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## Childbirth in Japan Compared with Childbirth in USA — Implications for Birth and Safety in Health Care —

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### Abstract

The infant mortality rate was 3.8% in Japan and 6.8% in the United States in 1999.

Even though the maternal death rate per 100,000 people is 7.1% in both Japan and the U.S., how does Japan have such a low infant mortality rate? This paper will present a general understanding of the way childbearing is handled today by Japanese people in comparison to Americans, touching on controversial and important issues in both cultures.

### 抄 録

1999年における日本の幼児死亡率は3.8%と米国の幼児死亡率は6.8%と比較して低い。母体死亡率はほぼ同様であるのに、何故日本の幼児死亡率がこのように低いのか? 本稿では今日の日本における分娩の様式について米国と比較し、これに関連して両国の文化における議論の多い重要な問題点について論じる。

### Introduction

In 1999, the infant mortality rate was 3.8% in Japan and 6.8% in the United States according to Vital Statistics issued by the Bureau of Census (Table 1)<sup>1, 2)</sup>. While Japan has the lowest infant mortality rate in the world, the United States is ranked 24<sup>th</sup>. Even though the maternal death rate per 100,000 people is 7.1% in both Japan and the U.S. (Table 1)<sup>1, 2)</sup>, why is it that the infant mortality rate is twice as high in the

United States? Inversely, how does Japan have such a low infant mortality rate? Japan and the United States are both industrious countries, yet there have not been many comparative studies on childbirth in Japan written in English. This paper will present a general understanding of the way childbearing is handled today by Japanese people in comparison to Americans, touching on controversial and important issues in both cultures.

**Table 1. Relevant Vital Statistics (Japanese Journal of Health Statics for Obstetrics and Midwifery 2000)**

1998	Japan	United States
Infant mortality rate/1,000	3.8	6.8
Perinatal death/1,000	1.4	4.3
Maternal death/100,000	7.1	7.1

The infant mortality is the number of babies who die in their first year of life for every 1,000 births. In all countries, people involved in health care believe that the minor differences in the infant mortality rate shows a great deal about other conditions related to health in a country, for example, food distribution, education, sanitation, and health care. Although Japan is densely populated, they rank number one in many health signs, such as life expectancy.

The following studies cover various angles that birth in Japan can be looked at ranging from traditional to technical aspects. It is important to keep in mind that there is a distinction made between the technocratic methods and holistic methods of care. The technocratic method usually refers to obstetrics in the formal, medical, hospital sense. The holistic method is the opposite of the technocratic, especially in the U.S., in the sense that it pertains to midwifery, at times the home or family, and the natural functions of the body. One clear example to illustrate the difference between these two models is that in the technocratic approach to birth **the doctor delivers the baby**, and the holistic method the **mother births her baby**. Both methods refer to the same event; however, the difference is not just a matter of semantics. The way they “treat” (technocratic) or “assist” (holistic) a “patient” (technocratic) or “person” (holistic) fundamentally changes the psychological effect on someone receiving care. A pregnant person is still viewed as a patient when they are in a hospital because everyone in the hospital who is not staff is a patient. To better illustrate this point, the Merriam-Webster dictionary defines “patient”<sup>1)</sup> as adjective, “bearing

pains or trials calmly or without complaint; manifesting forbearance under provocation or strain; not hasty or impetuous; steadfast despite opposition, difficulty, or adversity; able or willing to bear;”<sup>2)</sup> as noun, “an individual awaiting or **under** medical care and treatment; the recipient of any of various personal services; one that is **acted upon**.” The etymology, which not surprisingly goes back to Latin and means suffer or suffering. Therefore, a pregnant woman is referred to as one who is suffering. Also, patient as an adjective seems to be all of the qualities that a doctor wants the person that they’re caring for to be; it’s like a subliminal message, please be the patient patient. In holistic medicine, specifically in midwifery, a person is treated like a person who needs advice on how to care for themselves, which really changes the sense of agency one has over their health, life, and body. Some have defined the technocratic model of birth as the male perspective, and the holistic model of birth as the female perspective.

### Comparisons between childbirth in Japan and in the United States

It is important to keep this separation in mind when comparisons are made between Japan and the United States because Japan’s view is often closer to the holistic stance and the U.S. is usually technocratic. Although this is an oversimplification, the report done by Fiedler explains in greater detail the technocratic versus holistic methods as viewed in Japan and the U.S.<sup>3)</sup> Most of the information Fiedler used in her investigation was obtained during 1987 through 1990 and three weeks in 1991 while observing a therapy group about pregnancy and childbirth in Tokyo. There is a tradition in Japan where woman go to their mother’s home, or in some cases the mother-in-law’s home, about two weeks before labor, and then return for about four weeks after the child is born in order to receive assistance in caring for the mother and child, thus making childbirth a family event. This is called Satogaeri, and this is what Fiedler was studying while

she was in Japan. Her primary source of information was taken from a number of interviews with 12 women during prenatal care. She attended routine check ups, “labor and birth, and the postpartum period” whenever allowed. Additionally, Fiedler interviewed doctors, midwives, nurses, people involved with childbirth both professional and non-professionals. The figures included in Fiedler’s study came from what she saw during check-ups and how the women were tended to in labor and birth, plus the videotape recordings she took of one birth in a hospital and one birth in a midwife clinic <sup>3)</sup>.

A study done by Sharts-Hopko, focused on a group of 20 American women who gave birth in Japan <sup>4)</sup>. All participants received prenatal care in the capital of Japan, Tokyo. One woman had grown up in Japan, and the other nineteen had lived in Japan for approximately 2.7 years on average before the birth. Seventeen of the participants were living in Japan because of their husbands. Two were there for their own studies or work. Plus there was one who grew up there. All attended college and had worked professionally at some time. For the most part, Sharts-Hopko conducted one interview with each woman. She taped the interviews from 1 to 4 hours, usually in the participant’s home <sup>4)</sup>. In Japanese anthropologist’s study, Matsuoka also suggested that postmodern midwives in Japan have somewhat holistic stance <sup>5)</sup>.

Yeo, Fetters, Maeda conducted an investigation with eleven couples who were pregnant and Japanese in Michigan at a clinic associated with a university <sup>6)</sup>. Since there are 5000 Japanese people, equal to 1% of the population of those who live in this area of south-east Michigan, the clinic staff was fluent in Japanese, claimed to be familiar with the culture, and ran a program to provide primary health care for people who spoke Japanese. Many Japanese people in this area are not in the U.S. permanently, therefore the residents move in and out frequently, despite the fact that the population count stays roughly the same. Although they try to educate themselves on the United States in

order to acclimate to the society, they are part of a Japanese community where it is easy for them to keep up with a “Japanese lifestyle,” for example, the food they eat or Saturday and Sunday Japanese language schools for their kids. Yeo, Fetters, and Maeda carried out the study by doing one prenatal interview and one postpartum interview, including a 31-question survey regarding previous experience with childbirth plus demography. The participants planned to stay in the United States for about 58 months, or 4.8 years. Each couple had been married for about 5.2 years. Six families already had one or two children in Japan <sup>6)</sup>.

While Fiedler’s study includes the way in which birth is defined by both its physical and social environments in contemporary Japan, she draws on information about the United States for comparison <sup>3)</sup>. She proves that the obstetrician is the one with “authoritative knowledge,” i.e. having the status of control and power. Fiedler is searching for the differences and similarities in the technocratic and holistic methods, which she renames “the obstetrical model and midwifery model,” respectively, to understand child-birthing in the context of Japan. Fiedler addresses the way that midwifery and obstetrical practice are intertwined in Japan more so than the U.S. In Japan, nurse-midwives work in the hospital alongside doctors, and those who work with doctors in the U.S. are nurses. She tries to show the role of midwives and obstetricians, as well as the woman’s power in her own pregnancy and birth in Japan. So, Fiedler searches for the settings, birthing technology, attendants/support systems, structure of the birth process, and who has ownership and control <sup>3)</sup>.

Sharts-Hopko emphasizes that foreigners in Japan feel stress from adjusting to a different culture, which plays a role in the experience of childbirth <sup>4)</sup>. In the beginning of the article, she seeks to define this stress and the visible signs of it, then moves on to address the more specific question of, what do women from the United States who gave birth in Japan say about

their experience? <sup>4)</sup>.

There were ten reoccurring issues that came up. Communication was naturally a problem in terms of language. Japanese people often reminded these women of their foreigner status, and for that reason they felt discriminated <sup>4)</sup>. For example, Japanese people will excuse many non-Japanese people for a cultural faux pas, like not bowing correctly. Specifically in this case, Sharts-Hopko wrote that women felt like Japanese people thought they were lacking mental strength <sup>4)</sup>. Also, there were variations of practice and habits, such as, Satogaeri (homecoming), averting the use of anesthesia or analgesia for the labor and birth, “eating during labor for energy versus withholding of food in the United States,” or the restriction of waiting a week in Japan after the child is born to wash the mother’s hair. Although, it is worth mentioning the fact that three of the interviewees knew and clearly stated that the maternal-infant morbidity and mortality data for Japan displays excellent results in comparison to the United State <sup>4)</sup>. I suppose this eased their mind if they had doubts about the care they were receiving.

Other issues included husband support, distance from their families, peer support, societal responses, and a need for knowledge. All of these conflicts caused stress for the American women in Japan, on top of the already existing stress of living in an unfamiliar country (Table 2) <sup>4)</sup>.

“Japanese Couples’ Childbirth Experiences in Michigan: Implications for Care,” is the title of Yeo, Fetters, and Maeda’s study <sup>6)</sup>. Their goal was to investigate the experiences of childbirth for Japanese families in the United States, by showing the extent that cultural difference played a part. They also discuss the ramifications for “providing culturally competent care,” and whether that is possible or not. The main issues that came up with all of the participants had to do with the language barrier, ultrasonography, prenatal vitamin supplementation, episiotomies, epidural analgesia, and the caregiver-client relation-

ship <sup>6)</sup>.

Yeo, Fetters, and Maeda report that even though the husbands were able to do studies with scientists in America at a University, they still had difficulty responding quickly in English to the doctors <sup>6)</sup>. The language barrier was larger for the women than it was for the men. The couples involved in this study had lived in the U.S. for an average of 2.5 years, but the women socialized with other Japanese for the most part. The men usually translated for their wives when they went to a clinic or hospital. They were able to understand everything apart from technical terms used in medical practice. However, it frustrated the couples that they could not understand the paramedical staff’s comments. There was an effort made to give written handouts to Japanese patients in order to bridge some of the gaps. The couples did not read them, and instead read material about childbirth sent from Japan <sup>6)</sup>.

Ultrasonography is performed for every check up during prenatal care in Japan <sup>7-13)</sup>. Naturally, the Japanese couples were shocked when they did not receive routine fetal sonograms. Especially for those who had previously bore a child in Japan, they remembered that being able to see the development of the fetus was a comforting experience. So, not being able to track the growth of the fetus made the pregnant women nervous and worried about her baby’s

**Table 2. Issues faced by American Woman giving birth in Japan (Sharts-Hopko, 1995)**

THEMES	ISSUES
Distance from family	Isolation
Peer support	Isolation, affirmation
Husband support	Isolation, affirmation
Preexisting stress	Isolation
Societal responses	Affirmation
Differences	Affirmation, cultural support
Differences	Cultural support
Ideal versus real birth	Control, cultural support
Need for knowledge	Control, security
Communication	Security

health. One woman's "need for seeing the sonograms of her baby, whether to fulfill cultural or emotional needs, was never discussed with her doctor (194)"<sup>61</sup>.

As for the prenatal vitamin supplements that doctors in the U.S. instructed the women to take daily, the participants confessed that they avoided taking the vitamins. They found it perplexing because they pride themselves on eating a well balanced diet and thought the iron supplements unnecessary. Moreover, "Japanese people perceive prenatal vitamins to be medicine (since they are prescribed by physicians), and a strong belief exists that pregnant women should avoid taking medications at all costs (194)." One participant recounted a conversation she had with her obstetrician in Japan who directed her to stop taking the prenatal vitamins<sup>61</sup>.

Yeo, Fetters, and Maeda report that routine episiotomies are done in Japan. One woman, who had been a health care practitioner in Japan, had been taught that performing an episiotomy would help the body heal faster as a straight cut, opposed to not performing the episiotomy where there would be the possibility of tearing, which would not heal as quickly. The conflict over episiotomy did not bother the Japanese couples that were not health-care workers<sup>61</sup>.

As was the case with the folic acid prenatal vitamins, women were extremely concerned about the use of epidural analgesia. Both obstetricians and midwives in Japan do not practice routine use of epidural analgesia for normal births. Between the women who questioned what side effects the fetus would feel, and the husbands that asked their wives, who expressed interest in receiving the epidural, not to use it, Yeo, Fetters, and Maeda report only one woman, a second-time mother, who asked for an epidural when the pain became unbearable<sup>61</sup>.

A few words that Yeo, Fetters, and Maeda report the participants using to describe the caregiver-client relationship of the American obstetricians were "highly professional, democratic, open, jovial"<sup>61</sup>. Nurses were said to be "supportive and friendly, yet knowl-

edgeable and timely." After interacting with the doctors in the U.S., the Japanese couples felt that doctors in Japan were "authoritative and overbearing, taking their hierarchical superiority for granted and acting almost oppressively<sup>61</sup>" towards the treatment of patients. The woman who had been a health care practitioner in Japan talked about her experience of times when she had been understaffed and managing multiple women about to give birth at the same time. While relating a fear she had in Japan, she expressed anxiety in the case that more than one patient would have some sort of complication at the same time. She observed no such situation in the United States<sup>61</sup>.

Fiedler's research on "authoritative knowledge and birth territories in contemporary Japan<sup>31</sup>" was fascinating because she juxtaposes the technocratic and holistic methods of birth care by comparing<sup>1</sup> Japan to the United States and<sup>2</sup> obstetrics in Japan to midwifery in Japan. This creates a more comprehensive framework to understand the similarities and differences between each of these locations. The technocratic model and the holistic model are at two opposite ends of the spectrum in the U.S., whereas obstetrics and midwifery, although two separate fields, have grown together and intertwined some concepts. For example, Japanese doctors and midwives view childbirth as normal, opposed to the obstetricians in the U.S. who consider it a disease in the sense that it is a condition that must be treated. This perspective in Japan is a view shared by midwives in the United States. Another explanation is that "female life-cycle transitions are generally less medicalized in Japan than in northern Europe and North America (200)." Coinciding with Yeo, Fetters, and Maeda's findings, Fiedler says that thinking of childbirth as normal:

fosters a less interventive approach to birth than is found in U.S. hospitals. For example, it is common for Japanese women to eat and drink during labor and to walk from the labor room to the delivery room; it is uncommon for them to routinely have analgesia, anesthesia,

or operative intervention during birth. The cesarean section rate for hospitals and obstetrician-operated clinics in 1990 was 11 percent and 8 percent, respectively (Japanese Ministry of Health and Welfare 1992: 114); in the same year the cesarean section rate in U.S. hospitals was 23.5 percent (Taffel et al. 1992:21)

The cesarean rate in Japan is low compared to the United States. So why is the U.S. percent so high? What effect does that cause? How many unnecessary cesareans are performed? What are the implications for the United States obstetrical practice? The high rate of cesarean sections in the United States proves that there are conflicts over who controls the female body. I wonder when and how did this disempowerment of women over their own body start? On another note, Fiedler made it clear that while Japan is generally more holistic and the United States generally more technologic, the power is still in the hands of a male dominated field<sup>3)</sup>. Nurse-midwives practice in both clinics and hospitals where they give most of the care. Nevertheless, even in a midwifery clinic, a doctor is required to step in at the last minute to deliver the baby. Yeo, Fedders, and Maeda point out that their interviewees realized how oppressive Japanese doctors were after their interactions with doctors in the U.S.<sup>6)</sup>. So, there seems to be a contradiction where Japan has excellent care with super strict attitudes from the doctor, whereas the U.S. has easy to get along with, less commanding doctors with poor care.

One thing that was not taken into account is the fact that midwives actually perform most of the care for pregnant and postpartum women. According to Yoshika Doi-Rutkin, a Japanese woman who had one child in a hospital and one in a midwifery clinic in Kyushu, Japan, the midwives were attentive and kind. She went on to say that the midwives made a point to keep her informed about what was going on and what they were doing, particularly during labor. It was not until the last minute that the doctor came in to deliver the baby, then left<sup>11)</sup>.

Sharts-Hopko's study and Yeo, Fedders, and Maeda's study balanced some of the questions I had because they presented two sides of the same coin<sup>4,6)</sup>. On one side, there was the study on American women in Japan, and the other were Japanese women in America. Therefore, questions about what it would be like if the situation were reversed came up while reading one article, but the other article answered it.

Repeatedly, questions of the history of midwifery in Japan and the U.S. came up, and I wondered why there is such a stark difference between the way obstetricians **handle** birth and midwives **guide** birth. What kind of education are obstetricians and midwives taught? What are the similarities and differences in their education? And in Japan, has it been such a harmonious bond between the practice of midwifery and the rise of obstetrics?

Although the studies presented here are thorough in their report on prenatal care, there was no mention of breastfeeding practices. Since Fiedler's focus was on satogaeri, which is a return home for a few weeks before and at least a month after the birth, it is surprising that she does not mention the importance of breastfeeding. Infants who are breastfed receive many nutrients to boost their immune system in their mother's milk. Many Japanese are encouraged to breastfeed by the government, the health caregivers, and family. In 1985, over 90% of new mothers breastfed and breastfed exclusively, without using formula, and in the U.S., breastfeeding peaked in 1982 at 59%<sup>14)</sup>.

Birth and safety are important for all people and should be a priority for the medical establishment who dominate the field of childbirth. One difference between prenatal care in Japan and the U.S. is ultrasonography, which is not usually used during the second trimester in the U.S., unless otherwise specifically asked for by the patient. However, ultrasonography is used for routine check-ups in Japan. It is unfortunate that health care is dependent on health insurance, which is defined by the government. In

the United States, health insurance defines what kind of health care you receive. If someone cannot afford to have ultrasound once every month of their pregnancy because health insurance usually does not cover that, then they cannot see their baby. Where as in Japan, it is expected to receive an ultrasound at almost every visit. Although a number of articles claim that the less frequent use of ultrasonography has no adverse effect on the outcome of babies in the U.S.<sup>8)</sup>, it is worth noting that the infant mortality rate is remarkably lower in Japan where ultrasound is used regularly. In other words, there may or may not be a correlation between the fact that in a Japan, where ultrasound is used in standard prenatal care, there are fewer infant deaths.

For those who think race is not just a factor but the reason for the differences in birth outcome, such notions should be refuted here. Certainly, there have been studies done on fertility, childbirth, infant mortality, etc. in the framework of separating the results for the racial categories that U.S. survey's acknowledge, i.e. Black/African-American, Hispanic, Asian/Pacific islander, and Caucasian. Not only is there no reason to go into detail about how problematic those categories are, but it is also not worth going into any of the specific numbers because the differences between race reflect class issues more than race. It is just as ludicrous to compare Japanese people and American people based on race for their infant mortality rate when the studies presented in this paper show that it is a matter of health care, the different approaches, and the different views held by each country.

Finally, it is clear from the studies on childbirth in Japan, which all used the U.S. model of care for comparison, that doctor's in Japan may at times be oppressive, and the doctor's in the U.S. cordial. However mean or nice, the infant mortality rate implies that the quality of health care for childbirth in Japan is better than the quality of health care for childbirth given to woman in the United States.

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