patient-as-person and doctor-as-person. Discussions, such as the authoritative power of professionals, client's autonomy, organisational environment, and the importance of clinical outcomes, are perhaps common issues in maternity care settings.

Midwifery relationships in the international context

The significance of the woman–midwife relationship

If human relationships are so important in medical and other social contexts, there is no doubt about the importance of the relationship in maternity care settings. Olza et al. (2018) conducted a meta-synthesis of eight qualitative studies, involving 94 women, regarding women's psychological experiences of physiological childbirth. The study included only women who had unmedicated births and many of the women had a homebirth. While the women trusted in their own capacity; others' capacity, including families and care providers, was highly relevant for how the women experienced their birthing process. Olza et al. found that midwives' presence,

including emotional support, is particularly important for women's psychological journey of childbirth. Currie and Barber (2016) explored the experiences of New Zealand women who experienced medical complications in pregnancy and reported on the importance that these women attached to their relationship with midwives. Midwives who cared for, listened to, and engaged with, and built strong relationships with the women were described as partners who were trustworthy, supportive, and confidence-building. For women in a medical crisis, the emotional support and engagement of a midwife was found to be vital (Currie & Barber, 2016). Olza et al., and Currie and Barber showed that midwives' existence plays an essential role for sustaining women's psychological well-being in their birth experience, regardless of birthplace and the level of risk.

Other studies also found that a well-established women–midwife relationship results in a feeling of satisfaction and positive birth experiences for women (Dahlberg et al., 2016; Hallam, Howard, Locke, & Thomas, 2016; Howarth et al., 2011; B. Hunter, 2006; Karlström, Nystedt, & Hildingsson, 2015; Leap et al., 2010; Lundgren & Berg, 2007). For example, in a study of birth experience of first-time mothers in New Zealand, the midwife relationship was notably important (Howarth et al., 2011). Women in the study of Howarth et al. (2011) desired a warm, caring, and personal relationship with their care providers, and they had a sense of security and reassurance when they placed their trust in midwives. In terms of trust, Lewis, Jones, and Hunter (2017) showed that a successful relationship is based on the mutual trust that develops between a woman and her midwife. Moreover, Boyle et al. (2016) argued such a trusting relationship empowers women in the process of decision making. Trust between women and midwives seems essential for women's positive birth experience. These three studies found that women develop such a trusting relationship through continuity of care with a known midwife. Howarth et al. (2011) also claimed that the sense of not being alone on their birth journey enhances a woman's belief in herself and positively introduces her to motherhood. That means the woman–midwife relationship greatly influences the woman's birth experience and her childrearing.

As key maternity care providers, midwives may also negatively affect women's experience. In the study of Currie and Barber (2016), some of the women reported disappointment with midwives who were difficult to contact, did not seem to care, appeared judgmental, or failed to be an advocate for their own desires and needs. Such midwives added to the women's distress. Boyle et al. (2016) also reported that women feel a sense of vulnerability and anxiety when they are not able to build a satisfactory relationship with their midwives. These studies offer clear evidence that the woman–midwife relationship significantly influence the women's birth experience and therefore one of the most important factors in improving the quality of maternity care. B. Hunter et al. (2008) asserted that the quality of maternity care is ultimately based on the quality of the relationship between the woman and her midwife. They described the woman–

midwife relationship as “the hidden threads in the tapestry of maternity care” (p. 132), through which quality of maternity care, clinical safety, women’s experiences and caregivers’ experiences, are interwoven and interlinked. This indicates that the woman–midwife relationship itself could be an invisible but essential ingredient for high quality maternity care.

The woman–midwife relationship also impacts on midwives. The caseload model of midwifery care, which is basically midwife-led continuity of care, could negatively affect professional and personal well-being because of the long hours on-call, excessive workloads, poor work-life balance and professional isolation. However, research has shown that the caseload model has extensive benefits for midwives. Midwives working in such a care model of continuity have reported lower levels of burnout, anxiety and depression, and higher levels of professional identity, autonomy and empowerment, as compared to midwives working in a non-continuity work environment (Dixon et al., 2017; Fenwick, Sidebotham, Gamble, & Creedy, 2018; Jepsen, Juul, Foureur, Sorensen, & Nohr, 2017; Newton, McLachlan, Willis, & Forster, 2014). McAra-Couper et al. (2014) found that the joy and passion for midwifery practice brought by partnership and reciprocal relationships with women are key to caseload midwives sustaining their practice.

Newton, McLachlan, Forster, and Willis (2016) observed that the relationship between the midwife and her woman is the focus of the caseload model. By working continuously with a woman and building the relationship, the midwife is able to thoroughly know the woman, engage with the woman, feel better prepared for the woman’s labour, birth and early parenting, and offer more appropriate care. Fenwick et al. (2018) also found that midwives recognise that they can take fuller advantage of their knowledge, skills, and resources in the continuity of care model. In short, the midwife is able to provide comprehensive care for the women. Such care enhances woman-centred care and empowers women to make decisions regarding their care (A. Hunter et al., 2017; Newton et al., 2016). These studies have suggested that both the woman and the midwife gain control and autonomy within the relationship.

Newton et al. (2016) claimed that the time and energy that the midwives invest in each woman are recouped by the relationship. Importantly, midwives in the study even felt that this way of working is ‘real’ midwifery. In this regard, Fenwick et al. (2018) indicated that midwives providing fragmented care on shift-based models have a greater risk of developing emotional distress. For instance, being on-call is quite different for standard care midwives who are on-call for unknown women as opposed to caseload midwives who know the women in their care (Homer, Brodie, & Leap, 2008; Newton et al., 2016). A positive relationship has been found to contribute to job satisfaction and sustains their passion for the job (B. Hunter et al., 2008; McAra-Couper et al., 2014; Stevens & McCourt, 2002). In many ways, building relationships with the women in their care is a significant factor in creating and maintaining a sustainable midwifery workforce.

While such positive relationships are rewarding, Deery and Hunter (2010) found that some midwives are emotionally fatigued when such relationships are not achieved. During the journey of pregnancy and childbirth, women and midwives have to deal with a variety of out-of-the-ordinary issues; including professional, private, social, physical, emotional, positive and negative events which sometimes put them at risk and causes pain (Deery & Hunter, 2010). B. Hunter (2006) argued that some relationships are problematic for midwives and require considerable emotional work, and that midwives are impoverished when unable to establish a good relationship. Further, Kirkham (2010b) maintained that the relationship is influenced by the organisational context, the care system, and the social context including values, beliefs, and obligations. Such contexts can be obstacles to building positive relationships, in addition to individual efforts and compatibility. When midwives are not able to build good relationships with women, they detach themselves from engaging with women which may lead to low morale, stress, and burn-out (Deery & Hunter, 2010). It appears essential, then, that midwives have a fulfilling relationship with the women in their care in order to sustain their practice and improve the birth experience for all involved.

As described, the interactions between women and their midwives can be both positive and negative, and they influence each other as long as they are being together in the care/world. The interactions and their effects are clearly reciprocal. Nevertheless, many studies' point of view tends to be singular and exclusive, adopting either the perspective of the woman or that of the midwife, while having focused on the experiences and perspectives of women and midwives. Thus, the emphasis is on either 'providing' care or 'receiving' care; rather than the mutual interactions involved. Relationship is the state of being connected and related, and the parties involved are engaged relationally with other parties rather than being passive recipients (Giles, 2011). The studies above have mentioned the importance of the woman–midwife relationship but have failed to address the issue substantively. There is a general absence of studies that explore the experiences of both parties in terms of a holistic concept and shared experience involving two parties. By examining and integrating experiences of both women and midwives, my study will allow us to understand how they take part in, interact within, share, influence and contribute to the woman–midwife relationship.

Furthermore, while much research and discussion regarding the woman–midwife relationship is seen in Western countries, the recent woman–midwife relationship in non-Western countries, including Japan, is rarely documented in English. It is not clear whether such studies are only being conducted in each local language or if simply little attention is paid to the woman–midwife relationship in those countries. In the case of Japan, both these concerns exist. I hardly found English literature examining the woman–midwife relationship in the Japanese context, and I

found very few in the Japanese language. I will discuss the relevant literature of the woman–midwife relationship in the Japanese context in detail, after first exploring the models and concepts relevant to the woman–midwife relationship in the international context.

Models and concepts of the woman–midwife relationship

As the significance of the woman–midwife relationship is evident, there are some models of care focusing on or related to their relationship. They are often considered as essential for midwifery care or for the establishment of a good woman–midwife relationship. This section explores two theoretical models of midwifery care, midwifery partnership and woman-centred care, and cultural concepts discussed in relation to the woman–midwife relationship.

Midwifery partnership

In terms of the relationship between women and midwives, the ICM (2017a) defined midwifery as a profession that "works in partnership with women" within the scope of midwifery practice (p. 1). The ICM (2014b) also stated that the partnership between women and midwives is fundamental to the philosophy and model of midwifery care. According to its position statement on *Partnership between Women and Midwives*, the ICM (2011b) urged midwives to work with women to encourage and promote the active roles of women for their own rights and well-being. Since the ICM adopted the partnership model at its triennial congress in 1993, partnership has become central to the woman–midwife relationship, and a principal concept of midwifery care globally.

Originally, the midwifery partnership concept appeared as one of the core philosophies of New Zealand midwifery, prior to its adaption to the ICM definition of the midwife (Freeman, Timperley, & Adair, 2004; Guilliland & Pairman, 2010a). Guilliland and Pairman (1994), two New Zealand midwives, stated that "midwifery is the partnership between the woman and the midwife" (p. 6). They defined the midwifery partnership as "a relationship of 'sharing' between the woman and the midwife, involving trust, shared control and responsibility and shared meaning through mutual understanding" (Guilliland & Pairman, 2010a, p. 7). New Zealand midwifery has promoted the partnership model at all levels, exercising its influence in politics, professional organisations, regulatory bodies, and education.

Guilliland and Pairman (2010a) asserted that equality between a woman and her midwife is a significant element in achieving a midwifery partnership. However, some researchers have questioned the feasibility of true equality since midwives have power over the relationship due to their professional knowledge and position (Boyle et al., 2016; Freeman et al., 2004; Skinner, 1999). Freeman et al. (2004) indicated that equality is not necessary for a midwifery partnership and argued that it is about how the woman and the midwife share power towards a common aim

that is the key to managing accountability, responsibility, and decision making. For Freeman et al., the tension with regard to equality does not mean that partnership is not achievable between professionals and patients or women. Freeman et al. maintained a midwifery partnership is achievable without equal status between a woman and a midwife as long as they negotiate and work together, they both are responsible, and they are accountable to each other. This idea is entirely consistent with the equality that Guilliland and Pairman discussed. They described equality as the woman and midwife working through issues of choice, consent, decision making, power sharing, mutual rights, and responsibilities; and that knowledge and power achieve a balance which is negotiated and mutually satisfactory. Definitions of equality vary among midwifery scholars and in other fields, such as business. In midwifery, however, it appears that researchers generally agree that, while the woman and the midwife may have different positions and responsibilities, they ultimately work together to achieve one goal, irrespective of whether their roles are viewed as equal (Freeman et al., 2004; Guilliland & Pairman, 2010a). While midwives have scientific knowledge and experience, women have their intuition, intrinsic wisdom, self-knowledge, and their own personal experiences. Guilliland and Pairman maintained that midwives should not, and generally do not, underestimate the woman's contributions to the relationship. Rather, the negotiations between the parties are an important part of the process of building their partnership.

Skinner (1999) also argued that there is a significant power imbalance when a woman and her midwife come from different knowledge bases involving a cultural aspect. Furthermore, Skinner pointed out the partnership model is seen as part of the growth of contractualism, which presumes that all women want partnership and control, and that informed consent is always achievable. She claimed that the partnership model will work only for white, articulate, educated, middle class-women; adding, that the complexities of culture, class, value, and expectation are not addressed sufficiently in the partnership model, especially at the practical level. Replying to Skinner's opinion, Daellenbach (1999) suggested, from the point of view of a consumer and sociologist, that partnership can be a way of addressing differences in the relationship, however they might form, with respect for the client and her needs. She thus suggested that the partnership model can be flexible enough to take different contexts into account.

Doering (2012) explored the birth experiences of Japanese women in New Zealand. In the study, the relationship between the women and midwives appeared smooth, but the women did not readily negotiate or else, passively followed their midwives to avoid any conflicts in the relationship, as they assumed that that is how it should be. In the model where both parties are expected to actively engage with each other, the Japanese women's way of being in relationship may not easily fit the partnership model. Daellenbach (1999) stated, while many midwives claim that some women are not interested in partnership, every woman wants to be treated with respect

by her midwife. She also argued that women neither want nor need to make a decision about everything in a partnership. Daellenbach, herself, was not an active partner in the relationship with her midwife when she was a young, single, and unprepared mother, but she considered the relationship a partnership. She suggested that the definitions of partnership need not be limited to just a few concepts. A woman may define partnership in her unique, dynamic relationship with her midwife.

As well as equality, individual negotiation, shared responsibility, empowerment, and informed choice and consent are the principles of the midwifery partnership (Guilliland & Pairman, 2010a). The emphasis of women's individuality, control, choice, and power could be supported by feminist perspectives. In fact, midwifery is described as a feminist profession (Guilliland & Pairman, 2010a; Surtees, 2003). Leading feminist, Wolf (2003), evaluated midwifery as an individual approach to childbirth. Feminism values each woman's unique view, way of knowing, and experience. Thus, feminist perspectives are required in midwifery and working with women in partnership appears as feminism. Guilliland and Pairman (2010a) argued that, as a result, feminism has significantly contributed to the midwifery partnership model.

However, Japanese society is often regarded as collective; in contrast to the individualism of Western societies. In terms of feminism, Kikuchi (2016b) and Matsushima (2006) argued that feminism, introduced to Japan in the 1970s, encouraged women to take a more assertive role in the birth care they received. The Lamaze Technique was symbolic of the trend (Funabashi, 1994). However, Kawai (personal communication, February 28, 2016), an award-winning Japanese birth journalist, looked back over decades of Japan's context of childbirth and concluded that paternalism was too deeply rooted. Hence, the feminist approach simply did not work in Japan, at least with respect to childbirth. Feminist perspectives are very important in midwifery. In Japan, however, it seems feminist approaches have failed, and the care model based on feminism may not fit Japanese culture.

Moreover, McAra-Couper, Jones, and Smythe (2011) found that women's choice is formed in a social and cultural context or even predetermined by the context. Feminist analysis often focuses on the medicalisation of childbirth (Martin, 2016). However, McAra-Couper et al. argued that the meaning of choice and control is more complex in an era where medicalised and technological birth is taken for granted and more women are in control of many things in the society. That a woman and a midwife negotiate the woman's right, choice, and uniqueness, may be a challenge in such a context. In this regard, Guilliland and Pairman (2010a) insisted that continuity of relationship between the woman and the midwife, or time to get to know each other and build trust and understanding, will help better decision making and informed consent.

Recognising the significance of midwifery partnership, some researchers have focused on the difficulties or even impossibility of achieving the model (Boyle et al., 2016; Kirkham, 2010b; Mander, 2011). Kirkham (2010b) argued that many midwives struggle with developing an ideal relationship with the women in their care. Moreover, in some countries, the maternity or midwifery care system designed to implement partnership principles is severely limited, causing midwives to face serious dilemmas (Boyle et al., 2016; Horiuchi et al., 2003; Kirkham, 2010a). Even in New Zealand, reaching a genuine partnership has always been challenging, especially for hospital midwives, because of the restrictions of hospital routines, institutional protocols, and employment contracts (Guilliland & Pairman, 2010a, 2010b). B. Hunter (2006) maintained, however, that the work of hospital midwives is more task-oriented because they have to work for institutional goals and processes in preference over women's needs and care. Hence, Guilliland and Pairman (2010a) argued that it is fundamental for midwives to practice autonomously if they are to develop a meaningful partnership. This is not a criticism of hospital and hospital practice because the role of hospital midwives is significant and midwives always need to work in collaboration with other professionals and institutions regardless of their styles of practice. However, autonomous midwifery practice makes it easier for midwives to establish midwifery partnership, meet women's needs on a case by case basis, and support women's wish for childbirth as a basic healthy life event (Guilliland & Pairman, 2010a).

In addition, Guilliland and Pairman (2010a) maintained midwife-led care and continuity of care are essential requirements for actualising the partnership model. However, Gilkison, McAra-Couper, Fielder, Hunter, and Austin (2017) argued hospital midwives in New Zealand play important roles for women in hospitals, and they are often able to quickly build a partnership with a woman. Partnership may be achieved with limited time, but it is also true that midwife-led continuity of care allows more opportunity for the woman and the midwife to know one another and develop trust. Even if continuity of care is not indispensable, it makes easier for them to have a partnership. Guilliland and Pairman emphasised the need for continuity of 'caregiver' as fundamental to forming a midwifery partnership. Continuity gives the midwife access to a woman's entire birth experience on a one-to-one basis, with obvious benefits (Guilliland & Pairman, 2010a). Dahlberg and Aune (2013) also argued that following and sharing a woman's personal birth experience has huge potential for forming a successful partnership and enables midwives to provide holistic care. Flint (1993) emphasised that the mutual trust and sense of security developed through partnership relationship also increase a woman's trust in herself to make decisions and control her own experience, which enhances her confidence, personal growth, and development.

Regardless of the attention to partnership model, the positive outcomes of midwife-led continuity of care (MLCC) is evidenced by the latest Cochrane review on this subject (Sandall, Soltani,

Gates, Shennan, & Devane, 2016). According to the systematic review of the MLCC model compared to other models of care, such as obstetrician-provided care and shared models of care, women with MLCC are more likely to experience spontaneous vaginal birth and less likely to experience pharmacological pain relief birth, episiotomy, instrumental vaginal birth, preterm birth, foetal loss, and neonatal death (Sandall et al., 2016). Women feel more satisfied with their care, and the cost-effectiveness of that care tends to be higher. Compared to other models of care, there appear to be no adverse outcomes for the women or their infants.

Women-centred care

While the woman and the midwife have equal status, Guilliland and Pairman (2010a) stated that "the midwifery partnership is woman-centred" (p. 38). This sounds contradictive but the midwifery partnership that Guilliland and Pairman called for is philosophically underpinned by its woman-centred nature. According to Guilliland and Pairman, in a midwifery partnership, the midwife focuses on the woman since "the midwifery relationship can only occur with a woman" (p. 39). This does not mean that the midwifery partnership or woman-centred concept excludes the baby and the family (Guilliland & Pairman, 2010a). They argued that *the woman* is primarily responsible for decision-making for herself and her baby. She focuses on herself, her baby, and her family, and identifies or defines other relationships with surrounding people. She also decides the priority of her care needs. The midwife, in turn, understands, works with, and advocates for the woman as her primary carer.

Pope, Graham, and Swattee (2001) argued that the growth of consumerism and individualisation in the early 1990s, in the United Kingdom, reinforced individual and holistic care in healthcare policy. To understand each person's unique experience of health and to meet individual needs, partnerships between healthcare professionals and the client were also recognised. This concept was interpreted as woman-centred care—the woman's needs being at the heart of the care—in the maternity care provision. The key principles are choice, continuity, and control, and midwives have aimed to increase continuity of care and woman-centred care (Pope et al., 2001). In Australia, Homer et al. (2009) identified the role of midwives from the viewpoints of women and midwives. In that study, being woman-centred was a significant element required of a midwife, as was providing safe and supportive care. The ability to develop respectful partnerships and trusting relationships with women, and to ensure that women have control over their care, has also been highlighted.

Berg, Asta Ólafsdóttir, and Lundgren (2012) attempted to develop a midwifery model of woman-centred care in Sweden and Iceland. They argued that reciprocal relationships, grounded knowledge of midwives and a birthing atmosphere facilitating feelings of calm, trust, and safety, as well as supporting normality, need to be embraced by cultural context. At the same time,

midwives are required to achieve an appropriate balance between these elements and medical demand. Davis and Walker (2011) insisted that midwives are able to challenge the notion of normal birth through woman-centred care. They suggested woman-centred continuity of care enhances the midwife to be with the woman and play an active role as a primary carer regardless of normal or abnormal birth. Overall, such discussions regarding woman-centred care are consistent and show that the woman-centred model has been given great attention in maternity care or in midwifery. However, the literature also indicates a number of barriers, such as a lack of resources, limited opportunities to practice woman-centred care, structural and regulation issues, and the educational needs of midwives (Berg et al., 2012; Homer et al., 2009; Pope et al., 2001).

Additionally, in Japan, Iida (2010) and Iida et al. (2012) described some of the positive characteristics of woman-centred care as being respected, having a feeling of encouragement, getting effective interaction, receiving help in decision-making, experiencing a non-threatening manner, and developing a sense of trust in the caregiver. Iida developed scales to measure the woman-centred care that women receive in Japan on the assumption that women-centred care underpins the woman–caregiver relationship. This is in a similar vein to the philosophical approach of midwifery partnership discussed earlier. By using the scales, Iida et al. studied the relationship between woman-centred care and women's birth experience, and compared the results among midwifery homes, obstetric clinics, and hospitals in Japan. They found that women cared for at midwifery homes ranked woman-centred care more highly, felt more in control, and were more satisfied with care than those who gave birth in obstetric clinics and hospitals. Iida et al. concluded that respectful communication and continuity of care provided in midwifery homes, as fundamental elements of women-centred care, made women feel more satisfied with the care.

Fontein-Kuipers, de Groot, and van Staa (2018), scholars from the Netherlands, attempted to clarify the conceptual foundation of woman-centred care by analysing eight studies, selected from over 1400 initially retrieved from the data based on their criteria. Of the eight papers, which demonstrate the clear presence of the concept maturity of woman-centred care, five studies were conducted in New Zealand, with the other study settings being Australia and European countries. This implies that woman-centred care is paramount and that the discussion is well-developed in New Zealand, where the midwifery partnership is grounded. The definition of woman-centred care as generated from the analysis is:

> Woman-centred care is a philosophy and a consciously chosen tool for the care management of the childbearing women, where the collaborative relationship between the woman—as an individual human being—and the midwife—as an individual and professional—is shaped through co-humanity and interaction; recognizing and respecting one another's respective fields of expertise. Woman-centred care has a dual and equal focus on the woman's individual experience, meaning and manageability of childbearing

> and childbirth, as well as on health and wellbeing of mother and child. Woman-centred care has a reciprocal character but fluctuates in equality and locus of control. (Fontein-Kuipers et al., 2018, p. 8)

The definition shows that a fundamental characteristic of woman-centred care is to respect woman's individuality. It also indicates that woman-centred care works only when the reciprocal relationship between the woman and the midwife is valued.

Cultural concepts of the woman–midwife relationship

Skinner (1999) asserted that the partnership model works only for white middle-class women. It is not clear that the internationally recognised concepts of midwifery care, such as partnership or woman-centred care, fit every woman and her culture, every variation of midwifery care, or every maternity care setting. In fact, Kenney (2011) argued that the partnership model and woman-centred midwifery are Euro-centric perspectives of maternity care and overlook the cultural appropriateness of the care. More specifically, in the New Zealand context, the individualised focus of the models disregards the presence of whānau ('family' in the Māori language) in the Māori birth culture. The Midwifery Council of New Zealand (2007) explained that "the word 'woman' or 'wahine' used throughout its documentation includes her baby/tamaiti/partner/family/whanau" (p. 1). Guilliland and Pairman (2010a) maintained that the midwifery partnership or woman-centred concept does not exclude the baby and the family. However, Kenney (2011) insisted that the additional note implies that the Euro-centric perspective is seen as defining the concept, and that such a midwifery principle still offers minimal respect and protection to Māori cultural values, beliefs, and decisions. According to Kenney, in the Māori world view, birth is located within and is the responsibility of the whānau, as cultural capital is gained through the intermediation of the whānau. Kenney proposed a bi-cultural partnership framework for practice, developed with the philosophical underpinnings of the Māori world by enhancing Māori perspectives, such as their way of ensuring safety, beliefs in infinite partnership, and values regarding what is sometimes referred to as the 'baskets of knowledge.'

In Australia, there is a maternity care model called *Birthing on Country* (BoC), wherein Aboriginal and Torres Strait Islander peoples embrace their traditional birthing practices as a way of connecting with their ancestors' land/country (Kildea, Magick Dennis, & Stapleton, 2013). The underlying philosophy is "respect for indigenous knowledge and incorporation of traditional practice, respect for family involvement, a partnership approach, women's business, continuity of carer, a capacity building approach," and a "holistic definition of health" (Kildea et al., 2013, p. 36). As key elements of the BoC model, Kildea et al. (2013) emphasised that midwives facilitate "an inclusive process for all of the community (including gender inclusiveness)" while "it is a women-centred service (women define their needs)" (p. 37). BoC also includes continuity

of carer for all women regardless of the risk factors. In the BoC model, who the caregivers should be is not specifically indicated; rather, the BoC model involves the wider community of people and professionals. The concept of BoC has some similarities to the concepts of partnership and woman-centred care, but the illustration shows that the woman and her baby are surrounded by many people based on the woman's cultural, social, emotional, and spiritual needs, as compared to the midwifery partnership model in which, at the centre, the woman and her midwife appear side-by-side (Guilliland & Pairman, 2010a; Kildea et al., 2013). Kildea et al. (2018) examined the outcomes of BoC in the urban setting of Brisbane and found that women and babies accessing BoC had significantly lower rates of preterm birth, Caesarean section and admissions to NICU compared with the national statistics for other Aboriginal and Torres Strait Islander peoples. The concept of BoC resonates with Kenney's proposal (2011) which emphasised the significance of maternity care based on Māori culture and perspectives.

In Canada, traditional Inuit childbirth care has been reinforced. A project called the *Irnisuksiiniq–Inuit Midwifery Network* aims to promote effective, contemporary maternity care models combined with cultural midwifery knowledge and practices (Inuit Tuttarvingat of the National Aboriginal Health Organization, 2009). According to Pauktuutit Inuit Women of Canada (2019), "Traditional childbirth practices were intrinsic to the Inuit way of life and crucial to maintaining the social fabric of Inuit communities" (para. 1). Community and connection are of primary importance. In Inuit communities, for example, the person who brings a child into the world is particularly significant and the midwife is expected to be with the child at her/his first effort at sewing or animal hunt (Pauktuutit Inuit Women of Canada, 2019). While Inuit women appreciate the value of modern medicine, their sense of loneliness, isolation, and separation has increased through their birth experience in southern hospitals. Pauktuutit Inuit Women of Canada maintained that "birthing closer to home remains a priority in Inuit communities" (Pauktuutit Inuit Women of Canada, 2019, para. 9). The historical body of knowledge regarding Inuit childbirth and midwifery has been revised in the last few decades, and Inuit communities have promoted the traditional midwifery knowledge and practice of Inuit as well as contributing to public policy (Inuit Tuttarvingat of the National Aboriginal Health Organization, 2009; Pauktuutit Inuit Women of Canada, 2019).

These discussions and movements are usually seen in native or indigenous communities, likely following a history in which traditional birth culture was ignored and unwillingly involved or absorbed into the mainstream of the greater society. In Japan, the situation may not be the same as the issues of indigenous communities, other than Ainu and other minority peoples in the country. Yet, the Japanese traditional birth culture was denied and ignored in the modernisation of society, specifically under the occupation by the United States (Fujita, 1988; Nakayama, 2001; Shirai, 2016c). Notably, in Japan, while childbirth at midwifery homes or in the home of the

mother came to account for less than 1% of all births, women who desire to give birth in this way never disappear. The safety and high-satisfaction level of women giving birth in these settings has been confirmed. According to Iida et al. (2012), the care at midwifery homes is more woman-centred than the care in hospitals and obstetric clinics. However, it is not clear that the concept of woman-centred care actually represents traditional Japanese care. Nor is this true of the partnership model, as there is little discussion about midwifery partnership in Japan, despite the fact that Japanese midwives often use the term. Named care models are attractive and an important trigger to grasping the essence of the care offered, but the name should accurately reflect the realities of the care and be culturally appropriate.

Even if the partnership term works in Japan, the meaning or components of the midwifery partnership may be different in Japan than elsewhere in the world. For example, while the woman–midwife relationship is likened to a friendship in Western countries (Pairman, 1998; Thomson & Downe, 2010; Walsh, 1999; Wilkins, 2010), the relationship is described as being similar to a daughter–mother relationship in Japan (M. Noguchi, 2002; Suzui, 1998). Suzui's study (1998), regarding the experience of pregnant Japanese women, indicated that women expect their midwives to display maternal affection, perceived the midwife's role as being like a mother of the pregnant woman, and expected support with motherly love. People usually do not describe a daughter–mother relationship as partnership. There are some differences also with regard to feminism and individualism referred to in the discourses on partnership and woman-centred care models.

The woman–midwife relationship in the Japanese context

Based on the ICM statement (2017a) and the global trend towards midwifery partnership, the ICM definition of the midwife and the statement of midwifery partnership were translated directly into Japanese and adopted by the JMA (n.d.-a) and JNA (2017b). In addition, Japanese midwives and researchers occasionally use the Japanese translation of the ICM statement that 'midwives work in partnership with women' to explain the role of midwives on the websites of maternity facilities and midwifery schools, and in midwifery scholarship (Iida et al., 2012; Kumatani, n.d.; Okada, 2013). However, the English word 'partnership' is translated directly using katakana—パートナーシップ (pā-to-nā-shi-ppu: the script most often used for transcription of words from foreign languages)—which may not adequately reflect the exact meaning of partnership in the Japanese context. There is also little discussion among Japanese midwives regarding precisely what the midwifery partnership implies.

In fact, there has been so little research undertaken on the topic of midwifery partnership or woman–midwife relationship in Japan that it is almost impossible to undertake a critique of the

literature. First, a literature search, using the key words ‘partnership’ and ‘midwives/midwifery,’ almost always produces results related to cooperation between midwives and doctors/obstetricians or the partnership between women and their partners/husbands (Ishibiki, Nagaoka, & Kanou, 2013; Kojima, 2014). This appears to be consistent with B. Hunter’s argument (2006) that relationships with colleagues and managers are of greater importance for hospital midwives because the majority of Japanese midwives work for hospitals and obstetric clinics. In Japan, where strong paternalism exists in the medical setting (Ishiwata & Sakai, 1994), midwives may think that their priority is getting along with obstetricians in order to provide better care for women.

In the literature search, no research specifically focuses on the partnership between women and midwives in the Japanese maternity care context. The term partnership appears in some papers, but it is merely mentioned and not the emphasis of the studies (Iida et al., 2012; Ono, 2015; Tsuji, 2007; Tsuji, Oguro, Doeda, Nakagawa, & Horiuchi, 2006). In terms of the relationship in Japanese maternity care settings, M. Abe, Kano, Shimada, Komatsu, and Sankai (2005) explored the relationship between mothers and medical systems and professionals, including midwives and doctors, by qualitatively analysing 11 interviews with women. The three categories that emerged from the study were; playing a patient role, having no freedom to express one’s own feelings, and position within the hierarchy. M. Abe et al. revealed that women suffered as a result of the social hierarchy embedded within the Japanese maternity care and the system. However, one confounding issue in the study is that midwives, nurses, and doctors were categorised together and the authors did not clarify the details of the hierarchy. Therefore, women’s experience and relationship, specifically with midwives, remains unclear in their study.

Fujii, Hinokuma, and Tsubota (2007) analysed video recordings of initial visits of three women who were satisfied with the antenatal care they had at a midwifery home. Their study concluded that the relationship established between the midwife and each pregnant woman was one of trust, which allowed the women to depend (*amae*) on the midwife. The study sample comprised of only three women and the methodology is not clear. Nevertheless, their findings do offer insight into the Japanese woman–midwife relationship. Trust is a common key factor with the woman–midwife relationship in Western literature, but idea of ‘dependence’ at first appears to be the opposite of the dominant discourse emphasising the importance of valuing women’s autonomy. Rather, Fujii et al. (2007) found that Japanese women felt that the midwife accepted them as they were and described the relationship as being similar to being with their mothers. This reduced women’s anxiety and made them feel they could depend on the midwife. Doi (1971) discussed dependence (*amae*) as a defining concept to understand Japanese social relations, and he argued the mother–child relationship underlines the Japanese concept of mutual dependency. Fujii et al. interpreted such a women’s dependency as trust to the midwife. If the concept of relationship is

based on a mother–child like dependency, then perhaps the Japanese approach to the woman–midwife relationship may also be different from a partnership model.

Other studies have mentioned or been associated with the woman–midwife relationship in Japan, but they have not focused their discussions on the relationship. The studies' topics and aims are various; for example, breastfeeding care, communication skills, midwives' experience in a specific context, and women's birth experience and satisfaction. The studies sometimes mention 'continuity of care' and 'trust,' in relation to establishing a trusting relationship (Kouketsu & Hattori, 2015; Takashima et al., 2014; Uto & Kawabata, 2015). However, most of the studies do not investigate or discuss in-depth the meaning of a trusting relationship and how to implement continuity of care in order to achieve it. Notably, many of the studies described the woman–midwife relationship at midwifery homes as an ideal relationship (M. Noguchi, 2002; Takehara et al., 2009; Uto & Kawabata, 2015). Thus, positive woman–midwife relationship as seen in the Japanese context, may be represented in the means, process, and consequences of relationship at Japanese midwifery homes.

It is clear that there is a dearth of research regarding midwifery partnership and woman–midwife relationship in Japan. On the other hand, M. Shimizu (2015), who works for a Japanese midwifery home, discussed the essence of forming a strong woman–midwife relationship from the midwife's perspective in a Japanese Midwifery Journal (magazine). According to Shimizu, the key to midwifery care was to accept each individual woman's values and to guide the women to make better decisions. She used the concept of empowerment and emphasised the significance of listening attentively, asking questions to raise awareness, engaging in healing dialogue with a laugh, and accompanying the woman through the process. In contrast, Shinohara (2011) conducted a survey of 673 Japanese midwives working for hospitals (70%) and midwifery homes (30%) in order to investigate their work behaviour. While more than half of the midwives in the study actively provided birthing care, only a quarter reported that they provided antenatal care and information for decision-making. Shinohara found that there is a general failure on the part of Japanese midwives to spend sufficient time with the women in their care and to take measures to empower them. She also cited a lack of competence and responsibility to provide proper care. The literature shows that, while discussing care to enhance the woman–midwife relationship, many midwives do not have much time to develop a relationship with each individual woman in Japan.

Of course, Japanese midwives and women engage in relationships wherever they encounter one another. In Japan, discourses on the midwifery relationship are rarely heard, but it may be that the individuals involved are simply unconscious of this process. This study will lead to a realisation regarding such care and the relationship that women and midwives perform daily. Also, exploring

the relationship between women and midwives, as underpinning the positive outcomes of midwifery homes, holds the promise of significantly improving the Japanese maternity care model. Such exploration can be useful in understanding the peculiar woman–midwife relationship in Japan, where a community-based, traditional style of birth care has long been offered in midwifery homes. At the same time, examining the woman–midwife relationship in Japanese hospitals and obstetric clinics is necessary to fully understand the current state of Japanese midwifery care, since most Japanese women, today, give birth in hospitals and obstetric clinics. B. Hunter (2006) maintained that community-based midwives and hospital-based midwives have a different experience with the women in their care. Establishing the essential woman–midwife relationship within the taken-for-granted dynamics of the modern Japanese maternity setting should help empower Japanese women in childbirth and improve their birth experience.

Summary

This chapter explored the background of the woman–midwife relationship. The first section reviewed concepts of relationships in other fields of study and then examined the Japanese worldview relevant to human relationships. The literature review showed that relationships are an essential factor for humans living as social beings. Further, some Japanese philosophers and other scholars suggested human relationship is not a simple interaction between individuals but rather a holistic concept connecting people and nature together in harmony. The significance of relationship was found to be similar in midwifery. Many studies have found that the woman–midwife relationship is influential and important for both women's and midwives' experience in the international context. The literature showed that the woman–midwife relationship is a fundamental component of maternity care and affects the quality of maternity care. However, many studies still do not fully integrate the experiences of both parties and the relational space between them. The international discussion of concepts central to woman–midwife relationships, including midwifery partnership, woman-centred care, and some culturally specific practices of care, were also explored. The discussions provided insights into the culturally specific character of woman–midwife relationships in Japan. Lastly, the woman–midwife in Japan was examined, demonstrating a clear lack of research around the topic. The literature review confirmed the necessity of understanding the meaning of the woman–midwife relationship in the Japanese context. The findings in the present study will contribute to the international discussion of the woman–midwife relationship, since the relationship is likely formed by recognitions and perspectives that are rooted in specific, possibly unique, cultural values.

Chapter Four: Methodology

This study uses the hermeneutic phenomenological approach of van Manen (2014, 2016a), supported by insights from Heidegger (1927/2010) and Gadamer (1960/2013), to provide the best platform from which to explore the relationship between women and midwives in Japan. Hermeneutic phenomenology reveals the meaning of human experience in the everyday world. It has a long historical tradition, with a specific group of philosophers who inform this approach. This chapter begins by tracing the tradition of hermeneutic phenomenology and explains why the methodology is best suited to this study through outlining key concepts and notions of the approach. The chapter concludes by exploring the way hermeneutic phenomenology relates to the Japanese world view and how this combination provides new insights for this study.

Philosophers underpinning hermeneutic phenomenology

This study is guided by hermeneutic phenomenology as described by Max van Manen [1942–] (2014, 2016a). Phenomenology and hermeneutics are informed by a long philosophical tradition. Indeed, van Manen (2014) studied and cited many philosophers and phenomenologists who have influenced his view of hermeneutic phenomenology. Hence, it is essential to trace the roots of hermeneutic phenomenology in order to refine the understanding of the style of hermeneutic phenomenology used in this study. Thus, this section explores the philosophical views of three main philosophers—Husserl, Heidegger, and Gadamer—who influenced the approach of van Manen, to clarify the ontology and epistemology of this theoretical framework.

Husserl's phenomenology

Phenomenology was initially popularised by Edmund Husserl [1859–1938]. Husserl's (1913/2012) work describes how we often experience things or lifeworld as what is taken for granted or common sense, without reflection or rational thoughts. Towards such an experience, the phenomenological inquiry asks, 'What is this experience like?' (Laverty, 2003). Husserl claimed that the phenomenological explication is about getting *back to things themselves*. He attempted to grasp the reality of the phenomenon through consciousness. Phenomenology is generally recognised as being the opposite of Cartesian dualism, which separates body and mind or things from the individual (Laverty, 2003). In Husserl's view, both mind and object are involved in experience, and consciousness is a dialogical bridge between the person and the world. He proposed that the attention of the human's mind was directed to the world through one's intention.

Husserl, who started his career through the sciences of physics, astronomy, and mathematics, attempted to objectively see phenomenon through unbiased eyes (Laverty, 2003). Husserl anticipated that one needed to be free from one's prejudice in order to reach the essences of the phenomenon. Therefore, his phenomenology proposes a detachment from the subjective by *bracketing* which is seen to suspend empirical intuitions (Husserl, 1913/2012). Husserl's concept of bracketing is called *epoché*, which means suspension; and *reduction* is a proposed method of controlling one's intention and reflecting on phenomena. van Manen (2014) clarified epoché and reduction in Husserl's phenomenology as:

> First the epoché or transcendental reduction is the moment of withdrawal from the natural attitude and from the everyday world toward the level of the transcendental ego; second, the phenomenological reduction or the constitution of meaning is the moment of returning to the world as it shows itself in consciousness. (pp. 91–92)

In Husserl's phenomenology, one needs to be consciously aware of the reality but needs to eliminate one's bias in order to understand phenomena as they are. This does not mean that one needs to exclude others. Rather, one could recognise the lifeworld through others—intersubjectivity (Husserl, 1913/2012; Sakakibara, 2018).

Husserl believed that experience could be captured in its essence and tried to find a universal foundation, certain meaning, and absolute truth of the experience, known as pure phenomenology. Husserl expanded his understanding into what he termed transcendental phenomenology (Cohen, 1987; Scruton, 2002); also called constitutive phenomenology because of the appointment of the reduction (the constitution of meaning) (van Manen, 2014). Therefore, his phenomenology focuses on the structure and description of the experience and does not allow for interpretation or explanation of a phenomenon. When this process is successful, it is assumed that the essence of the phenomenon is truly revealed, making it easier to reflect on, revisit, and share with others the experience of the phenomenon. van Manen (2014) described Husserl's phenomenology as "a descriptive philosophy of the essences of pure experiences" (p. 89).

Heideggerian phenomenology

Martin Heidegger [1889–1976] (1927/2010), a student of Husserl, argued for the recognition of *being* as dwelling, proposing that our understanding of the world is entirely enmeshed with one's *being-in-the-world*. In contrast to Husserl, who argued phenomenology as epistemology, Heidegger proposed phenomenology as ontology (van Manen, 2014). Whereas Husserl described experience as a way of knowing the world as descriptive (or transcendental) phenomenology, Heidegger sought the meaning of phenomenon itself and introduced the ontological concept of being-in-the-world—interpretive (or ontological) phenomenology (Reiners, 2012; van Manen, 2014). Both these German philosophers shared a common interest to uncover the lifeworld as it

is lived, but they developed different methodological foundations. The present hermeneutic phenomenological study interprets the experiences to reveal the lifeworld of a phenomenon based on the assumption that the interpretation is influenced by how the participants and the researcher experience the world. In this matter, this study is more aligned with Heidegger's than Husserl's phenomenology.

In *Being and Time*, Heidegger (1927/2010) focused on *Dasein* which is defined as "the being of human being" (p. 24). Dasein is also translated as everyday human existence; but, Heidegger is not an existential phenomenologist (Dreyfus, 2001). Heidegger maintained "understanding is always attuned" (p. 138), meaning we cannot interpret existence or any way of being-in-the-world in an essentialising or fundamental way. To be attuned is to change with the world. For Heidegger, human beings are always already in attunement, and being (ontology) and our understanding of being (epistemology) depend on the moods (not an individualised emotional or psychological construct) which emerge from a shared communication (Crowther, Smythe, & Spence, 2014b). At the same time, Dasein is not something objectively present, but a potentiality of being in understanding (Heidegger, 1927/2010). This potentiality is conceived by Heidegger as emerging from human beings' *thrownness* into a phenomenon, containing all the frustrations, demands, and social conventions that one must work within, through, or against to re-create a world (Heidegger, 1927/2010). In this way, Dasein is experienced as an attunement and thrownness in the world.

Furthermore, Heidegger (1927/2010) outlined two concerns of Dasein's characteristics. First, "the 'essence' of Dasein lies in its existence" (Heidegger, 1927/2010, p. 41). This suggests the term Dasein is an action rather than a noun, seeking to explain the existence of being in its various forms, but not what a being or thing *is*. That is, the whatness of being needs to be understood as its being. Second, "Dasein is always my own" (Heidegger, 1927/2010, p. 42). It is always determined by being-mine and its possibility of the being. Additionally, in Heideggerian phenomenology, understanding is seeing the possibilities of being in another's experience rather than just re-experiencing another's experience or societal demands.

According to Heidegger (1927/2010), every questioning is a knowing search for being and is led by what is sought. Therefore, the meaning of being is already there prior to questioning, which raises his concern with time. Heidegger stated the meaning of being of Dasein would be found in temporality. For Heidegger, beings *are* time—the past, present, and future emerging at once. To understand experience is, therefore, to attempt to comprehend time as a unity of these three dimensions, interpreting time itself as this unity of experience. Thus, Dasein describes how and what a phenomenon already was; therefore, containing its historicity. As previously mentioned, Dasein also contains potentiality which is a future coming-into-being that is not contained by the past. This excess of being unfolds in the present. Temporality is defined by the unity of these

three dimensions and without this temporality there is no being, existence, or phenomenon (Heidegger, 1927/2010). Dasein itself is, therefore, ontological in that humans are being-in-the-world. Dasein's ontology is the active unfolding of temporality, and not a stable or defined essence.

Dreyfus (2001) attempted to illuminate the Dasein's pre-ontological understanding of being with an example of contrasting child-rearing practices in the United States and Japan. A Japanese mother takes care of her baby physically (e.g., lulling, carrying, and rocking) rather than verbally; whereas an American mother stimulates her baby by looking and chatting to her baby. It seems the American mother wants the baby's active and vocal responses while the Japanese mother wants to have a quiet, content baby. In either case, babies are socialised from the early stages of their life. The cultural accuracy of this example, however, is not important. Rather, with this example, Dreyfus demonstrated that the understanding of being is the result of embodying social practices that already contain an interpretation. Such an element of Dasein is key to this study, as explained by Heidegger (1927/2010):

> In its manner of existing at any given time, and thus also with the understanding of being that belongs to it, Dasein grows into a customary interpretation of itself and grows up on that interpretation. It understands itself initially in terms of this interpretation and, within a certain range, constantly does so. (p. 19)

At the same time, an important premise of hermeneutic phenomenology is that our pre-understanding influences our interpretations. Heidegger (1927/2010) insisted that we always have a pre-understanding of the world through which we see or interpret a phenomenon: what Heidegger termed *fore-having*, *fore-sight*, and *fore-conception*. According to Heidegger, to understand something is always done based on fore-having, a totality of that which has already been understood. What is held in view, by way of fore-having, is fore-sight. The interpretation grounded in fore-having and fore-sight draws from the conceptuality which belongs to the interpreted beings (Heidegger, 1927/2010). Hence, interpretation is always already decided on a definite conceptuality, grounded in fore-conception. Interpretation can, at times, appear as self-evident—think of when you hear the 'perfect quotation' when giving an interview as if one already knows what one is looking for. This pre-understanding is inevitable within Dasein. What is important is to recognise the pre-understanding rather than eliminate it, as Husserl suggested. Our interpretation cannot be more than interpretation already in fore-having, fore-sight, and fore-conception (Heidegger, 1927/2010). Therefore, phenomenology is hermeneutic in Heidegger's concept of being-in-the-world. After all, our understanding of being never reaches completeness since we already dwell in the world.

Gadamer's phenomenology

Hans-Georg Gadamer [1900–2002] (1960/2013), influenced by the work of both Husserl and Heidegger, followed Heidegger's view of interpretive phenomenology. He applied hermeneutics to human experience and life whilst criticising the hermeneutics developed by Friedrich Schleiermacher and Wilhelm Dilthey as romantic hermeneutics, described as a procedure to reconstruct the past. Gadamer stated "the understanding of something written is not a repetition of something past but the sharing of a present meaning" (p. 334). Gadamer argued that it is difficult to place oneself in the reconstructed historical context. Rather, one places the interpretation of the original text in the context of one's own being. Like Heidegger, Gadamer claimed the importance of awareness of one's own bias. The reader cannot separate oneself from the meaning of a text because the person belongs to the text when reading and interpreting it. Thus, he saw bracketing and a definitive interpretation as impossible; supporting one's prejudice as a fundamental condition of understanding (Gadamer, 1960/2013; Laverty, 2003).

Gadamer developed Heidegger's ideas by claiming that understanding and interpretation depend on a person's standpoint. He called this *fusion of horizons* (Gadamer, 1960/2013). Horizon is a field of vision formed by one's held knowledge and worldview. A standpoint is also formed historically and culturally, and one's understanding is always one's interpretation and always unique. Gadamer agreed with Heidegger's view that language has a significant role in understanding human beings in the world. Gadamer (1960/2013) maintained, "language is the universal medium in which understanding occurs" (p. 331) and claimed that conversation is a means to approach an understanding.

Gadamer's view that distinguishes some kinds of conversations from 'true' conversation is interesting in the context of the current study and exploring the relationship between two people; woman and midwife. According to Gadamer (1960/2013), within true conversation, each person truly opens herself, accepts the point of view, and transposes herself into the other's context based on what she understands about what the other says. However, Gadamer insisted that two people rarely try to come to an understanding in a real sense when one perceives the other as an individual autonomous subject conceived as separate or distinct from oneself, as in psychological therapeutic conversation. His view of the true conversation seems to be consistent with Giles, Smythe, and Spence's (2012) description of the relationship as a phenomenon that two people merged into rather than something existing between individuals. Respecting individuals and its individuality is an important attitude in the fields of healthcare and midwifery. However, Gadamer's view implies that such an attitude might make true conversation difficult for the involved people, or true conversation requires more than respecting each other. The current study explores how women and midwives experience and understand their shared conversation while respecting individuals or in a relationship that possibly unites two people.

Following Heidegger (1927/2010), who argued that questioning is seeking the being (meaning) of being, Gadamer also carefully explored the significance of questioning. He stated, "the essence of the question is to open up possibilities and keep them open" (Gadamer, 1960/2013, p. 259). Questioning, including answering, is a form of conversation which leads to one's understanding. Gadamer (1960/2013) claimed that understanding is not just recreation of someone's meaning but what is meaningful could be opened up and passed into one's thinking by questioning. Conversation and questioning occur within one person as well as between people. This inquiry opens up the possibilities of understanding of others and situations, as well as within oneself. Therefore, the quality of questions matters in order to understand meaning as the answer of the question (Gadamer, 1960/2013). Openness, as well as sensitivity to the historical and cultural context, is required to interpret and understand the text in Gadamer's hermeneutic phenomenology. At the same time, Gadamer was also aware that our understanding would never be complete. There is no definitive interpretation, but it is possible that the more exposed one is to the phenomenon, the closer one can be to the experience.

van Manen and phenomenology of practice

van Manen (2014, 2016a) developed the phenomenology of Husserl, Heidegger, and other philosophers as a base for what he termed human science, with a particular focus on education and pedagogy. Health science research, particularly nursing then adapted van Manen's approach in seeking to understand professionals' and patients' experiences (Errasti-Ibarrondo, Jordan, Diez-Del-Corral, & Arantzamendi, 2019). van Manen (2016a) insisted, in pedagogy, both a phenomenological sensitivity and a hermeneutic ability are required in order to make interpretive sense of the phenomena of children or students' realities and lifeworlds. For this, van Manen endeavoured to generate a way of knowing in the human science that serves practical aims. van Manen explained phenomenology as "how one orients to lived experience" and hermeneutics as "how one interprets the 'text' of life" (p. 4); and claimed that his methodology required both roles of phenomenology and hermeneutics to develop a pedagogy for human science. Hence, when van Manen uses the terms human science or phenomenology, he is referring to hermeneutic phenomenology. Such sensitivity to the phenomenon and an ability to interpret the phenomena are also required in this study in order to understand lifeworlds of women and midwives.

van Manen (2014) developed his methodology, *phenomenology of practice*, based on practical examples while following the tradition and foundation of the philosophy of hermeneutic phenomenology. It intends to be sensitive to the personal and social practices of daily living by distinguishing itself from "the more purely philosophical phenomenologies that deal with theoretical and technical philosophical issues" (van Manen, 2014, p. 213). Furthermore, van Manen developed and articulated meaning-giving methods of hermeneutic phenomenology by

stressing ‘phenomenological’ inquiry, reflection, data, analysis, meaning, and insights. I explore the details of hermeneutic phenomenology described by van Manen as the methodological foundation of this study in the following section.

Philosophical and methodological foundations of the study

Hermeneutic phenomenology as the research methodology

Hermeneutic phenomenology aims to reveal the meaning of human experience in the everyday world (van Manen, 2016a). The hermeneutic approach seeks to uncover how a person sees the world and how she experiences it by interpreting the experience. Hermeneutic phenomenology deals with lifeworld in which the person lived, and the reality in the lifeworld is described as lived experience (van Manen, 2016a). A stance of hermeneutic phenomenology is that the essence of the lived experience is concealed within our experiences and it can be revealed or closely reached by means of consciousness and language.

In midwifery care settings where women and midwives encounter one another, the woman–midwife relationship is the lived experience of both parties’ day-to-day reality (Guilliland & Pairman, 2010a). Although the lived experience is an integral component of women’s maternity and birth experience and is a fundamental characteristic of midwifery, it is often taken for granted within the care settings. Currently, there is little understanding within Japan of the experience and meaning of this relationship. Hermeneutic phenomenology reveals the meaning of the lived experience through the consciousness and language, and this may have the potential to improve women’s birth experience in Japan.

van Manen (2016a) claimed that *thoughtfulness*; that is, minding, heeding, caring, and concern, is the most appropriate word to characterise (hermeneutic) phenomenology (Heidegger, 1927/2010). van Manen emphasised the significance of attitudes in his field of study:

> For us this phenomenological interest of doing research materializes itself in our everyday practical concerns as parents, teachers, teacher educators, psychologists, childcare specialists or school administrators. As educators we must act responsibly and responsively in all our relations with children, with youth, or with those to whom we stand in a pedagogical relationship. So for us the theoretical practice of phenomenological research stands in the service of the mundane practice of pedagogy: it is a ministering of thoughtfulness. (p. 12)

Certainly, midwifery has a common interest in its own setting—thoughtfulness, caring, and concern for women. Through the practice of hermeneutic phenomenological research, one requires attentive thoughtfulness to the everyday practice and pedagogy of midwifery; we care for women *and* the phenomenon as a subject of study in a totality of being-a-midwife in the world.

At the same time, conducting hermeneutic phenomenology may further enlighten the practice of midwifery as thoughtful professional or human activity.

In order to know the world as human beings live in it, humans' lived experience is the important mediation in hermeneutic phenomenology (van Manen, 2014, 2016a, 2017b). van Manen (2016a) stressed, "lived experience is the starting point and end point of phenomenological research" (p. 36) because lived experience belongs to the human being and she can go back to the phenomenon by being aware of it. Therefore, lived experience is a central methodological requirement of hermeneutic phenomenology, and doing phenomenological study is researching lived experience. A subject of phenomenological inquiry can be any experience; but concepts, words, or texts can never be the primary focus (van Manen, 2017b).

Hermeneutic phenomenological research seeks 'what gives itself' in lived experience but, more specifically, what gives itself *as* lived experience (van Manen, 2017b). However, in hermeneutic phenomenology, lived experience itself is just the name of our everyday life experience (van Manen, 2017b). We do not think or phenomenologically reflect on our experiences while living them. When we reflect on the lived experience through phenomenological inquiry, we can go back to the phenomenon and seek the meaning of the phenomenon for the first time. Thus, hermeneutic phenomenology is described as the reflective study of pre-reflective experience (van Manen, 2014).

In order to attain genuine phenomenological reflection and insights, it is essential to have phenomenological inquiry (van Manen, 2014). The basic question of phenomenology is 'What is this experience like?' or 'What is it like to…?' In hermeneutic phenomenological research, the meaning of a certain moment of lived experience is brought into focus while we wonder about it with such a question (van Manen, 2017b). The moment is already in the past and we usually cannot access the lived meaning while living the experience. van Manen (2017b) insisted that we would not need phenomenology if we could have perfect sense of clarifying the meanings of our everyday existence. If so, there would not be concealing or hiding meaning in our experiences. The meaning of phenomenon is essentially withdrawn and hidden, forgotten, covered up, and even disguised (Crowther et al., 2014a). It lies hidden in the background familiarity of experiences. Heidegger (1920/2013) described such a feature of lived meaning as *fading*. According to van Manen, Heidegger suggested we should ask *what* had faded and *how* phenomena gave themselves to study a certain lived experience.

As discussed, only lived experience can be the data of hermeneutic phenomenological research to answer phenomenological inquiries (van Manen, 2017b). Since recounting the lived experience is a subjective and modified recollection of experience, we may have opinions and critiques

regarding the experience, but this cannot be the data. The lived experience needs to be directly described as lived by the person without explanation of the causal relation or generalisation of the experience. Moreover, van Manen (2017b) argued that the term *data* is unsuited to phenomenological inquiry; hence, some phenomenologists use terms such as 'meaning units.' Yet, van Manen agreed with the use of the term data because etymologically data means 'givenness' or 'what is *given*.' What van Manen intends for us is to refine our idea of data. Hermeneutic phenomenological research, as methodology, deals with data as 'phenomenological examples' but not numerical, coded, or objectifying data (van Manen, 2017b).

Furthermore, phenomenological research uses personal experience as a starting point based on the agreement that one's lived experience could possibly be the experience of others when it is described. van Manen (2016a) stated:

> The point of phenomenological research is to 'borrow' other people's experiences and their reflections on their experiences in order to better be able to come to an understanding of the deeper meaning or significance of an aspect of human experience, in the context of the whole of human experience…We gather other people's experiences because they allow us to become more experienced ourselves. (p. 62)

Hence, researchers try to be reflectively aware of the experience to the extent that they could understand people's experience as if they experienced it. In this respect, hermeneutic phenomenological descriptions are intersubjective, and a possible human experience is the phenomenon that phenomenology always addresses (van Manen, 2016a). Further, phenomenology collects the lived experience with language in order to investigate the meaning of the experience but not necessarily the meaning of the words. The lived experiences underlying the words need to be examined as with, for example, the term partnership in this study.

Meaning in hermeneutic phenomenology

My first question before starting this study was 'What is the relationship between women and midwives?' I probably hoped to find some fixed, essentialised, and finalised definition of the relationship, but I soon realised this impossibility as the experience of relationships is different each and every time. Hermeneutic phenomenology is therefore a useful approach for this study as it attempts to understand the meaning of a phenomenon each unique time rather than produce a generalisable meaning of a phenomenon. According to van Manen (2016a), essence is not a single fixed feature, rather the essence of something is constituted by a complicated arrangement of aspects, properties, and qualities (van Manen, 2016a).

In hermeneutic phenomenology, the essence arises through lived experience, and the lived experience is the reality of the phenomenon for us (or the participants) even if it might not directly

tell us the exact meaning. The realities and interpretations will help guide us to what the phenomenon is in the real sense. So although each phenomenon is part of a collective and shared experience, this also means there is no definitive or conclusive nature of the phenomenon because lived experience and the interpretation vary among human beings. van Manen (2016a) stated:

> The term essence derives from the verb to be—by definition a profoundly existential notion. It asks what something 'is' for the one who asks the question. Essence asks for what something is, and without which it would no longer be what it is. And it asks this question while being aware of context, (inter)subjectivity, language, and so forth. It is for this reason that human science is such a fascinating project: every interpretation can be called into question, every inquiry we can being anew; every hermeneutic phenomenological conversation is unending. (p. xv)

We may be caught up in stereotypes or tend to generalise about any given subject as if the answer is the absolute nature of the being; for instance, what women are, what midwives are, what doctors are, what childbirth is, and what the relationship is. However, at each time when we know the thing/phenomenon through lived experience, there is a renewed opportunity to obtain different or deeper views with respect to the being of the thing because the lived experience is always unique.

Through the study of hermeneutic phenomenology, I came to acknowledge the diversity and complexity of a phenomenon. Therefore, this hermeneutic phenomenological journey is to seek and understand the lived meaning of the phenomenon rather than defining the nature of the phenomenon, although there may be some aspects that are crucial to the being of the woman–midwife relationship. Though the terms essence and nature are still used in hermeneutic phenomenology, the meaning is different from common sense use of the words. In order to clarify the idea, I use the term meaning and this study explores the 'meaning' of the woman–midwife relationship.

Heidegger (1927/2010) described the meaning of meaning through the concept of Dasein.

> Meaning is that wherein the intelligibility of something maintains itself. …Meaning is an existential of Dasein, not a property that is attached to beings, which lies 'behind' them or floats somewhere as a 'realm between.' Only Dasein 'has' meaning in that the disclosedness of being-in-the-world can be 'fulfilled' through the beings discoverable in it. (pp. 146–147)

van Manen (2016a) explained lived meaning as "the way that a person experiences and understands his or her world as real and meaningful" (p. 183). The meaning still needs to be revealed as experienced by the person in the situation in hermeneutic phenomenology. van Manen (2017b) also claimed that the aim of hermeneutic phenomenological research is *meaning insights*. Insight literally and definitionally relates to "inseeing, ingrasping and inception" and "gets at the very phenomenology of its meaning" (van Manen, 2017b, p. 822). van Manen (2017b)

emphasised that phenomenologically, insight is to achieve the originary meaning of phenomenon; wherein originary means inceptual (beginning) rather than original. It is not conceptual either, because a concept generalises and leaves out many aspects of being. An incept, however, paints a picture of the richness and uniqueness of particulars because inceptual insights reveal the primal significance of a phenomenon (van Manen, 2017b). Moreover, meaning insights are more likely to occur when we wonder about the inceptual meaning of an experiential phenomenon. We encounter, discover, or find meaning insights but they are not methodically or technically collected (van Manen, 2017b). Insights may even be given in the moment of letting go after we stop or give up thinking.

Lifeworld existentials

van Manen (2014, 2016a) maintained that existential methods help our reflective inquiry process to explore phenomena in a hermeneutic way. van Manen (2014) discussed five *lifeworld existentials* which are especially helpful as guides for the research process; lived relation (relationality), lived body (corporeality), lived time (temporality), lived space (spatiality), and lived things (materiality) or technology. van Manen (2014, 2016a) claimed these existential themes universally exist in human's everyday lives regardless of their history, culture, or social situation. In hermeneutic phenomenology, they are considered to belong to the fundamental structure of human's lifeworld (van Manen, 2016a). Furthermore, some phenomenological researchers specialise in one of the themes; for instance, focusing on corporeality as the primary motif to understand human phenomena in their research (van Manen, 2014).

Lived experience is often difficult to express with numbers and language, like the atmosphere of a particular space, the extent of the pain, or the depth of grief a person feels. Therefore, lifeworld existentials help researchers reflect lived experience, which are difficult to put into words, through complex aspects of human's lifeworld. In fact, the study participants' experience of lived relation, body, time, space, and things appear in their stories, and they are significant mediators to understand the women and midwives' lived experience in this study. Using examples from the interviews I now detail how each lifeworld existential—relationality, corporeality, temporality, spatiality and materiality—can aid in our understandings of the woman–midwife relationship.

Relationality

van Manen (2014) suggested that the existential theme of relationality will guide us to reflect "how self and others are experienced with respect to the phenomenon that is being studied" (p. 303). Since researchers ask how self and others are experienced in a situation, relationality can also be described as lived others or lived self-other (van Manen, 2014). van Manen (2016a) suggested lived others is the relationality which humans maintain with others in the shared interpersonal space. Humans seek relationship with others in order to live communal and social

lives, which could be considered the purpose of living (van Manen, 2016a). Therefore, being with others is a significant human experience in our day-to-day life and is an aspect of being-in-the-world. van Manen (2014) claimed that we even experience a 'nonrelational relation' with invisible others. Also, human beings experience many relations in parallel, and they become interwoven (Dickinson et al., 2006). I would see a woman and a midwife living their relationship by involving other relations such as the woman's family, other midwives, and healthcare professionals. van Manen (2014) argued we can reflect on phenomena by examining how relations are experienced in the phenomenon. Paying attention to concurrent, wider relationships around the participants brings further insights to the broader woman–midwife relational context.

Corporeality

In regards to the lived body, van Manen (2014) suggested to reflect on "how the body is experienced with respect to the phenomenon" (p. 304). In the lived experience, humans experience the world through the body by touching, bodily reacting, and feeling something as physical matter. van Manen claimed our own body is probably the first contact to the world and referred to the philosophy of Maurice Merleau-Ponty [1908–1961]. In Merleau-Ponty's philosophy of the body, he emphasised embodiment as the primal motif to know human phenomena. In his philosophy, the body itself is the very thing of himself (Merleau-Ponty, 1945/2014). Regardless of awareness, humans are corporally engaged in the world. I have recognised as my pre-understanding that embodiment may be one of the vital themes to understand participants' experiences because Japanese people tend to value the non-verbal (Okoshi, 2005). For example, one participant described her reaction to meeting a new midwife as, 'I recoiled,' instead of naming her feelings; thus, highlighting how the woman lived the phenomenon through her body. Embodiment is an important concept in the Japanese context, and I will explore this theme later in the chapter.

Temporality

According to van Manen (2014), time is an essential existential element to understand phenomena as lived. Human beings may feel and express time as passing slowly or quickly, even when time passes through the same pace. There is a vast range of experiences between cosmic/clock time and lived/phenomenological time (van Manen, 2014, 2016a). For Heidegger (1927/2010), temporality was the fundamental motif to understand human phenomena. In *Being and Time*, Heidegger described being as time. Our lifeworld is formed by time—the past, present, and future; thus, "there would not be being" without time (Heidegger, 1927/2010; van Manen, 2014, p. 306). Similarly, how a woman and her midwife experience their shared time is critical for exploring their relationship. For example, one participant woman described her experience of temporality in the present study. She was on a birthing table, legs opened, and states she was told by a midwife, 'Wait a second.' In reality, it might have been a few minutes, but she describes the event as if the

time was much longer. How long and how often a woman and her midwife spent time together, and how much they commit to each other in their shared time, also affected their experiences. Understanding how time is experienced by women and midwives would add insights to the meaning of the woman–midwife relationship.

Spatiality

Spatiality—specifically how space is experienced—also helps guide our reflection in regard to the phenomenon (van Manen, 2014). Space can be both visible (e.g., house) and invisible (e.g., atmosphere). Humans may shape space, and space may shape humans. In this study, one midwife described her experience of visiting a pregnant woman's house for antenatal care which was different from that with other women in a birth facility. Moreover, how space is experienced differs among individuals, even if they are in the same room (van Manen, 2014). For example, one woman described the atmosphere of the hospital as 'chilly;' although she guessed it might have been different for other patients in the hospital. What she is hinting at, is how perception of space differs among people depending on their relationship with others. Even for the individual, she may experience a space differently at different times of the day, in varied weather, or changing physical conditions. van Manen (2014) argued lived time and lived space are mingled because we experience time as space and space is an aspect of time. In fact, the study participants talked about how wonderful the time and space were when describing their experiences at midwifery homes where they gave birth and stayed thereafter. The relationships with their midwives are clearly reflected in their expressions of time and space.

Materiality and lived technology

As well as lived things (materiality), human beings have increasingly taken advantage of materials and new technology (van Manen, 2014). It is taken for granted that technologies have an almost inevitable influence on women's birth experience in maternity care settings. Douché (2009) argued that those technologies even define women's birth experience in the modern world; suggesting that materiality and lived technology will be seen in the lived experience of the woman–midwife relationship. The relationship between women and midwives itself seems a pure human relationship experience, but women and midwives possibly experience the relationship with or through technologies. In the stories of the participant women, computers and labour and foetal heart monitors appear, and those technologies seem to affect their experiences of midwives and thus the woman–midwife relationship. van Manen (2014) argued fans of technology often think technology is all good. In maternity care settings, technology can be convenient and make care safer, easier, and more efficient, but it is often unclear as to how it works within human relationships. Women's and midwives' lifeworld can be multiple, as the qualities and realities appear differently depending on how it is experienced (van Manen, 2016a). To be sensitive to

those existential elements would achieve deeper insights of the lived experience of the woman–midwife relationship.

Pre-understanding and openness

The epoché-reduction

van Manen (2014) discussed the epoché and the reduction differently to Husserl, who emphasised epoché (bracketing) and reduction (the construction of meaning or the moment of returning to the world as it shows itself by bracketing). Husserl's stance seems different from Heidegger (1927/2010) who maintained the significance of fore-having, fore-sight, and fore-conception; and Gadamer (1960/2013) who argued for a fusion of horizons, wherein it appears our interpretation is grounded in our pre-knowledge and standing points. In Husserl's phenomenology, epistemologically the reduction is supposed to construct transparent knowledge of a phenomenon but, for Heidegger, ontologically the reduction is always imperfect, and the meaning of phenomenon is brought incompletely. Yet, van Manen pointed out that Heidegger described reduction in a way that closely aligns with Husserl's original idea. The difference is that Heidegger aimed to understand the mode of being by being-in-the-world, while Husserl attempted to understand the invariant meaning of something by stepping out to grasp the meaning from above.

It sounds as if the epoché and hermeneutic ways of phenomenology are a contradiction and, in fact, Husserl's phenomenology is not interpretive or hermeneutic. However, van Manen (2014) discussed the differences of interpretation of the epoché and the reduction among phenomenologists and suggested:

> in any confusion surrounding the reduction, it is helpful to keep in mind the underlying idea and purpose of the reduction: to gain access, via the epoché and the vocative, to the world of prereflective experience-as-lived in order to mine its meanings. (p. 221)

Husserl's view saw the reduction as an end in itself but the reduction is just a method of reflecting the phenomenon (van Manen, 2016a). van Manen (2014) stressed that phenomenological reduction is not reducing meaning; rather, is a means of returning to the world. Moreover, he described hermeneutic epoché-reduction as an invitation to openness. According to van Manen, the fundamental meaning of epoché is that one places oneself in the open to access the world as experienced, and hermeneutic reduction aims to seek the true openness in conversation with the phenomenon. For this, one needs to be aware of one's own inclination and pre-understandings which led to the motivation and the nature of the question, and overcoming one's preference and expectations. However, leaving one's pre-understanding is not possible. van Manen, therefore, suggested, "phenomenological inquiry continually is open to questioning assumptions and

preunderstanding—this opening up and making explicit assumptions is part of the phenomenological reflection itself" (p. 224).

For instance, each midwife has an image, idea, or belief about midwifery. These beliefs may be different among midwives, cultures, and countries. When a Japanese midwife hears the different ways of providing care or working as a midwife in another country, she might first try to understand the way or meaning within her limited knowledge. At that time, the epoché allows her to suspend her taken-for-granted ideas or common sense and think why the midwife in another country works in that way or even what midwifery is in the first place. Hence, the epoché gives her openness and it may lead to phenomenological reduction. In order to suspend own thoughts or prejudice, she needs to be aware of her taken-for-granted assumptions. At the same time, there must be recognition that it is impossible to eliminate all the influence of one's pre-understandings because "human being is essentially simply self-interpreting" (Dreyfus, 2001, p. 23). Thoughts are uncontrollable at times, but it is possible to question one's own thoughts. In hermeneutic phenomenological study, while trying to suspend or question our own beliefs by thinking, wondering, writing, and interpreting the lived experience, one might be able to encounter the meaning insights of the phenomenon as it is lived. According to van Manen (2014, 2017b), this may also occur in a heuristic way in the interval or at the break of thinking.

Hermeneutic circle

The journey of interpretation to encounter the meaning of a phenomenon is a circular process. van Manen (2016a) explicated the structural approach for hermeneutic phenomenological research, and the last sixth step is "balancing the research context by considering parts and whole" (p. 30). The dynamic movement occurring between the whole and parts in the text is referred to as hermeneutic circle. Understanding a part of the text modifies the whole and vice versa, and the reciprocal process achieves the discovery of the meaning of the phenomenon (Stenner, Mitchell, & Palmer, 2017). In hermeneutic circle, pre-understanding and fusion of horizons are inevitably involved as a hermeneutic manner. Once entering the circulation of understanding the text, researchers repeatedly think and write with their own understandings and interpretations between the whole and the parts. Furthermore, Dowling (2007) argued that lifeworld existentials, described by van Manen, illustrate "a fusion of the objectivist hermeneutic circle (part–whole) and the alethic hermeneutic circle (pre-understanding) as they acknowledge the experience of a phenomenon in a whole experience and also the researcher's role in the research process" (p. 138).

The circle is spiral in nature and expanded with the manner of openness. Thus, it does not have an end point. Yet, researchers would achieve *phenomenological nod* which is a phenomenological description that we can nod as an experience that we (could) have had (van Manen, 2016a). In other words, it is termed as *validating circle of inquiry* and van Manen (2016a) emphasised "a

good phenomenological description is collected by lived experience and recollects lived experience—is validated by lived experience and it validates lived experience" (p. 27). Including all these attitudes and sensibilities, for van Manen (2017b), hermeneutic phenomenology is still *nonmethodical method*, meaning it does not have a plenary theory, demonstrative skills, or a systematic way to access data in phenomenology such as coding, categorising, and conceptualising. Rather, hermeneutic phenomenology itself is already a method to know the lifeworld because it is rooted in a philosophy that values reflection and insights through lived experience. van Manen's guide to conducting hermeneutic phenomenological research is detailed in the methods chapter.

To summarise, researchers can interpret and understand another's experience because they have prior interests and pre-understanding that influences one's understanding of the phenomenon. van Manen (1997) stated that we investigate a phenomenon not because we know little about it. We already know too much. However, the pre-understanding limits what can be known about a phenomenon when we are not aware of it. Therefore, researchers need to clarify their own pre-understandings that influence interpretations beforehand rather than ignoring it. Unless we recognise it, we cannot be open to understandings that differ from our own. As a Japanese midwife and mother who gave birth with midwives, I have my own experiences, pre-knowledge, and pre-understanding in regard to the relationship between a woman and her midwife. Due to my unique experience of being a midwife in Japan, a mother receiving midwifery care in foreign countries, and a student learning from New Zealand midwives, my own pre-understanding of woman–midwife relationship is different from other Japanese midwives and midwives in other countries. My previous knowledge and experience may be unconsciously employed to seek the phenomenological inquiry. Yet, openness is key to achieve the meaning of the phenomenon. Researchers need to be keep questioning their own pre-understandings, prejudice, and standing points to open to the world.

Japanese philosophy and worldview

My pre-understanding and unique position require me to address a few issues before conducting a hermeneutic phenomenological study involving Japanese women and midwives. While there is a field of study called *Japanese philosophy*, it has been said that there is no philosophy in Japan and there is some discussion about why Japanese do not have or need philosophy (Inoue, 2008; Kanno, 2003). Heidegger claimed that the idea of philosophy is Western (Kida, 2000), and van Manen (2016a) stated that phenomenological human science is a Western research method to distinguish it from eastern meditative techniques. However, Heidegger was influenced by Eastern and Japanese thoughts (Asano, 2009; Kawahara, 1992) and several modern Japanese philosophers learned phenomenology directly from Heidegger. Hence, philosophy is not a concept that Japanese can never understand or use; rather, Japanese are said to be generally unfamiliar with

philosophy. While there are some Japanese studies applying phenomenology following European philosophers, the philosophical approach to this study needs to be supplemented with a discussion of Japanese ways of thinking and being in order to understand the experience of Japanese women and midwives.

Japanese philosophy and worldviews are different from Western ones. Japanese philosophy is, historically, a fusion of both indigenous Shinto and continental religions such as Buddhism and Confucianism, with modern Japanese philosophy influenced by Western philosophy. Kitaro Nishida [1870–1945] (1911/1979) fused Zen and Western thought. Nishida insisted on pure experience in which there is no opposition between subjectivity and objectivity. His ontology derived from an understanding of absolute nothingness. Tetsuro Watsuji [1889–1960] (1934/2007), a Japanese philosopher who learned from Heidegger, criticised Western individualism. His ethics say human beings are not living by oneself but are always in relation to others. In Japanese society often characterised by its collectivism, keeping harmony with others and being the same as others are of great value. Therefore, insisting on one's own ideas, existence, and ego is not preferable; an attitude that discourages Japanese from expressing their ideas. Furthermore, guessing others' thinking and feeling without asking is valued. In Japan, it is often assumed that everyone has the same or similar ideas and values (Nakane, 1967). This means that everything they do is taken for granted as a common understanding, which may be why Japanese midwives do not talk about philosophy of their practice including relationship. Japanese also value highly non-verbal communication, and are commonly uncomfortable to express using words (Okoshi, 2005). These differences have been reflected for me in personal situations.

My husband is from a Western country, Canada, where he practiced a Japanese martial art called Aikido five days a week. He also had many books about the history and philosophy of Aikido. After a few years, he moved to Japan and was excited about practicing Aikido at the home of Aikido. In Canada, according to my husband, when teachers introduce a new skill, they give a lot of information including the philosophy and way of performing the skill. My husband enjoyed these discussions with teachers and other students. In Japan, however, teachers demonstrate a skill at the beginning of class, and students start practicing the skill without any discussion. They endlessly keep practicing one skill. No one talks about the details of the skill and there is no talk of philosophy. The approaches are obviously different between Canada and Japan, although they play the same martial art. In Japan, it is learned through the body rather than the language.

Another example of Japanese philosophy and practice is demonstrated in the American documentary film titled *Jiro dreams of sushi* (Iwashita, Pellegrini, & Gelb, 2011). The movie follows Jiro, an 85-years-old sushi master chef and provides a typical example of a Japanese way of knowing or learning. In this film, an apprentice is allowed to make *tamagoyaki*, an egg/omelette

put on sushi rice, after working under Jiro more than a decade. He has practiced making *tamagoyaki* before and tries hundreds of times for another several months until Jiro says his tamagoyaki is okay. Jiro does not teach him exactly how to make it and how it should be. When Jiro finally says yes or good to the taste of *tamagoyaki*, the apprentice is called a sushi chef for the first time. This is probably not a surprising thing for Japanese but came across as unusual for many Western viewers.

In a culture emphasising the importance of non-verbal communication, Japanese believe it is disgraceful to express feelings and to tell the way or philosophy with words. Moreover, it seems Japanese, like Jiro, believe that human beings can never reach the place, stage, or thing in a real sense with words. They believe that people understand or completely acquire the practice or skill only when they experience it or achieve it by their own effort. Japanese traditionally learn work, art, and sports by watching and feeling rather than being taught or instructed. They usually learn only basic technical skills and knowledge at school and have on-the-job training after employment (OECD, 2016). The same is true for midwifery education. The skills, knowledge, and wisdom of traditional midwives have been handed down and learned on the job rather than discussed or documented.

van Manen (2016a) was also aware of cultural difference and stated:

> One important difference is that western human science aims at acquiring understandings about concrete lived experiences by means of language, whereas eastern methods may practise other non-script-oriented reflective techniques. (p. 23)

These may be reasons why Japanese midwives do not ostensibly or literally have philosophies or concepts of midwifery as Western midwives do. Japanese midwifery seldom discusses the philosophies that underpin their practice. Therefore, the significance of midwifery may have not been well explored and documented in Japan, although it has long history. As previously mentioned, this does not mean Japanese midwives undervalue the significance of midwifery or the woman–midwife relationship. They have philosophical foundations in their practice among traditional and experienced midwives. Rather, they have not had a chance to express, or they are not familiar with expressing the philosophy underpinning their knowledge, skills, wisdoms, and passion in their own words. Or, they might have expressed it in different ways, or experienced it in different ways. Hence, focusing on their experiences is a good path to understand the phenomenon.

The examples of Aikido and sushi chefs are not universal, but there are some similarities in midwifery. Student midwives learn many skills under teachers' detailed instruction during nursing and midwifery education. However, even if students learn how to palpate a woman's

belly and correctly tell the position of the foetuses, they cannot say they have completely acquired the skill. To do so, would mean also telling the condition of the uterus, the amniotic fluid and the foetus. Thus, communicating with the woman's body and the foetus through palpation is something they have to keep practicing. Moreover, in terms of palpation, I saw an experienced midwife warming up her hands with warm water every time before palpation or antenatal care and another experienced midwife performing a palpation to see whether the foetus was a boy or girl. Another midwife provided external cephalic version for a breech baby. However, we do not officially learn those things. We are expected to 'look and learn' or 'steal' the skills and wisdom from experienced people in practice rather than be taught. Experienced midwives are usually able to obtain more information than new midwives from one palpation. Skills are learned and deepened through repeated practice. In Japan, midwives may be considered as a type of artisan, because midwifery is a form of art and its essence is often beyond expression. Yet, Western philosophy would still try to understand it by means of language while Eastern philosophy would attempt to get it into the body with instinctive knowledge.

In Japan, there have been endeavours to put the phenomenon and embodied experience into words. Nishimura (2018) studied the relationship between nurses and comatose patients through the Merleau-Ponty's concepts of embodiment. She found that the eyes (line of sight) of a nurse and a patient were entwined, that the feelings of touch (the patient's hand) was kept on a nurse's hand (after-sensation), and that a nurse felt the timing was synchronised between her and a patient during care. Nishimura's descriptions suggested that nurses and patients were interacting. The nurses even felt cared for by the patients through their communication. Natural science diagnoses comatose patients as consciousness disorder, but phenomenology describes what those patients are and the phenomenon as lived by the nurses. It also tells us the meaning of the relationship between nurses and the patients; thereby, demonstrating the power of language. Without knowing such aspects of the patients, our understanding of comatose patients or consciousness disorder would be limited.

In consideration of Japanese characteristics explored earlier, research designs involving observational or less verbal methods, such as ethnography or observational studies, could be seen as providing a more suitable research methodology. However, this study set out to value the participants' spoken lived experience. Adams and van Manen (2017) argued that "concrete, first-person descriptions of an experience are often the starting point for phenomenological reflection and exploration" (p. 784). Listening to the participants' own experiences could deepen or expand my interpretations regarding the phenomenon rather than relying on observation. Nishimura (2018) reached the same understanding when she researched Japanese nurses' interaction with their patients using the nurses' narratives. Likewise, the meaning of the phenomenon of Japanese relationships could be captured through the lived experience as described by the women and

midwives. Japanese culture may have less expressive verbal communication, but what the participants describe is equally valuable to that of any culture. Based on the participants' stories and non-verbal expression, this study attempts to acquire insightful contextual descriptions that illustrate the meaning of the woman–midwife relationship rooted in Japanese culture and society.

At the same time, we need to be reminded that although language allows us to share and understand the experience, it is impossible to reach an absolute understanding. Heidegger (1927/2010) and Gadamer (1960/2013) maintained that there is no closure or completeness in our understandings. Hence, it is necessary to keep open to other interpretations and understandings. Especially for Japanese, it is potentially too risky to rely on only the words they speak, and it is important to obtain other ways of expression such as pause and meaning between or behind words. Therefore, a hermeneutic phenomenological approach supports a reflection of their lived experience. Words are not almighty but are definitely helpful to understand the woman–midwife relationship. The relationship should always be there or hidden in any situation between women and midwives, and understanding and documenting the experiences with words, is increasingly important for current Japanese midwifery. This study seeks to help Japanese midwifery to enhance the woman–midwife relationship for women's positive birth experience. Sharing and reflecting on the experiences and findings will provide other midwives in Japan significant insight towards their relationships with women as professionals. This study is an opportunity and challenge to describe and interpret the woman–midwife lived experiences through phenomenology expressed in language.

Summary

This chapter has outlined the methodology of hermeneutic phenomenology underpinning this study. Hermeneutic phenomenology is well suited to exploring the research question because the woman–midwife relationship is a significant part of the lived birth experience and is often taken for granted in day-to-day life. The chapter has traced the long tradition of hermeneutic phenomenology, focusing on the philosophies of Husserl, Heidegger, and Gadamer. While the study employs the hermeneutic phenomenological approach described by van Manen, the methodology is also informed by Heidegger's concept of Dasein and Gadamer's notions of pre-understanding and fusion of horizons. van Manen's philosophy offers insights for practice to understand phenomena within contemporary human science. The hermeneutic phenomenological attitude requires a commitment to the lived experience, while interpreting the text in various aspects. The hermeneutic circle is a part of the process used to develop the interpretations, and researchers will encounter the meaning of the phenomenon by means of language through the journey. Japanese ways of knowing are at times different from Western ways of knowing, in that knowledge is developed through unspoken action. Therefore, it might be challenging for Japanese to uncover the phenomenon in the same manner as Western researchers. However, it is important

for the current Japanese midwifery context to understand and interpret the woman–midwife phenomenon in and through language, so to give voice to Japanese women's and midwives' experience, while respecting traditional Japanese epistemologies.

Chapter Five: Methods

This chapter describes the methods used in the study based on the philosophy and methodology of hermeneutic phenomenology and a Japanese worldview. A hermeneutic phenomenological study does not have a procedural or systematic method (van Manen, 2014). Nonetheless, the path is methodologically guided by its philosophy, and the approach of van Manen (2014, 2016a). Referring to van Manen, and other philosophers' insights, this chapter clarifies what is considered to be data, how it were actually gathered and treated, and how the meaning of the phenomenon emerged throughout the process. I begin this chapter with a discussion on the ethical concerns and procedures I experienced in the research process.

Ethical considerations

Ethics approval for this study (16/429) was granted on 17th November 2016 by Auckland University of Technology Ethics Committee (AUTEC) (see Appendix A). Before seeking AUTEC approval, I discussed potential issues with my supervisors, attended a research ethics workshop, and consulted an AUTEC advisor. I also consulted JMA in Tokyo, which has its own ethics committee, because I planned to conduct interviews with Japanese women and midwives in Japan. With advice from JMA, which did not indicate the necessity of ethics approval in Japan, I reached a decision that ethical approval from AUTEC would cover my study even though it was being conducted in Japan. At the same time, I referred to the Japan Society for the Promotion of Science (JSPS) ethics guidelines to ensure the research methods being proposed were congruent with how research is conducted in Japan. Consultations also occurred with a Japanese midwife/university professor and a mother/representative of a birth advocacy group in Japan. Following their advice, there were minor changes of the Japanese language written in the participant information sheets, but not the content.

Before starting data collection, serious ethical issues were not anticipated. However, the possibility that the participants would reflect negatively on their experience and become emotional was acknowledged. Therefore, as the interviewer, I was careful about the participants' vulnerability at the interviews and prepared to lessen their stress and support them if any negative feelings or experience surfaced. No negative or traumatic incidents or feedback from the participants or people who introduced the participants have been received. Conversely, some participants appreciated the opportunity to reflect on their birth experience.

Cultural conditions were also taken into consideration. As a Japanese midwife and mother, I am familiar with the social and cultural context of the participants. There were few difficulties with

communication or conducting the interviews because both the participants and I are native speakers of the Japanese language. However, translating their Japanese texts into English was difficult due to the different cultural contexts between Japanese and English speaking countries. I will discuss issues arising and the process of translation later in this chapter. Additionally, required documents, such as information sheets and consent forms, were prepared in both Japanese and English for the ethics application and to ensure participants full understanding.

Participants

Recruitment

Since the woman–midwife relationship is an integrated phenomenon of a woman and a midwife's experiences, I decided to document the lived experiences from both parties and planned to recruit 10–12 mothers and 10–12 midwives residing in Japan for the interviews. After ethics approval, email advertisements (Appendix B), which introduced me to potential participants, were sent to mothers' groups and midwifery colleagues and friends through my networks. Information sheets written in Japanese were prepared for women and midwives respectively (Appendices C and D) and provided to potential participants who showed interest in taking part in the study. After reading the information sheet, potential participants contacted me to confirm their involvement and I made an appointment with each participant for the interview.

Women were invited to participate in the interviews regardless of birth facilities or mode of birth (hospital birth, homebirth, vaginal birth, Caesarean section, etc.), but confirmation as to whether or not they met with midwives during pregnancy, childbirth, or postpartum was requested because in Japan some women give birth without meeting midwives. In order to collect women's experiences in the current context, mothers with children between six weeks and five years of age were actively recruited. With regard to midwives, it was planned to recruit at least one midwife from each type of birth facility, including midwifery homes, obstetric clinics, and hospitals regardless of the length of their career, and that naturally occurred without special efforts. The women and midwives were recruited separately because it was felt that participants may hesitate to share experiences if they knew their midwives or women also participated in this study. Hence, the women and the midwives selected as a sample did not have any connection. The recruitment of the women went quicker than that of the midwives. After having gathered 10 women, four women contacted me around the same time. Thus, I stopped recruiting midwives by 10 and invited all the four women. In the end, 14 women and 10 midwives decided to participate in the interviews.

Consent, confidentiality, and anonymity

Potential participants were provided with an information sheet (Appendices C and D) and asked to sign a consent form (Appendix F) prior to their participation. As per AUTEC requirements and as an ethical researcher, I have paid maximum attention to protecting the participants'

confidentiality and anonymity. Participant names and contact details, such as email addresses, were kept in a password locked document in order to contact the participants after the interviews. Signed consent forms were scanned and password locked, and the paper forms were shredded. As well as protecting the participants' personal information, their anonymity in their stories must also be guaranteed. For example, participants might talk about an institution, a facility, another healthcare professional which would make them identifiable. I deleted those identifiable data or replaced words which cannot be identified in the transcriptions. All other information, such as participant ages and documents, including the researcher's notes and the transcriptions, have been managed by numbering, and each participant was given a pseudonym chosen from a list of popular Japanese female names. In the research process, any identifiable information has not been used.

Gathering the data

Individual interviews and participants' profile

Individual interviews were conducted with 14 women and 10 midwives in 9 prefectures across Japan between January and October 2017. The interviews took place at participants' homes, cafés, a corner of a mothers' gathering salon, hospitals and midwifery homes where the midwife participants work. Locations were agreed upon with participants where privacy and quiet could be maintained. The interviewer/researcher and the participants were all women, and all the venues for the interviews were safe places. However, the interviewer followed the research protocol to ensure the safety of herself and participants (Appendix E). These face-to-face interviews were conducted in Japanese and took between 50 and 120 minutes. All the interviews were digitally audio-recorded with the consent of the participants. When I introduced myself as a midwife at the time of the interviews, it seems that this made the participants feel easier to talk about their experience because I understood the context of maternity care they were discussing. I also attempted to provide a safe and relaxed environment for each interview and communicated with each participant in a polite and sincere manner. In addition, a shopping voucher (¥2,000) was given to each participant following the interview to thank them for their time and contribution to the study.

The women who participated in the study were aged between 33 and 43 years. Each woman had her last baby within six years in hospitals (six women), obstetric clinics (one woman), at midwifery homes (five women), and at their own home (two 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. The information of women participants is listed in Table 1 (p. 80).

Table 1: Women participants

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

The midwife participants were aged between 23 and 64 years. Their career ranged from 10 months to 30 years. Five midwives worked for hospitals, one midwife worked for an obstetric clinic, three midwives ran midwifery homes, and one midwife had just started running midwifery home while also working part-time in an obstetric clinic at the time of the interview (see Table 2, p. 80).

Table 2: Midwife participants

Name	Age	Length of practice	Place of practice
Noriko	45	10 months	Hospital
Yuki	44	23 years	Hospital
Aiko	23	2 years	Hospital
Rika	24	2 years	Hospital
Kazue	50s	28 years	Midwifery home
Hitomi	51	23 years	Hospital
Takako	39	15 years	Obstetric clinic
Miho	39	18 years	Obstetric clinic and midwifery home
Izumi	64	30 years	Midwifery home
Jun	51	27 years	Midwifery home

Hermeneutic phenomenological interview

According to Gadamer (1960/2013), thinking is asking questions. Gadamer stressed the significance of asking questions because the questions we ask direct the openness of dialogue as well as shape and guide future questions. Hence, the questions the researcher asks are key elements in the construction of different interpretations, which affect how we understand the experiences of women and midwives.

van Manen (2014) also maintained that phenomenological research needs to be guided by an appropriate phenomenological question. Phenomenological reflection and exploration require lived experience descriptions but not perceptions, views, beliefs, or interpretations. Therefore, the interviewer needs to ask open-ended questions, such as 'What was the experience like?' 'What did you do?' 'What did you say?' and 'What happened?' van Manen suggested focusing on a single, concrete moment of the experience lived as abstract, theoretical, and conceptual questions. Questions asking for explanations and perceptions, will fail to gather rich experiential material; for example, 'What is your opinion …?' 'Do you think that …?' and 'Why do you think …?'

With this in mind, I prepared a protocol and semi-structured interview guide prior to the interviews (Appendix G). I referred to the protocol, but I gradually learned how to best start the interviews and which kinds of questions might work to draw their stories out. For example, in the interviews with the women, I often started by asking, '(When/where) did you meet a midwife/midwives? Could you tell me what it was like (what happened) at that time?' I also asked about their experience of pregnancy, birth, and postpartum. In the stories, they naturally discussed what midwives did or said, what the women did and how they felt at that time. They provided rich experiential stories. One reason why they freely and openly presented their stories is that they could objectively reflect and describe their experiences rather than talking about ideas. The experiences of women were, of course, limited by the numbers of births they had and the midwives they had met, which meant they were very specific and detailed in their accounts. Whereas many of the midwife participants had a long career and met many women in their day-to-day practice. Hence, it was more difficult to bring out their lived experience descriptions. At times as they tended to generalise their midwifery practice and experiences with women and give their opinions. I did not stop them from expressing their perceptions and interpretations, but tried to expand or deepen their stories by asking for the details of their experiences with questions, such as 'Who do you remember the most in your experiences?' 'Could you tell me what happened with that woman?' and 'Could you give me one example of that experience?'

More importantly, I realised that I did not need to ask many questions to elicit detailed responses because the participants naturally talked once the interviews started. Often simple probing gestures, like friendly nod was enough to keep their stories developing. Also, I noticed that what

the participants meant to say was partly understandable from their non-verbal expressions. Accordingly, in interviews or conversations, a more important skill than asking questions is perhaps listening. Western philosophies depend on expressive language (Fiumara, 1995). Language is the tool to access the world in the methodology of hermeneutic phenomenology (van Manen, 2016a). This study relied primarily on language to collect the participants' lived experience and to understand the woman–midwife relationship in Japan. However, much remains unspoken in the everyday experience of midwifery; therefore, paying attention and listening to the silences is also an important method to elicit stories. As discussed in the methodology chapter, it is particularly important for Japanese to obtain some ways of expression other than language such as a tone of voice, pause, and meaning between or behind words. Genuine listening and silence will allow space for such expressions. People can listen to approximately 400 words while they can speak approximately 150 words (Orr, Friedman, & Williams, 1965; Piquado, Benichov, Brownell, & Wingfield, 2012); hence, listening is easier for human beings. However, for this reason, people do other things while listening. As a mother, I often cook while my children talk to me rather than attentively listening to them. Even when both people sit and face each other, one often keeps thinking of something or is distracted by deciding what to say next while the other person is talking. People may not be listening as much as they think. Gadamer (1960/2013) stated, "Anyone who listens is fundamentally open" (p. 301) and possesses an attitude that will develop the relationship between people communicating.

I was careful about attentively listening and patiently waiting for participants' words and responses rather than asking more questions. In addition, I took notes regarding participants backgrounds and their stories, narratives that made an impression, their facial expressions and way of talking, and what I heard from their stories and interviews soon after the interviews. Not all the participants' whole stories were lived experience descriptions for the focus of hermeneutic phenomenological questions; sometimes we enjoyed talking about their children and sometimes they wanted to discuss opinions rather than their experience. However, the participants definitely provided rich descriptions of their lived experience of woman–midwife relationship in the interviews.

Working with the data

Nonmethodical method

van Manen (1997) combined methodological explications with a practical approach to develop a hermeneutic phenomenological inquiry. He claimed that phenomenology has a methodological foundation informed by tradition, a body of knowledge, and a history of lives of thinkers, even if there is no formalised method. Accordingly, he indicated methodical structure consisting of six research activities to conduct hermeneutic phenomenological research. Those activities are:

> 1) turning to a phenomenon which seriously interests us and commits us to the world;
> 2) investigating experience as we live it rather than as we conceptualize it;
> 3) reflecting on the essential themes which characterize the phenomenon;
> 4) describing the phenomenon through the art of writing and rewriting;
> 5) maintaining a strong and oriented (pedagogical) relation to the phenomenon;
> 6) balancing the research context by considering parts and whole. (van Manen, 2016a, p. 30)

van Manen (2016a) emphasised these activities do not need to be performed and completed one by one, or as a 'step' in a sequential order. He pointed out the artificiality and awkwardness of the presentation when the methodological themes are separately organised. In the actual work, the process would occur irregularly and concurrently through various aspects (van Manen, 2016a). Thus, van Manen's approach differs from technical procedures of other qualitative research such as coding and methods comprised of a step-by-step procedure. van Manen (2017b) highlighted this point when he wrote:

> Researchers look for the right door to which the key gives access. When they cannot find the door, they reject the method. However, the gateless gate teaches that the keyhole needs no key, because there is no door. It is a gateless gate. So the problem is that some researchers are so consumed by the idea or promise of a 'method' (such as a procedural scheme or program for doing 'interpretive phenomenological analysis') that will yield important qualitative understandings and insights that they don't allow themselves to recognize an insight when they stumble over it is a 'nonmethodical moment.' (p. 820)

For van Manen (2014), hermeneutic phenomenology, itself, is the method to reflect the experience and attitude of the phenomenon. He claimed that the most dangerous assumption in hermeneutic phenomenological study is that the understandings or themes will automatically emerge through the prescribed steps of data analysis (van Manen, 2017a). With this in mind, the texts of this study were analysed along the methodical approach van Manen (2014, 2016a) described. Figure 4 below (p. 84) illustrates my analysis process. I will detail the process in the following sections.

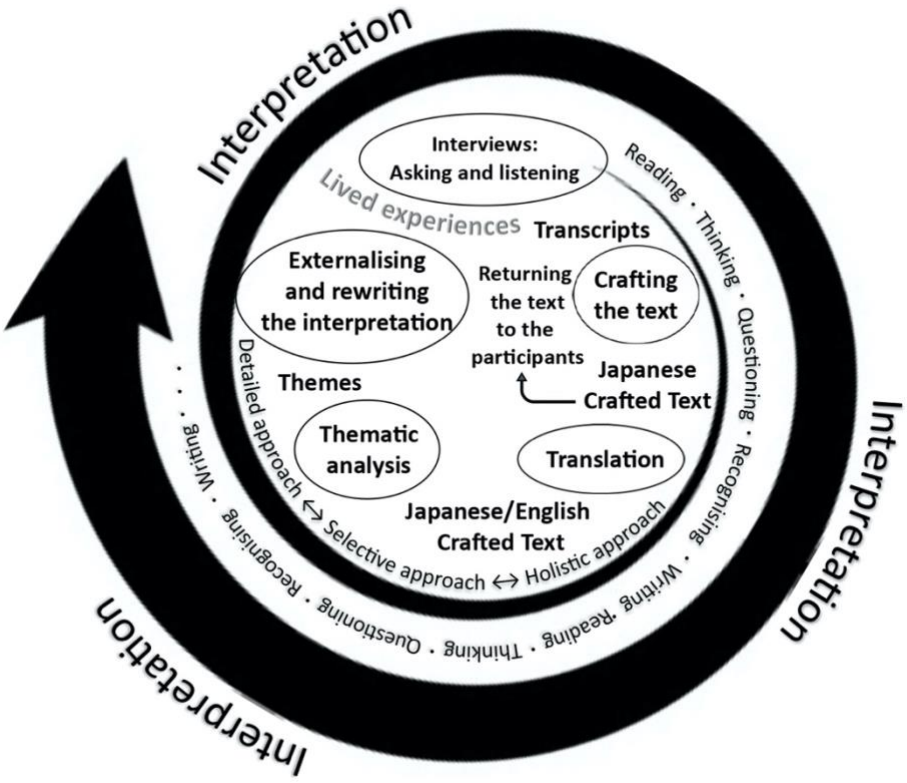


Figure 4: Hermeneutic circle of this study

Interpreting the data: Hermeneutic phenomenological analysis

Transcribing and crafting the data

Following each interview, the audio-recorded data were transcribed. I transcribed four interviews (two women and two midwives) and the remaining interviews were transcribed through a professional service. The transcriber signed confidentiality agreement (Appendix H) before commencing work. I confirmed the contents of the transcripts from the service by listening to the original audio-recorded interviews.

After transcribing the data, I crafted and edited each text. I had two stages of crafting the data because I worked with the data first in Japanese and later translated the texts into English. The major part of the crafting process was done at the first stage, but the translation also required certain amount of crafting and editing to bridge linguistic difference. Details of the translation process are described later.

In terms of crafting the data, Crowther, Ironside, Spence, and Smythe (2017) suggested that working with data requires the practical sense of how to craft stories from verbatim transcripts and the ontological sense to 'attune' to the crafting. While removing extraneous detail and keeping the sentences that seem to hold the meaning, the crafting forms a condensed story that captures richness and meaningfulness of the experience (Crowther et al., 2017). Hence, this is

part of the interpretive process, and I was required to think, feel, wonder, and question to craft each text in attunement with the story. During the crafting process, I endeavoured to capture the meaning of the participants' experience by keeping the flow of the story.

More specifically, I first removed the parts of the transcripts that were irrelevant to the research question or were repeated phrases. This included the participants' verbal tics, such as 'you know' and 'like' in case of English. I also removed or rephrased the parts which could identify specific person or parties. Next, I attempted to condense the participants' stories by finding and keeping the parts that held some significance of the participants' experiences. The process of removing and selecting parts of the data was repeated, and done little by little, because I first felt all the data were important and I was afraid of losing or missing out on important parts without knowing. Lastly, I moved and edited selected parts in order to improve the flow of the stories. An example of how I crafted the data is attached in Appendix I. The process was not simply straight forward as described. Inspired by the hermeneutic approach, I went back and forth, read parts and wholes, and made continuous small editing amendments until the findings were presented in this thesis.

Thinking and rewriting the text brings clarity and depth for a rich or dense story (D. Smith, 1997). Crowther et al. (2017) discussed that such crafted stories bring us a powerful 'felt' knowing that we cannot easily summarise. In working with the texts by rereading, rethinking, and rewriting them, it became clear which passages needed to remain, which sentences were irrelevant or less significant to the research question and which words need to be corrected. It seemed that something was coming up, showing itself, or becoming visible. van Manen (2014) stated well-written and well-edited stories may give us the experience of presence or closeness in place or time. In fact, by reading and rereading I became immersed in participants' stories, and I was gradually able to visualise the scene of the participants' experience while crafting and editing the data. I actively recreated what happened in the participants' experiences, and that helped me interpret and craft their stories.

I returned the crafted stories and the original interview transcripts to the participants at the early stage of analysis to gain their agreement with how their narratives had been crafted and to confirm/refer the contents of the interviews. I told them the crafted text was my interpretation, but within the transcripts and stories I sent, it was difficult to say exactly which parts were my interpretation. Therefore, I thematically framed their stories in a way that expressed my interpretation of their experiences with headings, for example 'trust.' Then, the participants saw how I was interpreting their stories.

Smythe (2011) claimed that the crafting of data honours the participants for the meaning they have shared. A few participants added a little information or a few comments, but they all, with

the exception of two participants, agreed with the contents and were satisfied with or interested in the crafted stories and emerging themes. One woman asked not to use the story with a midwife because the midwife might easily be detected because of her unique background and work style. The information possibly detecting the midwife was not mentioned in the text, but the woman's story was withdrawn from the data analysis following her request. One midwife was worried that her opinion in the transcript might sound too critical towards hospital midwives and this part was omitted in the following analysis.

Translating the data

After crafting and rewriting participants' stories, I translated them into English from Japanese. This was done in order to discuss the analysis with my supervisors and for the purpose of the PhD which is in English. It was essential and helpful that my supervisors read those stories, understood my interpretations, confirmed whether those interpretations made sense, and discussed the meanings of the experience and interpretations with me. Through shared discussion with my supervisors, I gained multiple opportunities to re-interpret the texts, and to realise what were common for me and not for them, others or outside Japan. This process also challenged my pre-understandings. With the realisation and feedback occurring in English, I kept working with the data written in Japanese in order to remain as close as possible to participants' experiences.

Translating the stories became another significant process within the crafting, as it offered me another standpoint and realisation. I re-crafted the stories by rethinking about what really needed to be conveyed in the stories and what was the essence of the experience beyond the linguistic difference. I was careful not to lose the original contextual meaning when translating the participants' experiences into English, but the translation process actually brought about a flood of phenomenological insights. Thus, translating the texts became a good opportunity to reach the meaning of the phenomenon because I tried to understand and focus on the meanings of the lived experience to keep the essence of the original texts between different languages and cultures. Translation is an interpretation. It would work better when the interpretation holistically keeps the essential meaning rather than when each single word is correctly, directly, or closely replaced into the word of another language.

Gadamer (1997/2007) argued, "the true task of translating means translating only the meaning-content in the text" (p. 177). Moreover, in his book, translated into English from German, it is stated that a free translation of his thought and not just of his words are performed following Gadamer's preference, and changes and additions are made to clarify the text that are "unspoken but self-evident in the German but not in English" (Gadamer, 1997/2007, p. 194). There are basically no major changes and additions through the translation of this study but, if necessary, information or resources are added in the footnote for readers. Moreover, in the dialogue between

Heidegger and Japanese scholars, Heidegger (1958/2000) maintained that he could not understand some Japanese words in German or English. This can happen between other languages too. By recognising the limitations, this study interprets the meaning of the experiences of Japanese women and midwives as clearly as possible in the English language.

However, I have chosen to directly use some Japanese words in this thesis. For example, the term *anshin* means feeling of security or safety, feeling of relief, feeling at ease, feeling comfortable, reassuring, and peace of mind. The word, at times, indicates more than one meaning and does not fit within one English word or phrase. Since I felt the danger and difficulty of translating the word into one word or meaning, I use *anshin* as it is. Also, Japanese grammar structure, honorific expressions, and specific phrases and metaphors were difficult points for me to translate into English. Amemiya (2007) claimed that traditional Japanese language does not have a subject. For instance, it is natural for Japanese conversations to develop without identifying who or what are grammatical subjects; pronouns and names, such as I, you, he, she, we, they, or even 'midwives' are often left out of the conversation. This was also the case for the participants' narratives. Therefore, I had to supplement *who* did something or *what* was so. It is often implied and can easily be guessed, but I sometimes needed to carefully think who it was. When the texts were returned to the participants, it was possible to confirm it. However, I later questioned whether 'midwife' could have meant a midwife or midwives in English. For example, the noun banana is just 'banana' in Japanese. When expressing 'I like bananas' in the language, people do not care if they like 'bananas,' 'a banana,' or 'the banana.' Japanese express 'banana *ga* like' (*ga* is a postpositional particle of Japanese) meaning '(I/you) like banana' unless you want to talk about specific bananas. At the same time, 'banana' appears like a subject, but there is no subject in this sentence.

Furthermore, Japanese language has more grades between casual and honorific expressions. One midwife kept using super honorific expressions towards women for whom she cared. It might be her personal characteristic, but it sounded like a distance established between her and mothers. It was difficult to translate her different way of talking from that of other participants. Japanese also often use passive tense for humble expressions which is not equivalently compatible with English. There were some difficulties when I translated Japanese sayings and metaphors into English. For instance, a woman said, '(I did) draw a *hazure* lot' (I drew a losing lottery ticket) in the interview. She meant that the midwife she met was not a good one among many midwives in the hospital. Yet, she did not say that, and she even stated that the midwife was kind. However, her phrase implies that she was disappointed and that she thinks which midwife she met was a matter of luck and she was unlucky. It seems that she does not think she had a choice. The readers might be able to guess from the phrase or her descriptive experience, but I struggled with such phrases when

translating. However, the process provided me with opportunities to further develop my thinking and interpretation.

Including these examples, I tried to interpret the uniqueness and nuance of the participants' narratives as much as possible. The internet, such as online dictionaries and online forums and blogs for English learners, was at times a useful technology that provided more varieties, detailed and realistic expressions than Japanese–English dictionaries. I also asked for help from English native speakers such as my supervisors, my friends (midwifes, medical doctors, other PhD students), and my Canadian husband to find the best English expressions by explaining the details of the situations, nuances, and my interpretations. The translation process was a challenge for me as English is my second language (professional translators usually translate from their second language into their first language). It was very time consuming, although equally interesting. I did not consider outsourcing the translation process to a professional service or anyone else. I probably felt that I knew the best translation of the stories, including the meanings between and behind the language because I directly heard their stories, faced the tellers of the stories, and was with them in certain moods or atmospheres. Translating the texts was a notably important process to obtain the meanings and insights of their experience, and I felt I could achieve convincing, accurate, and satisfying translations.

The accuracy of the translation was confirmed with a Japanese mentor, who is a midwife and a professor in a university in Japan. She has done her doctoral study using phenomenology based on the philosophy of Merleau-Ponty and has published her work in English. She checked two texts (one each from women's and midwives' stories) between Japanese original texts and English translated texts. Her feedback was positive and assessed I had an adequate skill and ability of translation. In addition, I sometimes translated back into Japanese from English translation when I wanted to confirm the accuracy. The method was inspired by Haruki H. Murakami (1979/2016), a Japanese novelist. He writes a story in English first then translates it into Japanese to simplify the passages and give his work a distinctive style (M. Tanaka, 2009). Back-translation was also employed in a hermeneutic phenomenological study of experiences of Japanese men during the transition to fatherhood and presented in English by Iwata (2014). We never reach absolute interpretations, expressions, and understandings even within the same language; therefore, the gap has to be filled by focusing on the experiences which tell us the meaning no matter which language is used.

Thematic analysis

Following translation, participants' stories were further interpreted and rewritten to search for themes revealing the meaning and essence of the experience of their relationship with midwives or women. van Manen (2017b) emphasised that phenomenological understanding and insights

are not necessarily, or even unlikely, to emerge from procedural analysis of the data, such as sorting, counting, and systematic coding. Rather, it occurs through an inceptual process of reflective wondering, deep questioning, careful recalling, and sensitively interpreting the primal meanings of human experiences. During the process of repeated reading, thinking, and wondering, I gradually started feeling what was important and meaningful in their experiences and recognised several themes had become clear. I had added thematical headings when I crafted the original text, but these headings sometimes changed while I repeatedly edited the text. Through the process, I felt I grew closer to the meanings of the woman–midwife relationship, and the themes started appearing in the interpretations. However, it was not easy to reach a fully convincing selection of themes across the many phenomena and experiences of 24 women and midwives, and to linguistically explicate them all. Therefore, I highlighted a sentence of passage that indicated the significance of each experience.

Before this point, the translation of the text from Japanese into English was completed. However, it was smoother for me to work with the Japanese text when I highlighted the passages. Working between Japanese and English was troublesome, and it might have simplified the process if I worked only in English once the translation was completed. Yet, I gained new insights and themes by going back to the original Japanese text. The interpretation became deeper and more nuanced while working between languages. Working between Japanese and English text had a positive influence for my interpretations, with some themes emerging through the practice of translation and provided further improvements for the analysis, including the translation and interpretation. It was a unique and beneficial process for this study.

The highlighted passages (in the Japanese language) contained the essence of the participants' experiences. Japanese communication, including oral and facial expressions, is often vague and unclear (Sonfa, 2009). Therefore, one cannot expect to understand the meaning of participants' experiences directly from what is said, but those passages often tacitly delivered what the participants' meant or experienced. I was partly able to notice the significant passages because I knew the whole story and the atmosphere in the interview. That is, it was helpful that I sensed the participants' subtle expression as the interviewer when I selected the relevant parts of the interviews. This is one way to communicate and represent an understanding of ambiguous Japanese expressions of experience. At the same time, I was able to recall the whole story from each selected part because I had directly heard their stories and read them countless times. In this way, I committed to phenomena and reflected on the stories themselves rather than seeking words and coding them. van Manen (2014) maintained that, in hermeneutic phenomenological research, a thematic understanding of a phenomenon does not emerge from coding, categorising, generalising, and theorising; it is a complex and creative process of insightful invention, discovery,

and disclosure by a free act of seeing meaning. After all, the phenomenon itself appears to consciousness as realisation (van Manen, 2016a).

Through the process of rethinking between the whole and the lines, and between the texts and the themes, 40 tentative themes emerged from the participants' experiences (Appendix J). At that time, the list of those themes was a mixture of themes representing the meaning of the experience (e.g. trust) and themes more directly describing experience (e.g. being left alone). Some themes were similar or related to other themes, and some phenomena fit into several themes. A few themes had already shown the meaningfulness of the woman–midwife relationship from the early stage of analysis, and some themes seemed less substantial. I further needed to arrange highlighted passages and themes to organise my thoughts and choose the right themes (Appendix K). While doing this, I reminded myself to reflect on the holistic experience of each passage. For theme analysis, van Manen (2014, 2016a) suggested to read the text at the different levels by thinking how the significance of the text can be captured as a whole, what statement particularly reveals the phenomenon, and what this sentence says about the experience in order to explore themes—holistic, selective, and detailed approach. I kept an attitude of this reading approach during thematic analysis. In the final analysis, four themes that recall the lived experience of woman–midwife relationship were considered rigorous and reliable findings that meaningfully describe the women and midwives' experience of their relationship. These four themes comprise the findings chapters of the thesis (Chapters Six to Nine).

According to van Manen (2016a), a theme is a tool to reach the notion we are trying to understand, and somehow touch the core of the notion by describing the detail of the notion. Along with the idea of van Manen (2014, 2016a, 2017b), the journey of thematic analysis went back and forth. That provided me with an opportunity to freshly re-engage with the text and interpret the text with another aspect. This process continued during the process of writing the interpretations. Importantly, the themes were required to be properly described in the English language. Also, I kept thinking about the relationship between the themes and my interpretation while writing the findings chapters in order to see both that the interpretation matched the themes and that the themes accurately portrayed the participants' lived experiences and the interpretation. The four themes are presented with the participants' lived experiences in the following chapters.

Externalising and rewriting the interpretation

I had been reading, thinking, writing, wondering, and questioning a lot by the time the four main themes were settled. However, I realised that the interpretation I felt within the participants' stories was not enough to explicitly put the meaning of the phenomenon into the words and present the findings. I needed to go back to the text to more deeply reflect on the participants' experiences and to unpack their meanings. Additionally, externalising my thoughts and

interpretation in words itself was challenging. Adams and van Manen (2017) and van Manen (2014) claimed that efforts to externalise what is internal with linguistic ability produces reflective attitudes, and the work of rewriting gives us more chance to achieve leaps of phenomenological insights. For me, externalising and rewriting the interpretation provided more opportunities to get closer to the meaning of the phenomenon—the woman–midwife relationship.

My writing of the interpretation started with describing what happened between the woman and midwife. At times, it was very difficult to go beyond the description of the phenomenon and to construct a convincing interpretation. At that time, I went back to what van Manen suggested for the hermeneutic phenomenological interpretation. Crowther et al. (2017) maintained that stories "call for us" (p. 833) what the experience is. I persistently asked myself (and was asked by my supervisors), 'What does this experience mean?' and 'What *is* this experience?' These simple questions allowed me to return to the basics of this study, enabling me to stay with the research question of the study.

According to van Manen (2016a), writing, including typing on the keyboard, is a main part of the method in the analysis of hermeneutic phenomenology. van Manen (2014) even claimed that writing is research and the researcher requires a solid commitment to writing to conduct phenomenological research. For this study, I really needed to write and rewrite to reach convincing interpretation. van Manen (2016a) also insisted on committing to the phenomenon and balancing parts and whole—hermeneutic circle—throughout the act of writing. I went to and fro within a text, and sometimes felt myself soaking, drowning, and playing with/in/between the texts.

van Manen (2014) further discussed that the act of writing may go beyond the physical movements of writing to simply being with words and reflecting on them. Indeed, I required repeated thinking and reflection on the phenomenon and literature to inspire my writing. The moment to be close, or reach certain understandings, was not only when writing. The encounter with new insights and the leaps to further interpretation occurred anywhere and anytime—in bed, in the bathtub, while cooking, while driving, and during conversations with friends. That is all part of my writing process.

Heidegger (1927/2010) and Gadamer (1960/2013) argued that it is impossible to achieve a complete understanding, but the journey reaches adequate convincing interpretations which are explicit, visible, and comprehensive. This is definitely not only the matter of how frequently a phenomenon is experienced or how dramatic or shocking the phenomenon. The emerging themes and lived experiences tell us the essence of the phenomenon that is important, but often taken for granted, what the woman–midwife relationship is like, as it is lived. van Manen (2016a)

consistently emphasised that the phenomenological description is collected by lived experience and recollections of lived experience. Thematic analysis and writing are the process to recover the meaning of such human experience embodied in a text (van Manen, 2014).

Before settling with the interpretation of the participants' experiences of the woman–midwife relationship, the writing process took me months and I rewrote each findings chapter several times. As discussed earlier, for Japanese midwifery, expressing the relationship between women and midwives with the language has a significant value. The meaning of the woman–midwife relationship I reached through the interpretation of the woman and midwives' lived experiences are presented in the following chapters. I also left some descriptions of the participants' experiences in the writings where I felt they could be helpful for the readers to see the process of my writing and to understand the specific context of Japanese maternity care settings. In addition, this writing process was mainly done in the English language while I kept reconfirming with the original Japanese text as a reminder of how the participants described their experiences in their words.

Rigour: Trustworthiness of the study

Compared to quantitative research, qualitative research may look to some as lacking in scientific rigour; and, in fact, has been criticised as anecdotal, impressionistic, subject to researcher bias (Koch & Harrington, 1998). The aim of this hermeneutic phenomenological study is to understand the meaning of the woman–midwife relationship, and hermeneutic understandings are always interpretations. One of the reasons why I employed the approach of van Manen (2014, 2016a) is that his methodological explication is more practice-based than that of other philosophers or phenomenologists. However, it is still more conceptual than a step-by-step structured method. At the same time, it does contain core principles and methodological foundations that forefront flexibility and openness, and includes repeated writing and hermeneutic reflection.

Smythe, Ironside, Sims, Swenson, and Spence (2008) suggested "it is time to hold ontic requirements more loosely and to bring greater trust to the ontological spirit of 'understanding'" (p. 1396). They added that in hermeneutic research we cannot ask readers to accept everything or anything as truth, rather we invite them to share the exploration and to question their own interpretations. The accuracy of the research is left to the decision or resonance of the readers who care and are considerate about the phenomenon (Schmidt, 2006; Smythe et al., 2008). Sandelowski (2015) also considered the quality of qualitative research in the context of taste. That is, judgmental standards such as aesthetic sensibilities or connoisseurship play an important role in the evaluation of qualitative research.

Nonetheless, it was not easy to completely trust what I am doing in the middle of challenging new research without an evaluation process or criteria. I also questioned, 'Am I doing a right thing for this study?' and 'Am I on the right track?' throughout this study. Thus, it is essential to demonstrate how research rigour was implemented. Whereas many scholars indicate conceptual frameworks or criteria for the validation of research rigour, Davies and Dodd (2002) argued that the criteria of research rigour differs among research and methods. This study checks its rigour with three frameworks—credibility, transferability, and dependability—described by Koch (1994/2006) who developed the criteria through her hermeneutic research in nursing, based on the discussion of Guba and Lincoln (1989).

Credibility

In order to clarify credibility, researchers need to demonstrate engagement, methods of observation, and audit trails (Cope, 2014). Koch (1994/2006) suggested that credibility is enhanced by describing and interpreting the experience of researchers. This encourages self-awareness of researchers about the rigour and trustworthiness of the process. In the first chapter, I presented how I relate to this study, including my motivation to conduct the study and my own pre-understandings. I described the philosophical, epistemological, and ontological underpinnings of my study in the methodology chapter, and the details of my experience throughout this research in this, the methods chapter. These descriptions would justify this study as research. Koch also suggested keeping a journal and consulting participants themselves as practical ways to establish credibility. Writing a journal and keeping field notes help me reflect and interpret my own experience, and allowed me to trace the process of thoughts, activities, and events. The participants read my interpretations of their experiences and I was able to discuss these interpretations with them. They were interested in, and agreed with, my interpretations. All the phenomena in this study are rooted in the participants' lived experience and reality. Thus, the participants were always present in my mind while undertaking thinking and writing.

In addition to the participants, regular meetings with supervisors provided me with opportunities to recognise and validate an audit trail. Smythe et al. (2008) stated, "the trustworthiness of a study is known first by researchers themselves who test out their thinking by engaging in everyday conversations with those who share the interest or who are living the phenomenon" (p. 1396). They also argued that others help open closed doors, although others cannot tell you what to do with the data. I have had great support from supervisors, mentors, and colleagues in conducting hermeneutic phenomenological research. Presentations and discussions of others' phenomenological research and a Heidegger reading group have inspired and guided me. On-going status of this study has been shared at conferences where I received valuable feedback. I have family and friends with whom I can discuss midwifery and philosophy. Furthermore, as a midwife and mother, I am familiar to the phenomenon and have opportunities to talk to other

midwives and mothers inside and outside Japan. All these people and opportunities have expanded my horizons. Heidegger (1927/2010) and Gadamer (1960/2013) emphasised being open to oneself being-in-the-world rather than being objective. Based on their philosophies, faithfulness to the research process, reflection and openness to engage in research activities enhance the qualitative credibility of the study.

Transferability

Transferability refers to the term fittingness, meaning whether the research results can fit into other contexts (Koch, 1994/2006). This is also judged by the readers of the research and whether or not they can associate the results with their own experiences. Sandelowski (1986, 1993) argued that transferability is not required unless the aim of the study is to generalise about the phenomenon, and repeatability is not essential, necessary, or sufficient in phenomenology. van Manen (2016a) emphasised, "The only generalization allowed by phenomenology is this: Never generalize!" (p. 22). The aim of this study is not the generalisation of the phenomenon, and neither are quantity or frequency of the phenomenon. Smythe et al. (2008) claimed that the themes do not need to be the same thing said again and again, but "rather an understanding that we have seen something that matters significantly" (p. 1392). Moreover, van Manen maintained that the researchers are reflectively aware of certain experiential meanings "to the extent that 'my' experiences could be 'our' experiences" (p. 56). In this respect, hermeneutic phenomenological descriptions can reach universal meanings, but not generalised meanings. For this hermeneutic phenomenological study, transferability intends to this sense of fittingness among others.

This study comprises a broad research field and a variety of participant backgrounds, with interviews taking place in 12 cities of 9 prefectures; from the farthest north to the farthest south across Japan. Accordingly, the participants provided rich, colourful, and multifarious examples; and each participant's experience is unique. The essence of the woman–midwife relationship condensed from such lived experiences shows us its universality. Their experience could call for familiarity, sympathy, nostalgia, or feelings such as happiness, sadness, anger, or repentance based on the readers' experiences. For me, as a mother and midwife, the meanings of the phenomenon are unique and familiar, although this decision is ultimately left to the thoughtful readers (Schmidt, 2006).

Dependability

Dependability is referred to as auditability (Koch, 1994/2006; Sandelowski, 1986). Koch and Harrington (1998) indicated, "establishing dependability or maintaining an audit trail means recording decisions throughout the research process and incorporating these in the final product" (p. 887). Sandelowski (1986) simplified this as "any reader or another researcher can follow the progression of events in the study and understand their logic" from its beginning to its end (p. 34).

In this chapter, I have stated the events that happened and the decisions and actions that I made throughout the research activities. The descriptions also include my pre-understandings, beliefs, struggles, and dilemmas during the process. As mentioned earlier, I have kept an audit trail of the journey with a journal, along with the history of the documents of the transcripts, crafted text, stories of the data, Japanese original text and translated text into English, and the drafts of the thesis. They are reliable sources when I trace back and reflect on the process of my study across time. The process was not straight forward and it might be difficult for readers to follow all of the interpretations occurring in my head. However, it should show the 'intrinsic/internal logic' of methodological and interpretive processes and decisions of this study (Koch & Harrington, 1998).

Summary

This chapter described the methodical journey of the current study. First, various ethical conditions were considered in order to conduct this study safely. The process of the study, such as the recruitment of the participants, the interviews, the analysis, was based on the philosophy and methodology described by van Manen with Japanese philosophy. While van Manen insisted on the non-methodical method, this study was well navigated by the methodical approach and insights van Manen provided. The translation of Japanese into English was an important process of this study. While the translation was challenging and time consuming, the process became an invaluable opportunity for the researcher to reflect and interpret the participants' lived experiences more deeply. Finally, the trustworthiness of the study was presented by referring to Koch and other scholars to clarify the audit trail. The following chapters present the findings that emerged from my analysis.

Chapter Six: Seeking a Connection

The next four chapters present the findings of the study. This chapter discusses the first theme which explores women's and midwives' experience of seeking a connection. The relationship between a woman and a midwife is always already there where they meet. However, some participants in this study described their experiences as if they had no relationship. This could mean that they did not feel a connection with their midwives or women because of insufficient interaction or a lack of something that would otherwise connect them. In fact, the women were often too nervous to open up when meeting new midwives; and the midwives were often too busy to be constantly with the women for whom they cared. Both women and midwives struggled with the situation and the relationships that resulted. Although these experiences may be negatively presented in their stories, this does not mean that no relationship existed. Even if they perceived the relationship as less than ideal, there was still a woman–midwife relationship. The focus of this chapter is on the complexity of the participants' experiences when they do not sense a connection with midwives or women, even though together they share a significant experience and seek connection.

Closed hearts and bodies in insecure relationships

Meeting a midwife can be a starting point of a relationship, but this is not always a simple experience for the participants in this study. In maternity care settings, women desire to meet midwives who can provide care and support that offer relief. However, for the women of this study, the encounters were at times defined by insecurity. Two first-time mothers, Maya and Shizu, illustrate how they felt when they first met a midwife during labour. Maya stated:

> I had never seen the midwife who attended my birth before. She didn't stay with me and left me alone [during labour]. She had a mask on her face and her eye-makeup was quite strong. So, I turned my eyes away from her instantly. She was not as bad as my first impression, but I was not able to open up to her. I wondered what kind of person she was. I got nervous. We had an awkward kind of atmosphere. But it was the first time for me, and I thought that was normal. While hearing other people's birth stories later, I realised that my experience, meeting the midwife suddenly during the labour, was a huge pressure on me. I also met other midwives, one after another, during my stay at the clinic because of their shift work. Midwives were like *Otsubone* (bossy office ladies). My impression of the midwives was like people who were older than me and bossy. They made me reluctant to express my idea.

Shizu describes a similar account:

> I think the first time I met the midwife we greeted each other by saying 'Hello' and 'Nice to meet you.' This was when she decided to have me admitted to the hospital for my labour after an internal examination. My legs were opened [when we greeted]. Then she came to check on me [during labour]. I saw her again when I was on the delivery table [when I was almost giving birth]. Meeting someone for the first time in such a situation is... you know. That's literally the first meeting. 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. That was not being shy exactly but I kind of didn't want anyone to see me in such a situation. 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. I wish I knew a midwife before because we didn't know each other. I remember I suddenly heard the door opening when I was with my husband in a room. I recoiled. I felt my tummy got stiff in pain when the midwife came into the room. You know where you are, so it's okay. But I think I was still sensitive. Also, I was thinking, 'Not there' when she gave me a massage. I was told to lie on my back, but I wanted to be on my hands and knees. Of course, I could say something, but I just followed what she said. We had just met so I was wondering how much I could say.

The midwives existed as strangers to Maya and Shizu. In this case, 'strangers' refers to a sense of detachment in the relationship. It implies an emotional distance between the women and their midwives that did not allow them to feel a connection. The midwife's covered face further enhanced the sense of her being unapproachable. The women were nervous, embarrassed, and hesitant in their relationship with the midwives. Correspondingly, such relationships became filled with insecurity for the women. Every relationship has a first encounter but one of the problems, as seen in the excerpts above, was that they had to build their new relationship during an intense period of childbirth. Furthermore, being physically left alone during labour aggravated their feeling of unconnectedness. They felt unconnected rather than disconnected from their midwives because they never felt connected to the midwives to begin with. Establishing a relationship often requires time and ongoing interaction to understand each other (Garratt, 2014). Building a new relationship in the limited time of labour put a lot of strain on the women, and this experience became a significant part of their birth experiences. The sense of insecurity in the midwife relationship, which Maya and Shizu felt throughout their labour and birth, 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 Shizu scared and she physically closed-off to the relationship. Her body, which recoiled and was stiff with pain, expressed her nervousness and anxiety about the new relationship with the midwife. Such an encounter was a disruption in her labour. Similarly, Maya's body unconsciously reacted due to the fear of looking the midwife in the eye. Their bodies instantly and honestly rejected the midwives before they rationally understood the situation. The lived body became a corporeal expression of the tension felt with respect to the phenomenon (van Manen, 2014). They found, through their own physical responses, that their hearts were closed as much

as their bodies in the relationship. The existing midwife relationship emotionally and corporeally co-produced a sense of fear and insecurity. van Manen (2014) claimed the body and mind influence each other's state. Likewise, here, the women could not feel safe and secure with their closed bodies and were never able to trust their bodies to their midwives or to the flow of the birth, having their closed hearts in the relationship.

Moreover, Maya signified the relationship with the midwives she encountered by naming them *Otsubone*. *Otsubone*, in Japanese, does not exactly mean the boss, but someone who is often in the same position and has had a long career in the office. The name implies a nagging or mean woman and is understood to be a woman ruling over colleagues in the office, which delineates hierarchal order (Matsumoto, 2012; Nihongo Zokugo Jisho, 2018). Maya might not have felt the obvious hierarchical relationship between her and the midwife. However, she felt the power of the midwives dominating her. Giving a name to something serves to know the world better through the subjectively felt meaning of one's relationship with others (van Manen, 1999). The nickname clearly indicates Maya's precarious position in the relationship. These relationships are stressful. The women felt as if they had no control over their fate. Under such threatening circumstances, they had to close their hearts to protect themselves. At least, it was difficult for them to open themselves up to the midwives, to relax, and focus on their labour and birth. If the women 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. For these women, not knowing the midwives during labour and birth meant they became closed-off from the relationship, which created a sense of anxiety.

Uta, another first-time mother, was also left alone, at times, during her labour. She describes, at length, how she felt during her labour and what she experienced with her midwife following her birth.

> I gave birth probably in four or five hours after I arrived the hospital. On arrival, it (the cervix) was already [dilated to] seven or eight centimetres. I had the same midwife through my labour and birth. I had not met her before. She was nice. She put the monitor on me and came to see me often. 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 five 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 how helpful the midwife might have been in practice, the resulting relationship Uta experienced was one of insecurity. 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 delivered 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 experienced disconnection from the relationship with the midwife to whom she felt she once belonged. The feelings of being known and recognised bring about a sense of security (Keegan, 2014). Conversely, the lack of recognition as an individual enhances feelings of anxiety and isolation. It seemed Uta's desire to make a connection with the midwife was not reciprocal, and that hurt her heart. She did not feel valued in the care and in the relationship with the midwife.

Uta could have asked the midwife to stay with her during labour and talked about her birth when she saw the midwife during her hospital stay, but she did not. In the new relationship, she was not ready to talk to the midwife openly, and their relational distance had not been resolved even after sharing a birth experience. Uta exchanged words and interacted with the midwife, but she did not obtain the sense that they shared their feelings—心が通う (*kokoro-ga-kayou*: *kokoro* means hearts and *kayou* means commuting in the Japanese language). That is, Uta did not feel she was communicating with her heart or developing an empathetic relationship. In other words, this experience of the relationship did not involve an emotional connection of their hearts. The continuous feeling of unconnectedness to the midwife did not allow Uta to open up herself to the midwife. Equally, she might have felt that the midwife's heart was not opened towards her. Relationship is reciprocal. When the midwife physically and emotionally stayed away from Uta, Uta lost the courage to approach the midwife and thus, could never feel a connection in the relationship. When Uta needed support after birth, she had already lost the relationship to which she could belong. The woman–midwife relationship disappointed her at a time when she wanted to be feeling the joy and relief of childbirth.

For these women—Maya, Shizu, and Uta—the midwife relationship was, first and foremost, a human relationship before it was a relationship with a health professional. They felt lonely and isolated in the relationship without any personal or emotional connection. A relationship with a stranger is like a relationship without a relation. Relating-to is *being known*, and it occurs through *being there* (Keegan, 2014). The women experienced the distress of being unknown and unremembered in the relationship. It was difficult to relate to midwives who were not always present. The women's feelings of insecurity prevented them from connecting closely and emotionally with the midwives, even though the midwives were helpful and delivered their babies safely. The women wanted to connect with their midwives through knowing, understanding, and remembering each other. Nevertheless, although they were in relation, the women were not able

to feel a connection to their midwives. This emotional and corporeal distance in the relationship caused a great feeling of insecurity in the women's minds.

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. For example, Uta's feeling of insecurity, as presented in the previous section, was further exacerbated by her experiences with other midwives. Similarly, Orie, as an anxious first-time mother, had a 'shocking' experience with a midwife. Both women describe their experiences of being scolded by midwives. Uta states:

> One midwife explained everything, such as how to use the nursing room and how to wash the nipples of the bottles, on the way to my room from the delivery room after my birth. I heard everything, and I thought I needed to pre-wash the nipples after using them. But it seemed I had to wash them properly with soap for the next person. I found that out on the day or the day before I left the hospital. I apologised, 'So sorry.' I felt sorry for other babies and even my baby was one of the victims. Then I got scolded with silence. I said to a midwife, 'I am sorry. I thought this, so I didn't wash them properly.' Then she sighed, 'Ahh [with disappointment]' and left. I can't forget the stern look on the midwife's face. It didn't have any warmth. That was the hardest point. Also, my baby cried in the middle of night, and I took him to the nursing room because there were other mothers in my room, then no midwife spoke to me. I didn't know what to do and felt insecure.

Orie describes her experience during her hospital stay following birth.

> [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 was crying after birth. I still remember an event because it had a strong impact. 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. She might not have meant it that way, but I cannot forget that. 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. It was not a happy stay in the hospital. I was unsure of myself with whatever I did while taking care of my first baby because I had this shocking experience.

Uta and Orie began developing feelings of hopelessness through their interactions with the midwives. They felt no one was there to help them in their care environment at the starting point

of their parenting. Being scolded and neglected by the midwives, who were supposed to help them, deeply hurt the women and produced a sense of loneliness. They were disappointed in the midwives and, at times, even felt they were unworthy of being cared for and undeserving of being treated kindly. Over time, through such experiences, the women learned how to read each midwife's face and mood within a temporary and fragmented relationship. They understood how their midwives affected their care. Even if they did not want relationships with midwives, it was difficult to avoid the relationships in the hospital space where 'care' must be provided for them. They felt vulnerable, and their energy and attention were directed towards how to survive the midwife relationship in order to protect themselves and receive the basic care. This woman–midwife relationship that lacked a humanistic and caring attitude discouraged the women.

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. 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. These relationships brought about feelings of hopelessness towards the midwives and made the women aware of their own helplessness. The midwife relationship the women experienced made them feel as if they could not do anything right for their babies. The women lost confidence in their abilities as mothers. Additionally, the women lost the courage to ask for help when they needed it and thus, the opportunity to learn new skills from midwives. Their unsatisfactory interactions with the midwives prevented them from embracing their new role as mother and made them feel that they would not be able to perform that role well. This sense of helplessness and loss of self-confidence has been shown to have adverse impacts on maternal self-esteem and self-efficacy (Maehara & Mori, 2005; H. Sasaki, Goto, Yabe, & Yasumura, 2010). That is, the woman–midwife relationship they experienced had the potential to negatively affect their state of mind as new mothers.

Similarly, another mother, Hana, also felt helpless at the very beginning of her mothering experience.

> At the first birth, 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 table, and my baby just born was sleeping in a basket next to me. Suddenly there were no midwives or doctors in the room. Only my baby and I were there. My legs were kept opened. I was really in such a posture. Then he (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 table and hold him while my legs were opened. When my baby was born, the midwife let me hold him once quickly, and put him there. 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. I would feel sorry if my daughters had to experience that cold feeling I felt at that birth [in the future].

Being left alone, with her legs apart and not being allowed 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 as she could not do anything for her baby in that situation. Hana felt she was not even allowed to close her legs on the delivery table. 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 from her autonomy. Her words imply just how traumatic the experience was for her. Nonetheless, it was nearly certain that the midwife meant no harm when she left Hana alone in this way. 'Wait a minute' could be among the most common words spoken by midwives in busy maternity care settings. There was a huge emotional gap between the midwife who uttered these words on a daily basis and Hana who felt almost tortured by the situation. At the very least, Hana's dignity was damaged by this experience.

Hana's experience was the result of the care (or lack thereof), and the care was a consequence of the interactions between her and the midwife (Y. Noguchi, 2002). However, this reciprocal interaction did not mean that they equally contributed to the care. Rather, Hana was physically and psychologically placed under the control of the midwife. It was this hierarchal relationship that produced a sense of helplessness in the situation described in Hana's excerpt above. Y. Noguchi (2002) argued that mutual understanding is a necessary element of a quality relationship; yet, in this experience, neither Hana nor the midwife understood each other or shared their feelings. Hana and the midwife were in relation, but they were physically and emotionally separated. As a result, the midwife relationship left Hana devastated and feeling hopeless.

Uta, Orie, and Hana described the sense of helplessness and hopelessness that marked the beginning of their motherhood due to their negative experiences with the 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. The thermal expressions they used, such as 'no warmth' (Uta), 'frozen heart' (Orie), and 'cold feeling' (Hana), 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 (van Manen, 2016b). 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. Atmosphere is also how one is present to another (van Manen, 2016b). The midwives were present to these women in a way that gave them a sense of coldness, helplessness, and deprivation. The atmosphere they experienced and described represented the disconnected nature of their relationship with the midwives.

Alienation

In addition to feelings of insecurity, hopelessness, and helplessness, the women felt isolated and alienated in their relationships with their midwives. For Juri and Rena, the experience of alienation was traumatic insofar as it negatively characterised their entire experience of pregnancy or childbirth. Juri, a first-time mother, speaks of her experience with a midwife during her labour.

> The pain was unbelievably intense. I couldn't even call anyone. I may be selfish, but no one came around to check on me. I suffered for probably three 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 me. She said, 'I am sorry to leave you alone. We had births back to back.' She also told me, 'Good. Your labour is proceeding. You may give birth today.' 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 use of 'losing ticket' and her sense that she had 'not met a midwife' clearly imply that she did not get what she had expected from the midwives she encountered. 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. She felt alienated from the care environment in the situation she was giving birth. Human beings seek to experience the other; that is, they seek meaningfulness in their relationship to others (van Manen, 2016a). 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.

Juri did not feel she deserved good care and concludes her experience as an unlucky event. She even blames herself. However, these expressions convey an anger underlying the experience. More specifically, Juri may have tried to hide or repress her anger by convincing herself that this is what giving birth is like. Japanese tend to restrain their anger to others, and their anger expressions are often nonverbal, implicit, or none (Kino, 2000). Emotional and offensive attitudes are the least expression styles among them. Moreover, humans cannot consciously capture their anger while they are angry, and the anger has already changed and dissipated when they reflect on the experience because it is already recollective (van Manen, 2016a). Juri's feelings could be

directed outside or at the midwife, but she has held the feelings within herself regardless of whether or not she is aware of that. Consequently, the traumatic experience does not heal and stays within her. This relationship made her feel abandoned and alienated in her birthing care.

The memory of encounter and interaction with midwives is more obscure for Rena.

> I guess I saw midwives, but I could not tell who the midwives were. I couldn't distinguish them from nurses. I did not know the differences between nurses and midwives. They looked the same, and they were different each time. One took my urine, another one measured me, and so on. It was an assembly line indeed. I did not see anyone who I could talk to. After checking weight, blood pressure, and urine, I was called into the doctor's consulting room. But I did not know what to talk in five or ten minutes. I really don't remember what kind of people were there. No memory at all. I just remember an unpleasant feeling from the doctor who didn't look me in the eye. He said, 'You are pregnant. Do this next' in a business tone. I felt I should have not been delighted by being pregnant.
>
> I always dreamed of being a mother. I was excited and had thought about how wonderful it would be. But there was a huge gap between the feelings and the atmosphere of the clinic. It was so quiet while I was waiting. They had a new electric machine. I sat on it and it moved and opened my legs automatically. A male doctor was behind the curtain. It was the first time that I had ever been to the obstetrics and gynaecology. Everything was new to me. So, I thought, 'What?' 'Really?' 'Is this the way?' rather than feeling happy. I was also shocked at myself that I did not know anything about childbirth although I really looked forward to being a mother. So, I had kept feeling somehow, 'This may not be a place for me.' I went there only for six months but I felt depressed every time.

Rena's experiences cast a dark cloud over her maternity experience. Although her journey to becoming a mother was supposed to be full of happiness, confidence, and caring support, it turned into a series of negative experiences. In the care environment, where the midwives prioritised the relationship with technology, Rena became a part of things, like a part of an electric chair or a machine on a conveyer belt. Not only did she feel alienated from the surrounding people in the space, she also experienced alienation from her own body. She was treated as an object, as if she did not have human emotions or feelings, and this meant that her being was denied. Her feeling of alienation from the people who provided the technology or care was inevitable in such a situation, especially since they also seemed to lack any feelings—much like machines. Rene was separated from her own body and the world, including the midwives and doctors, during her antenatal care. There was no way that she could feel a connection with someone during this experience.

Consequently, these negative experiences led her to feel that she knew nothing about childbirth. She felt disempowered and undermined by all that was shaping her experience. Indeed, the only

thing she could think about was that she needed antenatal care but that this was not the right place for her. Belonging is a product of a particular relationship between people (Miller, 2006). The institutionalised relationship with the midwives of the clinic brought about a sense of alienation that did not allow her to belong to anyone and anywhere. Her feeling of rejection was a natural reaction, causing her great reluctance to belong to the place and to enter into a relationship.

The complexity of these situations is reflected in the comments by Juri and Rena which convey that they had not met nor could they remember a midwife, although midwives were involved in their experiences. In fact, their relationship with midwives shaped a significant part of their consequential experiences. This would mean that the experience of the midwives is not worth remembering, or they do not even want to remember it. van Manen (2016b) asserted that in the field of education, when teachers fail to *be* what they should be, they are not at all genuinely present to their students. He added that in those cases, something essential is absent from the teachers' presence despite their being physically present. In a similar manner, the midwives here failed to be genuinely present to these women, although their physical presence was undeniable. 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 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.

Uta remembers midwives; however, her experiences with them relate to a lack of essential being of midwives.

> I still don't know if midwives' work is the same as doctors'. I was afraid of them 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 received my maternal handbook and showed me only her back during the antenatal care. She was deciding the next appointment or something and 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 just wanted one person who could do that for me. This needed to be neither a midwife nor a doctor. If there was one person who had that role, I didn't need to expect so much from midwives. I wish I had someone somewhere. I didn't know the difference between nurses and midwives, either. I really couldn't ask small things to them. If I didn't ask there, I would never get answers, so I should have asked them. But it depended on people indeed. 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, even if I didn't ask them.

Uta struggled with meeting someone with whom she could have a meaningful relationship during her maternity. Her story indicates that she felt no one had helped her in the hospital. Midwives

had been among the professionals who would have occupied this role; but she was at a loss to meet even one midwife who engaged with her in a convincing manner. Uta was afraid of the midwives she met. She felt alienated by those who turned their backs, never paying her full attention, even during her care. These experiences were definitely not what she expected from people called midwives. There was neither comfort and encouragement nor empowerment in her experience with the midwives. She was confused about who they were, and she 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 did not help, but rather hurt, her. Yet, Uta still expected their help because she needed caring support in the transition of becoming a mother. After all, she could not find anyone to care for her in that way; she was left alone without help in her care. She could never be empowered to be a confident mother in this experience—in a midwife relationship full of insecurity.

Ambiguous existence of midwives made these women's experiences traumatic. The midwives did not exist in a way whereby the women felt the midwives' role was substantial. In other words, the midwives were ineffectual and sometimes harmful in terms of providing quality maternity care. This estranged the women from their midwives and enhanced their sense of alienation. At the same time, this way of being a midwife and the women's negative feelings were related to the care system. Juri believes that she drew a losing lottery ticket, but she might well have had a similar experience with any of the midwives at the hospital due to the nature and mechanism of the care system. Rena, too, would likely have experienced similar feelings with any of the midwives given the humiliation of that dreadful machine and her sense that she was riding on a maternity care conveyor belt. Uta was also on an assembly line of care which did not allow her to genuinely interact with each midwife. Their experiences of the midwife relationship were hugely influenced by the care system they entered.

Another implicative meaning of 'alienation' is the phenomenon that sees humans becoming ruled by what they made for purposes other than the original purpose (Harvey, 2014). In such situations, people lose the meaning of being themselves. The technology and care system the women experienced here were produced by humans in order to improve care. However, the women and midwives were negatively and unknowingly dominated by the care environment. The technology, care system, and midwives that should have been made for women, instead alienated the women. The care system did not place importance on a humanistic relationship, and the women struggled with seeking and making a connection. The experiences of the women did not occur in isolation; they were always being shaped by the things, people, space, and time in which they lived.

As the relationship is always reciprocal, the midwives' lived experiences are co-constitutive with the women's experiences. In terms of fragmented care, midwives may have also experienced alienation as workers in the modern healthcare system. In the following section, I explore the participant midwives' experiences in order to seek other sides of the woman–midwife relationship, including the kinds of circumstances that surround the resulting relationships.

Compromising a way of being a midwife

The midwives of this study also expressed difficulties in having a relationship with the women for whom they cared. Aiko, a midwife in the third year of her career, works shifts at a hospital. She talks about the first meeting experience with women from a midwife's point of view.

> I seldom see patients during their pregnancy. So, I meet most of them at birth for the first time by saying, 'Nice to meet you.' I tend to see how their labour is going rather than their impression or characters at the time. I focus on seeing 'how the pain is' and 'how soon or far to give birth.' Senior colleagues often say, 'Then, it is important how you interact with the patients.' So, I try to stay with them as much as possible and gather information such as how they cope with the pain and their personality. I sometimes have to look after three people in labour at the same time. I would like to be with them, but I tend to stay with the closest one to the delivery. I feel sorry for them.

In the excerpt above, Aiko expresses frustration for the fact that she cannot be with women during their labour, and the care has already exerted a negative influence on her relationship with the women. She considers women's personality only when she has time because she must first assess the women's clinical condition. When attending only to a woman's clinical condition, her interest always comes a distant second. As a result, she lacks interest in the individual women for whom she cares. Yet, if she was in a relationship that sought to empower the woman, she could not help but see the woman as a unique and whole human being (van Manen, 2016b). Furthermore, when people want to know a person, they are interested in that person's life history and direction in life because the temporal dimensions of past, present, and future forms how the person carries herself (van Manen, 2016a). Aiko is not allowed to see each woman in these ways. Instead, she is likely to "group, sort, sift, measure, manage, and respond to" women in preconceived and processing ways (van Manen, 2016b, p. 25). In this relationship, there is a danger of passing over each woman's uniqueness, and the women she cares for will never feel a genuine connection to her because she cannot deeply understand them.

In front of Aiko, childbearing women become 'patients'—as she calls them. Due to limited time and contact, she cannot see the whole picture of a woman's maternity life journey, including the woman's personal background, history, and beliefs; and she grasps one-time information to provide immediate solutions. In such a context, it is difficult for her to see women as human beings who are transforming into mothers and creating a new way of life and family. Therefore,

the women become patients who face tense clinical issues rather than experiencing a normal life event. The overall atmosphere and environment of the medical hospital might have made Aiko think this way as well. In fact, even though all the women (discussed above) were in the state of normal pregnancy and childbirth, they were forced to be very patient and face difficulties during their care.

The woman–midwife relationship is also shaped by a medical foundational knowledge. It becomes natural for Aiko to feel she must provide technical skills and technology before developing a human relationship with each woman. She has to be the skilled expert who provides clinical skills to the women rather than being in relation with the women. Building good relationships with their clients is important for other healthcare providers, too, but if her relationship with childbearing women is the same as the relationship between patient and medical staff, it is difficult for Aiko to feel her value as a midwife. Such a woman–midwife relationship loses its meaning. The lack of time and interactions with each woman compromises Aiko's midwifery identity which would see her supporting women as individuals.

The encounter to each woman is also short for Yuki and Noriko. They detail their regular working life. Yuki has worked for two decades in a hospital, and Noriko is a first-year midwife. Yuki starts:

> We call it 'functional modality.' Some take care of admitted pregnant women, some are in charge of birth, some provide postnatal care, and we have a midwife in charge of instructions. The midwife calls in all the mothers who haven't had guidance before returning babies to the mothers. The staff at the ward and at the outpatient (antenatal care) are separated. I have focused on only birth (care). Basically, we say, 'Nice to meet you.' 'Congratulations' and finish at birth. Because if there are other women in labour, we have to go there. Even if we visit women's room after birth, if the timing is not good, we can't see them, and we will never see them again. If you are working in such a system, you have no choice but to do so. It is difficult to build a relationship with women for sure. I have been working in this style for a quite long time, so I probably know the point to provide care. For example, I am good at involving their families to help women. But because the time passes so quickly, I sometimes don't get a chance to talk much to women.

Noriko struggles more with the style of care described by Yuki.

> There are only two of us and I must collect information of 16 people when it is full and keep tabs on them. I basically see all mothers I have to take care of on the day. Yet, I can't help but spend time for mothers having difficulties breastfeeding. So, I barely spend much time for breastfeeding guidance for multiparas and mothers spending time with babies in their own room. I check on them at least once a day, but you cannot spend time with each mother. Senior colleagues tell me that I would never finish my work unless I check the time and decide when to leave each mother. I spend so little time for each woman, so I wonder if I have been able to listen to mothers. I have to leave once the baby

> latches on, although I think they need more help to latch on better. Even if I would like to give myself time to take care of them, for example, for breastfeeding guidance, I probably do not have time to be with them from the beginning to the end for one breastfeeding. At the beginning, I had maintained what I did as a student. I stayed with one person for a long time. I think that allowed for good communication. Now I turned my focus on seeing everyone. I don't mean that I make light of women, but I feel sorry and wish I can listen to them more. I would like to do more for women, but I cannot. This is my dilemma.

The lack of connection with women has become taken for granted in Yuki and Noriko's daily work style as a midwife. They always have no time and cannot be with each woman. Giving time shows respect for women and acknowledges their needs (Richards, 2017). When midwives cannot give women time, it is difficult to show respect as well as understand and respond to women's needs. Moreover, "an empathic presence is given in the form of joining or being with the other" (Rosan, 2012, p. 131). No matter whether midwives are experienced or kind, it is highly challenging to be emotionally present to women in the limited time allotted. They almost lose the way to be a midwife who genuinely respects and supports women. Consequently, women and midwives are separated and can never feel a real connection.

The midwives' relationship with the women for whom they care is solely determined by the hospital's priority of providing efficient care. Being 'in charge of' something and providing instruction, guidance, and routine care, rather than being with women, are how it works if they are to complete their assigned tasks within the system. They know such task-oriented care makes it difficult to listen to the women. Even if they know the importance of staying at the women's side, the system simply does not allow it. They are frustrated and unsatisfied with not being with each woman. When no connection with women is taken for granted in their work style, this way of being a midwife defines these midwives' identity. In fact, an experienced midwife, Yuki is resigned to, or has accepted, this situation rather than feeling frustrated. Identity is shaped by one's relationship with others (van Manen, 2014). Midwives shape who they are and how they act through their relationship with the women in front of them. Despite their concerns, they have actually chosen to work in this way, and leaving women alone is what they do. For these midwives, to prioritise completing their multi-task assignment over the needs of the women is how to *be* a midwife in the given world.

Being in this way, they may somehow feel a sense of accomplishment when they complete their tasks on the shift and can justify their work as long as the women have safely given birth and left the hospital. By compromising their way of being, they allow themselves to be that sort of midwife in the relationship with women; and therefore, somehow survive in the relationship. However, they may lose hope while working in that way. van Manen (2016b) maintained that "the language of outcomes, delivery, assessment, inputs, consumer satisfaction is a disembodied

language of hope" (p. 83). The midwives themselves perform and act out an industrial model of care by using such language. He added, "To hope is to believe in possibilities" (van Manen, 2016b, p. 83). The women who encounter these midwives will be placed in a relationship with a lack of hope and trust in their potential. In fact, the women of this study felt hopeless and helpless in the relationship with busy midwives providing impersonal care caused by a care system that compromises their way of relating to women.

Despair of a midwife

Hitomi seems further frustrated with her experience with the women she cares for due to her complex work environment. She literally takes care of patients in a mixed-patient ward of a hospital while caring for childbearing women.

> I have taken care of both a patient who die and women in labour on the same shift many times. When I see someone passing away on one side and someone born on the other side, I think, 'The door of the heaven is now opened [both for the patient and the baby].' On the mixed-patient ward, we recognise that birth and death happen almost at the same time. I cannot switch my feelings so easily and cannot be emotionally involved in either side. So, I kill my feelings and see both birth and death. Otherwise, I cannot respond to the situation. It is not something you get used to it. You just try not to face it and wait for the time passed. I organise things properly on the surface, but I have to shut down my heart to keep myself working. I take care of both with respect, but I deal with it as an operation. It may be cold, but I cannot survive there. I cannot be happy at birth just after seeing a dying patient. I want to be happy from the heart with birthing women but it's impossible. I can't.

Hitomi and the women she cares for are emotionally separated in this situation. Empathy is a significant way of communication that childbearing women value, as it demonstrates respectful maternity care (Shakibazadeh et al., 2018). Earlier in this chapter, the women talked about the cold feelings they felt from midwives and the overall atmosphere. Hitomi is aware that she may be cold as a midwife, but it is her way to survive in context. When Hitomi has to close her heart and suppress her feelings, she limits the care and emotional connection she can develop with each woman. She feels undermined as a midwife. At the same time, self-preservation is a natural consequence because caring for a dying patient alone, already involves many difficulties (Curcio, 2017). She struggles with her identity as a midwife in this complex circumstance and is never satisfied with how she acts as a midwife. Nonetheless, she still feels that this is the model of relationality that she must negotiate given the nature of this system.

Hitomi even despairs of no connection with childbearing women. "Burnout is not necessarily a symptom of excessive effort or being overworked. It is the condition of no longer knowing why we are doing what we are doing. Burnout is the evidence of hopelessness" (van Manen, 2016b, p. 84). Without an empathic connection or meaningful relationship with the women in their care,

Hitomi, and midwives like her, cannot find hope in what they do and may lose the meaning behind being a midwife. Childbearing women perceive midwives' work-related psychological distress as a barrier to receiving high-quality care because their distress can manifest in various ways, such as being rushed, providing poor communication, or exhibiting a lack of compassion (Pezaro, Pearce, & Bailey, 2019). As long as a woman and a midwife are relating to one another, they cannot avoid such reciprocal influences, both positive and negative.

'We should but we cannot' is perhaps the midwives' most frequent claim in this chapter. Although they accept the situation, they are frustrated and confused because they think that it is not the right way. The participant women in this chapter were disempowered and undermined by this way of being a midwife. Midwives unconsciously shape the experiences of women by choosing to, being forced, or adapting to the systematic, impersonal work style required by the system. Ironically, the midwives are also disempowered and undermined by this relationship they create. Even if midwives became used to being a midwife in this way, the women in their care will still be isolated, and the woman–midwife relationship will continue to be too discouraging to empower anyone. Both the women and the midwives hope to build a good relationship and emotionally connect to one another. Nevertheless, there is a real struggle with obtaining a satisfying relationship.

Women's vulnerability and desire for positive relationships

In this chapter, all of the participants struggled in their woman–midwife relationship. The resulting relationships were unsatisfactory, but they all had hope and tried to develop a good woman–midwife relationship. They struggled because they wanted better experiences with their women or midwives, even if it could not be achieved. Two mothers, Shizu and Chika, describe the actions they took to develop a better relationship, and their wishes about what kind of relationship they want to have with midwives the next time to give birth. First, they illustrate the actual relationship they experienced; in particular, how they acted in the relationship with their midwives. Shizu states:

> I struggled with finding a hospital to give birth because I moved during my pregnancy. Only the hospital I gave birth said, 'You can come anytime.' That's how a big hospital works. Anyone can go, but they 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 [no to disturb busy midwives].

Chika describes:

> During my pregnancy, I thought this midwife knew less than me, this one had a different opinion from mine, and that one didn't use honorific (respective) language, but I couldn't think like that after birth. I got confused and had no idea after birth. I was desperate for any help, so I wasn't picky [about midwives]. I wanted to talk to and learn from them.

> Actually, I was almost going to warn the midwife who didn't use honorific language at antenatal care. She was obviously younger than me, so I thought I should have told her not to talk like friends. I talked with my husband about that too, but we thought we shouldn't because she might take care of me after birth. Then she actually did. She helped me a lot after birth. It was good that we didn't have awkward atmosphere by me warning her way of talking. I didn't tell her, but I still think she should use honorific language. Generally, I thank them that they took care of me and helped me. I take my hat off to midwives for their expertise. I thought they were great, and I was impressed with them. But, after all, midwives of a big hospital are midwives of an organisation and their knowledge is based on modern medicine.

Shizu and Chika recognised their vulnerability in terms of their relationship with midwives. The hospitals provided maternity care for them, and they needed help from midwives. They felt vulnerable and were silenced, as if these conditions defined how their relationship should be. They worried about themselves as beings that needed to be helped by the midwives and perceived how they should act in the presence of the midwives in this relationship. Perhaps, they tried to be a nice person. They had unconsciously felt pressure from the midwives they encountered. They wanted a good relationship with their midwives because they wanted good care. They also 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. They realised that they could not feel a connection and build a good relationship without being themselves.

Shizu and Chika were more concerned about being modest and nice than being themselves in the midwife relationship. They carefully watched midwives' attitudes and were not always happy about how they were treated. However, the difference in standing position was a barrier for these women to express what they thought or behave as they wanted. Shizu wanted to be cared for as an individual person and to communicate with midwives. Chika wanted a midwife to show her respect, and she was eager for midwives' help. No matter how properly the midwives performed their duties, these actions could not evoke the emotional connection the women expected and desired. Creating such feelings through their care and attitudes seemed to them to be beyond the routine care that the midwives provided them as professionals. Similar to the other participants, who looked for a meaningful relationship with their midwives, Shizu and Chika wanted to connect warmly and reassuringly with the midwives they met.

While Shizu and Chika were resigned to their situations, they were also longing for a connection with midwives. They further expressed their wishes based on their experiences. Shizu states:

> 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.

Chika describes how she feels:

> I felt I would like to meet midwives in the community and skilled midwives who support natural ways. I saw mothers who gave birth at midwifery homes. I thought that's great when I heard they received continuous care. It also sounded like a homely atmosphere. I had to go to a different place to have breastfeeding care [from the hospital]. I wished I could have had care at the same place. Next time, I think I will be able to talk about anything if I see someone from pregnancy and I can communicate well with the midwife. I think I will feel close to the midwife who delivers my baby and I can talk to her easily.

Shizu and Chika desire to have a longer relationship and continuity of care with the same midwife. The hospital midwives' professionalism looked perfect, and they might have practiced properly, but what these women really wanted is a more direct and deeper connection with a midwife. They wanted to be understood and supported their way of being in a warm atmosphere which would enable them to be close and talk to a midwife freely and easily. The implication is that, this time, there was obvious emotional separation between these women and midwives. The women neither want to be on the assembly line care nor a fragmented service to meet each need, such as birthing or breastfeeding care. Their aspiration is to belong or connect to one person with whom they can truly feel free, close, and trust.

Although birth is an extremely important experience for every woman to become a mother, the care and care system provided are built on endurance and self-sacrifice of women like Shizu and Chika. These women's experiences represent the other side of the experiences of busy midwives. The women and midwives rarely share their feelings and experiences. Although a relationship is an integrated phenomenon between two people (Giles et al., 2012), the two sides here have different realities and are emotionally separated. Still, this *is* their woman–midwife relationship. The only hope is that Shizu and Chika have not entirely given up hope on midwives. They have not completely denied the necessities of midwives for their future maternity experiences. They still believe they can build better relationships with midwives, even though they acknowledge the place and care style may limit such possibilities.

All the women in this chapter were seeking a positive connection with a midwife in their relationship. Likewise, the midwives sought a connection with women. Where a woman and a midwife meet, there is always a woman–midwife relationship, and they are involved in an integrated experience. Human beings naturally hope that they have a meaningful relationship with others (van Manen, 2016a). Nonetheless, the participants' relationships were not what they expected; potentially even traumatic and disempowering. This means their experiences are never caused only by their own existence. All happen within the relationship with others, care systems, and many other circumstances. This context gives us insights into them being-in-the-world and

implies the phenomenon of the woman–midwife relationship is created in an intricately intertwined world.

Summary

The participants in this chapter explicitly revealed their experiences with the women–midwife relationship in Japan's institutionalised care system. The system is dominant in the current maternity care context in Japan, which means that their experiences may be considered typical in this setting. With unknown midwives, the women were nervous. They were unable to open their hearts and felt they were not in control of the situation. They were often left alone and sometimes scolded. They felt insecure, helpless, and alienated because of the emotional separation from their midwives. Without a humanistic relationship, the women lost confidence in themselves as mothers. There was an obvious lack of connection between these women and midwives. Their midwives were essentially absent and unable to support the women in any real sense due to the task-oriented work environment. In such a situation, the woman and her midwife would not share their experiences.

These situations, in which the midwives are unable to give their full attention to each woman and touch her heart, breed only technocratic acts (van Manen, 2016b). The participant midwives are well aware of this situation but believe that it cannot be helped. While they see themselves as ostensibly midwives, they are dissatisfied with the way in which they must play this role. This dissatisfaction undermines their sense of self and causes them to struggle with their own identity as midwives. However, the participant women had deeply unsatisfying and traumatic experiences due to the ambiguous role of the midwives. Placing value on the human relationship between woman and midwife is impossible under such circumstances. The women in this study generally put up with such care without complaining, but their experiences have remained deep within their hearts. Both women and midwives struggled in their relationships. Yet, both still wanted to develop an emotional connection and could not stop seeking it, as the relationship is always there. In the next chapter, the experiences of women and midwives who do, in fact, feel a connection are presented, and what allows them to connect is examined.

Chapter Seven: Being Present

In the previous chapter, a number of women and midwives who participated in this study reported that they had felt no connection with one another and that both struggled with their relationality due to the ambiguous being of the midwives. However, as opposed to the women who felt part of an assembly line of care, other participants in the study reported a strong and satisfying connection. Some of these women describe their experience as 'the midwife was always there for me.' That is, the women and their midwives were genuinely present to one another, both physically and emotionally, sharing each moment of their experiences.

When a woman and a midwife feel truly present to each other, they begin working together and sharing something in a very real way. As explored in the previous chapter, the relationship does not occur simply by being in the same space at the same time. To feel that they are truly together, more is required. Spending time together can be an important entry to being present by making it easier to *be* in each other's world. Furthermore, when the two parties share time on a deeper level, the experience will generate more interaction, enabling richer two-way communication and a harmonious relationship rather than simply spending time together. The resulting relationship allows the women and their midwives to be present and connect with one another. This chapter explores the data that shows participants' experience of presence in the woman–midwife relationship and examines what the sharing of time and space makes possible.

Sharing time and space

In Japan, the time women spend with midwives is often short; in spite of this, a few participants developed a connection during that limited time. For example, Tae talks about her memorable experience with a midwife in a busy hospital.

> My son was born without fingers and toes. He has some fingers, but some stick to each other and some are half. At a pre-school, I was hurt very much by what one kid innocently said to him. I was not going to say anything about that when I went to the hospital, but I couldn't stop my tears once I saw one midwife. She must have been busy, but she prepared a room for me and listened to my story. A lot happened to me but that became the biggest support for me. Since then, I hadn't had a chance to see her. We (my son and I) regularly go to the NICU, but I don't go to the obstetric department anymore. So, I didn't see her. But we happened to pass each other when I went to the hospital the other day. Once I saw her face, I recognised her. But I thought she could never remember me because there are so many patients and she had worked there so long. She was also talking with someone and I couldn't interrupt them. So, I was going through there with my son and slightly bowed to her. Then she remembered me and waved at me. I was deeply

> touched by that. She sees many people and we talked almost four years ago. I thought it's an incredible job. I was struck by that.

Tae experienced deep relief and connection with the midwife in a limited time and acknowledges the midwife's quality of presence in the time and space that she gives only to Tae. The midwife may have said something supportive to Tae, but the important component of her story is that she was happy about sharing time and space together, and being listened to by the midwife. The time and space had a depth and quality that other participants did not experience and, hence, they did not feel a connection in the woman–midwife relationship. Sharing time is a purposeful action, and people need to make the effort and be willing to commit for it to occur (McDonald, 2017). Being present, in a true sense, requires the whole of one's self (Stockmann, 2018). The midwife's giving of time and space to Tae demonstrated the midwife's commitment to her; moreover, the midwife devoted herself solely to Tae during that time. As a result, Tae felt cared for and valued. The full presence of the midwife made their time together meaningful; Tae felt the sharing of time with the midwife rather than just receiving care from her.

It was the quality of time spent together, not the length, that allowed Tae to freely express her feelings. Humans need to be open in order to be present (Stockmann, 2018). By being herself, Tae was also able to be present in the relationship. Moreover, being remembered all those years later by the midwife, even without exchanging words, enhanced Tae's feeling that she was present in the midwife's mind—rooted in the meaningful time they had shared years before. The strong feelings evoked by her shared time with the midwife continued to encourage and empower Tae long after that moment had taken place. The midwife's commitment changed the quality of time and space in the woman–midwife relationship.

Another first-time mother, Naomi, emphasises the significance of the time and space of the midwifery home. Naomi describes her experience there with her midwife.

> The stay at the midwifery home after the birth was great. Every meal was so delicious, and I was healed by the meals. Also, the midwife took a great care of breastfeeding and taught me how to do it. I was also able to relax and talk about how I was and what I thought during the labour while she gave me a massage. The time was so nice. I talked about something inside of myself during the labour. The time was so special for me, and I was very satisfied. The birth was also great. When I left the midwifery home, I was ready to go home and excited. I wondered how it would go.
>
> She (the midwife) is like the sun to me. She shines on us whenever something happens. I always thought she was definitely like a sun. She is also trustworthy. If I get pregnant again, I will give birth at her place absolutely. Homebirth would be good, but I like midwifery home after all. I wish I could stay at the midwifery home again. It a soothing place. I think whether or not you can spend such time at such place through your pregnancy, birth, and after birth makes a difference.

Izumi, a self-employed midwife who runs a midwifery home, also describes the woman–midwife relationship in her midwifery home in relation to time.

> I associate with them for one and half years and it is like a training camp for a week after the birth. The birth and staying together at my home make us close. I guess that's why mothers think they can come to my midwifery home if anything happens.

Naomi praises the midwifery home because the time she spent there was 'great.' Time felt rich and dense for her because she felt deeply cared for by her midwife. The midwife was fully present, concentrating exclusively on Naomi and spending time together. Naomi prefers giving birth in the midwifery home to giving birth in her own home. In a way, the midwifery home might have a greater capacity to deepen the woman–midwife relationship because there is more time. In the medical birth facilities, midwives are often too busy to be with women and have to prioritise many procedures and rules over women's needs. At women's homes, women can always be with their family, but midwives are not always available. The midwifery home, especially a Japanese type of midwifery home where only one or a few midwives take care of each woman almost 24 hours a day for a week, offers women a special time. Midwife Izumi's statement shows how the time shared at a midwifery home is intense, allowing for a deep connection between a woman and her midwife. It is natural for Izumi to focus on, and commit to, each woman, especially during the 'camp.' Japanese midwifery home protects the time and space only for women and midwives (and sometimes women's family members). Thus, women and midwives can be fully present to each other.

Naomi and Izumi sense the time and space as a fused phenomenon, with space experienced as time and vice versa (van Manen, 2014). For Naomi, the midwifery home had the spatial property that provides a peaceful time; the time made her feel the midwifery home as a secure place. Simultaneously, a warm atmosphere was produced in the time and space shared by Naomi and her midwife. This atmosphere deepened their relationship; meaning, they sensed the value of their relationship through this time and space. Moreover, humans experience space as mood (Smythe, Spence, & Gray, 2019). The same could be said about time. Naomi's story reveals the many positive emotions she experienced, as she used such terms as 'great,' 'relax,' 'nice,' 'special,' 'satisfied,' 'excited,' 'trustworthy,' and 'soothing.' She experienced time and space as mood, and the woman–midwife relationship she had at the midwifery home at that time was definitely positive. Thus, the sensed time and space as well as the created mood represent the woman–midwife relationship she experienced.

The mood was significantly influenced by the being of the midwife. Naomi describes her midwife as 'the sun.' The sun is warm and bright, brings a light and life by offering a sunny place to

humans. The midwife brought Naomi warmth and shined on her becoming a mother. The full attention that she received from her midwife allowed her to perceive the true presence of the midwife, as if soaking in the sunshine. This manner of presence transcends technical expertise. Naomi felt valued and understood; she was being listened to and believed that her midwife was truly interested in her and that the midwife cared for her and treated her kindly. This made her feel accepted just as she was. At the same time, Naomi also contributed to the mood, as sharing time always involves more than two people—the relationship cannot be one-way (McDonald, 2017). Their mutual interactions created their own time, space, and mood which made the situation comfortable for both Naomi and her midwife. In such time and space, she was free, open, and respected. While with her midwife, Naomi was also relaxed and relieved. However, in the end, Naomi was excited to go home with her baby, and such positive experiences would become the encouragement needed to move forward as a mother. The woman–midwife relationship empowered her.

Miho had recently become a self-employed midwife supporting homebirth. She also spoke of sharing space, and describes her experience of visiting a woman in her home.

> It is nice to visit the person's own environment. It's completely different. It is really entering into her room. I think the women become independent there with no thought. When I welcome them at the [obstetric] clinic, it is like 'Welcome to my territory' but at their home, it is the opposite. I feel I go to the place where the woman feels easy to move as she likes. That is probably the right thing. I guess she can be as she is. Also looking at someone's house is interesting. I can see what she cares for. I have not visited so many yet, but I will probably think, 'This woman folds up the laundry like this.' I guess the way of folding the laundry shows the person's life. Some may fold it up roughly and some may do it so neatly. As the person's way of being is left in the space. I think even if I don't understand that with my head, my cells would understand the information. I think I absorb the woman's information like that. So, I think it is lucky to visit the woman's space.

The woman's personal space spoke of the woman's life to Miho. Even the way of folding the laundry offered insights into the woman's uniqueness. Further, the kind of house space that was created, how it was decorated, and how tidy or messy the room was might show the woman's personality. Miho was able to see multiple aspects of the woman by entering into the woman's space. Being there enabled Miho to absorb information without words, and she would feel she was getting know the woman. In this way, Miho provides continuity of care for her women. Her embodied knowledge of each woman will be deepened by repeatedly spending time in the woman's personal space.

Home is a special place for individuals. By visiting the woman's home, Miho was able to feel and understand the substantial being of the woman. "Home is where we can *be* what *we are*" (van

Manen, 2016a, p. 102). Home is also a sanctuary where humans can feel secure and fundamentally belong (Heidegger, 1971). The being of the woman became clear in her own home, which was difficult for Miho to see in less personal medical facilities. This personal space also provided Miho and the woman with a one-to-one environment that they could have all to themselves without other concerns or responsibilities. Here, each was easily able to be present to the other.

Space influences the dynamics of the woman–midwife relationship. Miho was a guest in the woman's home, which meant it would be easier for the woman to take the initiative. At the same time, Miho was able to enhance her woman-centred perspective in the woman's private space. Smythe et al. (2016) suggested that midwives have time to focus on "what matters" (p. 31) in a home-like environment and that relationships change there. In the woman's home, Miho was able to focus on the woman and care about what mattered to the woman without worrying about institutional rules and tasks. Sharing the woman's space, as a guest, gave Miho a better opportunity to understand the woman than if they were simply sharing a neutral space. Such a condition could maximise Miho's ability as a midwife, which might well lead to a greater satisfaction with her role as a midwife.

Time and space are fundamental components of shared experiences, and they provide opportunities for women and midwives to be present to one another and deepen their relationship. As Tae experienced, women and midwives could truly be present in the relationship when the midwives commit to, listen to, and provide kind care for the women, regardless of the length of time and the type of birth facilities. In Tae's case, one of the reasons that she was given time and space was that she was crying and obviously needed help at that moment. Also, she was familiar with the faces of the midwives in the hospital because she was previously hospitalised during pregnancy for complications. In the limited time and space of busy hospitals in Japan, it might be difficult for many women who are low risk and appear to be without problems to get the midwives' attention and commitment as much as Tae did.

It seems that time and space are essential parts of forming a meaningful relationship. Women and their midwives need time and space to be present, listen to, and know each other. In Japan, nonetheless, it is not easy for midwives to be fully present to each woman while carrying out multiple tasks in busy care settings, and for women to feel their midwives' true presence. If that is the case, having the same midwife throughout antenatal, birth, and postnatal will provide women and midwives more opportunities to receive the significant gifts of sharing time and space. Sharing time and space are not simple solutions, but sufficient time could provide a base to develop the woman–midwife relationship. In fact, many of the participants' positive experiences involve a continuation of the relationship between the woman and her midwife (e.g., Naomi, Izumi, and Miho). In the following section, such extended sharing experiences are explored.

Sharing time throughout pregnancy, birth, and postpartum

Based on the experiences of participants in this study, it is anticipated that the longer the woman–midwife relationship, the deeper and stronger their connection, as the extended time offers more opportunities to be present to one another. In midwifery care, it is possible for midwives to follow a woman's maternity life journey from pregnancy through childbirth and the postpartum period. This kind of care is often regarded as one-to-one care or continuity of care. Two mothers, Hana and Orie, describe how their positive birth experiences were enhanced by sharing time with their midwives throughout pregnancy, birth, and postpartum. Hana had her own midwife for the first time for her third pregnancy.

> Only at the third birth, I had the same midwife throughout pregnancy, birth, and postnatal period. I was really assured by having the same professional. I felt someone always cared for me, and her care was warm. I felt it was different from previous experiences. I felt at ease and the communication was deeper because we had seen each other throughout a long time. The same professional took continuous care as part of my process. I enjoyed the greatness of having the same midwife continuously for the first time during the third birth. My parents live far, so it was great reassurance that I had someone I could freely talk to. And the person was a professional on top of that. In hospital, check-ups finish in a few minutes unless you have a problem. So, I didn't talk much there. I went to the hospital [for compulsory check-ups] just to confirm the safety and did not expect anything like care. Probably because I had someone like 'my midwife' [at the midwifery home].

Orie describes a similar experience during her third birth.

> The contents of the conversation I had with the midwife were different from that I did with other midwives. I finished conversation somehow with other midwives, but with this midwife, I talked about a lot of things including my son and daughter. She was different for me. During the first birth, conversations with midwives were random, temporary, and transient. Especially as a first-time mother, everything was new. I was anxious that I couldn't continue conversations from the previous ones. I didn't even know how to breastfeed and how to change nappies. I tried to ask but there was the gap between the conversations. I did not know from which point I had to explain and how much I could ask.

Hana and Orie describe their midwives as 'my midwife.' Both fully appreciated the significance of sharing time with their midwives and having the same midwife throughout the whole of their maternity experience. The depth of conversation with their midwives was especially valuable to them. They both saw significant contrast in the nature of communications between the different care systems, suggesting that 'random, temporary, and transient' conversation is characteristic of large-scale maternity care settings while communication with one's own midwife is 'deeper,' smoother, and filled with a sense of trust and safety. Ikegami and Campbell (1996) observed that

Japanese culture values being in tune with one another without the need to exchange words as a necessary part of building a relationship between health care professionals and clients. In the Japanese culture, expressing, asking, or explaining each and every detail of a process or situation is considered uncouth and uncomfortable. However, the kind of nonverbal communication that is valued is often difficult to manage in situations where care is fragmented. Thus, continuity of care in the Japanese context may help women and their midwives realise more satisfying communications that lead to enduring, reciprocal relationships.

It is natural that the woman–midwife relationship becomes more personal and holistic when the two parties communicate with one another over a period of time, such as throughout a pregnancy. Hana and Orie seemed to most appreciate the human relationship that they developed with their midwives rather than the professional expertise that the midwives provided (although this, too, was clearly important). When the women reflected on their experiences, their connection with their midwives were so strong that the midwives were fully integrated into their birth experiences. The intense events of pregnancy and birth provided an opportunity for the women to deeply connect with someone with whom they could talk freely and to whom they could comfortably open themselves. At the same time, the women needed a person who would be consistently present with them and support them during an event that potentially involves significant worries, changes, and challenges. Their special relationship with their midwives had a significant impact on their birth experiences.

Aki also felt the strong presence of her midwife while sharing time throughout her maternity journey.

> She (the midwife) was the one who always supervised me whether I was on the right track, and who played a role to redirect me when I was losing my confidence. Also, she gave me a sense of safety that I felt she was always with me and I did not give birth alone. The feeling of safety was always there. That was the biggest thing at the birth. The feeling of trust and safety. It was like everything is going to be fine with her. I felt she was there for me whenever I needed to talk to her after birth, too. I would have been reluctant to talk to someone who did not know who I was and how I had been. I wanted to talk to the midwife only because she had seen me all the way through.

Aki describes the midwife's presence as a kind of *omamori* (a Japanese charm) that encouraged and protected her throughout pregnancy, birth, and parenting. She felt her midwife was there for her, whenever she needed, and that the midwife was always on her side. The midwife's continuous and stable presence brought her deep feelings of safety and trust. Such feelings evoked a strong emotional connection between the two of them, and the relationship helped her maintain her psychological strength. Stockmann (2018) argued that the presence of a midwife who commits to the woman helps her achieve an understanding of her own being. In the continuous relationship

with her midwife, Aki was able to better understand herself, grow, and become more confident. The firm emotional support and connection to her midwife made her feel positive and strong as an expectant mother.

Getting to know each other more and more, allowed Aki to open herself to her midwife, as she came to trust her and felt secure in the relationship. Aki valued two kinds of temporality in the relationship. The first one is the temporality that forms herself, which is her temporal landscape (van Manen, 2016a). She possesses her own background and history, and she felt she could open herself only to someone who understood the personal landscape—her past, present, and future. Aki was able to open herself to her midwife because she felt understood as a complete person by her midwife who kept caring for and being with her. The second temporality is the history built between Aki and her midwife over the period of her pregnancy and birth. The well-developed relationship allowed her to be comfortable to open her heart only to the midwife. The singular relationship encompassing both of these significant temporalities was created with both parties' firm presence throughout Aki's pregnancy, birth, and postpartum period.

Time causes things to mature. The time continuously shared by the women and their midwives caused many aspects of their relationship to mature and brought about mutual understanding and trust. The relationship that developed is the comprehensive outcome of their shared time and experiences—a result that is impossible with only one-time interactions or in intermittent relationships. Care is not an act but a relationship (Yoshimura, 2009). For better care, the woman–midwife relationship needs to be satisfying for women and midwives. If the relationship is well developed over an extended time, there is the possibility to enrich the quality of care. Importantly, every woman is unique and undergoes changes through her maternity life experiences. The extended time enables a relationship that understands the woman's uniqueness and to be aware of such changes because the woman and her midwife can be steadily present and respond to changes as they emerge over a long period of time. Moreover, sharing the woman's whole maternity life journey allows midwives to see the new landscape of the woman's being and to view their relationship as if they were viewing it from the top of a mountain after making the climb. The meaning of the woman–midwife relationship can be more easily and clearly seen when the relationship develops over time. In other words, the woman–midwife relationship requires time to make the experience feel safer and more satisfactory.

Listening and being listened to

When a woman and her midwife share time and space so deeply, as to be present in a real sense, they have many opportunities or ways to connect because that time and space offer multiple possibilities (Smythe et al., 2019). Listening and being listened to is one of the significant experiences described in many of the participants' stories; they found themselves present in the

relationship while listening to or being listened to by the other. Jun is a self-employed midwife running her own midwifery home. She provides the women in her care with a comfortable space for them to stop by and talk about anything. She describes how she listens to the women there.

> A midwifery home is a place that women can visit even though they are not sick. On top of that we have professional knowledge, they can talk to us casually. The mothers [I cared for] do not need to explain each thing to me [because we have known each other]. They can get to the main point from the beginning. So, I think it is not such a hassle for them to talk about their things to me. For example, I know about women's family members, things which happened to their older children and how hard it was for them, or that a husband cheated but he supported his wife very much at birth etcetera, etcetera. I have seen and heard all about those things. So, women come to me to talk about very private issues which they cannot tell their friends and families. I think women do not want solutions for the issues from me. They just want to be listened and I would say, 'Really? It must be hard,' 'That's terrible, isn't it,' or 'You know, you are really doing so well.' I think they have already made some kinds of decisions by the time they come to my place. Then they need a bit more supportive push, or they want to confirm their decisions, and they ripen their resolutions through conversation with me.

The significance of Jun's existence, for the women she attends, is her unconditional listening. When she listens, the act involves a giving of her time, committing to the women, showing empathy, and understanding each woman as a unique person. In other words, the act of listening contains the essence of being present: being physically and emotionally available, attentive, interactive, and responsive to the woman (Stockmann, 2018). The simple act of making herself available makes the women feel that she always listens to them and affords them much comfort and relief. This becomes emotional support for the women and emotionally connects Jun to each of them.

With this way of listening, Jun focuses on being there for the women above all else. She knows that she does not need to do much, such as providing professional expertise or giving advice. When she is there for the women, by sincerely listening she is already being with them. This attitude also involves her trust in the women's ability to think about and solve their own issues. This process is a kind of Socratic way of listening, referred to as the maieutic method (Fiumara, 1995). Asking questions is stressed in the Socratic maieutic process, which aims to bring out another's thoughts. It is not clear for us how Jun asks the women questions, but she seems to naturally make the women ponder within themselves and brings out the women's feelings and thoughts through the act of listening. She encourages and empowers them as well as reassures them by her way of listening.

Jun is capable of listening in a very natural and intuitive way, but her way of listening is also deliberate. She may appear to be simply listening to the women, but this is active listening, which is a significant therapeutic communication skill (Stockmann, 2018). It involves a variety of timing

measures such as *ma* (間), which means a pause or space between words, and a fluctuation of words while the language is being spoken (Washida, 2015). Jun exquisitely follows and adjusts her breath (timing) as the women speak. This way of listening involves an openness, tolerance, and perseverance in order to continuously accept and believe in each woman. When she devotes herself to the women in these ways, they cannot help but feel her presence to them. This therapeutic use of herself would be regarded as her firm caring presence for the women (T. D. Smith, 2001).

The continuity of her relationship with the women surely helps her to communicate in this way. By repeatedly sharing time, she is increasingly able to understand the women; and the fact that she knows them, allows the women to talk to her more freely and openly. This allows her to listen to the women even more deeply. There is no doubt that Jun and each of the women deepen their trusting relationship through such an interaction of listening and being listened to.

The participant women also felt their midwives' presence by being listened to. Tae and Rena speak about their experiences of being listened to by their midwives. Tae, who was admitted to the hospital due to certain abnormal pregnancy conditions, describes her experience at that time.

> Rather than giving advice, of course the midwives gave me a lot of advice, but they listened to me and agreed with me just by saying 'Right.' I think that was the warmest thing for me. I think we sometimes want someone just to listen. I felt I was allowed to whine. When I felt depressed, I whined to midwives. I always talked to them.

Rena describes her experience in similar terms.

> The midwife listened to everything I said, and it was not like checking on the baby. She always took care of me as if saying, 'I care about *you*.' We had a lot of small and irrelevant talks. She was like my mother, indeed, and I relied on her. I didn't need to ask each small thing anymore and felt everything's going to be okay. She always gave me such a feeling of security.

Being listened to was a gift that Tae and Rena received from their midwives. People cannot really listen to another without being truly there. Thus, the women naturally felt their midwives' presence and their commitment to them when they felt listened to. At the same time, the simple act of listening showed the midwives' attentiveness and unconditional regard for them. Those midwives' attitudes made the women feel that they were at the centre of the care they were being given. The point is that being present and listening are basic elements of the woman–midwife relationship that makes the woman feel in control of her own care. The care was also administered with warmth, kindness, and safety. Consequently, their experiences of being listened to became that of being cared for and valued. Since they were filled with such feelings and found themselves

immersed in such an atmosphere, Tae was comfortable talking to the midwives about anything; and Rena felt relaxed and relieved, so much so that her worries disappeared.

Both women felt secure because they felt wholly accepted by their midwives while talking to them. There was no need for them to worry about their voices not being heard. Speaking does not always lead to being listened to (Washida, 2015). Spoken words may not always be heard, as the listener's mind may be somewhere else, the listener may disagree with what is being said, or the listener may misinterpret what she/he heard. In the women's experiences, they did not have such worries when talking to their midwives. That this was the case shows how firmly and steadily the women found themselves and their midwives present in their relationship.

The women, thus far in the chapter, always felt listened to during the time with their midwives. They were surrounded by an atmosphere that allowed them to express themselves freely and openly. While such communication between women and their midwives is significant, time and space for such communication are not always guaranteed, especially in large birth facilities in Japan. This means that it can be difficult for women and their midwives to listen to or be listened to, and thus to feel the other's presence. For example, Rika and Noriko, two midwives who work in busy hospitals, describe their communication difficulties. Rika states:

> I'm not good at communicating, so I think I need to talk more. If mothers are open, it is easy to communicate, but I feel awkward and wonder how to talk to mothers who don't talk much.

Noriko describes her relationship with various types of women.

> There are mothers whom I feel easy to talk to and who ask me a lot of questions. Those who have talked to me a lot, call me even when I look busy and rushing in the ward. I feel I have developed relationship with them. There are also quiet mothers and when the conversation fails us, it is not exactly awkward, but it's difficult. Somehow, I feel distance between us, and I don't think we relate well to each other. After all, it is by the woman's own personality rather than how much you interact. I have had a woman who I built a relationship within a short period, even I met her just before she gave birth at the second stage. Women's characters have a huge effect on the relationship. I think women who talk a lot and express what they want are easy to build a relationship because I can respond to that.

Quiet women present special difficulties for Rika and Noriko. Both find that their communication with quiet women does not go well. This suggests that it is difficult for them to build a positive relationship unless the women actively talk to them. Rika questions her professionalism and ability to communicate with women. Noriko blames the women's personality while failing to consider her own communication skills and the environment in which the women are placed. In reality, both Rika and Noriko have neither the time nor the capacity to be with or listen to the

women, at least in part because of their work environment. Hence, they unconsciously prefer a quick, efficient way of communicating or favour women who clearly and frequently express themselves. They are unable to or do not intend to listen to the women unless the women drive the conversation and actively engage with them as midwives. Gadamer (1960/2013) insisted, "belonging together always also means being able to listen to one another" (p. 301). When midwives are unable to listen to the women, they cannot truly be with the women and share their world.

In such a situation, the midwives may be required to be unilaterally active rather than being receptive or reciprocal in their communication with the women. Thus, Rika and Noriko focus on talking rather than listening. They are even frightened of not exchanging words. Listening shows openness and acceptance, which imply unconditional interest (Fiumara, 1995; Yoshimura, 2009). For this, listening may require silence while one carefully waits for another's words or allows another to take her own time. Silence is not empty conversation (Washida, 2015). Silence can be a means of vocal expression and can achieve a true conversation when it is meaningfully shared (Lagaay, 2011; van Manen, 2016b). Nevertheless, silence is almost unacceptable for Rika and Noriko. Due to their limited time with the women, they appear to be unaware that listening can be more powerful than speaking to deepen the relationship with women. Accordingly, they may lack the willingness or ability to be open, accepting, and committed to the interests of the women. In these circumstances, and with these attitudes, it is very difficult for them to be truly present to the women or be aware of the being of each woman. Such a relationship can mute the voices of the women and obscure their presence.

Two first-time mothers, Uta and Naomi, provide a glimpse of the other side of the communication issues described above. Both talk about their experiences of communicating with their midwives. First, Uta describes her hospital experience.

> I am not good at showing or telling my feelings and tend to hesitate to speak. So, it is probably difficult for midwives to understand my feelings and that's my fault. I wondered when I should have asked my concerns to midwives. It's probably my personality, and I couldn't ask them much although I had a lot of things I wanted to ask. I met different midwives each time. There were differences among them. Some were easy to talk. There were no midwives who were bad enough to complain about, but they didn't have a good way of communication, like asking, 'What do you worry about?' They treated me with a smile. But, for example, even when they checked on my baby's heartbeat, I wanted to know every single thing because it's the first time for me. They might have explained what they were going to do a little, but I wanted to ask many small things. The check-ups were short. They told me to write down what I ate for a week. So, I did and brought the paper, but they didn't care. A midwife looked at it, but she gave me no review and no instruction. She just said to keep doing that and returned it to me. I actually worked hard for the diet diary. When their way of communication was not good like that, I became anxious. I lost heart to ask them anything. Also, I hesitated to ask questions because it

> was a big hospital and there were a lot of people waiting. I often waited for a long time, so I thought I should not ask about such small things not to waste their time.

Naomi compares her communication experiences in hospital to those in the midwifery home. She makes clear the distinction.

> Because I switched from a hospital to the midwife's place, I saw the clear difference between the hospital and the midwifery home. First of all, you have to wait for 1 hour and can see a doctor for 10 minutes in the hospital, but in the midwifery home, it's the opposite. Also, even if the doctor asked me, 'Do you have any concerns?' what I replied was different within the 10-minute check-up, although he was a nice listener. Even if I had anxiety about something small, I thought I probably needed not to ask and just said, 'I am good.' Then in the conversation with the midwife (of the midwifery home), I felt I was allowed to tell her even small things. There were midwives in the hospital, but I mainly saw the doctor. I don't know what those midwives were doing there. I might have talked to them a little before talking to the doctor. But I don't remember them, indeed.

The women unconsciously sensed whether the midwives were genuinely present. More specifically, they were aware of whether the midwives were truly listening and paying attention irrespective of how nice they may have looked on the surface or how impressive their technical expertise may have been. In Uta's experience, the insufficiency of her midwives' communication was perceived as absence of attention, interest, and compassion. She felt muted, unheard, and deserted, as if the midwives were not present to her. Her experience with the midwives left her feeling neglected and unvalued.

Both Uta and Naomi directly and indirectly experienced the pressures of time in a busy hospital environment. This further discouraged them from communicating with their care providers. Their experiences appear to be the opposite of midwives Rika and Noriko. While the midwives and the women spent time together, they were rarely able to share anything meaningful. Thus, Naomi's memory of the hospital midwives is almost non-existent, which implies that the midwives were not present to her in any real sense.

Unlike Naomi, Uta remembers the midwives, which means that the midwives were somehow present in her world. However, she feels she was not present to the midwives—Uta was invisible. It is clear that this kind of relationship was not caused solely by the women's personalities. They were not able to talk because they did not feel listened to. In fact, Naomi's experience changed 180 degrees when she moved from one care setting to the other. The lack of time and invisible midwives that she experienced during her antenatal care at the hospital made her quiet and only added to her anxiety and dissatisfaction. In contrast, she was deeply reassured by her midwife at the midwifery home. A midwife's communication skills and the nature of the care system have a clear influence on the communication that takes place between a woman and her midwife.

Additionally, talking about ‘small’ things meant a lot to Uta, Naomi, and the other women described above. Small things, irrelevant topics, and private issues require intimacy between the people communicating, and need to be cared about and valued by both parties. When these small things were spoken of, the women were sure that they would be kindly received by their midwives. Thus, talking about small things represented their relationality. Fiumara (1995) argued, “Something can ‘speak’ if it is listened to” (p. 72). No matter how big or small the topic, how lively or silent the conversation, or how quiet the woman or midwife, their conversation had a significant meaning when it was listened to. Meaningful connections between a woman and her midwife can be defined by how they communicate and relate to each other (McDonald, 2017). When they are genuinely present to each other, both intend to listen to the other and feel that the other will embrace and understand what is being said. Listening and being listened to represent their interests, meaning they think of/about the other. The communication experiences of the participants reflect how they were present, and how they connected, in the woman–midwife relationship.

A sense of unity

The genuine presence and deep connection between women and midwives are also expressed as harmony in the participants’ experiences. For example, Hana experienced a sense of unity with her midwife in various ways during her labour and birth.

> I felt I had very special and precious care. She (the midwife) moved like she was harmonising with my anticipation. She had visited my house, and she knew where she could find stuff. So, she quickly brought the stuff such as cushions while my husband and children were in panic. That reassured me. That’s why I was able to focus on my birth. I really thought her hands were magic hands. Her hands were like sticking to my body. Even small touch to the back was totally different. At the peak [of contraction], when I was really suffering, her hands became one with my back and hips. That absolutely felt good. When I had a baby in an obstetric clinic, midwives came to check on me sometimes. But they took a quick look at the monitor, and said, ‘It is not yet. Okay. Good-bye’ and they were gone.

Hanna attests to the significance of feeling united with the midwife to perceive the midwife’s presence. The physical and psychological oneness Hana felt with her midwife was a product of their intimacy and togetherness, created through their continuous relationship. Their harmonious relationship may even transcend the idea of a relationship composed of individual people because the presence of the midwife seemed to disappear as she became a part of Hana in Hana’s mind. The Japanese language expresses the greatest harmony between people, including the experience of working together perfectly, as ‘matching the breath (*iki ga au*)’ (Washida, 2015). While their

breaths were in tune, Hana felt as if the midwife was almost like the air that supplied her with the necessary oxygen and energy without disturbing her world. Thus, Hana could focus on her birth.

During this harmonisation, Hana 'absolutely felt good,' 'reassured,' and comfortable, despite 'really suffering' from labour pain. This illustrates how the woman–midwife relationship can empower women during labour and birth. The closeness, comfortableness, and deep relaxation between them could not be obtained overnight. By the time of birth and during labour, Hana and her midwife had shared significant time and experiences—they understood each other. This enabled the level of unity and satisfaction that shaped the experience.

Moreover, Hana powerfully captures the contrast between continuity of care and fragmented care in terms of birthing experiences. During her homebirth, Hana felt the pleasure of the midwife's hands and worked with the midwife based on their trusting relationship. She describes this experience with words such as 'precious,' 'harmonising,' 'reassuring,' 'focus,' 'magic hands,' and 'touch.' Alternatively, Hana describes her experience in a clinic with words such as 'check on me,' 'quick look,' 'monitor,' 'good-bye' and 'gone.' These words denote distance in the relationship, quick interaction, and a sense of being left alone and unsafe. This kind of care, including the midwives' behaviour and technology, prevented Hana from feeling the midwives' presence. At the birth, meanwhile, Hana and her midwife shared a reciprocal and united moment without any distance and interference. How Hana related to a midwife changed her whole experience of childbirth. The relationship could possibly affect the safety and outcome of the birth and the following events in parenthood.

Miho, as a midwife, also talks about her experience of corporeal connection with a woman for whom she cared, and gestures towards the relationship between such an experience and the safety of birth. She recently became a self-employed midwife.

> I didn't know mothers at birth when working at the clinic. I saw that they could not open their bodies since they had not opened their heart yet. I understood that and tried to make them relax. I did my best by bringing all my skills, but I think they would never be the same as them at the birth with the midwives they really trust. Now (after becoming a self-employed midwife and providing continuity of care) I clearly see a woman changing during her pregnancy. I realise the changes only with her presence. I cannot express well with words, but it is comfortable. The birth is easier, too. I could naturally put my hands to her without any words. We were connected by skin-to-skin. How the body accepts me is completely different from the time when I touched someone for the first time.
>
> I had a fear of being a self-employed midwife, but I guess the midwife in the old days (most of them were self-employed midwives) dealt with the fear with the interrelationship and trust with women. I think I can do more things for women as an independent midwife because I can decide and practice by myself. I have to take all the responsibility, but the freedom which gives me flexibility for women is huge.

Miho's sense of grasping the being, feelings, and changes of a woman was much increased by the continuity of her relationship with the woman. Now she can concentrate on understanding the woman by fully using herself. Thus, she is able to experience the oneness with the woman through her skin, demonstrating the potential for midwives to have positive feelings in accordance with women and vice versa. The embodied sense shared between Miho and the woman made sure that all their feelings, intentions, and actions were directed towards their common goal. All that Miho experienced with the woman, such as naturally accepting each other, moving the body, and noticing small changes, probably entailed understanding the world along with the woman. This mutual embodied meaning forged a strong connection between Miho and the woman. Miho also perceived that this birth is easier compared to that of the obstetric clinic, which suggests that the deep connection might enhance the safety of birth. This recognition of safety is not based on logical or technological evidence; rather, Miho was more confident and comfortable as a result of what she shared with the woman.

Miho's experience also indicates that being autonomous allowed her to be present for the woman. A firm sense of oneself, shared rich time, and deep communication are enabled by each person's autonomous existence. That is, the positive relationship between women and midwives requires the women as they are and the midwives as they should be. Miho, thus, sought to be present to the women by leaving the birth facility and becoming a self-employed midwife. Becoming a self-employed midwife changed Miho's relationship with women as she obtained the freedom and flexibility needed to be truly present for the women. The freedom and flexibility she obtained involved more responsibility, but this responsibility is more likely to encourage her to be with the women. By changing the environment of her midwifery practice, she realised the limitations of being present for the women in the current care system facilities.

Being present for women means being with the women, and this is taken for granted in midwifery theory. However, it is not always guaranteed in Japan's current practical context. Being with women sounds simple, but presence is an interpersonal experience requiring the whole of oneself (Stockmann, 2018). In the participants' stories, positive experiences were defined by sharing time and space, listening in a real sense, paying full attention, accepting the other as a whole person, being supportive, and many other components. Furthermore, the interactions were reciprocal. The relationship between women and midwives can be developed in these deep reciprocal experiences resulting from the true presence of one another.

Timeless relationship and presence

Even if a woman and a midwife are firmly present to each other and build a good relationship, childbearing is a limited period in one's life, and the woman–midwife relationship will be over at

some point in terms of official midwifery care. However, women often remember the experience of birth and care for years afterwards. It is no surprise that the woman–midwife relationship, fostered with time and mutual understanding, can influence the woman's life or develop after the care itself. For instance, Kumi and Maya talk about their relationships with midwives after they left the care. Kumi had one midwife throughout her pregnancy and birth.

> When my child turned one year old, I sent her (the midwife) a text. She replied, 'The first year must have been quite hard, but your baby will get more and more precious and you will feel it gets easier and easier.' I was very happy with that and felt I tried very hard over the past year. I guess my family also understood that, but I felt her message was a little different from a message from my family. My midwife tells me 'Drop in anytime.' So, I am comfortable to visit her. She is a busy person. [Last time] she was just in the middle of someone's care, so I didn't talk to her much. But she was happy to see my two children and said, 'You grow up so well!' I think I will ask her a lot of things and I would like to show her our faces sometimes.

Maya gave birth at an obstetric clinic.

> I didn't feel a connection with them at all. I never saw them after the one-month check-up. I gave birth smoothly without problems. So, it seemed that that's all for midwives and doctors. I stayed there for several days and I remember them, but they would forget me. Although I chose to give birth in my neighbourhood, it was not the place where I could run to when I was suffering after birth.

The depth of the woman–midwife relationship during the care may be proportional to the women's feelings of connection to their midwives afterwards. It is easy to imagine that Kumi had an intimate interrelationship with her midwife by sharing time throughout her pregnancy, birth, and postpartum. She absolutely trusts and feels safe with the midwife, and the emotional connection has continued to sustain her. She probably feels as though her midwife is always next to her while raising her children. By contrast, the presence of the midwives has been distant for Maya after the care, although they reside in her neighbourhood. She remembers them, but that is not something that makes her feel better. Their stories suggest women and midwives are still in the woman–midwife relationship even after the care is over, regardless of merit. That is, the woman–midwife relationship is continuous, ongoing, and even timeless.

The women's lives have continued without any breaks after birth, and life stages are gradually changing. In the subsequent life stages, the midwives may not be required, but the human relationship that the woman and her midwife developed around childbirth does not suddenly vanish. Childbirth may be merely the starting point of the woman's life as a mother, but it definitely matters for her psychological well-being after birth. The participants have shown that meeting a midwife with whom the woman is able to connect, changes her birth and life experience. Midwives could truly follow the woman's life (or take care of the woman's health) only when

they developed a valuable ongoing relationship, and not just because a midwife's professional role involves taking care of women's health throughout life. Kumi and her midwife created timeless values through their intense experience of childbearing.

Izumi, a self-employed midwife, also occasionally sees the women for whom she cared. In Japan, pregnant women sometimes go back to their parents' home before birth and stay there for a few months afterwards in order to receive help from their mother and family. Izumi describes the timeless relationship with those women.

> The mothers who came back to their parents' home and gave birth at my place visit me on the Bon Festival and the New Year[2]. They call me, 'I am back at my parents' house and coming to your home.' I think, 'Please do not come on New Year's Day.' But it is actually nice and fun. The older children look forward to playing toys at my place. The mothers enjoy chatting. I guess they come to my place as if they are coming back to their parents' home.

Izumi's midwifery home is like a parents' home to go back to at seasonal occasions as well as a comfortable space for the women for whom she has cared. Women have an attachment to her; and their birthplace, as much as it can be, is considered a second home. As discussed earlier, home is a very special space beyond protecting people with a roof and walls (van Manen, 2016a). van Manen (2016a) insisted that home has "something to do with the fundamental sense of our being" (p. 102). Going home is a human's fundamental need. The women feel the connection with Izumi's midwifery home. Thus, they are coming back to her place. Like Kumi, those mothers want to see Izumi and to keep connecting with Izumi. She is like a parent for them; hence, it is natural to return to her place. Birthplaces and birth attendants have great significance for women. The bond between Izumi and each of her women is powerfully rooted into the relationship developed during the care.

Kazue and Jun are self-employed midwives. Their relationship with the women they cared for is also timeless. Kazue states:

> We have notebooks for mothers to write whatever they want to say. One person who had three children here visited me when her children grew up. They were around adolescent middle school students going through puberty and she seemed troubled. She dropped by and she said she wanted to make a photocopy of the notebook. She told me that she wanted to renew herself. Then I made a photocopy for her. I know she divorced later.

Jun describes:

[2] Two of the biggest family gathering occasions in Japan

> I received a postcard to announce house-moving from a mother who gave birth at my midwifery home. She greeted me in the card like, 'Hello. How are you? We've moved closer to you so we will visit you soon' or something like that. She had a baby with me about three years ago and she has not visited me once we finished the care. And she wrote to me, 'Please stay well forever. You are my last bastion' at the end of the card. I wondered that she might have serious issues or fraught worries. I am wondering when she would come, but she has not come yet. So, I think she is doing okay. She does not need to use the last bastion yet. Thinking of that, I guess she has lived well by herself, with family, with friends, and in the community. I say, 'Well done' to her in my heart.

Both Kazue and Jun are present for the women years after the birthing care. Although they do not often see them, these midwives remain available for women to return to when facing difficulties or important turning points in their lives. For one woman, the relationship with Kazue enabled her to reflect on the past, think of the future, and make an important decision. By meeting and talking with Kazue, the woman tried to change her perspective on life and create a fresh start for herself. Childbirth can be a significant event in terms of being reborn and a starting point of a new life for women. The woman in question might have felt the potential to be reborn in the presence of Kazue during the important turning points in her life.

Jun has not seen the woman who sent a card to her, but there is an invisible tie between them. van Manen (2016b) argued in terms of the relationship between students and teachers, "we may be physically absent from children while in a different sense they remain present in our lives after school, and we remain present to them" (p. 59). Jun is present in a similar way for the woman. She is physically absent but present in the woman's heart. This does not happen unless they built a meaningful relationship during the care. People live on in the history of their own experiences and views formed from their fusion of horizons (Gadamer, 1960/2013). This means the woman's fusion of horizons was partly built on her experiences with Jun. At her midwifery home, Jun was genuinely present to the woman; thereby, they deeply shared the woman's birth experience. The connection the woman continues to feel with Jun is based on the experience and has led to the timeless presence of Jun in the woman's life.

More specifically, the last words from the woman—'last bastion'—show how significant the existence of her midwife, Jun, is for the woman. The woman is probably doing her best in her life after becoming confident through her birth journey or time with Jun. However, if anything that she cannot handle happens, she knows she has Jun as her last bastion. The woman does not need to see Jun now or cannot see Jun often, but Jun remains as a lifesaver in the woman's mind. By reading the card from the woman, Jun also gives more than a passing thought to the woman and acknowledges the woman is living her life on her own power. The timeless connection with women like this would also encourage Jun to continue her practice.

The participants have shown that the mutual presence of women and midwives transcends mere midwifery care: it expands beyond physical time and space (Stockmann, 2018). Regardless of whether or not they have direct or physical interactions, such as sending cards and seeing each other, their emotional and spiritual connections can continue forever. The strong connection developed during a woman's birth journey is unshakable and has the potential to shape the women's psychological well-being. If this remains in their hearts and sustains them even after the care, the woman–midwife relationship can make a great difference in women's lives and families, as well as wider society. The relationship also increases midwives' satisfaction and motivation in their practice.

Summary

Women and midwives can have a strong connection that supports, protects, encourages, and empowers the women. In order to obtain such a connection, genuine presence of both parties, which requires time, space, and the reliable act of listening, is fundamental in the woman–midwife relationship. The resulting relationship also satisfies and empowers the midwives. In other words, it is difficult to feel a connection and build a positive relationship without feeling each other's presence. Being present to the other is enabled when one fully concentrates on the other and engages in the moment. The participants in this study used their whole self to commit to interactions with the other. Thus, the women were satisfied with the relationship when they had their own time and space to share with the midwives, and when they felt the midwives' full attention. Being listened to was a significant experience they felt in the midwives' presence. They sensitively felt their midwives' presence through these experiences, the midwives' attitudes, and the surrounding atmosphere. The midwives also tried to be with the women by listening and being autonomous.

Moreover, the woman–midwife relationship became deeper and stronger when they shared the whole experience of the woman's maternity life journey as it made it easier for them to be present to each other. They also had many opportunities to understand and trust each other through their communication and shared experiences. The relationship was embodied; for example, as a sense of unity and harmony, and the embodiment of the deep relationship made the birth easier and safer. For the women, especially, such a relationship with their midwives almost represented their birth experience. Eventually, this relationship offered great potential to sustain their psychological and spiritual well-being thereafter. The participants' experiences clearly showed that the woman–midwife relationship has a long-term impact and marks a change in their life. Being present is ultimately using the whole of oneself. Therefore, the woman and the midwife are strongly connected to each other when this happens, and the relationship impacts almost the whole experience of birth and parenting.

Chapter Eight: Having a Voice

The last chapter explored how women and midwives felt present, or not, to one another. This chapter develops on their experiences by examining the experience of having a voice in the woman–midwife relationship. When women and midwives spend time together and develop their relationship, they share their ideas and values, thereby enabling them to understand each other. For women in this study, having a shared understanding meant that they felt they had a voice within the relationship, which allowed them to express themselves. Having a voice is a legitimate right for women in their maternity care; yet, this was not always the reality of participants' experiences with midwives. Conversely, some participants found their own voices in their midwife relationship. Their voices were shared with their midwives, and the midwives were able to speak for the women due to the mutual understanding. The participants' experiences of having and not having a voice convey how the woman and the midwife related to each other. This chapter begins by exploring women's experiences of their voices being unheard.

Voices unheard

In the maternity care setting, women's rights, informed choice, and effective communication between the woman and the professionals involved in her care should be promoted (WHO, 2018a). In Japan, sharing a woman's birth plan is one of the ways women can express their voice and choices for their birth. However, many of the study participants felt that they did not have a voice in their birth planning process. Juri and Uta speak of their relationship with their midwives through their experiences of birth plans. First, Juri describes her experience, including what happened after birth.

> I think I saw doctors and nurses at antenatal care. They asked me a lot of questions with something like a survey sheet, for example, whether I would want to have my baby in my room. I said yes, but that never happened. I first thought, 'Didn't I have a baby? Where is my baby?' on the second day after birth (Caesarean section). I was a bit absentminded and timidly asked, 'Can I see my baby?' Then a midwife said very lightly, 'Here you are.' I asked when I would breastfeed my baby and she said, 'Oh, do you want to? Is this the first time? I will explain.' It was light-hearted. If I did not ask them, I might not even get to see my baby.

Uta was also asked about her wishes for her birth, particularly about having an epidural. She describes her experience at antenatal care.

> Just fear. I had only fear toward my birth. I chose an epidural only due to the fear of the pain. That's all. At the very beginning, the doctor said that they could provide an epidural

> and I had to book if I wanted. I was asked yes or no at the first check-up. He booked it for me just in case and gave me the instruction like a brochure. There was no chance to talk about the fear and an epidural with doctors and midwives [during the ensuing antenatal care], and I didn't get any explanation about epidurals. So, I asked them when I would have an explanation. They said they had already given me a brochure about epidurals, which I had already read, and would listen if I had any questions. If I didn't say anything, they wouldn't say anything. I heard the doctor's explanation, but I don't remember it. It was almost nothing.

Juri and Uta were asked to choose their options for birth and breastfeeding as though they were choosing from a menu at a fast food shop. There was little enough communication, no explanation, and insufficient support or time to think and choose what they truly wanted. The professionals assumed that they shared or understood the women's preferences, but they simply listed the choices and sought yes-no answers from the women who were forced to choose. To make matters worse, Juri's plan was not shared with, or recognised by, the midwives, and she was left alone without seeing her baby after birth. Uta was distressed and fearful throughout her pregnancy. She implies that what she really wanted was the opportunity to talk and be listened to about her worry and fear of labour pains and birth rather than merely being told that she could choose to have an epidural or being given a technical explanation of the epidural procedure. These women did not feel cared for because they were not allowed to have a real voice in the process. Consequently, they felt unrecognised, unvalued, and disrespected.

Far from having a voice, the women were unheard. Voice is not merely a medium for words (Fuyarchuk, 2017; Lagaay, 2011). It can be an inner voice indicating one's values and beliefs. The midwives, however, showed no interest in the women's values or beliefs; nor did they attempt to listen to the women's real or direct voices during their antenatal care. It seems clear that the midwives did not intend to actively build a relationship with the women. If the midwives had truly cared for the women, they would have been interested in their views, thoughts, ideas, and ways of thinking, at least regarding birth, in order to better understand them and provide proper care. The women did not have such attentions and thus did not feel understood by any of those who were responsible for their care. Of course, in this situation, the women had no understanding of what the midwives were thinking. Understanding is being-in-the-world, and understanding means that something has already been expressed (Heidegger, 1927/2010). For the women, there was no understanding in the world with their midwives because nothing was heard on either side. This is how they experienced being-in-the-world in their relationship with their midwives.

Waka, another first-time mother, tried to talk about her birth plan to a midwife in the hospital. This was her only memory of the hospital midwives.

> There were midwives [at antenatal care] but no opportunity to connect with them. To be honest, I have no memory of them. Only when I talked to a midwife about my birth plan

> with the assumption that it wouldn't do any harm, I remember that the midwife got stiff as soon as I started talking. I guess they couldn't accept birth plans as a routine response. Her attitude showed the rejection. I understood that I couldn't make my birth plan possible there. I talked about some birth plans such as what to do with the umbilical cord, then her face stiffened up, not even refused softly. I don't remember the details of the conversation, but I remember the atmosphere. She looked softer before the conversation, but suddenly turned very stern. I thought I knew it. I had no choice and I was angry with myself because I chose the hospital. I definitely had an unpleasant feeling. She was completely unapproachable. Even if it was impossible to accept my birth plan, she could at least show her concern and listen to me. If she had said just one thing, 'You wish these things, don't you?' I would not have had such feelings. She put down a shutter all of a sudden. I knew it was a hospital and that would happen, but I was very disappointed. The incident added more encouragement for me to think that I wanted to give birth at midwifery home. I thought, 'It is impossible to give birth here,' and 'I don't want to have my baby here.' I thought I couldn't give birth there no matter what.

Waka's experience with this midwife was complete rejection. She felt both her birth plan and she, herself, were rejected by the midwife. As a result, she also rejected the midwife and the hospital. She felt rejected because there was no intention to build a positive relationship given the dismissive and closed attitude of the midwife. She was completely unheard by the midwife and lost her voice. Individuals cannot form a genuine bond without openness to one another (Gadamer, 1960/2013). Openness comes prior to bonding and understanding. A genuine human bond also involves an emotional connection brought about by caring, accepting, and trusting one another. It was impossible for Waka to gain any of these with the midwife without openness. She met and related to the midwife, but she claims no connection or memory of the midwives during her time in the hospital. This might indicate that there was no positive relationship with the midwives there and that her experiences with the midwives were not worth remembering—or that she did not want to remember them.

This experience raised strong emotions in Waka. She remembers the atmosphere that she sensed there. van Manen (2016b) stated that "atmosphere or mood is a way of knowing and being in the world" (p. 69). Waka perceived what was happening between her and the midwife through the atmosphere rather than the midwife's words. She cannot forget her feelings or the atmosphere and, equally, cannot remember what the midwife actually said. The atmosphere that denied and excluded Waka from her own care denoted the relationship that would never develop between Waka and the midwife. The atmosphere was too unsympathetic to share their voices; thus, they never understood each other.

Maya also brought her birth plan to the obstetric clinic where she was having her antenatal care. She was asked by a midwife why she did not go to a midwifery home. She describes the experience.

> Nearly at the eighth or ninth month of my pregnancy, I brought a paper I wrote about how I wanted to give birth. For example, I wanted them to turn down lighting and wait for cutting the umbilical cord. I shyly wrote those things and brought it because they never asked me. I was nervous, but the doctor said they were all acceptable as normal matters. Then a midwife came out and talked to me. She asked me why I didn't choose midwifery home if I wished those things. I didn't know there was a huge difference between midwifery home and normal clinics. I found later that my image of the birth was a birth at midwifery home. I thought I could give birth as I wanted at clinics as well for some reason.
>
> My birth was not what I expected. They tried to listen to my wishes, but midwives looked very busy at the moment of the birth. Soon after my baby was born, it seemed they had to wrap my baby, take a photo of my baby, and so on. The doctor asked me, 'Can I cut the umbilical cord?' 'Can I? Can I?' But it was my first birth and I didn't know the timing. I was also feeling faint with bleeding. So, I just said yes, yes, yes. They said, 'I will put you on an IV drip.' 'Whatever you like.' I replied. I also had an episiotomy [although I hoped not]. I let them do whatever they wanted after all. I felt their consideration in their own way, but I strongly felt I was in their sumo ring (on their terms) and followed them, the midwives rather than the doctor. I hadn't had water breaking, and I think the midwife ruptured the membrane when she checked on my cervix. She said nothing to me and did it on her timing. I think they put a mark on me because I wrote how I wanted to give birth. They might have thought I would be troublesome. I didn't mean that. I wanted more heart-to-heart understanding. My family didn't understand that either, so they couldn't cover the lack of support and I was alone after all. It was all good because my baby was born safely and smoothly though.

Maya had no control over her birth care. Her birth plan had been accepted, but the midwives did not really discuss it with Maya and prioritised their tasks as they wished. It is difficult to implement birth plans without truly understanding them. Maya's plan received only ostensible acceptance, and Maya herself was actually unheard. She must have sensed the authoritarian power or hierarchy in her relationship with her midwives. This is likely the reason she was nervous and too shy to express her wishes or say anything to them despite being unhappy with her care. Maya stated that she felt as if she was in their sumo ring, indicating that she felt alone or (had to fight) away from home. In other words, she did not have a sense of belonging to the relationship. They had a relationship, but, as she said, it was not a human, heart-to-heart relationship that could put her at ease or make her feel satisfied. She was not at the centre of her care. Rather, she felt like a fish out of water as a troublemaker in the clinic.

The experiences of women are often downplayed in relation to the safe birth of a healthy baby (Simelela, 2018). Maya tries to convince herself that the birth was fine because it was safe and her baby was healthy. However, this seems a rationalisation of the largely technological birth experience and excuses the midwives' attitudes and the poor relationship that Maya had with them. Maya's story reveals she was disappointed in her care. Even the midwife might have recognised this, as she suggested that there were differences between giving birth at the clinic and

giving birth at a midwifery home. The implication here is that the midwife saw a difference in midwifery care and the woman–midwife relationship between the two types of birth facilities. The difference lies in whether or not the woman's voice is heard. Maya's wishes and dissatisfaction were unheard or unnoticed at the clinic; however, the midwife imagined that Maya's voice would be heard in a midwifery home. In Japan, there is an obvious unbalanced relationship between women and their midwives in some settings. This only exacerbates the problem of the woman's voice not being heard.

Birth plans are one of the tools that enable midwives to understand each woman's wishes for birth, and discussing a birth plan can be a great opportunity for the woman and her midwife to share their ideas and values. However, the participants described thus far, did not have this opportunity. A woman's birth plan is about what she values in her birthing experience. Her values represent her identity and how she lives her life (Ozawa, 2002). Thus, when their birth plans are refused, denied, or ignored, women feel that they themselves are being denied by the midwives. For a birthing woman, being unheard is negative and disrespectful treatment and may cause serious damage to her long-term psychological well-being.

Additionally, Japanese tend to place importance on belonging to a relationship in harmony with others rather than being independent (Kitayama, 1994). They often worry about being denied or excluded from a relationship. The women here likely knew that their wishes might be denied in their relationship with their midwives or sensed that they could not speak openly in the atmosphere in which they found themselves. At the very least, they were afraid to tell their midwives everything. No matter how unwise a choice this might be, trying to maintain harmony is a value shared by most Japanese. Consequently, the women might have reluctantly accepted having a small voice—or no voice at all—in such an unreliable relationship in order to receive at least a minimum level of care.

Having a birth plan for one's birthing experience is a legitimate right for expectant mothers. Nonetheless, many of the study participants were not allowed to express or share their plan with their midwives. There are more women who talked about their experiences of birth plans, and the stories are abundant. As the interviewer, I did not ask participants about their birth plans and experiences, but these stories naturally came out. They might have felt they had no choice in the relationship, but they were obviously unhappy about these experiences of the woman–midwife relationship. Their experiences of birth plans revealed what women truly wish and what really matters for women regardless of the specific details of their birth plans. This was the women's experience of being unheard, and how the midwives responded to the women clearly indicated their relationship. When the midwives could not open themselves to the women's values, it was very difficult for the women to have a voice, even though it was about their birth. The women

desired to have someone who had openness and worked together to accomplish their goals during their birth journey. This is not possible to achieve only with a written form or one-off contact. Women and midwives need to be free and open to talk, even if midwives have to refuse or cannot implement women's birth plans for some reasons. It is a process of mutual response and understanding. Their relationship will develop in, with, and through reciprocity.

Losing a voice

Like the women above, Chika did not have a voice in her relationship with her midwives and gradually lost her voice through her birth experience. Chika's story illustrates how her voice became smaller and was ultimately lost.

> My water broke early in the morning and the contractions didn't come at all. In the evening, they started the induction but my baby still didn't come down the next day. They induced me more and more, my blood pressure jumped up, and I had an emergency Caesarean section on the third day. I asked a midwife 'Why did this happen to me?' and she told me, 'Your body isn't suitable for birth.' That remains most in my mind. I wondered if I was not suitable for birth and whether or not there were people suitable and not suitable for birth. They said, 'Your body is at the end of its rope. If you didn't have a Caesarean section, your life would be in danger.' I didn't think I was in danger so much, but they told my blood pressure was getting very high. Many midwives and doctors rushed to me and I was sent to an operation theatre. That was the most impressive moment. I mean what they said, 'Your body isn't for birth.' and 'Your body is screaming.' I had a Caesarean section although I really wanted to have a natural birth. And I had the induction, although I didn't want to. I was so disappointed that I couldn't have my ideal birth. I felt a rush of the emotion at the end, after birth. But when I was told that, I was like, 'okay….' It was shocking. Rather it was disappointing. It was sad.
>
> I didn't feel good after birth, but I didn't tell doctors and midwives how I felt. I said that I was not well only when one midwife asked me. The midwife asked me, 'How are you?' and I answered, 'I don't feel good.' Then she asked me 'Where don't you feel well?' I do not know why she asked but she seemed trying to ask me, so I told her, 'It hurts here. I keep feeling unwell.' She brought a hot towel to make me feel better. I wanted to go home sooner [after birth]. It was not because I was confident with my breastfeeding. I just wanted to leave the hospital. I was not well for the whole month after birth. I thought some mothers might think, 'I am suffering because I had this baby.' I was okay, but I wasn't well just imagining that.

Chika's autonomy and vigour were utterly weakened in her birth experience. She needed a Caesarean section because of the complications. Although the medical reasons were given to her and she understood them, she still could not fully accept what happened to her. Even if it was emergency, she might be able to accept her situation if she had someone who was continuously and emotionally present for her. Instead, a midwife's words remained in her mind. Those words sounded as if she was not qualified to have a baby. She described being devastated about her situation. The midwife's words lay heavily on Chika's mind and heart, and became trauma for

her while reflecting on her birth experience and moving on with life after birth. She was disempowered by the words and the whole experience. The midwife's words were products of their relationship. The midwife almost certainly did not mean any harm but, if she had known Chika better, understood her values, or been aware of Chika's inner voice, she would not have spoken such words. The negative impact of these words and the poor relationship Chika had with the midwives is immeasurable—on her bonding to her baby, her parenting, and her entire life.

After birth, Chika had no courage to be open with anyone, and she was not comfortable to stay in the hospital. She had lost motivation to speak her true feelings, even to the midwife who worried and asked how she was. Her physical and psychological states rejected the people and space for whatever reason. At the same time, she tried to hide her disappointment and devastated feelings in her body. Japanese mothers tend to express their emotional distress as poor physical conditions after birth (Yoshida et al., 1997). Body could also be the place where one can hide and expose one's emotion, secrets, and other immanent acts (van Manen, 2014). Chika was probably too tired or afraid to communicate to anyone after the traumatic experience with midwives and doctors, and the body was the only place she could hide and express herself after she lost her voice. Thus, she expressed her emotional damage as a poor physical condition, and it was treated as a physical matter by the midwife. The whole atmosphere in the hospital, including the people, did not allow her to feel free to talk about herself. Even if her physical condition was due to the medical complications rather than her mental issues, she was left alone without enough care for the rest of the month. Chika felt deserted without any reliable relationship.

Chika's birth experience restrained her from raising her voice, but she had actually been losing her voice since pregnancy through her experiences with midwives. She continues her story of what happened before and after her birth.

> [Before birth] It wasn't possible to tell them my wishes. I asked a midwife if they accepted birth plans, and she told me they didn't. She asked me, 'What do you want, for example?' I told her, 'I want to have skin-to-skin care with my baby,' and 'I want a dimly lit room [during labour].' But I couldn't tell her everything. 'I would like… (in small voice).' I talked like that. Also, I couldn't say, 'I never want an induction.' It was not an atmosphere where I could speak freely. It was hard to talk to them like that, so there was no way to look back the birth with them. But, before taking my baby away [at Caesarean section], a midwife put my baby around my face and neck saying, 'This is not actually allowed though.' I think it was to take a picture [of me and my baby]. I was glad that she also made my baby kiss me when I went back to my room with saying, 'This is not allowed but you said that you wanted [to touch your baby].' I guess she sympathised with my feeling, and she did as much as she could.

Since her antenatal care, Chika had found herself increasingly under the control of hospital rules, and her voice literally became smaller in her conversations with a midwife. She was deprived of

her voice and control at the same time. That is, when she had no voice regarding her care, she had no control over her birthing. She felt vulnerable in her midwife relationship; she had no midwife who offered the kind of atmosphere that would enable her to freely express herself and no midwife who stood by her in a way that allowed her to have her voice heard. She acknowledges that one midwife tried hard to follow her birth wishes but, even here, she was told that what the midwife did for her was something that was not officially allowed. Both before and after birth, she was repeatedly told that what she wanted, including simply being able to touch her baby, was not allowed. Losing her voice was losing her rights as a mother. As a result, she may well feel remorse for her birth and lose confidence in herself as a mother. Receiving care that was against the rules could also give her a sense of guilt, and the midwives' behaviour further restrained her from raising her voice.

Chika's birth plan was not accepted. Her actual birth situation was distanced more and more from her ideal birth, her physical ability of giving birth was denied by professionals, and no one really understood or cared for her feelings after birth. Through these situations, Chika's ability to raise a voice for herself was disabled, and no midwives could advocate for her. All these experiences shaped her birth experience. She is parenting with this experience and the lasting words from the midwives. She could not share her values with anyone and did not find a positive connection and trusting relationship with anyone in this experience. After all, she had no voice, no control, no rights, and no freedom in her midwife relationship, nor, as a consequence, in her care.

Having a voice

While many participant women had minimal or no voice in their relationship with midwives, there are some who gained or had a voice in this relationship. Aki describes her experience.

> I think I talked about my birth wish and the midwife also told me her opinion. We had quite a lot of opportunities to talk at antenatal classes and personal antenatal care. I think she tried to consider my wishes and said, 'Okay, I got it. Let's do it,' every time when I said I would like to do something. I thought she understood my birth plan while we shared our intention. I didn't think I needed to write it down expressly and writing it down might have even made distance between us. I was going to write it actually, but I came to think that it's not necessary. I knew her basic way of thinking, I mean what she was thinking, and she knew what I was thinking. We knew the way of thinking each other. That's huge.

Aki assuredly had a voice in the relationship, which meant that her right of choice was protected by her midwife. Aki and her midwife obtained mutual understanding by repeatedly sharing ideas. Aki felt listened to, accepted, understood, and cared for, which ensured that she had the best possible experience. She conveys a scenario in which the woman and midwife do not always require a written form to share the woman's birth plan, as long as they openly communicate for their mutual understanding. In fact, for Aki, the written form was a barrier between them. As seen

in the previous sections, the concept of a birth plan has apparently lost its value in the care. By contrast, Aki embodied the quintessence of seeking, finding, and achieving her own birth wishes in the midwife relationship without adhering to the existing concept of a written birth plan. Aki and her midwife took time and deepened their relationship. The continuity of care made the experience easier, and their mutual understanding enhanced Aki's sense of trust and safety in the relationship.

Aki and her midwife made mutual efforts, including shared commitment, negotiation, and agreement to foster their trusting relationship. Their interaction shows that the woman–midwife relationship consists of reciprocity, which can be one of the central concepts that evokes presence, affirmation, availability, and participation in the relationship (Berg et al., 2012). Reciprocity cultivates a motivation to develop the midwifery partnership (McAra-Couper et al., 2014). Aki was being listened to and accepted and was able to hear her midwife's voice. Knowing the midwife's ideas and thoughts was an important factor for her as a partner in the relationship. Aki and her midwife shared and protected their own voices in the reciprocity. Indeed, when both individuals have a full voice in the conversation, it brings about equity in the relationship (Bazerman, 2017). The reciprocity that promoted both parties' full presence and participation thus transcended the different standpoints that women and midwives might have.

Eventually, Aki and her midwife's voices became one. Every culture is created out of mutual interactions, and Aki and her midwife worked together by expressing themselves and hearing each other's voice; thereby creating their own voice, relationship, and world. This does not mean that a woman and her midwife must have the same opinions and values. In their relationship, Aki and her midwife discussed, negotiated, and harmonised their voices. In Aki's experience, the negotiation was constructive, and she was placed at the centre to bring out one voice. The process made their connection stronger and the shared voice meant that they could protect themselves and experience safe and satisfying birth care.

Hana was similarly able to be herself by expressing her voice in the relationship with her midwife.

> I had been working full-time, self-employed, and I kind of neglected my health, such as the diet and the life rhythm. I was not confident to deal with those things by myself during my pregnancy. I worried whether I could take care of myself with few-minute check-ups in the hospital. If I went to the midwifery home, the same specialist would provide care through pregnancy and after birth. That was reassuring for me. I frankly told that to my midwife. She understood my work and situation. I thought she was empathetic, and she would give me advice and care that was not conventional and was special for me [and she did].

Hana sought and found a place and midwife that meant she could raise her own voice. Consequently, she obtained personalised care which enabled her to be herself. The woman–midwife relationship was one that enabled her to keep her voice and protect her identity while also promoting safety of pregnancy and birth. Hana was aware, however, that it is difficult to obtain such a relationship in the current care system of hospitals and clinics in Japan. As seen in the participants' experiences, the quality of midwifery care and the woman–midwife relationship depends to a large extent on birth facilities and the care system. Thus, Hana knew she needed to find a specific midwife who would hear her voice and see her as a whole person. Abitbol (2016, 2019) described voice as the fingerprint of our soul, an independent entity, and the umbilical cord of humanity. Voice represents oneself as a human being. For Hana, having a voice meant being herself; without a voice, she knew she could not give birth as she really was.

Hana felt that her midwife was carefully listening to her voice, with empathy being one of the significant gifts that Hana received in the relationship. The midwife's empathic attitude created an emotional connection with Hana because empathy entails caring, valuing, accepting, and understanding another person, as well as showing kindness and compassion (Moloney & Gair, 2015). It further enhances the spiritual presence of the midwife and her embracement of the woman's dignity. Moloney and Gair (2015) argued that midwives not having empathy and spiritual care is no better than midwives having power over women, and that this would cause enduring distress and trauma among the women. Due to the empathetic and spiritual relationship with her midwife, Hana, by contrast, experienced having a voice, control, and power over her own maternity life and birth. She felt valued and respected by the midwife sincerely hearing her voice. Moreover, she sensed that the midwife's voice was coming from the heart. She was, therefore, able to trust her midwife deeply, and the relationship was reassuring.

Having a voice entailed keeping choice, control, and dignity in the woman's hands during her birth experiences. The woman–midwife relationship can enhance and protect this legitimate right of women when the woman and her midwife commit to mutual respect and understanding. This also creates a kind, caring, and compassionate atmosphere where they are willing to hear each other's voice. The woman–midwife relationship thus, emotionally and spiritually, connects the woman and her midwife by valuing the woman's voice and their shared voice.

Finding an inner voice

Voice is not only something expressed. Through the conversation with her midwife, Hana experienced finding her inner voice. Another mother, Naomi, had a similar experience. They describe their experiences of finding their voices with their midwives. Hana talks about the conversation with her midwife during the postnatal period.

> She (the midwife) called me even if it was not the day to visit. She asked me, 'Is she drinking milk?' I answered, 'I think she is. I think I started understanding her now.' She replied, 'Yeah, it's gonna be all right.' That gave me confidence. I think you would gain confidence to think like, 'Yes! I can raise this baby, let's keep it this way.' Even if I had already had two children, this one was different. It was good that I was able to realise that at the early stage. I appreciate that she (the midwife) made me realise that by myself, rather than in the way that the professional taught me that. If I was in hospital and worried, I would probably be told, 'Do this' and 'Do that.' And although I would do as they said, it wouldn't go well, and I would have a dilemma.

Naomi, likewise, describes the communication with her midwife during her pregnancy.

> I gained a lot of weight in the middle of the pregnancy, but she (the midwife) never got upset and told me to make me aware. So, I did not feel the pressure like I had to do this or that. Instead, she passed on important messages nicely. That suited me perfectly. I felt she was aware of me. I am not sure if she understood everything about me, but she accepted everything what I told her, and I think she caught things even when I did not say. She conveyed that to me well. I was reassured. She took care of my husband as well. She was good at getting across to him about things that I couldn't express well. She gave us such care. So, I looked forward to my birth. I was a little scared, but I really enjoyed the time before the birth.

Hana and Naomi were able to listen to their own voices through conversation with their midwives. The inner voice is an unsaid idea, a meaning behind or beyond words, an idea before it appears or an "infinite inexhaustible idea of being-as-a-whole" (Fuyarchuk, 2017, p. 45). The means of communication their midwives used to hear the women's voices is similar to the Socratic maieutic mode of communication which, as discussed in the previous chapter, brings out another's thoughts (Fiumara, 1995). The women and their midwives worked together to seek, feel, catch, and transmit their inner voices; and led the women to finding their voices. Doing so, became a means of determining a way to move forward for the women. Thus, the women obtained self-awareness and confidence in the communication. Further, the women suggest that self-awareness could be more empowering than being taught. The communication Hana and Naomi had with their midwives was constructive, careful, and warm. Such communication made the woman–midwife relationship meaningful, trustful, and valuable.

The midwives might not have known everything about the women, but they could observe the whole picture of the woman and be sensitive to each woman's unique experiences. The midwives sensed the words of the women's being-as-a-whole. That made the women feel understood by their midwives, and this evoked a deep feeling of safety and other positive feelings in their minds. The sensitivity to, and tacit understanding of, the other's voice was enabled because of their close relationship developed through continuous interaction, as well as their mutual attention, interest, and respect. This intimacy allowed them to identify with each other and to find or help express the woman's inner voice (Fuyarchuk, 2017).

In the case of Ema, only her midwife was able to find the words Ema needed when she struggled with life after birth. She describes the experience.

> During the first month after birth, I was very unstable. I was hurt, moved, and cried about nothing. I couldn't stop that though I understood it was because of hormone. I spent most of the time for breastfeeding and holding my baby, but my breast milk was not enough. Then my mother came into the room with a formula saying to my baby, 'Here's your favourite milk! I can't wait to feed you!' That hurt me more. I thought I was a bad mother and cried every day. I met a midwife when my baby's weight was not gaining well, and I was feeling down. I talked to her about using cloth nappies and other things I was caring for my baby. Then she told me, 'Using cloth nappies is an unimportant thing. To gain your baby's weight is more important, isn't it?' She was probably right. But I was doing that for my baby and enjoying washing the nappies. So, I was a little hurt. During that time, I talked and sent texts to my midwife (another midwife), and she gave me messages like, 'Ema, the cherry blossoms are in full bloom outside. You could go outside a little, so why don't you see the cherry blossoms with your baby. That will be a good memory.' I got moved to tears by the message. I was glad and felt that my heart became opened and brighter.

The reasons Ema struggled during the postpartum period appeared to be obvious to herself and surrounding people, but she could not help feeling down. That is, Ema was not able to feel better with direct advice or solutions alone, and even she did not know what to do and what kind of help she needed in her struggle. However, her midwife had meaningful words that tapped into Ema's inner voice—something she was holding in a deep place or losing in her struggle. What Ema really wanted and needed was to be acknowledged as a mother nurturing a new life, to enjoy time with her baby, and to embrace a new, challenging role. Ema's midwife noticed her inner struggle and brought out Ema's previously silent voice.

Ema's midwife has *tact*. According to van Manen (2016b), tact is a form of human interaction, and keen senses to know what to do and what to say in a relationship. He claimed that tact cannot be planned and does not belong to any theoretical knowledge, skills, and rules. One can act tactfully with thoughtfulness and endeavours to understand the other and the situation. van Manen also emphasised the significance of 'sensing' what is important in the moment of having to act. To develop this sense and tact, midwives first need to repeatedly and carefully see, listen to, and understand each woman. The relationship, well developed between Ema and her midwife during pregnancy and birth, allowed her midwife to easily recognise what was really necessary to Ema at that moment.

Ema's midwife also had a bird's-eye view. Using a holistic approach, Ema was cared for as a whole person rather than attention being focused on a single aspect such as breastfeeding. While her midwife was able to find Ema's inner voice, due to her deep understanding of Ema, their

trusting relationship assigned a power to the midwife's words. Ema was touched by the message because, by that time, they deeply trusted each other and their relationship brought about the most appropriate words for them.

Speaking for women

A midwife who hears the voice of the woman in her care and truly understands her will be able to advocate and speak for the woman. The midwife's voice becomes the woman's voice. Because they share and negotiate their ideas, theirs is a joint voice. The midwife may also speak for the woman with a sense of actually being the woman due to the well-established and intimate relationship they have developed. Kazue, a self-employed midwife, describes her experience of advocating for a woman by being very understanding of her.

> It is a one-to-one personal relationship so once I even went to the woman's house to clean for her before she gave birth because she lived in a house full of garbage. I said, 'Let's clean your house today!' She had her second baby at my midwifery home, and before having her third baby, she told me she couldn't clean her house. So, I told her I would come to help clean. That's a midwife's job because she had to take her baby home, and the house should be clean. She is such kind of person and her middle child has a developmental disorder. Teachers of his pre-school told her something like the disorder is due to a lack of maternal affection. I know she is a rough mother, but she was raising her children with love. So, when she came to talk to me, I spontaneously told her, 'What? You shower your children with love.' Then she cried. She looks like a party girl and people judge her like that. She started working from one month after birth because her husband didn't earn much money. She was trying very hard in my eyes. I had seen her living life quite well. She is a bit rough, but she loves her children. So, no way, it's not a lack of love.

Kazue's words to the woman were not simply words of comfort or empathy; she was actually upset by what the woman was told by the pre-school teachers as if it were something that had been said to Kazue herself. Kazue might have been the only person who could advocate and speak for the woman. She understood and trusted the woman more than anyone because she had seen the woman since her pregnancy; they had shared the intense time of childbirth and she cared for the woman afterwards. They had nurtured their trusting relationship through long periods of shared time. Moreover, Kazue had a non-judgmental attitude and cared for the woman with a multidimensional view. Her care was based on a life or social model rather than a medical model (Ikai, 2016; Wagner, 1994). At first glance, cleaning the house might look irrelevant to childbirth; but for Kazue, everything was linked to seeing the woman delivering a new life as a whole person. Kazue's efforts to understand the woman in all aspects of life, including her living environment, family relationship, and financial situation, allowed her to see the woman's true and total being as a woman, mother, and wife.

When a midwife has a true interest in the woman in her care, she cannot help but see the woman as a unique and complete human being (van Manen, 2016b). Such a holistic view and interest enabled Kazue to pay sincere attention to the woman. Thus, she heard the woman's voice about cleaning the house and other things. That the woman loved her children was clear in Kazue's mind, although others may not have understood. Kazue was hearing the woman's inner voice while caring for her. Secure in this caring relationship, the woman was able to open up and ask Kazue for help. Their strong connection, developed with holistic interactions, supported the woman's psychological well-being.

Yuki, another midwife, has provided fragmented care in a busy hospital for more than two decades. She became close to one pregnant woman and had the most memorable experience in her career. Their relationship enabled Yuki to speak for the woman several times. She describes one of these experiences.

> A mother was admitted to the hospital for quite a long time due to threatened premature labour (TPL). One of her twin babies had malformation and was diagnosed that he would not be alive long after birth. She said I delivered her second baby and I was also at her first birth, but I did not remember that. She asked me to be at her birth again for the third time. I knew she had ultrasound scans on the same day every week, so on those days, I went to her bedside and asked, 'How was it?' I also tried to bring her meals when we serve them. So, I had a lot of chances to talk to her. I felt I played favourite with her. Although there were other women staying in the hospital due to TPL, I went to her bedside closed with curtains and chatted.
>
> One day I went to her bedside asking, 'How was the check-up today? Huh, where is the photo of the other one (the baby with malformation)?' She told me, 'I would like to see the baby's face, but I think the doctor considers my feelings and tried not to show him for me.' It seems the doctor thought she would feel herself weakening by seeing the baby's face. Then he told me, 'It is better not to show the baby to her. If she doted on him, it would be cruel.' They both worried and cared for each other. I asked him to show her the baby and when he did so, her reaction was very good. The doctor saw that and said to me, 'She wanted to see the baby, didn't she?' He showed her the baby at every scan after that.
>
> I thought I might be able to do something by negotiating between them. I talked to both of them and I think I could connect their compassion for each other. I wonder if women did not have TPL or any problem and just came to antenatal care, we would have few chances to talk to them. Then they (women and doctors) could not say anything while they consider each other. I was able to talk with her because she was in hospital for a long time and asked me to be at her birth. If women had staff, even one staff, they could talk to at antenatal care, I guess that would make a difference.

The woman gained her voice by having Yuki as her midwife. Yuki was able to speak for the woman and negotiate with the doctor because she stayed present for the woman, listened to her voice, and understood her hopes. Her actions for the woman were not done in conformance to

standard routines or rules; she knew what to do as a midwife in her interrelationship with the woman (van Manen, 2015). She did not judge what the woman needed in her tragic situation as did the doctor. She was with the woman and sensed what the woman wanted from her being. When people have a specific relationship that emotionally or personally connects them, they do not have doubt as to what to do for the other irrespective of general principle or courage (Sakakibara, 2018). The deep relationship between Yuki and the woman naturally led Yuki to lift her voice for the woman.

Relative to her daily work, Yuki realised the increased possibilities of midwifery care in the relationship she had with the woman. The situation of the woman who was losing one of her babies was tragic. However, Yuki was far more satisfied with the relationship than her usual relationships with other women because she felt closer and more useful to the woman. The woman was also pleased to have Yuki. Their relationship allowed Yuki to recall her value as a midwife. Understanding the other is understanding oneself in the relationship (van Manen, 2016b). Here, Yuki understood herself as a midwife or the meaning of being a midwife while understanding the woman. Yuki found her inner voice as a midwife, and the relationship with the woman was what she desired in her midwifery practice.

However, while Yuki appreciated this relationship, she also had a sense of guilt. She had forgotten that she had previously attended the birth of the woman's other children. Had the woman not asked Yuki to attend her new birth, she would not have had such a relationship. Also, the relationship with the woman was unusual for her and made her feel sorry for other women in that she favoured the woman. Through this experience, she could not help but recognise the contrast between this and other relationships she had had in the hospital. The relationship with the woman was ideal and satisfying for her, but she honestly felt it was unrealistic to have such a relationship with each woman in her daily work at the hospital. While this created a dilemma, the experience at least made her imagine more possibilities regarding what she and other midwives could do for the women in their care.

In maternity care settings, emergencies can arise—intense or difficult situations due to clinical issues. In such situations, it is not easy for a woman to openly and frankly express her own voice. Even when it is not urgent, a woman may hesitate or be reluctant to talk about her needs or ideas to healthcare professionals due to her inherent Japanese character or the hierarchical tendencies of Japanese healthcare. However, study participants showed that the woman–midwife relationship can be the place for a woman to freely express herself and a place for the midwives to protect the woman and carry her voice to the outside. In fact, the woman in Yuki's care openly expressed her hope to Yuki but could not do so to the doctor. The well-developed woman–midwife relationship is likely to exclude all hierarchy from the connection. When the woman and

her midwife have a mutual understanding, the woman's voice is audible even in urgent situations. Since maternity care can sometimes involve urgency, women need to have a relationship with someone who can speak for them in any situation.

Summary

This chapter presented participant stories about having a voice. Having a voice is a woman's legitimate right in her maternity care. However, the voices of some of the women were often unheard and lost in the midwifery relationship. When the women had a small voice, or no voice at all, their choice, control, and freedom were lost in their birth experiences. Such women felt that they were not understood, valued, or respected and that they were disempowered as a birthing woman and mother. Even if they had a safe birth and a healthy baby, their birth experience could not be fully positive without having a voice.

Some of the women, however, found that they did indeed have a voice in the relationship with their midwives. In such cases, they were free to express themselves, negotiate their ideas, and develop a shared voice. The mutual interactions in bringing about their shared voice fostered a deep relationship, and their closeness and mutual understanding allowed the midwives to bring out the women's inner voice. These women maintained their identity and dignity by having a voice in the midwife relationship. The midwives who took a holistic view of the woman in their care truly understood the voice of the woman, including her unspoken voice. In these relationships, the midwives sincerely sensed the woman's voice and understood the woman as a whole person, allowing her to be herself. The holistic and personalised care enabled the midwives to advocate and speak for the woman. Moreover, being able to carry the voice of the woman enabled the midwife to better understand herself and reconsider her role as a midwife.

Having a voice in their birth experience is a significant matter for women. The woman–midwife relationship has great possibilities to protect the woman's voice, as well as her choice, control, freedom, dignity, and autonomy. In a well-established relationship, women and their midwives are able to raise a stronger voice, have their needs and wishes realised, and gain a clearer sense of identity. When the woman–midwife relationship is experienced in this way, a woman's birth experience becomes more positive, regardless of her issues.

Chapter Nine: Sensing a Peace of Mind and Trust

This, the last findings chapter, focuses on the participants' experiences of having a sense of safety and trust. It has been demonstrated in previous chapters that the women in this study almost always had or sought a feeling of safety and trust in their relationship with midwives. Safety and trust are essential components to connect a woman and a midwife in their relationship and are almost inseparable in their lived experiences. Moreover, the participants' experiences show that there are different kinds or levels of a feeling of safety and trust. When women truly feel safe and trust in their midwives, their mind is calm and peaceful regardless of their issues. These feelings further enhance the participants' inner strength and empower them to become confident mothers.

In this chapter I use Japanese words to interpret the participants' emotional experiences. For example, I use the Japanese word *anshin* (安心)—an expression of the participants' emotional state. I have translated *anshin* as 'a feeling of safety' in the English language. *Anshin(-suru)* is also a verb and, in that case, it is translated as 'I am relieved, reassured, or at ease,' depending on the situation. I use Japanese terms because I believe those words most closely convey the participants' feelings in the Japanese context when interpreting their lived experiences. The most commonly expressed emotions by the participants—*anshin* (peace of mind) and trust—are at the core of the woman–midwife relationship. While it is difficult to separate the feelings of *anshin* from trust, I will first focus on a sense of *anshin* followed by a discussion of trust later in the chapter.

A sense of *anshin*

Anshin (安心) is a Japanese term meaning ease, relief, repose, or security. More specifically, *anshin* implies that one's heart is at peace. 安(*an*) represents having peace of mind or no difficulty, and 心(*shin*) means heart or a core. *Fuan* (不安) is another feeling the women express. 不(*fu*) is negative prefix such as un- and non-, so *fuan* is the opposite of *anshin*, suggesting not having a peace of mind. It also means anxiety and worry. Safety and security can also be translated into *anzen* (安全) in the Japanese language. 全(zen) means all, whole, and total; and *anzen* (noun and adjective) implies having no/low risk. *Anzen* is often used for material or physical concerns while *anshin* is a state of mind.

The women in this study sometimes express *anshin* or *fuan* indirectly, but their experiences clearly show they feel *anshin*/*fuan* or desire to feel *anshin* in the relationship with the midwives they meet. When the women have a positive experience in the relationship with a midwife, they

often express a state of *anshin*. An example can be seen in the experience of Naomi, a first-time mother giving birth at a midwifery home. She felt *anshin* when she saw the midwife she knew and trusted at birth.

> At the birth, I went to the midwifery home when I already suffered a lot from the pain. The midwife waited for me, and I was relieved when I saw her. I'd trusted her so much by that time. I think I gradually developed a trusting relationship while talking to her [during pregnancy].

Aki, another mother, also had feelings of *anshin* and trust towards her midwife at birth.

> [At the homebirth] when she (the midwife) arrived, I was so relieved. 'Oh, she is here.' I strongly remember the feeling of relief at that time. Also, at the birth of my first baby [at the midwifery home], I went there at the very last minute. When I arrived there, I really felt relieved to see her face. I thought, 'Oh, I am here. Everything is gonna be fine,' and felt reassured for sure. At arriving, I had reached full dilation. I think she told me, 'You did very well up to now.' I felt happy and thought, 'She praised me! She did!'

Having a known midwife at birth clearly enhanced Naomi and Aki's *anshin* and had a positive impact on their birth experience. When they said they felt relief, they show the meaning of *anshin*. They felt *anshin* by seeing their midwives' faces because they had established a trusting relationship with these midwives. Further, they trusted their midwives due to the atmosphere of *anshin* that surrounded them during antenatal care. The feeling of *anshin* seems concurrent with the feeling of trusting midwives, and vice versa. *Anshin* and trust do not suddenly appear between people. For the women, *anshin* and trust were gained through familiarity with their midwives throughout their pregnancy so that they felt *anshin* on seeing their known midwives in labour.

Each woman and midwife built their relationship over time by sharing experiences; thereby, deepening *anshin* and trust. Thus, even being praised by the midwife was unexpectedly valuable for Aki. She was glad because she was praised by the trusted person. This experience also shows that she knew from their shared experiences that her midwife did not often praise people. According to Gadamer's (1960/2013) fusion of horizons, the understanding and interpretation of phenomenon disclose what matters for a person. The women had shaped their fusion of horizons in the world shared with their trusted midwives. The nature of their relationship added extra meanings to their birth experiences.

Due to their trusting relationship, Naomi and Aki achieved a sense of *anshin* even during the intense period of labour. Their experiences of birth were filled with *anshin* and trust, so they felt there was no way that things would go wrong. Even if it did go wrong, they could believe in overcoming problems along with their midwives because trust and confidence lay in the woman–midwife relationship and they always felt *anshin* as a result. The women sensed that having

trusted midwives is a significant part of giving birth, with a sense of *anshin* and bringing about the best possible experiences. Heidegger (1927/2010) stated, "only because the 'senses' belong ontologically to a being whose kind of being is an attuned being-in-the-world can they be 'touched' and 'have a sense' for something so that what touches them shows itself in an affect" (p. 134). The women became attuned to a world of *anshin* and trust by establishing a good relationship with their midwives, and they could stay within the relationship no matter what happened. The woman–midwife relationship encloses the sense of *anshin* and trust, which positively characterises the phenomena they encounter.

In the same way, when women sense *anshin* and trust in the midwife relationship, they unexpectedly have positive feelings in spite of difficult situations. Rena describes such an experience.

> I had terrible varicose veins on the groin. It was so swollen. It started hurting and was terrible look when I checked it in a mirror. I thought I should go to see a doctor because it was abnormal. But I realised I would see Tanaka-san (the midwife) in a week for a check-up. I thought I would go to see a doctor if she said to do so. I wanted to show it to her before anyone else. I knew it was so bad, but I couldn't think to see a doctor right at that time. Thanks to that decision, I didn't need to show it to any other person. Tanaka-san told me, 'This is the worst one I have ever seen.' I was actually proud of what I was told, 'No.1 (the worst one)' by her who has such a long career. She also said that I would not need to see a doctor. She was calm, and her answer was simple. 'It's varicose veins. This happens. It is a little severe one, but it would disappear in two weeks. It may hurt, but you will be fine.' Like that. My mother raised me by saying, 'You will be fine.' It is something like trust. I really feel that I will be fine when my mother or Tanaka-san tells me that.

Even though it was an abnormal situation, Rena's experience of having varicose veins was not negative at all. She was even proud of the words spoken by the midwife. She was told that her varicose veins were the worst the midwife had ever seen; but, in Rena's mind, the meaning of the words was perceived and transformed into 'No. 1' in a positive way, as if she was the best woman in her midwife's career. The relationship that Rena had developed with her midwife led to this interpretation. Rena's trust in the midwife changed how she perceived and experienced this situation.

Rena knew she would be able to feel better if she saw her midwife in any situation. The choice of seeing the midwife made her feel *anshin* more than seeing a doctor to receive diagnosis and treatment. Thus, she calmly waited to see the midwife until the next appointment without unnecessarily worrying, panicking, or rushing to hospital. She was attuned to a calm and peaceful world based on the midwife relationship. She had a midwife who always allowed her to be attuned to the sense of *anshin*, whatever happened, which meant her midwife was always present in

Rena's mind. *Anshin* she obtained with her midwife affected her emotional state and actions in her everyday life during pregnancy.

Rena's confidence in her experience could also be based on the relationship with the midwife, which she describes as akin to the relationship with her mother. The midwife's words 'You will be fine' evoked trust, and Rena probably gained confidence from her mother in the same way. The relationship between Rena and her midwife encompassed *anshin* and trust like the relationship between a mother and a daughter. The midwife relationship thus recalled such unconditional maternal love in Rena's mind and made her positive and confident throughout the abnormal situation. She was encouraged by the warm and caring atmosphere of the relationship, allowing her to be attuned to a world of love, peace, trust, and confidence.

Rena's experience of her first son's birth illustrates the power of such a woman–midwife relationship helping, healing, and empowering the woman. Rena describes as follows.

> When my first baby was born, only he was taken to a hospital. Tanaka-san (the midwife) told me that he might be breathing rapidly. She decided to send him to a hospital by ambulance. It was her assessment, so I just asked her to do so. I probably felt down for just half a day. Of course, it was sad, but she took care of me brightly as usual, and I felt he was okay. She took me to the hospital in a wheelchair soon after that. I felt sorry, but she pushed my wheelchair and let me see my baby. My baby was obviously bigger than other babies there and I kind of knew he would be fine. Tanaka-san also said he seemed to be good. He was good, but he had to take all the exams in the hospital, and it took two weeks. It was sad not to be with my baby for two weeks. It felt very long, but I am smiling and holding a breast pump with Tanaka-san in a picture taken a couple days after the birth. So, I was not so bad. I would say it was nothing when looking back that. I could have freaked out in the situation, but I had a trusting relationship with Tanaka-san, and I thought it must have been alright as long as she said so. Even if something bad happened.

Being separated from her baby for two weeks could have been a devastating and alarming situation for Rena as a first-time mother. However, she was embraced by *anshin* and trust during the unfortunate situation. Again, she was able to be attuned to the world of *anshin* due to the trusting relationship with her midwife, even though something undesirable happened. Rena stated, "*daijobu* (alright) as long as she (the midwife) said so." *Daijobu* means 'I am fine,' 'everything is okay,' or 'it is gonna be alright.' This represents her feeling of *anshin* and trust towards her midwife and shows that she was able to find a hope and belief by being with her midwife. Rena would have worried a great deal, even if she had stayed in the same hospital with her baby, but she calmly, positively, and honestly accepted the things happening to her by being with her midwife. The relationship with her midwife emotionally supported and protected Rena during this difficult time.

Rena's trust in her midwife may sound naive, but she had developed a trusting relationship with her midwife over time and had substantial shared experiences that resulted from the midwife's warm attitudes, professional practice and care, and the mutual interactions and understanding between Rena and her midwife. There were a good balance of technical safety (*anzen*) and emotional safety (*anshin*) and a synergetic effect of both, which fostered trust and confidence. If either had been missing, Rena might not have been able to gain this level of *anshin* and to trust her midwife in the situation.

Rena was previously devastated when she found out about her pregnancy and had antenatal care at an obstetric clinic (Chapter Six). She had neither confidence nor *anshin*, and she felt could not trust anyone in the clinic. Having professional care did not bring any positivity to her experience there but, when she moved, her experience of pregnancy changed dramatically due to the relationship with her midwife at the midwifery home. Rena and the midwife were emotionally connected. She sensed the midwife cared for her, trust her, and was genuinely present for her. Even if she was not aware of that, the atmosphere between herself and the midwife brought her unconditional *anshin* and absolute trust. This relationship was undoubtedly meaningful for her and made the entire experience of pregnancy and birth positive despite the two-week separation from her new baby.

Midwives' *anshin* and quality of care

The participants showed the significance of the woman–midwife relationship that embraces *anshin* and trust. The relationship was more of a human relationship than a simple relationship between care giver and receiver. Thus, for midwives, the woman–midwife relationship requires more than professional knowledge and skills. However, professional expertise does not ensure the full sense of *anshin* and trust in the current context of midwifery care in Japan. This may mean that midwives also feel *anshin* and trust in various ways in the woman–midwife relationship besides their confidence and competence as professionals. Takako, an experienced midwife, describes the difference in her emotional states while seeing many women in her practice.

> [When I see birthing women who I have met at antenatal care] I don't feel that it is easy, but I feel at ease a little because that is not the first meeting for me. It is like 'Ah, this one' because I know the person somehow. I don't know everything about her at all, but I kind of feel relieved just because we have seen each other before. I don't need to start with wondering what kind of person she is. I would like to take care of them without problems at birth, and it is good for me to know them and their family. I think women also feel at ease to talk to me when we have met before. I feel they respond to me more than those whom I have not met before when we communicate.

Just having seen a woman makes a difference to Takako's feelings in her practice. Takako feels more *anshin*, which implies that her care experience becomes more positive. Takako's meeting

with each woman is usually temporary, like a dot that is a disconnected part of the woman's maternity care. However, when she sees one woman more than twice, her relationship with the woman becomes a line connecting the dots. The more dots she has with the woman, the line becomes longer and thicker on account of the high density. This line becomes a source of her *anshin* because there are more possibilities for strengthening the emotional connection between Takako and the woman in her care. Takako can hardly see the entire maternity life of one woman in her work environment, but she has sensed the difference between caring for a woman whom she knows and caring for a woman who she does not know. The sense, such as *anshin*, resonates with each individual woman–midwife relationship. Therefore, being in the state of *anshin*, by knowing the women in their care, is important for midwives, too. The midwife's state of mind will affect the atmosphere of the relationship and thus the experiences of both parties.

As seen in Takako's experience, the difference in the midwives' state of mind can make a difference in quality of the woman–midwife relationship. It also affects the quality of care because relationship constitutes care (Y. Noguchi, 2002). Midwives are both professional caregivers and human beings, and like childbearing women, they have emotions and personal backgrounds. The care is always created in the reciprocal human relationship between the woman and her midwife. In the positive woman–midwife relationship, the participants have found extra depth of quality of care more than technically safe (*anzen*) practice. Takako's positive state of mind, such as feeling more *anshin* and more relaxed, possibly adds the positive influence in the depth of quality of care. Feelings, atmosphere, and care are all connected and affect one another in the women–midwife relationship. Midwives' *anshin* enhances women's *anshin*, quality of care, trust in the relationship, and overall positivity of the experience. Therefore, the woman–midwife relationship requires of the midwives a good, healthy state of mind, rather than a polite smile or self-sacrifice.

Different kinds of trust—*shin'yō* and *shinrai*

The participants of this study expressed their feelings of *anshin* and trust in various ways. At the same time, they sensed the difference between the *anshin* and trust in a business/impersonal relationship and that which is developed on a more personal human relationship. Just like a sense of *anshin*, there are different kinds of expressions of trust in the Japanese language. Maya, a first-time mother, talked about the difference from her experience. She earlier stated that she perceived 'an awkward atmosphere' with her midwife, who she met for the first time at her birth. She describes her feelings regarding *anshin* and trust at that time.

> I could trust the midwife because I saw her professionalism or thought she did her job properly. But it was not like I felt at ease or that I could rely on her for everything. The feeling of safety was there but not from the roots. This feeling remained until the end.

Maya implies that there is superficial state of *anshin* and trust in the woman–midwife relationship. She felt *anshin* with and trusted the midwife, but the extent of her feelings was clearly different from how Naomi, Aki, and Rena experienced the relationship with their midwives. In the Japanese language, there are at least two types of expressions for trust—*shin'yō* (信用) and *shinrai* (信頼). *Shin'yō* (信用) basically means credit and to trust based on past records, result, or performance. 信(*shin*) represents to trust or believe someone or something, and 用(*yō*) is (some)thing or business. This is probably the trust which women have when they go to see doctors and midwives in the first place. The trust belongs to the title of the professions and facilities. Maya trusted the midwife, but the trust was based on *shin'yō* as a professional carer. She explains how *shin'yō* did not provide enough *anshin* in her midwife relationship. She required another kind of trust to improve her birth experience.

Shinrai (信頼), another Japanese term for trust, means to place trust in someone. 頼(rai) represents to depend or rely on someone. This includes hopes and expectations of the person as an individual. Maya expected warm care and a relationship that gave her *anshin* and *shinrai*, but her expectations gradually diminished while interacting with a midwife who displayed a rather impersonal attitude. Thus, she ended up not being able to rely on the midwife in a real sense. The ideal relationship between women and midwives has always entailed *shinrai*, whereby individuals can personally trust and emotionally connect with each other—*shinrai* emerges from the other's attitudes or the human relationship; not from professional qualifications or technical performance. *Shin'yō* (professional trust) towards the profession of maternity care is necessary in the woman–midwife relationship, but Maya wanted *shinrai* with the midwife. There was no *shinrai* based on a deep human relationship between Maya and her midwife, and that is why she was not able to feel *anshin* 'from the roots.' *Shinrai* is built on the relationality and history between woman and midwife. When they really develop their relationship, *anshin* and *shinrai* will take root in their shared world. Then, they can feel *anshin* and *shinrai* from the heart for the first time.

Maya was not able to obtain *anshin* and *shinrai* in the woman–midwife relationship, and the relationship affected her life after birth. She comments:

> I didn't feel a connection with them at all. I never saw them after the one-month check-up. I gave birth smoothly without problems. So, it seemed that that's all for midwives and doctors. I stayed there for several days and I remember them, but they would forget me. Although I chose to give birth in my neighbourhood, it was not the place where I could run to when I was suffering after birth.

Due to the lack of emotional connection, including *anshin* and *shinrai*, Maya was not able to ask for help after she left the clinic. Her state of mind was based on her experiences during the clinic stay. She could have gone to the clinic to ask for help, but the atmosphere she sensed there did

not allow her to do so. She was not able to become attuned to a world of *anshin* and *shinrai* until the end, and her parenting life became hopeless due to the influence of the woman–midwife relationship. She could not blame the midwives because she did not have any specific problems in terms of her pregnancy and birth, and their care was technically and managerially safe and proper. However, she was not able to live her life after birth with a sense of *anshin* and *shinrai*. In Japan, many women suffer from postnatal depression and psychological issues after giving birth. To this point, not being attuned to a world of *anshin* and *shinrai* in the woman–midwife relationship is a considerable matter for the women's psychological well-being.

Being a professional or providing proper care was different from bringing about *anshin* and *shinrai* in the participants' experiences. If *anshin* and *shinrai* are such significant matters in the woman–midwife relationship and affect experiences during and after the women's maternity life, emotionally and humanly connecting with each woman and providing *anshin* and *shinrai* should be part of midwives' professional expertise. However, *anshin* and *shinrai* are not something they can simply 'provide.' Also, there is no clear border between professional trust and human relational trust in the woman–midwife relationship. *Anshin* and *shinrai* are phenomena of fusion between the being of a woman and a midwife, and they are built through reciprocal experiences. As a result, women and midwives are spontaneously attuned, where possible, to a world of *anshin* and *shinrai*. Enhancing the human relationship can be a way to achieve such a woman–midwife relationship and to sustain women's psychological well-being.

Relying on and entrusting midwives

The participants further describe their experiences of the woman–midwife relationship based on human or *shinrai* (trusting) relationship. More specifically, their experiences illustrate what allowed them to really rely on or entrust their midwives. Two mothers, Uta and Aki, had situations where they might have needed help from midwives, but their experiences were contrasting. Uta describes her experience.

> I was told that they (the hospital) couldn't help with breastfeeding much after I was discharged, and to call someone on the list they gave me if I needed to ask for help. I called the hospital once because I worried about my discharge. But they recommended me to go to a clinic close to my house because I had to wait to see a doctor and had to pay extra 5000 yen (NZ$40) without a reference letter even though I had a baby there. I found out they really can't help me after I left there. I wanted to ask for help [on breastfeeding], but I didn't call any place on the list. I wished I had a place to talk casually. A place to get a support. I really didn't have it. My mother told me to call the hospital once, but I knew they wouldn't take care of me. I just struggled with looking after my baby at that time.

Aki also speaks of her experience when she had trouble with breastfeeding.

> I had a lot of problems with breastfeeding with my first baby. I had thought I would talk with my midwife when needed, but I was able to manage somehow by myself. With my second baby, it was very smooth and I had no problem, so I didn't need to ask her help. But I knew that I could have asked her if something had happened. The idea was always in my mind. I had always trusted her indeed. If I had been separated [from my midwife] after birth and had to go another place for breastfeeding care, it would have been very challenging.

Both Uta and Aki had trouble with breastfeeding, but their experiences and state of mind were very different. Events, such as parenting and experiencing problems, were not themselves the cause of how these women came to be. Rather, the women's being was already there in the world in which they were situated. That is, Uta's postnatal issues did not directly make her suffer or feel anxious; she was filled with *fuan* (anxiety) because of her situation in which she did not have anyone to rely on. Uta's experience also shows us that the care system disconnected her and the midwives. Uta was previously not able to strongly connect to, and rely on, any midwives in the hospital. However, she once tried to ask for help because the hospital was the only place where she could imagine asking for assistance when needed. The experience instead resulted in the collapse of her last remnants of courage and hope. The system, which hinders any kind of relationship, ignored her hopes and feelings, as well as midwives' possible hopes for continuing to care for one woman. It broke Uta's last emotional connection to the professionals and the opportunity to obtain the necessary care.

Giving women a list of clinics or midwifery homes providing breastfeeding care was a mode of seamless care for the midwives of the hospital or the maternity care system, but there was a huge gap for Uta between asking for help from the midwives she knew and asking new people. As a consequence of the fragmented care she was full of *fuan*, and no one knew her suffering. Uta and Aki show us again that women cannot ask for help or rely on midwives just because they are professionals. These women wanted to ask for help only from the midwives they knew. The care system ignored, or was not aware of, the significance of human relationality and women's state of mind.

In contrast, Aki was in the profound state of *anshin* (peaceful mind) due to deep *shinrai* (personal trust) in the midwife, regardless of any issues. In Aki's mind, the midwifery care continued as she felt her midwife would help her anytime she wanted. The *anshin* and *shinrai* she obtained from the midwife relationship during her pregnancy and birth shaped her world, affected life after birth, and gave her the confidence to deal with problems by herself as much as she could. The woman–midwife relationship of the midwifery home, which is usually developed through repeated personal shared experiences, had meaningfully constituted her world. This relationship

resulted in great possibilities for avoiding the adverse effects of the dominant care system and filling Aki's life with *anshin, shinrai,* and confidence, whatever happens.

Being able to ask for help without hesitation and to rely on a midwife indicates *anshin* and *shinrai* in the relationship. When women achieve a satisfying relationship with their midwives, they also entrust their midwives with everything. Ema and Hana describe how they entrusted their midwives and how that made a difference in their birth experiences. Ema moved from a hospital to a midwifery home for her maternity care, and she describes the experience as follows.

> The doctor told me that there was no choice other than giving birth on a birthing table as normal. After I knew that I couldn't give birth as I wanted in the hospital, I talked to someone about that. The person suggested to wait to go to the hospital until the very end of the labour. But giving birth with such worries was not natural. That was not what I wanted to experience for my birth. So, I had to worry a lot. I had many unnecessary anxieties, for example, whether or not I could refuse medical interventions. At the midwifery home, I thought, 'I can really listen to everything what this person says.' I was sure that I could follow the midwife if she said that I had to go to hospital because of some problems. I trusted her, and I thought I could focus on my birth without any concerns with her.

Hana describes her experience of her third baby's birth, including the significance of having had the same midwife throughout her maternity care for the first time.

> The way of entrusting myself to the midwife was different at the peak of the labour. I could focus on only myself without thinking. I think I could do that only when the same person was with me. You open up your legs in front of someone you have never seen before in the hospital. I might be embarrassed by that even if I was already in pain and knew that was the only choice. Some people may not want anyone they know to see their birth, but it was good for me because I could completely give myself to her. When I gave birth, I felt 'I did it!' I don't know how to express that, but I didn't have any discontent. Her care couldn't be better, although I wouldn't say the birth was perfect. We had older children, so the room was messy, and I was going to use aroma therapy, but I didn't. But I didn't have any regrets at all.

Anshin and *shinrai* allowed Ema and Hana to completely entrust their birth and themselves to their midwives. The sense of trust in professionals entirely changed based on different places and relationships. This means that the difference in the relationship changed these women's ontological world. In Ema's case, even though she tried and struggled with taking initiative in the hospital, she let go of the initiative in the relationship with her midwife. Or perhaps she was sure that she already had initiative and did not need to fight or stick to it. Entrusting someone with one's birth and body is not giving up one's voice or initiative. It occurs in *shinrai*. The relationship between these women and their midwives deserved the confidence gained from entrusting a person whatever happens.

Ema also sensed what the professionals valued in her care through interactions with the doctor and midwives in the hospital and her midwife from the midwifery home. That is, she identified the difference between hospital-centred care and woman-centred care. The midwife allowing Ema to be at the centre of her care engendered *shinrai*, which was something that was not supplied by the doctor and midwives who did not really listen to her hopes. That was more valuable than advanced medical services and professionals for Ema. This is a reasonable outlook on her part because she had to keep worrying about what would happen during her birth under the hospital's care. There was no real safety; It would be medically safe (*anzen*), but there was no *anshin* and *shinrai* in the hospital. The women relied on and entrusted their midwives when they felt that the midwives personally deserved *shinrai*. Alongside other participants, Hana and Ema intuitively distinguished these differences among midwives or professionals.

Hana's experience of entrusting her midwife further resulted in great concentration and a feeling of achievement upon giving birth. She was fully empowered by the sense of *anshin* and *shinrai* developed in the midwife relationship throughout her maternity life journey. The sense was embodied and cast away any concern or doubts in her mind. The body was the very subject of the experience (van Manen, 2014). Hana was able to open up her body and let it go without hesitation because she had completely opened up to and entrusted her midwife. She let everything go based on *anshin* and *shinrai* in the relationship, and this was far different from giving up or following everything. Her world, including the woman–midwife relationship, was ready to be oriented toward a sense of satisfaction and empowerment. Such an affirmative experience will help attune these women to an overall positive attitude towards childbirth and their futures as new mothers.

Becoming/making a mother

As seen in the experiences of the women above, a woman–midwife relationship wherein women can entrust themselves to their midwives' care is more likely to empower women rather than lead women to over-depend on their midwives. Both Kumi and Uta believe that they were helped greatly by their midwives during their birth facility stays, but their experiences were in complete contrast. Each describes how the woman–midwife relationship affected her state of mind when leaving the facility. Kumi had the same midwife throughout her maternity life journey with her two children and recounts her experience as follows.

> [During the labour] she (the midwife) massaged the right spot even though I didn't say anything. That was amazing. It was exactly in the right spot and the pressure was perfect. It was incredible. She let me do as I liked, and I did what I wanted. When it was all finished, I felt a sense of accomplishment. The birth was not so easy, but I was so excited. After birth, I stayed at her maternity home for four nights. The meals were so delicious. I was able to spend my time with my pace there. Both babies (the first and second babies)

> slept very well, so I didn't need to struggle with them. But my second one didn't sleep one night. Then when I was sleepy, she (the midwife) told me, 'I will take care of her.' She looked after her for about two hours. I was able to have a good sleep and when I woke up, my baby was sleeping next to me. That was very helpful. She told me, 'Tell me anything' and 'If there are any questions, call me anytime, even after the midnight.' She always came to see me. She came quickly even for a small thing. She was sleeping at the same place, probably next to my room. So, if my baby cried long, she soon came and asked me, 'Are you okay?' I was so relieved. She answered all my questions and I spent time there with feeling safe. I didn't want to go home. She told me, 'You can stay more, but we have nothing to do.' I said, 'If so, I will go home.' I had a plenty of breastmilk and was able to imagine how to take care of my baby. I was confident to go home with my baby. She taught me how to bath the baby, how to change nappies, and how to burp the baby. She taught me thoroughly for four or five days, so I felt I could go home.

Uta describes her experience during her postnatal hospital stay and her state of mind when she left the hospital.

> The midwives might have said that I had to breastfeed every two hours in a class or somewhere, but I didn't remember that. I realised that I really had to do that three days after the birth. On the previous day, I had guests and did not breastfeed my baby for four or five hours. A midwife checked my record and I got in trouble. When I was told that, I was shocked because I felt so sorry for my baby. They explained that concern to me as if I had already known everything. I couldn't catch every important thing from the beginning. I had to take care of my baby with all new knowledge. Therefore, I had to listen to what they said with anxiety while wondering if I was really doing okay. I even became too nervous to remember what they said. I had only anxiety when I left the hospital. I wondered how I could look after my baby by myself at home because I was doing that somehow with a lot of their help in the hospital. The only thing I could do was to encourage myself, telling myself that I just had to do it and that everyone did that. I was full of anxiety at that time.

Kumi and Uta's attitude towards motherhood reflected the care and the woman–midwife relationship they had experienced. Kumi's midwife instinctively knew how Kumi was doing by being present for her. In contrast, Uta's care was managed with a written record of fragmented care and under the direction of the midwives. While Uta feels that she had considerable help during her stay in the hospital, the help she received did not encourage or empower her in any way, as there was no *anshin* and *shinrai* between Uta and the midwives. In fact, she became nervous and anxious through her interactions with them. In contrast, Kumi became self-reliant after her deep dependency on her midwife. The utmost care and attention that Kumi received sounds almost as though she was being spoiled by the midwife's care. However, Kumi realised her own self-accomplishment in her baby's birth and was confident when she left the midwifery home. With her midwife, Kumi was surrounded by a warm, relaxing, and respectful atmosphere, which brought her the maximum *anshin* and *shinrai*. She felt protected, and the place was so safe and reassuring for Kumi that she felt ready to leave and move on to her new life. Uta, however, found her care and midwife relationship to be threatening to her transition to being a mother,

fostering negative feelings such as loneliness and helplessness in her parenting life. In both cases, the midwife relationship shaped their lives as mothers.

Childbirth is "about making mothers—strong, competent, capable mothers who trust themselves and know their inner strength" (Rothman, 1996, p. 254). Kumi and Uta show that they were not ready to become such a mother simply because they gave birth. In order to become confident mothers, they needed to immerse themselves in a warm, respectful atmosphere more than merely receiving the help of their midwives. The atmosphere that surrounded them deeply affected what they would become. In other words, they could become confident mothers only when being kindly cared for, feeling cherished, being filled with a sense of *anshin* by others, and being able to *shinrai* others; rather than being directly encouraged to be autonomous individuals. Such a relationship with a midwife allows them to feel connected and maintain the harmony with others in their lived world—an important element of many Japanese cultural practices.

Furthermore, a midwife relationship filled with *anshin* and *shinrai* works as invisible protection and a safety net for the women as they confront their new roles as mother. Kirkham (2010b) insisted that the feeling of safety 'held' by her midwife enhances a woman's long-term confidence as a mother. Accordingly, *anshin* in the midwife relationship enhanced Kumi's self-confidence, and *shinrai* in the relationship evoked trust in herself. For Kumi, the time, space, atmosphere, and even food positively constituted the world that formed her; and her relationship with the midwife created a world that defined her as the mother she would be. There is no doubt that Kumi became positive and confident in the satisfying relationship she had with her midwife.

Kumi described her midwife's care as 'amazing,' 'perfect,' and 'incredible.' Of course, her midwife's skills as a caregiver must have been high quality, but not necessarily extraordinary in any technical sense. Why did Kumi have such high praise? Kumi's valuation resulted from the totality of the experiences she had in her history with her midwife, beginning with her first pregnancy. More specifically, the sense of *anshin* and *shinrai* she felt towards her midwife already ensured the midwife's high quality of care. The intuition and bond established with her midwife allowed her to achieve this exceptional level of satisfaction and positive experience. Ultimately, the woman–midwife relationship is not a managerial option that can be selected; rather, it is the ontological foundation of the care and experiences. The woman–midwife relationship creates the woman's perspective and being, and the relationship is established through the time, space, and atmosphere that the woman and her midwife share. Through this process, it is important that women feel *anshin* and *shinrai*. This changes their entire experience and perspective of becoming a mother.

From the viewpoint of a self-employed midwife, Jun states how she encourages the women becoming mothers when they leave her midwifery home.

> I tell mothers to call me to think the reason together when their babies cry in the night and they really don't know what to do. My words become an *omamori* (a Japanese charm) for them. They think that they don't need to solve everything by themselves. They can call me anytime and when we think together, they ease up. I guess then babies feel the calm feelings from their mothers. I help them to find the answer. I support them and sometimes offer suggestions. I want them to stand on their feet, but the genuine independence is not doing everything all by themselves. People who can ask for help when they really suffer or when they did their best are independent people in the real sense of the term. Women who try hard and hold their issues by themselves until committing suicide are not the ones we call independent.

For Jun, maintaining a woman's *anshin* is a way to encourage the woman to become a self-sustaining mother. To do so, she assures the women in her care of their continuous connection with her even after they leave her midwifery home. *Omamori* is a Japanese charm that offers luck and protection. People usually obtain it at shrines, which is blessed by a Shinto priest. At times, people make it for others to support them by making a wish. In a previous study, Doering (2012) described how Japanese women who gave birth in New Zealand kept *omamori* around them during pregnancy and grasped it tightly during labour. *Omamori* made those women feel at ease simply by holding it while they gave birth in a foreign culture. Likewise, Jun recognises that mothers need to feel protected in challenging situations and she has a role to be such an *omamori* that can give them *anshin*. Here, *omamori* is a supportive encouragement and protection from Jun to the women, which they can keep in their mind, even after they physically separate from one another.

The relationship Jun develops with the women allows her to be always present in their mind, like an *omamori*, because she has already established a strong connection with each of the women and she will respond to them whenever they might need her in the future. Thus, having a trusted midwife enables the woman to approach new challenges, in addition to birth, with confidence (Edwards, 2010). The hospital midwives may also say, 'call us anytime' to give a feeling of *anshin* to the women in their care, but calling a hospital and directly calling a trusted midwife are vastly different experiences. Only when the woman and her midwife have established a *shinrai* (trusting) relationship can this *anshin* become like an *omamori*. In fragmented care, moreover, the midwife needs to focus on immediate issues and solutions, and the care is more likely to be routine or haphazard, lacking a long-range or holistic view. It is difficult for those who seldom see the consequences of their care to imagine how each woman will be as a mother and to provide lasting *anshin* and *shinrai* that the women carry with them into motherhood.

In contrast, the relationship Jun builds with each woman serves the woman's inner strength during the childbearing period and afterwards. In fact, Jun cares for each woman by looking to future consequences or imagining what kind of mother the woman will be. Jun has a long-term relationship with each woman, and thereby she naturally has a long-term perspective when taking care of the woman. That is, Jun attempts to share the sense of *anshin* and *shinrai* with the women for their future. With this anticipation, the woman's parenting life seems to be already directed in a positive way that benefits the woman's baby and family; as Jun states, a woman's *anshin* influences her baby.

Edwards (2010) maintained that becoming a competent mother is developing agency, which is "a relational process that is best accomplished with supportive others" (p. 103). The woman–midwife relationship involving *anshin* and *shinrai* can be the agency that develops a mother with courage and confidence. Jun facilitates and recognises the woman's growth and independence by being present for, listening to, talking to, and helping her. Hence, the *anshin* and *shinrai* of the woman–midwife relationship fundamentally brings about the woman's strength as a mother—her self-knowledge, self-trust, self-determination, and the strength to ask for help. The well-established woman–midwife relationship filled with *anshin* and *shinrai* can be the foundation for making a strong and supple mother.

An emotional bridge

Women meet their midwives during their journey to becoming a mother. The women in this study have shown that the woman–midwife relationship has a significant impact on their journey and how they become a mother. When they begin their new life as a mother in a positive way, *anshin* and *shinrai* have always already been in their world. At that time, they are also empowered and mentally sustained by the relationship with their midwives. The women of this study show the meaning of being empowered in the midwife relationship and how their midwives' care constituted themselves as a mother. Orie describes it in the following way:

> I became sleepy during labour [of the second birth]. Then the midwife told me, 'If you are sleepy, just sleep' and we dozed off together. At the first birth, I had midwives, but they were switched a lot. They were strict and said, 'Don't sleep. Move to accelerate your labour.' I had serious vomiting and diarrhoea, but they didn't give me good care. I felt left alone. I had my baby safely, but I left the hospital with unpleasant feelings. I don't remember the midwives, but I remember an atmosphere of 'Not again!' from them when I vomited and called them. Therefore, I changed the hospitals for the second time. She (the midwife of the second birth) accepted me. During labour, I kept saying my leg would break and asked her to hold it. She kept holding my leg for a long time. That remains in my mind. Also, when my baby put out his right arm with his head [while being born], she told me, 'You can touch your baby now.' If she was the kind of person who thinks only delivering a baby, she would never have said that. Then when my hand reached to him, we held hands. I was so moved by that. That created, and still is, an emotional bridge for

> me. I think I drew influence from the midwife of the second and third birth through the pregnancy and after. I became positive. I sometimes remember her. The biggest thing she gave me was a peace of mind.

Orie's experience of the woman–midwife relationship was that it restored a peace of mind—*anshin*—as a mother. She was once hurt, but now empowered by midwives through her different birth experiences. Perhaps only midwives could heal the emotional damage that was caused by midwives. In fact, even though her emotional scars had remained for the years until her second birth, another midwife's care, simply holding her leg during labour and letting Orie touch her baby's hand, was enough to make Orie positive. She felt kindly cared for and respected as a person in the new relationship. The relationship with a midwife can be that simple and powerful for women. Orie did not feel that extent of care from the midwives during her first birth experience, and there is no doubt that she felt devastated as a first-time mother. Conversely, Orie regained her self-respect by feeling treated as an important person during her second birth. The relationship with the midwife re-established her confidence as well as a sense of *anshin* and *shinrai* to be a confident mother.

In Chapter Six, Orie talked about her experience of feeling scolded by a midwife and stated, "I was insecure with whatever I did to care for my first baby because I had this shocking experience." The woman–midwife relationship became the source of her torment during her first parenting, although simple interactions with another midwife made a positive difference in Orie's state of mind. Thus, a woman's negative birth experience can negatively affect her parenting and life after birth, in the same way that a positive experience positively affects these things. These experiences are rooted in the relationship that a woman has with her midwife. The differences in both experiences were whether Orie felt the care atmosphere was warm and respectful, and whether the relationship evoked *anshin* and *shinrai* between Orie and the midwives. The differences had significant impacts on her psychological well-being as a mother.

Orie's positive experience with her midwife created an emotional bridge towards motherhood and possibly a lifetime. Creating an emotional bridge means that her experience became an emotional support and developed a psychological foundation that she can stay strong. She was encouraged and empowered by having a trustful midwife who respected her and gave her *anshin*. Due to this experience, she can now believe in her own strength as a mother. An emotional bridge was one of the most meaningful consequences Orie could have in the relationship with her midwife. In other words, women may lose mental sustenance to live as a capable mother when the midwifery care and relationship lack *anshin* and *shinrai*.

Aki also talks about how she gained strength as a mother from the woman–midwife relationship.

> I powerfully felt that I achieved that on my own [when the baby was born]. I did my best and my baby was finally born. The gladness of the birth was, no, it was not like that. I was relieved at the moment. 'It's out!' But when I hold my baby in my arm and spent with him all night for the first time, I could not sleep at all. I kept staring at the face of my baby. I never got tired of watching. I could keep watching him all night. I wondered 'What is this? This is amazing.' and I was so, so happy. I had never felt such a feeling before, and the night was terrific. I had the [special] night. That's why I always feel my baby is precious. Until then I didn't have confidence in child-raising. Not only raising a child but also giving birth. I had a kind of trauma and felt, 'Can I raise a baby properly? Can I think the baby is precious? I am not sure.' But thanks to the midwife, it turned into a really valuable experience. That really made a difference and connects to all aspects of raising children after. She treated me as a person even when checking on me [at antenatal care]. I realised this when I had a palpation. She really considered me, and that was exactly how to be treated nicely. How you are treated will be how you treat your own children. I really thought that. She respected my dignity. That gave me confidence when I accomplished [my birth].

The relationship with her midwife enabled Aki to maintain her dignity, and positively guided the way in which she would live her life with her baby. She achieved the greatest satisfaction in the warm and respectful atmosphere, and the experiences strongly bonded her and her baby. The bond fundamentally changed her mind towards child-raising. She believes this emotional bridge was brought about by her midwife. Her midwife's care made her feel valued, and she learned first-hand how to treat others and their babies, how to be thoughtful of others, and what valuing the dignity of other means. She learned valuing of both herself and others through the relationship with the midwife. Aki pays forward the positive relationship she experienced with her midwife to the relationship with her baby. Her experience suggests that women who are respected by their midwives will know how to respect their children. Also, the *anshin* and *shinrai* that embraced the women will spread to their babies and those around them.

In addition to the bond developed with her baby, Aki gained self-esteem as a person. This may appear to happen almost in a moment during the accomplishment of her birth, but it is also the gift of the relationship developed between Aki and her midwife. Her sense of fulfilment was cultivated in the relationship with her midwife who believed in Aki's potentiality to become a loving and competent mother over time. She was filled with *anshin* in the relationship by feeling love, kindness, respect, and *shinrai* from her midwife. The emotional connection she felt with her midwife empowered her as a mother. The woman–midwife relationship can build women's self-esteem and confidence as mothers, as well as their maternal instincts to attach their babies. In Japanese society, where many mothers suffer from anxiety and depression, and infant and child abuse is a serious issue, the woman–midwife relationship, as seen in Orie and Aki's experiences, may play an important role in improving this regrettable situation. The women–midwife relationship that assured *anshin* and *shinrai* rebuilt the women's self-esteem, boosted their capability as a mother, and created an emotional bridge.

Summary

This chapter focused on the participants' lived experiences of *anshin* (peace of mind) and *shinrai* (trust) in the woman–midwife relationship. In the relationship, the women of this study deepened their feelings of *anshin* and *shinrai* by accumulating many meaningful shared experiences with their midwives, and these feelings mutually deepened through the shared experiences. It was also shown how *anshin* and *shinrai* are different from obstetric or technical safety and trust towards professional qualifications. Rather, it is a personal, human relationship between individuals, in which *anshin* and *shinrai* are developed over time through reciprocal interactions and understandings between a woman and her midwife. Having known each other enhanced their sense of *anshin* and *shinrai*; and for the women, *anshin* and *shinrai* were fundamental positive birthing and parenting experiences.

The participants of this study showed that the women were able to ask midwives for help and rely on their midwives without hesitation only when they felt *anshin* and *shinrai* in the woman–midwife relationship. Within the *anshin* and *shinrai* relationship, they could entrust everything to their midwives and let things develop naturally during labour and birth. As a result, the women were able to focus on their birth and obtain a sense of accomplishment. Through such a process, the women experienced trusting in themselves, gained confidence and became independent. The sense of *anshin* and *shinrai* underlay such experiences at all times. These experiences, as well as the experiences of not having *anshin* and *shinrai*, affected their experiences of parenting.

Where the woman–midwife relationship was well established, there was always warm and respectful care. Such care further enhanced the women's self-esteem, self-confidence, and self-reliance. Midwifery care is all about the relationship between woman and midwife, because care is constituted by themselves. The care and relationship characterised the women and midwives' perspectives of their experiences and directed their future experiences. Relationships embracing *anshin* and *shinrai* were shown to empower the women to become capable mothers and to enhance the bonding between woman and baby. This means the ontological being of the woman–midwife relationship forms the being of the mothers in the future. Such experiences are a significant part of the journey towards confident motherhood and create an emotional bridge for the women.

Chapter Ten: Discussion and Conclusion

This thesis has explored the meanings of the woman–midwife relationship in Japan. The study found the significance of the woman–midwife relationship is that it provides psychological safety for both parties in maternity care settings. The relationship has clear implications for the women's birth experience, and it was shown that a positive relationship with their midwives improved women's birth experience and empowered them as they become mothers. Such a relationship should not be an option; rather, a basic human right for women in all maternity care settings. However, it appears Japan is far from achieving this basic human right for women. As the study showed, the importance of the woman–midwife relationship is not holistically valued in many of the care settings within Japan. Without a more nuanced awareness of the effects of the woman–midwife relationship, and institutional transformation to relationship-based care, any concepts of midwifery care will remain limited in their ability to create a maternity care environment where women feel psychologically safe, secure, and empowered.

This chapter synthesises the findings of the study with related literature and draws conclusions regarding the meaning of the woman–midwife relationship in Japan. The discussions of the study findings suggest implications for midwifery education, practice, and further research. Strengths and limitations are also considered to evaluate the significance of this study and to establish connections to future research. I conclude this thesis with my thoughts, self-evaluation, and hopes in relation to the woman–midwife relationship in Japan.

Psychological safety and safe care

This study found the woman–midwife relationship is important because it offers the time and space for women to experience and cultivate the feelings of *anshin* (safety), *shinrai* (trust), and confidence. Japan is internationally recognised as the safest country in which to give birth or be born due to its world-leading low maternal and neonatal mortality rates (UNICEF, 2018; WHO, 2019). While these statistics are impressive, it is important to recognise that women's anxiety during maternity life and child-rearing, postpartum depression, suicide of pregnant women and new mothers, and baby abuse have increasingly become serious social issues in Japan (S. Abe, 2016a; JAOG, 2017a). Thus, women and their babies' may be physically healthy and survive birth but, as this study found, in many places there is a lack of psychological support in maternity care. That is, many women do not feel psychologically safe giving birth in Japan, although a 'safe birth' is technically guaranteed. In fact, some study participants reported feeling nervous and anxious in the 'cold' care settings of birth facilities; while others felt helpless, alienated, and unconnected in the experiences with their carers. Even if they did not directly express the feelings,

the atmosphere they described and their embodied responses revealed the absence of psychological safety.

Some participants did have positive birth experiences based on the relationships with their midwives. In such a relationship, the woman and her midwife knew each other, felt an emotional connection, and developed a mutual understanding and trust. They also expressed themselves freely and openly in their own voice. Above all, they felt *anshin* and *shinrai* in the relationship. The woman–midwife relationship comprising of such elements could be acknowledged as a positive or well-developed relationship. This kind of relationship is what ensured women's psychological safety. This study has shown that such psychological safety accounts for the physical, emotional, spiritual, and social safety of women. van Manen (2016b) discussed the meaning of a phenomenon is a fundamental essence that shapes everyone's experience by rights. In maternity care, psychological safety is that which all women should have by rights. In other words, the woman–midwife relationship can serve as the foundation of psychological safety for women going through their maternity life journey.

In the current context, where ideas of risk and fear are the norm regarding childbirth, pregnant women and mothers are naturally worried and scared (Lyberg & Severinsson, 2010; McAra-Couper, 2007; Nilsson & Lundgren, 2009). This discourse of risk and fear helps idealise a medicalised vision of birth, where trust in medical facilities and advanced technology are perceived as the tool to ensure a safe birth. However, in this process, psychological safety plays only a minor role. For women, maternity life includes more than just the clinical procedures involved in having a baby. It is a physical, emotional, social, and personal journey that poses challenges in the life of pregnant women. During the journey, it is essential to feel safe, and this study has shown that psychological safety is ultimately obtained through human relationships. In the absence of such a relationship, women's journey through childbirth will be a daunting challenge, and women and their babies would be unequipped to deal with the very real dangers posed by postpartum depression, suicide, and infant abuse that is so prevalent in Japan.

Safety in the birth experience is the first priority for all women and midwives; but, often forgotten, is that safety consists of both psychological and clinical dimensions. B. Hunter et al. (2008) maintained that relationship sustains safe maternity care. The meaning of the woman–midwife relationship is to create and achieve real safety by nurturing and protecting women's psychological well-being. The WHO (2018a) maintained 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. This resonates with the meaning of the woman–midwife relationship and the significance of ensuring both psychological and clinical safety for women as indicated in the current study.

The woman–midwife relationship is meaningful for women because even negative clinical experiences can become positive if there is someone to psychologically support them with their concerns. In the study, when two women had a similar incident involving breastfeeding troubles, their experiences ended very differently depending on what kind of relationship they had with their midwives. In these cases, the relationship with the midwife was not an additional option to help solve their issues. Rather, the relationship shaped their behaviour and actions, and subsequent experiences, in terms of how they dealt with their problems. That is, good relationships positively shape their experiences, and the relationships lacking psychological safety, such as *anshin* and *shinrai*, negatively affect their experiences. The woman–midwife relationship clearly makes a difference in the woman's experience.

The participant women's experience also implies the possibility that the midwife relationship may impact women's birth experiences to a greater extent than technical, practical, or clinical issues. If so, the woman–midwife relationship could help women overcome difficult situations they may face during their maternity journey. One woman in the study perceived her experience positively because she had felt *anshin* and *shinrai* with her midwife, although her baby was transferred to a hospital and she was away from her baby for two weeks. For those who had good relationships with their midwives, their resulting experiences and perspectives created an attitude that allowed them to respond in a positive way, even in the face of adversity. Deery and Hunter (2010) maintained that even in sorrowful situations, such as a still birth, a trustful relationship between woman and midwife supports the woman, and the woman and her midwife can accept the experience as one that was as good as it could be. The woman–midwife relationship has such a potentiality as its value.

The relationship becomes a safety net and instils confidence in the mothers because they can be attuned to the world of *anshin* and *shinrai* anytime due to the relationship they established with their midwives. Such a woman–midwife relationship was described as an *omamori*[3] in this study. The *omamori* for the women was the ability to think *daijobu* (大丈夫), which means 'I am okay,' 'I will be fine,' and 'it is going to be all right.' The term *daijobu* is also used to mean 'No problem,' 'You are fine,' and 'Don't worry' in the Japanese language. The word *omamori* was spoken by one of the midwives as a metaphor in her interview, but the participant women also used the word *daijobu*, meaning that they felt okay (*daijobu*) as long as they were with their midwives. In the minds of those women, the midwife relationship evoked a sense of *daijobu* based on their feeling of *anshin* and *shinrai*, and it became a belief and protection, like an *omamori*. Such a relationship

[3] Japanese charms that offer luck and protection—usually blessed by Shinto priests and given to people at shrines

clearly enhances women's psychological safety. However, developing such a relationship requires time to be genuinely present to, commit to, listen to, and understand each other.

As previously noted, postnatal issues, such as postpartum depression, have become serious in Japan. Yet, the Japanese health care system, including midwifery care, has focused on treating the symptoms and addressing these issues at the individual level during the postpartum period. This study indicates there are potentially greater possibilities to redress such issues during the antenatal and birthing phases. For instance, women and midwives can develop a relationship across all phases of the maternity and birth experience, in order to obtain the feelings of *anshin* and *shinrai* and instil confidence in women, which is one of the most powerful preventive measures for postnatal mental health issues. During the period of preparing to become a mother, it is essential for a woman to build a good relationship with her midwife and to foster her psychological well-being, which can significantly affect her postpartum, child-rearing, and life.

The current maternity care strategies of the Japanese government and maternity care facilities emphasise the implementation of the care model entitled 'seamless support' in order to improve women's postnatal experience (MHLW, 2017d). However, little attention or consideration is given to continuity of human relationships in the model, as the care still focuses on managing women's information and resolving problems, including the screening and sorting of issues. Professionals and facilities may think they provide women with continuity of care by sharing information among professionals, but the care is not really continued for women and does not actually connect individual women with midwives. Perdok et al. (2018) labelled such continuity of care as information or management continuity. The women of this study described such care, which constantly meant having to meet new midwives, and involved discomfort, hesitation, and other negative feelings. Those women would not be able to psychologically feel safe in the current care system. Providing enough time for the women to truly feel safe requires continuity of the relationship with their midwives throughout their maternity life journey.

Midwifery continuity of care

Midwifery continuity of care (MCOC) is the model that ensures a woman has maternity care from a midwife, or a small group of midwives, throughout her antenatal, intrapartum, and postpartum periods. This means the woman and her midwife have many opportunities to share time and know each other throughout her maternity life. Research has shown that MCOC improves clinical outcomes, women's satisfaction, and cost-effective care (Boyle et al., 2016; Homer, Brodie, Sandall, & Leap, 2019; Moncrieff, 2018; Sandall et al., 2016; Tracy et al., 2013). However, it is not clear *what* precisely makes MCOC so beneficial (Sandall et al., 2016; WHO, 2018a). To address this concern, Perriman, Davis, and Ferguson (2018) have conducted a systematic review to identify women's perspectives on MCOC and found that women value personalised care, trust,

and empowerment that the MCOC model offered. The current study shows similar findings but further suggests, through analysing the participants' lived experiences, that development and continuity of the relationship in the MCOC model also establishes psychological safety between the woman and her midwife, resulting in positive clinical safety of women and their babies.

That is, women's positive outlook or peace of mind, such as *anshin* and *shinrai*, are founded on a human relationship with their midwives, and such a positive state of mind could lead to desirable outcomes for their health and well-being. In fact, the participants' minds and bodies simultaneously and instantaneously responded to their experiences. This implies psychological safety enhances clinical safety. MCOC makes clinical care even safer and leads to improved outcomes because the potential to develop a relationship through MCOC makes women feel safer due to the many positive factors discussed throughout the findings chapters. Childbirth is highly medicalised in Japan, and increasingly more women are diagnosed as 'high-risk' in this maternity care system (Nakai, 2019). Even if Japan has low maternal and perinatal mortality rates, MCOC will further improve clinical issues. Of course, psychological safety does not always guarantee positive clinical outcomes. However, as mentioned earlier, psychological safety developed in a woman–midwife relationship makes a difference in women's perspectives of their experiences even when they face clinical difficulties.

In the present study, the participant women and midwives who were involved in midwifery home care had more positive woman–midwife relationships, and birth or work experiences, than those participants who resided or worked in medical facilities. Research supports women's higher level of satisfaction and has confirmed safety of birth in midwifery homes (Igarashi, Wakita, Miyazaki, & Nakayama, 2014; Iida et al., 2012; M. Noguchi, 2002; S. Suzuki, 2016), which seems a logical consequence in terms of the woman–midwife relationship. Community-based midwifery care, such as care in midwifery homes and homebirth, often involves continuity of carer and a life model that enhances a holistic view towards the life of each woman; not a medical model that tends to seek out and focus on issues.

The current study also found that, in continuous relationships of midwifery home or homebirth care, women and midwives are able to know and understand each other through sharing information, ideas, and experiences. The midwives can be present, listening, and being with women, because they can have or create time and space to do so. The woman and her midwife are relaxed in that familiarity and they come to trust and rely on each other. The midwife also recognises small signs and changes of physical and psychological conditions of the woman. It is reasonable that midwives' practice becomes proper and safer in such a well-developed relationship with the women in their care. Some participant midwives of this study also stated they felt more secure and the birth was easier with women they knew. Real safety of childbirth

may occur with such feelings of relaxation and safety. The continuity of the woman–midwife relationship supplements and completes the safety of care.

Midwives' care, including their words, attitudes, and methods of communication, will also change in continuity of relationship, because midwives understand the *being* of the woman—her history, beliefs, hopes, and potential abilities. For example, the midwife will know better about what to say and how to assist the woman when they know each other. That is, the continuity of relationship enhances midwives' *tactfulness*. van Manen (2016b) discussed how tact in a relationship grows on the basis of seeing, listening, and responding to the other; and that tact comes from the heart while knowledge is external. There are no certain rules or right answers as to what to say or what to do in a relationship because everyone's experience is unique. Each midwife's tactful care emerges from her thoughtfulness, imagination, understanding, and trust, deepened in each relationship with a woman. Similarly, midwives can trust the woman's ability and assess her capabilities in a more nuanced way for the woman.

Phronesis is defined as moral knowledge acquired through experiences rather than derived from theory (Gadamer, 1960/2013). In midwifery practice, phronesis may be thought of as the art of practice. Japanese midwives have traditionally valued acquiring and embodying knowledge and skills through practice rather than languages. Midwives' phronesis can be elevated only through the experience of being with women, and this might be a more adequate or favourable way of fostering the knowledge and skills of Japanese midwives. Midwives can improve and maximise their competence, including tact and phronesis, while developing relationships with the women in their care. Safety of childbirth is ensured by the combination of such midwives' abilities based on a relationship with each woman with scientific knowledge, clinical skills, and resources.

This study shows the MCOC model will be beneficial particularly for Japanese women. The women of this study were nervous, hesitant, and anxious. They even looked scared to meet new midwives, especially during labour and birth. Japanese generally value non-verbal communication, which means they require more time to open themselves up to midwives. Without meaning to generalise or stereotype Japanese women, it is suggested that MCOC will help women feel safe and comfortable in their care because they are allowed more time to get to know their midwives, directly and indirectly express themselves, and be understood for who they are by developing a relationship with their midwife. MCOC is even more necessary for Japanese women who may not readily speak their opinions.

Women may have instinctively known that they could obtain real safety in the relationship with their midwives. Therefore, the women of this study desired an emotional connection with their midwives, and they hoped to have a longer relationship with the same midwife, although they had

little or no previous knowledge of the continuity model of care theory. According to a survey conducted with 310 women in Japan, approximately 90% of the women answered that they wanted continuity of care from the same midwife (Morita, 2020). It is natural to seek such a relationship in maternity care settings to enhance their sense of safety and provide them with the best possible birth experience.

In Japan, there are no statistics concerning how many women have MCOC. The reality is that few hospitals and clinics provide this model of care, and midwifery homes or homebirth care environments are almost the only settings that ensure continuity of carer in Japan. Nevertheless, the total percentage of birth in midwifery homes and women's homes is less than 1% (MHLW, 2018i). It is essential to maintain and increase the care model of midwifery homes and to inform more women that this is even a choice in Japan. At the same time, some women need medical assistance for their complications. Regardless of the level of risk and birth facilities, all women should be able to access MCOC to ensure their psychological safety as a basic right of childbirth.

Respectful care and woman-centred care

In the hospitals and clinics, the midwives of this study busily worked on multiple tasks during shifts, and the women felt as though they were on an assembly line in these busy surroundings. Such situations made connecting both parties very difficult. In Japan, most women give birth in hospitals and obstetric clinics, and most midwives, likewise, work in these settings; settings that commonly provide fragmented care. Further, in order to deliver 'efficient' care, these facilities have to follow many procedures and rules before considering individual needs. Such situations imply that most Japanese maternity care settings do not value or cannot provide relationship-based care; thereby, providing an insufficient quality of maternity care.

Some women in the study did not feel *anshin* and *shinrai* in their midwife relationship, and they were sometimes scared of midwives' overbearing mannerisms. They also said that they felt alone and that their wishes were not heard, while stating that midwives looked kind and their professional work was impressive. Likewise, they felt as though they could not talk or put questions to midwives as much as they wanted. Where it is difficult for women and midwives to build good relationships, midwives tend to place women in a passive role, indicating a lack of belief in women's ability. Additionally, in a one-off relationship, midwives' professional expertise may work as an authorised power, no matter how well they practice. The care the women negatively experienced might not look violent or harmful but it still left the women psychologically hurt in the care and in the relationship with the midwives, no matter how safe their births and how healthy their babies.

The WHO (2018a) recommended respectful maternity care as a human rights-based approach. According to the WHO guideline, respectful care includes maintaining women's dignity, privacy, and confidentiality, ensuring freedom from harm and mistreatment, and enabling informed choice. Jolivet (2011) also maintained that respectful maternity care is a universal right for women. She discussed rights of childbearing women, such as respect for choices and preferences, liberty, autonomy, self-determination, freedom from coercion, as well as other rights similar to the WHO guideline. These elements of respectful care were sometimes lacking; and respectful care, including encouragement of women's autonomy, was not always guaranteed in the experiences of the women who participated in the current study.

In Japan, disrespectful care is often seen as an issue pertaining to foreign countries, especially low-income countries where a Japanese development assistance committee sends midwives and healthcare delegates in order to provide projects of respectful or humanised maternity care (Japan International Cooperation Agency, 2018). 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 blessed circumstance because of good clinical outcomes. However, this study found that respectful maternity care is not always ensured in Japan.

Some of the participant women's experiences were traumatic and involved serious anxiety, alienation, neglect, and refusal from care providers. Reed, Sharman, and Inglis (2017) studied interpersonal factors of traumatic birth experience. They identified that in addition to threats and violence, institutionally prioritising the care providers' agenda over the women's and disregarding embodied knowledge are also considered part of the traumatic birth experience among women. In the present study, the women's voices were sometimes unheard, ignored, and refused; and their midwives prioritised institutional demands over women's needs. Reed et al. also argued women's traumatic experience of childbirth affects their postnatal mental health. Such a consequence has already been seen in Japan. Some of the Japanese women's difficulties during the postnatal period are probably caused by such disrespectful care.

Shakibazadeh et al. (2018) discussed how effective communication, the physical environment, competent and motivated human resources, and continuity of care help to ensure respectful maternity care. Care givers' manners, skills, and physical resources are important, but respectful care first requires a meeting and relationship with a care giver who is free from many aspects potentially restricting her ability to respect and care for the woman, such as limited time, organisational rules, and medical hierarchy. Women's dignity is also maintained by a carer who prioritises the woman's will and needs in her care. That is, respectful care requires midwives' autonomy to ensure women's needs are prioritised in practice.

The same can be said of other philosophical foundations of midwifery care, such as woman-centred care. In the *2020 Evidenced-based guidelines for midwifery care*, issued by the Japan Academy of Midwifery, Iida (2020) emphasised the importance of woman-centred care and identified four defining features; respect, safety, holistic practice, and partnership. She also listed 10 actions for health professionals in order to practice woman-centred care; for instance, use communication skills depending on women's situations, support women's decision-making, advocate for women, and be with women. However, she did not discuss how midwives can establish the kinds of environments needed to take these actions and to ensure the four features of woman-centred care can occur in Japanese maternity care settings where they are too busy to provide such care.

Iida (2020) concluded that woman-centred care contributes to midwives' autonomy, the provision of "care with higher expertise" and "virtuous circle" between women and care givers (p. 10). It is not clear in which way woman-centred care lead to these situations. The present study suggests that midwives' autonomy and the good relationship between woman and midwife is the foundation for establishing woman-centred care in maternity care settings. In discussion of Japanese midwifery, care concepts, such as woman-centred care, respectful care, and empowerment seem like optional care provided with particular conditions rather than a philosophical foundation or an essential element of the care. A current matter impeding quality maternity care in Japan is the environment in which the woman and her midwife cannot build a meaningful relationship and the fact that they often give up on the idea of changing the environment. Women and midwives require time and space where they can be genuinely present, listen, talk, and feel an emotional connection to one another. Respectful care and woman-centred care emerge in such communication and relationships.

The participants' experiences of birth plans provided good examples of the nominal midwifery concepts failing in terms of respectful care, women-centred care, women's autonomy, and decision making. In my field notes, there is reference to another episode relating to a birth plan. On social media, I saw a Japanese midwife discussing women who returned blank birth plans in her practice. She stated that those women were not thinking about their birth seriously or they did not know or try to know anything about birth. From the perspective of the current study, I cannot help but wonder what kind of relationship the midwife had with those women and whether the women had a midwife with whom they could freely talk to about their birth. I could also further imagine the feelings of the women when they received the birth plan sheet without any meaningful communication or relationship with their carer. The midwife might have thought she could do her best for the women if they expressed their wishes. However, what the midwife and the women first needed was to build a relationship wherein they could feel *anshin* and *shinrai*

each other. Women's autonomy, including the ability to express themselves through their birth plan, follows such a relationship.

Midwives sometimes use the term 'women with peculiar tastes' even in Japanese midwifery journals (Takada, Unno, Suzuki, & Murakami, 2020). The aim of their discussion is how to respond to those women as individuals in care; however, using such a term categorises the women and identifies them as being fussy. This was the experience of the participant women during the negotiation of their birth plans. It is questionable how midwives can speak of the issue of 'women with peculiar tastes' while at the same time trying to promote the idea of women-centred or individualised care. Women's 'peculiar tastes' may appear as an annoyance within assembly line care, but they represent women's hopes and needs. There is obvious inconsistency between what midwives do in practice and what they claim to be the foundation of midwifery in Japan.

There are benefits of writing birth plans and a wealth of evidence supporting many other skills and approaches to maternity care, from skin-to-skin care to emotional support. The philosophical foundations of care, such as woman-centred care, are also discussed as important factors. Midwives thus have a wealth of knowledge, skills, and philosophical ideas, and they know what to do for women in this regard. However, many midwives are not in situations where they can provide such care in Japan. Thus, they cannot sense and embody the philosophical concepts of midwifery. Midwives are attempting ideal care without building the foundation of the care—the woman–midwife relationship. Quality care is ensured in well-developed woman–midwife relationship. The relationship allows women to have what they really need. For this, women should have, as a basic right, access to their own midwives and some form of continuity of care.

Shaping midwives' identity

The present study also found that the woman–midwife relationship has a significant impact on midwives' care/work experiences and is embodied in their identity as midwife professionals. Deery and Hunter (2010) contended the relationship with women can be a source of emotional satisfaction or difficulty for midwives. In this study, participants' experiences further showed that the relationship with women shapes their identity as a midwife because the relationship with women in their care reflects their manner as a midwife. Midwifery is about being with women, and a connection with women is supposed to be the top priority and the foundation of midwifery (Deery & Hunter, 2010). When they have a good relationship and feel an emotional connection with women for whom they are caring, their work can be rewarding and enriching. If not, it would be very difficult for midwives to maintain their motivation, and their identity as a midwife would be threatened. These midwives' emotional states and ways of being further affect their relationship with women.

Wilkins (2010) maintained, “midwives are the embodiment of women’s experiences of childbirth” (p. 75). Such a comment suggests that the quality of midwives’ experiences is also important for women’s positive birth experiences, and it is essential for midwives to be in a good condition to build a relationship with women. Nonetheless, the midwives’ experiences, as expressed in the current study, were not always positive, especially in clinics and hospitals. B. Hunter (2004) discussed that the cause of midwives’ emotional stress is not only emotional work with their clients but also a conflict of occupational identities and ideologies that differ among work settings. Hunter claimed hospital midwives’ ideology is, by necessity, “with institution” (p. 266) because midwifery is dominated by the needs of institutions. Alternatively, the ideology professionally and academically supported in midwifery is “with woman” (B. Hunter, 2004, p. 266), and this is often experienced by community-based midwives. Newton et al. (2016) also discussed how the midwives in their study recognised being with women as “real” midwifery (p. 229) and that it established midwives’ professional identity.

The differences in ideology were seen in the present study as well. The midwives in medical facilities faced emotional conflicts and dilemmas because they were not able to be with the women for whom they cared, as much as they wanted. The midwives working at midwifery homes or in homebirth were much more likely to work with women, an ideal ideology. Their work, as well as their relationship with the women they cared for, was emotionally fulfilling. In Japan, where hospital care is the mainstay of midwifery care, it is almost unquestionable that the majority of midwives cannot be ‘with woman’ and cannot practice ‘real’ midwifery. In such a situation, is emphasising the ‘with woman’ ideology nonsense, outdated, or unrealistic? Indeed, it could be unrealistic, and many midwives might be overwhelmed by feeling such excessive expectations. However, accepting this situation is to give up on building better relationships with women and thus women’s positive experience of childbirth.

Page (2019) claimed the current mainstream maternity care system has become unsustainable. In Japan, the maternity care system which is dependent on obstetric management is facing a crisis of the so-called ‘collapse of obstetric care,’ as a result of the shortage of obstetricians, overwork, and the closure of maternity clinics and departments. The midwife participants also experienced distress, dilemmas, and despair in the fragmented care setting and mixed patient departments. Midwives have tried to adapt to today’s medicalised care system, but their situations are neither healthy nor sustainable. Above all, women are psychologically hurt and suffering from the impersonal care they receive in such settings.

Midwives are a significant factor in determining the quality of women’s birth experiences. Without changing the ideology of standard midwifery care, midwives’ work and emotional experiences will not be improved; therefore, women’s birth experiences cannot be made better.

The quality of the woman–midwife relationship is also essential in midwives' work experience itself because, to midwives, the relationship (or the place where the woman they care for is) is the original place of their work, and the state of the relationship shapes their professional identity. In order to protect women's rights in maternity care, midwives also have to protect their expertise, philosophy, and identity. Ultimately, developing the woman–midwife relationship is a right as well as an obligation of midwives. As such, midwives need to reconsider their way of working and create a system where they can commit to the best possible care.

In summary, women's psychological safety, respectful care, woman-centred care, or simply quality care, are all women's rights in maternity care. These women's rights cannot be ensured unless each woman and her midwife develop their relationship in a positive way. Thus, experiencing a good relationship with a midwife must also be guaranteed as a women's right in maternity care. In a well-developed relationship, women can obtain psychological safety because they feel understood and respected as unique individuals. Midwives can also fully exert their abilities and act in the most suitable way for each woman in such relationships. These benefits are all made possible because the relationship is the foundation of the care and their experience, and this experience impacts women's well-being even after birth. Therefore, quality care first has to ensure the provision of sufficient opportunities and an environment wherein women and midwives can develop their relationship. For women to achieve a positive birth experience, it is essential for midwives to reconsider how they work in order to develop a better relationship with each woman and rebuild their identities as midwives.

Implications for practice

In accordance with the discussions above, the following recommendations could be implemented to improve midwifery practice and the woman–midwife relationship in Japan.

Japanese maternity/midwifery care will be improved by:

- Creating awareness of the significance of relationship-based care
- Implementing a model of MCOC
- Regaining midwives' autonomous practice
- Maintaining midwives' competence and confidence with post-registration training and recertification programmes
- Establishing a support network for autonomous midwifery practice/MCOC
- Developing practical understanding and implementation of midwifery philosophy

It is essential that the impact of the woman–midwife relationship on safe care and women's birth experience is widely informed and recognised among women, midwives, and other health

professionals, and within society. In Japanese maternity care settings, it is not regarded as natural to value the significance of the relationship. An awareness building will be a challenge but can be done using many measures, such as personal communication, academic publications and presentations, flyers, brochures, posters, symposium, campaign events, web information, social media, mass media, and lobbying.

The implementation of the MCOC model is also vital because it clearly enhances the quality of the woman–midwife relationship and care. While MCOC should not be regarded as a single absolute solution to improving maternity care, the potential contribution that MCOC could provide to Japanese maternity care is considerable. The practice of many care initiatives and approaches, including woman-centred care, will also become much easier. The MCOC model is actually the traditional framework of midwifery care in Japan, and it is extremely important to keep emphasising its significance at a time when midwifery homes are disappearing in Japanese society. Concurrently, all women in maternity care should be able to experience MCOC, regardless of differences in birth facilities and the level of risk.

In order to put the MCOC model into practice, midwives need to be retrained for autonomous midwifery practice in Japan. Midwives will enhance their competence and confidence through post-registration training programmes and first-hand experience of MCOC and relationships with women in midwifery practice. A system to maintain each midwife's competence should be enforced for all midwives in Japan, and the recertification programme should incorporate the practice of continuity of care. When Japanese midwives achieve full autonomy as midwifery professionals, women and midwives will be able to renegotiate and rebuild many current conditions and restrictions of birth facilities and establish the easiest way to connect to each other. It is important to note that freedom from the restrictions of facilities and the current care system should not limit access to medical aid for women and midwives. The MCOC model requires the backup network to protect them in abnormal and emergency situations while they are allowed to directly and freely connect to each other. Taking these various factors into account, it is evident that the Japanese care system needs to shift from an institution-centred care model to women-centred care by promoting MCOC.

The implementation of the MCOC model is an opportunity for midwives to put the philosophical concepts of midwifery care and maternity care initiatives into practice. Midwives' way of being will change when they start prioritising women's needs and experiencing the significance of the relationship with women. This implies reformation of the midwifery system, including midwives' way of working, and the system will become more open, responsive, flexible, and responsible to women. The implementation of MCOC will be challenging and require radical changes to the maternity care system in Japan. However, this is what women desire. They want a human

relationship with a midwife for their maternity journey. More specifically, they want the fundamental right to psychological safety and a positive birth experience through quality care. Midwives need to commit themselves to work together with women, as well as communities, health professionals, politicians, and other stakeholders, in order to facilitate institutional change.

Implications for education

Midwifery education provides the building blocks that lay the foundations of all midwifery practice. It is, therefore, critical that midwifery students learn and understand the relationship with women in maternity care. Accordingly, the recommendations for midwifery education are provided below.

Japanese midwifery education needs to be reformed by:

- Sharing midwifery philosophies with students in order to fully understand midwifery and its practice.
- Providing students with more opportunities to spend extended time with women and follow women through their entire maternity life journey
- Establishing a training programme and evaluation system to ensure students are competent and confident to provide autonomous practice and MCOC
- Coordinating a pre-registration educational curriculum that meets the ICM global standards for midwifery education
- Separating midwifery education from nursing education

Currently, Japanese midwifery does not have a shared philosophy underpinning midwifery practice among midwives. Midwives need a philosophical foundation to guide their practice. Midwifery education must ensure that students, through their education, understand who midwives are and whom midwives work for and with. For this to happen, students should discuss, learn, and implement ideas to find their practice cornerstone. The importance of the woman–midwife relationship and the benefits must also be emphasised in the education. It is important for these insights to be developed through practical experience that allows students to spend more time with women in maternity care.

Pre-registration education must guarantee the minimum level of graduates' competence to autonomously practice midwifery and the MCOC model (with colleagues or mentors' support and the network of care providers) at the time of graduation. Midwife students should have training to experience care of physiological birth, care at midwifery home or women's home, community-based birth care, and MCOC. In order to understand relationship-based care and woman-centred care, students have to follow women throughout their maternity life journey

regardless of where the women give birth, what kind of risk or complications they have, and whom they see for their maternity care. It is important for the students to meet those women directly, not only through birth facilities. Also, more women should be involved in planning, implementing, and evaluating the educational programme that students require.

In Japan, the education programmes do not currently meet the ICM global standards for midwifery education (Imura et al., 2016; ICM, 2013). Even though pre-registration education takes six years to become a midwife, midwifery education itself is less than two years (one year under the law). Students are only required to attend 10 births during their education, and experiencing continuity of care is not a requirement of the curriculum. Consequently, many student midwives in Japan are not confident about their skills and knowledge at graduation, as discussed in the context chapter (Chapter Two). Meeting ICM standards means that more time and practical-based approaches must be ensured in the education curriculum. The programme has to be raised to the global level to ensure the quality of education and practice of Japanese midwives.

Furthermore, student midwives spend much more time learning about nursing in Japan (four out of six years). Nursing, thus, becomes their foundation rather than midwifery; yet the two professions have different contexts and philosophies. This can be a cause for insufficient midwifery education, as well as a source of confusion between the different roles and responsibilities of nursing and midwifery in practice, leading to Japanese midwives' ambiguous professional identity, and the current situation where women often find themselves left unattended during care in medical facilities. If this is the case, then midwifery education has to be separated from nursing education. This does not mean denying nursing education or midwives who have had nursing education. However, nursing and midwifery are different disciplines and are founded on different philosophical foundations. There is a demand for distinct streams of nursing and midwifery education. Concerning more practical matters, it is also not necessary for student midwives to spend time and money for six years of education. Midwifery education could be reformed to focus on its core learning principles and desired outcomes.

Implications for future research

This study revealed the importance of women's psychological safety for their maternity journey and the woman–midwife relationship to protect their safety. Feeling safe in maternity care and having such a relationship should be a women's universal right, and it was shown that these are essential for women to have positive birth experiences. Women can also be empowered through such an experience. The findings of the study were achieved, in part, by van Manen's hermeneutic phenomenology which helped worked to draw out and interpret the lived experiences of the Japanese women and midwives' relationship. While this approach does not aim to generalise the

meaning of the phenomenon, a number of studies will confirm the findings of the current study and add deeper insights to the meaning of the woman–midwife relationship.

At the same time, the woman–midwife relationship in Japan could be explored from a variety of different angles and with many approaches, such as ethnography, to add more knowledge. I also understand that women's and midwives' experiences of maternity care are complicated and interwoven with many other people, aspects, perspectives, and values that go beyond the single woman–midwife relationship. In order to fully understand the woman–midwife relationship, more layers of the relationship need to be examined with wider scope and in relation to or comparison with other phenomena through future research that utilises both a qualitative and quantitative design. In addition, considering the relationship from an axiological perspective is another important area for future research. Readers already familiar with axiology could likely see a connection between the concept and the discussions regarding a Japanese worldview and value system in the text, such as the prominence of non-verbal communication. Adding an axiological lens that includes ethics (what is goodness and what ought to be done) and aesthetics (the study of beauty) to the study may provide with new insights into the different value systems of the woman–midwife relationship from a diverse range of cultural contexts.

In Japan, even simply meeting a midwife is not guaranteed in maternity care. Future research may first need to clarify the present situation of the woman–midwife relationship in care settings. More specifically, how many/often/percentage of women in Japan have opportunities to meet or relate to midwives, or how women in care perceive or emotionally connect to midwives. Also, the actual state of MCOC is not clear in Japan. In order to effectively promote the MCOC model, it would be useful to first understand the reality of MCOC with statistics, such as the percentage of the women having MCOC and the number of birth facilities providing MCOC. Women's and midwives' experiences and perspectives of MCOC are also worthy of future exploration.

A particular interest for future research would be to further clarify the impact of the woman–midwife relationship and MCOC on women's postnatal well-being. This is an important research area for a Japanese maternity care system facing serious concerns regarding women's postnatal mental health. Research could explore the differences in women's psychological well-being during early motherhood between those who gave birth in midwifery homes (with the MCOC model) and those who gave birth in medical facilities (with other models of care). If the study found the MCOC model clearly made a difference in women's postnatal psychological and physiological conditions, the implementation of the MCOC model could be accelerated.

When the significance of the woman–midwife relationship is considered, the current maternity and midwifery care systems would increasingly be challenged to make a change. Systematic

change requires solid evidence to receive broad support and approval from stakeholders and all parties involved. The process of change, including planning, trial and error, evaluation and results, is also deserving of future research, including action research activities.

Currently, there is little research studying the woman–midwife relationship and MCOC in Japan. Future studies deepening the understanding of the woman–midwife relationship, assessing the impact of the relationship, and identifying the potential positive outcomes of the relationship are required and will make important contributions to the field.

Strengths and limitations

The strength of this study is that it is the first to research women and midwives' lived experience of relationships in Japan. The rich data the participants provided for this study are the biggest contribution to the findings of the study. As a result, their lived experiences showed the full potential of the woman–midwife relationship in maternity care, and the study demonstrated the positive impact of the relationship as women's basic human right in maternity care. The study further endorses the idea that the woman–midwife relationship plays a significant role in improving the experiences of both the woman and the midwife. There are some limitations of hermeneutic phenomenological research, such as linguistic limitation and the difficulty of generalising the findings and recommendations. Different methodologies might have revealed different findings. However, no methodology is perfect, and this study examined the research question to the fullest extent possible by using the methodology.

This study is also unique due to the process of translation between Japanese and English. Japanese peculiarity in terms of language, values, and attitudes contributed to the enriched interpretation of the lived experience. At the same time, difficulties of working between languages were a limitation. It was at times difficult to interpret and express Japanese ideas in English language and Western thoughts. However, we never reach absolute interpretations and understandings even within the same language. Working between two languages may be considered somewhat of a limitation, but the study successfully revealed the significance and meaning of the woman–midwife relationship in Japan in the English language. Due to the language barrier, the actual situations of Japanese maternity care and midwifery are not well known outside of Japan. This study plays an important role in documenting and informing part of the context of Japanese maternity and midwifery care in English.

That I put the meaning of the woman–midwife relationship into words also has a great value for Japanese midwifery, especially in the current situation. I believe Japanese midwives have always treasured their relationship with women. However, it has become increasingly difficult to do so in busy, complicated, and medicalised care settings. This study contributes to Japanese midwifery

by asking all midwives to reconsider the relationship with women, 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.

This study also contributes to international debates concerning the woman–midwife relationship and its diversity of meanings. There are cultural differences in terms of the woman–midwife relationship, and this study makes an important contribution to the literature by articulating the meaning of this relationship in the Japanese context. The limitation is that the findings of this study are not generalisable and there is no universal meaning of the woman–midwife relationship to be drawn from this study. However, it is valuable to be culturally specific and understand cultural diversity.

The current study is just a first step to starting a discussion about the woman–midwife relationship in Japan. As mentioned earlier, future studies and practical experiences will add depth of meaning of the woman–midwife relationship both domestically and internationally. I hope some limitations of this study will be supplemented by on-going interests, future research, enthusiastic discussion, and practical challenges based on midwives' aspirations to support all women to have the best possible birth experience and motherhood.

Closing thoughts

The relationship between women and midwives is the very foundation of midwifery care. Nevertheless, studying this relationship was almost like entering into the unknown for me. Many other midwives in Japan must have also taken the relationship for granted. I was drawn to the profound impact of the woman–midwife relationship by having come to know the New Zealand midwifery system, including my birth experience there. Hermeneutic phenomenology helped me see the relationship in a different way. The relationship seemed complex, but at times it appeared very simple; relationships are the foundation of midwifery care. Honestly speaking, the experiences of the woman–midwife relationship described by many participants of this study were crueller than I thought they would be. When I struggled with interpreting their lived experiences and was on the verge of being discouraged, not to waste their experiences and voices was the biggest motivation for me to continue with the study. Concurrently, some women and midwives' positive experiences offered hope that midwifery has valued the relationship. All of the participants' experiences proved vital for this hermeneutic phenomenological study to reveal the meaning of the woman–midwife relationship in Japan.

This study found the woman–midwife relationship leads to psychological safety and safe childbirth when women and midwives shared time, experiences, ideas, and thoughts. Feeling safe and having a positive birth experience in maternity care are women's basic human right. This

means that having a relationship with a known, trusted midwife is also women's basic human right. Moreover, women can thrive as confident mothers beyond the birth experience when a woman and her midwife are given time and space to develop their relationship. This is crucial in the current context of Japan.

In the country constantly identified and celebrated as the world's safest place for childbirth, many Japanese women do not feel safe during their maternity care. Midwifery is a profession fundamentally woman-centred. Nevertheless, Japanese midwifery has overlooked the importance of the woman–midwife relationship. Combined with other studies, there is solid evidence to significantly improve women's safety and positive birth experience through developing the relationship between the two parties. The woman–midwife relationship affects all aspects of maternity care and thus women's birth experience and life thereafter. Therefore, women need to receive the meaning of the woman–midwife relationship as a fundamental right. Protecting women's right in maternity care is the mission of midwifery, and the future of Japanese midwifery will also be protected by pursuing this right. Relationship-based care is fundamental to maximising the value of midwifery and improving all women's birth experience.

References

Abe, M., Kano, N., Shimada, C., Komatsu, M., & Sankai, C. (2005). Iryōsha, shisutemu tono kankeisei wo toraenaosu, josei ga kataru shussan taiken: 'Shussan no basho' toshiteno tokushusei [Women's stories of birth experience to re-capture the relationship with medical professionals and the system: The importance of 'place for giving birth']. *Ibaraki-ken Bosei Eisei Gakkaishi, 25*, 43–54. Retrieved from http://www.midwifery.ipu.ac.jp/page07bosei.html

Abe, S. (2016a, April 24th). Ninsanpu jisatsu: Jū nen de rokujū-san nin, Tokyo nijū-san ku sango utsu eikyō ka [Suicide of expectant and nursing mothers: 63 women in the last decade in 23 wards of Tokyo, caused by postpartum depression?]. *Mainichi Shimbun*. Retrieved from http://mainichi.jp/articles/20160424/k00/00m/040/088000c

Abe, S. (2016b, May 12th). Ninsanpu yon-man nin ni seishin kea hitsuyō 'sanka seisinka renkei wo' kōrōshō suikei ['Cooperation between obstetrics and psychiatry required,' Ministry of Health estimates 40,000 expectant and nursing mothers need mental health care] *Mainichi Shimbun*. Retrieved from http://mainichi.jp/articles/20160512/k00/00e/040/230000c

Abitbol, J. (2016). *The power of the voice*. San Diego, CA: Plural Publishing.

Abitbol, J. (2019). *The female voice*. San Diego, CA: Plural Publishing.

Adams, C., & van Manen, M. A. (2017). Teaching phenomenological research and writing. *Qualitative Health Research, 27*(6), 780–791. https://doi.org/10.1177/1049732317698960

Aita, K. (2013). Kanja no ishi wo sonchō shita iryō oyobi kea towa: Ishi kettei nōryoku wo misuete [Medical treatment and care that respect patients' decision-making: Perspectives on the ability for decision-making]. *Nihon Rōnen Igakukai Zasshi, 50*(4), 487–490. https://doi.org/10.3143/geriatrics.50.487

Akita, H., & Sasaki, M. (2017). The perception of midwifery educators against the coaching to students in continuous care practices. *Kagawa Daigaku Kangogaku Zasshi, 21*(1), 25–40. Retrieved from http://shark.lib.kagawa-u.ac.jp/kuir/list/jtitle/

Amemiya, T. (2007). Gengo to tetsugaku: Nihongo no tetsugakuteki kōyō [Language and philosophy: Philosophical effect of the Japanese language]. *Tokyo Kaiyō Daigaku Kenkyū Hōkoku, 3*, 5–12. Retrieved from https://oacis.repo.nii.ac.jp

Araki, M., Nakao, Y., & Oishi, K. (2010). Involvement that is supportive for pregnant women in cases of continuous care by midwifery students. *Nihon Josan Gakkaishi, 24*(1), 65–73. https://doi.org/10.3418/jjam.24.65

Árnason, V. (2000). Gadamerian dialogue in the patient–professional interaction. *Medicine, Health Care and Philosophy, 3*, 17–23. https://doi.org/10.1023/A:1009908132170

Asahi Shimbun. (2007, February 10th). Kaigyō josanjo, san wari pinchi shokutakui gimuka ni

kakuho kibishiku [30% of midwifery homes in a crisis, hard to find backup doctors]. *Asahi Shimbun*.

Asano, A. (2009). Haidegā to shūkyō [Heidegger and religion]. *Nihon Daigaku Daigakuin Sōgō Shakai Jōhō Kenkyūka Kiyō, 10*, 49–60. Retrieved from https://atlantic2.gssc.nihon-u.ac.jp/journal

Attanasio, L., McPherson, M., & Kozhimannil, K. (2014). Positive childbirth experiences in US hospitals: A mixed methods analysis. *Maternal and Child Health Journal, 18*(5), 1280–1290. https://doi.org/10.1007/s10995-013-1363-1

Bazerman, C. (2017). Equity means having full voice in the conversation. *Lenguas Modernas, 50*, 33–46. Retrieved from https://lenguasmodernas.uchile.cl

Beauchamp, T. L., & Childress, J. F. (2013). *Principles of biomedical ethics* (7th ed.). New York, NY: Oxford University Press.

Bell, A. F., & Andersson, E. (2016). The birth experience and women's postnatal depression: A systematic review. *Midwifery, 39*, 112–123. https://doi.org/10.1016/j.midw.2016.04.014

Berg, M., Asta Ólafsdóttir, Ó., & Lundgren, I. (2012). A midwifery model of woman-centred childbirth care: In Swedish and Icelandic settings. *Sexual & Reproductive Healthcare, 3*, 79–87. https://doi.org/10.1016/j.srhc.2012.03.001

Berkman, L. F., Glass, T., Brissette, I., & Seeman, T. E. (2000). From social integration to health: Durkheim in the new millennium. *Social Science & Medicine, 51*, 843–857. https://doi.org/10.1016/s0277-9536(00)00065-4

Boyle, S., Thomas, H., & Brooks, F. (2016). Women's views on partnership working with midwives during pregnancy and childbirth. *Midwifery, 32*, 21–29. https://doi.org/10.1016/j.midw.2015.09.001

Bridges, J., Nicholson, C., Maben, J., Pope, C., Flatley, M., Wilkinson, C., . . . Tziggili, M. (2013). Capacity for care: Meta-ethnography of acute care nurses' experiences of the nurse–patient relationship. *Journal of Advanced Nursing, 69*(4), 760–772. https://doi.org/10.1111/jan.12050

Cabinet Office. (2018a). *Heisei sanjū nen ban kōrei shakai hakusho [White paper on aged society 2017]*. Tokyo, Japan: Cabinet Office of Japan. Retrieved from http://www8.cao.go.jp/kourei/whitepaper/w-2018/zenbun/30pdf_index.html

Cabinet Office. (2018b). *Heisei sanjū nen ban shōshika shakai taisaku hakusho [White paper on countermeasures for the society with declining birthrate 2017]*. Tokyo, Japan: Cabinet Office of Japan. Retrieved from http://www8.cao.go.jp/shoushi/shoushika/whitepaper/index.html

Campbell, C., Scott, K., Skovdal, M., Madanhire, C., Nyamukapa, C., & Gregson, S. (2015). A good patient? How notions of 'a good patient' affect patient–nurse relationships and ART adherence in Zimbabwe. *BMC Infectious Diseases, 15*(404), 1–11. https://doi.org/10.1186/s12879-015-1139-x

Chin, J. J. (2002). Doctor–patient relationship: From medical paternalism to enhanced autonomy.

Singapore Medical Journal, 43(3), 152–155. Retrieved from http://www.smj.org.sg

Cohen, M. Z. (1987). A historical overview of the phenomenologic movement. *Journal of Nursing Scholarship, 19*(1), 31–34. https://doi.org/10.1111/j.1547-5069.1987.tb00584.x

Coombs, M. A. (2004). *Power and conflict between doctors and nurses: Breaking through the inner circle in clinical care*. London, England: Routledge.

Cope, D. G. (2014). Methods and meanings: Credibility and trustworthiness of qualitative research. *Oncology Nursing Forum, 41*(1), 89–91. https://doi.org/10.7748/nr2009.07.16.4.40.c7160

Crowther, S., Ironside, P., Spence, D., & Smythe, L. (2017). Crafting stories in hermeneutic phenomenology research: A methodological device. *Qualitative Health Research, 27*(6), 826–835. https://doi.org/10.1177/1049732316656161

Crowther, S., Smythe, L., & Spence, D. (2014a). The joy at birth: An interpretive hermeneutic literature review. *Midwifery, 30*(4), e157–e165. https://doi.org/10.1016/j.midw.2014.01.004

Crowther, S., Smythe, L., & Spence, D. (2014b). Mood and birth experience. *Women and Birth, 27*(1), 21–25. https://doi.org/10.1016/j.wombi.2013.02.004

Curcio, D. L. (2017). The lived experiences of nurses caring for dying pediatric patients. *Pediatric Nursing, 43*(1), 8–14. Retrieved from http://www.pediatricnursing.net

Currie, J., & Barber, C. C. (2016). Pregnancy gone wrong: Women's experiences of care in relation to coping with a medical complication in pregnancy. *New Zealand College of Midwives Journal, 52*, 35–40. Retrieved from https://www.midwife.org.nz/midwives/publications/college-journal

Cushing, A. (2016). History of the doctor–patient relationship. In J. Brown, L. M. Noble, A. Papageorgiou, & J. Kidd (Eds.), *Clinical communication in medicine* (pp. 22–40). Chichester, England: John Wiley & Sons.

Daellenbach, R. (1999). Midwifery partnership: A consumer's perspective. *New Zealand College of Midwives Journal, 21*, 22–23. Retrieved from https://www.midwife.org.nz/midwives/publications/college-journal

Dahlberg, U., & Aune, I. (2013). The woman's birth experience: The effect of interpersonal relationships and continuity of care. *Midwifery, 29*, 407–415. https://doi.org/10.1016/j.midw.2012.09.006

Dahlberg, U., Persen, J., Skogås, A.-K., Selboe, S.-T., Torvik, H. M., & Aune, I. (2016). How can midwives promote a normal birth and a positive birth experience? The experience of first-time Norwegian mothers. *Sexual & Reproductive Healthcare, 7*, 2–7. https://doi.org/10.1016/j.srhc.2015.08.001

Davies, D., & Dodd, J. (2002). Qualitative research and the question of rigour. *Qualitative Health Research, 12*(2), 279–289. https://doi.org/10.1177/104973230201200211

Davis, D. L., & Walker, K. (2011). Case-loading midwifery in New Zealand: Bridging the normal/abnormal divide 'with woman'. *Midwifery, 27*(1), 46–52. https://doi.org/10.1016/j.midw.2009.09.007

Davis-Floyd, R. E., & Sargent, C. F. (Eds.). (1997). *Childbirth and authoritative knowledge: Cross-cultural perspectives*. Berkeley, CA: University of California Press.

Deery, R., & Hunter, B. (2010). Emotional work and relationships in midwifery. In M. Kirkham (Ed.), *The midwife–mother relationship* (2nd ed., pp. 37–54). Basingstoke, England: Palgrave Macmillan.

Delaney, J. J., & Martin, D. (2016). Therapy, enhancement, and medicine: Challenges for the doctor–patient relationship and patient safety. *Journal of Business Ethics, 146*(4), 831–844. https://doi.org/10.1007/s10551-016-3042-9

Delbanco, T. L. (1992). Enriching the doctor–patient relationship by inviting the patient's perspective. *Annals of Internal Medicine, 116*(5), 414–418. https://doi.org/10.7326/0003-4819-116-5-414

Dickinson, A. R., Smythe, L., & Spence, D. (2006). Within the web: The family–practitioner relationship in the context of chronic childhood illness. *Journal of Child Health Care, 10*(4), 309–325. https://doi.org/10.1177/1367493506067883

Dixon, L., Guilliland, K., Pallant, J., Sidebotham, M., Fenwick, J., McAra-Couper, J., & Gilkison, A. (2017). The emotional wellbeing of New Zealand midwives: Comparing responses for midwives in caseloading and shift work settings. *New Zealand College of Midwives Journal, 53*, 5–14. Retrieved from https://www.midwife.org.nz/midwives/publications/college-journal

Doering, K. (2012). *Maintaining wa (harmony): Japanese women negotiating their birth experiences in New Zealand* (Unpublished master's thesis). Otago Polytechnic, Dunedin, New Zealand.

Doering, K., Patterson, J., & Griffiths, C. (2014). Japanese women's experiences of pharmacological pain relief in New Zealand. *Woman and Birth, 27*, 121–125. https://doi.org/10.1016/j.wombi.2013.11.005

Doi, T. (1971). *'Amae' no kōzō [The anatomy of dependence]* Tokyo, Japan: Kōbunsha.

Douché, J. (2009). Rhetorical (de)vices and the construction of a 'natural' caesarean. *New Zealand College of Midwives Journal, 40*, 20–23. Retrieved from https://www.midwife.org.nz/midwives/publications/college-journal

Dowling, M. (2007). From Husserl to van Manen: A review of different phenomenological approaches. *International Journal of Nursing Studies, 44*(1), 131–142. https://doi.org/10.1016/j.ijnurstu.2005.11.026

Dreyfus, H. L. (2001). *Being-in-the-world: A commentary on Heidegger's being and time, division I*. Cambridge, England: MIT Press.

Dyer, S., Chambers, G. M., de Mouzon, J., Nygren, K. G., Zegers-Hochschild, F., Mansour, R., . . . Adamson, G. D. (2016). International Committee for Monitoring Assisted Reproductive

Technologies world report: Assisted reproductive technology 2008, 2009 and 2010. *Human Reproduction, 31*(7), 1588–1609. https://doi.org/10.1093/humrep/dew082

e-Sta: Portal Site of Official Statistics of Japan. (2018a). *Eisei gyōsei hōkokurei [Report on public health administration and services]*. Retrieved from https://www.e-stat.go.jp/stat-search/files?page=1&toukei=00450027&tstat=000001031469

e-Sta: Portal Site of Official Statistics of Japan. (2018b). *Haha no nenreibetsu nimita nenjibetsu shusseisu, hyakubunritsū oyobi shusseiritsu (josei jinkō sen tai) [Trends in live births, percent distribution and rates (per 1,000 females) by age of mother]*. Retrieved from https://www.e-stat.go.jp/dbview?sid=0003217250

e-Stat: Portal Site of Official Statistics of Japan. (2018). *Shusseisū, shussan no basho, shusseiji no tachiaisha, todōfuken sibu gunbu (daitoshi saikei) betsu [Live births by place and attendant of delivery, each prefecture and major cities (regrouped)]*. Retrieved from https://www.e-stat.go.jp/dbview?sid=0003214922

Edwards, N. (2010). 'There's so much potential… and for whatever reason it's not being realized': Women's relationships with midwives as a negotiation of ideology and practice In M. Kirkham (Ed.), *The midwife–mother relationship* (pp. 91–115). Basingstoke, England: Palgrave Macmillan.

Ehime Prefecture. (n.d.). *Syūgyō hokenshi, josanshi, (jun) kangoshi, ritsu (jinkō jū man tai) nenjibetsu [The number and percentage (per 100,000 population) of public health nurses, midwives, and (assistant) nurses by year]*. Ehime, Japan: Author. Retrieved from http://www.pref.ehime.jp/h20100/kenkou/iryou/tokei/nenpou25/documents/5-9.pdf

Eigen, M. (2014). *The birth of experience*. London, England: Karnac.

Errasti-Ibarrondo, B., Jordan, J. A., Diez-Del-Corral, M. P., & Arantzamendi, M. (2019). van Manen's phenomenology of practice: How can it contribute to nursing? *Nursing Inquiry, 26*(1), e12259. https://doi.org/10.1111/nin.12259

Fainzang, S. (2016). *An anthropology of lying: Information in the doctor–patient relationship*. London, England: Routledge.

Fenwick, J., Sidebotham, M., Gamble, J., & Creedy, D. K. (2018). The emotional and professional wellbeing of Australian midwives: A comparison between those providing continuity of midwifery care and those not providing continuity. *Women and Birth, 31*(1), 38–43. https://doi.org/10.1016/j.wombi.2017.06.013

Firoz, T., Chou, D., Dadelszen, P. v., Agrawal, P., Vanderkruik, R., Tunçalp, O., . . . Say, L. (2013). Measuring maternal health: Focus on maternal morbidity. *Bulletin of the World Health Organization, 91*, 794–796. https://doi.org/10.2471/BLT.13.117564

Fiumara, G. C. (1995). *The other side of language: A philosophy of listening* (C. Lambert, Trans.). London, England: Routledge.

Flint, C. (1993). *Midwifery teams and caseloads*. Oxford, England: Butterworth-Heinemann.

Fontein-Kuipers, Y., de Groot, R., & van Staa, A. (2018). Woman-centered care 2.0: Bringing the concept into focus. *European Journal of Midwifery, 2*(5), 1–12.

https://doi.org/10.18332/ejm/91492

Freeman, L. M., Timperley, H., & Adair, V. (2004). Partnership in midwifery care in New Zealand. *Midwifery, 20*, 2–14. https://doi.org/10.1016/S0266-6138(03)00043-3

Fry, J., Scammell, J., & Barker, S. (2017). Drowning in muddied waters or swimming downstream?: A critical analysis of literature reviewing in a phenomenological study through an exploration of the lifeworld, reflexivity and role of the Rresearcher. *Indo-Pacific Journal of Phenomenology, 17*(1), 1–12. https://doi.org/10.1080/20797222.2017.1293355

Fujii, M., Hinokuma, F., & Tsubota, A. (2007). Analysis of process of forming the 'ability to become a parent': What relation is established between a pregnant woman and a midwife in the initial checkup? *Ningen Kangogaku Kenkyū 5*, 73–79. Retrieved from http://www.usp.ac.jp/gakubu/nursing/gakubu/gyouseki

Fujita, S. (1988). *Osan kakumei [Childbirth revolution]*. Tokyo, Japan: Asahi Shimbunsha.

Fukui, T. (2013). *Josanshi no heya [Midwives' room]*. Retrieved from https://www.nurse.or.jp/nursing/josan/oyakudachi/kanren/sasshi/room/index.html

Fukui, T. (2015, March 23rd). Imakoso josanshi zō wo egaku hitsuyō ga aru [A pressing need for having midwives' common vision]. *Shūkan Igakukai Shimbun,* pp. 1–2. Retrieved from https://www.igaku-shoin.co.jp/nwsppr/pdf/3118.pdf

Fukui, T., Imura, M., & Kitagawa, M. (2016). Josangaku jissyū no ba wa dōaru bekika [The ideal environment for midwifery practical training]. *Josan Zasshi, 70*(7), 520–527. https://doi.org/10.11477/mf.1665200516

Fukumaru, Y., Ochiai, R., & Matsuzaka, A. (2010). Changes in perception toward student practical training by women continuously attended by student midwives. *Nihon Josan Gakkaishi, 24*(2), 322–332. https://doi.org/10.3418/jjam.24.322

Funabashi, K. (1994). *Akachan wo umuto iukoto: Shakaigaku karano kokoromi [Having a baby: Perspectives from sociology]*. Tokyo, Japan: NHK Publishing.

Fuyarchuk, A. (2017). *The inner voice in Gadamer's hermeneutics: Mediating between modes of cognition in the humanities and sciences* Lanham, MD: Lexington Books.

Gadamer, H.-G. (1960/2013). *Truth and method* (J. Weinsheimer & D. G. Marshall, Trans.). London, England: Bloomsbury Academic. Retrieved from https://ebookcentral.proquest.com

Gadamer, H.-G. (1997/2007). *The Gadamer reader: A bouquet of the later writings*. Evanston, IL: Northwestern University Press.

Garratt, R. A. (2014). *Connecting with women: The working lives of independent midwives and their perceptions of the mother–midwife relationship* (Unpublished doctoral dissertation). De Montfort University, Leicester, UK.

Giles, D. (2011). Relationships always matter: Findings from a phenomenological research

inquiry. *Australian Journal of Teacher Education, 36*(6), 80–91. https://doi.org/10.14221/ajte.2011v36n6.1

Giles, D., Smythe, L., & Spence, D. (2012). Exploring relationships in education: A phenomenological inquiry. *Australian Journal of Adult Learning, 52*(2), 214–236. Retrieved from https://www.ajal.net.au

Gilkison, A., McAra-Couper, J., Fielder, A., Hunter, M., & Austin, D. (2017). The core of the core: What is at the heart of hospital core midwifery practice in New Zealand? *New Zealand College of Midwives Journal, 53*, 30–37. Retrieved from https://www.midwife.org.nz/midwives/publications/college-journal

Gilkison, A., Pairman, S., McAra-Couper, J., Kensington, M., & James, L. (2016). Midwifery education in New Zealand: Education, practice and autonomy. *Midwifery, 33*, 31–33. https://doi.org/10.1016/j.midw.2015.12.001

Goodyear-Smith, F., & Buetow, S. (2001). Power issues in the doctor–patient relationship. *Health Care Analysis, 9*, 449–462. https://doi.org/10.1023/A:1013812802937

Goold, S. D., & Lipkin Jr., M. (1999). The doctor–patient relationship: Challenges, opportunities and strategies. *Journal of General Internal Medicine, 14*(1), 26–33. https://doi.org/10.1046/j.1525-1497.1999.00267.x

Gottvall, K., & Waldenström, U. (2002). Does a traumatic birth experience have an impact on future reproduction? *BJOG: An International Journal of Obstetrics and Gynaecology, 109*, 254–260. https://doi.org/10.1111/j.1471-0528.2002.01200.x

Guba, E. G., & Lincoln, Y. S. (1989). *Fourth generation evaluation*. Newbury Park, CA: Sage Publications.

Guilliland, K., & Pairman, S. (1994). The midwifery partnership: A model for practice. *New Zealand College of Midwives Journal, 11*, 5–9. Retrieved from https://www.midwife.org.nz/midwives/publications/college-journal

Guilliland, K., & Pairman, S. (2010a). *The midwifery partnership: A model for practice* (2nd ed.). Christchurch, New Zealand: New Zealand College of Midwives.

Guilliland, K., & Pairman, S. (2010b). *Women's business: The story of the New Zealand College of Midwives 1986–2010*. Christchurch, New Zealand: New Zealand College of Midwives.

Ha, J. F., & Longnecker, N. (2010). Doctor–patient communication: A review. *The Ochsner Journal, 10*(1), 38–43. Retrieved from http://www.ochsnerjournal.org

Hagihara, A., & Tarumi, K. (2006). Doctor and patient perceptions of the level of doctor explanation and quality of patient–doctor communication. *Scandinavian Journal of Caring Sciences, 20*, 143–150. https://doi.org/10.1111/j.1471-6712.2006.00420.x

Hallam, J. L., Howard, C. D., Locke, A., & Thomas, M. (2016). Communicating choice: An exploration of mothers' experiences of birth. *Journal of Reproductive and Infant Psychology, 34*(2), 175–184. https://doi.org/10.1080/02646838.2015.1119260

Harvey, D. (2014). *Seventeen contradictions and the end of capitalism*. Oxford, England: Oxford University Press.

Hashimoto, N. (2009). Living with 'uncertainly': Women's experience of breastfeeding in the current Japanese social context. In C. McCourt (Ed.), *Childbirth, midwifery and concepts of time*. New York, NY: Berghahn Books.

Haugan, G. (2014). The relationship between nurse–patient interaction and meaning-in-life in cognitively intact nursing home patients. *Journal of Advanced Nursing, 70*(1), 107–120. https://doi.org/10.1111/jan.12173

Hefner, J., Berberich, S., Lanvers, E., Sanning, M., Steimer, A. K., & Kunzmann, V. (2018). Patient–doctor relationship and adherence to capecitabine in outpatients of a German comprehensive cancer center. *Patient Preference and Adherence, 12*, 1875–1887. https://doi.org/10.2147/PPA.S169354

Heidegger, M. (1920/2013). *Basic problems of phenomenology: Winter semester 1919/1920* (S. Campbell, Trans.). London, England: Bloomsbury Academic.

Heidegger, M. (1927/2010). *Being and time: A revised edition of the Stambaugh translation* (J. Stambaugh, Trans.). Albany, NY: State University of New York Press.

Heidegger, M. (1958/2000). *Kotoba ni tsuite no taiwa: Nihon-jin to touhito tono aidano [A dialogue on language: Between a Japanese and an inquirer]* (T. Takada, Trans.). Tokyo, Japan: Heibonsha.

Heidegger, M. (1971). *Poetry, language, thought*. New York, NY: Harper and Row.

Hirota, N. (2012). Tayō na nīzu ni kotaeru anzenna ninnshin shussan e no sien: Mutsū bunben [Safe support responding to various needs for pregnancy and childbirth: Painless birth]. *Tokyo Bosei Eisei Gakkaishi, 29*(1), 28. Retrieved from http://tsmh.kenkyuukai.jp/information

Homer, C., Brodie, P., & Leap, N. (2008). *Midwifery continuity of care: A practical guide*. Chatswood, Australia: Elsevier.

Homer, C., Brodie, P., Sandall, J., & Leap, N. (2019). *Midwifery continuity of care* (2nd ed.). Chatswood, Australia: Elsevier.

Homer, C., Passant, L., Brodie, P. M., Kildea, S., Leap, N., Pincombe, J., & Thorogood, C. (2009). The role of the midwife in Australia: Views of women and midwives. *Midwifery, 25*(6), 673–681. https://doi.org/10.1016/j.midw.2007.11.003

Hooks, B. (2003). *Teaching community: A pedagogy of hope*. New York, NY Routledge.

Horiuchi, S., Mori, A., Emisu, F., Fujimoto, E., Kishida, S., Naitoh, K., & Iwasawa, K. (2003). Barriers to the development of the midwifery model: Problems of hospital care systems, as seen by midwives. *Nihon Josan Gakkaishi, 17*(1), 47–53. https://doi.org/10.3418/jjam.17.47

Horiuchi, S., Shimada, K., Suzuki, M., Mohri, T., Taniguchi, M., Taga, Y., & Miyazato, K. (1997).

Quality of cares during pregnancy, delivery and postpartum periods evaluated by women. *Nihon Josan Gakkaishi, 11*(1), 9–16. https://doi.org/10.3418/jjam.11.9

Horton, R., & Astudillo, O. (2014). The power of midwifery. *The Lancet, 384*(9948), 1075–1076. https://doi.org/10.1016/S0140-6736(14)60855-2

Howarth, A., Swain, N., & Treharne, G. J. (2011). First-time New Zealand mothers' experience of birth: Importance of relationship and support. *New Zealand College of Midwives Journal, 45*, 6–1. Retrieved from https://www.midwife.org.nz/midwives/publications/college-journal

Hunter, A., Devane, D., Houghton, C., Grealish, A., Tully, A., & Smith, V. (2017). Woman-centred care during pregnancy and birth in Ireland: Thematic analysis of women's and clinicians' experiences. *BMC Pregnancy and Childbirth, 17*(1), 322–332. https://doi.org/10.1186/s12884-017-1521-3

Hunter, B. (2004). Conflicting ideologies as a source of emotion work in midwifery. *Midwifery, 20*(3), 261–272. https://doi.org/10.1016/j.midw.2003.12.004

Hunter, B. (2006). The importance of reciprocity in relationships between community-based midwives and mothers. *Midwifery, 22*, 308–322. https://doi.org/10.1016/j.midw.2005.11.002

Hunter, B., Berg, M., Lundgren, I., Ólafsdóttir, Ó. Á., & Kirkham, M. (2008). Relationships: The hidden threads in the tapestry of maternity care. *Midwifery, 24*(2), 132–137. https://doi.org/10.1016/j.midw.2008.02.003

Husserl, E. (1913/2012). *Ideas: General introduction to pure phenomenology* (D. Moran, Trans.). Abingdon, England: Routledge. Retrieved from https://ebookcentral.proquest.com

Ichikawa, K. (2017). Sango kea wo seikō ni michibiku kotsu [Tips for successful postnatal care]. *Josan Zasshi, 71*(3), 181–184. https://doi.org/10.11477/mf.1665200712

Ichikawa, K., & Kamada, J. (2009). How does a midwives' care affect mothers' valuable childbirth experience?: The research through CBE-scale. *Bosei Eisei, 50*(1), 79–87. Retrieved from http://www.bosei-eisei.org/gakkaishi

Igarashi, T., Wakita, M., Miyazaki, K., & Nakayama, T. (2014). Birth environment facilitation by midwives assisting in non-hospital births: A qualitative interview study. *Midwifery, 30*, 877–884. https://doi.org/10.1016/j.midw.2014.02.004

Iida, M. (2010). Developing and testing of an instrument to assess women-centered care during pregnancy. *Nihon Josan Gakkaishi, 24*(2), 284–293.

Iida, M. (2020). Woman-centred care. In Japan Academy of Midwifery Guidelines Committee (Ed.), *2020 Evidenced-based guidelines for midwifery care* (pp. 9–10). Tokyo, Japan: Japan Academy of Midwifery.

Iida, M., Horiuchi, S., & Nagamori, K. (2014). A comparison of midwife-led care versus obstetrician-led care for low-risk women in Japan. *Women and Birth, 27*, 202–207. https://doi.org/10.1016/j.wombi.2014.05.001

Iida, M., Horiuchi, S., & Porter, S. E. (2012). The relationship between women-centred care and women's birth experiences: A comparison between birth centres, clinics, and hospitals in Japan. *Midwifery, 28*, 398–405. https://doi.org/10.1016/j.midw.2011.07.002

Ikai, S. (2016). Theoretical foundation of social policy for caring. *Shakai Hoshō Kenkyū, 1*(1), 38–56. Retrieved from http://www.ipss.go.jp/syoushika/bunken/sakuin/kikanshi/sakuin1.htm

Ikegami, N., & Campbell, J. C. (1996). *Nihon no iryō: Tōsei to baransu kankaku [Medical care in Japan: Control and sense of balance]*. Tokyo, Japan: Chūō Koron Shinsha.

Imura, M., Ohta, E., & Takegata, M. (2016). *A literature review of practical training in midwifery program and review of midwifery program in other countries*. Tokyo, Japan: Japan Society of Midwifery Education. Retrieved from http://www.zenjomid.org/info/img/20160927.pdf

Imura, M., Saito, E., Nitta, M., Kita, R., Chiba, K., Mizuno, M., . . . Iida, C. (2017). *Educational methods survey of Japanese midwifery training course*. Tokyo, Japan: Japan Society of Midwifery Education. Retrieved from http://www.zenjomid.org/info/index.html

Inoue, K. (2008). Katachi naki mono no katachi, koe naki mono no koe [The shape of things with no shape, the voice of things with no voice]. *Basho, 7*, 1–18. Retrieved from https://kansai-u.repo.nii.ac.jp

International Confederation of Midwives. (2011a). *Global standards of midwifery regulation*. The Hague, The Netherlands: Author. Retrieved from https://www.k4health.org/sites/default/files/GLOBAL%20STANDARDS%20FOR%20MIDWIFERY%20REGULATION%20ENG.pdf

International Confederation of Midwives. (2011b). *Partnership between women and midwives*. The Hague, The Netherlands: Author. Retrieved from http://www.internationalmidwives.org/assets/uploads/documents/Position%20Statements%20-%20English/PS2011_015%20ENG%20Partnership%20between%20women%20and%20midwives.pdf

International Confederation of Midwives. (2013). *Global standards for midwifery education (2010): Amended 2013*. The Hague, The Netherlands: Author. Retrieved from http://www.internationalmidwives.org/what-we-do/education-coredocuments/global-standards-education/

International Confederation of Midwives. (2014a). *Keeping birth normal*. The Hague, The Netherlands: Author. Retrieved from https://www.internationalmidwives.org/assets/files/statement-files/2018/04/keeping-birth-normal-eng.pdf

International Confederation of Midwives. (2014b). *Philosophy and model of midwifery care*. The Hague, The Netherlands: Author. Retrieved from https://www.internationalmidwives.org/assets/files/definitions-files/2018/06/eng-philosophy-and-model-of-midwifery-care.pdf

International Confederation of Midwives. (2017a). *International definition of the midwife*. The Hague, The Netherlands: Author. Retrieved from

https://www.internationalmidwives.org/assets/files/definitions-files/2018/06/eng-definition_of_the_midwife-2017.pdf

International Confederation of Midwives. (2017b). *Midwifery led care, the first choice for all women*. The Hague, The Netherlands: Author. Retrieved from https://www.nurse.or.jp/nursing/international/icm/basic/statement/pdf/Midwifery_Led_Care_the_First_Choice_for_All_Women_en.pdf

International Confederation of Midwives. (2017c). *Midwifery: An autonomous profession*. The Hague, The Netherlands: Author. Retrieved from https://www.internationalmidwives.org/assets/files/statement-files/2018/04/midwifery-an-autonomous-profession.pdf

International Confederation of Midwives. (n.d.). *Education, Regulation, and Association*. The Hague, The Netherlands: Author. Retrieved from http://internationalmidwives.org/what-we-do/education-regulation-association/

Inuit Tuttarvingat of the National Aboriginal Health Organization. (2009). *A case study of the Irnisuksiiniq: Inuit Midwifery Network*. Ottawa, Canada: Author. Retrieved from http://tools.hhr-rhs.ca/index.php?option=com_mtree&task=att_download&link_id=7774&cf_id=68&lang=en

Ishibiki, K., Nagaoka, Y., & Kanou, N. (2013). Study on collaboration of midwives with obstetricians: With special focus on midwifery autonomy. *Nihon Josan Gakkaishi, 27*(1), 60–71. https://doi.org/10.3418/jjam.27.60

Ishiwata, R., & Sakai, A. (1994). The physician–patient relationship and medical ethics in Japan. *Cambridge Quarterly of Healthcare Ethics, 3*(1), 60–66. https://doi.org/10.1017/s0963180100004722

Iwamoto, N. (2015). Kodomo gyakutai yobō kara sango utsu taisaku e [From prevention of child abuse to countermeasures for postpartum depression]. *Kōsyū Eisei, 79*(11), 801–804. https://doi.org/10.11477/mf.1401208309

Iwasawa, M., & Mita, F. (2007). Delayed childbearing and the changing age composition of women who desire childre. *Jinko Mondai Kenkyu, 63*(3), 24–41. Retrieved from http://websv.ipss.go.jp

Iwashita, K., Pellegrini, T. (Producer), & Gelb, D. (Director). (2011). *Jiro dreams of sushi* [Motion picture]. United States: Magnolia Pictures.

Iwata, H. (2014). Experiences of Japanese men during the transition to fatherhood. *Journal of Transcultural Nursing, 25*(2), 159–166. https://doi.org/10.1177/1043659613515712

Jackson-Dwyer, D. (1995). *Interpersonal relationship*. Hove, England: Routledge.

Japan Association of Obstetricians and Gynecologists. (2006a). *Josanjo tono shokutakui keiyaku ni tsuite [The contract with midwifery homes]*. Retrieved from http://www.jaog.or.jp/sep2012/JAPANESE/jigyo/TAISAKU/keiyaku/keiyaku_277.htm

Japan Association of Obstetricians and Gynecologists. (2006b). *Shūsanki iryō hōkai no genjō to*

taisaku: 'Osan nanmin yonjū kara gojū man nin' wo dasanai tameni [The current situation and countermeasure of collapse of perinatal medical care: How to avoid creating '400,000–500,000 birth refugees']. Tokyo, Japan: Author. Retrieved from http://www.oitaog.jp/syoko/senryaku/1.pdf

Japan Association of Obstetricians and Gynecologists. (2017a). *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]*. Tokyo, Japan: Japan Association of Obstetricians and Gynecologists. Retrieved from http://www.jaog.or.jp/wp/wp-content/uploads/2017/06/jaogmental_L_0001.pdf

Japan Association of Obstetricians and Gynecologists. (2017b). *Sanfujinka kinmui no taigū kaizen to josei ishi no shūrō kankyō ni kansuru ankēto chōsa hōkoku [A survey on the improvement of working conditions of employed obstetricians and working environments of female doctors]*. Tokyo, Japan: Author. Retrieved from http://www.jaog.or.jp/wp/wp-content/uploads/2018/01/kinmui201712.pdf

Japan International Cooperation Agency. (2018). *Ningenteki na osan [Humanised birth]*. Tokyo, Japan: Author. Retrieved from https://www.jica.go.jp/activities/issues/health/ku57pq00000wwjhn-att/panf_hoken49.pdf

Japan Society of Midwifery Education. (2016). *Josan gakusei no bunbenki kea nōryōku gakushū tōtatsu ni kansuru chōsa hōkokusho [Survey report on midwifery students' achievement of competency for delivery care]*. Tokyo, Japan: Author. Retrieved from http://www.zenjomid.org/info/img/20160927.pdf

Japan Society of Midwifery Education. (2018). *Josan kyōiku sotsugyō (shūryō) ji no tōtatsudo: Jikohyōka ni kansuru jittai chōsa (katei betsu) nisen-ju-hachi nen san gatsu shūryōsei [A survey on educational achievement in midwifery: Self-evaluation among the graduates of March 2018]*. Tokyo, Japan: Author.

Japan Society of Obstetrics and Gynecology. (2017). *Ninsanjokufu no shibō shindansho no kinyū ni tsuite no onegai [Requests for death certificates for pregnant women, childbearing women, and puerperant]*. Retrieved from http://www.jsog.or.jp/modules/news_m/index.php?content_id=206

Japanese Midwives Association. (2018). *Nihon Josanshi kai [Japanese Midwives Association]*. Retrieved from http://www.midwife.or.jp/index.html

Japanese Midwives Association. (n.d.-a). *Josanshi no teigi [Definition of the midwife]*. Retrieved from http://www.midwife.or.jp/general/definition.html

Japanese Midwives Association. (n.d.-b). *Nihon josanshi kai no ayumi (rekishi) [The history of Japanese Midwives Association]*. Retrieved from http://www.midwife.or.jp/association/ayumi.html

Japanese Nursing Association. (2014a). *'Osan nanmin' no ohanashi [The story of 'birth refugees']*. Retrieved from https://www.nurse.or.jp/nursing/josan/oyakudachi/kanren/sasshi/room/index05.html

Japanese Nursing Association. (2014b). *Sanka kongō byōtō yunitto manējimento dōnyū no tebiki*

[A guide for the unit management of obstetric mixed-patient wards]. Tokyo, Japan: Author. Retrieved from https://www.nurse.or.jp/nursing/josan/oyakudachi/kanren/sasshi/pdf/sankakongo.pdf

Japanese Nursing Association. (2017a). *Heisei nijū-hachi nendo bunben toriatsukai shisetsu ni okeru uimenzu herusu kea to josan kea teikyō jōkyō tō ni kansuru jittai chōsa hōkokusho [Survey report on the provision of women's health and midwifery care in birth facilities 2016]*. Tokyo, Japan: Author. Retrieved from https://www.nurse.or.jp/home/publication/pdf/2017/h28_report.pdf

Japanese Nursing Association. (2017b). *International definition of the midwife*. Retrieved from https://www.nurse.or.jp/nursing/international/icm/basic/definition/index.html

Japanese Nursing Association. (2018a). *Innai josan, josanshi gairai gaidorain nisen-jū-hachi [Guidelines on midwife-led antenatal and birth care in hospitals 2018]*. Tokyo, Japan: Author.

Japanese Nursing Association. (2018b). *Todōfuken betsu, josanshi katei [Midwifery courses by prefecture]*. Tokyo, Japan: Author. Retrieved from https://www.nurse.or.jp/home/statistics/index.html

Jepsen, I., Juul, S., Foureur, M., Sorensen, E. E., & Nohr, E. A. (2017). Is caseload midwifery a healthy work-form?: A survey of burnout among midwives in Denmark. *Sexual & Reproductive Healthcare, 11*, 102–106. https://doi.org/10.1016/j.srhc.2016.12.001

Jikumaru, Y. (2009). *Rupo sanka iryō hōkai [Report on collapse of obstetric care]*. Tokyo, Japan: Chikuma Shobō.

Jolivet, R. (2011). *Respectful maternity Care: The universal rights of childbearing women*. Retrieved from http://www.healthpolicyproject.com/index.cfm?ID=publications&get=pubID&pubID=46

Kaba, R., & Sooriakumaran, P. (2007). The evolution of the doctor–patient relationship. *International Journal of Surgery, 5*(1), 57–65. https://doi.org/10.1016/j.ijsu.2006.01.005

Kaibara, K. (2017, October 29th). Hirogaru 'sanka kongō byōtō' shōsika, akibeddo ni ippan kanja [The increase in 'obstetric mixed-patient wards': Sick patients occupy beds in maternity wards due to fewer births]. *Kobe Shimbun*. Retrieved from https://www.kobe-np.co.jp/news/iryou/201710/0010686426.shtml

Kamiya, N., & Ishiwata, I. (2009). *Sankai to josanshi no kyōdō ni tsuite [Cooperation between obstetricians and midwives]*. Tokyo, Japan: Japan Association of Obstetricians and gynecologists. Retrieved from http://www.jaog.or.jp/sep2012/know/kisyakon/26_091014_b.pdf

Kanno, K. (2003). Nihon ni tetsugaku nashi to iukoto [The meaning of 'no philosophy in Japan']. *Sōshi, 5*(5), 23–30. Retrieved from https://ci.nii.ac.jp/naid/40006782024

Karlström, A., Nystedt, A., & Hildingsson, I. (2015). The meaning of a very positive birth experience: Focus groups discussions with women. *BMC Pregnancy and Childbirth, 15*, 251–258. https://doi.org/10.1186/s12884-015-0683-0

Kataoka, Y., Eto, H., & Iida, M. (2013). Outcomes of independent midwifery attended births in birth centres and home births: A retrospective cohort study in Japan. *Midwifery, 29*(8), 965–972. https://doi.org/10.1016/j.midw.2012.12.020

Katsukawa, Y., Sakanashi, K., Usui, M., & Mizuno, S. (2014). Pregnant woman's needs and problems of perinatal system with birth-center. *Kantō Gakuin Kangogaku Zasshi, 1*(1), 40–47. Retrieved from http://kango.kanto-gakuin.ac.jp/education/gakkai

Kawahara, E. (1992). *Haidegā sanjutsu [Honouring Heidegger]*. Tokyo, Japan: Nansōsha.

Kawai, R. (2007). *Josanshi to umu: Byōin demo, josanin demo, jitaku demo [Giving birth with midwives: Hospitals, maternity homes, and homes]*. Tokyo, Japan: Iwanami Shoten.

Kawai, R. (2009). *Anzen na osan, anshin na osan: 'Tsunagari' de kizuku kowarenai iryō [Safe birth and birth with peace of mind: Establishing unshakable medical care system in 'connections']*. Tokyo, Japan: Iwanami Shoten.

Kee, J. W. Y., Khoo, H. S., Lim, I., & Koh, M. Y. H. (2018). Communication skills in patient–doctor interactions: Learning from patient complaints. *Health Professions Education, 4*(2), 97–106. https://doi.org/10.1016/j.hpe.2017.03.006

Keegan, D. (2014). *Patients' lived experience of encounters with hospital staff that made a difference* (Unpublished master's thesis). Auckland University of Technology, Auckland, New Zealand.

Kelly, M., Ellaway, R. H., Reid, H., Ganshorn, H., Yardley, S., Bennett, D., & Dornan, T. (2018). Considering axiological integrity: A methodological analysis of qualitative evidence syntheses, and its implications for health professions education. *Advances in Health Sciences Education, 23*(4), 833–851. https://doi.org/10.1007/s10459-018-9829-y

Kenney, C. M. (2011). Midwives, women and their families: A Māori gaze: Towards partnerships for maternity care in Aotearoa New Zealand. *AlterNative: An International Journal of Indigenous Peoples, 7*(2), 123–137. https://doi.org/10.1177/117718011100700205

Kida, G. (2000). *Haidegā 'sonzai to jikan' no kōchiku [Formulation of Heidegger's 'being and time']*. Tokyo, Japan: Iwanami Shoten.

Kido, Y., Yoko'o, K., Fukuhara, R., Ozawa, M., & Fujimoto, S. (2012). Experiences of mothers with infants admitted to neonatal intensive care unit preceding the decision to discharge: Focusing on mothers with infants suffering from diseases that might require long hospitalization. *Nihon Shinseiji Kango Gakkaishi, 18*(2), 10–18. Retrieved from http://www.jann.gr.jp

Kikuchi, S. (2007). Shussan shintai wo meguru 'manazashi' no hensen [The change of people's gaze towards birthing bodies]. *Nijūisseiki Shakai Dezain Kenkyū, 6*, 77–88. Retrieved from https://sds.rikkyo.ac.jp

Kikuchi, S. (2016a). Shōhi shakai no shussan bunka [Birth culture in the consumer society]. In C. Shirai (Ed.), *Umi sodate to josan no rekishi: Kindaika no nihyaku nen wo furikaeru [History of childbirth and childrearing: Looking back on 200 years of modernisation]* (pp. 248–262). Tokyo, Japan: Igaku Shoin.

Kikuchi, S. (2016b). Tōjishasei no kakuritsu: Shussan no iryōka to josei tachi no teikō [Establishment of the parties' participation: Medicalisation of childbirth and women's resistance]. In C. Shirai (Ed.), *Umi sodate to josan no rekishi: Kindaika no nihyaku nen wo furikaeru [History of childbirth and childrearing: Looking back on 200 years of modernisation]* (pp. 214–232). Tokyo, Japan: Igaku Shoin.

Kildea, S., Hickey, S., Nelson, C., Currie, J., Carson, A., Reynolds, M., . . . Tracy, S. (2018). Birthing on country (in our community): A case study of engaging stakeholders and developing a best-practice Indigenous maternity service in an urban setting. *Australian Health Review, 42*(2), 230–238. https://doi.org/10.1071/AH16218

Kildea, S., Magick Dennis, F., & Stapleton, H. (2013). *Birthing on country workshop report, Alice Springs, 4 July 2012*. Sydney, Australia: Australian Health Ministers' Advisory Council. Retrieved from https://health.act.gov.au/sites/default/files/2018-09/Birthing%20on%20Country%20Workshop%20Report.pdf

King, A. (2018, February 21st). Japan the safest place to give birth: UNICEF. *Nikkei Asian Review*. Retrieved from https://asia.nikkei.com/Politics/International-Relations/Japan-the-safest-place-to-give-birth-UNICEF

Kino, K. (2000). Japanese anger expression style and their interpersonal influence. *Shinrigaku Kenkyū, 70*(6), 494–502. https://doi.org/10.4992/jjpsy.70.494

Kirkham, M. (2010a). The maternity services context. In M. Kirkham (Ed.), *The midwife–mother relationship* (2nd ed., pp. 1–16). Basingstoke, England: Palgrave Macmillan.

Kirkham, M. (Ed.). (2010b). *The midwife–mother relationship* (2nd ed.). Basingstoke, England: Palgrave Macmillan.

Kitajima, H. (2008). Relationship between nursing care in mixed and obstetrics-only wards at large hospitals in Japan and the frequency of MRSA infection in neonates. *Kankyō Kansenshi, 23*(2), 129–134. Retrieved from http://www.kankyokansen.org/modules/publication

Kitayama, S. (1994). Cultural views of self and psychological processes. *Shakai Shinrigaku Kenkyū, 10*(3), 153–167. Retrieved from http://www.socialpsychology.jp/journal/index.html

Klaus, M. H., Kennell, J. H., & Klaus, P. H. (1995). *Bonding: Building the foundations of secure attachment and independence*. Reading, MA: Addison-Wesley.

Koba, Y., Kashima, H., Moriwaki, H., Teraoka, C., & Maeomichi, N. (2014). The relation between the smoking, lifestyle, and eating habits of women before and during pregnancy. *Hijiyama Daigaku Kiyō, 21*, 221–231. Retrieved from http://harp.lib.hiroshima-u.ac.jp/hijiyama-u/list/journals/

Kobayashi, M., & Watanabe, N. (2008). The sense, behaviors and standard of selection of women in childbed considering the difference of the place of childbirth and existence of the experience of childbirth. *Niigata Seiryō Daigaku Kiyō, 8*, 9–20. Retrieved from http://www.n-seiryo.ac.jp/library/kiyo

Koch, T. (1994/2006). Establishing rigour in qualitative research: The decision trail. *Journal of*

Advanced Nursing, 53(1), 91–103. https://doi.org/10.1111/j.1365-2648.2006.03681.x

Koch, T., & Harrington, A. (1998). Reconceptualizing rigour: The case for reflexivity. *Journal of Advanced Nursing, 28*(4), 882–890. https://doi.org/10.1046/j.1365-2648.1998.00725.x

Kojima, R. (2014). Support for marital relationships during the perinatal period: A qualitative study on the practice carried out by midwives at birthing centers. *Ritsumeikan Ningen Kagaku Kenkyū, 29*, 35–37. Retrieved from https://www.ritsumeihuman.com/publication

Kouketsu, N., & Hattori, R. (2015). Child-rearing assistance from pregnancy provided by midwife. *Gifu Kenritsu Kango Daigaku Kiyō, 15*(1), 29–41. Retrieved from https://www.gifu-cn.ac.jp/library/repo

Kouta, C. (2016). 'Bāsu hapinesu wo kangaeru shinpojiumu' wo kikaku kaisai shite [Report on planning and holding 'a symposium for birth happiness']. *Josan Zasshi, 70*(7), 566–569. https://doi.org/10.11477/mf.1665200526

Kouta, C. (2017). *Teno kakaranai ninsanpu no 'kokoro no mamō': Sanka kongō byōtō ga hahaoya ni oyobosu eikyō ['Worn heart' of low-risk childbearing women: The impact of obstetric mixed-patient wards on mothers]* presented at the meeting of the Dai-gojū-hachi-kai Nihon Bosei Eisei Gakkai Sōkai Gakujutsu Shūkai, Kobe, Hyogo.

Kumatani, Y. (n.d.). *Yūko josanin [Yūko midwifery home]*. Retrieved from http://www.yu-ko903.jp/aboutus/

Kunikiyo, K. (2012). Childbirth experiences based on locus of control and their meanings. *Kitakantō Igaku, 62*(3), 337–338. https://doi.org/10.2974/kmj.62.337

Kuwaki, K. (2016). *Wagakuni ni okeru shōni iryō teikyō taisei [Japan's system for the provision of pediatric medical care]* Tokyo, Japan: Ministry of Health, Labour and Welfare of Japan. Retrieved from https://www.nurse.or.jp/nursing/josan/oyakudachi/kanren/2016/pdf/20161103.pdf

Lagaay, A. (2011). Towards a (negative) philosophy of voice. In L. Kendrick & D. Roesner (Eds.), *Theatre noise: The sound of performance* (pp. 57–69). Newcastle upon Tyne, England: Cambridge Scholars Publishing.

Larsen, L. T. (2016). No third parties. The medical profession reclaims authority in doctor–patient relationships. *Professions and Professionalism, 6*(2), 1–14. https://doi.org/10.7577/pp.1622

Laverty, S. M. (2003). Hermeneutic phenomenology and phenomenology: A comparison of historical and methodological considerations. *International Journal of Qualitative Methods, 2*(3), 21–35. https://doi.org/10.1177/160940690300200303

Leap, N., Sandall, J., Buckland, S., & Huber, U. (2010). Journey to confidence: Women's experiences of pain in labour and relational continuity of care. *Journal of Midwifery & Women's Health, 55*(3), 234–242. https://doi.org/10.1016/j.jmwh.2010.02.001

Lewis, M., Jones, A., & Hunter, B. (2017). Women's experience of trust within the midwife–mother relationship. *International Journal of childbirth, 7*(1), 40–52. https://doi.org/10.1891/2156-5287.7.1.40

Linder, F. E., & Grove, R. D. (1947). *Vital statistics rates in the United States 1900-1940*. Washington, D.C.: United States Government Printing Office. Retrieved from http://www.nber.org/vital-stats-books/vsrates1900_40.CV.pdf

Lopes, S. C., Nove, A., Hoope-Bender, P. t., Bernis, L. d., Bokosi, M., Moyo, N. T., & Homer, C. S. E. (2016). A descriptive analysis of midwifery education, regulation and association in 73 countries: The baseline for a post-2015 pathway. *Human Resources for Health, 14*(37), 1–12. https://doi.org/10.1186/s12960-016-0134-7

Lundgren, I., & Berg, M. (2007). Central concepts in the midwife–woman relationship. *Scandinavian Journal of Caring Sciences, 21*, 220–228. https://doi.org/10.1111/j.1471-6712.2007.00460.x

Lyberg, A., & Severinsson, E. (2010). Fear of childbirth: Mothers' experiences of team-midwifery care: A follow-up study. *Journal of Nursing Management, 18*, 383–390. https://doi.org/10.1111/j.1365-2834.2010.01103.x

Maeda, E., Ishihara, O., Tomio, J., Sato, A., Terada, Y., Kobayashi, Y., & Murata, K. (2018). Cesarean section rates and local resources for perinatal care in Japan: A nationwide ecological study using the national database of health insurance claims. *Journal of Obstetrics and Gynaecology Research, 44*(2), 208–216. https://doi.org/10.1111/jog.13518

Maehara, K., & Mori, E. (2005). Development of the postpartum maternal confidence scale and the postpartum maternal satisfaction scale. *Chiba Daigaku Kango Gakubu Kiyō, 27*, 9–18. Retrieved from https://opac.ll.chiba-u.jp/da/curator

Mahmud, A. (2009). Doctor–patient relationship. *Pulse, 3*(1), 12–14. https://doi.org/10.3329/pulse.v3i1.6546

Makoul, G., & Dulmen, S. v. (2016). What is effective doctor–patient communication? Review of the evidence. In J. Brown, L. M. Noble, A. Papageorgiou, & J. Kidd (Eds.), *Clinical communication in medicine* (pp. 53–65). Chichester, England: John Wiley & Sons.

Mander, R. (2011). The partnership model. In R. Bryar & M. Sinclaire (Eds.), *Theory for midwifery practice* (2nd ed., pp. 304–317). Basingstoke, England: Palgrave Macmillan.

Martin, K. A. (2016). Giving birth like a girl. *Gender & Society, 17*(1), 54–72. https://doi.org/10.1177/0891243202238978

Matsui, H., Saito, K., Futakawa, K., Sasano, K., & Hasegawa, T. (2019). Lessons learned from experiences by Clinical Ladder of Competencies for Midwifery Practice Level I Midwives in the care of women with high-risk pregnancy in the delivery stage. *Josan Gakkaishi, 33*(1), 27–37. https://doi.org/10.3418/jjam.JJAM-2018-0022

Matsumoto, A. (2012). *Otsubone*. Retrieved from https://dictionary.goo.ne.jp/word

Matsuoka, E. (1993). Shussan no basho to anzensei ni tsuite: Jinkō dōtain tōkei yori [Birth place and safety: Vital statistics]. *Asahikawa Ikadaigaku Kiyō, 14*, 45–62. Retrieved from http://amcor.asahikawa-med.ac.jp/modules/xoonips/listitem.php

Matsuoka, E. (1995). Josanjo shussan no anzensei wo kangaeru: Byōin bunben no zōka to osan

no anzensei [Safety of birth in midwifery homes: The increase in hospital birth and the safety of birth]. *Josanpu, 49*(4), 55–59. Retrieved from http://www.midwifepc.co.jp

Matsuoka, E. (1999). Sanka kankyō no hensen: Tekunorojī to sono yūkōsei [The change of obstetric environment: Technology and its effectiveness]. In N. Yoshimura (Ed.), *Shussan zengo no kankyō: Karada, bunka, kindai iryō [Environment before and after birth: Body, culture, and modern medical care]*. Kyoto, Japan: Shōwado.

Matsushima, K. (2006). Shussan no iryōka to 'ii osan': Kobetsuka sareru shussan taiken to shintai no shakaiteki tōsei [Medicalisation of childbirth and 'good birth': Individualised birth experience and social control of the body]. *Ritsumeikan Ningen Kagaku Kenkyū, 11*(2), 147–159. Retrieved from https://www.ritsumeihuman.com/publication

McAra-Couper, J. (2007). *What is shaping the practice of health professionals and the understanding of the public in relation to increasing intervention in childbirth* (Unpublished doctoral dissertation). Auckland University of Auckland, Auckland, New Zealand.

McAra-Couper, J., Gilkison, A., Crowther, S., Hunter, M., Hotchin, C., & Gunn, J. (2014). Partnership and reciprocity with women sustain lead maternity carer midwives in practice. *New Zealand College of Midwives Journal, 49*, 29–33. Retrieved from https://www.midwife.org.nz/midwives/publications/college-journal

McAra-Couper, J., Jones, M., & Smythe, L. (2011). Caesarean-section, my body, my choice: The construction of 'informed choice' in relation to intervention in childbirth. *Feminism & Psychology, 22*(1), 81–97. https://doi.org/10.1177/0959353511424369

McCormack, B., Dulmen, S. v., Eide, H., Skovdahl, K., & Eide, T. (Eds.). (2017). *Person-centred healthcare research* Hoboken, NJ: Wiley.

McDonald, C. (2017). *Working collaboratively in hospice and palliative care: Sharing time* (Unpublished doctoral dissertation). Auckland University of Technology, Auckland, New Zealand.

McGowan, S. (2014). Does the maternal experience of childbirth affect mother–infant attachment and bonding? *Journal of Health Visiting, 2*(11), 606–616. https://doi.org/10.12968/johv.2014.2.11.606

Merleau-Ponty, M. (1945/2014). *Phenomenology of perception* (D. A. Landes, Trans.). Abingdon, England: Routledge.

Metcalfe, A., & Game, A. (2006). The teacher's enthusiasm. *The Australian Educational Researcher, 33*(3), 91–106. https://doi.org/10.1007/BF03216843

Midwifery Council of New Zealand. (2007). *The competencies for entry to the register of midwives*. Wellington, New Zealand: Author. Retrieved from https://www.midwiferycouncil.health.nz/midwives/maintaining-competence

Miki, K. (1940/1976). *Tetsugaku nyūmon [Introduction to philosophy]*. Tokyo, Japan: Iwanami Shoten.

Miller, L. (2006). *Being and belonging* (Unpublished doctoral dissertation). University of

Tasmania, Tasmania, Australia.

Ministry of Health. (2019). *Report on maternity 2017*. Wellington, New Zealand: Ministry of Health of New Zealand. Retrieved from https://www.health.govt.nz/publication/report-maternity-2017

Ministry of Health, Labour and Welfare. (2010). *Kangoshitō yōseijo no un'ei ni kansuru shidō yōryō [Guideline for running nurses' training school]* Tokyo, Japan: Ministry of Health, Labour and Welfare of Japan. Retrieved from https://www.mhlw.go.jp/web/t_doc?dataId=00tb6819&dataType=1&pageNo=1

Ministry of Health, Labour and Welfare. (2011). *Kango kyōiku no naiyō to hōhō ni kansuru kentōkai daiichiji hōkoku [First report of the review meeting regarding the contents and methods of nursing education]*. Tokyo, Japan: Ministry of Health, Labour and Welfare of Japan. Retrieved from https://www.mhlw.go.jp/stf/shingi/2r9852000001316y.html

Ministry of Health, Labour and Welfare. (2014). *Shussan ikuji ichijikin no minaoshi ni tsuite [Revision of the lump-sum allowance for childbirth]*. Tokyo, Japan: Ministry of Health, Labour and Welfare of Japan. Retrieved from https://www.mhlw.go.jp/file/05-Shingikai-12601000-Seisakutoukatsukan-Sanjikanshitsu_Shakaihoshoutantou/0000050441.pdf

Ministry of Health, Labour and Welfare. (2015a). *Heisei nijū-nana nen ban kōsei rōdō hakusho [Annual health, labour and welfare report 2015]*. Tokyo, Japan: Ministry of Health, Labour and Welfare of Japan. Retrieved from https://www.mhlw.go.jp/wp/hakusyo/kousei/15-1/dl/gaiyou.pdf

Ministry of Health, Labour and Welfare. (2015b). *Josanshi no shūgyō jōkyō to katsuyō ni tsuite [The employment conditions and utilisation of midwives]*. Tokyo, Japan: Ministry of Health, Labour and Welfare of Japan. Retrieved from https://www.mhlw.go.jp/stf/shingi2/0000101460.html

Ministry of Health, Labour and Welfare. (2015c). *Shūsanki iryō taisei no genjō ni tsuite [The current situation of the perinatal medical care system]*. Tokyo, Japan: Ministry of Health, Labour and Welfare of Japan. Retrieved from https://www.mhlw.go.jp/file/05-Shingikai-10801000-Iseikyoku-Soumuka/0000096037.pdf

Ministry of Health, Labour and Welfare. (2017a). *Chiiki shūsanki boshi iryō sentā ichiran [List of regional perinatal medical centres]* Tokyo, Japan: Ministry of Health, Labour and Welfare of Japan. Retrieved from http://www.jaog.or.jp/wp/wp-content/uploads/2017/05/Perinatal_c20170401.pdf

Ministry of Health, Labour and Welfare. (2017b). *Heisei nijū-hachi nen eisei gyōsei hōkokurei (shūgyō iryō kankeisha) no gaikyō [Report on public health administration and services (employed medical personnel) 2016]*. Tokyo, Japan: Ministry of Health, Labour and Welfare of Japan. Retrieved from https://www.mhlw.go.jp/toukei/saikin/hw/eisei/16/

Ministry of Health, Labour and Welfare. (2017c). *Hokenshi josanshi kangoshi gakkō yōseijo shitei kisoku [Regulations for public health nurses,' midwives,' and nurses' training school]*. Retrieved from https://www.mhlw.go.jp/web/t_doc?dataId=80081000&dataType=0&pageNo=1

Ministry of Health, Labour and Welfare. (2017d). *Kosodate sedai hōkatsu shien sentā gyōmu*

gaidorain, sanzen sango sapōto jigyō gaidorain oyobi sango kea jigyō gaidorain ni tsuite [Service guidelines for comprehensive support centers for families with children, service guidelines for antenatal and postnatal support, and service guidelines for postnatal care]. Tokyo, Japan: Ministry of Health, Labour and Welfare of Japan. Retrieved from https://www.mhlw.go.jp/stf/houdou/0000172988.html

Ministry of Health, Labour and Welfare. (2017e). *Sōgō shūsanki boshi iryō sentā ichiran [List of general perinatal medical centres]*. Tokyo, Japan: Ministry of Health, Labour and Welfare of Japan. Retrieved from http://www.jaog.or.jp/wp/wp-content/uploads/2017/05/Perinatal_s20170401.pdf

Ministry of Health, Labour and Welfare. (2018a). *Heisei nijū-kyū nen (nisen-jū-nana) iryō shisetsu (seitai, dōtai) chōsa, byōin hōkoku no gaikyō [Summary of static/dynamic survey of medical institutions and hospital report 2017]*. Tokyo, Japan: Ministry of Health, Labour and Welfare of Japan. Retrieved from https://www.mhlw.go.jp/toukei/saikin/hw/iryosd/17/

Ministry of Health, Labour and Welfare. (2018b). *Heisei nijū-kyū nen (nisen-jū-nana) jinkō dōtai tōkei geppō nenkei (gaisū) no gaikyō: Kekka no gaiyō [Digest of vital statistics, monthly report and annual total (round number) 2017: Summary of results]*. Tokyo, Japan: Ministry of Health, Labour and Welfare of Japan. Retrieved from https://www.mhlw.go.jp/toukei/saikin/hw/jinkou/geppo/nengai17/dl/kekka29-190703.pdf

Ministry of Health, Labour and Welfare. (2018c). *Heisei nijū-kyū nen chū ni okeru jisatsu no jōkyō [The situation of suicide in 2017]*. Tokyo, Japan: Ministry of Health, Labour and Welfare of Japan. Retrieved from https://www.mhlw.go.jp/file/06-Seisakujouhou-12200000-Shakaiengokyokushougaihokenfukushibu/h29kakutei-01_1.pdf

Ministry of Health, Labour and Welfare. (2018d). *Heisei nijū-kyū nen jinkō dōtai tōkei geppō nenkei (gaisū) no gaikyō: Shusseisū no nenji suii, haha no nenrei (go sai kaikyū) betsu [Digest of vital statistics, monthly report and annual total (round number) 2017: Annual trends in live births by age of mother (5-year age group)]*. Tokyo, Japan: Ministry of Health, Labour and Welfare of Japan. Retrieved from https://www.mhlw.go.jp/toukei/saikin/hw/jinkou/geppo/nengai17/dl/h3-4.pdf

Ministry of Health, Labour and Welfare. (2018e). *Heisei nijū-kyū nen kan'i seimeihyō no gaikyō [Digest of abridged life table 2017]* Tokyo, Japan: Ministry of Health, Labour and Welfare of Japan. Retrieved from https://www.mhlw.go.jp/toukei/saikin/hw/life/life17/index.html

Ministry of Health, Labour and Welfare. (2018f). *Heisei nijū-kyū nendo no jidō sōdansho deno jidō gyakutai sōdan taiō kensū [The number of child abuse cases responded to by child consultation centres in 2017]*. Tokyo, Japan: Ministry of Health, Labour and Welfare of Japan. Retrieved from https://www.mhlw.go.jp/content/11901000/000348313.pdf

Ministry of Health, Labour and Welfare. (2018g). *Kodomo gyakutai niyoru sibō jirei tō no kenshō kekka tō ni tsuite (dai jū-yon ji hōkoku) [Validation results of death cases by child abuse (the 14th report)]*. Tokyo, Japan: Ministry of Health, Labour and Welfare of Japan. Retrieved from https://www.mhlw.go.jp/stf/seisakunitsuite/bunya/0000173329_00001.html

Ministry of Health, Labour and Welfare. (2018h). *Mutsū bunben no jittai haaku oyobi anzen kanri*

taisei no kōchiku ni tsuite [Understanding the situation of painless birth and building a safe management system]. Tokyo, Japan: Ministry of Health, Labour and Welfare of Japan. Retrieved from https://www.mhlw.go.jp/content/11121000/000347868.pdf

Ministry of Health, Labour and Welfare. (2018i). *Percent distribution of live births by place of delivery: Japan, each prefecture and 21 major cities, 2017*. Tokyo, Japan: Ministry of Health, Labour and Welfare of Japan. Retrieved from https://www.e-stat.go.jp/en/stat-search/files?page=1&layout=datalist&toukei=00450011&tstat=000001028897&cycle=7&year=20170&month=0&tclass1=000001053058&tclass2=000001053061&tclass3=000001053064&stat_infid=000031743393&result_back=1

Ministry of Health, Labour and Welfare. (2018j). *Shigoto to funin chiryō no ryōritsu no tameni [Balancing jobs and treatment for infertility]*. Tokyo, Japan: Ministry of Health, Labour and Welfare of Japan. Retrieved from https://www.mhlw.go.jp/bunya/koyoukintou/pamphlet/30.html

Misago, C., Shimane, T., Noguchi, M., Takenaka, M., Sugawara, M., Fukushima, F., . . . Kobayashi, H. (2005). The development of transforming birth experience scale: A trial to define autonomous birth. *Rinsyō Fujinka Sanka, 59*(9), 1303–1311. https://doi.org/10.11477/mf.1409100403

Mitou, T., Ishida, M., Ohgushi, M., Kitaura, A., & Iseda, A. (2007). *Kangoshokusha no tameno seisaku katei nyūmon: Seido wo kaeruto kango ga kawaru [The introduction of policy process for nursing professionals: Changing the system changes nursing]* Tokyo, Japan: Japanese Nursing Association Publishing Company.

Mitsui, M., Karasawa, I., & Ohno, H. (2004). Josangaku kyōiku no tenbō: Kangokei daigaku no jittai chōsa [Prospects of midwifery education: Fact-finding survey of nursing universities]. *Gifu Iryōgijutsu Tankidaigaku Kiyō, 20*, 115–120. Retrieved from https://www.u-gifu-ms.ac.jp

Mitsui, M., Mori, H., & Kuroki, C. (2002). Dansei josanshi zehiron [Arguing for and against male midwives]. *Gifu Iryōgijutsu Tankidaigaku Kiyō, 18*, 85–96. Retrieved from https://www.u-gifu-ms.ac.jp

Moloney, S., & Gair, S. (2015). Empathy and spiritual care in midwifery practice: Contributing to women's enhanced birth experiences. *Women and Birth, 28*(4), 323–328. https://doi.org/10.1016/j.wombi.2015.04.009

Momoi, M. (2003). *Shōshika taisaku taikō an eno teigen [Recommendations for the proposed framework of countermeasures to the falling birthrate]*. Tokyo, Japan: Cabinet Office of Japan. Retrieved from https://www8.cao.go.jp/shoushi/shoushika/meeting/outline/k_1/s1_8momoi.html

Moncrieff, G. (2018). Can continuity bring birth back to women and normality back to midwives? *British Journal of Midwifery, 26*(10), 642–650. https://doi.org/10.12968/bjom.2018.26.10.642

Morita, Y. (2020, February 16th). Shitteru? 'mai josanshi' (3) 'Ninpu wo marugoto mamoru,' joseino kyū wari nozonda chōsa mo [Do you know 'my midwife'? (3) 'Holistic support for pregnant women,' 90% of the women in a survey said they wanted it]. *Tanba Shimbun*. Retrieved from https://tanba.jp/2020/02

Murakami, A. (2013). Daigaku de kango to josan no ryōhō wo manabu to iukoto [The meaning of studying both nursing and midwifery in universities]. *Kango Kyōiku, 54*(11), 994–997. https://doi.org/10.11477/mf.1663102550

Murakami, H. (1979/2016). *Hear the wind sing*. London, England: Vintage.

Nakagawa, Y. (2001). Eastern philosophy and holistic education. In J. P. Miller, K. Nigh, M. J. Binder, B. Novak, & S. Crowell (Eds.), *International handbook of holistic education* (pp. 42–50). New York, NY: Routledge.

Nakai, A. (2014). *Sanfujinka ishi no kinmu jittai to shōrai bijon [Working situation and future vision of obstetricians]*. Tokyo, Japan: Japan Association of Obstetricians and Gynecologists.

Nakai, A. (2019). *Ninsanpu no shinryō no genjō to kadai [The current situation and issues of medical care for pregnant and childbearing women]*. Tokyo, Japan: Ministry of Health, Labour and Welfare of Japan. Retrieved from https://www.mhlw.go.jp/content/12401000/000488877.pdf

Nakaita, I., & Sano, S. (2012). Research into factors during pregnancy for predicting postpartum depression: From the viewpoint of prevention of child abuse. *Shōni Hoken Kenkyū, 71*(5), 737–747. Retrieved from https://www.jschild.or.jp/research/archive

Nakajima, K., Kunikiyo, K., Sakamoto, S., Arai, H., & Tokiwa, Y. (2009). The assignment of practice of clinical care delivery and continuing midwifery care from the perspective of newly graduated midwives. *Nihon Josan Gakkaishi, 23*(1), 5–15. https://doi.org/10.3418/jjam.23.5

Nakane, C. (1967). *Tate shakai no ningen kankei: Tan'itsu shakai no riron [Japanese society: A practical guide to understand the Japanese mindset and culture]*. Tokyo, Japan: Kōbunsha.

Nakayama, M. (2001). *Shintai wo meguru seisaku to kojin: Boshi kenkō sentā jigyō no kenkyū [Policy and individuality over the body: A study of the mother and child health centre services]*. Tokyo, Japan: Keisō Shobō.

Nakayama, M. (2015). *Shussan shisetsu wa naze hihei shitanoka: Nichibo sanka kango gakuin, iryōhō kaisei, kōsei 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]* Tokyo, Japan: Nihon Hyōronsha.

National Institute of Population and Social Security Research. (2018). *Ninsanpu shibōsū oyobi ritsu: Sen-happyaku-kyūjū-kyū kara nisen-jū-roku nen [The number and percentage of maternal deaths: 1899–2016]*. Retrieved from http://www.ipss.go.jp/syoushika/tohkei/Popular/P_Detail2018.asp?fname=T05-28.htm&title1=%87X%81D%8E%80%96S%81E%8E%F5%96%BD&title2=%95%5C%82T%81%7C28+%94D%8EY%95w%8E%80%96S%90%94%82%A8%82%E6%82%D1%97%A6%81F1899%81%602016%94N

Newton, M. S., McLachlan, H. L., Forster, D. A., & Willis, K. F. (2016). Understanding the 'work' of caseload midwives: A mixed-methods exploration of two caseload midwifery models in Victoria, Australia. *Women and Birth, 29*(3), 223–233.

https://doi.org/10.1016/j.wombi.2015.10.011

Newton, M. S., McLachlan, H. L., Willis, K. F., & Forster, D. A. (2014). Comparing satisfaction and burnout between caseload and standard care midwives: Findings from two cross-sectional surveys conducted in Victoria, Australia. *BMC Pregnancy and Childbirth, 14*, 426–441. https://doi.org/10.1186/s12884-014-0426-7

Nihongo Zokugo Jisho. (2018). *Otsubone*. Retrieved from http://zokugo-dict.com/05o/otubone.htm

Nilsson, C., & Lundgren, I. (2009). Women's lived experience of fear of childbirth. *Midwifery, 25*(2), 1–9. https://doi.org/10.1016/j.midw.2007.01.017

Nishida, K. (1911/1979). *Zen no kenkyū [A study of good]*. Tokyo, Japan: Iwanami Shoten.

Nishigaki, E., Asai, A., Ohnishi, M., & Fukui, T. (2004). Concepts of trust and distrust in physician–patient relationship in Japan. *Taijin-shakai-shinrigaku Kenkyū, 4*, 11–20. https://doi.org/10.18910/5396

Nishimura, Y. (2018). *Katarikakeru shintai: Kango kea no genshōgaku [The telling body: Phenomenology in nursing]*. Tokyo, Japan: Kōdansha.

Noble, L. M. (2016). The future of the doctor–patient relationship. In J. Brown, L. M. Noble, A. Papageorgiou, & J. Kidd (Eds.), *Clinical communication in medicine* (pp. 86–95). Chichester, England: John Wiley & Sons.

Noguchi, M. (2002). Women's positive childbirth experience at a birthing home and knowledge by acquaintance. *Nihon Josan Gakkaishi, 15*(2), 7–14. https://doi.org/10.3418/jjam.15.2_7

Noguchi, Y. (2002). *Monogatari toshiteno kea: Naratibu apurōchi no sekai e [Care as a story: Towards the world of narrative approach]*. Tokyo, Japan: Igaku Shoin.

Ogawa, K. (2016). Seiyō kindai igaku no dōnyū to sanba no yōsei [The introduction of Western modern medicine and training of midwives]. In C. Shirai (Ed.), *Umi sodate to josan no rekishi: Kindaika no nihyaku nen wo furikaeru [History of childbirth and childrearing: Looking back on 200 years of modernisation]* (pp. 26–46). Tokyo, Japan: Igaku Shoin.

Ohbayashi, M. (1989). *Josanpu no sengo [Postwar midwives]*. Tokyo, Japan: Keisō Shobō.

Ohde, H. (2016). Sengo no josanpu kyōiku [Midwifery education after the war]. In C. Shirai (Ed.), *Umi sodate to josan no rekishi: Kindaika no nihyaku nen wo furikaeru [History of childbirth and childrearing: Looking back on 200 years of modernisation]* (pp. 154–162). Tokyo, Japan: Igau Shoin.

Ohde, H. (2018). *Sanba to san'in no nihon kindai [Modernisation of midwives and birth facilities in Japan]*. Tokyo, Japan: Seikyūsha.

Oishi, T. (2015). Josanshi no yakuwari kakudai wo misueta josanshi kyōiku no shōrai bijon wo [Future vision of midwifery education for the expansion of midwives' role]. *Japan Society of Midwifery Education, 84*, 1. Retrieved from

http://www.zenjomid.org/activities/img/news_84.pdf

Okada, R. (2013). *The midwifery department*. Retrieved from http://www.eiseikansen.com/mc/index.html

Okamoto, K. (2017). *Heisei no josanshikai kakumei [A revolution of Japanese Midwives Association in the Heisei era]* Tokyo, Japan: Japanese Midwives' Publishing Corporation.

Okino, Y. (2002). Analyses of in-patients' cognition about informed consent and factors that influence their decision-making to treatment or procedure. *Nihon Hoken Fukushi Gakkaishi, 8*(2), 29–39. https://doi.org/10.20681/hwelfare.8.2_29

Okoshi, A. (2005). *Nihon oyobi nihon-jin [Japan and the Japanese]*. Tokyo, Japan: Chōeisha.

Olza, I., Leahy-Warren, P., Benyamini, Y., Kazmierczak, M., Karlsdottir, S. I., Spyridou, A., . . . Nieuwenhuijze, M. J. (2018). Women's psychological experiences of physiological childbirth: A meta-synthesis. *BMJ Open, 8*(10), 1–11. https://doi.org/10.1136/bmjopen-2017-020347

Ono, C. (2015). Wagakuni no kaigyō josanshi no jissen nōryoku ni kansuru kenkyū: Hajimete hahaoya ni naru josei ni enpawamento wo motarasu kea [A study of practical competences of self-employed midwives in Japan: Care to empower first-time mothers]. *Gendai Shakai Kenkyū, 13*, 227–234. Retrieved from http://www.kobegakuin-css.jp/archives/book/01

Organisation for Economic Co-operation and Development. (2016). *Japan: Boosting growth and well-being in an ageing society (Japanese version)*. Paris, France: OECD Publishing.

Organisation for Economic Co-operation and Development. (2017). *Health at a glance 2017: OECD indicators*. Paris, France: OECD Publishing. Retrieved from https://www.oecd-ilibrary.org/docserver/health_glance-2017-en.pdf?expires=1539138068&id=id&accname=guest&checksum=31E8B4EEB14C17D7505CBC53A10F5C80

Orr, D. B., Friedman, H. L., & Williams, J. C. C. (1965). Trainability of listening comprehension of speeded discourse. *Journal of Educational Psychology, 56*(3), 148–156. Retrieved from https://www.apa.org/pubs/journals/edu

Ozawa, K. (2002). Place and identity by phenomenological approach. *Tokyo Kōgei Daigaku Kōgakubu Kiyō, 25*(2), 30–40. Retrieved from https://www.t-kougei.ac.jp/activity/bulletin_e/

Page, L. (2019). Foreword. In C. Homer, P. Brodie, J. Sandall, & N. Leap (Eds.), *Midwifery continuity of care* (2nd ed.). Chatswood, Australia: Elsevier.

Pairman, S. (1998). Women-centred midwifery: Partnerships or professional friendships? *New Zealand College of Midwives Journal, 19*, 5–10. Retrieved from https://www.midwife.org.nz/midwives/publications/college-journal

Pairman, S., & Tumilty, E. (2016). *ICM regulation toolkit*. The Hague, The Netherlands: International Confederation of Midwives. Retrieved from http://www.internationalmidwives.org/assets/uploads/documents/Global%20Standards

%20Comptencies%20Tools/English/ICM_Toolkit_ENG.pdf

Pauktuutit Inuit Women of Canada. (2019). *Midwifery*. Retrieved from https://www.pauktuutit.ca/health/maternal-health/midwifery

Perdok, H., Verhoeven, C. J., van Dillen, J., Schuitmaker, T. J., Hoogendoorn, K., Colli, J., . . . de Jonge, A. (2018). 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. *BMC Pregnancy and Childbirth, 18*(1), 13–21. https://doi.org/10.1186/s12884-017-1615-y

Perkins, J. M., Subramanian, S. V., & Christakis, N. A. (2015). Social networks and health: A systematic review of sociocentric network studies in low- and middle-income countries. *Social Science & Medicine, 125*, 60–78. https://doi.org/10.1016/j.socscimed.2014.08.019

Perriman, N., Davis, D. L., & Ferguson, S. (2018). What women value in the midwifery continuity of care model: A systematic review with meta-synthesis. *Midwifery, 62*, 220–229. https://doi.org/10.1016/j.midw.2018.04.011

Pezaro, S., Pearce, G., & Bailey, E. (2019). Childbearing women's experiences of midwives' workplace distress: Patient and public involvement. *British Journal of Midwifery, 26*(10), 659–669. https://doi.org/10.12968/bjom.2018.26.10.659

Piquado, T., Benichov, J. I., Brownell, H., & Wingfield, A. (2012). The hidden effect of hearing acuity on speech recall, and compensatory effects of self-paced listening. *International Journal of Audiology, 51*(8), 576–583. https://doi.org/10.3109/14992027.2012.684403

Pope, R., Graham, L., & Swattee, P. (2001). Woman-centred care. *International Journal of Nursing Studies, 38*, 227–238. https://doi.org/10.1016/S0020-7489(00)00034-1

Reed, R., Sharman, R., & Inglis, C. (2017). Women's descriptions of childbirth trauma relating to care provider actions and interactions. *BMC Pregnancy and Childbirth, 17*(1), 21–30. https://doi.org/10.1186/s12884-016-1197-0

Reiners, G. M. (2012). Understanding the differences between Husserl's (descriptive) and Heidegger's (interpretive) phenomenological research. *Journal of Nursing and Care, 1*(5), 1–3. https://doi.org/10.4172/2167-1168.1000119

Richards, B. (2017). *The meaning of breastfeeding support for six New Zealand women in the first six weeks postpartum* (Unpublished master's thesis). Auckland University of Technology, Auckland, New Zealand.

Rosan, P. J. (2012). The poetics of intersubjective life: Empathy and the other. *The Humanistic Psychologist, 40*(2), 115–135. https://doi.org/10.1080/08873267.2012.643685

Rothman, B. K. (1996). Women, providers, and control. *Journal of Obstetric, Gynecologic and Neonatal Nursing, 25*(3), 253–256. https://doi.org/10.1111/j.1552-6909.1996.tb02433.x

Sadati, A. K., Tabei, S. Z., & Lankarani, K. B. (2018). A qualitative study on the importance and value of doctor–patient relationship in Iran: Physicians' views. *Macedonian Journal of Medical Sciences, 6*(10), 1895–1901. https://doi.org/10.3889/oamjms.2018.361

Safran, D. G., Miller, W., & Beckman, H. (2006). Organizational dimensions of relationship-centered care. Theory, evidence, and practice. *Journal of General Internal Medicine, 21*(1), 9–15. https://doi.org/10.1111/j.1525-1497.2006.00303.x

Saito, I. (2018). Dēta kara mita sanka kongō byōtō: Taka no kanja no sibōji kango oyobi bunbenji no kango no jūfuku [Obstetric mixed-patient wards, perspectives from the data: Concurrent nursing care for dying patients and birthing women]. *Josan Zasshi, 72*(4), 253–258. https://doi.org/10.11477/mf.1665200979

Sakakibara, T. (2018). *Iryō kea wo toinaosu: Kanja wo tōtaru ni mirukoto no genshōgaku [Re-inquiring medical care: Phenomenology of holistic view towards patients]* Tokyo, Japan: Chikuma Shobō.

Sandall, J., Soltani, H., Gates, S., Shennan, A., & Devane, D. (2016). Midwife-led continuity models versus other models of care for childbearing women. *Cochrane Database of Systematic Reviews, 4*, CD004667. https://doi.org/10.1002/14651858.CD004667.pub5

Sandelowski, M. (1986). The problem of rigor in qualitative research. *Advances in Nursing Science, 8*(3), 27–37. https://doi.org/10.1097/00012272-198604000-00005

Sandelowski, M. (1993). Rigor or rigor mortis: The problem of rigor in qualitative research revised. *Advances in Nursing Science, 16*(2), 1–8. https://doi.org/10.1097/00012272-199312000-00002

Sandelowski, M. (2015). A matter of taste: Evaluating the quality of qualitative research. *Nursing Inquiry, 22*(2), 86–94. https://doi.org/10.1111/nin.12080

Sanyō Shimbun. (2014, August 3rd). Fueru zaitaku no jūshōji: Fukamaru kazoku no kizuna, kaigo futan wa omoku [Increase in home nursing for seriously ill children: Deepening family ties, but a heavy burden of nursing on family]. *Sanyō Shimbun*. Retrieved from http://medica.sanyonews.jp/article/3858/

Sasaki, H., Goto, A., Yabe, J., & Yasumura, S. (2010). Factors associated with general self-efficacy in Japanese mothers of infants: A cohort study utilizing data collected routinely at the time of child health check. *Shōni Hoken Kenkyū, 69*(5), 666–675. Retrieved from https://www.jschild.or.jp/research/archive

Sasaki, M. (2016). *'Umu sei' to gendai shakai: Osan kankyō wo meguru minzokugaku ['Birthing sex' and modern society: Folklore of the birth environment]*. Tokyo, Japan: Iwata Shoin.

Schmidt, L. K. (2006). *Understanding hermeneutics*. Durham, England: Acumen Publishing. Retrieved from https://ebookcentral.proquest.com/lib/aut/reader.action?docID=3060911

Scruton, R. (2002). *A short history of modern philosophy: From Descartes to Wittgenstein* (2nd ed.). London , England: Routledge.

Sekimoto, M., Asai, A., Ohnishi, M., Nishigaki, E., Fukui, T., Shimbo, T., & Imanaka, Y. (2004). Patients' preferences for involvement in treatment decision making in Japan. *BMC Family Practice, 5*(1), 1–10. https://doi.org/10.1186/1471-2296-5-1

Shakibazadeh, E., Namadian, M., Bohren, M. A., Vogel, J. P., Rashidian, A., Pileggi, V. N., . . . Gülmezoglu, A. M. (2018). Respectful care during childbirth in health facilities globally:

A qualitative evidence synthesis. *BJOG: An International Journal of Obstetrics and Gynaecology, 125*(8), 932–942. https://doi.org/10.1111/1471-0528.15015

Shibata, H. (2017). *Kosodate shien to keizai seichō [Parenting support and economic growth]*. Tokyo, Japan: Asahi Shimbun Shuppan.

Shimada, M. (2009). Gakushi katei ni okeru josanshi kyōiku [Midwifery education in bachelor's degree programmes]. *Josanshi, 63*(4), 19–21. Retrieved from http://www.midwifepc.co.jp

Shimada, M. (2017). *Sango kea gaidorain no sakusei oyobi sanzen sango no sien no arikata ni kansuru kenkyū [A study of making guidelines for postnatal care and methods of antenatal and postnatal support]*. Tokyo, Japan: Japanese Midwives Association. Retrieved from http://www.midwife.or.jp/pdf/h28result/kodomokosodate_290412_3.pdf

Shimada, M. (2018). Sango kea de josanshi ga ninau yakuwari towa: Kihonteki na kangaekata to sono haikei [Midwives' roles in postnatal care: Fundamental ideas and background]. *Josan Zasshi, 72*(6), 406–409. https://doi.org/10.11477/mf.1665201019

Shimada, M., Kamiya, S., Nakane, N., Toda, T., Agata, T., Takeuchi, M., & Adachi, K. (2002). National survey on birth attendant in Japan: Comparison with birth certificate. *Nihon Josan Gakkaishi, 15*(2), 15–21. https://doi.org/10.3418/jjam.15.2_15

Shimada, T., Abe, N., & Kawamura, K. (2003). Analysis of the relations between a newborn infants hospitalization days and the number of obstetricians and midwives. *Kenritsu Nagasaki Shīboruto Daigaku Kango Eiyō Gakubu Kiyō, 4*, 95–102. Retrieved from https://ci.nii.ac.jp/ncid/AA11563124

Shimizu, M. (2015). Ninshinki no josan kea [Midwifery care during the gestation period]. *Josan Zasshi, 69*(5), 368–373. https://doi.org/10.11477/mf.1665200192

Shimizu, Y. (2011). *Josan jisshū ni okeru sanpu no kea nōryoku ni kansuru gakusei no manabi: Bunben kaijo wo chūshin toshite [Students' learning regarding competency of care for childbearing women in the midwifery placement with the focus of birth attendance*. Nagano, Japan: Nagano College of Nursing. Retrieved from https://www.nagano-nurs.ac.jp

Shinohara, Y. (2011). Influence factors in the current job behaviors of midwives. *Kokusai Hokengaku Kenkyū: Tsukuba Kokusai Daigaku Kiyō, 2*, 65–77. Retrieved from https://www.ktt.ac.jp/tiu/hs-study/hs-study.htm

Shirai, C. (2016a). Sengo no uni sodate no hensen [The change of childbirth and childrearing after the war]. In C. Shirai (Ed.), *Umi sodate to josan no rekishi: Kindaika no nihyaku nen wo furikaeru [History of childbirth and childrearing: Looking back on 200 years of modernisation]*. Tokyo, Japan: Igaku Shoin.

Shirai, C. (2016b). Shōshika to sanka iryō hōkai [The decline in the birthrate and collapse of obstetric medical care]. In C. Shirai (Ed.), *Umi sodate to josan no rekishi: Kindaika no nihyaku nen wo furikaeru [History of childbirth and childrearing: Looking back on 200 years of modernisation]* (pp. 294–302). Tokyo, Japan: Igaku Shoin.

Shirai, C. (Ed.). (2016c). *Umi sodate to josan no rekishi: Kindaika no nihyaku nen wo furikaeru*

[History of childbirth and childrearing: Looking back on 200 years of modernisation]. Tokyo, Japan: Igaku Shoin.

Simelela, P. N. (2018). *A 'good birth' goes beyond having a healthy baby*. Retrieved from https://www.who.int/mediacentre/commentaries/2018/having-a-healthy-baby/en/

Singh, M. (2016). Communication as a bridge to build a sound doctor–patient/parent relationship. *Indian Journal of Pediatrics, 83*(1), 33–37. https://doi.org/10.1007/s12098-015-1853-9

Skinner, J. (1999). Midwifery partnership: Individualism contractualism or feminist praxis? *New Zealand College of Midwives Journal, 21*, 14–17. Retrieved from https://www.midwife.org.nz/midwives/publications/college-journal

Smith, D. (1997). Phenomenology: Methodology and method. In J. Higgs (Ed.), *Qualitative research: Discourse on methodologies*. Sydney, Australia: Hampden Press.

Smith, T. D. (2001). The concept of nursing presence: State of the science. *Scholarly Inquiry for Nursing Practice, 15*(4), 299–322. Retrieved from https://connect.springerpub.com/content/sgrsinp

Smythe, L. (2011). From beginning to end: How to do hermeneutic interpretive phenomenology. In G. Thomson, F. Dykes, & S. Downe (Eds.), *Qualitative research in midwifery and childbirth phenomenological approaches* (pp. 35–54). Abingdon, England: Routledge.

Smythe, L., Hunter, M., Gunn, J., Crowther, S., Couper, J. M., Wilson, S., & Payne, D. (2016). Midwifing the notion of a 'good' birth: A philosophical analysis. *Midwifery, 37*, 25–31. https://doi.org/10.1016/j.midw.2016.03.012

Smythe, L., Ironside, P. M., Sims, S. L., Swenson, M. M., & Spence, D. G. (2008). Doing Heideggerian hermeneutic research: A discussion paper. *International Journal of Nursing Studies, 45*(9), 1389–1397. https://doi.org/10.1016/j.ijnurstu.2007.09.005

Smythe, L., & Spence, D. (2012). Re-viewing literature in hermeneutic research. *International Journal of Qualitative Methods, 11*(1), 12–25. https://doi.org/10.1177/160940691201100102

Smythe, L., Spence, D., & Gray, J. (2019). From place to space: A Heideggerian analysis. *Indo-Pacific Journal of Phenomenology, 18*(2), 87–97. https://doi.org/10.1080/20797222.2018.1542769

Sonfa, O. (2009). *Nihon no aimai ryoku [The power of vagueness of Japan]*. Tokyo, Japan: PHP Kenkyūjo.

Statistics Bureau of Japan. (2018). *Nihon no tōkei [Statistics of Japan]*. Retrieved from http://www.stat.go.jp/data/nihon/index2.html

Stats NZ Tatauranga Aotearoa. (2017). *Three in four New Zealanders live in the North Island*. Retrieved from https://www.stats.govt.nz/news/three-in-four-new-zealanders-live-in-the-north-island

Stavropoulou, C. (2011). Non-adherence to medication and doctor–patient relationship: Evidence

from a European survey. *Patient Education and Counseling, 83*(1), 7–13. https://doi.org/10.1016/j.pec.2010.04.039

Stenner, R., Mitchell, T., & Palmer, S. (2017). The role of philosophical hermeneutics in contributing to an understanding of physiotherapy practice: A reflexive illustration. *Physiotherapy, 103*(3), 330–334. https://doi.org/10.1016/j.physio.2016.05.003

Stevens, T., & McCourt, C. (2002). One-to-one midwifery practice part 2: The transition period. *British Journal of Midwifery, 10*(1), 45–50. https://doi.org/10.12968/bjom.2002.10.1.10051

Stockmann, C. (2018). Presence in the nurse–client relationship: An integrative review. *International Journal for Human Caring, 22*(2), 49–64. https://doi.org/10.20467/1091-5710.22.2.49

Sullivan, L. S. (2017). Dynamic axes of informed consent in Japan. *Social Science and Medicine, 174*, 159–168. https://doi.org/10.1016/j.socscimed.2016.12.031

Surtees, R. J. (2003). *Midwifery as feminist praxis in Aotearoa/New Zealand* (Unpublished doctoral dissertation). University of Canterbury, Christchurch, New Zealand.

Suzui, E. (1998). Midwifery practices during antenatal examinations: Positive interpersonal interactions between midwife and pregnant woman. *Kawasaki Iryō Fukushi Gakkaishi, 8*(2), 319–328. Retrieved from http://www.kawasaki-m.ac.jp/soc/mw/journal/jp

Suzui, E. (2016a). Chō-onpa shindan to josan [Ultrasonic diagnosis and midwifery] In C. Shirai (Ed.), *Umi sodate to josan no rekishi: Kindaika no nihyaku nen wo furikaeru [History of childbirth and childrearing: Looking back on 200 years of modernisation]* (pp. 183–205). Tokyo, Japan: Igaku Shoin.

Suzui, E. (2016b). Kangokei daigaku no kakudai ni tomonau josanshi kyōiku no henyō [The change of midwifery education following the increase of nursing universities]. In C. Shirai (Ed.), *Umi sodate to josan no rekishi: Kindaika no nihyaku nen wo furikaeru [History of childbirth and childrearing: Looking back on 200 years of modernisation]* (pp. 267–280). Tokyo, Japan: Igaku Shoin.

Suzuki, S. (2012). The attitude of 'low risk' pregnant women in Japan toward midwife-led care during pregnancy and labor. *Journal of Maternal-Fetal and Neonatal Medicine, 25*(10), 2141–2142. https://doi.org/10.3109/14767058.2012.684162

Suzuki, S. (2016). Recent clinical characteristics of labors using three Japanese systems of midwife-led primary delivery care. *Nursing Research and Practice, 9101479*, 1–4. https://doi.org/10.1155/2016/9101479

Suzuki, Y., & Shimada, Y. (2014). Concerning about the significance of the continuation case in a midwifery training. *Kiryu Daigaku Kiyō, 25*, 109–114. Retrieved from https://www.kiryu-u.ac.jp/library/bulletin/

Tahara, Y. (2016). Cardiopulmonary resuscitation in a super-aging society: Is there an age limit for cardiopulmonary resuscitation? *Circulation Journal, 80*(5), 1102–1103. https://doi.org/10.1253/circj.CJ-16-0307

Takada, M., Unno, N., Suzuki, A., & Murakami, A. (2020). Zadankai: ima motomerareteiru josanshi no jissenryoku [Symposium on the practical ability required for current midwives]. *Adobansu Josanshi, 6,* 2–5. Retrieved from https://josan-hyoka.org

Takashima, Y., Takatsuka, M., Kikuchi, M., Yuminamochi, H., & Nakashima, M. (2012). The present state of midwifery education and the future associated issues at Niigata College of Nursing: Focusing on the degree of acquisition of midwifery technique part2. *Niigata Kenritsu Kango Daigaku Kiyō, 1*, 36–41. Retrieved from http://www.niigata-cn.ac.jp

Takashima, Y., Tsukamoto, Y., & Nakashima, M. (2014). The experience of women who have maintained a sense of trust in their midwife even following a midwifery accident. *Nihon Josan Gakkaishi, 28*(1), 26–38. https://doi.org/10.3418/jjam.28.26

Takeda, S. (2017). *Ninsanpu no jisatsu: Sono jittai [Suicide of expectant and nursing mothers: The actual situation]*. Tokyo, Japan: Japan Association of Obstetricians and Gynecologists. Retrieved from http://www.jaog.or.jp/wp/wp-content/uploads/2017/11/11643745157d48555ead55ae19d42a0a.pdf

Takehara, K., Okamoto, N., Yoshida, K., Misago, C., Osanai, Y., Okamoto, K., & Minoura, S. (2009). 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), 190–198. Retrieved from http://bosei-eisei.org/gakkaishi/index.php

Takeuchi, H. (2012). Daigaku kiyō toiu media: Kagirinaku tōmei ni chikai gurei [University journals as the media: Grey extremely near to transparency]. *Jōhō no Kagaku to Gijutsu, 62*(2), 72–77. Retrieved from https://www.infosta.or.jp/journal-top

Tamura, M. (2013). *Jūshō no mansei shikkanji no zaitaku to byōtō deno ryōyō ryōiku kankyō no jūjitsu ni kansuru kenkyū [A study of nursing environments for severe chronically diseased children treated at home and in the hospital]* Tokyo, Japan: Ministry of Health, Labour and Welfare of Japan. Retrieved from https://www.mhlw.go.jp/seisakunitsuite/bunya/hokabunya/kenkyujigyou/hojokin-koubo-h29/gaiyo/04.html

Tanaka, E., Morofushi, M., Tokida, N., & Kanou, A. (2017). Mutsū bunben wo nozomu ninsanpu tono kakawari no nakade omoukoto [Things that we think in the interaction with women hoping for painless birth]. *Josan Zasshi, 71*(1), 35–39. Retrieved from https://www.igaku-shoin.co.jp/journalDetail.do?journal=37566

Tanaka, M. (2009). Murakami Haruki no buntai, honyaku kenkyū: ‘Kaze no uta wo kike’ niokeru ‘yōni’ wo chūshinni [A study of Haruki Murakami’s literary style and translation: A focus on ‘like’ in ‘hear the wind sing’]. *Nagasaki Kokusai Daigaku Ronsō, 9*, 9–21. Retrieved from https://niu.repo.nii.ac.jp

Terui, K. (2011). *Zenkoku no bunben toriatsukai shisetsu ni okeru masuika shinryō jittai chōsa [Survey on anaesthetic practice in birth facilities in Japan]*. Tokyo, Japan: Ministry of Health, Labour and Welfare of Japan. Retrieved from https://www.mhlw.go.jp/bunya/kenkyuujigyou/hojokin-koubo14/08.html

Thomson, G. M., & Downe, S. (2010). Changing the future to change the past: Women’s experiences of a positive birth following a traumatic birth experience. *Journal of Reproductive and Infant Psychology, 28*(1), 102–112. https://doi.org/10.1080/02646830903295000

Todres, L., Galvin, K. T., & Holloway, I. (2009). The humanization of healthcare: A value framework for qualitative research. *International Journal of Qualitative Studies on Health and Well-being, 4*(2), 68–77. https://doi.org/10.1080/17482620802646204

Tracy, S. K., Hartz, D. L., Tracy, M. B., Allen, J., Forti, A., Hall, B., . . . Kildea, S. (2013). Caseload midwifery care versus standard maternity care for women of any risk: M@NGO, a randomised controlled trial. *The Lancet, 382*, 1723–1732. https://doi.org/10.1016/S0140-6736(13)61406-3

Tsai, A. C., & Papachristos, A. V. (2015). From social networks to health: Durkheim after the turn of the millennium. *Social Science & Medicine, 125*, 1–7. https://doi.org/10.1016/j.socscimed.2014.10.045

Tsuji, K. (2007). Shared decision making: A concept analysis. *Nihon Josan Gakkaishi, 21*(2), 12–22. https://doi.org/10.3418/jjam.21.2_12

Tsuji, K., Oguro, M., Doeda, N., Nakagawa, Y., & Horiuchi, S. (2006). Women-centred care in midwifery: Reconsidering the application of the episiotomy. *Nihon Josan Gakkaishi, 20*(1), 7–15. https://doi.org/10.3418/jjam.20.1_7

Tsurumachi, H. (2018). *Sango no nyūin kikan, nissū wa dorekurai? [How long do women stay in hospitals after birth?]*. Retrieved from https://192abc.com/68084

UNICEF [UNICEF]. (2018, February 28). Japan is the safest place to be born according to our new report. But where is the most dangerous? Find out → http://uni.cf/actnow #EveryChildALIVE [Tweet]. Retrieved from https://twitter.com/unicef/status/968969252064714752

United Nations Children's Fund. (2018). *Every child alive: The urgent need to end newborn deaths*. Geneva, Switzerland: Author. Retrieved from https://www.unicef.org/publications/files/Every_Child_Alive_The_urgent_need_to_end_newborn_deaths.pdf

Uto, H., & Kawabata, Y. (2015). Analysis of factors which influence decision making on selecting the maternity home and the childbirth experience in the multipara. *Minami Kyūshū Chiiki Kagaku Kenkyūsho Shohō, 31*, 7–11. Retrieved from https://kwjc.repo.nii.ac.jp/index.php?action=pages_view_main&active_action=repository_view_main_item_snippet&index_id=54&pn=1&count=50&order=17&lang=japanese&page_id=13&block_id=17

van Manen, M. (1999). The pathic nature of inquiry and nursing. In I. Madjar & J. Walton (Eds.), *Nursing and the experience of illness: Phenomenology in practice* (pp. 17–35). London, England: Routledge.

van Manen, M. (2014). *Phenomenology of practice: Meaning-giving methods in phenomenological research and writing*. Walnut Creek, CA: Left Coast Press.

van Manen, M. (2015). *Pedagogical tact: Knowing what to do when you don't know what to do*. London, England: Routledge.

van Manen, M. (2016a). *Researching lived experience* (2nd ed.). New York, NY: Routledge.

van Manen, M. (2016b). *The tone of teaching* (2nd ed.). Abingdon, England: Routledge.

van Manen, M. (2017a). But is it phenomenology? *Qualitative Health Research, 27*(6), 775–779. https://doi.org/10.1177/1049732317699570

van Manen, M. (2017b). Phenomenology in its original sense. *Qualitative Health Research, 27*(6), 810–825. https://doi.org/10.1177/1049732317699381

Vogel, J. P., Betrán, A. P., Vindevoghel, N., Souza, J. P., Torloni, M. R., Zhang, J., . . . Temmerman, M. (2015). Use of the Robson classification to assess caesarean section trends in 21 countries: a secondary analysis of two WHO multicountry surveys. *The Lancet Global Health, 3*, e260–e270. https://doi.org/10.1016/S2214-109X(15)70094-X

Wagner, M. (1994). *Pursuing the birth machine: The search for appropriate birth technology*. Camperdown, Australia: ACE Graphics.

Walsh, D. (1999). An ethnographic study of women's experience of partnership caseload midwifery practice: The professional as a friend. *Midwifery, 15*(3), 165–176. https://doi.org/10.1016/S0266-6138(99)90061-X

Washida, K. (2015). *'Kiku' kotono chikara: Rinshō tetsugaku shiron [The power of 'listening': An essay of clinical philosophy]*. Tokyo, Japan: Chikuma Shobō.

Watanabe, N. (2013). Daigaku deno josanshi kyōiku [Midwifery education in universities]. *Kango Kyōiku, 54*(11), 986–992. https://doi.org/10.11477/mf.1663102549

Watsuji, T. (1934/2007). *Ningen no gaku toshite no rinrigaku [Ethics as the study of man]*. Tokyo, Japan: Iwanami Shoten.

Weiner, S. J., Schwartz, A., Sharma, G., Binns-Calvey, A., Ashley, N., Kelly, B., . . . Harris, I. (2013). Patient-centered decision making and health care outcomes: An observational study. *Annals of Internal Medicine, 158*(8), 573–579. https://doi.org/10.7326/0003-4819-158-8-201304160-00001

Wilkins, R. (2010). Poor relations: The paucity of the professional paradigm. In M. Kirkham (Ed.), *The midwife–mother relationship* (2nd ed., pp. 66–90). Basingstoke, England: Palgrave Macmillan.

Wolf, N. (2003). *Misconceptions: Truth, lies, and the unexpected on the journey to motherhood*. New York, NY: Anchor Books.

World Bank Group. (2019). *GDP (current US$)*. Retrieved from https://data.worldbank.org/indicator/NY.GDP.MKTP.CD?most_recent_value_desc=true

World Economic Forum. (2019). *Global Gender Gap Report 2020*. Geneva, Switzerland: Author. Retrieved from https://www.weforum.org/reports/gender-gap-2020-report-100-years-pay-equality

World Health Organization. (2015). *WHO statement on caesarean section rates*. Geneva, Switzerland: Author. Retrieved from http://www.who.int/reproductivehealth/publications/maternal_perinatal_health/cs-

statement/en/

World Health Organization. (2016). *World health statistics 2016: Monitoring health for the SDGs, sustainable development goals*. Geneva, Switzerland: Author. Retrieved from http://www.who.int/gho/publications/world_health_statistics/2016/en/

World Health Organization. (2018a). *WHO recommendations: Intrapartum care for a positive childbirth experience*. Geneva, Switzerland: Author. Retrieved from https://apps.who.int/iris/bitstream/handle/10665/260178/9789241550215-eng.pdf;jsessionid=E25CCC7C105606319925BD0733E51B49?sequence=1

World Health Organization. (2018b). *World health statistics 2018: Monitoring health for the SDGs, sustainable development goals*. Geneva, Switzerland: Author. Retrieved from http://apps.who.int/iris/bitstream/handle/10665/272596/9789241565585-eng.pdf?ua=1

World Health Organization. (2019). *Trends in maternal mortality 2000 to 2017: Estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division*. Geneva, Switzerland: Author. Retrieved from https://data.unicef.org/resources/trends-maternal-mortality-2000-2017/

Yamamoto, U., Adachi, K., Kasai, K., & Okamoto, T. (2018). Josanshi ga ‘chiiki’ de torikumu sanzen sango kea ni mukete: Nihon josanshikai no kangaekata to katsudō [Antenatal and postnatal care provided by midwives in ‘the community’: The way of thinking and activities of Japanese Midwives Association]. *Josan Zasshi, 72*(6), 410–417. https://doi.org/10.11477/mf.1665201020

Yamashita, C. (2011). The study of the concept about the professional autonomy in the case of Japariese physician. *Informatics, 4*(2), 5–16. Retrieved from https://m-repo.lib.meiji.ac.jp/dspace/handle/10291/6317

Yoshida, K., Marksa, M. N., Kibeb, N., Kumara, R., Nakanoc, H., & Tashiro, N. (1997). Postnatal depression in Japanese women who have given birth in England. *Journal of Affective Disorders, 43*, 69–77. https://doi.org/10.1016/s0165-0327(96)01419-x

Yoshimura, M. (2009). Literature review of attitude of listening in nursing practice. *Narakenritsu Ikadaigaku Igakubu Kangogakka Kiyō, 5*, 37–44. Retrieved from http://ginmu.naramed-u.ac.jp/dspace/handle/10564/1405

Appendices

Appendix A: Ethics approval

AUTEC Secretariat

Auckland University of Technology
D-88, WU406 Level 4 WU Building City Campus
T: +64 9 921 9999 ext. 8316
E: ethics@aut.ac.nz
www.aut.ac.nz/researchethics

17 November 2016

Andrea Gilkison
Faculty of Health and Environmental Sciences

Dear Andrea

Ethics Application: 16/429 **The relationship between woman and midwife in Japan: A hermeneutic phenomenological study.**

Thank you for submitting your application for ethical review to the Auckland University of Technology Ethics Committee (AUTEC). I am pleased to confirm that your ethics application has been approved for three years until 15 November 2019.

As part of the ethics approval process, you are required to submit the following to AUTEC:

- A brief annual progress report using form EA2, which is available online through http://www.aut.ac.nz/researchethics. When necessary this form may also be used to request an extension of the approval at least one month prior to its expiry on 15 November 2019;
- A brief report on the status of the project using form EA3, which is available online through http://www.aut.ac.nz/researchethics. This report is to be submitted either when the approval expires on 15 November 2019 or on completion of the project;

It is a condition of approval that AUTEC is notified of any adverse events or if the research does not commence. AUTEC approval needs to be sought for any alteration to the research, including any alteration of or addition to any documents that are provided to participants. You are responsible for ensuring that research undertaken under this approval occurs within the parameters outlined in the approved application.

AUTEC grants ethical approval only. If you require management approval from an institution or organisation for your research, then you will need to obtain this. If your research is undertaken within a jurisdiction outside New Zealand, you will need to make the arrangements necessary to meet the legal and ethical requirements that apply there.

To enable us to provide you with efficient service, we ask that you use the application number and study title in all correspondence with us. If you have any enquiries about this application, or anything else, please do contact us at ethics@aut.ac.nz.

All the very best with your research,

Kate O'Connor
Executive Secretary
Auckland University of Technology Ethics Committee

Cc: keiko.doering@aut.ac.nz; mwkeiko@yahoo.co.jp; jmcaraco@aut.ac.nz

Appendix B: Email advertisement

(Japanese)

*** 様

こんにちは、ドーリング景子です。いかがお過ごしでしょうか。

現在、私はニュージーランドのオークランド工科大学の博士課程学生として、日本の女性と助産師の関係についての研究を行っています。この研究は、女性との関係性を重視した助産ケアの強化と、それによって女性の出産体験をより良いものにすることを目的としています。この研究のために、約１時間の個別インタビューに協力してくださるお母さん方と助産師さんを探しています。生後６週から５歳までのお子さんを持つお母さんと、助産院や自宅出産、診療所、病院で活動する助産師が対象です。お母さん方の出産場所や分娩様式（帝王切開・経膣分娩等）は問いません。助産師の経験年数も問いません。また、お母さんと助産師さんの募集は別々（つながりは不要）であり、ケアを提供した助産師と受けたお母さんの同時募集ではありません。

このメールに、お母さん方と助産師さん方への協力依頼書をそれぞれ添付しております。研究参加に興味をもっていただけそうなお母さん方や助産師さんがいらっしゃいましたら、ぜひ、協力依頼書とともに、この研究をご紹介いただけないでしょうか。

この研究参加に関する問い合わせ、また協力してくださる方は、以下の連絡先へご連絡をいただければ幸いです。ご協力のほど、どうぞよろしくお願いいたします。

ドーリング景子
ニュージーランド・オークランド工科大学　健康・環境科学学部　博士課程学生
Email: Keiko.doering@aut.ac.nz または mwkeiko@yahoo.co.jp
Tel: 080-8145-9784

(English translation)

Dear ***,

This is Keiko Doering. How are you?
I am currently a PhD student of Auckland University of Technology, New Zealand, and conducting a study regarding the relationship between woman and midwife in Japan. The study aims to enhance the relationally based midwifery care and to improve women's birth experience in Japan. For the research, I am looking for mothers and midwives who are interested in participating in a one-hour individual interview. I am recruiting mothers with children between 6 weeks old and 5 years old regardless of the place of birth and the mode of birth. Midwives who work for hospitals, clinics, midwifery homes, or homebirth regardless of the length of their practice are also recruited for the interviews. I need 10-12 mothers and 10-12 midwives. I am recruiting mothers and midwives separately, so they do not need to have connections.

I have attached the information sheets for mothers and midwives to this email. So, please share this study and information sheets to mothers and midwives.

Please tell my contact details to mothers and midwives who may be interested in participating in the interviews, and contact me if there is any questions or concerns.

Thank you very much in advance for your help and generosity.

Keiko Doering
PhD candidate, Faculty of Health and Environmental Science, Auckland University of Technology, New Zealand
Email: keiko.doering@aut.ac.nz or mwkeiko@yahoo.co.jp
Phone: 080-8145-9784

Appendix C: Participant information sheet for women

(Japanese)

お母さん方へ

「女性と助産師の関係」に関する研究へのご協力のお願い

依頼書の作成日

2016 年 11 月 1 日

研究テーマ

日本における女性と助産師の関係

研究への協力のお願い

ニュージーランド・オークランド工科大学（Auckland University of Technology）学生のドーリング景子と申します。現在、日本における女性と助産師の関係についての研究を行っており、日本で助産師のケアを受けたお母さん方へ、研究参加のご協力をお願いしています。この研究について、またご協力いただく内容について記載していますので、ぜひ、この依頼書をお読みいただき、研究へのご協力をいただければ幸いです。研究への参加は、ご本人の自由な意思によって行われます。協力の途中でも、情報の分析開始以前（2017 年 9 月末まで）であれば、いつでも参加を中止していただくことが可能です。この研究は、研究者（ドーリング景子）の博士号取得課程の研究でもあります。

研究の目的

この研究では、日本での女性の出産体験をよりよくするために、助産師と女性の関係について、女性と助産師、両方の体験を調査します。女性と助産師の関係が女性の出産体験に影響を与えることは、すでに明らかになっていますが、日本では、女性や助産師の関係に焦点を当てた研究はほとんどありません。この研究は、日本の母親と助産師の関係を明らかにすることで、助産ケアの向上や女性のよりよい出産体験に貢献することが期待されています。この研究の結果は、国内外の学術雑誌や本、または学会などで発表される予定です。

協力依頼の対象者

これまでの妊娠・出産・産後で、助産師からケアを受けた女性に協力のお願いをさせていただいております。いつ、どこで、どのようにお産をしたかは参加条件に含まれませんが、たくさんの方からご協力いただける場合、産後 6 週以降で 5 年以内に出産された方を優先させていただきます。この研究では、10〜12 名のお母さん方の協力を必要としています。

研究協力への同意

研究にご協力頂ける場合は、同意書を送らせていただきます。同意書の内容をご確認いただき、ご協力頂ける場合は、インタビュー当日までに同意書に署名し、研究者へお渡しください。

研究への参加は、ご本人の自由な選択によって行われ、参加の有無によって損益が生じることはありません。また、いつでも参加を辞退することができます。もし、参加を中止する場合、ご本人の情報をすべて削除するか、そのまま使わせていただくかを選択していただきます。ただし、データ分析後は、個人のデータを取り除くことは難しくなることをご了承ください。

協力内容

研究参加に同意していただいた場合、約 1 時間の個別インタビューを行います。インタビュー場所は、参加者ご本人の希望に沿い、ご自宅、カフェなどで行わせていただきます。インタビューでは、妊娠・出産・産後、またその後の助産師さんとの関わりに関する体験をお話しいただきます。インタビューは録音させていただき、後で文章に書き起こします。また、研究者がメモをとることがあります。その音源や文章は、研究指導教官、書き起こし作業者、研究者の間のみの機密資料となります。また、録音、文章、論文等では、本人が確定されないよう、匿名（偽名や仮名）を使用します。インタビューの内容と分析を後日お送りし、内容を確認していただきます。

参加協力のリスク

研究参加に際して、リスクが伴うことは予想されません。しかしながら、出産での体験をお話しいただくことにより、精神・感情的に脆弱な状態を感じることがあるかもしれません。

リスク軽減への対処

インタビューでどのような情報を提供していただくかは、参加される方の自由な選択で行われ、すべての質問に答える必要はありません。必要な時はいつでも休憩を取ることができ、インタビューを中止することもできます。インタビューの情報から特定の方に影響が及ぶこともありません。研究参加によりカウンセリングが必要になった場合は、地域の保健所を通し、カウンセリング・サービスを紹介させていただけるよう手配いたします。

研究参加による利点

研究への参加によって、助産師のケアの改善やこれから出産する女性のよりよい体験を手助けすることができます。また、女性とケア提供者の関係性を重視した出産ケアの発展、女性と助産師の関係やその重要性に対する理解を広め、深めることへの貢献にもなります。この研究により、研究者の博士学位授与も見込まれます。

プライバシーの保護

個人情報の保護をお約束いたします。録音データや書き起こした文章は、研究指導教官、書き起こし作業者、研究者の間のみの機密資料となります。書き起こし作業者は、作業前に機密保持の同意書にサインをします。機密保持のため、あなたの個人情報がそれ以外の人に公開されることはありません。データや報告書ではすべて仮名や偽名が使われます。すべての情報は６年間、安全に保管された後、研究者の責任で、消去・破棄されます。

研究参加者の負担

研究に参加していただく場合、約１時間のインタビュー時間をいただきます。また、インタビュー参加のための交通にかかる時間と費用をご負担していただくことになります。

協力への検討・同意のタイミング

研究にご参加いただける場合、インタビューを行う時点で参加への最終的な確認をさせていただきます。

研究結果の報告

研究のすべてが終了した後、日本語で研究結果の概要を送らせていただきます。研究結果は学術雑誌などの出版物、または学会などで発表されるかもしれません。この研究は研究者の博士論文（英語）となり、大学の図書館やオンラインで閲覧が可能です。

研究に関する問題等への対処

この研究に際し、問題や懸念が生じた場合は、研究指導教官、Andrea Gilkison (*andrea.gilkison@aut.ac.nz*, +64 9 921 9999 内線 7720)、または、日隈ふみ子（hinokuma@bukkyo-u.ac.jp 075-491-2141 内線 8254）へご連絡ください。

研究実施内容に関する問題は、オークランド工科大学倫理審査委員会事務局長、Kate O'Connor (*ethics@aut.ac.nz* , 921 9999 内線 6038) へご連絡ください。

研究に関する問い合わせ先

この研究依頼書と同意書は、今後の確認のため保管をお願いいたします。研究に関するお問い合わせは、下記の研究メンバーへお問い合わせください。

研究者連絡先*:*

ドーリング景子　オークランド工科大学　健康環境科学学部・臨床科学学科（助産）　博士課程学生
Phone: 080-8245-9784
Email: keiko.doering@aut.ac.nz/mwkeiko@yahoo.co.jp

研究指導者連絡先*:*

Dr. Andrea Gilkison, Associate Head Postgraduate School of Clinical Sciences, Auckland University of Technology
Phone: +64 9 921 9999 ext. 7720
Email: andrea.gilkison@aut.ac.nz

2016 年 11 月 17 日オークランド工科大学倫理委員会承認

照会番号：16/429

(English translation)

To mothers

Participant Information Sheet

Date Information Sheet Produced:

01 November 2016

Project Title

The study of relationship between woman and midwife in Japan

An Invitation

I am Keiko Doering, and a student of Auckland University of Technology in New Zealand. I am inviting you to take part in research exploring women's experience of midwives in Japan. I am recruiting mothers who had midwifery care in Japan. Please take time to read this information sheet. This sheet will tell you what the study is about and explains what your participation would involve. Your participation is voluntary. You may withdraw from the study up until the time when data collection is complete (30th September 2017). This research will contribute toward my studies for a Doctor of Health Science degree.

What is the purpose of this research?

The study aims to improve women's birth experiences in Japan by exploring both women and midwives' experience. Woman-midwife relationships affect women's birth experiences, but there is little research focusing on the relationships in Japan. The study may contribute to enhance mother-midwife relationship which improves the quality of midwifery care and women's birth experiences. The research results will be published as journal articles or books, and presented at conferences domestically and internationally to inform to the public.

How was I identified and why am I being invited to participate in this research?

You have been asked to take part in this research if you had maternity care from midwives while you were pregnant and/or giving birth. When, where and how you gave birth do not affect your involvement of participation. However, mothers who had children between six weeks old and five years may be given priority. This study requires 10-12 mothers who can take part in the interviews.

How do I agree to participate in this research?

If you are happy to participate in this research, the researcher will send you Consent Form. You will read and sign on the form prior to your participation.

Your participation in this research is voluntary (it is your choice) and whether or not you choose to participate will neither advantage nor disadvantage you. You are able to withdraw from the study at any time. If you choose to withdraw from the study, then you will be offered the choice between having any data that is identifiable as belonging to you removed or allowing it to continue to be used. However, once the findings have been produced, removal of your data may not be possible.

What will happen in this research?

Taking part in this research will involve an hour individual interview lasting one hour. The place of the interview will depend on your request (e.g. your home, café). In the interview, you will be asked to talk about your experience of your midwife during your pregnancy, childbirth, postnatal and after the event. The interview will be audio taped and later transcribed, and the researcher may also take notes during the interview. The recorded data and transcript remain confidential to my supervisors, a transcriber, and myself. A pseudonym or false name will be used on all the tapes, transcripts and reports to protect your identity. I will return the transcription and the analysis to you to confirm the contents and the interpretation with you.

What are the discomforts and risks?

I do not anticipate any risks to you from this study. However, sometimes such interviews in which you share your experiences and emotions can make a person feel vulnerable.

How will these discomforts and risks be alleviated?

You will be in control of how much information you share. You do not have to answer all the questions. You can take a short break during the interview or stop the interview at any time. No information will be reported in the interview that could identify any person. Counselling services will be introduced through your local public health centre if you need them as a result of the study.

What are the benefits?

The benefits of taking part in this research are that you will be part of new research that has potential to Improve midwives' care and to benefit women who will have babies in the future. Your contribution will also develop relational based maternity care and understanding of woman-midwife relationships and the significance. The study may also assist me in obtaining a qualification.

How will my privacy be protected?

Confidentiality will be assured. The recorded data and transcripts remain confidential to my research supervisors, transcribers and myself. Transcribers involved in the study will be required to sign a confidentiality form. To ensure confidentiality, your identity will not be disclosed to anyone. A pseudonym or false name will be used on all the tapes, transcripts and reports to protect your identity. All information relating to you will be stored securely for six years. The researcher will be responsible for destroying the data after the period.

What are the costs of participating in this research?

The costs to you will include your time involved in attending the interview and your transport costs to the venue for the interview.

What opportunity do I have to consider this invitation?

If you would like to take part in the study, a commitment from you will be required at the time of the interview.

Will I receive feedback on the results of this research?

A summary of the research result written in Japanese will be offered once the research is completed. Research findings may also be appeared in publications and at conferences. The research will be published as a PhD thesis in English, which will be available in the university library and online.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Andrea Gilkison (*andrea.gilkison@aut.ac.nz*, +64 9 921 9999 ext.7720) or Fumiko Hinokuma (hinokuma@bukkyo-u.ac.jp 075-491-2141 ext.8254)

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEC, Kate O'Connor, *ethics@aut.ac.nz*, 921 9999 ext.6038.

Whom do I contact for further information about this research?

Please keep this Information Sheet and a copy of the Consent Form for your future reference. You are also able to contact the research team as follows:

Researcher Contact Details:

Keiko Doering
PhD candidate, Midwifery, School of Clinical Sciences,
Faculty of Health and Environmental Sciences, Auckland University of Technology
Phone: 080-8145-9784
Email: keiko.doering@aut.ac.nz/mwkeiko@yahoo.co.jp

Project Supervisor Contact Details:

Dr. Andrea Gilkison
Associate Head Postgraduate School of Clinical Sciences, Auckland University of Technology
Phone: +64 9 921 9999 ext.7720
Email: *andrea.gilkison@aut.ac.nz*

Approved by the Auckland University of Technology Ethics Committee on 17th November 2016,

AUTEC Reference number 16/429.

Appendix D: Participant information sheet for midwives

(Japanese)

助産師の皆様へ

「女性と助産師の関係」に関する研究へのご協力のお願い

依頼書の作成日

2016 年 11 月 1 日

研究テーマ

日本における女性と助産師の関係

研究への協力のお願い

ニュージーランド・オークランド工科大学（Auckland University of Technology）学生のドーリング景子と申します。現在、日本における女性と助産師の関係についての研究を行っており、日本の助産師の皆様へ、研究参加のご協力をお願いしています。この研究について、またご協力いただく内容について記載していますので、ぜひ、この依頼書をお読みいただき、研究へのご協力をいただければ幸いです。研究への参加は、ご本人の自由な意思によって行われます。協力の途中でも、情報の分析開始以前（2017 年 9 月末まで）であれば、いつでも参加を中止していただくことが可能です。この研究は、研究者（ドーリング景子）の博士号取得課程の研究でもあります。

研究の目的

この研究では、日本での女性の出産体験をよりよくするために、助産師と女性の関係について、女性と助産師、両方の体験を調査します。女性と助産師の関係が女性の出産体験に影響を与えることは、すでに明らかになっていますが、日本では、女性や助産師の関係に焦点を当てた研究はほとんどありません。この研究は、日本の母親と助産師の関係を明らかにすることで、助産ケアの向上や女性のよりよい出産体験に貢献することが期待されています。この研究の結果は、国内外の学術雑誌や本、または学会などで発表される予定です。

協力依頼の対象者

助産業務を行っている助産師に研究参加のお願いをさせていただいております。勤務形態や年数は問いません。この研究では、10〜12 名の助産師の協力を必要としています。

研究協力への同意

研究にご協力頂ける場合は、同意書を送らせていただきます。同意書の内容をご確認いただき、ご協力頂ける場合は、インタビュー当日までに同意書に署名し、研究者へお渡しください。

研究への参加は、ご本人の自由な選択によって行われ、参加の有無によって損益が生じることはありません。また、いつでも参加を辞退することができます。もし、参加を中止する場合、ご本人の情報をすべて削除するか、そのまま使わせていただくかを選択していただきます。ただし、データの分析結果が得られた後は、ご本人のデータを取り除くことは難しくなることをご了承ください。

協力内容

研究参加に同意していただいた場合、約 1 時間の個別インタビューを行います。インタビュー場所は、参加者ご本人の希望に沿い、ご自宅、カフェなどで行わせていただきます。インタビューでは、これまでの助産ケアの中での妊婦さんやお母さん方との関わりに関する体験をお話しいただきます。インタビューは録音させていただき、後で文章に書き起こします。また、研究者がメモをとることがあります。その音源や文章は、研究指導教官、書き起こし作業者、研究者の間のみの機密資料となります。また、録音、文章、論文等では、本人が確定されないよう、匿名（偽名や仮名）を使用します。インタビューの内容と分析を後日お送りし、内容を確認していただきます。

参加協力のリスク

研究参加に際して、リスクが伴うことは予想されません。しかしながら、ご自身の体験をお話しいただくことにより、精神・感情的に脆弱な状態を感じることがあるかもしれません。

リスク軽減への対処

インタビューでどのような情報を提供していただくかは、参加される方の自由な選択で行われ、すべての質問に答える必要はありません。必要な時はいつでも休憩を取ることができ、インタビューを中止することもできます。インタビューの情報から特定の方に影響が及ぶこともありません。研究参加によりカウンセリングが必要になった場合は、地域の保健所を通し、カウンセリング・サービスを紹介させていただけるよう手配いたします。

研究参加による利点

研究への参加によって、助産師のケアの改善やこれから出産する女性のよりよい体験を手助けすることができます。また、女性とケア提供者の関係性を重視した出産ケアの発展、女性と助産師の関係やその重要性に対する理解を広め、深めることへの貢献にもなります。この研究により、研究者の博士学位授与も見込まれます。

プライバシーの保護

個人情報の保護をお約束いたします。録音データや書き起こした文章は、研究指導教官、書き起こし作業者、研究者の間のみの機密資料となります。書き起こし作業者は、作業前に機密保持の同意書にサインをします。機密保持のため、あなたの個人情報がそれ以外の人に公開されることはありません。データや報告書ではすべて仮名や偽名が使われます。すべての情報は６年間、安全に保管された後、研究者の責任で、消去・破棄されます。

研究参加者の負担

研究に参加していただく場合、約１時間のインタビュー時間をいただきます。また、インタビュー参加のための交通にかかる時間と費用をご負担していただくことになります。

協力への検討・同意のタイミング

研究にご参加いただける場合、インタビューを行う時点で参加への最終的な確認をさせていただきます。

研究結果の報告

研究のすべてが終了した後、日本語で研究結果の概要を送らせていただきます。研究結果は学術雑誌などの出版物、または学会などで発表されるかもしれません。この研究は研究者の博士論文（英語）となり、大学の図書館やオンラインで閲覧が可能です。

研究に関する問題等への対処

この研究に際し、問題や懸念が生じた場合は、研究指導教官、Andrea Gilkison (*andrea.gilkison@aut.ac.nz*, +64 9 921 9999 内線 7720)、または、日隈ふみ子（hinokuma@bukkyo-u.ac.jp 075-491-2141 内線 8254）へご連絡ください。

研究実施内容に関する問題は、オークランド工科大学倫理審査委員会事務局長、Kate O'Connor (*ethics@aut.ac.nz* , 921 9999 内線 6038) へご連絡ください。

研究に関する問い合わせ先

この研究依頼書と同意書は、今後の確認のため保管をお願いいたします。研究に関するお問い合わせは、下記の研究メンバーへお問い合わせください。

研究者連絡先*:*

ドーリング景子　オークランド工科大学　健康環境科学学部・臨床科学学科（助産）　博士課程学生
Phone: 080-8245-9784
Email: keiko.doering@aut.ac.nz/mwkeiko@yahoo.co.jp

研究指導者連絡先*:*

Dr. Andrea Gilkison, Associate Head Postgraduate School of Clinical Sciences, Auckland University of Technology
Phone: +64 9 921 9999 ext. 7720
Email: andrea.gilkison@aut.ac.nz

2016 年 11 月 17 日オークランド工科大学倫理委員会承認

照会番号：16/429

(English translation)

To Midwives

Participant Information Sheet

Date Information Sheet Produced:

01 November 2016

Project Title

The study of relationship between woman and midwife in Japan

An Invitation

I am Keiko Doering, and a student of Auckland University of Technology in New Zealand. I am recruiting Japanese midwives, and inviting you to take part in research exploring women's experience of midwives in Japan. Please take time to read this information sheet. This sheet will tell you what the study is about and explains what your participation would involve. Your participation is voluntary. You may withdraw from the study up until the time when data collection is complete (30th September 2017). This research will contribute toward my studies for a Doctor of Health Science degree.

What is the purpose of this research?

The study aims to improve women's birth experiences in Japan by exploring both women and midwives' experience. Woman-midwife relationships affect women's birth experiences, but there is little research focusing on the relationships in Japan. The study may contribute to enhance mother-midwife relationship which improves the quality of midwifery care and women's birth experiences. The research results will be published as journal articles or books, and presented at conferences domestically and internationally to inform to the public.

How was I identified and why am I being invited to participate in this research?

You have been asked to take part in this research if you have practiced as a qualified midwife. Where you work and how long you have practiced do not affect your involvement of participation. This study requires 10-12 midwives who can take part in the interviews.

How do I agree to participate in this research?

If you are happy to participate in this research, the researcher will send you Consent Form. You will read and sign on the form prior to your participation.

Your participation in this research is voluntary (it is your choice) and whether or not you choose to participate will neither advantage nor disadvantage you. You are able to withdraw from the study at any time. If you choose to withdraw from the study, then you will be offered the choice between having any data that is identifiable as belonging to you removed or allowing it to continue to be used. However, once the findings have been produced, removal of your data may not be possible.

What will happen in this research?

Taking part in this research will involve an individual interview lasting one hour. The place of the interview will depend on your request (e.g. your home, café). In the interview, you will be asked to talk about your experience of your midwife during your pregnancy, childbirth, postnatal and after the event. The interview will be audio taped and later transcribed, and the researcher may also take notes during the interview. The recorded data and transcript remain confidential to my supervisors, a transcriber, and myself. A pseudonym or false name will be used on all the tapes, transcripts and reports to protect your identity. I will return the transcription and the analysis to you to confirm the contents and the interpretations with you.

What are the discomforts and risks?

I do not anticipate any risks to you from this study. However, sometimes such interviews in which you share your experiences and emotions can make a person feel vulnerable.

How will these discomforts and risks be alleviated?

You will be in control of how much information you share. You do not have to answer all the questions. You can take a short break during the interview or stop the interview at any time. No information will be reported in the interview that could identify any person. Counselling services will be introduced through your local public health centre if you need them as a result of the study.

What are the benefits?

The benefits of taking part in this research are that you will be part of new research that has potential to Improve midwives' care and to benefit women who will have babies in the future. Your contribution will also develop relational based maternity care and understanding of woman-midwife relationships and the significance. The study may also assist me in obtaining a PhD qualification.

How will my privacy be protected?

Confidentiality will be assured. The recorded data and transcripts remain confidential to my research supervisors, transcribers and myself. Transcribers involved in the study will be required to sign a confidentiality form. To ensure confidentiality, your identity will not be disclosed to anyone. A pseudonym or false name will be used on all the tapes, transcripts and reports to protect your identity. All information relating to you will be stored securely for six years. The researcher will be responsible for destroying the data after the period.

What are the costs of participating in this research?

The costs to you will include your time involved in attending the interview and your transport costs to the venue for the interview.

What opportunity do I have to consider this invitation?

If you would like to take part in the study, a commitment from you will be required at the time of the interview.

Will I receive feedback on the results of this research?

A summary of the research result written in Japanese will be offered once the research is completed. Research findings may also be appeared in publications and at conferences. The research will be published as a PhD thesis in English, which will be available in the university library and online.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Andrea Gilkison (*andrea.gilkison@aut.ac.nz*, +64 9 921 9999 ext.7720) or Fumiko Hinokuma (hinokuma@bukkyo-u.ac.jp 075-491-2141 ext.8254)

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEC, Kate O'Connor, *ethics@aut.ac.nz*, 921 9999 ext.6038.

Whom do I contact for further information about this research?

Please keep this Information Sheet and a copy of the Consent Form for your future reference. You are also able to contact the research team as follows:

Researcher Contact Details:

Keiko Doering
PhD candidate, Midwifery, School of Clinical Sciences,
Faculty of Health and Environmental Sciences, Auckland University of Technology
Phone: 080-8145-9784
Email: keiko.doering@aut.ac.nz/mwkeiko@yahoo.co.jp

Project Supervisor Contact Details:

Dr. Andrea Gilkison
Associate Head Postgraduate School of Clinical Sciences, Auckland University of Technology
Phone: +64 9 921 9999 ext.7720
Email: *andrea.gilkison@aut.ac.nz*

Approved by the Auckland University of Technology Ethics Committee on 17th November 2016,

AUTEC Reference number 16/429.

Appendix E: Research safety protocol

Research Safety Protocol

The data collection of the study is face-to-face individual interviews and will be conducted at participants' homes or in a quiet part of a café depending on the participants' request.

The interviewer/researcher and all the participants are women and do not have any risky or power relationships between them. Participant's homes and cafés should be a safe venue for the interviews.

However, the interviewer will follow the procedure below for the safety when she conducts the interviews at participants' homes.

- The interviewer will confirm with each participant regarding who may be with the participant in her house during the interview.
- The participant can have anyone besides her during the interview if she wishes and as long as she is comfortable. However, the interviewer may recommend or ask the participant to keep one-to-one space between the participant and the interviewer for free conversations and the safety.
- The interviewer will let her family know the place where she has an interview before each interview.
- The interviewer will call or text her family before she visits the participant's house and after she leaves the participant's house.
- The interviewer will leave the place of the interview if she feels it is unsafe.
- The interviewer will leave the participants' homes once the interviews end.

Appendix F: Consent form

(Japanese)

同意書

研究題目: 日本における女性と助産師の関係

研究指導教官: **Andrea Gilkison**

研究者: ドーリング景子

- ○ 私は、2016 年 11 月 1 日作成の研究協力依頼書を読み、研究内容について理解しました。
- ○ 私は、質問をすることやその答えを得ることができます。
- ○ 私は、インタビュー中に研究者がメモをとることや、インタビューを録音し、書き起こすことを了承しています。
- ○ 私は、この研究への参加が自分の自由な選択によって行われ、不利益を被ることなくいつでも辞退できることを理解しています。
- ○ 私は、研究への参加を辞退する場合、自分の情報をすべて研究から取り除くか、情報が使用できるよう残すか選択することができます。ただし、分析開始後は、データを取り除くことができない可能性があることを了承しています。
- ○ 私は、この研究に参加することに同意します。
- ○ 私は、研究結果の概要を受け取ることを希望します（選択してください）。 はい□ いいえ□

参加者の署名: .....

参加者の名前: .....

参加者の連絡先 (必要時のみ):

.....

.....

.....

.....

日付:

2016 年 11 月 17 日、オークランド工科大学倫理委員会 (AUTEC) 承認済み

AUTEC 照会番号：16/429

注: 参加者はこの同意書のコピーを保管してください。

(English translation)

Consent Form

Project title: ***The relationship between woman and midwife in Japan***

Project Supervisor: ***Andrea Gilkison***

Researcher: ***Keiko Doering***

- ○ I have read and understood the information provided about this research project in the Information Sheet dated 01 November 2016.
- ○ I have had an opportunity to ask questions and to have them answered.
- ○ I understand that notes will be taken during the interviews and that they will also be audio-taped and transcribed.
- ○ I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time without being disadvantaged in any way.
- ○ I understand that if I withdraw from the study then I will be offered the choice between having any data that is identifiable as belonging to me removed or allowing it to continue to be used. However, once the findings have been produced, removal of my data may not be possible.
- ○ I agree to take part in this research.
- ○ I wish to receive a summary of the research findings (please tick one): Yes○ No○

Participant's signature: .....

Participant's name: .....

Participant's Contact Details (if appropriate):

.....

.....

.....

.....

Date:

Approved by the Auckland University of Technology Ethics Committee on 17th November 2016

AUTEC Reference number 16/429

Note: The Participant should retain a copy of this form.

Appendix G: Protocol and conversation guide for interviews

Protocol and Conversation Guide for Interviews

Individual face-to-face interviews will be conducted with 10-12 women and 10-12 midwives in Japanese. Interviews are semi-structured, and questions are more likely open-ended and no control over participants' responses. The interviewer will build rapport with participants to help them open-up and express themselves in their own way. The below is opening and closing questions and some expected questions may be asked. Each interview will last approximately an hour and will be audio-recorded.

Following greeting, introduction and answering questions:

<For women>

- ケアをした助産師との思い出や関わった体験を話していただけますか。
  Tell me about your experience of midwives who provided care for you?
- 他に助産師さんとの関わりでお話ししていただけることはありますか。
  Is there anything you can talk more about your experience of your midwife or relationship with your midwife?

<For midwives>

- 妊産婦さんやお母さんとの関係で一番思い出／記憶に残っていることは何ですか。
  What was your most memorable experience of relationship with a woman in your care?
- 女性との関係を築くのが難しかった経験はありますか。
  Have you experienced any difficulties to build a relationship with a woman?
- これまでの経験の中で女性との関係に変化を感じていますか。
  Have you seen differences of relationships with women over your career? (for experienced midwives)
- 他に女性との関わりについてお話ししていただけることはありますか。
  Is there anything you can talk more about your experience of women or relationship with women?

* Probing questions will also be used in order to draw their stories.

- そのことについて、もう少し詳しく教えてください。
  Tell me more about it.
- 例えば。具体的には。
  Give me an example.

Appendix H: Confidentiality agreement

(Japanese)

秘密保持に関する同意書

研究題目: *日本における女性と助産師の関係*

研究指導教官: *Andrea Gilkison*

研究者: *ドーリング景子*

- 私は、書き起こし依頼のあったデータすべてが秘密保持の対象であることを理解しています。
- 私は、データの中身について研究者とのみ話し合うことができることを理解しています。
- 私は、書き起こした資料を保持することも、第三者が、それにアクセスすることもありません。

作業者署名: .....

作業者指名: .....

作業者の連絡先 (必要時のみ):

.....

.....

.....

.....

日付:

研究指導教官の連絡先 (必要時のみ):

.....

.....

.....

.....

日付:

2016 年 11 月 17 日　オークランド工科大学倫理委員会 承認済み

AUTEC 照会番号：16/429

注：作業者はこの同意書のコピーを保管してください。

(English translation)

Confidentiality Agreement

Project title: *The relationship between woman and midwife*

Project Supervisor: *Andrea Gilkison*

Researcher: *Keiko Doering*

- ○ I understand that all the material I will be asked to type is confidential.
- ○ I understand that the contents of the notes or recordings can only be discussed with the researchers.
- ○ I will not keep any copies of the transcripts nor allow third parties access to them.

Typist's signature: .....

Typist's name: .....

Typist's Contact Details (if appropriate):

.....

.....

.....

.....

Date:

Project Supervisor's Contact Details (if appropriate):

.....

.....

.....

.....

Approved by the Auckland University of Technology Ethics Committee on 17th November 2016

AUTEC Reference number 16/429

Note: The Typist should retain a copy of this form.

Appendix I: An example of crafting the data

①Transcript

私、初めクリニックで産んで、っていうのは、3 月に S に私引っ越して、旦那さんはその 10 月に会社の都合で引っ越し、私、先生やってたので 3 月終わった時点で行ったんですけど。その行ったすぐに妊娠が判明して、で、まだ地名とかも分からないから、地図見ても私のいる位置からここは近いのかどうなのか分からないし、全く本当に知り合いがいない所に急に行ったので。でも、つわりものすごくひどくて。で、何となく見て近いだろうっていうとこ、クリニックに行って。そこは本当、個人病院で、まだ建ってそんな経ってない、すごくきれいで。受付の人が本当、貴族みたいななんか、貴族の、なんかこんな、ちょっと高いこう、襟のついたブラウスを着てるような。私が思ってた、私ずーっと、お母さんになるのが夢で、「どんだけうれしんだろう」っていうことで、そのワクワクはしてたんですけど、あまりにもギャップがあった。その、そこの雰囲気と、診察に至るまでの待ち時間と静寂と、実際に尿を取ってとか、判明して。で、また最新機械が入ってるとこだったので、本当に、対峙して、で、「じゃあ診ますね」って、こうビーンってこう、なんか電動でやって、足をばーって開けて、で、そこにカーテンがあるような、男の先生がいて。ただでさえ病院も好きじゃないし、その産婦人科行くのも初めてだし、知らない土地だし、初めてのことで、うれしいことよりもなんか「え！？」って思うことが、「あれ？こんなん？」っていう感じで。で、実際に「お母さんになりたい」ってすごく思ってたのに、お産について知らなすぎることに驚愕をするっていうか。で、何となくやっぱり、「ここで産みたくないな」っていう思いがあったんですけど、でも 6 カ月間も本当つわりが、すごくひどくて、血を吐くほどに。切れちゃって。で、つらいし、もう太陽の光がまず気持ち悪い。文字も気持ち悪いし、テレビも気持ち悪いし、もちろん食べるものも気持ち悪いんですけど。で、実家に帰ったんですよ。で、私、先生やってたので、教え子だった子が助と看護師さんになった子が多くて。で、ちょうど実習をして、何年か前に送り出した子たちが看護師の卵として助産院に見学する機会があって。で、H は私が住んでた地域は、その時はまだ分娩できる助産院が一軒もなくて、だからそういう発想もなかったんですけど、その子たちが、みんなで「私産むとしたら、助産院がいいと思う」って言って、その研修を終えたばかりだったと思うんですけど、それが 8 月で、それを聞いて「あ、その選択もあったか」って、それもすごく偶然なんですけど。で、「そんな選択もあったんだ、じゃあ」と思って、母子手帳、当時のに、S は、「私たちはここにいます」みたいなのが、一覧は載ってるのがあって。ただ、見てもやっぱり分からなくて、近そうだろうって K さんを選んでというか、電話して。もうそのときに、「じゃあ一回おいでよ」みたいな感じでいって、実際に、うちから 10 分ぐらいのとこだったんですけど。で、もう入った途端に、何だろう、K さん見た瞬間、ちょっと話した瞬間、もうなんか、本当に体と心に効くというか、つわりが本当に和らぐみたいな感じで、もう「ここで産みたい」と。で、誕生の記録、あれを見たときに、「やっぱりお産って楽しみだよな、楽しみなことだし、すごくワクワクするよな」と思って。で、K さんからいろんな話を聞いて、ま、見学するところもすごく少ないじゃないですか。で、「ここ？あ、ここで産むのか」って、ずいぶん違うけど、本当に自然と、ずっとやっぱり病院に対しては、聞きたいことも聞けなかったし、なんかすごい恥ずかしい思いもあったし、何だろう、あと決定的だったのが、母親教室に行ったときに、業者が来て、いろんな、フォローアップミルク？そんな聞いたこともないようなものを、これありきで配られて、で、ビタミン剤とか配られたのは、「あれ？そういうもの？」っていうか、「私が知らなすぎなだけ？」っていう。でも、全然疑いもなくおっぱいをあげるつもりだったし、それをなんか、「あれ？ちょっと違うぞ」ってすごく思ったのもあって。で、そう、それで、そのタイミングもいろいろあって、もうついにここで、「絶対にここで産むんだ」っていうのがあって。で、その次に病院に行ったときに、「変えようと思う」と。で、もし、病院に行く健診があるっていうのは知ってたので、「どうしたらいいですか？」って言ったら、「もうここで産まないなら来なくて、一切」みたいな、すごくなんか冷たく、「もう来なくていいです」みたいなことを言われて、「あ、やっぱり良かったんだ」と思って。それから本当に、すごくワクワクしながら毎月のように通ったっていう感じですね。もう、すごく。楽しかったですね。つわりも、なんか、すごいつわりがひどくて実家に帰ってたのも、「大げさなんだから」みたいな。「でも、そういう人もいるよね」みたいな。でも、何でも聞いてくれるし、赤ちゃんがどうこうっていうよりも、「あなたが心配なのよ」みたいな感じでいつも接してくれたから、無駄話っていうか。で、私、本当に一人だったので、旦那さん本当、仕事始めたばっかりで忙しくって、つわりのこととかも分かってもらえないので、それをとがめられたりすることはないんですけど、分かってもらえる人がいないし、そうそう実家にも帰れないし、唯一知ってるのが K さんぐらいな感じだったので、本当にお母さんみたいな感じで、ずっと頼りにしていたって。今も、旦那さんも、「なんでみんな助産院で産まないのかね」っていうぐらい、K さんのことをすごい信頼してるし、大好きだしっていう感じですね。で、やっぱり本を読むと、お母さんたちが、こう、ツラツラ書いてて、すごく長くかかった人もいるし、やっぱりすごく安産だったとかっていう人もいるし、私の前後で産んだ人が、ちょうど水中出産だったんですけど、「そういう選択肢もあるんだよ」みたいな。いろんな細かいことを聞かなくても、なんか大丈夫っていうか、そういう安心感はいつも与えてくれたなって。本にね、その K さんに対する言葉とかが、やっぱり書いてあって。「そうだよな」みたいな、すごくありましたね。

②crafted text

初めクリニックに行って。私ずーっと、お母さんになるのが夢で、「どんだけうれしんだろう」って~~いうことで~~、そのワクワクはしてたんですけど、あまりにもギャップがあった。~~その、~~そこの雰囲気と、診察に至るまでの待ち時間と静寂と、実際に尿を取ってとか、判明して。~~で、また~~最新機械が入ってるとこだったので、~~本当に、~~対峙して~~、で、~~「じゃあ診ますね」って、~~こうビーンってこう、~~なんか電動でやって、足をばーって開けて、~~で、~~そこにカーテンがあるような、男の先生がいて。~~ただでさえ病院も好きじゃないし、その産婦人科行くのも初めてだし、知らない土地だし、~~初めてのことで、うれしいことよりもなんか「え！？」って思うことが、「あれ？こんなん？」っていう感じで。~~で、~~実際に「お母さんになりたい」ってすごく思ってたのに、お産について知らなすぎることに驚愕をするっていうか。何となくやっぱり、「ここで産みたくないな」っていう思いがあったんですけど、6カ月間も本当つわりが、すごくひどくて、血を吐くほどに。（助産院に）電話して。~~そのときに、「じゃあ一回おいでよ」みたいな感じで~~いって、もう入った途端に、Kさん見た瞬間、ちょっと話した瞬間、本当に体と心に効くというか、つわりが本当に和らぐみたいな感じで、もう「ここで産みたい」と。で、誕生の記録~~、あれ~~を見たときに、「やっぱりお産って楽しみだよな、楽しみなことだし、すごくワクワクするよな」と思って。Kさんからいろんな話を聞いて~~、で、「ここ？あ、ここで産むのか」って、本当に自然と、~~ずっと病院に対しては、聞きたいことも聞けなかったし、なんかすごい恥ずかしい思いもあったし、あと決定的だったのが、母親教室に行ったときに、業者が来て、ビタミン剤とか配られたのは、「あれ？そういうもの？」、「私が知らなすぎなだけ？」っていう。~~全然疑いもなくおっぱいをあげるつもりだったし、「あれ？ちょっと違うぞ」ってすごく思ったのもあって。~~そのタイミングもいろいろあって、もうついにここで、「絶対にここで産むんだ」っていうのがあって。その次に病院に行ったときに、「変えようと思う」と。病院に行く健診があるっていうのは知ってたので、「どうしたらいいですか？」って言ったら、「もうここで産まないなら来なくて、一切」みたいな、すごく~~なんか~~冷たく、「もう来なくていいです」みたいなことを言われて、「あ、やっぱり良かったんだ」と思って。それから本当に、すごくワクワクしながら毎月のように通ったっていう感じですね。もう、すごく。楽しかったですね。すごいつわりがひどくて実家に帰ってたのも、「大げさなんだから」みたいな。「でも、そういう人もいるよね」みたいな。何でも聞いてくれるし、赤ちゃんがどうこうっていうよりも、「あなたが心配なのよ」みたいな感じでいつも接してくれたから、無駄話っていうか。私、本当に一人だったので、分かってもらえる人がいないし、そうそう実家にも帰れないし、唯一知ってるのがKさんぐらい~~な感じ~~だったので、本当にお母さんみたいな感じで、ずっと頼りにしてい~~たっ~~て。~~今も、~~旦那さんも、「なんでみんな助産院で産まないのかね」っていうぐらい、Kさんのことをすごい信頼してるし、大好きだしっていう感じですね。いろんな細かいことを聞かなくても、なんか大丈夫っていうか、そういう安心感はいつも与えてくれたなって。

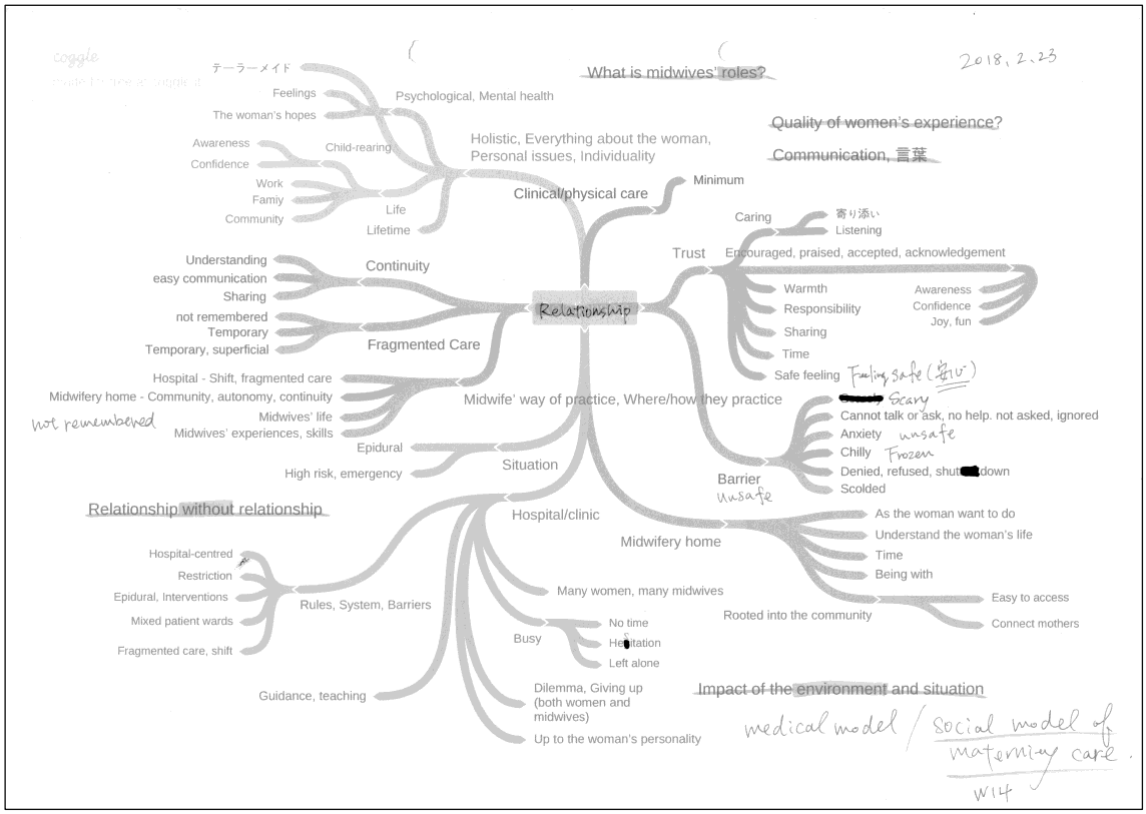
③further crafted and edited text

初めクリニックに行って。私ずーっとお母さんになるのが夢で「どんだけうれしんだろう」って、ワクワクしてたんですけど、あまりにもギャップがあった。そこの雰囲気と、診察に至るまでの待ち時間と静寂と、実際に尿を取って判定して。最新機械が入っているところだったので、対峙して「じゃあ診ますね」って電動で足をばーって開けて、そこにカーテンがあって男の先生がいて。初めてのことで、うれしいことよりも「え！？あれ？こんなん？」っていう感じで。実際に「お母さんになりたい」ってすごく思ってたのに、お産について知らなすぎることに驚愕するっていうか。何となく「ここで産みたくないな」っていう思いがあったんですけど、6カ月間も（通って）、つわりが、すごくひどくて。（助産院に）入った途端に、K さん見た瞬間、ちょっと話した瞬間、本当に体と心に効くというか、つわりが本当に和らぐみたいな感じで、もう「ここで産みたい」と。（助産院にある）誕生の記録を見たときに、「やっぱりお産って楽しみだよな、楽しみなことだし、すごくワクワクするよな」と思って。Kさんからいろんな話を聞いて。ずっと病院に対しては、聞きたいことも聞けなかったし、なんかすごい恥ずかしい思いもあったし。タイミングもいろいろあって「絶対にここ（助産院）で産むんだ」って。その次に病院に行ったときに「どうしたらいいですか？」って言ったら、「もうここで産まないなら一切来ないで」みたいな、すごく冷たく「もう来なくていいです」みたいなことを言われて、「あ、やっぱり良かったんだ」と思った。それから本当に、すごくワクワクしながら毎月のように通ったっていう感じですね。もう、すごく楽しかったですね。つわりがひどくて実家に帰ってたのも、「大げさなんだから、でも、そういう人もいるよね」みたいな。何でも聞いてくれるし、赤ちゃんがどうこうっていうよりも、「あなたが心配なのよ」みたいな感じでいつも接してくれたから、無駄話っていうか。そうそう実家にも帰れないし、唯一知ってるのが K さんぐらいな感じだったので、本当にお母さんみたいな感じで、ずっと頼りにしていました。旦那さんも「なんでみんな助産院で産まないのかね」っていうぐらい K さんのことをすごい信頼してるし、大好きだしっていう感じですね。いろんな細かいことを聞かなくても、なんか大丈夫っていうか、そういう安心感はいつも与えてくれたなって。

Appendix J: Tentative themes emerged from the participants' experiences

Forty tentative themes (the experience or meaning of the woman–midwife relationship)

全人的	特別な関係	緊張	家族
助産師の励み	距離感	遠慮	バースプラン
指導	交渉	会話	ひとりぼっち
個別性	継続	心地よさ	分業
バースレビュー	責任	安心	複数の助産師
拒絶・壁	共有	承認	時間・対応・ケア
触れる	気づき	信頼	気遣い
環境	役割	自信	専門家
コミュニケーション	助産師の印象・イメージ	相談	対人（人と人）
混合病棟	初対面	精神性	産後の関係



Appendix K: An example of organising themes and selected passages for thematic analysis

27

	信頼 ←Theme: the experience or meaning of the woman–midwife relationship (e.g. Trust)
1	第一印象
2	共有・働きかけ
3	家族の信頼 ←Sub-themes: summary of the participants' experience/passages
4	また戻って来る (e.g. First impressions, I can ask her anything, Trust towards professionals)
5	産後もずっと、会っていなくてもずっと
6	助産師の信念
7	絶対的な信頼感
8	なんでも聞ける、信じれる
9	時間、積み重ね
10	身を委ねられる
11	助産師の判断
12	専門家
13	信頼関係を築く努力
14	女性を信じている
15	自分の体を楽にしてくれた

		Notes
1	第一印象	
	意見ははっきりおっしゃる方で、信頼できるなっていうのが最初の印象だったと思います。W3 ←Passages (statements of the participants) reflecting each theme	
2	共有・働きかけ	
	私個人的に自分の精神面の不安を抱えてて、それを先生に共有していただいて、どうにかしようというようなアプローチで働きかけていただいたことが、やっぱりグッと自分が先生に対する信頼を深めるきっかけになったと思います。W3	
	何ていうのか、お母さんみたいな、見守ってもくれるし、個人も尊重してくれるし、いざとなったらやっぱり的確だし。でもそれを、何だろう、安心感ですかね。信頼っていうか。Kさんの人柄もそうですし。見守ってくれて。W14	見守り、尊重、的確
3	家族の信頼	
	徐々にやっぱり旦那も先生を信頼するようになってきて。で、話は飛ぶんですけども、最終的には「おまえ、あそこで産んで良かったな」っていうふうに、A先生の話がやっぱり絶対だっていうふうに旦那も私も思うようになってましたね。W3	Mw５、１０と同じ。
	旦那が変わったのは、やっぱり私自身が満足して、安心して、信頼してる姿を見るからですかね。で、旦那の自身もその場に受け入れられて、雰囲気的にもう、排除されるような雰囲気でもないですし、温かいし、やっぱり人柄も信頼に至るっていうような認識が、やっぱり少しずつ検診に付いてくるようなことも通して積み重なっていったのかなとは思いますね。W3	「積み重なって」＝継続
4	また戻って来る	
	でもやっぱり二人目妊娠したときに先生にお願いするしか、もう全然考えられなかったんで、そこでお願いして。W3	
5	産後もずっと、会っていなくてもずっと	
	一人目の時は、おっぱいのトラブルけっこうあったんで、いざとなったら先生に相談しようと思ってたんですけども、何とか自分でやれちゃったんで、やり切れたんで。でも二人目の時はすごいスムーズだったんで、トラブル、先生にも相談することもなく、本当に。何かあったら先生に聞けばいいやっていう思いはずっとあったので、それは本当にずっと信頼してました。W3	
6	助産師の信念	
	先生がすごい率直におっしゃる方で、自分の信念もはっきりと持ってらっしゃる方なので、やっぱり出産するってなったら自分の体のメンテナンスであったりとか、そういった責任って自覚した上で行動してほしいっていう思いが強いので、言い方もやっぱりきつくなるっていうところはあると思うんですけど。それが一般的な病院の対応に慣れてらっしゃる方にとってはキツイっていうふうに感じられるんだろうなとは感じましたが。自分としては、はっきりおっしゃっていただいた方が、もうしんどい時はありますけど、ごめんなさいとは思いますけど、かえって信頼できるという方に認識できたと思いますね。W3	信念や哲学が伝わることが信頼につながる
7	絶対的な信頼感	