Historical Dynamism of Childbirth in Japan: Medicalization and its Normative Politics, 1868–2017

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Abstract: This article explores the changing institutional and technological frameworks of childbirth practices in Japan, highlighting the historical dynamism and the normative dimensions of women's experiences. Childbirth practices vary from context to context, depending on normative factors, institutional conditions, and policy measures shaping the reproductive aspirations and practices of ordinary women and families. This article shows how childbirth in Japan was subject to a very powerful and far-reaching process of medicalization going back to the mid- 19th century. In the 1970s, there emerged a natural childbirth movement amongst midwives and obstetric professionals but this movement never really pushed for the de-institutionalization and de-medicalization of childbirth. In present-day Japan, the drive towards high-tech medicalization remains strong, but there is also an emphasis on the need to be "natural" and "healthy" and to avoid unnecessary medical interventions in the body. These two seemingly contradictory sets of demands are an important feature of contemporary Japanese society. Their coexistence is only possible due to the continuing hold of a system of moral responsibility that emphasizes the duty of mothers to do whatever is necessary in terms of medical care to protect the safety and the well-being

of their babies.

This article explores the changing institutional and technological frameworks shaping childbirth practices and highlights the dynamics of modernization and normative dimensions of Japanese women's experiences of childbirth between 1868 and 2017. Aiming to move beyond merely documenting historical changes in childbirth practices, I show how Japanese women found agency within a changing birthing system that increasingly valued technological intervention. To these ends, I examine three interconnected dimensions of the larger process of childbirth modernization: institutionalization, medicalization, and professionalization. By exploring these changes, we can better understand how cultural norms and individual experiences mediate policies and trends to modernize birth. This case contributes to a better understanding of how significant institutional and technological change does not necessarily converge with or reflect social values and may provide individuals with ways to conform or not.

The process of childbirth modernization in Japan entailed many different historical moments and waves of transformation – from the mid-nineteenth century standardization of midwifery care, to bringing births to hospitals during the Second World War, and to more recent developments such as the introduction of prenatal ultrasounds or the emergence of the "natural childbirth" movement. These changes created a complex birthing system that is

informed by multiple values and shaped by two sometimes competing priorities: the drive toward high-tech medicalization of birth and the drive to be "natural" and "healthy" and avoid unnecessary medical interventions in the process of birth. Caught between these two seemingly contradictory sets of guidelines, pregnant women are expected to do whatever is deemed necessary by experts to protect the well-being of their fetuses. At the same time, the biomedical management and control of pregnant women's health extends beyond individual women as it also supports national population policy.

This gendered biopolitics of national population creates complex dilemmas for women and constitutes an important feature of the contemporary Japanese reproductive landscape. Being a pregnant woman in present-day Japan creates a double bind mentality—keeping a "natural body" while accepting medicalization—, and this double bind shapes cultural norms of childbirth and motherhood. Historically, the construction of this double bind model of childbirth and motherhood was shaped by a threefold process of *institutionalization* (i.e., the systematization of laws, medical qualifications, and administration by the national government), *medicalization* (i.e., a process by which human life processes are defined and treated as medical problems under the framework of "scientific medicine"), and *professionalization* (i.e., the formalization of the medical profession through education and qualifications)[1]. This article seeks to identify, document, and analyze key

[1] Conrad, "Medicalization," 210-211.

moments in time where the institutionalization and medicalization of childbirth and the professionalization of midwives created conditions for the construction of a birthing system that places seemingly irreconcilable demands on Japanese women.

Institutionalization, Medicalization and Professionalization of Birth from the Meiji Era to Post World War Two

Institutionalization of the medical profession in Japan,[2] particularly the midwifery profession, goes back to the Meiji era (1868-1912),[3] a key moment in Japanese history when the state ended national isolation and the modern nation officially came into being. The legalization and "qualificationization" (*Shikaku-ka 資格化*)[4] of midwifery resulted in the professionalization of the role of *Sanba 産婆* (direct-entry midwives with national certification). Despite the formalization of midwifery, these women were prohibited from using instruments to assist in labor and delivery reflecting official concerns that these instruments could be used to perform abortions. The practice of abortion was widespread in Japan at least since the seventeenth century and was regularly performed by doctors, midwives, and other experts by means of tools, drugs, and various substances. The first official attempt to ban the practice of abortion goes back to the early years of the Edo

[2] The medicalization of childbirth in Japan began in the 17th and 18th centuries, but I do not have space to discuss this here. For more details see Matsuoka, Postmodern midwives in Japan," and Shirai, *History of Childbirth, Childrearing and Midwifery in Japan.*

[3] The Edo period lasted from 1603–1868, the Meiji period from 1868–1912, the Taisho period from 1912–1926, the Showa period from 1926–1989, and the Heisei period from 1989 to 2019.

[4] The Japanese term "qualificationization" (*Shikaku-ka 資格化*) means that the modern state started to regulate and manage the various professions by means of a system of qualifications or credentials.

Shogunate (1603-1868) when the Shogun and various feudal clans issued orders forbidding "thinning" [*mabiki 間引き or kogaeshi 子返し*] (abortion and infanticide for adjusting number and interval of birth, maintaining a standard of living, mother's physical condition, succession strategy of Ie, Ohta, 2007). In 1868, the newly established Meiji government expanded its control over childbirth by prohibiting midwives from selling abortifacients, in addition to performing abortion. Throughout the Edo and Meiji eras, the prohibition of abortion was an important component of state reproductive policy, and this prohibition would remain in place during the first decades of the twentieth century. Although a movement for family planning began in the 1920s in Japan, this movement was suppressed and the practice of abortion remained illegal. This means that at least until World War II, the police continued to control birth and adoption, and medical professionals required a special legal permission to perform an abortion (Norgren 2001, Ohta, 2007, Ogino 2008).[5]

Professionalization of Midwifery and Childbirth Care

Longstanding state supervision of midwifery may help explain how midwives played an important role in propagating modern concepts of hygiene and medicine throughout Japan. By the first decades of the 20th century, midwives were providing care and assistance to a large share of home deliveries in Japan. As early as the 1920s, there was a movement to enact

[5] On the other hand, under the National Eugenic Act (1940) and the Eugenic Protection Act (1948), eugenic sterilization was practiced. These legal stipulations were repealed only in 1996.

a Midwife Law to ensure that midwives, not doctors, were the attendants at routine births.[6] This Midwife Law was never enacted but it revealed societal recognition for the profession of midwives. Midwives would remain central features of the Japanese project of childbirth modernization from the 1920s onwards. Urbanization made problems associated with poverty much more visible, as social inequality increased and the working poor moved into urban areas. In response to labor movement activism, a new health insurance program emerged to deal with the illnesses associated with factory labor, and social services were augmented, including midwifery services for pregnant women in cities, and village midwives in rural areas. In both cases, local authorities, social service agencies, and health insurance societies supplied midwives with a salary or payment for midwifery services, and provided pregnant women and nursing mothers with access to midwives at little or no charge.

Maternity hospitals were also created as a social project in urban areas. Hospitals assisted the poor in accessing health care and many of the maternity hospitals sent visiting midwives to pregnant women's homes. Assistance for home birth was performed free of charge for the poor. The purview of physician's role in pregnancy and their exclusion from childbirth is reflected in a newspaper article titled "Fetal and maternal protection is a major

[6] This movement was led by midwives and was supported by politicians and lawmakers concerned with midwifery. In 1925, when this movement took place, almost 100% of women gave birth at home instead of institution. (There are no statistics at the time, but in 1947 97.6% were born at home.) If there were no abnormalities, they did not go to the hospital, and births without abnormalities were handled by midwives. In 1925, the number of midwives was 42,877 and the number of doctors was 45,327 but obstetrics is not specialty. So the midwife was very powerful. However, the wartime regime ended the debate in the Diet and no midwife law was ultimately enacted in the end.

problem in national health" (Yomiuri Shimbun, 30th Aug 1920). It states that female industrial workers were required to have a checkup by a doctor during pregnancy and to rest after childbirth. In this period, we see a division of labor in the management of reproduction; physicians were requested for prenatal checkups and midwives managed "where" and "how" to give birth.

In the 1930s, leading up to the Second World War, responsibility for spreading delivery care by health professionals shifted from individual cities, local governments, social service agencies, and health insurance societies to the national government. From the 1930s onward, the Japanese state invested significant efforts to promote the availability of midwives and more generally in promoting "services of delivery care by a health professional." Most midwives after 1940 became "travelling guidance instructors for infant and motherhood protection,"[7] and their work supported the 1941 Medical Protection Law encouraging the protection of maternal and infant health. In addition to the work of midwives, government pronatalism (a slogan of the time was "Beget and Multiply"[8]) led to policies such as the use of nationally administered "pregnancy passbooks" to promote safer, healthier births and to provide pregnant women and mothers with extra entitlements under wartime rationing. Midwives as health professionals helped to facilitate and enact state policies and priorities by playing a central role in shaping reproductive health care and in promoting population growth

[7] *Nyuuyouji Bosei Hogo Junkai Shidouhu: 乳幼児母性保護巡回指導婦*
[8] *Umeyo Fuyaseyo: 産めよ増やせよ*

during this era.

The shift from births attended by a family member to those supervised by "modern midwives" (*Kindai Samba: 近代産婆*) took time. Especially in rural areas, pregnant women gave birth by themselves, with female members of the community, or their family. For example, in 1932-33, only one out of three childbirths was attended by a professional midwife in one rural prefecture.[9] National level statistics in 1939, show that midwives attended 74.0% of births, 6% of births occurred in a clinic or hospital and 20% of births were overseen by lay/family members. However much variation occurred in these patterns across different parts of the country -– with some regions reporting that lay/family attendance ranged from 0.0% to 62.5%. Thus there existed significant regional differences in the centrality of midwives in managing childbirth. Some variation in urban areas may be attributed to the fact that poor women were provided free access to midwives and maternity hospitals through local governments and social welfare agencies. The attractiveness of such support also extended to those who could not afford to pay for midwife care (Tokyo shisei chousakai, 1928).

Hospitals however, were not, in the early twentieth century, necessarily considered a

[9] Aiikukai, *Infant Death Situation Survey in Ishikawa and Nagano Prefecture*, interim report, first (1936:4). This is one of the first statistics with data on infant mortality in Japan. The number of births attended by midwives in this rural prefecture is not very high (one in three births), but it can be inferred from the data that local interest in getting the support of midwives was high because Nagano prefecture is located in a mountainous area and there were limited medical facilities in each village. Aiiku Foundation is a foundation that promotes healthcare of mothers and children in rural areas.

good alternative to midwives and home births.[10] Newspaper reports confirmed that the hospital might be a less desirable place to give birth. As one 1922 headline pronounced: " Pregnant patients care for new mothers, who then care for the next pregnant patient in hospital during childbirth" (Yomiuri Shimbun September 22, 1922), in short, the irony is that there are not enough people to care in hospital and the patient is taking care of the patient.; " City maternity hospitals have fewer pregnant patients, so you could be admitted at any time—please apply if you are poor." (June 3, 1926), in other words, the irony is that the hospital is vacant because it is not popular, so you can go to see a doctor and be hospitalized anytime. Thus, it seems that hospital reputations for admitting or treating women were not good in the 1920s but their presence as a place for childbirth was becoming more established in Japanese society.

A convergence of developments brought about the possibility of experiencing childbirth in hospitals, as these institutions partnered with midwife training schools to establish "free maternity hospitals" [*muryo san'in 無料産院*] in the years leading up to the Second World War. At the same time, smaller midwifery homes and medical clinics with in-patient beds were established, partly because urban dwellings were too small to house extra family members to manage childbirth and care for the new mother and infant. It was after the Second World War that the policies promoting the professionalization of childbirth started to

[10] In addition to free hospitalization of the poor, maternity hospitals dispatched a visiting midwife to their home free of charge.

focus on the location of childbirth. To this end, the state supported the establishment of public general hospitals and "Maternal and Child Health Centers"[11]. In rural areas especially in the second half of the 1950s, the Ministry of Health also worked to establish these centers where professional midwives oversaw childbirth for the women in their villages.

State policy, however still prohibited midwives from performing many treatments related to childbirth and they could not prescribe and sell medicines. Stays in midwifery homes were also not covered by health insurance. Physicians, on the other hand, could oversee childbirth, perform abortions, diagnose and treat gynecological problems and prescribe drugs. Childbirth overseen by physicians was also covered by insurance. The differences in the range of practice options resulted in a decrease in the number of midwifery homes, while childbirth at clinics and hospitals increased. As a consequence, local governments also shut down public Maternal and Child Health Centers. To provide a sense of how rapidly these changes occurred: if up until 1955, 80% or more of women in Japan gave birth at home; in 1965, a mere ten years later, 80% or more gave birth in medical institutions. The rate of birth in these institutional settings eventually reached almost 100% of births, and the primary role of delivery care shifted to doctors.

Managing Childbirth: From Midwives to Physicians

[11] *Boshi Kenkou Sentaa 母子健康センター*

Following Japan's defeat in the Second World War, direct entry midwives or *Sanba* became nurse midwives or *Josanpu* (*助産婦*). The nurse midwife was defined as one of three nursing roles in the profession, along with the general practice nurse and the public health nurse. Thus, midwives were formally positioned as paramedics in the hierarchy of health professionals despite their specialized training. The number of professional midwives did not increase during this period. Before the war, when qualifications were acquired by passing the license examination, the number of qualified midwives increased perhaps indicating the attraction of licensure and professionalization for these practitioners. However, with the war, license examinations ended, as did the direct entry midwifery school. While licensure, educational requirements, and professional standards remained in place, they had minimal impact on the profession. Indeed most schools closed during the war, and it took more than 10 years to establish new educational facilities in the post-war period. Hence the availability of training and licensure during the war years meant that women could not easily enter the profession. Moreover, significant obstacles existed for aspiring midwives. In order to enter the midwifery school, one had to be a qualified nurse and entering nursing school required graduation from high school. Yet during the war years, many women did not attend high school. These requirements have contributed to the long-term decline in the number of midwifery professionals. While the early post-war period saw a rise, today, there are approximately 34,000 midwives working in Japan, about half of the peak number of

registered midwives in 1951.[12]

This decline in the number of certified midwives went hand in hand with their post-war replacement by physicians and obstetric nurses as key childbirth attendants. After the war, Japan Association for Maternal Welfare (JAMW, present Japan Association of Obstetricians and Gynecologists: JAOG) started to train nurses as "JAMW certified obstetric nurses" with new specialized obstetric training. JAMW took this step because prewar midwives did not have prerequisite nursing qualifications and there were only a limited number of practicing, professional midwives after the war. While JAMW nurses did not have midwifery qualifications, doctors in small clinics allowed them to work in delivery care. This initiative further solidified the replacement of midwives by hospital-based physicians and obstetric nurses in the supervision of childbirth. In addition to the redefinition of who was qualified to oversee childbirth, the introduction of drugs for labor stimulation and induction also made their way into the hospital delivery room. In this way, as the location and supervision of birth shifted, so did the types of technologies used to manage the process. As a result of broader historical circumstances shaped by World War Two as well as state and physician's professional agendas, midwives lost ground, as childbirth became increasingly the purview of physicians and obstetric nurses.

[12] Shirai, *Childbirth*, 247

Women's Reactions and the Social Norms of Modern Childbirth

Women's reactions to the cascade of changes that turned childbirth into a medical issue requiring professional intervention in hospitals played an important role in the rise of the seemingly contradictory set of values described at the beginning of this article. If childbirth was increasingly seen to require various forms of medical supervision and intervention, there was also the expectation that one must also seek to maintain the natural maternal body.

Prior to World War Two, women were beginning to accept medical professionals to oversee childbirth; however, neither medical professionals nor women necessarily accepted pharmaceutical intervention. One newspaper article dating from 1918 reflects this mindset as is apparent in the title: "Childbirth without pain is not good. Stop painless labor."[13] The article emphasizes that using medical drugs for painless labor is a "poison," and is dangerous: "From long ago, Japanese women are famous for childbirth as they are quiet, so it is not necessary." In another series of newspaper articles, a physician author emphasized that the responsibilities for a healthy pregnancy and birth rested on women's shoulders. Titles such as: "A puerperal woman should cure herself" (Yomiuri Shimbun, 25th Sep. 1915); "Nutrients for birth" (Yomiuri Shimbun, 21st Jan. 1928); "To prevent infant death, rest after childbirth is absolutely necessary" (Yomiuri Shimbun, 11 Mar. 1937). The popular sentiment apparent in

[13] Yomiuri Shimbun, November 22, 1918

these early twentieth century newspaper articles persists well into the present time.

Social norms of childbirth changed dramatically in the post-war period with the acceleration of the process of medicalization. With 100% of all births occurring in hospitals and maternity clinics by 1965, childbirth had become a fully institutionalized process. A second baby boom between 1971 and 1974 meant that these institutions were operating at full capacity. Most importantly, pharmaceuticals became more regularly used to stimulate and induce childbirth as a way of controlling the timing of the process. Drugs were not used, however, to reduce the pain of childbirth. Many women, who had accepted that birth would occur in a hospital, resisted medical interventions including labor induction, anesthesia, and episiotomy. Their resistance may have been reinforced by social norms that continued to value the minimal intrusion of medical technologies like pharmaceuticals into what was viewed as a natural, bodily process. These concerns also reflected social expectations that good mothers should actively work to protect the fetus. Newspaper articles from the 1960s regularly noted that it was a woman's responsibility to create and maintain "the precious womb environment" (Yomiuri Shimbun, 4th Jan. 1963) to protect the fetus.

This points to a somewhat contradictory system of social and medical norms regulating the process of childbirth: A good mother is expected to subject herself to medicalized childbirth, but she is also expected to resist medical intervention and actively work to create a safe, natural and healthy fetal environment.

Medicalization, Midwifery, and Natural Childbirth: 1970s-1990s

During the 1970s and 1980s, the medicalization of childbirth was criticized for leading to an increase in medical accidents, especially accidents during labor induction, and a number of instances of medical malpractice came to public awareness. Mass media reports as well as lobbying by victims' organizations brought attention to the dangers of medicalized childbirth, making room for alternative practices and ways of giving birth. By the 1990s, new possibilities for how women could birth arose with the formation of organizations and networks that promoted natural childbirth, active birth, and freestyle childbirth. But one of the distinctive features of Japan's natural childbirth movement is that it never really pushed for the de-medicalization of childbirth, as was the case in much of Western Europe and North America. This section brings to light some of the intersections between the effects of global birthing movements like the Lamaze method, midwifery practices and hospital births.

Global Natural Childbirth Models Travel to Japan, 1970s

The Lamaze method of childbirth arrived in Japan in the 1970s, after birth had become exclusively hospital based and delivery was largely managed by pharmaceutical induction and labor stimulation. Popularized beginning in the 1950s by French physician Fernand Lamaze who based his techniques on observations in the Soviet Union where

hospital based childbirth did not rely on medical intervention or pain relief medication. Rather, women were taught techniques for breathing and relaxation to manage the pain of labor and to avoid the use of drugs during delivery. The Lamaze technique gained popularity in the United States in the 1960s and 1970s through feminist organizations that sought to change birth from something that was managed by male physicians to an occasion where women could take some control over their birthing process.[14] The technique relies on a partner who assists and guides the woman in labor through breathing and relaxation practices. The requirement of a partner for using the Lamaze method is responsible for the increased presence of husbands in delivery rooms in Japan beginning in the 1980s. Its appearance in Japan marks the beginning of the natural childbirth movement in Japan.[15]

In Japan, practicing midwives played an important role in promoting the Lamaze method. The civic organization [*osan'no gakkyo お産の学校*, School of Giving Birth] invited a midwife trained in Lamaze practices, Yoshiko Mimori, to lecture from 1977 onwards, and promoted the training for over 17 years. By the 1980s, the midwives wrestled with the Lamaze method as a professional specialization. The Japanese Midwives' Association held classes for midwives, while the midwives' professional journal published a special edition about the Lamaze method. Moreover, "birth classes" to teach couples about

[14] Michaels, *Lamaze*, 3

[15] As social background, since the mid-1960s, love marriages based on individual choice became more prevalent than marriages arranged by parents and relatives. The Lamaze method, and husbands' attendance at childbirth, thereby conformed to this emerging model of companionate couples.

the Lamaze method became widespread. Although the number of births in midwifery homes did increase with the introduction of the Lamaze method in Japan, the title "midwife" acquired metaphorical weight in the manner described by Eric Hobsbawm and Terence Ranger as "The Invention of Tradition."[16] If midwives were once represented as agents of modernization, they became "carriers of natural birth," and under the influence of the Lamaze method, midwifery started to be connected to Japan's history and traditions at a time when 99.2% of childbirths occurred in hospitals. The Lamaze method eventually became a new option in the hospital, but it did not result in the de-medicalization of birth or the growth of the midwifery profession. Ultimately, women continued to give birth with the benefit of bio-medicine in institutional settings like hospitals and midwifery homes.

"Natural Birth" in Medical Settings, 1980s and 1990s

In line with global developments, a new trend emerged in the 1980s and 1990s to engage in various types of "natural childbirth," such as active birth (childbirth where the woman is free to move during labor, to use different postures during deliver rather than being placed into stirrups or the lithotomy position), freestyle birth (childbirth in any posture), sophrologic delivery (psychological painless delivery method)[17], and home birth. The trend toward "natural childbirth" arose at the same time that the number of childbirth technologies

[16] Hobsbawm and Ranger, *Invention of Tradition*.
[17] A birthing technique using western relaxation and yoga/meditation techniques

and experiences has multiplied and a new, more consumer-oriented approach to birth has taken hold. For example, it is now possible for mothers as consumers to choose a "gorgeous delivery" in hotel-like rooms with piano performances and full-course dinners, painless birth like epidural anesthesia, and even pickup by limousine. This state of affairs resembles what French sociologist Jean Baudrillard described as the "consumer society,"[18] in which macrobiotics, haute cuisine, and McDonald's hamburgers are selected as commodities by consumers while taking on the role of symbols of "individuality" and "lifestyle options." In this emerging McDonaldized society[19], "natural childbirth" is the choice made by consumers who are concerned with the problems caused by excessive medicalization and who want to protect their bodies and their fetuses from unnecessary medical interventions.

What did "natural childbirth" mean to the Japanese women who - back in the 1980s and 1990s - started to choose this approach? In this section, drawing on an analysis of sixty-two journals written by 3,465 women who delivered naturally in midwifery homes between 1979–2002, I show how these women completely changed their conceptualization of birth over the decades.[20] At the beginning of the study period, in 1979-80, women did not use the word "natural childbirth" [*shizenshussan* 自然出産] in their comments. Occasionally, they described the midwifery home as a "hospital" or a "maternity hospital" rather than

[18] Baudrillard, *Consummation, 1970*.
[19] Ritzer, *McDonaldization, 1993*
[20] Shirai, "What is Natural Birth?" 2008.The midwife running the midwifery home from which the "childbirth journals" were collected was born in 1922 and earned her *sanba* qualification in 1939. She established a midwifery home with beds in 1954. Her mother was also a practicing *sanba*. This midwife allowed the author to analyze and view the notes.

recognizing it as an institution offering natural childbirth.

In the late 1980s, women began to distinguish midwifery home based childbirth from hospital based childbirth, and came to use the term “natural childbirth” more regularly. They indicated that hospital childbirth was “artificial,” “mechanical,” “inorganic,” and “businesslike,” relying on medicine, episiotomy, and vacuum delivery. Whereas midwifery home births came to be depicted as places of “nostalgia,” “familiarity,” and “traditional care using Eastern medicine.” This contrasts with the 1960s and 1970s, when midwifery home births were associated with “the new childbirth method,” i.e., the Lamaze techniques. By the 1990s, midwifery homes were also recognized by women as places offering a growing diversity of new methods and techniques to facilitate birth, including water birth, freestyle birth, qigong, aromatherapy, and oil massage. These practices were associated with tradition and nature and have come to hold value for many Japanese women in their decisions about where to give birth.

In connection to this growing emphasis on nature and tradition, there is also an increasing focus on the importance of resisting to “intervention, [and] invasion to the body”. In Japan, it is often recommended to women that they should avoid medical interventions, meaning that they should give birth without a cesarean section, without an episiotomy, without painless labor, or without labor stimulation or induction. Instead, they should “get over” the pain by practicing breathing during birth, and not by relying on anesthesia. One

representative newspaper article published in 1975 advises women to "wait for natural labor" by reporting accidents caused by labor inducing agents (Yomiuri Shimbun, 16th Oct. 1975). This newspaper article cites a comment made by the mother about the complications she experienced during birth. Here is what the mother says: "If I care enough about the fetus, I should not have given birth by 'scheduled labor' with induction because it can be harmful to the unborn baby. It is my responsibility if my child is born with disabilities." The article also cites a comment made by an obstetrician and gynecologist: "It is good to wait for labor starting naturally." "A good mother" gives birth in the hospital while keeping a "natural body." Ultimately women were expected to minimize medical intervention while giving birth in hospitals where such practices are routine.

The shifts in how women characterized births in the spaces of hospitals and midwifery homes also represent and reinforce changes in the symbolic values of the technologies and techniques associated with each, and echo Baudrillard's observations about how individuality and lifestyle choices shape a consumer society. Moreover, the importance of choice in where and how women give birth emerges clearly by the 1980s and childbirth in midwifery homes is consistently depicted in the journals as what women "chose." Since they had made an active decision, women felt high satisfaction in their choice.

This emphasis on choice and on natural birth is not incompatible with increasing medicalization of childbirth procedures. The notes from our sample of women's journals

indicate that midwives used labor stimulation, labor induction, and hemostat injections in the 1990s and 2000s, and women thanked midwives for being lifesavers.[21] These women were all engaging with new notions of "natural birth" but the "natural" in "natural birth" is not necessarily "an untouched thing." There is a significant body of literature showing that the concept and definition of "natural birth" differs between age groups, societies, and cultures.[22] Women in the 1990s had a particular image of what constituted a "natural birth" in midwifery homes; they also had a particular image of the role of the "midwife". Early twentieth century midwives working at the community level were responsible for handling both "normal" and "difficult" deliveries, and in both instances, they relied on biomedical technologies and techniques to ensure a healthy delivery. By the 1990s, midwives continued to rely on biomedical technologies and techniques, but they became primarily associated with "normal" deliveries and they were only allowed to participate in deliveries that are not considered dangerous. Today, midwifery homes are legally prohibited from performing breech delivery, post-term delivery, Vaginal Birth After Caesarean: VBAC, older primipara, or multiple pregnancies as stipulated by the "Midwifery Home Guideline" issued in 2004.[23]

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[21] The midwife was expected to perform all possible measures and not call a medical practitioner or take the mother to hospital from a home birth. This is why, although midwife's remuneration was "all possible remuneration," a doctor was able to charge regular expenses in the usual fashion. Women wanted to avoid burdening the family, and calling a doctor or dystocia were considered "shameful." Therefore, midwives who opened practices in the past were proud that they could respond as effectively as a doctor.

[22] Most Japanese medical dictionaries do not have an entry for "natural birth" or "natural delivery," but "normal delivery, eutocia" is usually listed.

[23] This set of guidelines was prepared by the Midwifery Professional Association in 2004. The guidelines state that midwives cannot use medical equipment, prescribe medicine to a patient, or give instructions about medicine (Act on Public Health Nurses, Midwives, and Nurses, Article 37). The professional association has enacted this set of guidelines, but no punishments are specified. The guidelines were created on the basis of the research conducted by the Obstetrics and Gynecologists Association.

Childbirth in Contemporary Japan

By the 21st century the landscape of Japan's childbirth system changed significantly. The change has been described in scholarly and popular media as the "collapse of obstetrics care *[sanka iryou houkai 産科医療崩壊]."* The crisis in obstetrics care has been linked to factors such as a decline in birthrates, the increasing risk of litigation for accidents or for medical malpractice, rising standards of security in the transportation of women for urgent care, the need for trained specialists (in anesthesiology and neo-natal care) to oversee safe and secure delivery, a remarkable rise in personnel expenses, and staffing difficulties. A key factor in this crisis of obstetric care is the high risk of being sued in the profession, which has led many gynecologists to stop practicing obstetrics. Another important factor is the introduction of important changes in the clinical internship system from 2004 onwards. These changes disrupted the steady supply of doctors in hospitals, and many hospitals had to suspend the handling of childbirth. In the wider society, there emerged growing concerns with the question of the quality of childbirth care.

The collapse of obstetric care only became a major social problem when it started to become clear that pregnant women were being refused emergency transport or could not find an emergency department who could handle an obstetric emergency. The crisis is best illustrated by the case of a pregnant woman who was turned away from nine hospitals and

ended up having a miscarriage. The term *"Pregnant Women Refugees"* [*shussan nanmin 出産難民*] has entered contemporary discourse to describe a pregnant woman who is unable to secure and reserve a location for childbirth.

In Japan, access to medical facilities, including birthing facilities, is open to everyone but the crisis of obstetric care has created a shortage of obstetricians. This had led government, prefectural, and professional organizations to develop a new "concentration of birthing facilities [*shuuyakuka 集約化*]" to guarantee access to birthing services. At the same time, there is a renewed emphasis on the use of midwives. The government is now backing the usage of midwives in hospitals and outpatient care provision. To ease the burden on obstetricians, the in-hospital midwifery clinic [*innai josan 院内助産*] is now recommended by Japanese authorities.[24] In 2017, only 0.6% of births occur in midwifery homes, while 99.3% were in hospitals or clinics. According to birth certificate data, 95.1% of births were attended by doctors, while midwives were responsible for only 4.8%.[25] For 0.03% of births, neither doctors nor midwives were in attendance.[26] The new policy supporting the use of midwives may increase the possibility of more births occurring under the supervision of

[24] In Japan, a medical institution must have at least 20 beds to be defined as a hospital. If the number is less than 20, it is a clinic (doctor's office or a shared practice) not a hospital. A midwifery home (*Josan-in* 助産院) is a place where midwives provide midwifery services to the general public and a select group of clients, excluding services provided in hospitals or clinics. Midwives have the right to open such homes in Japan since the beginning of modern legal era. For in-hospital midwifery clinic, see *Midwifery in Japan*: 20-21.A midwifery home is limited in size, and must consist of facilities that accommodate fewer than ten pregnant, parturient, or puerperal women.

[25] Ministry of Health, Labor and Welfare, *Vital Statistics*, 2017. Official directions indicate that when a doctor and a midwife both attend the birth, the doctor's name should be written.

[26] For example, an ambulance crew or the people present.

midwives and outside hospital facilities.

Standardization of Birth and Prenatal Testing

In the 21st century, childbirth has become not just highly medicalized and institutionalized but also highly standardized, i.e., women have access to similar services and have similar childbirth experiences. Some pregnant women seek the support of private sector midwifery care services and other forms of childbirth assistance at their own expense, but the majority - an overwhelming 99.3% - give birth inside hospitals and clinics, where the charges are mostly paid by health insurance in a lump sum.[27]

Ultrasound exams and maternal check-ups are almost entirely free in Japan; health checkup vouchers are available from public health centers. Over 95% of pregnant women have ultrasound examinations. The frequency of these tests is also quite standard. Pregnant women in Japan have ultrasound examinations nearly every time at each health checkup, 10 to 14 times per pregnancy.[28] Thus prenatal checkups and prenatal testing establish the routine nature of biomedicalization in pregnancy and birth.

Contemporary Normative Dilemmas: Bodily Intervention

[27] The health insurance provides a 420,000 Japanese Yen Lump-sum allowance for childbirth. According to a survey by All-Japan Federation of National Health Insurance Organizations, the average hospitalization normal delivery cost was 505,759 JPY in 2016.
[28] Tama et al., " Nara Prefecture Safe Delivery," 2011.

The effects of the macro level dynamics as just described are shaping social and women's normative values about pregnancy and birth. At first glance, it may appear that opposite norms are at work. For example, the biomedicalization of pregnancy and birth has led to characterizing women who do not attend prenatal checkups or those who do not maintain their own health as perpetrators of "fetal abuse [*taiji-gyakutai 胎児虐待*]." To be "good mothers," pregnant women must accept medical intervention even before becoming pregnant and undergo health checkups at fixed intervals. At the same time, to be "good mothers," women must maintain a "natural body," especially during childbirth by accepting pain without anesthesia, refusing cesarean sections, episiotomy.

Good Mothers and Prenatal Checkups

In present-day Japan, not receiving medical treatment is criticized as a lapse in "motherhood." A pregnant woman who has not undergone health checkups for pregnant women is called "*mijushin-ninpu"[未受診妊婦*], or a "woman with no prenatal care." These are more than just labels. Hospitals can refuse transportation to such women even in an emergency situation. These women are also considered to be at a high risk for child abuse (because of unplanned pregnancies, poverty, or neglect). The *mijushin-ninpu* seem to be not able to see a doctor even though they are aware of their pregnancy. There may be many reasons why they do not seek care. Yet national attempts to ensure that women do receive

prenatal care are extensive. For example, the Equal Employment Opportunity Law (amended 1986) and the Labor Standards Law (amended 1985) specifies that employers must make time available for pregnant women to attend medical health checkups. While the Maternal and Child Health Act (1940) specifies that local authorities should perform medical examinations for pregnant women.

Pregnant women's obligations to care for themselves and by extension, the fetus also extend from policy. The amended 1997 version of the Maternal and Child Health Act states: "A mother must deepen the right understanding of pregnancy, childbirth, and childrearing, and must maintain and improve her health on her own" (Article 4). As stated in a 2011 article published in the Japanese newspaper Sankei Shimbun, if pregnant women do not undergo the required health checkups, this is called "fetal abuse", though it is not a crime (Sankei Shimbun, 24th November 2011).[29] In the Social Networking Service, SNS[30] of obstetric doctors, a woman with no prenatal care is stigmatized as a "[*nora-ninpu 野良妊婦*] stray pregnant woman" or a "[*tobikomi-chussan 飛び込み出産*] walk-in delivery." Thus the nurturing, monitoring, and screening - "whether there are any signs of abnormalities" is made into an obligation for mothers, based on a sense of "self-responsibility" for the fetus.

In present-day Japan, both doctors and ordinary people tend to assume that it is the

[29] Terms used in an announcement and related symposium of the Japan Medical Association, the research report of the Osaka Association of Obstetricians and Gynecologists, newspaper articles, etc.
[30] The SNS is a 2 channel. "2ch" is an anonymous textboard website in Japan, and actually is said to be a website that 4chan was modeled after.

duty of the expectant mother to offer sufficient medical treatment to a fetus. Pregnant women are assumed to provide "the environment of the fetus"[31] and it is a duty of motherhood to safeguard the fetus. This means that Japanese pregnant women are morally expected to give priority to the medical needs of the fetus over matters of self-actualization. In this highly monitored environment, there is very little space for resistance to medical intervention in pregnancy and childbirth. However, within an historical context these are not new developments and date back to the strengthening of maternity policy in the late 1930s.

These imperatives form a continuum of duties and responsibilities for parents, especially for mothers, to provide children with medical treatment after they are born. When parents do not allow their child to receive necessary medical treatment, this is termed "medical neglect." As noted by an obstetrician and gynecologist quoted in the above mentioned Sankei Shimbun newspaper article entitled "No Prenatal Care is Fetal Abuse"[32] "it is fetal abuse not to undergo prenatal checkups when there are coupons for prenatal checkups. Pregnant women who engage in fetal abuse are at higher risk of engaging in child abuse."

Similarly, natural childbirth is viewed as something that should be carried out "under the guidance of a health professional." Even if someone else, such as a partner, assists the birth at home, it is called "non-assisted childbirth" [*mukaijo-shussan* 無介助出産 or *private*

[31] Ivry, "Embodied Responsibilities," 2007 and "Embodying Culture," 2009.
[32] Sankei Shimbun, 24th November 2011

shussan プライベート（私的）出産], and is considered a form of egoism reflective of a consumer society that exposes the fetus to danger for the purpose of the self-fulfilment of parents.

Natural Body: Refusal of Bodily Intervention

According to large-scale data on the experience of birth in Japan, by 2005 medical intervention and medical treatment had become routine for women (Shimada 2007: 95-117).[33] However, the rate of regional (epidural, combined spinal-epidural, or spinal) anesthesia remains low, just 2.1% of deliveries in Japan. This section looks at management of pain in labor and Japan's low cesarean section rates

The minimal use of anesthesia in Japan contrasts with that of the United States where 61% of vaginal deliveries relied on anesthesia,[34] or the 25–98% rates found in Western Europe.[35] In Asia, some have argued that the rate of anesthesia is rising in South Korea due to the introduction of the coverage of epidural anesthesia by health insurance.[36] However, Japan's low use of local anesthesia for childbirth reflects values and norms that

[33] Shimada "Development of the Guideline" is one of the largest surveys conducted by the Ministry of Health, Labor, and Welfare. 95–117. The rate of natural birth was 69.8%, Cesarean section 15.7%, vacuum extraction 7.4%, forceps delivery 0.8%, labor induction 8.4%, labor stimulation 12.3%, painless labor 2.1%, episiotomy 51.4%, enema 22.1%, shaving 40.2%, and infusion 67.6%. Many births would involve multiple procedures.
[34] Osterman, "Epidural," 2008. There are significant variations within each context regarding rates of anesthesia. Such variations are not just regional; there are also significant variations across institutions and even within the same institution. Social variables including place of residence, social class, and level of education have an important impact, but so do cultural factors and moral dimensions such as the desired extent of medical intervention and attitude toward pain.
[35] *European J Obstetrics Gynecology Reproductive Biology* 2002, 103:4-13.
[36] Chung, Cesarean Section Rate, 2012

emphasize the dangers of anesthesia and the continuing responsibilities of mothers for the wellbeing of their child during pregnancy and birth. A 2006 newspaper article contrasting "painless delivery" with "natural birth quotes a physician who says that in Japan to give birth is "to hurt your stomach" because pain is often seen to be a necessary component of childbirth[37]. This statement captures a larger cultural assumption that often prevents mothers from choosing painless delivery. Recent accidents involving epidural anesthesia delivery have been reported frequently in the media, making the public aware of its dangers and reinforcing the notion that pain in childbirth may be preferable to managing that pain using medical intervention.

As for cesarean section, the number per 100 live births in Japan is 20.4.[38] From a global standpoint, the rate of cesarean sections is quite low, compared to other Organization for Economic Co-operation and Development (OECD) countries—countries with high rates include Turkey (53.1%), Korea (45.2%), while low rates are found in Norway (16.0%), Sweden (16.6%), Israel (14.8%), and Iceland (16.2%), compared to 20.4% in Japan (see Figure 4 below).[39] Low rates of cesarean section and anesthesia cannot be explained by shortcomings of medical infrastructure or training. One reason for these low rates is likely

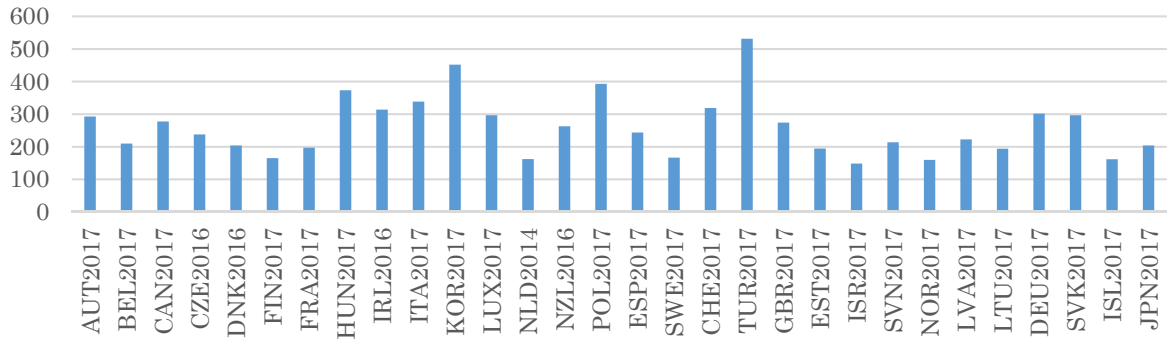
[37] Asahi shimbun, "Painless birth VS natural birth," 10th June ,2006: "Painless birth does not require physical strength and women retain consciousness and are able to attain a sense of fulfillment". The assumption in Japan is that to become a mother one needs to overcome the pain of "natural" childbirth. The main reason for selecting natural childbirth is refusing medical intervention. The conclusion is that "it is important for individuals to choose freely."

[38] Survey of Medical Institutions 2017.

[39] OECD (2019), Caesarean sections (indicator).

because Japan's health insurance does not cover expenses for births by elective cesarean section. Applications for coverage usually require strong medical reasons; a personal preference for a cesarean section is not accepted.

Figure 1 Cesarean sections total, Per 1000 live births



Source: OECD Data https://data.oecd.org/

Note: Japan was calculated by the author from Ministry of Health, Labour and Welfare, Survey of Medical Institutions 2017

In terms of social norms and values, women who have cesarean sections are viewed by others and often internalize a lack in not experiencing the pain of childbirth and are characterized as simple pulling the baby out of the stomach. The seriousness of this situation is reflected in the educational lectures and counseling available for those who gave birth by cesarean section. For many people, a cesarean section is a viewed as a very negative experience and a potential failing of the mother.

The pressure to maintain a 'natural' body with regard to reproduction extends before and beyond pregnancy and childbirth. Contraceptive practices and breastfeeding also emphasize the normative value of adhering to minimally invasive or artificial means of managing these moments in women's reproductive lives.

Japan's primary mode of contraception is overwhelmingly the condom (34.9%), while chemical methods and devices in the body (including "the pill," implants, and IUDs) have low rates (2.9% for the pill, no reported data for implants and 0.4% for IUDs). There is also a tendency to avoid contraception through such sterilization procedures as vasectomy or tubal ligation.

Table 1. Estimates of contraceptive prevalence by method among women, married or living common-law, ages 15 to 49[40]

	Male condom (%)	Pill (%)	IUD (%)	Male sterilization (%)	Female sterilization (%)
Japan 2015	34.9	2.9	0.4	0.1	0.6
China 2017	23.2	2.4	26.2	1.1	14.1
Republic of	20.6	3.3	8.8	9.5	3.7

[40] United Nations, "Contraceptive Use by Method" 2019.

Korea 2009					

The breastfeeding rate is also high in Japan, with 51.3% of babies being raised solely on mother's milk, *bonyu* 母乳, one month after birth, and 54.7% three months after birth. A mixture of artificial milk and mother's milk is used for 45.2% and 35.1% of babies at one month and three months, respectively while artificial milk alone is used in 3.6% and 10.2% of cases, at those times. "The rate of complete breastfeeding" is rising annually, and has now reached the highest rate since surveys began in 1985.[41] While not the focus of this article, these data on contraception and infant feeding demonstrate that the tensions between maintaining and managing the maternal body without medical intervention are highly valued in contemporary Japanese society.

Conclusion

The policies of the three historical eras analyzed in this article - the period from the Meiji Era to Post World War Two, the period from the 1970s to the 1990s, and the period from the turn of the millennium to the present - reflect dynamic and changing contexts related to war, politics, economics, and demographics. Yet women always carry powerful, normative

[41] Ministry of Health, Labor, and Welfare, infant nutrition survey. Enforcement 2015. In a 1998 investigation in South Korea, mother's milk childcare rates comprised 13.9%, mixture 40.0%, and bottle-feeding 46.1% (Choi, YY and C. Sohn, "Mother's Milk South Korea," in Japanese). However, the mother's milk childcare rate is also rising in Republic of Korea.

perceptions of being a “good mother.” In these different historical moments, we see how the double bind of keeping a natural body while accepting medical care and technologies emerged and how this bind became a powerful norm for being “a good mother.” This dual bind is shaped by profound moral contradictions. On the one hand, there is a strong emphasis on a model of “natural” pregnancy and childbirth that builds on the idea that mothers should avoid medical interventions as much as possible. On the other hand, there is also a strong emphasis on the virtues of a highly medicalized model of pregnancy and childbirth that stipulates that mothers have a moral responsibility to make sure that their fetus receives proper institutional medical care. The tensions between these two models of pregnancy and childbirth and the different technologies they employ take different forms depending on the historical period and reflect larger processes and frameworks of population policy and national education. Thus, the history of childbirth in modern Japan is a process of dynamic interaction that involves both macro-level changes in society, in the economy, as well as in public health policies, technological changes, and policy issues arising within medical professions, and the evolving moral expectations placed on childbearing women.

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