

**Maintaining *wa* (harmony):
Japanese women negotiating their birth experiences
in New Zealand**

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A thesis in fulfilment of the degree Master of Midwifery
at Otago Polytechnic, Dunedin, New Zealand

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**Declaration Concerning Thesis Presented for
the Degree of Master of Midwifery**

I, **Keiko Doering** of **68 Blacks Road, North East Valley, Dunedin**, solemnly and sincerely declare, in relation to the thesis entitled:

Maintaining *wa* (harmony): Japanese women negotiating their birth experiences in New Zealand

(a) That work was done by me, personally

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Abstract

This thesis explores Japanese women's birth experiences in Dunedin, New Zealand. New Zealand is a multicultural society comprised of people from diverse ethnic backgrounds. Currently, nearly 10% of the population identify as being of Asian descent, and this group has grown the fastest among all ethnic groups. A part of this demographic shift has been the rapidly increasing the Japanese population. In this social and cultural context, New Zealand health services have adopted the concept of cultural safety as an essential requirement for all health care providers. While the childbirth experiences of Māori, Pacific Islanders and Europeans have been well documented, this is not the case for Japanese and many other minority ethnic groups in New Zealand.

To begin to address this gap for Japanese women, a qualitative study was undertaken. Nine Japanese women currently living in Dunedin were interviewed. The key findings from the interviews were then further explored within a focus group comprising of four additional Japanese women. Thematic analysis was used to analyse the data and four main themes emerged as the results: 1) how the women understood the New Zealand maternity care system, 2) how they negotiated keeping Japanese customs, 3) the complexity of giving birth in another country, and 4) how the women dealt with cultural differences.

Building on some of the issues highlighted in the themes, the discussion chapter examines in greater detail how women understand and experience giving birth as a Japanese woman in the New Zealand context. The first discussion investigates how the different birth contexts between New Zealand and Japan and the Japanese women's style of communication affect their birth experiences in New Zealand. The second area of concern focuses of the different perspectives on labour pain between the two countries, and how this difference shapes the birth experiences. Next, the study explores the importance of maintaining traditional birth practices in another country and support required to achieve this goal. The discussion chapter concludes with a consideration of how these women negotiate their complex birth experiences in New Zealand through a Japanese philosophical worldview, such as maintaining *wa* (harmony), and investigates how the idea of maintaining harmony affects their care and experiences. Each discussion also highlights the strong influence of the care providers, especially

midwives, on the women's birth experience. It further recognises that understanding the cultural backgrounds of the women is required in order to improve their care.

The study concludes with several recommendations for midwives and health managers concerning cultural sensitivity, communication processes and practical support which would enable Japanese women to enjoy a safe and satisfying birth while also maintaining their own culture within New Zealand.

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Chapter One: Introduction

Childbirth is a significant social, cultural and often religious event while one of life's ordinary processes for women and their families around the world. In this regard, giving birth in a different culture adds an additional challenge for women as they negotiate differences in systems, customs and perspectives. New Zealand is a country with a diverse ethnic population. Accordingly, many women in New Zealand face this challenge. At the same time, midwives, who are the primary providers of maternity care in New Zealand, are largely of European descent, while there are few midwives from other ethnicities. In this context, the birth beliefs of immigrant women may not be understood well by care providers. In order to offer the most appropriate care for these women, and to promote a satisfying birth experience, it is important to understand their beliefs about childbirth and, whenever possible, enable them to include these practices in their care plan.

In New Zealand, the population of first generation Japanese has been rapidly increasing alongside other Asian ethnic groups. This research aims to explore the experiences of New Zealand maternity care through a sample of Japanese women who gave birth in Dunedin, New Zealand. It is anticipated that the results of this study will increase awareness by midwives and other health professionals of Japanese women's unique cultural needs, and inform Japanese women about the New Zealand maternity system and how they might negotiate ways to maintain cultural practices important to them and their families.

Inspiration for this study

I am a Japanese mother living in Dunedin, New Zealand, and also a midwife certified in Japan. Before moving to New Zealand, I had my first baby in a small town in Canada. I did not expect to have difficulties having a baby there because I thought childbirth would be physically and biologically the same no matter where I was. I was also confident that I had enough skills and knowledge to take care of my baby as a midwife. My birth was smooth and normal, and taking care of my baby was not difficult for me at all. However, I was uncomfortable, confused, and suffered mentally and physically from the different perspectives regarding childbirth and the different model of care. The

source of my discomfort emerged from the different perspectives on diet, postnatal life of mothers, even the different types of baby clothes and nappies. There were no other Japanese with whom to share my feelings or experiences in this small town, and I had to be patient and endure this distress on my own.

Since I moved to New Zealand, I have met many Japanese mothers of small children with whom I have shared childbirth experiences. Through these conversations, I knew that there were many Japanese women who had similar experiences to me in New Zealand. I also wondered if our experiences and concerns were known to other people such as non-Japanese family members and midwives. This concern became the inspiration of this study. At the same time, I had my second baby in New Zealand while conducting my research, and am expecting another one soon after I complete this thesis. These personal events have given me a unique insight into the experiences of the women in my study.

As a midwife from Japan, which is considered to be a homogeneous country, learning about the culturally diverse characteristics of New Zealand society surrounding childbirth is a challenge; in particular the concept of cultural care. It is hoped that this study inspired by my personal experiences and written alongside other Japanese women in New Zealand will contribute to a greater understanding of the immigrants' birth experience in New Zealand and help Japanese women and their families achieve satisfying birth experiences.

Maternity care in the New Zealand context

New Zealand midwives became autonomous maternity service providers with the enactment of the Nurses Amendment Act in 1990 (Pairman, 1998). In 1996, the Lead Maternity Carer (LMC)¹ system was introduced which has resulted in over 75% of women choosing midwives as their LMC (New Zealand Ministry of Health [NZMH], 2011). The service is funded by the government, and LMCs are reimbursed equally for

¹ According to Primary Maternity Services Notice 2007 (NZMH, 2007b), “a general practitioner with a Diploma in Obstetrics; or a midwife; or an obstetrician” can be a LMC under Section 88 of the New Zealand Public Health and Disability Act 2000. LMCs claim the same budget regardless of their professions under the notice (Guilliland, 1997).

primary maternity services regardless of their professions (Guilliland, 1997). This service provides continuous and complete maternity care throughout childbirth for each individual woman (Hendry, 2009). The uniqueness of the New Zealand maternity service has emerged and developed from a specific cultural, historical and environmental context. Therefore, understanding the New Zealand context, especially with respect to culture, is an important starting point for this study.

Cultural discourses in New Zealand

New Zealand is a bicultural country with obligations under the Treaty of Waitangi. The treaty was signed between the Tangata Whenua (people of the land - Māori) and the British Crown in 1840 (Phillips, 2009b). Despite the legal recognition that Māori are the indigenous people of New Zealand, there are many studies documenting the inequalities experienced by Māori in health services (Charman, 1988; Durie, 1989, 2000; Ellison-Loschmann, 2006; Reid, Robson, & Jones, 2000). Consequently, governmental strategies, policies, and practical guidelines considering Māori cultural practices, rights, needs, and interests have recently been developed and issued to specifically address Māori health issues (Crengle, 2000; NZMOH, 2010; Otago District Health Board, n.d.).

Recently, it has been argued that New Zealand is multicultural because it is home to a large number of immigrants (Mulgan & Aimer, 2004; Panny, 1998; Phillips, 2009c). For example in 2004, New Zealand had the second highest proportion of immigrants in the workforce in the world (Phillips, 2009a). In 2006, there were 879,543 foreign-born people comprising 21.8% of the population. Two thirds of these people came from the Pacific Islands, Africa, the Middle East, and Asia (Statistics New Zealand [SNZ], 2007a); thus a variety of people with different cultures live and work in contemporary New Zealand society.

It is suggested by Liu, McCreanor, McIntosh, and Teaiwa (2005) that New Zealand society needs to foster a culture of mutual respect and cooperation regardless of ethnic origin or population sizes. Further, the government needs to develop appropriate policies and resources to address culturally diverse needs recognising the fundamental human rights of all people in New Zealand. Mulgan and Aimer (2004) emphasise that each culture, not only Māori and Pakeha (European), should be guaranteed equal rights regardless of the necessity of historical priority, hegemonic dominance, or a harmonious

public unity. Ideally, a multicultural approach allows individuals to keep their distinctive cultural traditions and contribute to the diversity of the society (Mulgan & Aimer, 2004). Such an approach, however, would be inconsistent with the articles of the Treaty of Waitangi which acknowledges just the two peoples, Māori and other. Thus all new immigrants become other in this context.

Important is the concept of Kawa Whakaruruhau (cultural safety within the Māori context) which has been a fundamental expectation for the conduct of health practitioners in New Zealand (Nursing Council of New Zealand [NCNZ], 2005; Ramsden, 2002; Wepa, 2005). This concept has not only produced awareness of cultural respect towards Māori from health practitioners, but it has also become a part of the educational curriculum for health practitioners. Cultural safety comprises 20% of both midwifery and nursing national examinations and is a crucial requirement of professional competency for their registration in New Zealand (Ellison-Loschmann & CPHR, n.d.; New Zealand College of Midwives [NZCOM], 2008; NCNZ, 2005). Thus the Treaty of Waitangi has played a significant role in the cultural development of New Zealand society and its health care system.

Cultural discourses in maternity care

The Midwifery Council of New Zealand [MCNZ] (2007, 2011) has established the requirement of cultural competence and the integration of Turanga Kaupapa² within midwifery practice into its Competencies for Entry to the Register of Midwives. The NZCOM (2008) also requires all midwives to have knowledge of cultural safety as a component of the Standards for Midwifery Practice. Perhaps most importantly, partnership between women and midwives is seen as the core philosophy of New Zealand midwifery; this idea of partnership originating from the principle of the partnership between Māori and the Crown developed from the Treaty of Waitangi (Guilliland & Pairman, 1995). Accordingly, a significant amount of research (Abel et

² Turanga Kaupapa are cultural guidelines for midwifery practice to ensure that cultural requirements are met for Māori during pregnancy and childbirth. It was developed by Nga Maia o Aotearoa me Te Waipounamu, the national organisation of Māori midwives and whanau (extended family in Māori) promoting and supporting Māori birthing, and formally adopted by both the Midwifery Council of New Zealand and the New Zealand College of Midwives (MCNZ, 2007, 2011).

al., 1999; Mead, 2003; Rimene, Hassan, & Broughton, 1998; Tipene-Leach, Abel, Finau, Park, & Lennan, 2000; Tūpara & Ihimaera, 2004) has been done concerning Māori childbirth and child-rearing practices and experiences.

Changes to ensure culturally safe practices for Māori childbirth have also helped to protect the customs of Pacific women in New Zealand according to Lukere (2002). Likewise, a number of studies and policies for Pacific Islanders including maternity settings (Abel et al., 1999; Abel, Park, Tipene-Leach, Finau, & Lennan, 2001; Donnelly, 1992; Sadler, McCowan, & Stone, 2002; Tanuvasa, 2010) have already been provided on account of the geographical and historical ties between the Pacific Islands and New Zealand. Similarly, considerable research has been undertaken for European women and families.

In contrast, there is a dearth of research concerning the birth experiences of women from other ethnic groups in New Zealand. In general, New Zealand studies with a cross-cultural, culture, and ethnic focus (Abel et al., 2001; Craig, Thompson, & Mitchell, 2002; Sadler et al., 2002) typically refer to Māori or Pacific Islanders, or divide samples into Māori, Pacific Islander, and European/other categories, following the categorisation of national statistics. According to Levine (2005), however, “cultural safety is a gift from Māori to everyone” (p. 113). Thus it is applicable to this increasingly diverse New Zealand population even though the concept was developed to address Māori cultural health issues. Indeed, New Zealand midwifery does not limit culturally safe practice to Māori only, but for all women receiving maternity care while also stressing the importance of its Māori origin (Pairman & McAra-Couper, 2006). To achieve cultural safety for all people in New Zealand, filling the gap between the knowledge concerning Māori, Pacific Islanders and European, and the knowledge of other ethnic groups in the maternity setting is a crucial issue in this culturally diverse society.

The significance of this study

There has been a significant amount of research concerning Māori, European, and Pacific Islanders’ childbirth experiences (Grayson, 1995; Rimene et al., 1998; Tūpara & Ihimaera, 2004). The issues of cultural safety have also been an important topic for health practitioners in New Zealand (Wepa, 2005). On the other hand, New Zealand has

a large number of immigrants from other countries, and the concept of cultural safety needs to reflect and respond to this increasingly diverse New Zealand population.

The dearth of research into the birth experiences of women from these other ethnic groups in New Zealand leaves a gap in the literature. In this study, the experiences of a sample of Japanese women experiencing childbirth in New Zealand is recorded with the aim of providing insights into how their care could be improved in the future. While this study focuses on Japanese women's experience in the New Zealand maternity setting, the findings may resonate with and inform Japanese women giving birth in other countries.

Aims of this study

Therefore, the aim of this study is to explore the pregnancy, childbirth and postnatal experiences of a group of Japanese women who gave birth in New Zealand. By exploring the birth experiences of Japanese women and publishing the findings, midwives, doctors and other health professionals will have the opportunity to understand their cultural differences better and be able to provide more appropriate care resulting in greater satisfaction and safety for everyone involved.

This study is guided by three specific aims:

1. To explore the benefits and/or satisfaction of the birth experience for Japanese women in New Zealand.
2. To clarify the difficulties and/or anxiety for Japanese women giving birth in New Zealand.
3. To uncover possible cultural conflicts Japanese women experience through their childbirth in New Zealand.

Summary

This chapter presented the inspiration and significance for the exploration of Japanese women's birth experiences in the New Zealand maternity care system. The researcher's

personal experience and interest triggered this research, and a review of the literature and the cultural context of New Zealand has demonstrated the need for such a study. In the following chapters, the cultural conflicts for a group of Japanese women are explored. Thus appropriate, culturally safe care from midwives and other care providers is needed to improve the birth experiences of immigrant women in New Zealand.

Thesis overview

The thesis comprises seven chapters.

Chapter Two presents the literature review which situates Japanese women's birth experiences in New Zealand. The discussion centres on the relationship between childbirth and culture, the context of childbirth in another culture, and the experiences of Asian and Japanese women in New Zealand and other Western cultures.

Chapter Three outlines the design and methodology for this study. First, the conceptual framework of qualitative description is outlined. Next, the data collection methods used for this study, individual interviews and a focus group, are detailed. Thirdly, the process of thematic analysis used to investigate the data is described. Lastly, the chapter discusses the ethical concerns and the relevance of the Treaty relationship with Māori in New Zealand.

In *Chapter Four*, the results of the individual interviews with nine Japanese women are detailed. Four themes emerged from the interview data. These and their sub-themes are presented and supported with the quotations from the participants.

Chapter Five details the results of the focus group with four Japanese women. The same four themes emerged, and selected segments of the conversations are included to illustrate each theme.

Chapter Six presents the four discussion topics which arose from the findings of the individual interviews and the focus group. The discussions include a comparison between New Zealand and Japanese birth contexts, a consideration of the different perspectives on labour pain, and the importance of traditional birth customs.

Furthermore, the culturally unique character of Japanese communication, attitudes and thinking are explored. These discussions reveal how Japanese women negotiate their experiences while striving to maintain harmony between the two cultures, and between themselves and others.

In *Chapter Seven*, the particular contribution this study offers for women, midwives and other health professionals is also reviewed and recommendations that could improve the birth experiences of Japanese women in New Zealand are suggested. The strengths and limitations of this study are discussed and future research possibilities are indicated.

Chapter Two: Literature review

Introduction

The purpose of this chapter is to review the literature that can help us understand about Japanese childbirth in New Zealand. First of all, culture is an important key word given that at least two cultural contexts, Japanese, New Zealand, and possibly another culture of the partner, simultaneously exist around the childbirth experience. This situation raises several questions: How do Japanese women experience childbirth in New Zealand? How do these cultures interact? And how do Japanese women manage their birth experience within this cultural environment?

To explore these issues, the relationship between childbirth and culture, and the ways in which women experience birth in a foreign culture are examined. As Japanese belong to the Asian category as the broad ethnic group, the childbirth experiences of women from other Asian cultures are also investigated. Finally, the state of the childbirth environment for Japanese and the characteristics of Japanese women in particular are identified as important factors when reviewing their childbirth experiences in New Zealand.

Childbirth and culture

Childbirth is a universal and natural phenomenon and is a process understood to be physically similar for all women (Priya, 1992). However, each woman has her own unique pregnancy and childbirth experience. Equally important, meanings of childbearing are various and women's perceptions and experiences of childbearing are strongly affected by their own cultures (Callister, 1995; Callister, Semenic, & Foster, 1999; Cheung, 2002; Ito & Sharts-Hopko, 2002; Jordan, 1980; Kartchner & Callister, 2003; Liamputtong & Naksook, 2003; Matsuoka, 1985). Jordan (1980) describes childbirth as a cultural, biosocial and interactional event through her fieldwork of four cultures, and from Jordan's work, Davis-Floyd and Sargent (1997) develop their concept of "authoritative knowledge" (p. 56), which empowers women to make decisions and take actions in childbirth. The use of authoritative knowledge by women is shown to be extremely different between cultures. However, culture is not static as each culture gives women and their families a diverse range of beliefs, values,

interpretations, perspectives and behaviours concerning childbirth. At the same time, the culture is also influenced by people's attitudes and personal beliefs (Ito & Sharts-Hopko, 2002).

Every culture has its own unique approach to birth which is often passed down from generation to generation by word of mouth. Furthermore, the cultural attitudes signify spiritual symbols and are validated through ritual (DeSouza, 2004). Historical, political and economical contexts of the society also affect childbirth experience because they form the maternity system and care (Matsuoka, 1985). Hence, cultural backgrounds associated with childbirth cannot be ignored when the value and psychosocial aspects of childbirth for women are examined. Sometimes these values contradict or transcend the ethics and scientific evidence due to strong cultural beliefs. Therefore, it is important for women to express their feelings about the cultural and spiritual meanings of giving birth (Callister, 1995).

Childbirth in another culture

In today's increasingly mobile society, people are moving from one culture to another culture more frequently than in the past. Transferring to a new culture is a stressful experience (Ozeki, 2008). Since childbirth has a strong connection with culture, having and rearing a baby in a foreign culture is also a big challenge. To make matters more difficult, birthing immigrants are often young and may not have had enough time to become familiar with their new culture and society before the event.

As women from different cultures perceive and experience childbirth differently, their experiences of childbirth in a new country might be very different from their expectations (Barclay & Kent, 1998; Rice, 1999). Raines and Morgan (2000) argue that even if mothers are born in the new country, different ethnicities have different expectations of the birth experience. So childbirth in a foreign country is particularly stressful, and the stress of mothers and their families can be extremely high particularly when becoming new parents overlaps with the early stage of migration (Foss, Chantal, & Hendrickson, 2004; Sharts-Hopko, 1995; Taniguchi & Baruffi, 2007).

Many difficulties for immigrant mothers are caused by language barriers, separation from family and friends, and discrimination (Tummala-Narra, 2004; Wiklund, Aden,

Hålgberg, Wikman, & Dahlgren, 2000). Inequity in the care of foreign-born women has also been reported (Diani, Zanconato, Foschi, Turinetti, & Franchi, 2003; Robertson, Malmström, & Johansson, 2005). The misery of these women is usually hidden and they suffer alone because they are often isolated in their new countries.

Studies (Diani et al., 2003; Foss et al., 2004; Robertson et al., 2005; Small, Lumley, & Yelland, 2003; Taniguchi & Baruffi, 2007) have also shown that foreign-born mothers experience more anxiety and are at higher risk of complications, medical interventions and depression than native-born mothers during the prenatal, delivery, and postnatal periods. Moreover, it has been claimed that these migrant mothers' situations possibly affect the well-being of their children. For example, Foss et al. (2004) reported a higher percentage of developmental delay among infants and toddlers of non-English-speaking mothers in the United States.

It is often assumed that a number of immigrants in Western countries are refugees and people from economically, hygienically, and medically disadvantaged nations. Under the situation in which childbearing and parenting beliefs of white and middle class people are dominant, and authoritative policies come from this majority group, immigrants are obliged to abandon their ways as minorities because they are often expected to feel lucky enough to be accepted in Western countries and expected to appreciate the host countries' hospitality (DeSouza, 2004, 2005). In such contexts, hardships and negative outcomes of immigrants' childbirth experiences are inevitable. Actually, these difficulties and inequalities are not limited to refugees and low-income immigrants. Middle class, highly educated women have also experienced these difficulties (Arisaka, 2000; Mayuzumi, 2008).

Asian childbirth in another culture

Asian childbirth in Western cultures

Due to the large scale of Asian immigration in the world, Asian women's childbirth experiences in Western countries is being discussed in the literature (Bowler, 1993; Cheung, 2002; DeSouza, 2004; Liamputtong & Naksook, 2003; Rice, 1999; Robertson et al., 2005). Robertson et al.'s (2005) study, which included more than 99% of all births in Sweden between 1996 and 1998, identified that women from Asia had over a

50% higher risk of abnormal birth than Swedish-born women. Robertson et al. (2005) suggested that this was a result of an unsuitable interaction between women having certain cultural beliefs and Swedish caregivers who were unaware of their needs and stereotyped foreign-born women. Such views are certainly problematic because caring interventions throughout the childbearing process should be culturally sensitive in order to promote positive outcomes for the women and their families (Callister, 1995).

Bowler (1993) studied stereotypes of Asian women in midwifery, and found that midwives' perceptions of Asian women were negative. For example, they identified Asian women as making a fuss about nothing. These midwives placed Asian families' attitudes and values outside of Western normality. According to Arisaka (2000) and DeSouza (2004), this hierarchical assumption of Asian inferiority and Western superiority originated from a modern, scientific, and philosophical discourse of Western thought as universal truth, and these attitudes remain today. Further, Arisaka (2000) states that the notion of "Asian women" itself is already stereotyped. As a result, many Asian women have given up their power and cultural traditions to be perceived as "good" or "normal" mothers in Western culture (Arisaka, 2000; Bowler, 1993; DeSouza, 2004).

Asian health and childbirth in New Zealand

In New Zealand, individuals with Asian ethnic backgrounds now account for 9.2% of the population, making this the biggest ethnic group after European and Māori (SNZ, 2006). Moreover, the Asian population is growing rapidly and is expected to have the highest growth rate, rising 3.4% per year, over the next twenty years, compared with Pacific, Māori, and European population where increases are estimated to be 2.4, 1.3 and 0.4% per year respectively (SNZ, 2010b). If these predictions are realised, Asians would become major users of health, welfare and all other social services. In fact, a survey conducted in Auckland and Wellington, New Zealand (North, Lovell, & Trlin, 2006) showed that health care providers identified Asian as the fastest growing immigrant group in their services. This also has implications for the maternity care system in New Zealand.

Asians have not been shown to have low health status in New Zealand (Harris et al., 2006; NZMH, 2007a; Rasanathan, Ameratunga, & Tse, 2006). If anything, they are

healthier than Māori, Pacific Islanders, and Europeans perhaps due to the “healthy immigrant effect,” that is the higher health status of immigrants than that of native-born people at the time of arrival (McDonald & Kennedy, 2004, p. 1613; Rasanathan, Ameratunga, et al., 2006). However, factors not directly but significantly affecting the health status of Asian immigrants, such as unemployment and racism, are issues in New Zealand society (Liu et al., 2005; McGrath, Butcher, Pickering, & Smith, 2005; Palat, 1996; Rasanathan, Ameratunga, et al., 2006).

There are claims that Asians are highly dissatisfied with health services because of the negative attitudes of care providers, unfair treatment, and a lack of resources (Harris et al., 2006; McGrath et al., 2005). While government, institutions, and health providers hold up cultural safety in an effort to reduce racial discrimination, disparities and stereotyped attitudes remain deeply rooted in New Zealand society. Rasanathan, Ameratunga, et al. (2006) also point out that Asian health remains outside the frame of reference for the majority of health professionals in New Zealand. Furthermore, North et al. (2006) investigated the perceptions of health professionals working with immigrants in New Zealand and found that 65% of the respondents reported feeling considerable pressure when providing services for immigrants. In addition, the study revealed 58% of these health professionals felt that immigrants were the same as other patients, and 42% of them believed immigrants were different. The reasons for these results were unclear, but the value of this study is that it showed there was as much confusion about health services among professionals as among immigrants. The attitudes of care providers have a significant effect on access to health care for Asian people (Harris et al., 2006). For this reason, further work is needed in the area of cultural safety and consumers’ health satisfaction.

It is not clear if Asian women are experiencing the same levels of discrimination in the New Zealand maternity setting. In the Maternity Report of New Zealand (NZHIS, 2007), however, it was recorded that Asian women had the highest percentage of abnormal birth, 42.2% requiring medical assistance and interventions such as Caesarean section, forceps extraction and vacuum extraction. This was almost twice that of Māori (21.2%) and Pacific women (24.7%). The use of inductions, epidurals and episiotomy were excluded from the medical assistance rates, but these interventions among Asian women were also higher than other ethnic groups. For example, the percentages of

epidural use were 36.4% for Asian, 33.0% for European, 18.4% for Pacific and 14.8% for Māori women.

It might be understandable that Asian babies had the lowest average birth weight (3.24kg) because of the physical differences in body shape and weight between Asian and Māori, Pacific, or European women. For example, in 2004 the average birth weight in Japan was 3030g while that of New Zealand newborns was 3430g (Japan Ministry of Health, Labour and Welfare [JMHLW], 2010b; NZHIS, 2007). However, the highest proportion of full-term babies with low birth weight (under 2.5kg) of Asian descent does raise some questions (NZHIS, 2007). Some studies in other countries (Acevedo-Garcia, Soobader, & Berkman, 2005; Diani et al., 2003; Fuentes-Afflick, Hessel, & Pérez-Stable, 1998) have also indicated the relationship between foreign-born mothers and low birth weight babies, so this may be of concern despite differences in stature.

There were other unique characteristics of Asian women cited in the Maternity Report (NZHIS, 2007). For example, in common with European mothers, Asian women were far more likely to choose general practitioners or obstetricians as their LMC compared with Māori and Pacific women (respectively 14.3%, 14.0%, 5.0%, and 5.3%), but the reasons for this have not been identified (NZHIS, 2007). Investigating the reasons for the negative outcomes of Asian women and considering the best ways to care for these women are important issues, but clearly the issue is complex.

DeSouza (2005, 2006a, 2006b), a mental-health nurse born in East Africa from a family of Goan origin, has provided a useful discussion about Asian migrant motherhood in New Zealand. She interviewed seven Goan migrant mothers to explore “the dual transition of migration and motherhood” in Auckland (DeSouza, 2005, p. 87). In the study, the importance of traditional childbirth rituals and practices for Goan women, which had been lost prior to or on the way to New Zealand, meant that the loss of these rituals made it more difficult for the immigrants to form their identities. Another important concern was the separation from sources of support and knowledge. However, some Goan women had rationalised this loss by accepting the new choices they were given in a new country and replaced cultural taboos with more positive attitudes towards childbirth in New Zealand. Thus the Goan women tried to hold “parallel beliefs” by negotiating two cultural practices and made efforts to assimilate the

values of care in their adopted country while conflicts between the two cultures, and inadequate care and advice from health professionals, which did not meet their needs and beliefs, still remained an issue (DeSouza, 2005, p. 93). DeSouza (2005) claimed that it was not unusual for Goan women to work with more than two beliefs as Goa has a long colonial and urbanisation history. She also showed how Goan women developed new networks within New Zealand's structured support, such as play centres, and adjusted family roles, especially husbands' roles, to fit in their new circumstances and isolation from extended family and friends.

DeSouza (2006a) also reported on the experiences of Indian, Chinese, and Korean migrant mothers with a particular focus on the information and learning process about childbirth in Auckland, New Zealand. Additionally, in a joint research project DeSouza (2006b) conducted focus group interviews with a mix of forty European, Indian, Chinese, Korean, and Arab migrant mothers, with findings similar to the struggles identified in the previous two studies. Recommendations from the research included the development of migrant parenthood services, additional support for migrant mother and partners, suitable information for all migrant mothers, and language specific resources of both written materials and for use in antenatal classes.

Strengthening the cultural safety competence of the health and social service workforce was also suggested by DeSouza (2005, 2006a, 2006b). In her studies, the roles of nurses and health care professionals were addressed, but not self-employed midwives despite the fact that references to midwives often appeared in participants' narratives. Many other studies of immigrants' childbirth (Callister, 1995; Callister et al., 1999; Foss et al., 2004; Kartchner & Callister, 2003; Wiklund et al., 2000) are also discussed from nurses' or doctors' points of view probably because of the authors' educational background or the care system of their countries. In New Zealand, it is important that midwives' views and roles are reviewed due to the maternity care context in which midwives are the LMCs chosen by over 75% of women (NZMH, 2011).

Participants in DeSouza's (2005, 2006a, 2006b) studies lived in Auckland and were from three different Asian countries. Despite these limitations, she attempted to generalise this perspective as representative of migrant motherhood in New Zealand. Auckland is the biggest city in New Zealand, so foreign mothers in smaller cities may

have different perspectives due to fewer resources, and possibly less support from members of their same ethnic groups. Also, a recognition that Asian migrant mothers are from more diverse backgrounds is required.

The diversity among “Asian”

As mentioned above, the term “Asian” is too broad to grasp the reality of diversity of the childbirth experiences and issues concerning women from this region of the world. Asians originate from approximately fifty nations and comprise more than half of the world’s population (United Nations, 2009). In 1987, New Zealand introduced the skilled labour immigration criteria which attracted a new type of migrant (Ip & Pang, 2005). As a result, a significant shift in ethnic minorities occurred in New Zealand. Immigrants from British and West European nations were replaced by non-white peoples and a diverse Asian population which extended beyond the more common Asian categories of Chinese and Indian (Ip & Pang, 2005). In this context, the use of Asian as a single ethnic category is problematic especially in the health sectors because the “averaging” leads to inaccurate understandings and inappropriate policy measures for their needs with the potential to affect health outcomes (Rasanathan, Ameratunga, et al., 2006, p. 3; Rasanathan, Craig, & Perkins, 2006, p. 219). What is worse, it may result in people identified as Asian experiencing poor health.

Ethnicity is defined as a sense of belonging to “ancestry, place of origin, common language, religion, cultural practices and behaviours, and lifestyle” (SNZ, 2004, p. 7). However, Arisaka (2000, p. 2) claims amongst Asian people and countries, “there is little unity; the only thing which brings any of these cultural traditions together is the fact that they are located in certain parts of the Earth.” Each Asian country has an independent and unique character. Therefore, grassroots studies of specific ethnic groups could enhance understandings of immigrants’ childbirth experiences. It has also been shown that there are different issues and birth outcomes among Asian subgroups (Fuentes-Afflick & Hessol, 1997; Singh & Yu, 1994). This suggests that it is important to realise these differences; thus the focus of this study is to explore how Japanese women experience childbirth in New Zealand.

Japanese childbirth in New Zealand

Japanese in New Zealand and Dunedin

After the Second World War, Japan became a leading trading partner of New Zealand, and the relationship between the two countries became stronger and more stable (Copland, 2009; New Zealand Ministry of Foreign Affairs and Trade, 2010). In addition to economic cooperation, human and cultural exchanges have been very active between the two countries in recent years (Goff, 2000; Peren, 1999). This corresponds with the statistics that show the number of Japanese visitors to New Zealand has been consistently ranked fourth following that of Australia, the United Kingdom and the United States (SNZ, 2010a). Furthermore, the bilateral working holiday scheme established in 1985 and other exchange programmes encouraged young Japanese to visit New Zealand. A number of Japanese have also come as students, and at one time Japanese comprised more than half of all students enrolled in English-language schools (Copland, 2009).

There are considerably more Japanese women than men living in New Zealand (SNZ, 2007b), and there are two potential explanations for this. First, the au pair programme attracted many Japanese women (Copland, 2009). Secondly, Japanese women who came to New Zealand as students and participants of exchange programmes frequently began relationships with New Zealand men and did not return home. Similarly, the New Zealand men, who married Japanese women through these exchange programmes and other work, also brought Japanese women to New Zealand (Boswell, 1995; Elliott & Elliott, 2003; Nishikawa, 2006). Alongside these programmes, Japanese immigration has dramatically increased over recent decades as a result of the change in immigration policies. Even after immigrants from other Asian regions started declining because of the Asian economic crisis and the introduction of English language requirements to the immigration criteria, the number of Japanese immigrants continued to increase (Nishikawa, 2006; K. Tanaka, 1999).

Only 47 Japanese residents were in New Zealand in 1951, but the population increased more than three times in the decade 1991-2001 (from 2,970 to 10,002 residents) (Copland, 2009; SNZ, 2002). According to Ministry of Foreign Affairs of Japan (2010), the number of registered Japanese in New Zealand reached 13,569 in 2010. Despite these trends, there are very few studies about the experiences of Japanese immigrants in

New Zealand. One exception is K. Tanaka's (1999) study which described characteristics of Japanese immigrants as "young" and "new" (p. 87). For instance, the median age of the Japanese group is 26.3 years old compared with 43.8 years old for that of the Dutch group (SNZ, 2002). Half of the Japanese population are in their twenties and thirties while 56% of the Dutch population are over forty years old. Therefore, most of the Japanese are first generation New Zealanders, which makes their presence different from other ethnic groups, such as the Dutch and Chinese, who have a long history in New Zealand.

Dunedin, once New Zealand's largest city, is the second largest city in the South Island with 118,683 people (SNZ, 2009b). Dunedin is a centre of tertiary education and research especially in medicine and science (McKinnon, 2010), and it holds the highest proportion of people with a post-school qualification in New Zealand (SNZ, 2009a). Twenty percent of the population are identified as students of University of Otago (University of Otago, n.d.), and the total number of people directly involved with education such as academics, researchers and students of all tertiary schools makes up a considerable proportion of the Dunedin population. Moreover, the increasing number of students and academic staff from overseas creates more diversity to the population (McKinnon, 2010).

According to the 2006 census (SNZ, 2007a), Dunedin has the fourth largest Japanese population in New Zealand with 381 long-term residents following 2784 in Auckland, 2208 in Christchurch, and 621 in Wellington. The Otago region, from where some women of childbearing age are likely to utilise the maternity services of Dunedin hospital, has 888 Japanese residents in total. However, this number does not take into account the students and temporary workers in Dunedin despite the obvious importance of these groups to this largely academic city. In fact, I am also a student with a temporary visa and have experienced giving birth in Dunedin.

Studies of Japanese childbirth in Western cultures

There have been some studies about Japanese women's childbirth experience in the United States (Ito & Sharts-Hopko, 2002; Taniguchi & Baruffi, 2007; Yeo, Fetters, & Maeda, 2000) and the United Kingdom (Yoshida et al., 1997; Yoshida, Yamashita, Ueda, & Tashiro, 2001). However, most of these studies focus on postnatal depression

and only a few of the American studies (Ito & Sharts-Hopko, 2002; Yeo et al., 2000) report on Japanese women's experiences of childbirth itself.

Yeo et al. (2000) interviewed five Japanese women and mainly discussed the struggles of Japanese couples within the American maternity care systems. Ito and Sharts-Hopko's (2002) study of eleven Japanese couples in the United States emphasised the importance of maintaining cultural practices related to childbirth and the need for ethnic-specific support systems. Both of these studies emphasised the language difficulties Japanese women experienced throughout childbirth care.

Sharts-Hopko (1995) reported the experiences of twenty American women who gave birth in Japan. Her study provided a useful point of view regarding Japanese birth context which was observed and experienced by Western people, and showed some system and cultural differences of maternity customs and care between the two countries. Engel (1989) also reported on the Japanese birth context based on her own experience, interviews with Japanese health care providers and Ministry of Health and Welfare officials, and visits to birth facilities. She described Japanese values, practices, and social structure related to childbirth in contrast with the American perspective. Some of the Japanese values and practices in her study are outdated because it was published more than two decades ago. Nevertheless, the distinctions between American and Japanese values, attitudes, and behaviours remain interesting and useful.

Japanese childbirth in New Zealand

New Zealand is recognised as a Western, developed, and culturally diverse country similar to the United States and the United Kingdom, so it is possible that the birth experiences of Japanese women in New Zealand could be similar. However, along with some European countries, New Zealand childbirth is described as a midwifery model compared to the medicalised birth or medical model of North America (Crabtree, 2002; Davis-Floyd, Barclay, Daviss, & Tritten, 2009; Davis-Floyd & Sargent, 1997; Jordan, 1980; Kornelsen, 2003; Page, 2001). This philosophical difference is supported by the unique LMC model of care described in chapter one.

Moreover, the social, political, historical, and cultural contexts are different between countries, creating culturally unique maternity care systems. For instance, all Japanese

couples in the study conducted by Yeo et al. (2000) in the United States had maternity care from a team of staff fluent in Japanese and knowledgeable about Japanese culture. In the case of the England study (Yoshida et al., 1997), 68% of Japanese women were cared for by either Japanese midwives or Japanese obstetric coordinators. Hospitals, clinics, and perinatal facilities where Japanese staff provide health services for Japanese people have become common in North America, Europe, Australia, and some Asian countries (Bangkok Hospital, 2010; Hospita.jp world, 2007; London Iryo Centre, 2010; SMS, 2010).

In comparison, according to MCNZ (personal communication, August 25, 2010), only two midwives in the North Island of New Zealand self-identify one of their ethnicities as Japanese (they are allowed to choose a maximum of three). However, no information about them could be obtained through the Embassy of Japan in New Zealand (personal communication, August 31, 2010), Japanese Society of Auckland, which is the biggest Japanese community in New Zealand (personal communication, August 31, 2010), or at nzdaisuki.com, which is the most popular website among Japanese immigrants in New Zealand containing a notice board and a mass of information about New Zealand life for Japanese (personal communication, August 30, 2010)³. Furthermore, no data is available about Japanese obstetricians and general practitioners providing maternity care from either government agencies or the professional organizations (NZMH, personal communication, August 27, 2010; Royal Australian and New Zealand College of Obstetricians and Gynaecologists, personal communication, August 25, 2010; Royal New Zealand College of General Practitioners, personal communication, August 26, 2010). Even if there were any, the number would be very small as only ten doctors identify as Japanese; six of whom have a primary qualification from Japan (Medical Council of New Zealand, personal communication, September 2, 2010). In addition, none are practicing in perinatal care in Dunedin (Southern District Health Board, personal communication, September 21, 2010). This suggests that Japanese women are unlikely to be able to request care from a Japanese midwife or doctor in New Zealand.

³ Later, it was found out through the midwife community in Japan that the two Japanese midwives working in the North Island had already left New Zealand.

After an extensive search in several literature databases, such as university library catalogues and Google Scholar, no research has been found regarding Japanese women's experience and circumstances in New Zealand maternity settings. Thanks to the spread of the Internet, we can read some parts of Japanese women's childbirth experiences in New Zealand through their blogs. However, while the information in the personal diaries is extremely useful for some Japanese women in New Zealand, it is rarely accessed by maternity care providers who do not read Japanese. Also, there is limited literature about Japanese childbirth culture, customs, and contexts in the English language (Behruzi et al., 2010; Fiedler, 1996; Matsuoka & Hinokuma, 2009; Yanagisawa, 2009). For this reason, exploring Japanese childbirth experiences in New Zealand would be meaningful for all care providers and those supporting Japanese women as well as Japanese women who birth in New Zealand in the future.

Summary

In summary, the significance of culture which has a strong influence on the perspectives and beliefs of childbirth experiences for women on childbirth has been reviewed. The studies have found that challenges and conflicts arise when childbirth takes place in a foreign environment. In New Zealand, a concept of cultural safety is well developed and integrated in the health setting due to the specific historical context. Nevertheless, inequalities among ethnic minorities have been maintained and this has a risk of impacting negatively on people's well-being. It is not clear whether such discrimination is happening in the maternity setting, but negative outcomes of childbirth among Asian women have been reported. A first step would be to explore Asian women's childbirth experiences so that some of these cultural and health issues can be addressed.

Problematic, however, is the use of the "Asian" category which tends to ignore the rich historical, political and cultural origins and differences between the countries included in this generalised term. There are several studies which explore the childbirth experiences of immigrants and Japanese women in some countries. In New Zealand, however, few studies were found, and none for Japanese women. Given that the population of Japanese women in New Zealand has increased significantly in recent years, it is timely to explore the birth experiences of Japanese women within the New Zealand context from the perspective of Japanese women themselves.

Chapter Three: Study design

Introduction

This chapter addresses the methodological framework used to explore Japanese women's birth experience in New Zealand. First, I discuss the qualitative approach used for this study and highlight the ability of qualitative description to give voice to the women's understanding of their lives and experiences in New Zealand. Secondly, I further explore the philosophical approach of this qualitative descriptive study with particular attention given to the implications of the researcher's personal position as a Japanese mother and midwife. Thirdly, I outline the methods and data collection process used to gather the information and describe how the information was analysed using thematic analysis. The chapter concludes by addressing the ethical and cultural concerns of this study, especially the implication for the Māori.

Methodology

Qualitative research

Recent literature in health services (Holloway & Wheeler, 2010; Neergaard, Olesen, Andersen, & Sondergaard, 2009) has suggested that qualitative research enables us to deepen our understanding of people's perception and experience. For example, Yatsu (2008, 2010) indicates that uncovering and describing the experience of a minority group in a health care environment is a critical strength of qualitative research. On the other hand, the validity of qualitative research is often questioned in a world dominated by scientific research as generalisation and replicating the findings are not achievable (Denzin & Lincoln, 1994; Sandelowski, 1986). However, it is maintained that qualitative research can address these limitations by detailing the structure of the events or phenomena studied and also specifying the research process used to achieve that understanding (Saijyo, 2008, 2009; Sandelowski, 1986). Saijyo (2008, 2009) adds that when health professionals try to understand the people or phenomena in their own contexts, qualitative research allows them to relate to existing literature that may fit their case based on the similarity of the situation or participants involved. Hence, it is expected that the results of qualitative research are applicable to people, research or cases outside of the immediate research context. While the first aim of this study is not

to generalise the women's experiences, this qualitative study has the potential to contribute these understandings to Japanese women who will give birth in New Zealand in the future, other women in similar situations, and their care providers.

Qualitative description

This study has been undertaken and informed using the qualitative description process described by Sandelowski (2000). Qualitative description has been criticised for its simplicity and lack of rigour (Neergaard et al., 2009; Sandelowski, 2000). However, there are neither superior nor inferior research methods, and which method is the most suitable to the research question is what matters most (Sandelowski, 2000). Braun and Clarke (2006), and Sandelowski (2000) point out, nevertheless, that research methods with so-called brand names have often ended up being legitimating titles without considering how or if these methods influenced the outcomes of the study.

This study aims to richly describe Japanese women's experience, but to neither write thick description, develop theory, nor interpret the meaning of an experience (Neergaard et al., 2009). As qualitative description does not move far from or into the data, this study also stays close to the women's voices, and the themes are driven by the data without adhering to a certain theory (Sandelowski, 2000). However, it does not mean that this approach has no interpretation at all (Sandelowski, 2010). Of particular importance to this study is the idea of reading *gyōkan* - between the lines - which is inevitable for Japanese who value the unexpressed parts of the communication (Kenmochi, 1992). Qualitative description entails "data-near" interpretation, but does not go "deeper", read "into" the data more than necessary, or go "over" or "beyond" the data as much as phenomenology or grounded theory (Sandelowski, 2000, p. 336; 2010, p. 78). In all cases, there is no complete objectivity, and the researcher's backgrounds, values, perceptions, inclinations, sensitivities, and sensibilities - the so-called epistemology - are always reflected in the descriptions (Holloway & Wheeler, 2010; Saijyo, 2007, 2009; Sandelowski, 2000, 2010).

Neergaard et al. (2009) state that qualitative description has no theoretical underpinning, allowing the researcher to stay close to the data. However, it should be noted that Sandelowski (2000, 2010) asserts that qualitative description has the least theoretical or philosophical orientation, but not none. If anything, it tends to be naturalism or a

naturalistic inquiry because it allows the phenomenon to present itself (Sandelowski, 2000, 2010). Sandelowski (2010, p. 79) argues that there are no “naked” studies, and Saijyo (2009) also emphasises that every methodology is based on some worldview or epistemology. T. A. Doering (2007) indicates that before understanding research methods one must understand the methodology, which is always informed by the theoretical perspective of the research, and their ontological stance and epistemological position. Therefore, it is important to become conscious of and to demonstrate one’s own way of understanding the world in an effort to engage closely and critically with different perspective holders (Saijyo, 2009). Again, as long as there are no pure eyes and “every word is a theory,” the researchers’ interest in their subjects and their personal worldviews theoretically or philosophically influences the analysis and the operation of the research even if the study does not have an explicit theory (Sandelowski, 2010, p. 79). Hence, the researcher must deal with their qualitative data carefully in such a research approach.

My position in this study

In connection to the researchers’ epistemology as discussed previously, I am concerned with my position in this study while I am less concerned about the epistemological position or ontological stance such as constructionist or relativism. Norimatsu (2005) argues that the impact of the researcher’s characteristic and cultural background on the study should never be underestimated. Also, recent literature (DeSouza, 2004; Pelias, 2011) suggests that it is critical to consider the writers’ own experience and culture in their writing because writing or research is such an evocative, reflexive and embodied work subjectively engaged with by the writer.

First, I am a researcher of this midwifery study. As a midwife, I naturally think in terms of “the nature of midwifery” and “the way midwives know the world” in common with other midwives (Skinner, 2005, p. 52). Yet, I have not practiced as a midwife in New Zealand. At the same time, I had my second baby, and am having my third one in New Zealand during this study. I also had my first one in Canada, and the experience inspired me to conduct this study. As a result of these experiences, I may have more of a connection with the women in the study rather than with the midwives in New Zealand.

This connection may impact the study. Through her cultural analysis of childrearing, Norimatsu (2005), a Japanese researcher, found that Japanese mothers did not dare talk to her about Japanese culture and childbearing because her Japanese cultural knowledge was simply assumed, rather, they talked openly of their individual experiences and personal agonies. On the other hand, mothers from other cultures discussed their cultural ways or views rather than individual issues. Therefore, even if I feel my position as a midwife stronger than as a Japanese mother, there is great possibility that the participants expect me to understand them as a Japanese mother and not just a midwife. Another implication of my position as a Japanese mother is that the women can express their experiences and feelings in their own Japanese language.

Equally important to this study is that as a Japanese researcher, I have a culturally different perspective from New Zealanders or Westerners. As Liu (2011) points out, Asian scholars have unique epistemologies and philosophies, which are historically, religiously and socially distinct from Western ones. I was born and raised in a Japanese family in Japan and spent the most part of my life there. I have never doubted my identity as Japanese in many aspects of my life, including my way of thinking. At the same time, it is a challenge for me to write this study in English not only because of the skill and knowledge required, but also because the linguistic difference influences the fundamental structure of the way of thinking and living (Hashimoto, 2009; Tachibana, 2009). All the philosophy and design of modern scientific research, even Japanese studies, is informed by ideas from the West, and I always wonder if such theories fit with Japanese studies. Therefore, selecting and examining the ideas carefully, and adjusting different ways of thinking are also important tasks in this study.

On the other hand, applying Western viewpoints or an outsider perspective to this study may provide me with an opportunity to reconsider many understandings taken for granted as Japanese. The dominance of the Western paradigm has been criticised in recent literature (DeSouza, 2004; Liu, 2011). However, I take the opportunity to conduct this study with Western knowledge as a positive process. I make no claims of being an insider of this study as a Japanese mother, but at the same time I believe that the fact this study was conducted in Western academia made it different from and hopefully more inclusive of alternate views than if I had conducted the same study in

Japan. Hence, I intend to be conscious of outsider views as well because I obviously have insider and emic views in this study.

Methods

Data collection

The data collection methods for this qualitative descriptive study consist of two parts. First, individual interviews were planned because it was expected that Japanese women's experience could be understood through their own personal narratives. Hearing their voices would be a women-centred way to seek their perspective about their lives and experiences of the health and maternity system (Holloway & Fulbrook, 2001). This enabled me to investigate the women's concerns or issues regarding their birth in New Zealand by listening to their free conversation of their birth experiences at each interview. Sandelowski (2000) also suggests that open-ended individual and/or focus group interviews, which are minimally or moderately structured, are useful techniques for data collection of qualitative descriptive studies. Building on the interview findings, the issues raised were confirmed and discussed in detail with the women in a subsequent focus group. By using these two processes of data collection, the trustworthiness of the data and the findings were expected to be more robust (Holloway & Wheeler, 2010).

Individual interview

Individual interviews were expected to allow the women to talk freely without feeling hesitant in the presence of others, and to explore their experiences and potential ideas without preconceived opinions. Therefore, the interviews were unstructured, open-ended, and endeavoured to follow the woman's lead (Holloway & Wheeler, 2010). The face-to-face interview also provided an opportunity to sense emotions and interpret non-verbal communication (Cluett & Bluff, 2006; Rees, 2003).

To recruit participants, permission was sought from the members of a Japanese community group *Tamariki* based in Dunedin to display an advertisement (Appendix B) about this study. The candidates for the study were limited to Japanese women who gave birth in New Zealand within the last three years at the point of the recruitment. This was to obtain both relatively new information and a reasonable number of the

participants. It was hoped that approximately 10 women would agree to participate in the interviews to secure an appropriate amount of the data within the limited time frame of this study. Finally, nine women who gave birth in Dunedin after 2008 responded by a “snowball” effect among the members. Each received an information sheet and agreed to sign a consent form (Appendix C & D).

The interviews were held in August and September 2010. The length of the interviews ranged between 50 minutes and 1 hour 40 minutes. The conversations were digitally recorded, and the researcher also took notes during the interviews. The recorded data from the interviews were transcribed by the researcher in order to become immersed in the data as an ongoing process. The transcriptions were then analysed using thematic analysis, which is discussed later in this chapter.

Focus group

Following the individual interviews and analysis, a focus group was conducted to confirm and obtain more details of the findings of the interviews. It is suggested that focus groups help restructure individual ideas, and guarantee the quality and validity of the data because participants revise incorrect or excessive views through their collective negotiation (Patton, 1990; Uwe, 2009). At the same time, Anme (2001) has suggested that focus groups can open up new ideas through this mutual effect. In order to obtain these advantages, power imbalances between the participants should be minimised (McIntosh, 2007).

Focus groups also require a small number of people for each group to allow an opportunity for each individual to present and exchange ideas with others (Holloway & Wheeler, 2010). To maintain a comfortable and productive group dynamic, the facilitator needs to ensure a comfortable environment in order to promote the smooth flow of the discussion, with appropriate encouragement, balance and consideration for each individual within the group (Anme, 2001).

The participants of the focus group for this study were recruited from the members of the same Japanese community group using the advertising process. Four women, who had not participated in the individual interviews, were invited to participate in the focus group. This was held in December 2011 for 1 hour 30 minutes. The discussions of the

focus group were developed mainly from the topics which surfaced in the initial analysis of the interview data, but there was also the opportunity for the participants to discuss other topics or issues. The digitally recorded data from the focus group was transcribed by the researcher and analysed using thematic analysis.

Thematic analysis

Sandelowski (2000) introduces qualitative content analysis as a method of data analysis for qualitative description. Content analysis is based on a coding system regardless of whether the data is qualitative or quantitative (Sandelowski, 2000). The information is summarised by counting the frequency of the code or the numbers of participants in each code (Morgan, 1993; Sandelowski, 2000). However, for this study I sought out other analytical processes that aligned more sympathetically with this study. Specifically, this study required a method which would enable me to respond to the women's personal voices regardless of the number of times that opinion or view was stated. Thematic analysis allowed me to achieve this.

Thematic analysis is flexible and can be applied to a wide range of qualitative research as it does not possess or require a particular theoretical or epistemological base such as grounded theory (Braun & Clarke, 2006). According to Braun and Clarke (2006), thematic analysis consists of collecting information and then organising the data into appropriate themes for further discussion. Like qualitative description, thematic analysis is not a brand name of data analysis, and because of this it is often seen as an inferior method. However, although it is rarely acknowledged, the process of gathering information and organising it into themes is a widely used strategy in most qualitative studies (Braun & Clarke, 2006).

This loose form of thematic analysis was reworked by Braun and Clarke (2006) to provide a concrete guideline thus adding rigour to the process. They argue that thematic analysis is a fundamental method to simply organise and describe the data, and search for themes or patterns following reading and re-reading of the transcriptions and generating initial codes. Therefore, it enabled me to stay close to the data and maintain a qualitative descriptive approach to this study. It also allowed me to identify the explicit meanings of the data through an inductive data-driven approach, and provide both a rich

thematic description and a detailed account of one particular theme (Braun & Clarke, 2006).

The presentation of the findings

The themes generated from the data are detailed and supported in the following chapters by direct quotations of the transcripts. The findings of the interviews are presented in Chapter Four and those of the focus group are presented in Chapter Five. The individual women's comments in the interviews are numbered thus "I/#." The numbers match the numbers of the women in tables 1 and 2 in Chapter Four. The women of the focus group are identified thus "F/#," and the numbers match the numbers of the women in tables 4 and 5 in Chapter Five. The number zero (F/0) represents a statement by the interviewer/researcher.

The interviews and the focus group were held in Japanese, so the quotations of the women's words were translated into English by the researcher. Due to the characteristics of Japanese, many subjects and objects in the sentences were missing, and there were Japanese metaphorical expressions and implicit words in the women's talk. The translation closely followed the originals, but some words were inserted into the translations to enable the reader to understand what was intended. Where text has been omitted, the suspension points are represented thus "... ."

Ethical concerns and process

Ethical issues for this study were carefully considered when writing the research proposal. This included how to handle and store information and data, issues of anonymity and confidentiality, and any potential harm for the participants involved. These ethical concerns were reviewed and approval given to undertake this study by the Otago Polytechnic Research Ethics Committee (Appendix A).

Treaty of Waitangi and acknowledgement of Māori knowledge

The implication of this study for the Māori of New Zealand was also considered during the process of ethical approval. I have lived in New Zealand for three years, so I am still in the early stages of learning about New Zealand society, politics and culture.

However, I have become aware of Māori knowledge and concerns through my previous study regarding cultural safety in New Zealand. I recognise that the Treaty of Waitangi is the founding document for New Zealand's national identity as a bicultural country within which both partners have participation, protection, equity, equality and many other shared values. Also, the principles of the Treaty of Waitangi are acknowledged as the basis of the New Zealand social framework. For instance, the partnership between women and midwives, which is a core philosophy of New Zealand midwifery, originated in the principle of partnership inherent in the Treaty of Waitangi (Guilliland & Pairman, 1995).

Previously, I have worked in Tanzania and Indonesia as a midwife. Each time, respecting the local culture and customs was the priority for my practice even if I thought that the choices people made put their health in danger. Moreover, we, as outsiders, were able to foster a positive working relationship with the community once we accepted their values and customs. I am living in New Zealand now, but I believe that my personal identity always belongs to Japan, and that has led me to undertake this research. My experiences overseas has taught me that if I want people to respect my life choices in another culture, I have to first understand the structures and rules of their society, and to respect their culture as much as I love and respect my own. It is in this spirit of cultural sensitivity that this study was undertaken.

The idea of cultural sensitivity has made me consider the significant role of the Māori in shaping the birth experiences for everyone in New Zealand. In particular, the concept of cultural safety that originated from Māori cultural issues has brought women of all ethnicities, including Japanese women, a way to discuss their own cultural concerns. Likewise, this study also has the potential to affect Māori and the local community directly and/or indirectly even though Māori women are not involved in this study. The recognition of these mutual impacts between Māori and others might help this study respectfully contribute to and share with the New Zealand society.

Summary

A qualitative research approach was considered to be the most appropriate way to accomplish the aims of this study. This chapter began by discussing the methodology of

qualitative description used as the fundamental framework for this study. Further, I considered my position in this study as a researcher, a midwife, and a mother who shares similar experiences to the participants, and how my Japanese worldview informed the study. I then described the research design which consisted of individual interviews and a subsequent focus group with a group of Japanese mothers in Dunedin as the primary means of data collection. Next, the process of thematic analysis was outlined for the data analysis. Ethical concerns were also considered as they are an important component of this study. Lastly, I acknowledged the Treaty of Waitangi and any potential impact this study might have for Māori. In the following chapter, I begin the presentation of the results from the individual interviews.

Chapter Four: Interview results

Introduction

The results of the interviews with nine Japanese women are discussed in this chapter. First, the women's backgrounds and birth information are presented as these could possibly affect the women's impressions, choices and actions towards childbirth. Secondly, the themes that emerged from the interviews are presented. In the interviews, the women talked about their birth experiences from pregnancy to the postnatal period. This data was transcribed and analysed using thematic analysis. Four themes composed of several sub-themes and their properties are described. These are 1) understanding the New Zealand maternity care system, 2) keeping Japanese customs, 3) experiencing childbirth in another country, and 4) dealing with the cultural differences. In this chapter, each theme is interpreted and discussed using excerpts from the women's transcripts.

Participants' profile

Participants' backgrounds

Nine women participated in the individual interviews. The age of the women ranged from 32 to 42 years of age with an average age of 37.1 years old. Three women came to New Zealand through the working holiday scheme, and another three came to study at schools. Two women met their partners in Japan and later moved to New Zealand with their husbands. The remaining woman came for a prearranged job. Seven of the nine women had married New Zealanders, and two had Japanese husbands, both of whom they met in New Zealand.

The length of the time since they arrived in New Zealand was between 2 and 11 years, with an average of 8 years and 9 months. Apart from the one woman who had lived in New Zealand for 2 years, the others had lived in New Zealand for over five years. Therefore, they were not new to New Zealand, which may be a trend specific to Dunedin. The women came to Dunedin for education when they were young and before they had children, or they arrived in Dunedin after travelling or living in other cities in New Zealand. In addition, they all had permanent New Zealand residency.

Table 1: Backgrounds of the interview participants

| | Age at interviews | Husbands | Reasons to come to NZ | The length of NZ residence |
|----------|--------------------------|-----------------|------------------------------|-----------------------------------|
| 1 | 37 | NZ | Working holiday | 11y7m |
| 2 | 32 | JP | Study | 10y0m |
| 3 | 42 | NZ | Study | 8y0m |
| 4 | 35 | NZ | Working holiday | 5y3m |
| 5 | 40 | JP | Working holiday | 11y7m |
| 6 | 42 | NZ | Followed husband | 2y3m |
| 7 | 35 | NZ | Study | 11y1m |
| 8 | 33 | NZ | Work | 6y11m |
| 9 | 38 | NZ | Followed husband | 12y3m |

Note: NZ stands for New Zealand or New Zealander, and JP stands for Japan or Japanese.

Their educational backgrounds also vary. One woman's last education was at a high school, while others continued their academic learning in universities or colleges in Japan. Seven women enrolled in New Zealand schools, with six of these women attending English language schools. Six of the women studied at universities, with one woman obtaining a PhD degree, in New Zealand.

Six of the women had worked in New Zealand. They held various jobs including a translator, a caregiver, a university tutor, a university demonstrator, a research assistant, and a tour guide. They had also had experience of working in hotels, cafes, and Japanese restaurants. The other two women who came to New Zealand following their New Zealand husbands had not worked in New Zealand. One woman did not have work experience either in Japan or in New Zealand. Three had worked as nurses in Japan, one of whom continued her nursing career in New Zealand. It is possible that their experience and knowledge as health professionals influenced their birth choices. In fact, two out of three women who chose an obstetrician as their LMC were nurses though the reason for this relationship is not clear. At the time of the interviews, one woman was working as a part-time nurse, but none of the other women were employed. The primary reason was so that they could take care of their small children, and a few women stopped working during their pregnancies because of concerns with work conditions.

It was difficult to assess the women's English ability fairly, but it was obvious that their English skills were adequate from their educational background and history of work experience in New Zealand. Each woman estimated that their fluency in English was

sufficient to manage daily life, but a few mentioned that they sometimes felt stressed when communicating in English.

Participants' birth information

All the participants gave birth within the last three years (2008-2010) of the date of the interviews, and were all over 30 years of age at their last births. Six of the women were over 35 and two women were over 40 years old. This age demographic may be because of their high educational backgrounds, work experience and the act of moving to New Zealand from Japan. Also, national statistics show trends of late childbearing in both New Zealand and Japan (JMHLW, 2010b; SNZ, n.d.). Five of the women had one child and four women had from two to four children. All their children were born in New Zealand, so none of the women had experienced birth in Japan.

Table 2: Birth information of the interview participants (latest birth)

| | No. of children | Age at the last birth | LMC | Interventions and type of birth (former birth) |
|---|-----------------|-----------------------|---------------------------|--|
| 1 | 1 | 36 | Midwife | Normal vaginal birth |
| 2 | 4 | 30 | Midwife | Entonox ⁴ (1 st birth: epidural, 2 nd & 3 rd birth: Entonox) |
| 3 | 1 | 40 | Obstetrician | Induction, Caesarean section |
| 4 | 1 | 33 | Midwife | Ventouse (tried Entonox) |
| 5 | 2 | 37 | Midwife | Emergency Caesarean section (1 st birth: Caesarean section) |
| 6 | 1 | 41 | Obstetrician | Induction, nitrous oxide, epidural, forceps birth |
| 7 | 2 | 35 | Midwife | Entonox (1 st birth: induction) |
| 8 | 1 | 31 | Midwife | Entonox, epidural, Caesarean section |
| 9 | 2 | 37 | Midwife with Obstetrician | Entonox (1 st birth: epidural) |

A midwife LMC was chosen by six of the women, while two chose an obstetrician. The other woman shared care with a midwife LMC and an obstetrician. She would have preferred the obstetrician as her LMC as she had done with her first birth but this was not possible as the obstetrician was no longer offering LMC services.

⁴ A gas mixture of nitrous oxide (50%) and oxygen (50%) used to ease labour pain by breathing in through a mouthpiece or a facemask (Medsafe, 2011; NZCOM, 2010). It is also called laughing gas. Entonox is a trade name, but this name will be used throughout this thesis except for the statements of the participants because this is the name of the drug which is used in New Zealand for the purpose.

All the women chose the hospital as a place to have their babies. In Dunedin, the hospital and homebirth are the only birth options; there are no primary birthing units. Six women gave birth vaginally and the other three women had non-elective Caesarean sections for their latest births. Interventions experienced by the women who had vaginal births included the use of Entonox and epidurals for pain relief, induction of labour, a vacuum extraction and a forceps delivery. Only one woman did not receive any medication or medical intervention during her birth.

Overview of the themes

After analysing the interview data, four major themes emerged: understanding the New Zealand maternity care system, keeping Japanese customs, experiencing childbirth in another country, and dealing with the cultural differences. Each theme is composed of sub-themes with further topics (Table 3).

Table 3: Themes and topics emerging in the interviews

| Major themes | Sub-themes | Topics discussed |
|--|--|---|
| 1. Understanding the New Zealand maternity care system | Accessing the care system | - Knowing the system - Looking for a LMC |
| | Perspectives on the midwifery care | - Having midwives as primary carers - The quality of the midwifery care |
| | Birth in New Zealand compared to Japan | - Ultrasound - The use of Entonox and epidurals - Birth outcomes - Having a shower after birth - Hospitalisation - Attitudes of carers |
| 2. Keeping Japanese customs | Ceremonies/rituals | |
| | Keeping umbilical cords | |
| | How to take care of women's bodies after birth | - Longer rest after birth - Avoiding the coldness - Differences in body characteristics |
| | How to take care of babies | - Bonding with babies following birth - Taking babies out - Japanese style baby clothes |
| 3. Experiencing childbirth in another country | Language and communication | - Written materials for childbearing - English language matters - The way of communication |
| | Support | - Support from the husbands - Support from Japanese mothers and community in Dunedin - Support from the women's mothers |
| 4. Dealing with the cultural differences | | |

Theme 1: Understanding the New Zealand maternity care system

While going through their pregnancy and birth experiences, the women came across many differences in terms of the maternity care and system from their knowledge or expectations shaped in Japan. What follows is a discussion of aspects of the system and care they were happy with or struggled with as told in their own words.

Accessing the care system

Knowing the system

First of all, the women had to know how to access the maternity care services in New Zealand. If they had been pregnant in Japan, they would have at least known where they needed to go from the knowledge naturally received from family, friends, and the media. However, most did not have any idea about the New Zealand maternity system or were unclear about it at the time of their pregnancy. In fact, they did not know that for health care generally they would have to register with a general practitioner (GP)⁵.

I did not know anything [about the maternity care system]. I wondered if I would be okay, and of course I was anxious because it was the first pregnant... I did not have any Japanese acquaintances at that time. If I had had any, I could have asked [about the system], but I had none... GP as well. I hadn't had a GP until my midwife introduced me to one. I did not even know the system of GP. I completely had no idea. (I/2)

This unfamiliarity of the New Zealand medical and maternity system affected the women even later. One of the women could not figure out where or whom she could talk to about her poor health during her pregnancy and postnatal period.

I wondered who I should talk to about my health. The check-ups were once a month at the beginning, weren't they? The specialist (obstetrician) looked busy. I think I could have contacted her, but I was reserved because I am Japanese. So I was confused about whom else I could have asked... If I had been in Japan and had gone to hospitals, there would have been someone to help me. I did not know

⁵ There are no GPs in Japan. With regard to the medical and maternity care system in Japan, please refer to Discussion 1 in Chapter Six.

[about that here], indeed... I didn't have anyone [who could help me]. I think I had not understood the system here, maybe. As I had been healthy, I had seldom seen the GP... I did not have any idea about those systems at all. So I just let myself be unwell. My husband was busy and not at home, so there was no one.
(I/9)

Looking for a LMC

After they discovered the New Zealand maternity care system, the first thing they came across was the unique LMC system. So, the first problem the women faced was how to find and choose a LMC.

I wondered how to find a LMC. I asked someone who was pregnant, and she told me to get a list from the hospital and call midwives by myself. But I wondered how I could know who was good for me only with names and phone numbers. Of course, I assumed every midwife is good. But I had no idea, so anyway I called the hospital again. Then I said that I did not know the system here and who was good, and asked them to recommend some midwives for me... You know, it is a relationship between a person and a person, so how can I decide only with paper?... I called a few midwives, but they said, "I am busy now, so I will call you back." A few never called me back. I was shocked... Finally, I could see only one midwife and she became my LMC. I could not see another midwife due to schedule conflicts or something. Two other midwives did not call me back. It is a matter of a relationship of mutual trust, isn't it? So I counted them out [from being my LMC] because that [irresponsible correspondence] might endanger my and my baby's life later... So as the system, there should be something more like a service or a person who to talk to because midwives are busy for sure. Maternity services are free here, so it might be difficult but something... Otherwise, I wonder how other people do it. Especially for foreigners, there might be something, the city council might have something, but I had to start from nothing. I had a good midwife fortunately, but there should be someone in charge of the service giving information about the system and midwives, introducing us suitable midwives, and so on. If there was something like that, it might have been much easier for me.
(I/8)

Anyhow, I decided to choose a name easy to call [for my LMC]. There was Anna (pseudonym) on the list. I thought Anna sounded easy to call somehow and chose at random. Then she said she had a long career and she was middle-aged. So, I thought she might be okay. (I/7)

Perspectives on the midwifery care

Having midwives as primary carers

Along with the LMC system, receiving care or services from midwives instead of doctors was another crucial matter for the women because obstetricians are commonly considered as the primary care providers for childbirth currently in Japan⁶. Generally, the women made a passive choice and chose a midwife because it was the common birthing practice in New Zealand. In contrast, however, one woman actively chose a midwife by recognising midwives as the professionals for childbirth. At the same time, there were those who strongly disagreed with the maternity care system and chose an obstetrician for their LMC.

I had roughly heard that midwives provide care, but [having babies] with only midwives is unthinkable in Japan. So I didn't want to do that and chose a specialist... It is probably because it's cheaper. I think that the system is designed make costs cheaper. That's why [women choose] midwives, because they're cheaper. (I/9)

Midwives hold a dominant position in New Zealand. I don't like that system. Midwives have the upper hand on doctors... Every one chooses a midwife because midwives are free. The government pays, so that the demand of midwives increases. That's why they are busy. I don't want them to make that an excuse for irresponsible care... The system forces us to have midwives even though we register with specialists [as LMCs], doesn't it? That is a rule in New Zealand, isn't it? I don't like the system, too. I feel "Why?" It is okay to have midwives, but they say different things every time. That is unpleasant. Then, although I trust doctors, midwives throw their weight around... It is said that the system is good. It is unique, but whether it is good or bad depends on each person. It shouldn't be

⁶ The context of the maternity care providers in Japan is presented in the first discussion of Chapter Six.

said that it is all good at someone's discretion. I think there are some good parts, but it doesn't mean that everything is good... The country should invest more to specialists. Then, there would be more choices. Those who don't have money can choose only midwives because they are free. I want the system to be better. Yes, midwives make their influence felt too much. Too much authority and too much domineering. (1/3)

Interestingly, at the interviews, most of the women called doctors *o-isha-san* (an honorific term for doctors in Japanese), but referred to midwives in English not *josanshi* (midwives in Japanese). Also, when I, the interviewer, used *josanshi* in the interviews, a few women asked me if *josanshi* meant midwives in Japanese. This implied that they did not know the title of midwives in Japanese, and they were not familiar with midwives in Japan. Possibly, they may have not known of even the existence of midwives in Japan.

The quality of the midwifery care

Regardless of whether their LMCs were midwives or obstetricians in the end, all the women were happy with their choice. However, the women talked about some dissatisfaction about other midwives who provided care in the hospital, who provided care with obstetrician LMCs, or midwives in general.

I think the care from a midwife after the Caesarean section in the maternity ward was not proper. I mean, mentally. First, she did not introduce herself. She came into the room suddenly and roughly. Then, she said that I had to keep the baby in the cot while no one was with me because I could not move the baby by myself after the Caesarean section. I wondered why I had to be told that. I felt I was being blamed that I had the Caesarean section. That was the first thing happened after I had an emergency Caesarean section... I thought that midwives here have to check the progress in more detail than nurses do. They were, if anything, more like doctors. I took that negatively especially after the emergency Caesarean section, when I was feeling low... They probably see many mothers and accept the unexpected number of mothers, but I think that the women after Caesarean sections need more care than the women after normal birth. I wanted her to

understand that. I felt that the mental care was not enough. This is painful for me even now. (I/5)

One woman who had an obstetrician LMC had to change her midwives once during pregnancy and again after her birth because of the midwives' holidays and work shift. She was dissatisfied that she was not given the chance to choose a midwife. To make matters worse, she felt that she did not receive the care she wanted after birth.

[My midwife] didn't help me with breastfeeding. Busy, busy. She sounded like she was the busiest midwife in Dunedin. If so, of course, she must have been busy and she couldn't have cared of me. She was irresponsible, she cancelled meetings at her convenience and she didn't keep her promise. Didn't she know that I had a few-day-old baby and needed help? The baby could not latch on well. I did not know how to do it. Even if I had enough milk, it would stop in such a situation. The baby's weight decreased. What am I supposed to do?... Midwives introduce or hand over the clients to the Plunket or something similar when they stop providing their care, don't they? She didn't do that. Of course, I didn't know such a thing because it was my first time. I found the number [of the Plunket service] in my Well Child Book when I was really struggling. (I/3)

Birth in New Zealand compared to Japan

Even if Japanese women know where to go when they get pregnant in Japan, they probably do not know the details of Japanese maternity care because usually the information is sought only when it is necessary. Furthermore, none of the women in the interviews had given birth in Japan. So it was difficult for the women to know the exact differences between the New Zealand and Japanese maternity care systems. However, they still had some ideas about care from Japanese books and magazines, and chatting with friends, siblings, and their mothers in Japan.

A variety of topics emerged in regard to elements within the different care system between the two countries.

Ultrasound

In terms of pregnancy care, in New Zealand the women had fewer ultrasound scans, no weight checks, less screening such as blood and urine tests, more supplements, and recommended changes to diet such as avoiding raw food during pregnancy. However, they focused most concern about the lack of regular ultrasound scans offered during their pregnancy. Ultrasounds are performed at every check-up in Japan while only one or two ultrasounds are offered through normal pregnancy in New Zealand. Some of the women accepted this passively although they would have preferred more. They felt uneasy not seeing their unborn child and convinced their midwives to order more ultrasounds.

We have ultrasound only twice during pregnancy [in New Zealand], don't we? I felt it should have been done every month. My friends had it every month in Japan and so did my sister, so I thought I would be able to do so, but it was only a few times in total. I thought, "Well, this is the way it is here, well, it seems different countries have different ways." However, I still wanted to see my baby and asked to give me the chance once a month, but I was told not to take it so often. Then even when I was really suffering from a tummy bug, I was not allowed to go to the hospital. I was worried about my baby a lot. Those caused me a dilemma. (1/6)

In Japan, ultrasound pictures throughout pregnancy are a service and also a keepsake including commercial products, which now include 3D, 4D, colour movies, memorial DVDs and ultrasound photo albums. Women with access to these images in Japan were the envy of some of the women.

The use of Entonox and epidurals

The use of Entonox⁷ and epidural analgesia was also a common topic. It was often discussed when the women talked about their birth process. Few women had a strong opinion on whether or not they would use Entonox or epidurals before birth, rather if anything, they would have liked to avoid using them.

⁷ Please refer to Footnote 4.

When I was asked about my birth plan, I answered I wanted have natural birth as much as possible. The ideal way was natural. So it should be natural as much as possible. I said that even if I had to use something, it would be only gas (Entonox) and that an epidural was out of the question. (I/8)

In the end, only one woman who had a vaginal birth did not use either Entonox or an epidural. The woman mentioned:

I told my midwife that I would never use the epidural. At the birth, nothing crossed my mind. It was too late to use anything. I was allowed to push when I arrived in the hospital. My body pushed and pushed with no space to think of such a thing. (I/1)

Six women used either Entonox or epidurals during labour. Most of them were encouraged to do so by their midwives, with some choosing to do so even without knowing exactly what they were.

My progress was good completely, but at the first birth I had a painless birth with the epidural because the labour took time. I used gas at every birth. I felt better with it. I might have just felt so, but I was relieved. My midwife said to me to try it because it might help me feel at ease, and it did. I feel it would be very difficult [to go through the labour] without it. Did it just control my feeling? What is that gas? I don't know. I don't understand it even now. (I/2)

I tried the gas, but I felt dizzy and stopped because I had not had the idea of how the gas worked. I had not decided if I would use it or not. I was thinking if it was recommended, I would just use it. I had controlled my breathing with a yoga breath. Then I was advised to use the gas, but I became in a muddle soon. I thought it was impossible to use it anymore. (I/4)

The use of Entonox and epidurals in New Zealand is far higher than that in Japan⁸. Regardless of whether they used them or not, and whether they knew the difference between New Zealand and Japan, the women were happy with having more choice in New Zealand.

Isn't there painless childbirth in Japan? I think I have heard there were those who went to America for the painless birth. I think I am lucky on that point. So I thought Japanese mothers were amazing... There are not many choices in Japan, so I was lucky. (I/4)

Only woman who had planned to use an epidural stated:

A good thing is that an epidural is right there as an option. In Japan, since the place I lived was in the country, there was nowhere and no hospital to do such a thing. I was thinking that I really did not want to give birth in Japan because I was sensitive to pain... So it was good to have choices here. (I/9)

Birth outcomes

While most of the women desired vaginal and natural birth, only one woman ended up without any medication or medical intervention. It is difficult to tell whether birth outcomes occurred because of different cultural or systematic circumstances or not. However, one woman reflected on her Caesarean section as below. She connected her outcome to the place of the birth.

When I heard the rate of Caesarean sections was high in Dunedin or New Zealand, I imagined how it would have been if I had given birth in Japan... With regard to the induction, my situation had not really needed it (Her labour was induced after a doctor's recommendation). When I went back to the point, I felt that it might have happened because I was in Dunedin. I wondered [how it would have been] if I had given birth in Japan. (I/5)

⁸ The differences of Entonox and epidural use between the two countries including the statistics are presented in Discussion 2 of Chapter Six.

Having a shower after birth

There were clear differences in after birth care. Following birth in Japan, women are recommended to have a long rest. Women usually start getting up two hours after the birth, but they just try to pass urine in the bathroom and go back to the bed as soon as possible. There are also women who do not stand up for a couple of days at homebirth or following birth at a maternity home. How quickly women start moving after birth in New Zealand surprised the Japanese women.

[I was told,] “Have a shower.” I put a pad (sanitary napkin) on after the shower. Then, [the midwife said,] “Let’s go to the room,” so I walked. [That happened] about 30 minutes after the birth and meal. I thought “Are you serious?” I was okay, but I was amazed. (I/4)

What I was surprised about was, well, it was my first birth, but I had heard the shower would be the next day or two days after birth [in Japan]. However, I was told to have a shower soon. I wondered whether this was okay, and said that I wouldn’t, but I was told to have a shower... I thought I might bleed... I was afraid a little, but the midwife said that I would be okay. I think I would not have been told to have a shower on the day of the delivery if I had been in Japan. Probably, right? I wondered if it is okay even to get up. I was worried when I was encouraged to get up and have a shower... There are cases that women may faint because of an attack of anaemia, aren’t there. It is scary. I said that I would be okay without shower, but she said that it would be good. Then I said that I was afraid to have a shower, but again she said that I would be okay, my blood pressure was stable, and to have a shower. It was not an order, but she urged me. So I thought, “Okay, if you say so strongly.” Then I had a quick shower a bit fearfully. I just put the water a little bit under my belly because I was scared... I have heard some women bleed a lot after birth... I was afraid because I had an idea that I wouldn’t have a shower if I had been in Japan. (I/6)

Hospitalisation

In Japan, women stay in maternity facilities for five days to a week after normal birth. In New Zealand, a few of the women voluntary chose to go back home sooner because it was difficult to relax in the hospital, whereas most preferred to stay longer in the

hospital to rest. Staying in hospitals as long as possible was desired by those who did not have help at home. This meant a struggle with the midwives to let them stay.

While I was in the hospital, the midwife was hard on me. She told me to go home soon and it was really hard. The request for me to go home was getting stronger, and then I was crying. Even if I said I couldn't go home yet, I was told that I was okay [to go]... The midwives said, "Don't think staying in hospitals is free," "It costs a lot in Japan, doesn't it?" or something like that. And I was told that I was okay. I was always told such things. So I was crying. I had a breastfeeding problem and many other problems so I was thinking I could not go home. My husband was working and not at home. No one was at home. I thought what I could do in such a situation... I said I could not go home, but I was told to go home again and again, so I cried a lot. (I/9)

It was crowded there. [I was told,] "Get out soon," "Go home." [I thought] why I had to leave there with such a body in terrible conditions. [A midwife said,] "It is important to get used to the life at home." [I replied,] "No, it is not. I need to be here. I still have an IV. I can't go to the bathroom by myself. Why do I have to go home?" [She said,] "Go home, go home." (I/3)

The longer stay seemed necessary for the women not only to have rest but also to settle and to get confident with taking care of their babies including establishing breastfeeding. Even if the LMC offered to visit them at home, they still wanted 24-hour care from midwives in the hospital.

I was in the hospital for two days. Then I left because I started wanting to go home, but that was not a good idea. I thought I should have stayed more because midwives there would also teach me a lot. (I/7)

I stayed in the hospital for five days. I had problems with breastfeeding, so I did not want to go home until it would be solved and I would feel more confident. (I/4)

The women's desire to stay in hospital is possibly linked to the Japanese custom of a longer rest period following birth as well as the issue of having a shower soon after birth. This is discussed later in the second theme - keeping Japanese customs - in this chapter.

Attitudes of carers

The women felt that the atmosphere and the attitudes of midwives, doctors and surrounding people were generally very relaxed in New Zealand. This was one of the biggest differences between New Zealand and Japan for the women.

I thought it was good to give birth in New Zealand. It is annoying in Japan. You are told, "Be careful with this," "Be careful with that." I was happy with the relaxed atmosphere here... It is meticulous in Japan. The Japanese maternity magazines surprised me. I borrowed some from my friends. Well, it seemed very attentive and cautious, even too much. (I/1)

The women generally enjoyed the New Zealand "take-it-easy" approach, but at the same time felt that something was missing.

[At check-ups] I thought it was not long enough and wondered if it was really okay only with that at the beginning. So I tried to talk more and more when I had questions. But I felt how short they were at the beginning because it was quite different from Japanese check-ups. (I/8)

When I was pregnant for the first time, I thought a little that I wanted to be taught more. I asked questions, but the answer was just, "All right, all right." I guess she just knew my anxious personality. (I/7)

The women also encountered a lack of punctuality in the New Zealand services. This was a big problem for some of the women, but others gave up worrying about it as long as their childbearing processes were going well.

[Midwives were] busy so [my midwife] did not come to the appointment. It happened often. She said that she would come at a specific time, and she did not come without notice. I waited and waited. It happened many times. I wondered if

this was normal in New Zealand. At the second pregnancy, I was getting used to it, so I just thought, “Okay, again” when it happened. However, I thought “What!” the first time around because it never happens in Japan. It is very punctual there. Even if the midwife came, she was always thirty minutes late... It was better when I waited at home, but it was worse when I drove, parked, and visited her office with small kids then she was not there. (I/2)

Through her birth journey, one woman found that how decisions were made was different in New Zealand compared to Japan. She did not want to be so involved in the decision making and preferred that her carers took responsibility for her care plan.

You would be asked how or what you want to do for anything [e.g. treatments] here. So do other hospitals. I just chose [which I want to do]. I thought it seemed I had to choose with my will. That gives me the responsibility after all. I thought all the responsibility lies with me if something happened [because I chose it]... I could not complain because I would be told that I had decided so. That is the way here. “You decide” for everything. You have to be strong; otherwise you are responsible for the consequences. This means, Japan is easier for me. I am at ease when someone instructs me. Then I could blame him or her if something happened. For my personality, it is easy to just follow instructions. It depends on the person, but the Japanese way may fit my characteristics. Following the instructions is easy for me, but anyway I haven’t had any problems here. (I/2)

Theme 2: Keeping Japanese customs

Whether or not the women kept Japanese traditional customs in relation to childbirth depended on their individual values. These were personal or family choices rather than complaints with health professionals or the maternity care system.

Ceremonies/rituals

A range of different birth customs between the two countries emerged. In Japan, there are some unique birth related traditions associated with pregnancy and child-rearing. Since those ceremonies or rituals are often fulfilled at shrines or with special materials, they are not easy to perform outside Japan. However, most of the women tried to

practice those traditions where possible. Even if they mentioned they were not interested or said they did not do those ceremonies, they had all done at least something.

My mother went [to a shrine] instead of me, of course. [She also got] haraobi⁹ from the shrine. She went to pray [for the birth] and got an omamori¹⁰, too. I also went [to shrines] when I went back to Japan during the pregnancy. I went [to shrines] several times. You feel you must do [those customs], don't you? Especially for old people, absolutely... Omiya-mairi¹¹, too. It is usually held a month after the birth, isn't it? We couldn't go at such a time, so we decided to go there when we go back to Japan. In that case, the babies were already one year old or so. It is strange, isn't it? But we can never miss that. It is a must... [Family and relatives] do customs like celebrations certainly. Because they are Japanese, they do all the celebrations properly and perfectly. (I/2)

Ofuda¹² were sent [by my parents]. They were returned [to the shrine] when my parents went back to the shrine to thank the gods for me [after the childbirth]. I had hung those ofuda on the wall of my bedroom [before each child's birth]. (I/7)

My mother sent an omamori and I always had it. I put all my prayers in the charm and grasped it tightly [during the labour]. (I/8)

No ceremonies. I wanted to go, but I did not have any composure after birth. However, I went back to Japan last year. The time of omiya-mairi had passed and we did not do (proper) omiya-mairi, but I supposed it was omiya-mairi only in my

⁹ It is also called *haraobi* or *iwataobi*. It is a girdle made of a 5-meter long cotton cloth to wrap around the pregnant abdomen. On the first day of the Dog's Day, one of the twelve-day cycle of animals on the old calendar, of the fifth month of the pregnancy (the fifth month means between the 20th and 23rd week of pregnancy in Japan), pregnant women and the families go to a shrine and pray for the women and babies. They also wrap the cloth around the woman's abdomen to make a wish on the day and some women continue wrapping it until the birth. Dogs, that usually have easy births, are symbols of the easy and safe birth in Japan.

¹⁰ A tiny bag shaped charm obtained from a shrine

¹¹ One month after the birth, the family takes the baby to a shrine and pray for the baby's healthy growth. Often, the baby is dressed in a special kimono.

¹² A wooden charm from a shrine

mind when we visited a shrine. I imagined omiya-mairi by myself. I was thinking only about myself because my husband doesn't understand these ceremonies... Everything was done in my imagination. (I/3)

I wanted to do Japanese customs... I wore haraobi during the first pregnancy. I wanted to do that to feel happy and to think how my baby would be like. Also, when I saw omiya-mairi on someone's blog, I wished I could do that... I thought those customs were meaningful, but I thought some were not so important and praying to god might be nothing. But I wanted to try some if possible. (I/9)

Some of the women considered those customs as events which mark the stages of their and babies' life. It is called *fushime* (*fushi* = joint or knot, *me* = eye or point) in Japanese. Two women told how much *fushime* was important for them as Japanese.

I wish I could pass down [Japanese] customs to my child... I like Japanese traditions taking each fushime is important. There is not much culture like that here. It is completely relaxed here, apart from Māori. (I/1)

I did rituals somehow. The Dog's Day¹³ and the first Boy's Festival¹⁴ in my own way. I thought it must have been good. I thought I should do each fushime because my child is Japanese too. I hoped to do those... Fushime is important, isn't it? There are not such things here. (I/6)

Keeping umbilical cords

Keeping the umbilical cord is one of the most common birth customs in Japan¹⁵. Regardless of religion or interest in Japanese customs, every woman tried to keep their babies' umbilical cords. This custom is also a Māori tradition around birth, along with keeping the whenua or placenta.

¹³ Please refer to Footnote 9.

¹⁴ It is also called Children's Day. One of the Japanese seasonal festivals wishes for the well growth of children, especially boys, on May 5th. People specially celebrate the first Children's Day after the birth for the boy. Girls are celebrated at the Girl's Festival (*Hinamaturi*) on March 3rd.

¹⁵ The meaning and way of keeping umbilical cords are mentioned in Discussion 3 of Chapter Six.

I am not interested in Japanese customs, but I have kept the umbilical cord, of course. (I/5)

I have kept the umbilical cord in my ring case. Cases [for umbilical cords] are not given here, are they? I wrapped it and put it in the case. My husband said “Yuck!” and told me not to keep it, but I told him Japanese kept it, and so I kept it in the ring case nicely... Umbilical cords are to be kept regardless. (I/6)

When my first baby was born, I was going to keep it, but I lost it... Umbilical cords were thrown away as if they did not have any value here. I didn't ask [the midwives] to keep it. When my second baby was born, I kept it once but it disappeared somewhere. It might have been dropped into a rubbish bin or disappear with the nappies while I was taking care of the baby with a sleepy mind. So I think I will regret that I don't have them in the future. I have mine here. It is properly in a box. I heard the pain would disappear if I rubbed wherever I hurt with it. This was given to me [by my parents]. I just have it, but it is important, isn't it? (I/7)

Only this woman did not keep her babies' umbilical cords. Nonetheless, she indicated that keeping umbilical cords is meaningful for her.

How to take care of women's bodies after birth

Longer rest after birth

In Japanese, the word *tokoage* means putting away the futons¹⁶, and women commonly do this three or four weeks after birth. So until then women spend most of the time in futons with their new born babies. During the term, their mothers and family usually do cooking and other housework. In Japan, it is believed that women will have tough menopausal disorders if they do not have enough rest after childbirth. This advice is frequently handed down from mothers to daughters.

Since when I was in the hospital, I was encouraged to have a shower and to walk. The wound of the Caesarean section hurt, but I followed what they said and tried

¹⁶ Japanese style sleeping mattress

to have a shower and to move as that sounded good. But after my mother came, she told me not to move and asked me why I was walking. That was a cultural difference I came across. Then what my mother said was that I should never move around. Even if I was fine at the time, it would affect the menopause. I heard that from many people not only from my mother... I see the difference between the idea that people here think it is good to move, regain muscle strength, and go back to the normal life as soon as possible and the Japanese idea which believes that you will get a trouble if you don't have a good rest after birth. (I/8)

People visited us [after birth]. Japanese especially who had had birth said not to get up and left soon, but kiwis (New Zealanders) stayed and sometimes started eating meals there. That made me so tired. My postnatal period started with the tiredness. I was tired while breastfeeding, so I felt sorry to my first baby. Then I decided to have a rest for at least one week and to let people visit us after that. That is the most important thing I've ever learnt from my experience. (I/7)

To carry out this custom, understanding and help from family and other people including the care providers are essential. Therefore, it was easier for those women who had help from their own mothers who came from Japan.

My mother stayed here for one month and did all the housework for me. It was helpful, otherwise you know... She told me, "The time after childbirth is very important, so never move around." She did everything for the house. (I/2)

On the other hand, it was very hard for women who did not have this assistance to carry out this custom.

I moved around. I must have done all by myself. [Women after birth] must rest in bed, mustn't they? It was impossible for me. In Japan, it is said never to move, isn't it? [Women after Caesarean section in Japan] stay in the hospital for two weeks, don't they? But I was not allowed [to stay in the hospital longer]. No one helped me... I had no one to depend on. (I/3)

I thought the Japanese custom of staying in the bed for three weeks was right. I was thinking that I could move around soon at the first birth, but I found that the custom was correct [from my experience]. Things told from ancient times are truly reliable. That is what I have realised. After birth women have to take a rest. (I/9)

To achieve a good rest after birth, *satogaeri* is a very helpful tradition in Japan. *Sato* means hometown, and *gaeri* means to return. So many women go back to their own parents' home when they have babies in Japan. The good point about *satogaeri* is that they can get a lot of help from their mothers and have a lot of rest. For the participants of this research, none did *satogaeri*. However, a few women were undecided at the beginning of their pregnancy, or regretted not going back to Japan when they were having a difficult time during the postnatal period.

I was hesitant [about giving birth in New Zealand] because I guessed the way of birthing might differ from country to country and I was anxious about that. However, my husband could not stay in Japan all the time and I would have had to fly back to New Zealand with a three or four month old baby if I had had a baby in Japan... I thought it would be fine if only I was patient... I thought it could be managed somehow. Pregnancy is not a disease. It is a natural thing. If I had a cancer or some disease, I might have gone back to Japan. But I believed that childbirth would go naturally... The happiness I received by feeling the baby grow inside of me was more important for me. However, the time after birth was unexpectedly difficult. (I/6)

As this woman said, she just had to be patient to have a baby in New Zealand. The women sometimes needed to be strongly determined not to go back to Japan, but the understanding from husbands was also a problem for one woman.

*It seemed that my husband could not understand *satogaeri* at the first birth. I wished I could go back to Japan because my family and I were very close. But my husband said that he could not see the baby's face and that would be cruel to him if I had had a baby in Japan. But the second time, he started saying that he felt sorry for me not having anyone from Japan and understanding how much I*

needed to take a rest since he saw me having hard time when the first baby was born. He said I could go to Japan if I wanted for the second time. He also said that the birth would be hard without support. So I felt he had changed a lot. (I/9)

Avoiding the coldness

*Hie*¹⁷ is the worst enemy for Japanese during childbearing and the postnatal periods, so the women tried to keep their bodies warm. Having a rest from the housework, like the dishes, and not washing the hair are done for this reason. The concerned is that it is easier for *hie* to enter the opened body after birth.

I took the most care not to let my body cool down. I knew that for some reason or other. For instance, not to have a cold belly, not to have cold feet, and take hot drinks, things like that. (I/8)

I felt at ease doing the same things as usual after birth, but of course I was careful not to expose myself to cold because it was in winter. It is bad to expose the body to chilly, isn't it? It will affect the body later. So I tried not to use the cold water and I went to the bed when I felt I was overworked. You know people [after birth] here are in T-shirts. It is not good to cool the body. I was also sitting while doing the dishes as I heard I shouldn't stand up much. (I/7)

Differences in body characteristics

These differences led into a conversation about the differences of body characteristics, eating habits, and values of Westerners compared to Japanese.

Don't you think that Asian women are more delicate? They are slender, too. I really think so. Everything looks same at a glance, but it is different. Even the types of hair are different. So the physique and functions are a little different.

¹⁷ *Hie* means chill or cold, but there is no equivalent concept in Western cultures. It does not simply mean to feel cold or to catch a cold like catching the flu. In Eastern culture, it is believed that *hie* develops into poor health and all kinds of illness when the body is exposed to cold (chilly), or is cooled down from inside because of cold foods, which are not just low temperature foods, or from outside because of a cold environment including clothes. *Hie* happens regardless of one's self-awareness, thinking or sensation. This is similar to the concept of "Yin and Yang," where *Hie* is more similar to the concept of "Yin."

Western people eat meat every day, but Japanese and Asian would get diseases if they did the same. I have seen the research. Enzymes people have to decompose are different between Western and Japanese. This would also work [at birth]. So this means, the delicacy should be regarded as important. People here are not caring about those points. They advise with their sense towards the size of babies, the results of medical examinations, and the amount of the pills. Having a shower after birth is also an example. Those should be different. They go home soon after birth. That, too. They maybe say [having a rest] is not necessary [but we need it].
(I/6)

How to take care of babies

Bonding with babies following birth

Care for babies after birth is not standardised in Japan. Many facilities still keep babies in nurseries intermittently, although the importance of bonding and breastfeeding is increasingly recognised in Japan. In the Japanese community in Dunedin, one Japanese woman who had her second baby in Japan after having her first in New Zealand said she felt left to herself after birth in New Zealand, and preferred the Japanese style where midwives and nurses came and took her baby to the nursery whenever she asked them, especially at night. None of the participants, however, complained of being with their babies after the birth in the hospital. If anything, they were happy with that. They thought it natural and felt responsible as mothers. For one woman, this practice provided an insight into the thinking in New Zealand about bonding.

As bonding is important in Western culture, they say that babies come to mothers' arms directly and sleep next to mothers in the bed after being born is bonding. Yet, I was surprised that they put babies with monitors in other rooms separated from their mothers and fathers. I thought which point of that was bonding? I thought "How cruel!" as compared with a Japanese way, which parents and children sleep together in the shape of river "川".¹⁸ (I:4)

¹⁸ As the shape of that parents sleep on both sides of the child looks like the shape of the Japanese character for river "川," people often say the style "sleeping in the character of river." This co-sleeping style which continues for several years is the traditional and usual way of sleeping in Japan.

Taking babies out

Many of the women were surprised to see tiny babies everywhere in the town such as grocery stores in New Zealand. It is considered that babies should also avoid getting stimulation in Japan, and Japanese are careful not to take babies outside. Since Japanese mothers are supposed to rest at home for a month, babies naturally stay home with their mothers. So while they did not want to take their babies out at the early stage, they had to struggle to accomplish that because their husbands wanted to take their babies out for fresh air or to show them off to friends.

I was surprised to see babies taken around outside. Babies are taken to the café, too. I thought I could never do that. That is unimaginable for Japanese. (1/8)

In the first place, the women felt that the worldview towards babies differs from Western culture to Japanese culture. Below is one episode that surprised one woman.

Here people often say that babies, even new born babies, are strong... Once, one of my friends almost dropped my baby and his [Western] wife said, “No problem. Babies are strong.” That would be okay if I had said so, but I did not want to hear that from her... I wondered what that means. So I was surprised at that. Japanese think a great deal of babies and take good care of them. I felt that there was a big difference. (1/8)

Japanese style baby clothes

Even in New Zealand where there is a whole range of babies’ outfits, the women preferred Japanese style and Japanese made baby clothes. Japanese newborn babies’ clothes are like robes. So you do not need to raise or move babies’ head, arms, legs and the whole body when putting them on babies. You just have to put a baby on clothes piled and spread, and put them on the baby like wrapping or closing with strings or buttons. Also as pants are not worn, you just open the clothes to change nappies. For



Figure 1: Japanese co-sleeping style - the character of 川 (Unno, 2011)

babies' comfort, Japanese baby clothes have the seams and tags sewn on the outside, and never have buttons on the back of the garments. Japanese style nappies feature a long thin cotton cloth in a shape of circle inside and a thin wool cover outside.

My mother in law said, "What's this?" but the Japanese babies' underwear was great... It was very easy to use those because new born babies' heads are unsteady. I could not believe the way they (New Zealanders) put on shirts from the babies' head. I was scared and could not do that. (I/8)

I did not like the type of clothes you had to put on from the head. Of course, [I used] the Japanese type which you tie here and ... yes, kimono style. Those are good, aren't they? I really needed them so I asked to send them from Japan. Everything such as nappies and underwear feels coarse and stiff here. But Japanese ones, that cottony stuff, are smooth and good quality. They are absolutely different. I used Japanese nappies, too. They are completely different. The quality is better for everything. (I/2)

Theme 3: Experiencing childbirth in another country

The women of this study raised two critical issues concerning their overseas birth experiences. The first concern was the communication issue, and the second one was with how to obtain the appropriate amount of support in a location where their immediate family members were not living.

Language and communication

Written materials for childbearing

For five of the women, this was their first experience with childbearing and child-rearing. They needed to learn about pregnancy, birth and how to take care of babies as well as how the maternity care system functioned, and mainly collected information from friends, antenatal classes and the Internet. When there were language barriers and the women were unable to obtain the information from the midwives and doctors, they looked for reassurance for their anxiety from Japanese books about birth. Rather, they preferred Japanese books as a way to collect the information. So, English leaflets and

books offered were seldom read even though the women could read English. One woman who had taught classes in a New Zealand university said:

I researched about pregnancy for myself. I was worried because it was my first pregnancy. I had to learn about birth from nothing. I looked around and read a lot of books... Those were all in Japanese. English books were also given to me, but I thought it would take me a year to read. (I/8)

One woman also found the contents of the English books unhelpful.

I learnt about pregnancy very much. They were mainly in Japanese, Japanese books. I also read books here a little bit, but there were some parts I did not understand. I wonder... I felt it was different, so I was reading Japanese books. I asked to send them from Japan and borrowed from Japanese mothers here. (I/6)

English language matters

None of the women mentioned problems with their English in daily life and through the pregnancy. They also seemed to have a confident level of English language. However, there were women who worried about their English at the beginning of their pregnancy, and a few experienced some difficulties using English during the labour.

I considered having the baby in Japan. I was worried about medical English. I could communicate [in English] in daily life, though. You know, medical words. I would have to go to the hospital and to see doctors for 10 months of the pregnancy. I was worried about miscommunication. I would not have been happy if [doctors] could not clearly understand what I was saying. (I/6)

I became not able to speak in English [during the labour]. I was taking gas and I could not be patient. English never came out. I just wanted to see my baby... So it seemed I was saying, "Baby, baby" [in Japanese]. As my midwife did not understand that I am saying, "It hurts," or "Baby," it was really good to have my sister with me. My sister translated [between me and the midwife]. (I/8)

When in the midst of experiencing labour pain, it was not only difficult to use English, but it was hard to understand the English spoken by the midwives or doctors they had just met. In these situations, the role of the husbands as translators was important. Even if their husbands did not speak Japanese, the translation from unfamiliar English to familiar English helped the women understand what was being said.

As it is difficult to understand English of people who I see for the first time, I glanced at my husband's face and he re-explained things for me. He translated from English to English, then I understood. Communication with my midwife during the labour was okay, well, but I might have looked at my husband's face even with her. (I/4)

One woman said, "I was thinking how much I wanted a Japanese midwife here during my pregnancy." She added, even if the system and the conditions were not good, she would have been content with her situation if she could talk to midwives in Japanese. Communicating in the mother tongue was very important for her. She also believes that language influences the way of thinking and deep understanding, and she needed a midwife who could understand that for her childbearing.

At the place where there are no Japanese midwives available, it is sometimes suggested Japanese women have an Asian midwife. Of the women interviewed, two women chose an Asian midwife as their LMC through someone's recommendation. However, both had communication problems with those midwives, and one ended up changing midwives before the birth. As discussed previously, Asians come from a range of very different cultural and language backgrounds, which makes communication amongst the Asian demographic challenging.

I did not have any problem regarding English for myself, but a thing I cannot understand is... what I was not satisfied with was that my midwife was not good at English. She might have understood all though... So I was worried if she was okay, if she understood English, and if she could communicate well. Also, when I talked to her, she did not understand and often said "Pardon?" I have never been told "Pardon?" by other people such as specialists and other midwives. They understood what I said. (I/9)

For the first midwife, I could not have confidence to say that I trusted her 100%... English wasn't her mother tongue, so it seemed she did not understand our conversations perfectly. Then I started doubting [if she was okay]. That happened several times. (I/1)

The way of communication

Not only were there problems with language, but also with different communication styles. One woman's experience provides an example.

I said I couldn't sleep and was suffering, but the specialist did not recognise that I was having a hard time and that my body was strange. I had to see a midwife and the midwife had probably not realised that, either. I might not have told them the entire truth. Then, when I was having a really difficult time, I had a check-up with the midwife. Do you know "maternity glow"? The midwife told me that she saw me having the maternity glow. This meant I was bright and I looked beautiful due to the pregnancy. Even though I was feeling unwell at the time, I was told things like that. I was thinking it was really different from how I was feeling. It seemed my pain wasn't obvious on the outside. I knew that they didn't see that. I just said, "Really? I am really painful. I am not like that." [in the small voice]. That's all I said. I should have told them more, and I should have gone to see the GP or someone. I thought I could talk only to the specialist and the midwife during the pregnancy and did not go to see any other people... I should have told them about my pain more, but I didn't. Communication was in English, so I couldn't get the message across. Wouldn't you agree that they don't work unless you push very much? That might have been a problem. It was painful, indeed. (I/9)

Support

Support from the husbands

How to get help during postnatal periods was an essential matter for the women living far from the home country because they did not have their family and relatives for support. So the support of their husbands was necessary in New Zealand, and indeed husbands were the most helpful supporters for some of the women.

My husband helped a great deal. I did not have my parents here and my siblings did not come to help me [from Japan], either. So my husband worked for me the most. (I/6)

Though, this support was not provided for all the women.

My husband was a student at the time. I should have asked him to take time off work for half the term. We talked about this, but I did not know how difficult it would be so I concluded that he did not need to stop his work. I should have asked him to stop. I should have asked someone to help me from Japan. (I/9)

I became sad. I was alone after all. I had not thought that because that [life without parents close by] was my normal situation and my husband's parents didn't live close, either. But I thought impulsively when I was filled by many things and lost my composure. "Why doesn't he help me?" like that. He is the only one I can depend on here... I should have told him. (I/8)

The husbands were all different regardless of whether they were New Zealanders or Japanese. However, both women above had New Zealand husbands, and stated, "I should have told/asked him ...". This could also be related to different communication patterns between cultures making misunderstandings inevitable.

Support from Japanese mothers and community in Dunedin

There is a strong Japanese community in Dunedin that offers support for each other. The women were mentally and materially supported by other experienced Japanese mothers when they did not have family nearby to help them.

Having Japanese mothers around was really good. They supported me mentally and taught me what I would need for the birth. If I had been by myself, I could not have prepared that much... [Women after birth] cannot move around for three or four weeks. So the fact that they helped me to prepare stuff before birth was very helpful. I had many experienced mothers around me and they supported me. (I/1)

I did not think about going back to Japan for my birth because I felt sorry for my husband. Also because I saw many Japanese mothers having babies here. So I thought that was common. If I was alone [the only Japanese here], I would have considered the option [going back to Japan] because there were parents, and I could communicate in Japanese [in Japan]. That would have made me feel at ease. (I/7)

Support from the women's mothers

Four of the women's mothers or mothers-in-law visited New Zealand to help their daughters. Thanks to them, those women were allowed to have a good rest.

Having my mother here reassured me and it was very helpful. She stayed here for one month and she did as much as she could. (I/8)

Having their mothers by their side was very helpful to the women, but many of the mothers did not speak English and were unfamiliar with the New Zealand ways of doing things.

I guessed I wouldn't be able to interpret for my mother at my birth, so I asked her to stay home during my labour. (I/4)

My mother came here just before the birth, and did all the housework for me. But my husband doesn't speak Japanese. I had to care for them, and I was the only one who could be an interpreter, wasn't I? Even though I was the most tired person. (I/7)

[My Japanese mother-in-law came to help after birth.] She could not go even shopping here... I had to set up menus and tell her how to do everything. Instead of not taking a rest, I was busier. (I/5)

Other problems and conflicts arose when the women's mothers came and helped because the mothers brought with them the Japanese customs, especially the way of taking care of babies. The women received the advice and learnt the ways as beginners of parenting. As words from their mothers, the advice was persuasive for the women,

and also easily understandable and acceptable for them as Japanese. So the conflicts actually occurred more often between the women's mothers and husbands or other people in New Zealand. The women were in an awkward position, caught between these two ways of caring for babies from different cultural perspectives.

When my mother was here, she did not want to take our baby outside because it was good for babies to stay home calmly and not to be exposed to the air outside. But my husband wanted to take our baby outside and really wanted to show her to other people. I was standing between them. I understood that my husband wanted to take our baby for a walk, give her fresh air, and show her to his friends, but taking the baby with little immunity out was... So I was stuck between them... I understood both ideas, and my husband took my mother's feeling into consideration and my mother was also worried about his feeling. My mother closed the baby's ears not to get the water in when giving the baby a bath. Then my husband asked me why she did such a thing and it was pitiful. There were those kinds of little cultural differences and different ideas. Then people do "bagworm" (wrapping a baby with a cloth tightly) here and my mother felt sorry to see our baby like that because it looked very tight and stiff. I had thought that "bagworm" was good until my mother said something. I thought it must have been comfortable because the shape is as if she was in the womb, but when my mother said sorry, I said that's right and I started feeling sorry for the baby... I gradually tried to understand what my baby wanted to do rather than sticking to one idea after all. But taking the baby outside was the most difficult thing. That caused me stress as I understood both sides. I wished that I did not hear both opinions. (I/8)

My mother said that babies were warm so not to put many clothes on them. So I put one Japanese cloth on my baby and let him sleep without the heater one night... My midwife said "Babies need more!" and to put many clothes, blankets and turn on a heater. I got scolded, but I did not know that. Well, that is a Japanese way and babies are warm because they sleep with parents in the same futon (bed). I was surprised at that... We used a cot instead of a futon. So my mother could not say anything regarding that... Also babies are wrapped here.

My mother had to shut her mouth and my husband's mother gave advice on those things. (I/4)

Even if the women's mothers could not come to New Zealand, they were still powerful supporters and advisers for the women.

There are Japanese boil-in-the-bag foods, aren't there? My mother sent me those and they were very useful after birth because I couldn't cook much... My mother wanted to come to help me but she couldn't due to her health issue. So she told me to have rest and offered to hire a housekeeper for me. I didn't need it, though. I had many friends helping me instead. (I/1)

My mother supported me [from Japan] and I was often asking her for an opinion when I did not have ideas. Even if she lived far, I could call and skype her. So I often talked to her. (I/6)

Whether they are visible or not, the existence of their mothers would be significant for childbearing and mothering women as role models, advisers and mental supporters. It seemed that as well as being very helpful, their mothers certainly influenced the women's experiences.

Theme 4: Dealing with the cultural differences

Each woman managed these differences in her own way. Since the women decided that they would have baby in New Zealand, most made up their minds to become familiar with the New Zealand maternity care system. One woman tried not to care about the differences, while another tried to remind herself to think "When in Rome, do as the Romans do," another took only the things that she liked or suited her from both cultures, and another felt that she did "*nai mono nedari*" which means wishing for something which does not exist there while also enjoying things existing there. These statements explained how they negotiated with themselves about what they experienced throughout their childbearing and postnatal terms and how they dealt with the differences.

I tried to accept anything suitable for us regardless of differences between Japan and New Zealand. However, we have firmly decided that we would never put the baby in a cot, say goodbye and close the door. Definitely. (I/4)

I read Japanese magazines and I avoided seeing things bothering me. You know, it is said that you have to have a good balanced diet for breastfeeding after childbirth, too. I avoided that kind of annoying information and did not eat only food affecting the baby directly. I did as I liked. Then, my children have been healthy so far. (I/7)

I think I have tried not to think of the gap. It is not use talking the gap in the situation. My sister [in Japan] was pregnant almost at the same time as I was and I heard her story, but I took it just as another piece of information... I was already here, so I had no choice but to go through the way here. (I/5)

Japanese friends envy me and say it is good that children can grow in a free and easy style here. It looks relaxed here for them... It sounds strict in Japan, but I envy them in Japan. There are a lot of facilities and stuff of good quality for anything. I say yours are good and they say mine is good. We just want what we don't have and envy each other. But I still think that the circumstances of birth and child-rearing are better in New Zealand actually. (I/2)

In these ways, many of the women tried to juggle the cultural differences and avoid falling into the cultural conflicts.

Summary

In this chapter, the four major themes that emerged from the interview data were presented. Each theme was composed of sub-themes, and the women's words provided the detail. The birth experiences of nine Japanese women showed the range of advantages, challenges and anxieties for Japanese women in a different maternity care system. In particular, the women highlighted how the cultural differences, language, lifestyle and ways of viewing childbirth and child care presented challenges for the

women living and birthing in New Zealand. In addition, the women talked of how they resolved the cultural differences in a practical way.

These themes were brought to the subsequent focus group to see if this different group of women could identify with the ideas and to capture other perspectives. The process and results of the focus group are presented in the next chapter. Both sets of findings are then collated and integrated in the discussion chapter.

Chapter Five: Focus group results

Introduction

This chapter builds on the interview results presented previously. A focus group was held with an additional four Japanese women to discuss the themes which emerged in the interviews, and to explore any new themes arising in the context of the focus group.

The chapter begins by outlining the background and the birth histories of the women. Next, the four themes emerging from the analysis of the focus group data are discussed: 1) understanding the New Zealand maternity care system, 2) keeping Japanese customs, 3) experiencing childbirth in another country, and 4) dealing with the cultural differences. These same themes had emerged during the interviews, and no new major theme ideas were recorded during the focus group discussions. This appears to confirm that the themes uncovered in the interview data were broad enough to encompass most of the childbirth experiences and issues for this group of Japanese women in Dunedin, New Zealand.

Although no new themes emerged, the women's discussion and interactions in the focus group allowed for a more detailed debate of the issues. The key discussions focused on the maternity care system, especially the care providers, ultrasound scanning, and the use of epidurals which all fall under the first theme, understanding the New Zealand maternity care. Further, the women offered new and richer descriptions of their childbirth experiences. In this chapter, the discussion is presented under the same theme headings.

Participants' profile

Participants' backgrounds

Four women from the Japanese community group, who had not participated in the individual interviews, were invited to participate in the focus group. The process for the recruitment of participants and the methods of data collection and analysis used for the focus group were presented in Chapter three.

The women were aged between 36 and 41 with an average of 37.75 years old. Two came to New Zealand for a working holiday, and one to study at a university. One had married a New Zealander in Japan before migrating to New Zealand. The husband of one woman was Japanese and the other two women had married men from other Western countries. Regardless of their husbands' nationality, all the women said that they had planned to stay in New Zealand permanently.

The shortest length of the residence was 7 years and 4 months, and the longest was 19 years and 8 months. These were similar patterns of long-term residence to the women participating in the interviews (Table 4).

Table 4: Backgrounds of the focus group participants

| | Age at interviews | Husbands | Reasons to came to NZ | The length of NZ residence |
|----------|--------------------------|------------------|------------------------------|-----------------------------------|
| 1 | 36 | NZ | Followed husband | 7y4m |
| 2 | 38 | JP | Study | 19y8m |
| 3 | 41 | Other (Western)* | Working holiday | 11y6m |
| 4 | 36 | Other (Western)* | Working holiday | 10y3m |

Note: NZ stands for New Zealand or New Zealander, and JP stands for Japan or Japanese.

* The nationalities of the husbands from countries neither New Zealand nor Japan are not presented because the information easily identifies them within the small Japanese community.

One of the women had lived in New Zealand for nearly twenty years, which was half of her life. There was discussion as to whether or not this woman should be involved in the study because Taniguchi and Baruffi (2007), who interviewed Japanese women who gave birth in Hawaii, excluded a woman who had lived in Hawaii over twenty years as a participant because of her long term residency. However, it was decided that it would not matter in this study since this woman said when approached, that the longer she stayed in New Zealand, the more she was conscious of herself as Japanese and as an outsider in New Zealand. In fact, she was the one who reported most strongly practicing Japanese birth customs.

All four women had graduated from universities either in New Zealand or Japan, so that they were similarly educated to the women interviewed. They also had a variety of work experiences since arriving in New Zealand, including employment as an administrator of a university, a dental hygienist, a chef, a caregiver for the elderly, a tour guide, and a

wedding adviser. Only one of the women was working at the time of the focus group, and none had difficulty communicating in English in their daily lives.

Participants' birth information

The information about the women's births is shown in Table 5. Three of the women had one child and the other woman had three children. At the last birth, the average age of the women was 36 years old. The woman who had three children had an obstetrician as her LMC for the first birth, but chose a midwife for her second and third births. The other three women also chose care by a midwife LMC. They all birthed in hospital. One woman tried Entonox for pain relief but stopped using it after one inhalation because she did not feel good. Another woman had a vacuum extraction, and one had an epidural after labour was induced. One woman, who was having her third baby, had a quick and normal birth in contrast to her previous births for which she had Entonox and epidurals.

Table 5: Birth information of the focus group participants (latest birth)

| | No. of children | Age at the last birth | LMC | Interventions and type of the birth (Former birth) |
|----------|------------------------|------------------------------|------------|---|
| 1 | 1 | 35 | Midwife | Natural vaginal birth (tried Entonox) |
| 2 | 1 | 37 | Midwife | Ventouse, Vaginal birth |
| 3 | 1 | 39 | Midwife | Induction, Epidural, Vaginal birth |
| 4 | 3 | 33 | Midwife | Natural vaginal birth (1 st & 2 nd births: Entonox and Epidural) |

Overview of the themes

The aim of the focus group was to explore the results of the interviews and to capture any new themes. The women introduced themselves, and in response to an open-ended question which asked that they briefly talk about their birth experiences, they began to spontaneously discuss the same topics raised by the women in the previous interviews. So, to avoid interrupting the flow of the conversation, the researcher did not introduce the key theme ideas as these emerged naturally over the course of conversation.

No new major themes or sub-themes emerged. This confirmed that the themes that emerged from the interviews were representative and important issues for Japanese women who had babies in Dunedin. During the focus group, the women discussed three of the topics in greater detail. These included perspectives on the midwifery care,

ultrasound, and the use of Entonox and epidurals. They discussed other topics, but to a much lesser extent than these three.

Table 6: Themes and topics emerging in the focus group

| Major themes | Sub-themes | Topics discussed (*main discussions) |
|--|--|---|
| 1. Understanding the New Zealand maternity care system | Perspectives on the midwifery care | - Having midwives as primary carers & the quality of the midwifery care* |
| | Birth in New Zealand compared to Japan | - Ultrasound* - The use of Entonox and epidurals* - Weight management - Having a shower after birth - Hospitalisation - Services and amenities |
| 2. Keeping Japanese customs | Ceremonies/rituals | |
| | Keeping umbilical cords | |
| | How to take care of women's bodies after birth | - Longer rest after birth |
| | How to take care of babies | - Bonding with babies following birth - Taking babies out |
| 3. Experiencing childbirth in another country | Language and communication | - English language matters |
| 4. Dealing with the cultural differences | | |

While these topics had been discussed in the previous interviews, these themes were revisited in order to get a broader understanding of the issues of each theme. By adding depth and complexity to the discussion, the focus group allowed a richer understanding of the Japanese women's experience of childbirth in New Zealand.

Theme 1: Understanding the New Zealand maternity care system

Most of the women's discussions in the focus group belong to the first theme. They mainly discussed three issues. One of the main topics concerned perspectives on their midwifery care. They shared their thoughts about care providers and their midwifery care. Other significant discussions centred on birth in New Zealand compared to Japan, specifically the use of ultrasound and epidurals. These topics tell us a lot about the women's understanding of the New Zealand maternity care system.

Perspectives on the maternity care

Having midwives as primary carers & the quality of the maternity care

The conversation started with one woman telling of her first birth experience with an obstetrician LMC. She had the view of taking it for granted that doctors should be the main carers, and she had chosen an obstetrician. However, she found the midwives more helpful for her. Following the initial comment, another woman also started talking about the maternity care providers. They did not oppose the idea that midwives are more useful, but they still expressed some difficulties with the idea of having a midwife as their LMC. Here, two interrelated topics - having midwives as primary carers, and quality of the maternity care - were discussed.

F/4: I had a specialist (an obstetrician) for the first time.

F/0: How was it?

F/4: He was not very useful. Wouldn't you agree that you were all anxious for your first birth? Also, there was a worry like "Is it really okay to have birth without doctors?" because you imagine a Japanese childbirth. I thought it must have been better to have a doctor's help right there just in case something happens. My mother was also worried, so I chose a doctor. But, midwives did everything for me anyway. The doctor appeared later saying, "I see, I see," and told me, "Push, push." He quickly departed saying, "Bye," and left everything to midwives after all. So I didn't need him.

F/0: So you had an obstetrician for your first birth, but had midwives for other births, didn't you?

F/4: Yes, I wasted money [on the first birth].

F/0: How was it having midwives for your primary carers?

F/2: That surprised me in New Zealand. I wondered why doctors wouldn't do anything for me.

...

F/4: A thing I was worried about was, I heard a rumour that midwives did not get money when their client had a Caesarean section in the end. So I was scared when I heard there were many midwives who tried too much [to deliver the baby by themselves] for this reason. Imagine if your midwife had done more

than her ability only for money. So I chose an experienced midwife as I thought they would not do such a thing.

...

F/2: Finding the right midwife is difficult. Doubts come up on the way while you are seeing them.

F/3: I agree. Even if people advised you that your midwife was strange, [it is difficult for you to take action]. My friend had a terrible experience with her midwife. When we heard her story, everyone said to her that her midwife did not sound good, but she was not certain whether she could change her midwife or not. The result was that she had a bad birth experience with the midwife (she explained her friend's experiences with the midwife after this).

F/4: One midwife [who was a back-up midwife instead of my LMC who was taking a day off] got mad with me, asking why I came to the hospital at such a time [because it was the midnight when my labour started]. She was very grumpy. She was reading a magazine on a couch and asking me, "Are you having stronger pain?" "Your cervix is not opened," and "Go for a walk." I was having contractions every three or five minutes, so I went to the hospital at midnight. But the contractions became a little less. I had my baby in four hours, though. I told my LMC that I was scared of that midwife and my LMC resumed the care for me after the birth.

Birth in New Zealand compared to Japan

Ultrasound

Similar to the statements in the interviews, the women in the focus group did not appear to be satisfied with the number of ultrasounds during pregnancy owing to the contrast to Japan where they are done much more frequently. Therefore, the researcher asked whether they had thought about why they only had a few ultrasounds in New Zealand and why they think they would have had many more in Japan. Their answers showed that their ideas were based on their image of New Zealand and the care rather than the effect, risk or evidence for ultrasound screening. In other words, they did not receive any detailed reasons or explanations as to the effective use of ultrasounds from their midwives and doctors although many of the women obviously struggled with this issue.

F/2: I hear there are more ultrasound scans in Japan. It is very few here, isn't it? In my case, my baby was in a good position but he turned wrong way or something at the last moment. I had to give birth in such a situation. In the end, his head got stuck and had to be pulled out after the cut (episiotomy). I am not sure because I am not a professional, but I wonder if there was something we could have done. For example, if I would have had one more ultrasound, we may have been able to find his bad position earlier on and try to fix it because my labour took one week... I wish [I had had ultrasounds] more often. I chose a midwife who practiced more natural ways. Maybe that's why. I felt it may have been easier if she had had a good balance between medical and natural approaches to birth.

F/0: What did the rest of you think about the frequency of ultrasounds?

F/4: I had one additional ultrasound since my baby stopped moving. But I still wondered whether it was seriously okay because the number was much fewer than in Japan. I also became anxious [during another pregnancy], so I asked to have one more.

F/1: I did, too. My midwife told me that she would need a reason to ask for another ultrasound for me. So, she said that she would write a letter saying that she could hear the baby's heart beat, but it was slower than last time. Then I had an ultrasound at last. Oh, I remember. I couldn't see my baby's face at the previous scan, so I said, "I really want to see the face," and she did that for me.

F/2: I also told my midwife that I wanted to do it one more time, but she told me, "There have not been any problems. Also, they (ultrasonographer) are probably busy, so you would not get an appointment." If I had taken a scan at that time, the problem of his position or the location of his head might have been different.

F/0: You only had a few ultrasounds in New Zealand while women have an ultrasound at every check-up in Japan. Have you ever thought why it is different?

F/1, F/2: I have never thought about that.

F/4: I thought it was because they didn't have enough equipment [in New Zealand].

F/1: I wondered if it was because they were not strict.

F/2: "It's no problem not to see" like that.

F/4: Are there any reasons?

F/0: There must be reasons. First of all, Japan is one of rare countries that you have ultrasounds so frequently, rather than saying it is too few in New Zealand.

F/2: Surely, the more ultrasounds you have, the more money they (obstetricians) get because you pay them every time [in Japan].

F/4: Every clinic and hospital has [an ultrasound machine in Japan], doesn't it? GPs here don't have one.

F/0: There are possibly financial reasons and a matter of equipment as you said. At the same time, there is research demonstrating both their efficacy and risk.

F/4: I have heard it may damage eyes.

F/2: Really?

F/0: So, were you just thinking that you only received a few ultrasounds without any special reasons [in New Zealand]?

F/2: Yes, that's exactly like New Zealand.

F/1: I just thought, "It is relaxed here. They don't check weight, either." Right?

F/0: Did you know that you would have an ultrasound every time [in Japan]?

F/4: Yes, I did. I heard from my mother. She asked me how the scan was after a check-up. I replied that I did not have it and she was surprised. Here midwives do not measure mother's belly, either. They do not do anything.

The use of Entonox and epidurals

The discussion concerning the use of medical pain relief such as Entonox and epidurals raised a point of conflict for the women. They had struggled with the Japanese belief, which trusts women's endurance to cope with the pain of labour. It seemed that the women who used epidurals found it necessary to provide justifiable reasons for using it,

but interestingly the women who did not use epidurals did not participate in this part of the discussion and did not mention the pros and cons on the usage in the focus group.

F/4: As a Japanese tradition, or somehow as Japanese, there was an idea that natural birth was a thing of beauty and there was an aesthetic value to it. I had a conflict in myself to release myself from the idea. My first birth was really hard. I used gas (Entonox) but it was not enough at all. I was in violent labour. It was terrible and the baby did not come out. Then I was asked, "Do you want an epidural?" but as Japanese, you know, I was thinking that everyone struggled with labour and that was common and natural, so I could not say yes at first. When I finally said, "Yes, I do," I was crying, "I am sorry," "I do [want an epidural]" like that. However, I said, "I will use it" from the beginning of the second birth, and even said, "I love it."

F/0: Why did you cry?

F/4: It was guilt. To the midwife and my husband. I felt like "I am sorry. I could not try hard enough" and "I am sorry I failed."

F/1: I said I wanted to use gas when the cervix was only opened 4cm, but I felt something strange in my throat [when I used the gas] so I stopped after one inhale. I thought I couldn't [use it any more]. I did not use an epidural. When I think of the pain now, it was manageable. But I panicked at that time [when I asked the gas].

F/0: You knew that you could use an epidural, didn't you?

F/1: Yes, I knew that.

F/0: Didn't you think that you wanted it?

F/1: At the beginning, probably before using gas I thought I couldn't do any more and asked the midwife to give me anything, but she told me "Already? It will be harder." So I thought I should not use it and would try a little harder, and I stopped asking.

F/3: I had been actually stuck on natural birth. It is exactly same with F/4. When I accidentally talked in a group of Japanese mothers, they were talking, "natural," "not natural," "I used epidural," or "I didn't," and it sounded like using gas or epidurals was not good. Then when I told my midwife that I

wanted to have a natural birth while discussing my birth plan with her, she told me, "I understand what you are thinking, I really understand, but your rib is broken and glucose has appeared in your urine, so I don't recommend that. Of course, you have a right to choose what to do, though." When I was told that much, I just said to her that I would leave it to her. So we decided I would have an epidural if necessary. I started using it 22 hours after the labour was induced because I said I preferred natural ways in the meeting.

F/0: Did you think you wanted to use an epidural during the labour?

F/3: I thought I might want to have one, but in my mind there are thoughts that the labour pains should have been like that, that I had to get over it because everyone went through it, and that I took being patient for granted. But my midwife recommended that I should use it by telling me that I had been doing my best and that the baby's health is the most important although the baby had not shown any problems. So I signed [a consent form] without any resistance when the anaesthetist came. I consented roughly. To be honest, I felt a little scared when the anaesthetist explained the risk, but my husband told me, "It's okay."

F/0: Did it work for you?

F/3: It worked. When it had an effect on me, I felt it's easy somehow, and I thought I didn't need to bother with the pain as long as the baby was born healthily. Then I was happy with my midwife and I thought it was good to follow her advice when my baby was born. I didn't feel the pain in the end, but I found out that I still had to push even if it was an epidural birth.

F/4: Yes, I also thought so. I thought that I would not be able to do anything, but I still had control.

...

F/4: I have a Kiwi friend who used an epidural. We discussed that no one would ask us if we used epidurals or not when our children become 20 years old. I was quite relieved after the conversation.

F/3: Mothers who did not use epidurals were proud that they had natural births. But it is good for both of us because the children's health is the most important.

F/4: Right, [It is perfect] as long as children are fine.

F/3: Yes, we [a Japanese mother who did not use an epidural and I] decided that it did not matter whichever we did. I did not know what she was really thinking, but it was okay as long as I am happy. No need to worry how others think.

F/4: I did not have any break because my labour was accelerated. Other people have a chance to have a rest between contractions but I didn't have it so it was really hard. Also my water bag ruptured before the labour started, so my baby was in danger. If the pains had lasted a couple more hours, I would not have had enough energy to push. So it was good to relax with an epidural. I thought it was good about the point later as well.

In addition to the main discussions above, the women discussed weight management, showering after birth and hospitalisation under this first theme. Showering after birth and hospitalisation associated with a long rest after birth are also keys for the next theme - keeping Japanese customs.

Weight management

In the interviews, the women mentioned “weight” briefly when they talked about the different patterns of care between New Zealand and Japan. For example, “There is no weight check, no abdominal measurement, and nothing in New Zealand” and “Weight control is very strict in Japan” were frequently stated. In the focus group, one woman raised the issue of weight management, and it was found that the women were conscious of the Japanese maternity care and were checking their weight themselves.

F/2: What I was happy about giving birth here was that there was no weight management. I gained 14kg in the end. Then I asked my midwife if I was okay to gain that much, but she told me that I had stored necessary things after birth so it was okay unless I gained on extreme amount. I was thankful for that.

F/0: Were you checking your weight by yourself?

F/2: Yes, I had been reading Japanese magazines casually, and they said the weight gain should be less than 8kg. I was alarmed that I had already gained

more than 8kg. I was worried about those kinds of things. I was told it was not to worry. I wondered but I was relieved... that was a good thing here. That it is not strict.

Having a shower after birth

A positive opinion with regard to having a shower soon after birth was not heard in the interviews, but there were both positive and negative views expressed in the focus group.

F/4: Having a shower after the birth made me tired.

F/1: It was good for me.

F/4: You got refreshed and clean, didn't you? ... but I felt dizzy.

Hospitalisation

How the women negotiated the length of their hospital stay was also debated. This was contrasted with the ideal period of rest advocated in the Japanese tradition.

F/4: I was surprised that mothers go home so soon after the birth. My parents strongly opposed it and told me to stay in the hospital, but you know, they (midwives) would gradually push you away. I felt I was pushed away. After three days, I was in a room full of four mothers and babies even though there were many other vacant rooms. Babies were crying all day and night. If it was in Japan, babies would be cared for in the nursery, but they were always next to mothers here, so I couldn't tolerate such chaos. That was a pressure to leave.

F/2: In my case, I stayed there for one week because my baby went to NICU on the second night. It seemed that it depended on the timing. When I had my baby, it was empty. But when my friend had her baby a month before me, it was really crowded as mothers had been transported from Christchurch due to the earthquake. Then midwives didn't come for one or two hours even if mothers called them. She had a very bad experience there so she is saying she will never go there again.

F/1: It was good for me.

F/4: The hospital was full when I had my third baby, so I was told to go home one hour after the birth. I asked my midwife to let me stay one night because I could not get hot water at home on that day, so she told me to have a shower “right now.” It was just after the birth. She said that she would help me to have a shower and had me have a shower about thirty minutes after the birth. Then I went back home about one hour after the birth.

F/2: You were forced to go home.

F/4: I was. You can't rest in hospital here, can you? As I said, babies are beside you, other babies are crying so much because you share a room, and you hear calls to get nurses from the passageway and the office during the night. So you can't sleep at all. Visitors also come from the next day. I couldn't sleep there and I felt relieved when I got home. So I understand that way also makes sense. They make us go home so we can be in a calm environment.

F/1: My situation was like that as well. I really wanted to go home. I had a baby just before 5 a.m. and went home at 12 p.m. I felt uneasy about the noise.

The women first expected the longer hospital stay because of the Japanese system and the traditional custom requiring a long rest after birth. However, their desires of the stay depended on the quality of the stay and the rest secured. Rather, it seemed that the noise, chaos, and busyness of the hospital encouraged them to go home. Besides birth care, the women also compared the service in the facility as the next topic.

Services and amenities

In Japan, there are over 3,000 birth facilities including national and private services, and the number becomes double when all the obstetric facilities possibly providing antenatal and postnatal services are included (JMHLW, 2009). Each facility considerably differs both materially and financially as there are no service standards for aspects of care. Therefore, not only are the carers or managers responsible for the care and the cost at each facility, but they also need to market their business and offer unique services and amenities to attract customers. Thus, extravagant Japanese meals, rooms, keepsakes and other services such as beauty treatments are provided in maternity hospitals and clinics in Japan, and these extras are often the subject of Japanese mothers' gossip in both New Zealand and Japan.

In the focus group, the women discussed the services unique to Japan. The women also talked about meals and other services in both countries. When they compared services between New Zealand and Japan, they were sometimes envious of Japanese services. However, it did not seem that the women viewed those extra services as the priority for their birth choices.

F/4: There are maternity hospitals that serve gorgeous meals and more in Japan.

F/2: I was surprised that my friend was going to have her baby in a hospital taking her to and from the hospital by a limousine.

All: At the labour?

F/2: Yes, a limousine would come to pick her up at her house and would drive her home when she discharges. The hospital also serves meals like hotels. However, she had hypertension before the birth and had to give birth at a city hospital... In Japan, there are many choices. People can choose clinics/hospitals. There is only one hospital to go to [in Dunedin].

F/4: Or house.

Theme 2: Keeping Japanese customs

Ceremonies/rituals

One woman was very keen on celebrating each Japanese custom both during pregnancy and after childbirth. Others did some or none depending on their interest or religion. On the other hand, one woman had a problem with a custom that is practiced in neither New Zealand nor Japan because her husband was from another Western country. In this case, the women who had husbands from outside New Zealand were influenced by at least three cultures at the time of their birth, further complicating the cultural issues.

F/3: I had a quarrel with my husband about circumcision. We don't do it in Japan, do we? What kind of problems does the baby have without doing it? We heard it was not done in New Zealand, either. But according to him, my baby would have a problem in the future [if we didn't do it]... After we discussed it and asked other fathers with boys, he agreed not to do one. But he got many emails from his family asking when we would do it for the baby, and he asked

our midwife about it because of that pressure... Then we had a big fight... A cultural difference. Circumcision is common in his country. I couldn't believe it. Anyway, we discussed and wrote to his family. His family understood easier than expected as we were in New Zealand and I was Japanese. He, his cousins, and his nephews, everyone had done it. They even celebrate it. So I had a trouble.

Keeping umbilical cords

Keeping umbilical cords was a common practice among the women in the focus group as it was in the interview group. Only one woman did not keep the umbilical cord because she did not notice when it separated. In the focus group, it was discovered that the women and probably the midwives did not know how to keep it.

F/2, F/3: I kept the umbilical cord.

F/1: I didn't.

F/4: The thing coming off later is the one, isn't it? I have kept it with the band the hospital put on the baby's arm.

F/1: I lost it. When I noticed, it wasn't there.

F/2: I asked my midwife. When she asked me what I wanted to do with the placenta, I answered that I didn't want the placenta, but wanted to keep the umbilical cord. Then she kept it for us at the birth, but I think we didn't keep it properly. My husband put it on a plate as long as it was and put it in the fridge, then it became like hard bacon.

F/1: I didn't tell my midwife and it was very short and smelled very bad. It was very crushed like a button, so I was wondering if I should have kept it. Then I realised when I changed nappies that it had been lost. So, I thought it's okay. [I may have kept it] if it had been long enough, but it was like a button.

...

F/3: My midwife told me, "You want the umbilical cord because you are a Japanese, don't you?" and checked when it would come off. Finally, she said she guessed it's okay to take it off and removed it. I was surprised, but it was

okay. She told me to care for the belly button with disinfectant and gave me it. I was gladly saying, "It came off, it came off."

How to take care of women's body after birth

Longer rest after birth

The importance of the rest after birth was recognised by all the women in the focus group, too. The women's conversation provided more details of taboos of Japanese women post birth. At the same time, it was shown that the women tried hard to follow their mothers' advice while they were half in doubt. Conflict also occurred when unexpected situations did not match their traditional values.

F/1: My mother told me to have a lot of rest after birth.

Others: Yes, I was told that, too.

F/1: My mother could not come to help, so she emphasised that very much. Not to look down, too. How can I do not to look down? Also, not to touch water.

Others: Yes, that is often said.

F/4: Standing long is not good because the womb comes down, etc. So I was told to lie down.

F/3: I felt better than I expected about two weeks later, so I drove to go shopping with my mother. Then my mother told me, "Japanese never do such a thing. You are allowed to do this because you are in New Zealand. I can't believe that you drive and go shopping only few weeks after the birth." But I was fine.

F/3: I was in the bed most of the time. So I was happy to have my mother with me. I also learnt from Japanese nursery books to lie down for two weeks as much as possible, then to feed babies whenever they want and to sleep with them when they sleep.

...

F/4: Friends of my husband visited us at our home. It was hard for me. I did not know them. I felt bad to be in pyjamas.

Others: I know, I know.

F/4: People here actively leave the house from the first day of the birth. So I wondered if Japanese hanging around in pyjamas all day looked strange when someone came to see me. In Japan, it is natural... My mother told me that I would regret it later [if I did not have a rest].

F/2: During menopause, right?

F/4: When we go through our menopause, [we would have problems if we did not have good rest].

F/3: If visitors were friends of mine, it would be better, but friends of my husband visited us. Of course, English [was spoken]... I exactly felt the same with F/4. I wondered if I was allowed to be in pyjamas.

F/4: Yes, English did not come out very easily when I was tired.

How to take care of babies

Bonding and co-sleeping with babies

During the interviews, the women mentioned co-sleeping with babies as a bonding practice following birth. The women in the focus group talked about co-sleeping with babies over an extended period of time. They found difficulties associated with sleeping with their babies in the same bed due to the cultural difference. How and where the women put their babies to sleep was influenced by the New Zealand/Western custom that, generally speaking, lets children sleep in their own beds, and later in their own rooms while the children are still small. Some women struggled between the Western and Japanese sleeping traditions, and the distress was much worse when their husbands did not agree with the Japanese tradition of sleeping together. However, the comment below shows that one woman obtained her husband's understanding in such a situation.

F/3: My husband opposed the idea of sleeping with our baby. I told him that Japanese sleep with children in shape of the character for river “川” but he didn't want to do that. However, we did that at my parents' home when we went to Japan. Then my husband saw that our baby slept much better, it's warm and of course it's nice, so he eventually changed his mind.

Taking babies out

Deciding whether or not to take the babies outside also caused women conflict with the Western husbands. This was not a concern for the woman who had a Japanese husband, and the couple reported being surprised at this cultural difference. However, there was more possibility of causing conflict in the case of international couples. Other women had to negotiate and convince their husbands with effort. Mutual understanding was also required.

F/4: I thought, "Is it okay to take such a newborn baby out?" "to expose a baby to the wind?" like that [when I saw tiny babies outside].

F/2: I thought it's too early, so I didn't take my baby out much for a while.

F/3: My husband wanted to take our baby out. He really wanted to go and show the baby [to his friends/anyone].

F/4: I know, I know.

F/3: I told him to wait, and I made up a reason of my own. "Viruses are everywhere and bad for babies. Our baby has Asian blood, so he may not be so strong." I made that up because I didn't want to take the baby outside.

F/2: You told him, "It is written in books," right?

F/3: Yes. Then we put our baby in a buggy for the first time and walked around the neighbourhood at two months old. At the time, I knew that my husband really wanted to go out with our baby. He said he dreamed of himself pushing the buggy.

Theme 3: Experiencing childbirth in another country

Similar to the individual interviews, language and support issues were also emphasised as a significant difficulty in the experience with childbirth outside of the home country. A particular issue that was raised in the focus group concerned the use of technical and medical vocabulary.

Language and communication

English language matters

The understanding of perinatal technical terms was introduced as an issue by the women. These words are probably unfamiliar even for native speakers, so understanding those words for these women was a challenge, especially in exceptional or emergency situations during labour and birth.

F/2: There was an inevitable wall or something like that, in respect to language, so I was often reading Japanese magazines and books.

F/0: Did you ever feel English was a barrier? (F/2 moved to New Zealand after her high school to enter a university and had lived in New Zealand for 20 years.)

F/2: Technical terms were used, weren't they? I heard words that had been completely unfamiliar for me. I could guess the meaning when I heard them, but I had to look them up in detail when I got back home. Then, after I learnt about the words, many questions like "How about in this case?" or "in that case?" came to mind, so I asked my midwife about these by email later. So when I heard something new, I could not quickly ask my questions or express my concerns.

...

F/3: When an epidural was going to be used, I did not have any problem or anxiety until I heard technical terms. An anaesthetist asked me many questions. I guessed he couldn't give me an epidural unless I signed the consent form. The questions were too specialised and I couldn't understand them, but my partner was with me and explained carefully for me. So I signed the form for the time being supposing it wouldn't be any problem...

Theme 4: Dealing with the cultural differences

With regard to the fourth theme, the women mainly discussed the issue in relation to each of the topics. The following statement also belongs to the topic "support" in the third theme, but it shows how this woman settled her situation as well.

F/4: My family was far away, so I did not have their support, of course. I wished I would have. But I chose to give birth here, so there was nothing I could do. I just had to do without it.

Strictly speaking, this example is not exactly about dealing with “the cultural differences” as titled. However, there is little difference in terms of how the women dealt with the childbirth experience in another culture. So this has been traversed in the theme above.

Summary

The results of the focus group were presented in this chapter. The purpose of the focus group was to explore the themes emerging from the interviews and to capture any new perspectives. The same themes from the interviews emerged in the focus group and the women expanded on these themes providing deeper insights, richer depictions and different views compared to the interview data.

The women discussed three main issues in the focus group in regard to the maternity care system. These included difficulties in having the practitioners of their choice and the number of ultrasounds they were entitled to in New Zealand. The use of epidurals was also noted as a conflict for some of the women given the absolute idea of natural childbirth in Japan.

Moreover, the women mentioned additional or different thoughts from the interviews concerning weight management, having a shower after birth, hospitalisation, extra services, ceremonies, keeping umbilical cords, having a longer rest after birth, bonding and co-sleeping with babies, taking babies outside, and English language matters.

The focus group was a lively discussion as the women shared their different experiences and views with each other. This resulted in further insights and new knowledge about the participants’ issues and concerns. In the next chapter, the significant points of interest indicated in both the interviews and focus group data will be further explored with reference to the literature and in terms of new knowledge of interest for Japanese women giving birth in New Zealand, and for those who care for them during childbirth.

Chapter Six: Discussion

Introduction

From the results of the interviews and the focus group with 13 Japanese women in Dunedin, we are able to get a better sense of how it felt for the women to experience childbirth in New Zealand. On the one hand, the women were generally satisfied giving birth in New Zealand's relaxed atmosphere. On the other hand, they experienced some issues throughout the pregnancy, birth and post birth periods. The findings also revealed how the New Zealand maternity care system was influencing their experiences and ideas about the meaning of childbirth. The women's concerns and difficulties were often caused by the tension between their expectations or understandings and their actual experiences. Further, it seemed that their expectations were based on implicit knowledge of the Japanese birth context, and their cultural behaviour and attitudes affected their understanding of their birth care in New Zealand. In this chapter, therefore, I will examine the cultural roots of their experiences by contrasting the birth contexts of New Zealand and Japan, explore the different social and cultural philosophy and histories of childbirth, and identify some unique Japanese cultural communication characteristics.

The chapter is divided into four sections. It begins with a discussion on how the Japanese women learnt about the New Zealand maternity care system and the ways their interpretations were influenced by the Japanese birth context. Secondly, the chapter explores the difference of the perspectives on labour pain and managing this pain between the two countries. Thirdly, the meanings and values of Japanese traditions and the environment needed to maintain these traditions are considered. Lastly, how the women negotiated their birth experiences in New Zealand as a whole is discussed from Japanese philosophical and social perspectives. Specific implications for midwifery practice are also included within each discussion.

Discussion 1: Japanese women's understanding of New Zealand maternity care

The different birth contexts between New Zealand and Japan

The fundamental cause of the women's satisfaction or difficulties they described seemed to be the result of the contrast between the New Zealand and Japanese birth contexts. Regardless of the quality of the care, the women naturally compared the New Zealand services to their basic understanding of how childbirth occurred in Japan. The most noticeable difference between these systems concerns who provides the primary maternity care.

Choosing a LMC

In New Zealand, pregnant women register with their own LMC, and nearly 80% of women choose midwives as their LMC (NZMH, 2011). In Japan, it is clear that the general awareness of the role of midwives to women is much lower than in New Zealand. This is evidenced in this study by the fact that the women did not even know what midwives were called in the Japanese language.

In a recent study exploring knowledge about midwives among university students in Japan (Shibata, Urushitani, Narashima, Yamamoto, & Fukumaru, 2008), 43% of respondents did not even know the concept of midwifery or knew only the occupational title. Shirai (2003) also points out that Japanese midwives are little known in the society because they play a minimal role. Furthermore, Kim (n.d.), who has worked as a midwife both in Japan and in New Zealand, notes in her essay how greatly the awareness of midwives differs between the two countries. She explores this difference through her experiences with how people react to her occupation in both countries. Kim (n.d.) also mentions the contrast of women's ability to tell the differences between midwives and nurses between the two countries.

In Japan, the number of midwives has halved since the 1960s, and the place of their practice has also dramatically changed from women's homes or maternity homes, which are owned by midwives, to clinics or hospitals. At present, although they have a legal right to practice autonomously for normal birth, only 6% of midwives work in maternity homes (JMHLW, 2011). Once midwives are involved in the formation of medical

facilities, they are mostly positioned within nursing departments, and there are a significant number of midwives working as nurses in hospitals contrary to their wishes (Kawai, 2007). Accordingly, it is often difficult for women to distinguish midwives from nurses in those facilities, and often women do not even think about the difference (K. Doering, 2006; Kawai, 2007) ¹⁹.

In addition, as there is no General Practitioner service in Japan, people go directly to see medical specialists for their health matters, and it is natural and common for women to go to clinics or hospitals to see obstetricians to confirm their pregnancy and continue to see them throughout their pregnancies. Under these circumstances, midwives are generally recognised by the public as professionals who provide care for women under the supervision of doctors, with the exception of a small group of people who think otherwise.

Statistically, while 78.2% of the births are registered with midwives in New Zealand, only 4.4% of the main birth attendants are midwives in Japan (JMHLW, 2010a; NZMH, 2011). However, according to Shimada et al. (2002), midwives attend 63.2% of the normal births as the main attendants in Japan. The figure of the national statistics is based on the professionals' titles on the birth registrations, and in all likelihood, obstetricians' names are shown on it as the representative of the team. As a result, a large gap between the figures about birth attendants in Japan occurs, and it does not show us the fact that midwives are caring for women during labour and birth much more than obstetricians in many cases (Shimada et al., 2002).

Therefore, most Japanese women do not realise that midwives principally provide care for them but not doctors during labour and birth until they have babies for the first time. Accordingly, Japanese women in New Zealand are not aware of midwives, especially those who have not given birth. This causes Japanese women in New Zealand to

¹⁹ One of the main historical reasons for such a weakened state of midwifery in Japanese society dates back to World War II. Under the governance of the United States after the end of the war, Japanese midwives, who had autonomous status and a strong position in the community, were reorganised as a part of nursing practitioners by American officers, who did not have midwives in their own country and did not recognise the importance of the roles (Obayashi, 1989).

hesitate to use midwives as their LMC. It also gives them the idea that midwives take care of pregnant and birthing women in New Zealand, but not in Japan.

Respect and esteem for medical doctors in Japanese society also affects the women's and the family's decisions about childbirth. Japanese patients are traditionally positioned in an authoritarian and paternalistic structure with medical doctors (Ito & Sharts-Hopko, 2002; Okoshi, 2005; Sharts-Hopko, 1995). Furthermore, there is a dominant social discourse that makes people fear childbirth, and go to see obstetricians just in case the worst happens (Alehagen, Wijma, & Wijma, 2006; McAra-Couper, 2007; Walsh, 2009).

Midwives' roles are now being reconsidered due to the shortage of obstetricians, and their care has become highly valued and demanded more and more by women in recent years in Japan (Kawai, 2007; Suganuma, 2011). However, the familiarity and status of Japanese midwives is still far from that of New Zealand midwives. Hence, it is difficult for Japanese women whose home country provides obstetricians as their primary carers, even if that is only in the face of statistics, to understand that midwives independently provide complete care for normal birth and continuous care in cooperation with doctors even if problems arise.

Japanese “strict care” and New Zealand “relaxed care”

The Japanese women also described the New Zealand maternity care as less strict than in Japan. This is because, for example, obstetricians and midwives do not weigh pregnant women in New Zealand while the women knew that in Japan their weight, abdominal circumference and uterine fundus would be checked at every pregnancy check-up. The strict weight check in Japan was a common discussion among all the participants. In Japan, the problems associated with a strict weight management have been pointed out, and the promotion of a strict diet during childbearing has also been reconsidered in recent years (JMHLW, 2006). However, strict weight management, which usually allows the maximum weight gain of up to 8kg, remains deeply rooted among professionals and Japanese women, including the women in the study.

The weight check was considered by the women in the study to be a difference in culture and national characteristics rather than a matter of the evidence informed care. It

seemed that the women thought that obstetricians and midwives do not check women's weight because the approach to care is more relaxed in New Zealand. In case of the weight management, most of the women looked favourably on New Zealand care whereas some of them were so worried that they recorded their weight themselves.

Overall, the women described New Zealand care as relaxed, loose, rough, no problem or take-it-easy care while recognising Japanese care as strict, fussy, thorough, worrier or concerned care. Generally, they enjoyed the New Zealand atmosphere. At the same time, however, the women felt that something was missing. They sometimes wanted more advice and detailed care, and at times felt anxious about New Zealand's apparent simple care. In other words, the women felt that Japanese care provided too much and New Zealand offered too little, including other services such as amenities and meals in hospital. As a result, they could not be completely satisfied with the care in New Zealand.

Wanting more ultrasounds

The New Zealand relaxed care did not concern the women most of the time, but the frequency of ultrasounds was an exception. Of all the differences in care between the two countries, the ultrasound was the most significant issue for them. Similar to the weight check, the women described the few ultrasounds offered during pregnancy in New Zealand as lax management.

It has been globally recognised that the routine use of ultrasounds does not improve the health of the mother or baby, or change the behaviour of pregnant women and the birth outcomes (Bricker, Neilson, & Dowswell, 2009; Ewigman et al., 1993). Accordingly, research (Neilson & Grant, 1989; Wagner, 2002) has indicated that there is no reason to provide all pregnant women with routine ultrasounds in terms of effect or cost. At the same time, the visualisation of the foetus has emerged as a significant social and ethical issue and has raised questions about the commercialisation of birth (Wagner, 2002; Women's Health Action Trust [WHAT], 2007). Furthermore, while it may give women psychological advantages, such as encouragement and reassurance, women are often unduly anxious when given unexpected, difficult, or ambiguous diagnoses about their foetus (Chervenak & McCullough, 1998; Garcia et al., 2002; WHAT, 2007).

In Japan, on the other hand, Suzui (2005c) points out that there have not been many discussions and studies about the long-term effect on foetuses or the financial efficacy of ultrasounds while many reports argue for their clinical efficacy. Moreover, despite research from Japan and abroad, the prevalence of ultrasounds has not decreased with an ultrasound at every check-up seen as essential care by health professionals and women in Japan.

Yet, the point of this issue for this study is not to discuss what frequency of ultrasounds is appropriate or how efficacious or risky they are. The problem was that the Japanese women in New Zealand were not informed that the limited number of ultrasounds was based on evidence. If they had been provided with an explanation about the benefits and issues concerning ultrasounds, their feelings of dissatisfaction may not have been so strong, and they would not have negatively associated the lesser number of ultrasounds with their unexpected birth outcomes. They might not have chosen obstetricians for their LMCs in order to have more ultrasounds, either. Whether the care providers were aware of the Japanese women's dissatisfaction about this issue or not, the women were still entitled to reasonable and understandable explanations about the ultrasound policy instead of giving the women an extra ultrasound with a fabricated reason or telling them that the reason they cannot have another ultrasound was because the ultrasonographers were too busy.

Suzui's (2005a) study shows that Japanese women are sensitive to their pregnant bodies and babies by using their own senses and the care providers' palpation apart from ultrasounds. In fact, one of the women in the study proudly stated that she could have told that if something had been wrong with her baby even if she had less detailed examinations or care of New Zealand. In another study by Suzui (2005b), 30% of the Japanese women mentioned negative comments concerning the image of their ultrasounds, for example, "It provided a feeling of strangeness," and "It reduced the feeling of looking forward to meeting the baby" (p. 94). So, ultrasounds do not always please Japanese women.

Further, Suzui (2005a) suggests that Japanese women do not gain a sense of ease and happiness only with the image on the screen of ultrasounds, rather, their psychological comfort is obtained only with the professionals' explanations and comments about the

development of the foetus in conjunction with the ultrasound. Therefore, there is a great possibility that improved communication between the women and their care providers can make up for the women's desire for more ultrasounds, as well as offering the women a sufficient amount of information concerning New Zealand's approach to ultrasound use. With improved communication and information, the women can make informed choices based on the evidence for ultrasound screening in New Zealand.

The impact of communication on the women's experiences

The Japanese women's experiences also seemed to be influenced by their subjective understanding gained as a result of how they communicated with their care providers. Moreover, there is every possibility that the communication and their reactions are related to language issues and particular Japanese ways of communicating. Therefore, issues and styles of communication for those who have Japanese cultural backgrounds in New Zealand or other Western countries will be worth discussing when considering the Japanese women's experiences within the New Zealand maternity care system.

Language barrier

The first issue concerns the English language. English is used in the maternity care at all times and is not their mother tongue. Most of the Japanese women in this study did not report feeling stress communicating in English in daily life, but they discussed the difficulties with the technical language used throughout pregnancy and labour. Furthermore, communicating in English all the time was frustrating, especially during labour and when they were exhausted from taking care of babies after birth. When people are stressed, it is often difficult to respond clearly to what they are asked or to understand what it is being discussed properly. Therefore, the language barrier would clearly be a source of dissatisfaction with their care and birth outcomes. Even when the women were calm during pregnancy, how deeply they could communicate and understand about their care was a concern because they avoided reading the English maternity information given to them. As it is, Yeo et al. (2000) suggest that care providers should not expect Japanese to read and understand written information however well they appear to understand English.

The difficulties for non-English native speakers within maternity care have been shown in several studies. For example, in the study of immigrant women in Australia (Small, Rice, Yelland, & Lumley, 1999), the women's English ability was strongly associated with their satisfaction of the maternity care. Further, the study showed that the rate of Caesarean section for the women who spoke limited English was double that of the women who spoke fluent English, 31.4% and 15.3% respectively. In the study, the immigrant women who did not have assistance from interpreters also had a higher rate of Caesarean section than those who had this option throughout labour and birth, 38.7% and 18.8% respectively. This shows the importance of having interpreters for non-English native speakers.

Like many women in the study by Small et al. (1999), the Japanese women in Dunedin had their husbands and family interpreting for them during labour and birth. However, the care providers must carefully consider these translations and the women's responses but not embrace them fully as the truth. The partners' assistance is obviously helpful, but, in fact, the husbands' interpretation is just a translation of the complicated explanations from the professionals into simple English words or sentences in order to let the women respond yes or no, or make them feel at ease. This was common to the experiences between the Japanese women in Dunedin and the immigrant women in Australia (Small et al., 1999). The women then respond to these simple questions, but in doing this possibly miss much information. Also, the immigrant women in Australia made negative comments regarding their experiences with their interpreters such as inaccurate interpretations and only partial interpretations (Small et al., 1999). So, the care providers may not be able to depend on verbal communication with the women during labour and birth, and require a more careful approach for those who are not English native speakers.

Passive attitudes

In addition to recognising the differences between languages, taking into consideration the Japanese way of communication is also a significant tool to help us better understand the Japanese women and their resultant experiences. Tachibana (2009) argues that the difference between languages also suggests a different way of thinking and communicating. Of course, the idea that the way of communication differs from culture to culture has been well documented (Aida, 1970; Gallois & Callan, 1997; Hall,

1976; Scollon & Scollon, 2001). The former American President Bill Clinton once stated, when a Japanese person said “yes,” they often meant “no.” This statement was criticised as lacking an understanding of the Japanese way of communication, which cares for personal relationships more than the messages of the words (Okoshi, 2005). Thus, understanding the different styles of communication of other cultures is very difficult.

Japanese value saying nothing and reading the atmosphere of someone’s emotion and messages between words or without words (Kenmochi, 1992; Okoshi, 2005). In fact, there are many proverbs in Japanese claiming that saying too many things or speaking too much is ungracious. Also, *hikaeme* - humility, modesty, humble, not showing one’s own opinions or not expressing one’s own emotions - is a virtue in Japanese culture. These Japanese characteristics have also been discussed in the theory of dependency, *amae* (Doi, 1971). Within the highly homogeneous society of Japan, people can expect other people to guess their intentions and implications based on this mutual dependency, so they can take a passive attitude, but this communication approach does not work well in the West.

Japanese society is also known as a collectivism or mutual collaboration in contrast to the individualism or mutual independence found in many Western societies (Fukasaku, 1971; Okoshi, 2005). With such a conformist Japanese worldview, people feel more comfortable to make the same decisions as other people and to follow someone’s opinion instead of arguing one’s own point of view in a relationship. However, this does not mean that people are necessarily happy with the choice and the result. As Inamura (1980) and Honjyo (2012) argue, many Japanese also have interpersonal stress or anxiety when they communicate with non-Japanese. Accordingly, the women hesitate to ask questions and often do not express what they really want, expecting the care providers to read their wishes without saying. Moreover, they may even rely on the care providers’ opinions, even if it goes against what they think should happen. These attitudes contribute to the lack of understanding, a feeling that something is missing and dissatisfaction with the care.

The passive attitude of Japanese is frequently discussed in the health and medical fields, and in terms of doctor-patient relationships in Japan (Nishiyama, 2009; Sameshima,

2010). This is called *omakase iryo*. *Omakase* means letting someone else make decisions for you or take the lead, and *iro* means medicine. For example, if you see an *omakase* course in a sushi restaurant, that means the sushi you would eat would be chef's choice. So many patients or clients trust doctors and tell them "*Omakase shimasu* - I will leave it to you" and entrust their treatment to doctors. This phrase was also stated by the women in this study on decision making for pain relief and other care choices. Of course, this trust and dependency exist on the basis of the belief that professionals know best. There is a well established Japanese structure and relationship between doctors and patients, where doctors are positioned above patients and lead them; absolute trust is often given to doctors in Japanese society (Okoshi, 2005). So although concepts of patients' rights including informed consent and second opinions are discussed more frequently in Japan, *omakase* is still a typical attitude towards medical services. This also helps us to understand why the Japanese women of this study desired doctors as their LMCs.

Omakase shussan (birth) is also said as the birth version of *omakase* medicine. Likewise, leaving the care of their bodies and babies up to doctors, professional centred care, and the medicalisation of women's bodies in the maternity care and reproductive health sectors have been criticised in contemporary Japan (Akai, Iwatani, Uchiyama, Kagitani, & Yamakawa, 2004; Kashiwaba, 2008; Misago, 2004; Namihira, 2005). These tendencies of *omakase* are completely irreconcilable to the midwifery practice characterised by women centred care and mutual communication. Where women have this attitude, it is difficult for the care providers to support the woman's aspirations for her childbirth care.

On the other hand, these Japanese women are probably easy to care for because they are "good" clients, in other words submissive. This is an obvious problem for women who have a different culture from the dominant view. In Small et al.'s (1999) study, when an immigrant woman made a decision that coincided with the dominant care in the West - having a shower after birth - but opposite to her birth culture, her midwife told her, "You're a good girl" (p. 97). This midwife did not push her opinion with respect for the woman's culture, but by complimenting on the woman's choice, she sent the message that she preferred her to act in accordance with her dominant worldview.

The Japanese women in this study also presented similar situations in terms of ultrasounds, pain relief and other care. For example, one woman stated that she had a shower on her midwife's advice despite being scared of having a shower. Being dutiful as well as not hurting the care provider's feelings or the relationship is often more important than asserting their own beliefs for Japanese women. For such women, the advice and opinions of the care providers are very influential. Therefore, the care providers need to carefully recognise the women's communicative background and reflect on how they are providing the care to the women.

At the same time, there is another danger of such an attitude in women. One woman in this study mentioned that she felt comfortable depending on the decisions of doctors and midwives, which happened more often in Japan, and she was bothered when doctors and midwives asked her opinions and options each time in New Zealand. This dependency, or *omakase*, over the decision making was supposed to be based on a traditional and an absolute trust with the professionals. However, she added that it was easy to depend on the professionals because she could complain to them if something happened. This motivation is obviously different from the previous *omakase* attitude, and seeks to avoid individual responsibility in a modern and Western way, which tends to settle problems that arise with judicial action. This Japanese woman also stated that leaving the decision to the women or clients in New Zealand was a way for professionals to avoid responsibility. So this decision making process is very complicated. At the same time, she might not have felt like this if she had received helpful information and supportive attitudes from the care providers about her decision-making responsibilities. Here, again, how care providers communicate based on awareness of cultural differences is essential.

Discussion 2: Japanese women's perspectives on managing labour pain

Frequent use of epidurals among the Japanese women in New Zealand

The frequency of pharmacological pain relief is also one of the most significant differences in care between New Zealand and Japan. The women's experiences with how labour pain was managed in New Zealand highlight different issues when compared with other aspects of care, such as choosing a LMC discussed previously.

Among the 13 participants in this study, two did not have the chance to feel labour pain as they had a Caesarean section before or at the very beginning of labour. Among the other eleven women, eight had used pharmacological methods to relieve their labour pain, and only three had not used any form of pharmacological pain relief during their birth experiences. All the women can be roughly divided into four groups in terms of the experiences of the pain relief. First, one woman really wanted to use an epidural and planned to use it. The New Zealand epidural-friendly birth culture was a source of pleasure and salvation for her because she thought she would never have a baby due to the fear of labour pain when she was in Japan.

Secondly, two women did not require or use any pharmacological pain relief and the option did not even cross their minds during their labour. It seemed that they were determined not to use such pain relief methods. Green (1993) discusses women intending to avoid drugs for labour pain are more likely not to use them. Their intention and preparation for natural birth looked strong and also signalled by their choice of midwife and the preparation of a birth plan. One of them first planned homebirth. She could not have her baby at home, but still chose a like-minded midwife who understood her desire to give birth in water. The other women's LMC was originally a homebirth midwife, and this woman was the only one who explicitly chose a midwife as her primary care provider while other women in the study were reluctant. The experiences of these two women agree with Leap's (1996, p. 2) hypothesis that homebirth midwives are more likely to support "working with pain" rather than trying to remove the pain.

The situation of the other woman who did not use pharmacological pain relief was different from these two women in the second group. This woman asked her midwife to give her any kind of pain relief, but finally she did not use any pharmacological pain relief with her midwife's advice. As she had little hesitation to use pain relief, her attitude towards pain relief probably more fits into the third group.

Approximately half of the women were not sure whether or not to use Entonox²⁰ and epidurals, or did not even consider their pain relief options before the labour. In the end, they all incorporated either Entonox or epidurals into their labour. The women in this

²⁰ Please refer to Footnote 4.

group accepted these forms of pain relief either positively or passively but comparatively smoothly and unquestioned when they were actually in pain. These women might have had modern and westernised ways of thinking about pain relief since women's values of labour pain are gradually changing and the demand or desire for epidurals is slightly increasing in Japan (Kikuchi, 2007).

When epidural birth is discussed in Japan in magazines and the Internet, or even by healthcare professionals, the major point emphasised is how common epidural birth is in other developed countries, such as the United States and France, often implying that Japan is very behind those countries in this respect (Amano, 2003; Kondo, 2007; Morishima, 2006). Western ideas have an inevitable impact in contemporary Japan (Hashimoto, 2009). For Japanese who are often said to have a feeling of yearning and inferiority to the West and greatly influenced by Western ideas (Hua, 2007; Takahashi, 2006), and especially for women who fear labour pain, this kind of information is particularly influential. In fact, the women in this group described themselves as being lucky to be in the New Zealand maternity care system that offered them these choices.

Lastly, there were a few women who hesitated to use epidurals even if they had allowed themselves to use Entonox, but they ended up having an epidural. For the women who did not want to use epidurals, the emotional effects were significant. This dilemma resulted in an intense inner conflict during and after their labour. The sense of resistance against pharmacological pain relief is probably rooted in a deeper part of Japanese sensibilities rather than just failure to stick to their birth plan. Furthermore, it seemed that they tried hard to justify or to convince themselves of the beneficial use of epidurals. Of course, there are women who hesitate to use epidurals for labour pain in any ethnicity, including Westerners. However, it should be recognised that these Japanese women came from a country having a strong aspiration of antidrug-orientated birth, especially for managing pain.

It is important for women dealing with these intense internal conflicts to have support during and after the birth to enable them to deal with their feelings in a more open way. It is also important for care providers to understand these feelings and their cultural background in order to provide appropriate care. Recognising the Japanese context and

the value and meaning of labour pain for Japanese must help care providers understand the experiences, concerns and issues of Japanese women in this situation.

Japanese context of pharmacological pain relief

Japan is a unique country in that it has a very small proportion of epidural births compared to other developed nations. The standard of Japanese medical care is as high as other developed and industrialised countries, which makes this discrepancy an interesting point of difference that should be further explored (Yoshida, 2008, 2010). Epidural birth in Japan has been estimated at 1% or at the outside less than 5% of births (Kondo, 2007; Okutomi, 2010; Yoshida, 2010). According to a recent study (Terui, 2011), which is the first data revealing the ratio of epidural birth in Japan, the current epidural rate is 2.6% of the births in Japan while in comparison it is 28% in New Zealand (NZHIS, 2007). In Japan, the administration of pethidine and Entonox is even less common than epidurals since studies and descriptions regarding these kinds of pain relief are rarely found. Hence, if the use of pethidine and Entonox in New Zealand were included to the statistics, the contrast between the two countries would be even greater.

The Japanese figures show that Japanese women seldom have epidurals to relieve their labour pain unless they choose to attend one of the few hospitals that provide epidurals as a common practice, and whose rates of epidural birth are inconceivably high ranging between 80% and 100% (Aiiiku Hospital, 2009; Y. Tanaka, 2012; Tokyo Adventist Hospital, 2012). So, many Japanese women intend to give birth without pharmacological pain relief in Japan. If anything, they do not even think about their pain relief options when they have babies since the choice is often not available.

In the first place, epidural birth is not generally known among women in Japan. In the study by Okutomi and Minagawa (2000), only a quarter of the Japanese women had heard about epidural birth, and only 16.5% of the women knew what it was. In contrast, the large majority of the women in the study knew about breathing methods (93%) and water birth (82%). Amano (2003) also mentions that epidural birth has never been able to attract the attention of Japanese who have a different cultural and social background from Western countries. Soutter (2005, p. ii) states that there is “the myth that many women in ‘normal birth’ require medicalised ‘pain relief’” in New Zealand, but that myth has never existed in Japan.

Additionally, while I was attending hundreds of births in Japanese hospitals, I never saw women requesting pharmacological pain relief. One of the main reasons is that the choice is not even an option or a part of normalised birth culture in Japan. A few women said, “Please cut my belly” when they really could not endure the pain. It does not mean that care providers would offer women a Caesarean section in response to such a request. In fact, the rate of Caesarean section is not high in Japan. It has been increasing, but the rate is 18.4% while that of New Zealand is 23.7% (JMHLW, 2010c; NZHIS, 2007). Thus, it is obvious that the use of pharmacological pain relief methods during labour in Japan is far less than in New Zealand, and the Japanese women of this study were also born and raised with this birth culture influencing their understanding of the role of labour pain and pain relief.

Japanese perspectives on labour pain

It has been discussed that Japanese have a nature-centred view of life and experience things more with a sense of the body rather than with the mind or rationally as in the West (Fukasaku, 1971; Kenmochi, 1992; Kono, 2004; Okoshi, 2005; Tachibana, 2009). Masao Watanabe (1976) suggests that the Japanese do not separate the human mind and body from the rest of the world and thus do not objectify or privilege themselves; everything is thought to occur as a continuous flow of life and nature. This Japanese worldview does not try to remove labour pain from the body, and would conversely suggest dealing with labour pain without the involving the mind and rationality. In fact, in an early Japanese book for childrearing Noguchi (1969) maintains that labour pain is not painful and you feel pain only when your brain is too sensitive. Ironically, this concept of coping with pain “with the body” echoes a current “working with pain” approach of NZCOM, “Trust your body not your brain” (NZCOM, 2010, p. 5).

In addition, the Japanese values of patience, endurance, perseverance, and self-restraint have been formed by the nation’s geographical features, climate and agricultural culture (Amanuma, 1987; Okoshi, 2005). The Japanese orderly manner maintained even in the midst of enormous disaster, like the earthquake and tsunami in 2011, has always been reported with some amazement all over the world (Okoshi, 2005). Such Japanese dispositions may be useful to be set as a premise of discussion about Japanese and labour pain.

Yoshida (2008) historically compared the treatment of labour and birth pain between Japan and the West. She argues that one of the reasons why Japanese do not use pharmacological pain relief for the birth is that birth is considered as the work of gods and using drugs to assist the birth means being against gods. Historically speaking too, the world's first anaesthetic surgery was successfully conducted in Japan in 1805, but it seems that no one imagined applying this skill to childbirth (Yoshida, 2008). In the West, however, anaesthesia was adopted for labour pain in England only four months after the first anaesthetic surgery in the United States in 1846 (Yoshida, 2008).

Why anaesthetic pain relief was applied to the birth so quickly and easily in the West can be explained by the different value and meaning of pain between cultures. Pain is considered an original sin within the Christian world while overcoming the labour pain is an honour in Japan (Simkin, 1989; Yoshida, 2008). Furthermore, the origin of the word "pain" comes from the Greek and Latin root meaning penalty or punishment. The original meaning of Japanese pain is tremendous, and does not involve sin or punishment. Yoshida (2008) discusses that understanding labour pain as an original sin tends to provoke women's antipathy, while considering it as an honour gives women more motivation to go through the pain. Therefore, labour pain is something to get rid of in the West while it is something to overcome in Japan. Moreover, contractions and labour pain are different words in English, but these words are represented as one word in Japanese, *jintu*. Conceived of in this way, contraction and labour pain accompany each other and cannot be separated for Japanese.

Removing the pain of labour is a reasonable right of women in the case that the pain is a penalty for nothing, but if labour pain is an honour, taking the pain away means losing a rite of passage and honour as a good mother. In fact, the Japanese women Yoshida (2008) interviewed gave labour pain a positive meaning by stating that overcoming the pain is a "women's privilege" and "gaining prestige" (p. 277). Of course, it is also denied that there is social pressure on women to overcome labour pain in such Japanese perspective (Yoshida, 2008).

For these reasons, Japanese women's sense of discomfort with epidurals might be stronger than Western women and other women who are in or from countries which have a high percentage of epidural birth. Furthermore, it is important to note that

Japanese women's feelings can be very vulnerable when they are not able to go through labour pain and therefore cannot obtain the honour it provides. When such Japanese women end up having an epidural birth, they often really struggle to accept this reality, and the feelings of disappointment, guilt, shame, defeat and self-denying become severe.

Moreover, the Japanese cultural practice of labour pain has been removed from or has not followed the westernised medical model of childbirth. Like the rest of the world, the place of birth dramatically shifted from homes to hospitals, the responsibility of birth was transferred from midwives to obstetricians, and medical interventions and routines were introduced in Japan (Kikuchi, 2007; Yoshida, 2008). However, the prevalence of epidural birth did not occur in Japan, even though it has rapidly increased in adjacent Asian countries such as South Korea and the urban area of China recently (Okada, Murayama, & Sato, 2008). Nelson (2006) indicates the choice of LMC depended on the relationship between women's inclinations for epidural birth and the recognition that obstetricians tend to recommend epidurals. However, one Japanese woman in this study who suffered from a mental conflict to accept an epidural during and after her labour chose an obstetrician for her LMC. Therefore, even if Japanese women prefer obstetricians and advanced medical hospitals, and accept other medication and interventions to have their babies, the use of pharmacological pain relief is probably a different matter.

Managing labour pain in different cultural contexts

As seen in the different perspectives on labour pain between Japan and the West, it is clear that interpretations of the pain differ by culture (Kay, 1982). Illich (1975) claims that pain has a place in traditional culture, and each culture has a way to accept the pain as a meaningful thing. Moreover, many other studies (Baker, Ferguson, Roach, & Dawson, 2001; Callister, Khalaf, Semenic, & Vehvilainen-Julkunen, 2003; Jordan, 1980; Kay, 1982; Moore & Moos, 2003; Schott & Henley, 1996; Weber, 1996) have also proved that the meaning of pain differs from culture to culture and the ways of coping are also various.

Fouche, Heyns, Fourie, Schoon, and Barn (1998) discuss how sensitivity to these cultural differences can reduce the anxiety and pain of labour and birth. This approach includes addressing the mental attitudes and confidence of women before labour.

Women who hear that labour is very painful and have fear and anxiety about labour pain quickly respond to the contraction as pain and feel the pain stronger (Green, 1993; Yoshida, 2008).

By contrast, one woman in this study, who had heard positive comments from her Japanese friends, had no anxiety about pain before the labour, and she received the pain positively, thinking that labour pain should be like that, during her labour. In Japanese society, traditional birthing practices are becoming less common, and fear about labour pain looks to be increasing among women (Kikuchi, 2007). However, Japanese society has accepted the role of labour pain more positively than Western societies. If culture and society play an important role in women's response to labour pain (Callister et al., 2003), it is not an exaggeration to say that there should be differences in psychosocial factors and birth outcomes between women who are socialised to accept labour pain and give birth in Japan and women who give birth in New Zealand.

Consequently, there is the high possibility that women who are isolated and far from their mothers, close friends, and their traditional community have less chance to receive culturally appropriate information about labour pain and the coping methods. In other words, the women's attitudes and experiences of labour pain are influenced by their loss of connection to their traditional birth practices in combination with the care choices made available to them in a different culture, new society, or with different people's perception. Maclean, McDermott, and May (2000) claim that culturally different women giving birth with birth attendants who do not share the woman's culture or language are at risk of increased anxiety and pain. Also, the offer of pharmacological pain relief can be more likely. In fact, the study by Malin and Gissler (2009) showed that immigrant women were more likely to receive epidurals.

Epidural use among ethnic women in New Zealand

New Zealand Statistics showed that 36.4% of Asian, 33.0% of European, 18.4% of Pacific peoples and 14.8% of Māori used epidurals during their labour in 2004 (NZHIS, 2007). McAra-Couper (2007) points out that women in some ethnic groups received epidurals more readily in New Zealand. The percentage of Japanese women or women from other countries and ethnicities who have epidural births is unclear. However, the ratio of Asians' epidural birth seems quite high judging not only from a Japanese

context but also from other Asian countries' birth context. It is said that women in Singapore and Hong Kong have comparatively more epidural birth than other Asian countries, but the rates are 16% and 15% respectively (Chan & Ng, 2000; Lee, Chen, & Ngan Kee W. D., 2003; Okutomi, Kato, & Nakagawa, 2012).

Nelson (2006) suggests that the lower use of epidurals among Māori women may occur due to unequal service provision and less choice than for non-Māori women. If this difference among ethnicities is a consequence of unequal care as he discussed, it still does not account for the high percentage of epidural use by Asians in New Zealand. There is a possibility that care providers misinterpret Asians' pain by their stereotyping as other researchers suggest (Bowler, 1993; McCourt & Pearce, 2000; Sheiner, Sheiner, Shoham-Vardi, Mazor, & Katz, 1999).

Regardless of the impartiality or partiality of the care, it is obvious that Asian women have an increased chance of having an epidural birth in New Zealand. In the New Zealand context, women can easily access pharmacological pain relief for labour pain, which could be said to be a significant characteristic of New Zealand birth culture. Japanese women seem to understand that casually recommending the use of Entonox and epidurals is common in the New Zealand maternity care system, like the ability to choose a LMC or the reality of having fewer ultrasounds. The use of pharmacological pain relief offers an exemplary instance of the ways Japanese and other Asian women are powerfully influenced by the culture of birth care practices in New Zealand.

Care providers' influence on decision making of using pain relief

In health care systems of the Western world including New Zealand, choice has encouraged the individual's right, self-determination, and control of one's own body, and a culture that makes choice an absolute and a value-free concept has been established in the last decades (McAra-Couper, 2007; White & Zimbelman, 1998). It looks as if this culture gives women these rights and freedoms. However, choice is not purely chosen by women, but shaped by media and the society (McAra-Couper, 2007). Furthermore, it is strongly influenced by the value of the information received from care providers under the guise of informed choice (McAra-Couper, 2007).

Banks (2010) cautions that dismissing unnecessary interventions in childbirth as women's choice is common, and women are not informed about the truth of medicalised birth for these choices in New Zealand. Stapleton, Kirkham, and Thomas (2002) also claim that women's choice of care is informed compliance where they follow the professionals' preference rather than informed choice and decision making. When choices are available, it looks like women are allowed to be proactive in giving birth on the surface. However, Japanese women in this study stated that they had had no idea what gas they used and what other medication and interventions were even after their births. Women were not informed; they just complied with their midwives' advice. Of course, they did not have any idea about the implications of choosing pharmacological pain relief such an increase of other interventions.

Thus, the way of thinking and attitudes of care providers affect choices of women in labour and birth (Banks, 2010; McAra-Couper, 2007; McCrea, Wright, & Murphy-Black, 1998; Weber, 1996). Accordingly, midwives influence not only the choices available to the women but also their experiences and birth outcomes. Therefore, the care providers, who are mostly midwives in New Zealand, have to recognise how powerful their influence is. If cultural diversity towards labour pain is not perceived by care providers, then the choice of how pain is managed may be based on the value of the care providers but not the women.

In the study by Sheiner et al. (1999), the self-reported pain of two ethnic group women, Jewish and Bedouin, are similar, but the women's pain assessed by Jewish doctors and midwives differ between these two groups of women. The gap between the women's self-reported pain and the care providers' assessments is more significant amongst Bedouin women. Sheiner et al. (1999) discuss how the lack of awareness by the Jewish care providers about women in labour pain from a different culture possibly caused the misinterpretation of the Bedouin women's experience of labour pain. Midwives in New Zealand, who are very conscious of cultural safety (NZCOM, 2008), need to be able to consider the disparity of cultural backgrounds. If they have only a superficial understanding or a false idea of the cultural characteristics, then the concept of cultural care is limited.

For example, before the birth one Japanese woman in this study told her midwife that she would like to give birth without an epidural, but her midwife told her, “I understand what you mean because you are Japanese,” and recommended her to use an epidural. During the labour, her midwife offered her an epidural by telling her “You have done very well” even though she had been coping with the pain positively. She told her midwife, “I’ll leave it to you - *Omakase shimasu*²¹” about the choice of pain relief because she completely trusted her midwife. As Stapleton et al. (2002) stated, it was compliance but not her choice. The midwife’s words “I understand what you mean because you are Japanese” demonstrate the midwife’s cultural understanding towards Japanese women. The words may be meaningful for Japanese women who committed to the idea of Japanese drug free birth while suffering from severe pain, and are undergoing mental conflicts due to the traditional thoughts. However, a question remains whether her judgment on this woman was appropriate. It can be her cultural stereotype of Japanese women that all Japanese women are unjustly patient in defiance of their wish for pain relief.

How other Japanese women in this study came to or did not come to use an epidural is also a significant point of discussion. The opinions of their midwives influenced the outcomes in a significant way. A few women were asked, “Would you like the gas/an epidural?” when they were not thinking about the pain relief at all. One woman asked her midwife to give her the pain relief, but she was told by her midwife that it was too early. The advice made her return to her senses and she did not use the pain relief after all. She reflected that she did not need pain relief when she calmly looked back over her labour. She just asked for pain relief while in a small panic during the labour pain. The other two Japanese women who did not use the pain relief stated that the idea of having pain relief did not cross their minds at all. This means that their midwives never mentioned anything about pain relief during their labour.

These Japanese women’s experiences show that the care and advice provided by midwives to women make a big difference. Most of the women in this study must have been uncertain whether to choose the pain relief or not. In a Japanese birth context, these women would not have been offered pharmacological pain relief. This does not

²¹ The meaning and background of this phrase are discussed in Discussion 1 of this chapter.

mean valuing Japanese birth practices over those in New Zealand or that forcing Japanese women to be patient with labour pain is a better way. However, there is some doubt as to whether pain relief is offered only to those who really need it and how this assessment is considered in New Zealand. There may be midwives who are uncomfortable with women voicing their pain or struggling with labour pain in New Zealand. Walsh (2007) discusses that the negative attitude towards pain is more about professional unease in institutionalised birth. To make matters worse, such a circumstance and care seriously affects women's perception of pain (Walsh, 2007).

Midwifery care Japanese women desire to manage labour pain

Yoshida (2008) argues that Japanese midwives have played an active role in ensuring a low use of pharmacological pain relief in Japan. She discusses how Japanese midwives did not disappear or lose their position to be with women even after birth place shifted from homes to hospitals, and obstetricians became the main care providers. As pharmacological pain relief is not readily available at many birth facilities, not only women but also midwives do not consider it an option to relieve labour pain in Japan. Therefore, midwives encourage women to work with the pain and provide women other support measures such as massage.

Miki Watanabe (2011) investigated what Japanese women expected midwives and family to do in order to get through labour pain, and the women's answers included staying with them, not to leave them alone, rubbing the body, massaging the lower back, holding hands, and talking to them. These are very simple methods, and midwives do not require any technology to ease their pain. Just being with them helps women overcome the labour and gives them confidence. It is common that family and care providers leave women to have a break or a meal once women have an epidural. Midwives are busy keeping record, giving reports, checking monitors, meeting the needs of obstetricians and socialising with other staff outside of the room (McCrea et al., 1998; Walsh, 2007). Japanese women in this study also mentioned that their midwives were doing paper work, reading magazines and attending to something else while they were in the labour. So the situation where women do not need midwife support all the time would be ideal for busy midwives.

In Japan, Enami (2006) shows that presence of midwives close to women and their physical touch gives women ease, security, and peace of mind. Women also feel cherished by midwives' touch (Enami, 2006). Yatsu (2004) states that women's will to give birth and confidence are based on senses of trust and gratitude for the midwives who have always been with them throughout their labour. At the same time, Enami (2006) found in her study that Japanese midwives admired women's attitudes and efforts towards managing their labour pain more than women's self-evaluation. The power of empathy and continuous affective support from being with women gives the women motivation and confidence.

Encouraging women to give birth by their own power is a midwife's role and sometimes not interrupting women's worlds by touching them is better for their birth process (Odent, 2003). At these points, midwives may not always need to be physically present as long as the emotional connection exists. However, being together and touch might be unique characteristics of Japanese who have a culture of dependence, and this may give us a clue as to the differences in care to Japanese women. At the same time, research over the world including Western countries (Hodnett, Gates, Hofmeyr, Sakala, & Weston, 2011; Kitzinger, 1997; McCrea et al., 1998) also shows that midwives' existence, touch, and continuous support is meaningful for women in labour, and reduce the use of pain relief. Therefore, this concept of care is not limited to Japanese but significant across a wide variety of cultures. Moreover, the New Zealand maternity care system is proud of the feature of continuous care so must be a rich ground for the care.

Discussion 3: The importance of birth traditions in another country

The meaning of maintaining traditional birth customs in another culture

The third key point of the discussions concerns the traditional Japanese customs of childbirth. There are many birth-related traditions throughout pregnancy, birth and post birth in Japanese culture, but some of them, mostly practiced during the first week after birth, have been declining since the place of childbirth moved from homes and community to medical facilities, especially during the Japanese post-war economic miracle in the 1960s (Ishii, 2005; Namihira, 2005). Most of the customs and rituals around childbirth are based on the concept of *kegare* meaning ritual impurity and defilement (Ishii, 2005). For the purification or avoidance of spreading *kegare*, the

customs have been held. These concepts originate from the Shinto religion, and the rituals are often rooted in these religious practices, including going to shrines.

In contemporary Japan where most people do not subscribe to any particular religion, people's awareness towards the religious meaning such as *kegare* has waned (Ishii, 2005). Regardless, the customs are still widely practiced. Matsuoka (2003) points out that the current generation practice and celebrate such traditional events more than did their parents' generation because of the information-oriented society and the influence of magazines. Furthermore, Yoshida (2008) argues that the birth customs and rituals help women cope with and reduce the anxiety and fear of childbirth in contemporary society. DeSouza (2005) also discusses how culturally protective and celebratory customs or rituals show women's presumed vulnerability as well as their new social status. Therefore, it is considered that birth customs and rituals play an important role in maintaining psychological well-being as well as protect and promote the physical wellness of pregnant and puerperal women.

The value of the customs and rituals should not be different for immigrant women. Rather, maintaining these customs in their life overseas and feeling connected with their original culture give the women something to believe in and a peaceful state of mind when giving birth without their family in a different culture (Taniguchi, Matsuyama, & Shimada, 2000). Modern technology such as the Internet enables women to collect the information about their customs and helps them obtain materials including maternity and babies' goods through internet-shopping even when they are far from their home country. Of course, practicing some customs and rituals are impossible. For example, many pregnant Japanese women go to Shinto shrines, which deify gods of childbirth, to pray for an easy birth and a healthy baby (*anzan-kigan*). It is also customary to return to the shrines a month after the birth to thank the gods for the safe birth and to pray for the babies' future well-being (*omiya-mairi*). The women in this study could not perform these traditional ceremonies because there are no shrines in Dunedin.

However, most of the women's parents in Japan went to shrines for the women and sent them charms for a good birth (*omamori*) and traditional maternity girdles (*haraobi*) from the shrines. It was obvious throughout the interviews that the women highly valued these customs and items even though most of them were not religious. They

always kept the charms or amulets with them or in their bedroom during pregnancy, and one woman stated that she kept holding the charm from Japan during her labour. Also, most of the women had been to shrines with their babies for *omiya-mairi* whenever they returned to Japan. Taniguchi et al. (2000) also found that Japanese women giving birth in Hawaii had felt a connection to their families with the birth charms and Japanese traditional maternity girdles sent by their families, and the ritual support from their families had helped their emotional well-being.

Keeping umbilical cords

Outside of Japan, the care providers may hardly be involved in the birth rituals. The women certainly do not ask the care providers how these rituals should be practiced as they would have been done in Japan realising that New Zealand's care providers would not know these traditions. Therefore, these practices probably happen without the care providers knowing about them most of the time. However, there are a few customs where the women needed help and understanding from the care providers in New Zealand. One such practice of the Japanese birth customs which require the care providers' practical help is keeping the umbilical cord.

The meaning of keeping umbilical cords for Japanese

Valuing umbilical cords as the foetuses' vital lifeline can be traced back to the Jomon period (10,000 B.C. – 300 B.C.) (Kamisho, 2000). Umbilical cords are even now kept as a keepsake and supposed to be taken with the children when they get married and when they die. It is also believed that it cures near-death disease once if taken, and helps the children in various ways depending on regional or family legend, as one woman stated in the interview. There are also many traditional beliefs in relation to umbilical cords in Japan. People used to care who cut the cord, what it is cut with, how to cut it, how much blood comes out when it is cut, how close or far from the baby's umbilicus it is cut, and how long it is kept (Kamata, Miyasato, Sukanuma, Furukawa, & Sakakura, 1990; Namihira, 2005). For example, it is said that if it was left long on the baby's body, he or she would live longer, and if the umbilical cord attaching to the baby was too short, he or she would be short tempered. How much the women in this study knew of the meaning of keeping the umbilical cord was unclear, but the idea of keeping them was quite common and taken for granted. In fact, all the women tried to keep the umbilical cords regardless of their religion beliefs, but two women lost them when the umbilical

cords fell off unnoticed by the women. The women had to accept the loss of the umbilical cords, but a woman explicitly stated that she would regret this loss in the future.

How to keep umbilical cords

In Japan, women stay in birth facilities for about one week. During that period, the babies' umbilical cords are carefully checked by the care providers. Once the umbilical cord separates at the umbilicus, it is wrapped with white paper, put in a small wooden box, and given to the mother. Speaking from my personal experience as a midwife in Japan, I had to check and record if the umbilical cords were on or off babies three times a day. I also had to cut and keep an inch of each umbilical cord when I examined placentas and umbilical cords after birth in case it was lost. When a baby's umbilical cord was lost and there was not a spare, one of my colleagues wrote an incident report, and our boss gave us lectures about how valuable umbilical cords were as a symbol of the tie between the mothers and babies. Thus, keeping the umbilical cord continues to be an important Japanese birth custom.

In New Zealand, umbilical cords attached to babies generally fall off at home since most of women go back home in a couple of days after birth. So midwives may be able to give advice to Japanese women when they are discharged as to the approximate time when the umbilical cord may fall off. Also, if a midwife sees that the umbilical cord is almost off at a home visit, she can tell that to the women, and the women can be careful not to lose or misplace it. If the woman requests it, the midwife may also cut and retain a piece of the cord attached to the placenta after birth just in case. Umbilical cords, well dried, can be kept in a small box or something selected by the women. Some women in the study told their midwives that they would want to keep the umbilical cords but some did not, so it is important for Japanese women to be asked about their wishes concerning this custom.

Postpartum life for the women

There are also other Japanese birth customs that require the understanding of the care providers and family during the post birth period. In particular, Japanese give great consideration to how women should spend the postpartum period. It is important to

explore what these postpartum values and beliefs are in order to understand their experiences. First, the most significant custom is the comparatively long rest after birth.

Longer rest after childbirth

Japanese do *tokoage* - folding up futon - three or four weeks after birth. This means that the women stay in bed until then. When I used to visit mothers and babies before one month old as a midwife in Japan, it was normal that I visited them in their bedroom and the women were in pyjamas. Japanese women used to give birth in a special house or room called *ubuya*, and stay there until the period of *imi* - ritual taboo or confinement - expires, which could be up to hundred days in the longest case (Ishii, 2005). This is mainly to isolate women in the state of *kegare* - ritual impurity and defilement - from other family members and the community, but it is also said that women were protected and allowed to have good rest in the pretext of this custom (Kamata et al., 1990; Okutani, 2009; Yanagisawa, 2009).

In contemporary Japan, it is believed that women would have bad health or menopausal disorders when they get older if they did not have a good rest after birth. As women are supposed to lie down in bed and avoid any stimuli, even sun light, it would be better for guests to avoid visiting them until later. People in Japan have an understanding that they should not visit women or if they do, stay only a very short time. However, Japanese women in another country may need to announce during their pregnancy their intention not to accept guests after birth if they would like to maintain this custom.

Some women in this study had guests from an early stage of post birth, but all of them were not happy with that. Other women requested that they would start accepting guests from one week after birth or later than that. Personally, I did not have any guests for three or four weeks when I had my baby in New Zealand. Fortunately, since one of my Asian friends, who had her baby just two weeks before me, followed the same custom, our mutual Western friends could understand my way. For other people, my husband answered all the phone calls without passing it to me, and kindly refused the offers to visit. Therefore, the women need to talk with their partners, family, and friends beforehand to promote understanding and support for this custom.

Midwives can also suggest to the women the necessity of thinking about these issues during their pregnancy. Pregnant women, especially primigravidas, often focus on childbirth as their goal, so it is difficult for them to imagine the postpartum. In fact, the women of this study noticed the differences between the maternity care systems mostly during their pregnancy, but had experienced the spiritual and cultural issues more during post birth. When the women who did not prepare for a rest postpartum finally realised the benefit of this custom, they were too tired and too busy taking care of newborn babies to deal with the issues or to improve their circumstances. Therefore, advice about what to expect and making arrangements for the post birth period would be helpful for them.

Additionally, Hashimoto (2009) discusses the different views concerning the transition period to motherhood between the West and Japan, and argues that “the Western notion of ‘back to normal’ gave a limited view to understand the transition” (p.242). The women in this study had also felt the sense of pressure of this Western perspective, with a few respondents reporting considerable stress from people expecting them to return normal life as soon as possible. Midwives need to be careful not to exert undue pressure or encourage Japanese women to go back to normal life quicker than they feel is appropriate for them.

The restriction of showering and other activities following birth

Having a shower soon after birth is also a major concern closely related to the rest custom. In Japan, washing hair and touching cold water are also traditionally prohibited after birth in order not to get *hie* - chill or cold - into the opened body of postpartum. Having rest and not doing housework help the women not to touch cold water. The diet is also specially arranged to avoid *hie* and to give the body good circulation. Not only washing hair, but also stimulating or using the head, which also includes thinking or worrying in the Japanese understanding, is also best avoided. There are other traditional taboos such as avoiding the use of eyes by reading books and sewing, which is believed to weaken eyesight and cause fatigue. According to Okutani (2009), stimulation of the head and eyes block the movement of the lumbar vertebra, which results in the disturbance of the recovery of the pelvis. For this reason, she recommends not to wash hair for six weeks and not to use eyes for eight weeks after birth.

Nowadays, these customs seem less common because, for example, many women start having a shower from the next day or in a couple of days after the birth in Japan (Kakizaki, 2009). However, Japanese women still do not have a bath for one month even though Japanese have a unique and enthusiastic bath culture characterised by the habit of soaking in the deep bath-tub every night (Japanese Culture Iroha Encyclopaedia Project Staff, 2006). Restrictions of women's movements and some activities such as washing hair are also still recommended in recently published books (Kawana & Matsubara, 2004; Kono, 2004; Okutani, 2009). The idea of avoiding *hie* and restrictions after birth were common knowledge for the women in this study, and were passed down to them from their mothers as an oral tradition. While some of the women questioned the meanings and values of those traditions in the New Zealand setting, they felt uncomfortable ignoring their mothers' advice and their own traditions. Rather, the women obviously cared for their customs. They found that they needed a lot of effort to practice them, and that they were sometimes forced to accept the cultural norms of New Zealand because of the lack of support and understanding for their views.

Beliefs about the different physical characteristics

In Japanese literature, it is maintained that Japanese women after birth should not stand until the pelvis closes, which is supposed to take from three to five days, to avoid physical problems such as backache from the standpoint of *seitai* - Japanese manual therapeutics (Kawana & Matsubara, 2004; Okutani, 2009). Additionally, still, calm or motionless life from three weeks to two months after birth is firmly recommended for the complete recovery of the pelvis (Kawana & Matsubara, 2004; Noguchi, 1969; Okutani, 2009). This can be a reason not to have a shower soon after birth as well as the issue of *hie*. Other than that, any evidence supporting either recommending or avoiding a shower immediately-postpartum was not found through the literature search. However, this custom is obviously a common practice shared across a broad range of Asian countries, and many Asian immigrants have been struggling with this difference in their new countries (Kakizaki, 2009; Rice, 1997; Small et al., 1999).

As the women reported in this study, the differences of body characteristics between ethnicities must also be considered. Not only are the cultural practices considering childbirth different but also life style and daily diet vary between cultures. Accordingly, many physical differences among ethnic people such as the lengths of colons, tolerance

towards some kinds of foods and bony framework have been acknowledged (Ota & Ota, 2007). Kawana and Matsubara (2004), and Kono (2004) also argue the genetic differences in relation to the pelvis recovery after birth between Westerners and Japanese again from the viewpoint of *seitai* therapists. Before discussing which custom or care is better or not, Japanese may need longer rest and Westerners may not need to rest as long as Japanese because each custom is based on the wisdoms and considerations built through a long history.

It seems that midwives in New Zealand think that it is okay or even better to have a shower soon after birth even if they recognise that as a cultural difference since they recommended the women to do so. In fact, many of the women in this study had a shower soon after the birth following the midwives' recommendation even though they were worried and scared. As long as there is no evidence arguing against a cultural practice, care providers cannot judge right or wrong of the custom unless it is obviously harmful to women. It is important for care providers not to assess, care, and give advice to women from different ethnicities or cultures from within their own standards and experiences. In this context, the practice needs to be respected as a cultural custom in common with the rejection of going back to normal life as soon as possible.

However, to respect the woman's culture would not mean just accepting whatever they want. Leininger (2002) suggests that cultural care demands discussion with women about whether their cultural ideals are maintained, adapted, or changed appropriately. Likewise, New Zealand midwives are required to recognise and respect women's cultural contexts by communicating and negotiating with women within the midwifery partnership and practice, in other words, applying the principles of cultural safety²². Thus midwives need to be flexible to the culturally different customs and discuss how these can be safely incorporated into the woman's care plan.

²² The cultural competence has been integrated in MCNZ's Competencies for Entry to the Register of Midwives (2007) and NZCOM's Standards for Midwifery Practice (2008).

How to take care of babies and togetherness with babies

Parallel to the postpartum life of the women, how to take care of their babies following childbirth was another culture concern mentioned by the women. First, taking babies outside from an early stage was a source of conflict for the women. As is the case with women, in Japan, babies also used to be taken in the state of *imi*, which is the restriction term of the movement because of *kegare*, for thirty days after the birth (Namihira, 2005). During this period, babies are supposed to be hidden from the public eye, and go out for the first time for *omiya-mairi*, - going to shrines - a month after the birth (Kamata et al., 1990; Namihira, 2005). The idea of *imi* and *kegare* seems no longer realistic for Japanese, but it is still common that babies are supposed to avoid any stimuli and stay home after birth as long as possible. If the women have a good environment to rest during postpartum, the babies will consequently stay home longer with the mothers. The necessity of rest for both mothers and babies keeps each other's rich and peaceful space and time. Co-sleeping, Japanese parents and children's traditional style of sleeping together, also makes the environment of women and babies' rest different. If mothers and babies sleep together in bed, mothers do not need to get up every time when the babies cry, want to be breastfed, or need a nappy change.

Japanese mothers do not use baby monitors and do not put babies in fenced cots or playpens (Vogel, 1971). Strollers are also relatively new products because babies have been traditionally carried on mothers' back. Besides, babies put in strollers are thought to be feeling fear because they are not only separated from their mothers but are also pushed forward before the parents at the height of many scary surrounding things (Kamisho, 2000). In Japan, mothers constantly attend to their babies and quickly respond to babies' cry or other demands (Doi, 2005; Fukasaku, 1971; Sharts-Hopko, 1995). Through the ethnographic study about Japanese women's breastfeeding, Hashimoto (2009, p. 235) found that such "a baby-centred way" is the Japanese approach for "a woman and her baby in tune," which relates the Japanese cosmology, "multidimensional time." The restriction of socialisation and intimate interaction of mothers and babies, especially for the first month, enable mothers to understand babies' demands, and to get to know and recognise their babies personality and needs (Namihira, 2005).

Babies and children are precious in every culture and society. However, the ways of child-rearing are not always same. For example, not being allowed to go outside and kept in a room or house for an extended period of time, such as being “grounding,” is often perceived as a punishment in Western culture which values freedom and promotes independence to respect individuals. In Japan, which has a group-mind that seeks to protect people in terms of a family or group, to be put outside of the house or separated from other family members is a punishment (Fukasaku, 1971; Slater & Rhys, 2012). Likewise, Doi (1971, 2005) argues that infants have to detach from their symbiosis with mothers to become autonomous in the West, and infants have to be taken into symbiosis to advance togetherness in Japan. Furthermore, Doi (1971) points out that the strong mother-infant bond underlies the world of *amae* - mutual dependency, which is continually discussed as a significant concept to understand Japanese characteristic structure and does not have an equivalent word in European languages. What is more, there is no doubt that this relationship sets the pattern for following personal connections, and always plays a central role in Japanese society. Since this is often used to explain the relationship between Japanese doctors and patients, knowing this concept may also be useful to understand Japanese communication and attitudes in health services.

Considering that such cultural differences are already established at this early stage of life, the ways should be respected as long as the women value them. It is discussed that the style of child-rearing has dramatically changed by westernisation after World War II in Japan (Masataka, 1999; Tashimo, 2006). However, traditional roots cannot be so easily changed since the differences originate in how babies are perceived among cultures; babies are taken as children of gods and dealt with as trust from gods in Japan (Kamata et al., 1990; Masataka, 1999; Namihira, 2005). Furthermore, mothers’ intuition and cultural wisdoms are often considered more reliable than science in terms of child-rearing. In fact, most of the women in this study had been conscious of Japanese traditional views lying deep in their hearts and mind while they were accepting and choosing some Western ways.

The influence of the women’s mothers through childbirth

With regard to how to spend the time following birth and how to take care of children, the women tended to follow Japanese traditions when their mothers came from Japan to

New Zealand to help them. In other words, their mothers shared with the women the Japanese ideas and customs that they brought with them. In those cases, the women were sometimes placed in a dilemma between two people who have different cultural beliefs. For example, the women would find themselves in a dilemma as to whose advice to follow; their mothers', their non-Japanese partner's, or their New Zealand care providers'.

In contrast, the women who did not have their mothers by their side seemed to be more willing to accept the advice of their partners, midwives, Plunket nurses and friends in New Zealand in the absence of their own cultural influences. As these women followed the New Zealand practices, they might suffer less from the dilemma, confusions and conflicts mentioned earlier but would miss the chance to continue their Japanese traditions. For these women, professional advice was especially powerful, and it was easier to follow the dominant practices of their environment in order to avoid confrontation and confusion. However, they still could not help being aware of the differences between what they believed to be appropriate for them and the New Zealand ways, for example, variations with how to put clothes on their babies and how to place their babies in bed. Therefore, the care providers should not only advise the practices that they know, but need to recognise different traditions and help the women choose the way they think is best for them. Occasionally, the care providers could learn Japanese customs from the women, for example, how to put Japanese nappies on babies or how to take care of babies in other ways. This process would enable the care providers to appreciate different traditions and why the women struggle so much between them.

***Satogaeri*: Japanese traditional support during postpartum**

In addition to the impact of the women's mothers, it should be noted that support around childbirth is customarily provided by women's mothers or families rather than their partners in Japan (Yoshida et al., 1997). This support system is called *satogaeri* birth (*sato* means hometown and *gaeri* means returning), and many Japanese women return to their parents' home from full term of the pregnancy until one or a few months after birth to receive support. This Japanese tradition is to protect the woman's mind and body before and after birth. *Satogaeri* is still common as two-thirds of the women believed it to be a common practice in the study by Kobayashi (2010). In Yoshida et

al.'s (2001) study, 70% of the pregnant women returned to their parents' home and 20% of the women had mothers at their home (reversed *satogaeri*). Other women gave up doing *satogaeri* to be with their own family or to maintain the same care providers. It is obviously difficult for women to achieve rest after birth without good support. This support is not only for physical benefits, but also plays a role in helping mothers learn how to take care of babies. Moreover, having their own mothers by their side gives them mental ease and empowers them because their mothers are the closest role models for women becoming mothers (Kobayashi, 2010).

The women in this study all gave birth in New Zealand, but there are other Japanese women from this community who went back to Japan to give birth. This option had been considered by the participants, but they decided to give birth in New Zealand for their husbands or because of other personal and family issues. Travelling overseas during pregnancy and with a newborn baby after birth was also a reason to stay, and their families in Japan also expressed concern about the women and babies travelling on such a long journey. At the same time, the women's parents were worried that their children were having babies in a foreign country without them. Consequently, the women and their families often talked over the phone and via emails, and kept their connection for the parents and women's mental well-being.

Partners' role

According to Kobayashi and Chen (2008), men's support during childbirth and child-rearing is quite deficient in Japan. Traditionally, there were taboos concerning the presence of husbands at childbirth in Japan (Kamata et al., 1990). For example, in some regions it was said that birth would be harder if husbands were in attendance. However, the father's absence in the process of childbirth has recently been criticised as a negative aspect of *satogaeri*, although there has not been any proof that the custom causes any disturbance of paternal formation or troubles in relationship between fathers and children or mothers (Kobayashi & Chen, 2008). With the changes in Japanese society, such as the increase in nuclear families and a rise in women's social status, the role of men in childbirth and child-rearing is shifting and men are becoming more involved in birth (Kamata et al., 1990). However, the cooperation from partners in Japan seems still much less than in New Zealand. In fact, all the women in this study who had a Japanese partner had their mothers come for support, and some of the women with New Zealand

husbands were pleased that partners commonly attend childbirth and do housework in New Zealand.

In all cases, the partners' understanding and help is essential to maintain the women's traditional birth customs, especially when the women do not have their mothers or sisters by their side around childbirth. This is because they have to ensure that the women do not need to do anything except take care of their babies. Part of this role is to protect the women from the pressure of people who have different views about mothers' life after birth. Where this support is lacking, it could cause significant stress for the women.

It might be more difficult for non-Japanese partners than for Japanese partners and even New Zealand care providers to respect the women's birth culture because they have different cultural histories and ideas. These may not be just about keeping the women in bed, but they may have completely different ideas of how to take care of babies. In fact, the women with non-Japanese partners mentioned their conflicts with their partners concerning the rest custom and baby care while the women with Japanese partners did not raise these issues. Taniguchi and Baruffi's (2007) study in Hawaii also shows that cross-cultural relationships with partners cause more difficulties for Japanese women around childbirth. Therefore, awareness by midwives of the conflict that might occur between women and the partners regarding this aspect of care is important. .

The importance of support from the local Japanese community

Local friends are key people as well as their partners. Yoshida et al. (1997) indicate that the lack of social support around childbirth in different cultures may lead to depression. Fortunately, the women in this study really appreciated a good support network of friends, especially other Japanese mothers who had experienced birth in New Zealand. Most of the women in this study had lived in New Zealand for quite a long time, and had already established a good connection with the community. However, looking back on the first birth at the beginning of her life in Dunedin, one woman stated the difficulties she had without any Japanese friends there for support. She appreciated it when her midwife introduced her to other Japanese women and helped develop her current network of friends in the community. Hence, the isolation especially from their own culture should be avoided, and introducing other women or attending groups from

a similar cultural background may be another indirect but significant way of supporting women.

Sharts-Hopko (1995) also indicates the positive influence of peer support on women having babies in foreign countries, and argues that social support and connections from their own cultural group give women confidence because they can learn their expected roles through the socialisation process and peer feedback. One woman in this study could not talk about the mental and physical stress she was going through to her care providers very well and could not get support from them during her pregnancy and postpartum, but she could open up her suffering to a Japanese friend. Dunedin local papers (“Setting can be ‘sad time’,” 2012) also reported one Japanese woman’s experience of isolation and loneliness during her pregnancy. She experienced depression and felt disconnected from the rest of the community, but the meeting with another Japanese woman helped her. At a weekly Japanese playgroup for mothers and toddlers in Dunedin, approximately twenty families regularly attend, and the mothers’ conversations never stop. Sharing the cultural background in which they can freely talk without hierarchy and any barriers in their own language is a relief for many Japanese women who are already not familiar with expressing their thoughts and emotions. Having good social support is absolutely imperative for women giving birth in a different culture.

Discussion 4: Japanese women negotiating the New Zealand birth context

Japanese women’s reactions to the birth experiences

The final discussion to explore is how Japanese women negotiated their birth experiences in New Zealand. When the women faced differences between the New Zealand and Japanese birth practices, they were surprised, shocked, worried, and confused. All the women had attempted to take some Japanese customs into their maternity experience. Sometimes they needed to modify these Japanese customs to fit their environment. Sometimes the women just had to abandon some of the ideas and practices they believed in. During these moments, the women hesitated to accept, compromised with, or adjusted to the system and care provided. A couple of the women said that they had no choice but to accept the New Zealand ways because they were in

New Zealand. On the other hand, they were also pleased and appreciated some aspects of New Zealand system and care that they experienced.

While the women described their various feelings and reactions to the New Zealand maternity care system, understanding, consent and being satisfied were seldom discussed in the interviews or focus group. This is probably because they managed these situations by themselves and dealt with their feelings internally. Most of the time, they did not negotiate or discuss their concerns and dissatisfactions with their care providers. Also, when their partners encouraged the women to get out of the bedroom and expected them to do housework from an early stage following birth, the women felt sad that their partners held different views from their own, but they did not argue or negotiate.

Philosophical concepts towards difficulties

The women's behaviour seemed influenced by Japanese characteristics as well as each one's personality. When compared with the Western ways, their behaviour may be misunderstood. Therefore, how the women negotiated their problems can be understood only in Japanese psychological and cultural terms.

Maintaining wa (harmony)

Wa means peace, total, harmony or circle. Yanagita (as cited in Yoshizaki, 2003), the pioneer of Japanese folklore, states that Japanese culture is defined by *wa*. One of the most well-known proverbs in Japan is "*Wa wo motte toutoshito nusu - Wa (harmony) is the greatest of virtues.*" This is stated at the beginning of Article 1 of Japan's first written constitution *Seventeen-article Constitution* authored by Prince Shōtoku in 604 (Kanaji, 1986). According to Okano (2003), this constitution is the starting point of Japanese spiritual or moral identity. Since then, or even before then, maintaining *wa* has been an important part of Japanese culture.

As mentioned before, Japanese tend not to show their emotions or argue their ideas preferring to hold back their opinions and avoid conflict. Japanese perceive human beings as part of nature, thus it is considered that life is thoroughly connected to the natural environment with which they co-exist (Hashimoto, 2009). Hence, expressing self implies disturbing the harmony between themselves and the environment.

Hashimoto (2009) states this Japanese cosmology as “living with others and nature in harmony” (p. 228). The attitude that shows this view can be seen in all aspects of life including motherhood. For example, one of the reasons for co-sleeping is to breastfeed the baby without disturbing other family members’ sleep during the night (Hashimoto, 2009). Another example is when Japanese mothers tell the children that they feel sad when the children misbehave instead of the Western custom where mothers may tell the children to go to their room. This also shows that Japanese children are socialised to care for other people rather than to think only about what will happen to themselves as a result of the bad behaviour (Slater & Rhys, 2012).

To maintain *wa*, silence is particularly valuable in Japanese culture whilst the spoken part of communication is more powerful in Western culture (Hashimoto, 2009). For Japanese, silence shows politeness to others because it is the way to respect others and the environment. As Japanese are more likely to be silent, they are also more likely to comply with the directions or advice of health professionals. As a result, many of their difficulties and conflicts remained unresolved. In the study of five Japanese women’s birth experiences in the United States (Ito & Sharts-Hopko, 2002), none of them tried to negotiate their cultural customs with the care providers. Ito and Sharts-Hopko (2002) also point out that the reasons for this is the Japanese inclination to play a passive role combined with the language barrier.

Akirame

In addition to silence, *akirame* - renunciation or resignation - is also an important concept to help understand Japanese behaviours. *Akirame* may be regarded as being the opposite side of the same coin with *gaman* - endurance, patient, perseverance or tolerance. *Gaman* has been introduced into English in the original word with *wa* by foreign journalists who were amazed to see the patience and perseverance of the Japanese during the Great Hanshin Earthquake in 1995 (Yoshizaki, 2003). Enduring pain and distress with patience has long been the virtue for Japanese as it was an important code of ethics for the samurai warriors, as reflected by Confucians (Eibun Nihon Daijiten, 1996). This is also cited as a reflection of fatalism, where people willingly endure and suffer unavoidable situations with a spirit of *akirame*, derived from Buddhist and Taoist philosophy. It seems stoical, but the fatalism also contains an optimistic view. The Japanese saying “Pain is followed by pleasure” is an expression of

the optimism in the fatalism, and it might have echoed the women's attitudes towards labour pain.

Japanese, as part of nature, naturally consider that life is hard and *hakanai* - transient or fragile - like nature (Eibun Nihon Daijiten, 1996). People are supposed to accept all aspects of the life - birth, aging, death, and more - because human life is part of nature's cycle in Japanese thought (Hashimoto, 2009). With this connected understanding with nature and the spiritual concept of *akirame* including the optimistic view, Japanese women might accept and endure their experiences within the New Zealand birth context whether their experiences met their needs and expectations or not.

Kakugo

Another key to understand the Japanese women's attitudes towards their birth experiences is *kakugo* - determination, resolution and preparedness. The women had chosen to live in another culture and made up their minds to persevere through all kinds of experiences that accompany life there. Every woman in this study had permanent residency status in New Zealand with most determined to live out their life in their adopted country.

A few of the women stated, "Childbirth is not a disease." The women, especially those who had been health professionals, had felt proud of the Japanese medical system. In fact, they stated that New Zealand medical care was ten years behind the Japanese one. Regardless of whether this statement is right or wrong, the women actually said that they would go back to Japan if they had a cancer or some serious disease, but not for childbirth. Childbirth is a normal part of their life, so having babies in New Zealand is a natural event for them as long as they are making a living there. Giving birth in New Zealand and accepting the ways are the same as accepting the climate, housing, laws, and the social systems of the country. When they chose to live in New Zealand, they also had to accept living far from their family in Japan. Even though some of them wondered if they might go back to Japan for the birth (*satogaeri*), they had made a decision to give birth in New Zealand at the early stage of their pregnancies. As a result, they could not allow themselves to complain. *Kakugo* is a firm determination, and is used for an inevitable and important resolution like "I am fully aware that I must take the consequences" and "I am prepared for the worst" in Japanese.

Japanese people have the world's longest life expectancy, and birth outcomes such as the perinatal mortality rate are among the best in the world (United Nations Statistics Division, 2012). What is more, the women recognised that all aspects of life in Japan were more convenient. The women living in New Zealand had already experienced these differences through their daily life. Thus giving birth was understood as just a part of their experiences of that life however inconvenient or uncomfortable the system is. There were also positive differences in the life. The women preferred the relaxed and slow life in New Zealand, and valued the differences between the two countries. Whatever the case, it was evident that they negotiated the gaps between the two cultures with *kakugo* as well as *akirame* to try to maintain peace or harmony in their mind and with their external environment.

Being Japanese

As such a Japanese worldview remains in the women even outside of Japan, it is still natural that they seek to hold their ways and feel comfortable with their traditions even if they have *kakugo*. Likewise, it is undeniable that traditional Japanese thought, originated from the religious influences of Buddhism, Shinto, and Confucianism, is naturally and unconsciously rooted in the women's minds. Even if they are not religious or have become westernised or modernised, their worldview has a long history and is not easily transformed. Interestingly, in addition to the meaning of harmony, *wa* also translates as "Japanese" and is common prefix attached to other words in order to identify their Japanese origin. For example, Japanese food is called *wa-shoku* (Japanese-meal) and Japanese traditional dress, *kimono*, is also called *wa-fuku* (Japanese-cloth). So maintaining *wa* also means to keep being Japanese.

Furthermore, in terms of Japanese view of thought, ideology and religion, Japan is often described as unique, even when compared to other Asian countries such as Korea, China and India (Immoos & Kato, 1999; Kato & Kaizuka, 1983; Tachibana, 2009). For example, Furuya (2003) indicates that Christians comprise only 1% of the population in Japan while a quarter of Koreans are Christians, and Christians in China have rapidly been increasing. Furuya (2003) argues that the reason for this is that the Japanese concept of values and life-orientation is fundamentally different from Christianity.

Clark and Takemura (1979) also argue that the psychology of Chinese or Korean people is similar to westerners', but Japanese psychology and ways of thinking are extremely different not only from westerners', but also from Chinese', Koreans' and Southeast Asians'. This raises a concern about whether or not the midwives' stereotype about Asians described by Bowler (1993), for example, making a fuss, fits Japanese women. Exploring the problem of defining Japanese as Asian may also help us understand the issues the women of this study had with Asian midwives. A recognition and understanding of the culturally specific needs and experiences of Japanese women is needed to improve the quality of the care.

Negotiating between two worlds

Dilemmas and decisions

The Japanese women in this study were not always sure what they wanted. They did not always know the details of Japanese system or customs, either. Their ideas of Japanese birth customs are selectively informed by their memories of life back in Japan, magazines, traditions, family and friends. Therefore, even if they felt or recognised the differences between the two countries, they still wondered which way they should take, and often could not decide what was better for them in their new environment. They did not simply dismiss the New Zealand birth practices. Some of them consciously adapted the practices and ideas they thought were good regardless of the culture. They also appreciated many aspects of the New Zealand maternity care and atmosphere. Sometimes, they just decided to take the easiest way and most convenient way. For example, Western diet and weight management practices, though they thought the Japanese ways would be better suited for their babies' health as well as their own.

DeSouza (2005, p. 93) found that Goan immigrant women held "parallel beliefs" rather than struggling to fit their beliefs into New Zealand practices. Thus, they valued Western care while keeping some of their traditional customs in New Zealand. This analogy fits for the Japanese women who also felt fortunate to have more choices in New Zealand than in Japan. Consequently, they had some positive feelings of the New Zealand maternity system and care. The relaxed care and environment were examples, and the women were able to juggle what they missed from Japan with those positive aspects.

Western influences in modern Japan

Interestingly, there is a phenomenon in Japan which echoes Japanese women's confusion and conflict between cultures in New Zealand. Hashimoto (2009) discusses Japanese ways of knowing, seeing, and believing in terms of breastfeeding. In her discussion, she argues that Japanese mothers' confusion has emerged due to the influence of Western ideas in the current Japanese context. Traditionally, Japanese have come to know things from other people's embodied actions, through one's own experiences and with one's own body (Hashimoto, 2009; Okoshi, 2005).

Tashimo (2006) also states that the confusion of Japanese child-rearing is the consequence of the introduction and imitation of Western styles that are inconsistent with Japanese culture. According to Tashimo (2006), Japanese did not have a theory of child-rearing until the Western ideas were introduced after World War II. Originally, Japanese did not need a theory, and they knew the meaning and methods of rearing children through unspoken or unstated actions through the everyday life of the family. However, Western ideas of child-rearing were introduced drastically in the 1960s in Japan. For example, Benjamin Spock's book *The common sense book of baby and child care* (1946/1998) was translated into Japanese in 1966 and has influenced many Japanese parents. Today, the appearances of abnormal behaviours of children and "monster parents" among Japanese born and bred after the 1960s have become common social phenomena in Japan. Yamamoto (1983) also argues that the trend of importing Western ideas led to the sharp rise of mixed feeding, breast milk and formula, in Japan. Furthermore, the recent introduction of demand feeding from the West created the confusion for Japanese women who had traditionally been feeding babies in a baby-centred way (Yamamoto, 1983).

This is not a criticism against Western ways of child-rearing. If anything, this shows Japanese *orokasa* - foolishness - for uncritically accepting Western customs. These examples demonstrate the problems of child-rearing caused by the adoption of ways inconsistent with the original culture and the women's confusion of being placed between contrasting ideas from different cultures.

Changes and reversals of childbirth practices in New Zealand

To make matters more complicated, Japanese women in New Zealand familiar with current maternity practices in Japan are unaware that these practices have been adopted from the West. This leads to confusion with aspects of care in New Zealand which is similar to traditional Japanese ways. For example, the women who consider mixed feeding as common from the current Japanese context were confused with the amount of care and attention paid to breastfeeding in New Zealand. However, the mixed feeding method was originally introduced to Japan from the West. Of course, westernisation did not only occur for child-rearing, but also for childbirth.

McCourt and Dykes (2009) describe the Japanese post-second-world-war reconstruction as a representative case in their discussion of historical changes of childbirth from traditionalism to modernity across the world. In fact, while 95% of childbirths occurred at home in 1950 in Japan, the location of childbirth quickly became split with 50% at homes and 50% in medical facilities by 1960, and by 1980 the ratio of the childbirth in medical facilities rapidly escalated to 99% (Suganuma, 2011). Japanese women's confusion and conflict towards cultural differences have such historical backgrounds in Japan, and the women's experiences in this study demonstrate this. An example is where the Japanese women hesitated to have midwives because they believed they should have doctors for birth even though historically Japanese women have given birth with midwives and the current Japanese medicalised context is a comparatively recent development.

We have seen evidence of these changes and reversals in maternity care in many cultures over time, and New Zealand is a prime example given the comparatively recent changes to the legislation restoring midwifery autonomy that occurred in 1990. This has led to a shift to midwives as the dominant maternity care providers in this country. So the women may well be confused given that they are expected to reframe their ideas about how birth care is delivered from "modern" ways as they see it in Japan to another model of care similar to what was their traditional Japanese model of maternity care.

The risk of trying to maintain wa

The fact that Japanese have a long history of accepting Western ideas unconditionally also shows in Japanese passive attitudes towards other cultures. At the same time, the

rooted and relatively fixed Japanese worldview has also been discussed. Consequently, these discussions suggest again that Japanese women hold the conflicts inside of their mind. It seemed that most of the women in this study were not able to express their opinions enough outside of the interviews, the focus group or friends who are in the same situation. They had often tried to settle the issues with *kokoro no motiyo* - a condition of mind, or how to hold your heart - alone without discussion or negotiation with others. Despite the confusion and conflict that one may hold inside, Japanese subconsciously communicate with a smiling face or mild facial expressions on the outside in order not to disturb the harmony with others, even when they are in agony or tragedy (Kagawa, 1997). As Ozeki (2008) maintains, accordingly, Japanese women tend to conceal true or negative feelings and often pretend to be cheerful even if they are in serious depression. They do not challenge or question authority including the care providers. So, when combined with the attitude to respectfully comply with authority, this can be dangerous for everyone involved. Additionally, Yoshida et al. (1997) report a limitation of utilising Western scales for assessing postnatal depression for Japanese women because of the different ways of self-reporting; Japanese women would rather not express their feelings.

Behind their smile, they possibly have plenty of emotions and various conflicts. Japanese women, who subconsciously privilege the harmony with the local environment and culture, the harmony with non-Japanese partners and the family, and the harmony with the care providers, may not be able to strongly show their emotions and articulate their own needs and desires. Of course, there are personal differences among Japanese women regarding how they express themselves. Hashimoto (2009) argues that more and more Japanese are living an increasingly self-centred life after Western individualism was introduced into Japan during the economic boom in the 1980s. This trend is even stronger when they do not learn the meaning of life for Japanese through family rituals. Japanese women living abroad may be more likely to identify with this trend given the lack of access to their traditions and the flexibility to survive in another culture.

Maintaining wa for cultural safety and a positive birth experience

Most importantly, “*Wa wo motte toutoshito nasu - Wa* (harmony) is the greatest of virtues” is generally understood and used as a caution to avoid fights and to respect others with peace, which includes restraining oneself to achieve harmony for the group.

However, it is said that the intention of Prince Shōtoku, the original author of the phrase, was to remind people to respect different points of views through lively debate, but not to hold back one's idea or avoid argument, since no one is superior or inferior (Kanaji, 1986; Okano, 2003). Therefore, what it really means is that people should negotiate and try to understand one another by expressing one's opinion and listening to others', then people can produce a collective harmony.

The philosophy of New Zealand midwifery practice, negotiation and shared responsibility between women and midwives, closely aligns with the original meaning of this phrase (Guilliland & Pairman, 1995). It is hoped that the real intention of negotiating harmony through discussions with others reflects the women's experiences with the New Zealand midwifery care. This achievement will enable the care providers to provide the women with the most appropriate care and the women to have a satisfying birth experience.

The influence of cultural background

To understand the women's experiences from many angles is an important step to improve their experiences of childbirth. This process begins by understanding that cultural background is one of the most pressing issues for immigrant women's care. For example, Japanese women tended to decline pharmacological pain relief and expect more ultrasounds. Considered only in terms of modern or medicalised care and birth, these Japanese women's attitudes sound like a contradiction. However, their expectations cannot be taken as their own selfish desires. Behind their views, there are always clear grounds built by their society, history and culture to explain these desires. Japanese women may not be able to explain these clearly because of cultural characteristics and language barriers. They may not even know why they have such ideas. If Japanese women and their care providers are able to discuss their cultural backgrounds and characteristics, how they feel, how they react, how they understand, and how they negotiate their difficulties in the New Zealand maternity setting might be different and both parties may learn something new.

Japanese women may need to express their emotions and opinions to others more and talk about their wishes with others even if they do not eventuate. This will help ensure that they go through their birth experiences with emotional and mental well-being in

New Zealand. At the same time, they should not worry too much about expressing everything they think and want in a verbal culture of the West because it is still natural for Japanese women to be silent to avoid the stress and breaking the harmony. It is important that Japanese women maintain a comfortable relationship with others, which involves expressing their opinions, but also at times maintaining their silence. Needless to say, midwives' roles are significant for building successful relationships and communication due to their impact as the care providers.

Summary

To explore Japanese women's birth experiences in New Zealand, four discussions were developed based on 13 women's birth experiences in Dunedin. First, how the Japanese women learnt about the New Zealand maternity care system was examined because it was surmised that their subjective understandings affected their birth experiences. In fact, their understandings were significantly shaped by them comparing the birth contexts of the two countries. Furthermore, it was noted that a lack of clear communication between the women and the care providers occurred in part because of Japanese communication style.

One discussion focused on the women's experiences regarding pharmacological pain relief during labour. To investigate the women's conflicts concerning the use of pain relief, the different perspectives towards labour pain were discussed. At the same time, the Japanese women were considered to be swept up by the New Zealand maternity culture and model of care. The discourse of women's choice and the influence of the care providers' attitudes underpinned the complexity of the phenomenon, and therefore, the midwifery care that the women desire was suggested.

The importance of Japanese birth traditions was also discussed through examples of the main Japanese customs which the women struggled to maintain in New Zealand. These traditional birth customs and perspectives of child-rearing had significantly shaped their experiences and meanings of motherhood, and connected them to the Japanese culture while living in another culture, even if they appreciated aspects of the culture and practices in New Zealand. Additionally, it was suggested that the understanding and

support from the care providers and their supporters were essential for them to maintain their traditions.

Finally, how the Japanese women negotiated their birth experiences in New Zealand was explored. As it was deemed difficult to understand the women's emotions and behaviours only using Western ideas, Japanese cosmology and concepts were introduced. Maintaining *wa* (harmony) is one of the significant principles and it is understood that this attitude deeply and widely underpins their birth experiences. Furthermore, it was found that their confusion and conflict echoed many of the same tensions that originated from Japanese history when Western culture was introduced in Japan. This suggested the complexity of their experiences and the importance of recognising and understanding the women's cultural background.

Through each discussion, issues and possibilities for midwives to reflect on when providing care for Japanese women were raised. These included the importance of communication, providing sufficient information and explanation, and the pitfalls of adopting generalised stereotypes. Basic knowledge of New Zealand maternity care is not common sense for Japanese women, and Japanese perspectives are not familiar to the care providers either. This recognition is a critical first step for establishing mutual understanding and forms the basis of the harmonious partnership between women and midwives who are brought together by different cultures.

Chapter Seven: Recommendations and conclusion

This study was a qualitative descriptive research exploring the satisfaction, difficulties and cultural conflicts of 13 Japanese women who gave birth in Dunedin, New Zealand. The women's stories and opinions were collected through nine interviews and one focus group, and analysed using thematic analysis to uncover the complexity of their experiences including inner conflicts. Four themes emerged from the data, which shaped the discussion around four subject areas. It was emphasised that the differences of the birth contexts between the two countries, Japanese traditional customs, worldviews and attitudes underpinned their understandings and experiences. To conclude, the strengths and limitations of this study are considered and recommendations are offered to assist maternity care providers to understand and provide more culturally safe care.

Reflections of the study

This study detailed birth experiences of 13 Japanese women in Dunedin, New Zealand using in-depth interviews and a focus group. The women's stories highlighted not only their personal struggles with language and cultural differences, but also with aspects of the New Zealand maternity care system. Japanese culture and perspectives on childbirth are not well documented in the West, so this study contributes critical information required to understand the issues for Japanese women giving birth in other cultures. The findings also indicate specific areas that could be improved to reduce cultural misunderstandings in the future. The positioning of the researcher, who is a Japanese mother herself, was also important as it enabled the participants to express themselves candidly and in their own language.

The participants in this study were all long term residents who already had established broad social networks and had some previous knowledge of the local community and the maternity care system. However, Japanese women who have been in New Zealand for a short time before giving birth or who are living in other cities in New Zealand including rural locations may have different experiences. Similarly, the experience will be different for Japanese women who return to Japan for their birth (*satogaeri*). While these women give birth in Japan, they receive maternity care in New Zealand during

their pregnancy and postnatally. So while understanding the experiences of these women is important, it lays beyond the scope of this study.

This study also examined the birth experiences of a relatively small group of Japanese women. Therefore, including the perspectives of more women, a comparison with the experiences of other New Zealanders, and insights from the perspectives of the care providers would add to our understanding of the broad childbirth experiences of Japanese women living in New Zealand.

Recommendations

Despite these limitations, the findings of this study uncovered several challenges for Japanese women giving birth in another culture. These included the differences not just in the language spoken, but also communication style and the customs surrounding birth. The following recommendations are offered as a gift to the midwives and other health carers in New Zealand with the goal of improving the childbirth experiences for all.

One

The provision of information in both Japanese and English languages, which explains the New Zealand maternity care system and the Lead Maternity Carer concept, is needed. Such resources could include links to websites with the contact details and practice philosophies of the midwives available in each area.

The information should also include a brief summary of the evidence for the current model of care. For example, the women need to be informed that the style of care is based on best practice and research evidence. This sharing of information and advice will help Japanese women make better informed decisions and feel supported by the system rather than alienated by it.

Two

When communicating with Japanese women, it is important that the care providers should not expect them to express all their opinions and feelings. This would include understanding the role of silence in the communication process. The care providers should avoid pressuring the women to express themselves, but

where there is a perceived shyness, the care providers should not assume that they are expected to make the decisions for them. Rather, the establishment of a trusting relationship, which allows for open communication, will help Japanese women discuss their emotions and desires for their birth experience.

Three

A combination of improved peer and official support structures would also remedy some of the issues outlined earlier. The women in this study did not feel that they required interpreters during their pregnancy as they were able to communicate in English in their daily life. However, communication was not always smooth for several women during labour and birth. So, having a Japanese speaker available to help interpret would be of benefit not just to the women, but also to assist care providers to understand the women's perspectives and attitudes towards labour pain and other birth events. The introduction to other Japanese mothers and the community would also be useful support for isolated Japanese women.

Official support systems, such as hospital care, are also required if the Japanese concept of an extended rest after birth is to be achieved. For example, postnatal stays may be extended in some instances, or the provision of a home support service for women living far from their family could be offered. Such a service may incur some expense for the women but would be appreciated to enable a sufficient rest period following birth as defined by their traditional customs.

Four

The final recommendation addresses issues of cultural safety and the need to avoid cultural stereotyping. Acknowledgement and respect for the women's cultural traditions is essential, but it does not mean that the care providers have to accept everything unconditionally. Each Japanese woman has her own view of what cultural aspects are important for her. Thus it is important within the relationship that discussion occurs as to which cultural practices may need to be supported, negotiated, or modified in the best interests of the woman and her family.

Conclusion

In this study, the experiences of Japanese women living between two worlds were described. They are a bridge between the two countries, on which a variety of dramas unfold. Childbirth is a significant event which may make women vulnerable, just like bridges in storms, especially when it occurs in another culture. Care providers have the power to reinforce the structure, and make the passage on the bridge smooth. Like reinforcement protects bridges from the damage of storms, the care providers' supportive care must support women to safely negotiate their difficulties and empower them to experience a rewarding childbirth experience, despite issues that may arise.

Cultural care and cultural safety have been widely discussed in midwifery and health services. In this study, cultural care and safety focused on Japanese women's situations in New Zealand and the ways the Japanese birth context, traditions and attitudes inform their birth experiences and understandings of care. From this perspective, we learnt culture always informs women's feelings, attitudes and experiences, and while we cannot know everything of each culture, we can be sensitive to their experiences by recognising that each woman has specific social, cultural and personal backgrounds. It suggests the necessity for care providers to engage with woman holistically, as an embodied being.

At the same time, the intention of exploring the Japanese birth context, customs, and perspectives is not to highlight or justify the unique Japanese characteristics. Rather, it is hoped that the knowledge of Japanese cultural approaches can improve care and the childbirth experience for all concerned. Most importantly, the information provided in this study is not intended to contribute to stereotypes of Japanese women. Instead, it provides a general idea to start the conversation about the women's care. Weber (1996) argues, "a generalisation is a beginning point" while "a stereotype is an endpoint" (p. 72). From this starting point, the midwives have to assess and understand each woman's needs.

There is no universal plan of care advocated. Care should always be provided to individuals who each have their own cultural starting point. All Japanese are not the same. Ultimately, care must follow and respect individuals regardless of culture. Midwives are charged with being flexible enough to provide care for women from

varied cultures and backgrounds. By working with women, midwives can seek the best way for each woman in each situation. This assessment and understanding begin with the midwives' sensitivity, communication skills, and careful consideration.

In contemporary society, with increasing modernisation, globalisation, and international marriages, it is questionable how much traditional and cultural birth practices can be sustained. However, the women in the study clearly demonstrated how they valued their own cultural practices while living a modern and westernised life. Rather, their traditional and cultural understandings were their primary source of knowledge, peace of mind and "home" within which they identify themselves in New Zealand. Certainly, the women's perspectives continuously shift as they negotiate life with non-Japanese partners within a new culture, but their fundamental beliefs and worldviews remain relatively stable. Thus, exploration of *wa* (harmony), in all its richness and complexity, allows for respectful discussion and negotiation in harmony with the changing worlds and views of each person involved.

I would like to conclude with a passage from Standlee's book *The Great Pulse* (1959) that highlights how Japanese women's experiences over 50 years ago are not very different from the themes of this study:

Pain was woman's portion, to be endured quietly, proudly, and with the appearance of pleasant composure. Westerners, however, are prone to be intolerant of the lowly estate of the stoic Oriental women. They felt compassion for the female child born in a society where human life is cheap. Nevertheless, in spite of the dogmas of religion, in spite of the many social and political indulgences accorded the "Yangs"²³ of the East, especially in Japan - from the privilege of first serving of food to that of the first dip in the communal bath - the women of Japan, like women the world over, had firm control of the traditional customs of the home. (p.26)

This passage summarises many of the issues raised by the Japanese women in this study. The Japanese women both in this study and in this book patiently and positively

²³ Yangs means men and yins means women here.

accept hardship as a part of their experiences, yet they hold their ground in order to keep their traditional customs in the Western/male dominant world. This approach to life is second nature to many Japanese women.

Like the women's attitudes, there are things that have not changed even with dramatic shifts in today's society. The fundamental concept of childbirth as a natural cycle is one of those stable ideas. For Japanese, the pregnancy term is still for 10 months because the women used to count it not with the solar calendar but with watching the moon closely connected with their bodies. Babies are believed to be born after spending ten months and ten days - 十月十日 - in the mothers' bellies. The characters, 十月十日, make the character for morning - 朝. Japanese philosophy of pregnancy and childbirth is always bound up with the natural time, space, and the universe. I bring this study to the end with my hope that babies will see a beautiful morning with their mothers and families after the journey of ten months and ten days anywhere in the world.

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Appendices

Appendix A: Ethical approval

31 August 2010

Keiko Doering
5 St. Leonards Drive
St. Leonards
Dunedin
90225



Dear Keiko,

ETHICS 470 – The birth experiences of Japanese women in Dunedin, New Zealand

Thank you very much for your application. The Otago Polytechnic Research Ethics Committee grants you approval to commence your project.

The Committee noted that it was an excellent application and they would also like your permission to make it available on the Polytechnic website as an example of best practice.

We wish you well with your study and remind you that at the conclusion of your research you should send a brief report with findings/conclusions to the Research Ethics Committee.

We wish you every success with this particular research project.

Sincerely,

Alex Morales
Administrator - Research Ethics Committee

Research Ethics Committee

Private Bag 1910
Dunedin 9054

Freephone 0800 762 786
Phone +64 3 477 3014
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Appendix B: Advertisement for recruitment (Japanese and English translation)

「ニュージーランド・ダニーデンにおける日本人女性の出産体験に関する研究」 研究協力へのお願い

寒い日が続いていますが、皆様いかがお過ごしですか。

私、ドーリング景子は現在、オタゴポリテクニク助産学部修士課程において、上記のようなテーマで研究を進めています。この研究では、日本人女性のニュージーランドでの出産体験を収集したく、皆様からのご協力をお願いしている次第です。研究についての概要は下記の通りです。お忙しい中大変恐縮ですが、ご検討いただければ幸いです。

研究の背景と趣旨

ニュージーランドでのアジア人の占める割合は、ヨーロッパ人、マオリ人に次いで多く、その増加率は他の民族をしのぐ勢いです。出産についての国の報告では、アジア人は帝王切開などの異常分娩の割合が最も高いことが示されています。しかし、アジア人という一つのカテゴリーはあまりにも大きく、それぞれ特有の文化や習慣を持った国・民族ごとの実態はほとんど報告されていません。アジアの一員である日本人のニュージーランドでの人口増加も著しく（過去10年で3倍以上）、日本人の出産体験を知ることは、ケアを提供する助産師や医師、これから出産を体験する日本人女性にとって有意義であると考えます。本研究では、ニュージーランドで出産された日本人女性に、その体験を伺っていきます。

研究の参加対象者

2008年1月以降にニュージーランド・ダニーデンで出産を体験した日本人女性、10名程度。

協力内容

1. インタビュー（面接）

参加者お一人お一人に、ニュージーランドでの妊娠・出産・産後の体験について、1時間程お話を聞かせていただきます。実施日時・場所については、個別に相談させていただきます。

2. フォーカスグループ（グループインタビュー／座談会）

少人数の参加者が集まり、上記の体験について2時間程話をします。日時の設定などにより、協力者全員を対象とできない可能性があります。

その他

- インタビューやフォーカスグループの内容は記述、録音させていただきます。それらの情報は厳重に管理されます。
- お名前が公開されることはありません。
- 研究の協力はいつでも拒否することができます。また、拒否されても研究協力者が不利益をこうむることは決してありません。
- インタビュー内容などの研究データは学術雑誌、学会などの発表で使用させていただく可能性があります。
- 研究終了後、参加者の方々へ、研究の結果をお伝えさせていただきます。

なお、この研究はオタゴポリテクニク倫理委員会での承認を得ています。

研究へ協力していただける方、質問のある方は、ドーリング景子（mizumk1@student.op.ac.nz または 03-471-0318）まで、ご連絡下さい。

**Invitation for women to participate in the research study;
“The birth experience of Japanese women in Dunedin, New Zealand”**

Hello everyone. How are you?

I, Keiko Doering, am working on a research project, titled the above, in the Master of Midwifery course at the School of Midwifery, Otago Polytechnic. To forward this study, I need your help and am looking for participants for this project. The outline of the project is as follows;

Background and aim of the project

The percentage of Asian population in New Zealand is the biggest after European and Maori, and the rate of growth is surpassing other ethnic groups. According to a national report, Asian women have the highest percentage of abnormal birth. However, a category “Asian” is too big and the situation of each country and ethnicity that has its own characteristic culture and customs has not been reported. The population of Japanese, a part of Asian, is also increasing rapidly (three times in the last decade) in New Zealand. Therefore, understanding the birth experience of Japanese women would be meaningful for care providers such as midwives and medical doctors and other Japanese women who will have babies in New Zealand in the future. For this research, Japanese women, who gave birth in New Zealand, will be asked about their birth experience.

Study participants

I am looking to invite about 10 Japanese women who gave birth in New Zealand after January, 2008 to participate in this study.

Methods

1. Interview
The researcher will ask the participants questions regarding their pregnancy, childbirth and postnatal experience in New Zealand. The interviews will be recorded individually and take approximately one hour. The date and place for the interview will be arranged to suit the participants.
2. Focus group
The researcher and a small group of Japanese women will meet following the interviews to talk about the topics that were raised in the individual interviews regarding the participant’s experiences of pregnancy, childbirth in the New Zealand setting. I estimate that the focus group will take around two hours.

Other information

- The discourse of the interview and the focus group will be digitally recorded.
- The data will be securely stored both during and after the research process.
- The name of the participants will be confidential to the researcher.
- The participants can decline to participate at anytime without any disadvantage.
- The data may be used for journal articles and presentations.
- At the end of the project, the participant will be sent the summary of the research findings.

This project has been reviewed and approved by the Otago Polytechnic Research Ethics Committee.

Please contact Keiko Doering (mizumk1@student.op.ac.nz or 03 471 0318) when you can participate to this research project and/or you have questions.

Appendix C: Information sheet (Japanese and English translation)

研究協力依頼書

以下の「研究背景」「研究の趣旨」ならびに「研究倫理」をご一読の上、可能な限りインタビュー（面接）およびフォーカスグループ（座談会）に協力していただきたく、お願い申し上げます。次第です。

研究題目

ニュージーランド・ダニーデンにおける日本人女性の出産体験に関する研究

研究背景

ニュージーランドでのアジア人の占める割合は、ヨーロッパ人、マオリ人に次いで多く、その増加率は他の民族をしのぐ勢いです。出産についての国の報告では、アジア人は帝王切開などの異常分娩の割合が最も高いことが示されています。しかし、アジア人という一つのカテゴリーはあまりにも大きく、それぞれ特有の文化や習慣を持った国・民族ごとの実態はほとんど報告されていません。アジアの一員である日本人のニュージーランドでの人口増加も著しく（過去10年で3倍以上）、日本人の出産体験を知ることは、ケアを提供する助産師や医師、これから出産を体験する日本人女性にとって有意義であると考えます。

研究の趣旨

本研究は、ニュージーランドで出産された日本人女性を対象に、その体験をお話ししていただきたいと思っています。研究協力者には約1時間のインタビュー、または約2時間のフォーカスグループに参加していただきます。インタビューおよびフォーカスグループの内容は録音させていただきます。

研究倫理

本研究は以下の研究倫理に沿って実施されます。

- インタビューやフォーカスグループの内容は記述、録音させていただきます。
- 研究協力者から得られた情報は研究者によって厳重に管理され、10年後に破棄されます。
- お名前が公開されることはありません。
- 研究の協力はいつでも拒否することができます。また、拒否されても研究協力者が不利益をこうむることは決してありません。質問への拒否もできます。
- 分析の過程では、個人を識別する情報を使用しないため、特定の情報のみを取り消すことが難しくなります。そのため、インタビュー内容の取り消しは、インタビュー終了後2週間以内とさせていただきます。
- フォーカスグループの場合、特定の情報の取り消しはさらに困難が予想されます。取り消しなどの希望は2週間以内に申し出ていただき、改めてその決定をご相談させていただきます。
- インタビューやフォーカスグループ後、情報や分析内容の確認のため、研究者から参加者へ連絡させていただく可能性があります。
- インタビュー内容などの研究データは学術雑誌、学会などの発表で使用させていただく可能性があります。
- 研究終了後、研究の結果をお伝えさせていただきます。
- 研究についての疑問は、いつでも研究者から説明を受けることができます。

なお、この研究はオタゴポリテクニク倫理委員会での承認を得ています。

20 年 月 日 ドーリング景子

Information Sheet

This information sheet outlines the background for the study and information about the study design for prospective participants.

Project title

The birth experience of Japanese women in Dunedin, New Zealand

Background of the project

The percentage of Asian population in New Zealand is the biggest after European and Maori, and the rate of growth is surpassing other ethnic groups. According to a national report, Asian women have the highest percentage of abnormal birth. However, a category “Asian” is too big and the situation of each country and ethnicity that has its own characteristic culture and customs has not been reported. The population of Japanese, a part of Asian, is also increasing rapidly (three times in the last decade) in New Zealand. Therefore, understanding the birth experience of Japanese women would be meaningful for care providers such as midwives and medical doctors and other Japanese women who will have babies in New Zealand in the future.

Participation to the project

Participants will be asked about their birth experience in individual interviews or in a subsequent focus group. The conversations during the interview and the focus group will be digitally recorded and field notes will also be taken.

Ethical concerns

The researcher has addressed the ethical concerns for the research project as follows.

- The discourse of the interviews and the focus group will be digitally recorded.
- The collected information from the participants will be securely stored and destroyed after 10 years.
- The names and identifying details of the participants will remain confidential.
- The participants can decline to participate at any time without any disadvantage. The participants can also refuse to answer any questions they object to during the course of the interview.
- Comments can be removed from the interview data up to two weeks following the interview but will not be able to be withdrawn once the data is merged during the process of analysis.
- It is expected that withdrawing particular comments from the focus group will be more difficult. However, if participants wish to withdraw a comment the researcher will do so. This will be possible up until data analysis has begun.
- The researcher may contact the participants following the interviews or focus group for clarification of particular comments.
- The data may be used for journal articles and presentations.
- The participants will be sent the summary of the research findings once the thesis is complete.
- The participants can ask any questions about the project of the researcher or her supervisor at any time.

This research project has been reviewed and approved by the Otago Polytechnic Research Ethics Committee.

00th September 20 , Keiko Doering

Appendix D: Consent form (Japanese and English translation)

同意書

私は、「ニュージーランド・ダニーデンにおける日本人の出産体験に関する研究」について、その「研究協力依頼書」を読み、次の事項について理解しましたので、研究に協力することを承諾します。

- 研究の目的と方法。
- インタビューやフォーカスグループの内容が記述、録音されること。
- 提供した情報は厳重に管理され、10年後に破棄されること。
- 名前は公開されないこと。
- 研究の協力はいつでも拒否でき、それによって不利益をこうむらないこと。
- 質問への回答を拒否することができること。
- インタビューやフォーカスグループの内容の取り消しは、それぞれ終了後2週間以内であること。
- インタビューやフォーカスグループの終了後に、研究者から内容確認をする可能性があること。
- 研究データは学術雑誌や学会などで発表される可能性があること。
- 研究結果の要約を受け取れること。
- 研究に関する疑問について、いつでも研究者から追加説明が受けられること。

追加情報および条件等

年 月 日

参加者の署名

研究者の署名

Consent form

I have read the information sheet concerning the project and understood what it is about. I consent to participate in the project as explained to me by the researcher in the information sheet and I understood as follows;

- The aim and process of the planned project.
- The discourse of the interview and the focus group will be recorded.
- The data will be securely stored and destroyed after 10 years.
- My name will not appear in the thesis or in any subsequent presentations or publications.
- I can decline to participate at any time without any disadvantage.
- I can refuse to answer any questions I am not comfortable with.
- The withdrawal of my comments will be possible up to two weeks after the completion of the interview and the focus group.
- I may be contacted by the researcher to clarify my comments after the interview or the focus group.
- The data may be used for journal articles and presentations.
- I will be sent a summary of the research findings.
- I can ask any questions about the project of the researcher or her supervisor at any time.

Additional information and conditions

Date

Signature of the participant

Signature of the researcher