MIDWIFERY IN JAPAN

Japanese Nursing Association
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References
1. Maternal and Child Health

1. Statistics

1) Trends in Indicators Concerning Maternal and Child Health

Perinatal and infant mortality rates in Japan, commonly regarded as maternal and child health indicators, rank among the lowest in the world. Special attention, however, should be directed in the future to measures for maternal and child health promotion and to improvement of perinatal medical service system.

(1) Births

In Japan, both the number of births and the total fertility rate tend to decrease. Although the birth rate shows a slight increase in the recent years, the increase is not large enough to overturn the ongoing issue of low birth rate in Japan. The total fertility rate in 2012 was 1.41, lower than 2.08 required for population stability. The total number of births in 2012 was 1.05 million, and if the current trend of decreasing birth rate continues, the projected number of births for 2025 is expected to be 0.78 million.

(2) Maternal Mortality

The maternal mortality rate in 2008 was 3.6, showing that Japan has one of the lowest maternal mortality rates in the world. However, the major causes of maternal mortality are preventable diseases, such as hypertension, and intrapartum hemorrhage.

(3) Perinatal Mortality

Japanese perinatal mortality refers to stillbirths after the 22nd week of pregnancy and early neonatal deaths within 1 week after birth. WHO states in its International Statistical Classification of Diseases and Related Health Problems-10 that the “perinatal period commences at 22 completed weeks (154 days) of gestation and ends seven completed days after birth.” Based on this definition, the method of calculating perinatal deaths was revised in 1995 in Japan.

The perinatal mortality rate, which is the combined number of stillbirths after the 28th week of pregnancy and of early neonatal deaths per 1,000 live births is also calculated to compare Japanese data with international data. Japan’s perinatal mortality rate in 2010 was 2.0, which is among the lowest in the world.

There are two main causes of perinatal deaths concerning the fetus, which include “diseases generated during the perinatal period” (85.3%), and “congenital malformations and chromosomal abnormalities” (13.7%). The non-fetal factors include “non-maternal based causes” (36.1%), “complications occurring in the placenta, umbilical cord and fetal membrane” (27.5%), and “maternal diseases that may be unrelated to the current pregnancy” (26.2%).

Table 1: Change in Maternal and Child Health Indicators

<table>
<thead>
<tr>
<th>Year</th>
<th>Population</th>
<th>Live Births</th>
<th>Birth Rate (per 1,000)</th>
<th>Total Fertility Rate</th>
<th>Maternal Mortality Rate (per 100,000 live births)</th>
<th>Perinatal Mortality Rate (International standard(**))</th>
<th>Infant Mortality Rate (per 1,000 live births)</th>
<th>Stillbirth Rate (per 1,000 births)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1960</td>
<td>93,418,501</td>
<td>1,606,041</td>
<td>17.2</td>
<td>2.00</td>
<td>130.6</td>
<td>41.4</td>
<td>30.7</td>
<td>100.4</td>
</tr>
<tr>
<td>1965</td>
<td>98,274,961</td>
<td>1,823,697</td>
<td>18.6</td>
<td>2.14</td>
<td>87.6</td>
<td>30.1</td>
<td>18.5</td>
<td>81.4</td>
</tr>
<tr>
<td>1970</td>
<td>103,119,447</td>
<td>1,934,239</td>
<td>18.8</td>
<td>2.13</td>
<td>52.1</td>
<td>21.7</td>
<td>13.1</td>
<td>65.3</td>
</tr>
<tr>
<td>1975</td>
<td>111,251,507</td>
<td>1,901,440</td>
<td>17.1</td>
<td>1.91</td>
<td>28.7</td>
<td>16.0</td>
<td>10.0</td>
<td>50.8</td>
</tr>
<tr>
<td>1980</td>
<td>116,320,358</td>
<td>1,576,889</td>
<td>13.6</td>
<td>1.75</td>
<td>20.5</td>
<td>11.7</td>
<td>7.5</td>
<td>46.8</td>
</tr>
<tr>
<td>1985</td>
<td>120,265,700</td>
<td>1,431,577</td>
<td>11.9</td>
<td>1.76</td>
<td>15.8</td>
<td>8.0</td>
<td>5.5</td>
<td>46.0</td>
</tr>
<tr>
<td>1990</td>
<td>122,721,397</td>
<td>1,221,585</td>
<td>10.0</td>
<td>1.54</td>
<td>8.6</td>
<td>5.7</td>
<td>4.6</td>
<td>42.3</td>
</tr>
<tr>
<td>1995</td>
<td>124,296,947</td>
<td>1,187,064</td>
<td>9.6</td>
<td>1.42</td>
<td>7.2</td>
<td>4.7</td>
<td>4.3</td>
<td>32.1</td>
</tr>
<tr>
<td>2000</td>
<td>125,612,633</td>
<td>1,190,547</td>
<td>9.5</td>
<td>1.36</td>
<td>6.6</td>
<td>3.8</td>
<td>3.2</td>
<td>31.2</td>
</tr>
<tr>
<td>2005</td>
<td>126,204,902</td>
<td>1,062,530</td>
<td>8.4</td>
<td>1.26</td>
<td>5.8</td>
<td>3.3</td>
<td>2.8</td>
<td>29.1</td>
</tr>
<tr>
<td>2010</td>
<td>128,057,000</td>
<td>1,071,304</td>
<td>8.5</td>
<td>1.39</td>
<td>4.1</td>
<td>2.0</td>
<td>2.3</td>
<td>24.2</td>
</tr>
<tr>
<td>2012</td>
<td>127,515,000</td>
<td>1,037,231</td>
<td>8.2</td>
<td>1.41</td>
<td>—</td>
<td>—</td>
<td>2.2</td>
<td>23.4</td>
</tr>
</tbody>
</table>

* Indicator for international comparison. Sum of the number of stillbirths after the 28th week of pregnancy and the number of deaths in early infancy divided by the number of live births, per 1,000 live births
(4) Infant Mortality

The infant mortality rate per 1,000 live births was 2.3 in 2011, showing that Japan has one of the lowest infant mortality rates in the world. The leading cause of infant death is "congenital malformation and chromosomal abnormality," followed by "perinatal-specific respiratory disorders and cardiovascular disorders" and "unforeseen accidents". The first leading cause of neonatal deaths within 1 month after birth is "congenital malformation and chromosomal abnormality," and the second is "perinatal-specific respiratory disorders and cardiovascular disorders".

After the Second World War, the major causes of infant deaths continued to be infectious diseases including pneumonia, bronchitis, enteritis, and other diarrheal diseases. Those causes have drastically decreased today. On the other hand, the number of infant deaths caused by congenital malformation and chromosomal abnormality, and diseases generated during the perinatal period have not decreased dramatically. These causes warrant further attention in the future.

2. Policies

The aim of the policies in Japan is to implement comprehensive maternal and child health care from adolescence to pregnancy, childbirth, neonatal and infant periods. The measures are differentiated for beneficiaries at different periods so that optimal services can be provided that suit their specific needs.

The Maternal and Child Health Act was established to maintain and promote maternal, newborn, and infant health and to contribute to improve the national health by figuring out principles of maternal and child health. The act also aims to provide mothers, newborns and infants health guidance and examination services and other medical measures. It stipulates that it is the role of the municipalities to provide health guidance to pregnant and postpartum women and health check-ups for newborns and infants.

### 1. Purposes

- The purposes of this act is to maintain and promote maternal, newborn, and infant health and to contribute to improve national health by figuring out principles of maternal and child health as well as providing mothers, newborns and infants with health guidance and examination services to take medical and other measures.

### 2. Major provisions

1. Health guidance (Article 10)
   - The Municipality shall provide pregnant/ postpartum women with the necessary health guidance on pregnancy, child delivery, and childrearing or shall recommend them to receive such health guidance.

2. Health check-ups (Articles 12 and 13)
   - The Municipality shall provide health check-ups for 18-month-old infants and 3-year-old infants.
   - In addition to the above, the Municipality shall provide health check-ups for pregnant/ postpartum women and newborns/ infants as needed, or shall encourage them to receive health check-ups.

3. Report on pregnancy (Article 15)
   - Those diagnosed to be pregnant shall immediately report their pregnancy to the mayor of the municipality.

   - The municipality shall issue the Maternal and Child Health Handbook to those who have reported their pregnancy.

5. Report on the birth of a low-birth weight child (Article 18)
   - Upon the birth of a baby weighing under 2,500 g, his/ her guardians shall immediately report to the municipality where the baby is located at the time.

6. Medical aid for premature infants (Article 20)
   - The municipality shall provide premature infants with the medical aids, or shall pay the full medical expenses.

Fig. 1: Outline of the Maternal and Child Health Act

1) Main Policies

(1) Sukoyaka Oyako 21 (Healthy Parents and Children 21)

Sukoyaka Oyako 21 (Healthy Parents and Children 21), a national campaign has been promoted since 2000 through the combined efforts of related organizations and groups working toward the common goals of systematizing outstanding and new issues and guiding maternal and child health care on its pathway for the 21st century. This program has four main challenges with 61 indicators as goals for the decade from 2001 to 2010. The four main challenges include: reinforcement health measures during adolescence and promotion of health education; ensuring of a safe and comfortable pregnancy/ childbirth, and assistance for infertility; development of environmental systems to maintain and improve pediatric medical standards; promotion of the sound development of children and reduction of anxiety concerning childrearing. An interim evaluation was conducted in 2005 and 2009 to review the program, and the
final evaluation was conducted in 2013. The results of the final evaluation indicated improvement in approximately 80% of the 69 indicators (74 items). Starting in 2014 a new set of indicators will be developed.

(2) Child and Childrearing Support Plan

In 2010, the Cabinet decided to formulate a new outline of measures for a society with a decreasing birthrate, “Children and Childrearing Vision – for the Society Full of Smiling Children –”. The new outline stipulated the basic idea of “Children First (Children at the center)” with the aim of building a society that values children.

In 2012, the Child and Childrearing Support Law was established to construct a new structure by unifying child and childrearing support systems and their funds. It comprehensively promotes improvement in school education, child care for toddlers, and community child and childrearing support. The law aims to achieve this goal through improvement of the approved child institution system, unified benefit payments to approved child institutions/kindergartens/day-care centers (institution-based benefit payment), along with the establishment of benefit payment to small-sized day-care service providers (community-based benefit payments), and the establishment of child and childrearing support conferences.

(3) Improvement of Child and Childrearing Support through Unified Reform of the Social Security and Taxation System

Childrearing support became one of the central targets of the unified reform of the social security and taxation system. A new system for child and childrearing support was established, permanent financial resources were secured for this system.

2) Main Measures

The aim of the policies is to implement comprehensive maternal and child health care under a consistent system covering premarital preparation, pregnancy, childbirth and the neonatal and infant periods.
A pregnant woman has to notify the municipality of her pregnancy (Maternal and Child Health Law, Article 15). Upon registration of pregnancy, the Maternal and Child Health Handbook is issued to her (Article 16).

The Maternal and Child Health Handbook originated from the Maternal Handbook first issued in 1942, which established a system of pregnancy registration and provided pregnant and postpartum women with health care support. The Maternal and Child Health Handbook is issued for pregnant women upon request to their municipality. The handbook functions as a maternal and infant health record that can be used to follow the development process, including pregnancy, birth, and infant growth, as well as an immunization record prior to reaching school age. Pregnant women can use their handbook as a database on the pregnancy process beyond the facility where they receive their health check-ups. Furthermore, the handbook can be used by the entire family for basic information on pregnancy, childbirth and child care. Various uses of the handbook are also effective in boosting awareness of the mother and the father.

As part of the measures to combat declining birth rate, the municipal subsidy for antenatal check-ups has been increased and the Maternal and Child Health Handbook now includes free coupons for 14 antenatal check-ups. The

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**Fig. 3: System of Measures for Maternal and Child Health**

1. **Distribution of the Maternal and Child Health Handbook**
   
   A pregnant woman has to notify the municipality of her pregnancy (Maternal and Child Health Law, Article 15). Upon registration of pregnancy, the Maternal and Child Health Handbook is issued to her (Article 16).

   The Maternal and Child Health Handbook originated from the Maternal Handbook first issued in 1942, which established a system of pregnancy registration and provided pregnant and postpartum women with health care support. The Maternal and Child Health Handbook is issued for pregnant women upon request to their municipality. The handbook functions as a maternal and infant health record that can be used to follow the development process, including pregnancy, birth, and infant growth, as well as an immunization record prior to reaching school age. Pregnant women can use their handbook as a database on the pregnancy process beyond the facility where they receive their health check-ups. Furthermore, the handbook can be used by the entire family for basic information on pregnancy, childbirth and child care. Such information is extremely helpful for coherent maternal and child health care throughout the period of pregnancy, childbirth and childcare. Various uses of the handbook are also effective in boosting awareness of the mother and the father.

   As part of the measures to combat declining birth rate, the municipal subsidy for antenatal check-ups has been increased and the Maternal and Child Health Handbook now includes free coupons for 14 antenatal check-ups. The
Maternal and Child Health Law also stipulates that the municipality provides health check-ups to infants of 18-months and 3-years of age. Other benefits include free coupons for health check-ups for infants and toddlers, although benefits depend on the municipality.

The handbook is available in a number of foreign languages (English, Chinese, Korean, Spanish, Indonesian, Portuguese, Thai, and Tagalog) for foreigners residing in Japan and for Japanese residing overseas.

(2) Health/Home Guidance for Pregnant Women and Infants

Health guidance and home guidance concerning pregnancy, childbirth, and child care are mainly provided by the municipality (Maternal and Child Health Law, Article 10). As needed, physicians, midwives, or public health nurses visit the homes of and provide health guidance for pregnant and postpartum women, newborns, and premature babies. (Articles 11, 17, and 19)

※ Home-visit Guidance Project for All Infants

Home visits are made for all households with infants aged up to 4 months so that their caregivers can discuss various problems or anxieties they have, and information on childrearing support can be provided. At the same time, mental and physical conditions of parents and children, as well as the childcare environment can be grasped, so that households that require support can be detected and appropriate services can be provided. In this way, a home-visit, which is the first opportunity for the household rearing infants to have contact with the local community, will help households keep away from being isolated and secure a sound childrearing environment.

(3) Other Measures

① Distribution of the Maternity Logo

As part of the Sukoyaka Oyako 21 (Healthy Parents and Children 21) campaign efforts, Maternity Logo was introduced in March 2006. The Logo promotes an environment of safety and comfort for women during pregnancy and child delivery period by promoting public recognition of pregnant women. By displaying the logo while pregnant women use public transportation, it is easier for them to show that they are pregnant, and thus the logo promotes the development of a friendly environment for pregnant/postpartum women. Public administrations and private businesses are actively engaged in increasing the distribution of Maternity Logos by distributing Maternity Logos with Maternal and Child Health Handbooks, and by displaying posters about Maternity Logos.
1. Midwifery Regulation

The midwife and her activities are defined under the Act on Public Health Nurse, Midwife and Nurse (No. 203) established in 1948. The purpose of this law is to improve the quality of public health nurses, midwives, and nurses, and promote medical care and public health. In December 2001, the law was partially revised, and the title of the law in Japanese was changed slightly.

Although the law had traditionally defined only professional roles, the revised law in 2006 added provisions concerning the titles of midwives, nurses and assistant nurses (See Article 42 (3) of the Act on Public Health Nurse, Midwife and Nurse).

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Act on Public Health Nurse, Midwife, Nurse (Acted in 1948, Revised in 2006)

[Definition of midwife]

Article 3 Under this law, “Midwife” refers to a woman licensed by the Minister of Health, Labour and Welfare, who practices midwifery or provides health care to pregnant women, women in the postpartum period, and newborn infants.

[Restrictions on midwifery activities]

Article 30 Only a midwife licensed under Article 3 shall engage in these activities, except in situations where those activities are performed in accordance with the provisions of the Medical Practitioner Law (Law No. 201, 1998).

[Restrictions on the use of titles]

Article 42 (3) 2. One who is not a midwife shall not refer to oneself as a midwife nor use other misleading titles.

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In addition, the Japanese Nursing Association (JNA) is a member of the International Confederation of Midwives (ICM) and has adopted the following ICM definition of the midwife, which was revised at the ICM International Council Meeting in Kobe in 1990 and ratified by the International Federation of Gynecology and Obstetrics (FIGO) in 1991, and then by the World Health Organization (WHO) in 1992. The recent revision was made in 2011 as following.

A midwife is a person who has successfully completed a midwifery education programme that is duly recognized in the country where it is located and that is based on the ICM Essential Competencies for Basic Midwifery Practice and the framework of the ICM Global Standards for Midwifery Education; who has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery and use the title ‘midwife’; and who demonstrates competency in the practice of midwifery.

Scope of Practice

The midwife is recognized as a responsible and accountable professional who works in partnership with women to give the necessary support, care and advice during pregnancy, labour and the postpartum period, to conduct births on the midwife’s own responsibility and to provide care for the newborn and the infant. This care includes preventative measures, the promotion of normal birth, the detection of complications in the mother and child, the accessing of medical care or other appropriate assistance and the carrying out of emergency measures.

The midwife has an important task in health counseling and education, not only for the woman, but also within the family and the community. This work should involve antenatal education and preparation for parenthood and may extend to women’s health, sexual or reproductive health and child care.

A midwife may practice in any setting including the home, community, hospitals, clinics or health units.

Revised and adopted by ICM Council June 15, 2011

Due for review 2017

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Midwives and their activities are regulated as follows by the Act on Public Health Nurse, Midwife and Nurse, as well
as other related laws, including the Medical Care Law and the Maternal Protection Law.

1) Definition of the Midwifery Home (Medical Law, Article 2)\(^{16}\)

A “Midwifery Home” is a place where a midwife provides midwifery services (excluding those given in a hospital or clinic) to the general public and selective group of people.

The Midwifery Home may not consist of facilities that can accommodate 10 or more pregnant, parturient, or puerperal women.

2) Registration of the Midwifery Home (Medical Law, Article 8)\(^{16}\)

When a midwife has established a midwifery home, she is required to notify the governor of the prefecture where it is located, within ten days of beginning operations.

3) Birth Control Instructor

Maternal Protection Law, Article 15 states as follows: “the practice of instructing women about birth control utilizing the contraceptive devices specified by the Minister of Health, Labour and Welfare is only permitted by physicians and those who are designated by the governor of the prefecture”. Those who may be designated by the governor of the prefecture are midwives, public health nurses or nurses who have finished the courses which the governor of the prefecture certifies according to the standard set by the Minister of Health, Labour and Welfare. (Article 15, Paragraph 2)

Nowadays, it is required to make efforts in a variety of places women and their families become aware of birth control at each life stage in addition to consultation as family planning experts. Persons who play such a role were nicknamed as “Reproductive Health Supporter” by JNA as of 2009.

4) Obligation to Confidentiality

Article 134 of the Penal Code states that physicians, vendors of pharmaceutical products, midwives, lawyers, defendants and notaries, as well as those who previously engaged in these occupations, can be punished by imprisonment for six months or less, or fined a maximum of 100,000 yen, if they breached confidentiality without legitimate grounds and disclosed others the clients’ information obtained through their practice.

2. Midwifery Education

1) Basic Midwifery Education

(1) Midwifery Education System

An applicant for the midwife license is required to have acquired certification as a nurse either prior to or simultaneously as acquiring the midwifery license. In addition, the person has to have studied midwifery for longer than one year at college or training school to obtain a midwifery license.

As shown in the figure on the next page, there are various midwifery education pathways in Japan.

JNA is making an effort to create a system that provides a 4-year basic nursing education in college/universities unified midwifery education at the graduate level.

Midwifery students learn about pregnancy/child delivery/postpartum care in various educational courses. They are also required to assist with child delivery approximately 10 times during the course of “Practical Training for Midwifery.” The practical midwifery training is provided in a hospital, clinic, or midwifery home. According to the regulations of The Educational Institutions of Public Health Nurses, Midwives and Nurses, the child delivery for midwifery students’ practical training should satisfy the following three conditions:

1: Delivery of a child during the period from the first day of the 37th week to the seventh day of the 41st week of pregnancy.
2: Vaginal delivery
3: Head-first delivery (the fetus is in a head-down position) and single birth (there is only one fetus).

(2) Number of Midwifery Schools/Programs

Over the past few years, there has been a slight increase in the number of midwifery schools. However, the number of students accepted for midwifery programs at four-year colleges/universities is small due to the difficulty securing facilities for clinical training. Consequently, the number of those who pass the national examination remains at about the
same level.

(3) Midwifery Curriculum

In line with the 1997 revision of regulations controlling midwifery education, the current curriculum consists of the Table 2 (See page 10).

As a result of the April 2008 revision of regulations controlling educational institutions of public health nurses, midwives and nurses, the number of credits for clinical midwifery training will increase to nine in 2010. In addition, the 2009 revision concerning extension of the total years of training in the Act on Public Health Nurse, Midwife and Nurse resulted in the increase in total number of credits for completing course from 22 to 28 for students starting the course in 2012 or later. Moreover, births that can be assisted by students will be limited, in principle, to full-term and vaginal births, and cephalic and single births, within a period of from the first stage of labour to two hours later than...
completing the third stages.

Exact curriculum details for the educational programs may be set at the discretion of each school, depending upon the school’s educational aims.

Table 2: Midwifery Course Content

<table>
<thead>
<tr>
<th>Subject</th>
<th>Credit</th>
<th>Content</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fundamental of Midwifery</td>
<td>6</td>
<td>○ To learn about basics of midwifery as an activity supporting women throughout their lifetime with a focus on reproductive health</td>
</tr>
<tr>
<td></td>
<td></td>
<td>○ To understand the midwife’s role to be responsible for respecting the life of mother and child at the same time and to learn bioethics in depth</td>
</tr>
<tr>
<td></td>
<td></td>
<td>○ To nurture the ability to support motherhood and fatherhood development placing particular importance on psychological and sociological perspectives of the family</td>
</tr>
<tr>
<td></td>
<td></td>
<td>○ To learn about team approach and coordination/ liaison with the related institutions</td>
</tr>
<tr>
<td></td>
<td></td>
<td>○ To learn about expertise of midwives, attitudes and stance required for midwives</td>
</tr>
<tr>
<td>Midwifery Diagnostics and Skills</td>
<td>8</td>
<td>○ To nurture the ability to diagnose normal/abnormal pregnancy progression and acquire the latest skills that fit the diagnosis</td>
</tr>
<tr>
<td></td>
<td></td>
<td>○ To ensure to acquire the essential midwifery skills required for implementing midwifery process, through improved and strengthened practical training designed for thorough acquisition of essential basic midwifery skills</td>
</tr>
<tr>
<td></td>
<td></td>
<td>○ To strengthen the ability responding to emergencies that can occur in childbirth (repair of perineorrhaphy and laceration, neonatal resuscitation, hemostatic treatment and assistance to parturient women and the family of abnormal newborns, etc.)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>○ To strengthen assessment techniques of health conditions of pregnant/puerperant women and newborns and assistance techniques based on the assessment result</td>
</tr>
<tr>
<td></td>
<td></td>
<td>○ To nurture the ability to assist childbirth respecting the pregnant and parturient women’s initiative</td>
</tr>
<tr>
<td>Maternal and Child Health in Community</td>
<td>1</td>
<td>○ To nurture the ability to provide maternal and child health services meeting the various needs of citizens as well as the ability to promote regional maternal and child health in cooperation and collaboration with the related persons in public health, medical care, and welfare</td>
</tr>
<tr>
<td>Midwifery Management</td>
<td>2</td>
<td>○ To learn about management of midwifery services, operation of maternity clinics, and the perinatal medical care system</td>
</tr>
<tr>
<td>Clinical Midwifery Training</td>
<td>11</td>
<td>○ To integrate clinical training in midwifery diagnostics and skills, maternal and child health care in the community, and midwifery management. Births assisted by students will be limited, in principle, to full-term, vaginal, cephalic and single births, during a period of from the first stage of labour up to two hours after the completion of the third stage</td>
</tr>
<tr>
<td></td>
<td></td>
<td>○ To provide continuous care at least one case of woman from her mid-pregnancy to one month after delivery during the training period</td>
</tr>
<tr>
<td></td>
<td></td>
<td>○ To include clinical training to strengthen the ability to assess pregnancy progression through antenatal health check-ups support breastfeeding of puerperant women, and conduct newborn babies’ assessment</td>
</tr>
<tr>
<td>TOTAL</td>
<td>28</td>
<td>○ To provide at least 930 hours of lecture, practical training, etc.</td>
</tr>
</tbody>
</table>

*The number of credits applied to students starting the course in 2012
*1 credit corresponds to 45 hours

(Note) When the applicant passes the national examination after completing 28 credits, the midwifery license is given by the Minister of Health, Labour and Welfare. Since it is not necessary to renew the license once it is obtained, the holder can continue midwifery practice indefinitely.

2) Education for Novice Midwives

The Ministry of Health, Labour and Welfare (MHLW) put forth the “Guidelines for Training Novice Nursing Staff” in December 2009 with concrete measures to secure the quality of nursing. This was with the understanding that “training of novice nursing staff is one of the primary ways to uplift the overall quality of the nursing staff, and warrants that as many institutions provide a standardized level of novice training”. In February 2011, “the Final Report of the Commission that Investigated the Training of Novice Nursing Staff” presented the guidelines for training of novice public health nurses and midwives. According to the report, since trainings of novice public health nurses and novice midwives are often provided at institutions, it is important that the philosophy/basic policy/structure of the training of novice midwives and trainer development be aligned with those for novice nursing staff training. As a result, the goals of midwifery techniques that midwives should obtain during the first year after they have started midwifery practice, the elements supporting their midwifery techniques, and examples of technical guidance have been added to the “Guidelines for Training Novice Nursing Staff.”

The major efforts by the MHLW concerning novice nursing staff training are presented in their website. It is pointed out in the “conclusion of the investigative commission on the ideal state of the Act on Public Health Nurse, Midwife
and Nurse (November 2005)” that institutionalization of novice nursing staff training is highly necessary. In the “interim conclusion on improvement and securing of nursing quality (March 2009),” it was also pointed out that it was necessary to urgently examine the contents, methods, and diffusion methods of novice nursing staff training, with an aim to institutionalize and make compulsory the training, and putting them into practice while making efforts to improve the basic nursing education. The Act on Public Health Nurse, Midwife and Nurse and the Act on Assurance of Work Forces of Nurses and Other Medical Experts were amended on July 15, 2009. According to the amendment, clinical training of nursing staff newly engaging in the practice became a nonbinding target, effective on April 1, 2010. According to the amendment, each nursing staff is responsible for improving her/his nursing capacity by undergoing clinical training and other training even after acquiring the license, while the director of the hospital, etc. should also make efforts to provide training and to secure opportunities for nursing staff to receive such training. It is of hope that utilization of the “Guidelines for Training Novice Nursing Staff” in many medical institutions contributes to improving the training of novice nursing staff and their nursing quality, to ensuring medical safety, and to preventing novice nursing staff from giving up their nursing career.

JNA formulated the “training guide for new graduate midwives” in 2012.

### Table 3: Clinical Ladder for Education for Novice Midwives

<table>
<thead>
<tr>
<th>Novice level</th>
<th>Level I</th>
<th>Level II</th>
<th>Level III</th>
<th>Level IV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goals</td>
<td>1. Able to provide midwifery care safely and surely in accordance with instructions, the procedure, and the guideline. 2. Able to provide midwifery care safely and surely, having acquired knowledge, skills, and a proper attitude to assist healthy living. 3. Know the contents of midwifery led care for in-patients and out-patients. <em>Able to understand the pathological conditions of high risk patients and proper way to cope with them.</em></td>
<td>1. Able to provide individualized care based on the midwifery process. 2. Able to provide care in the in-hospital midwifery clinic with support. 3. Able to provide midwifery care together with the senior midwife in the in-hospital midwifery care unit. <em>Able to judge whether the symptom is high or low risk and provide the initial intervention</em></td>
<td>1. Able to responsibly provide midwifery care of the pregnant/puerperant woman and the newborn throughout the hospitalization period. 2. Able to autonomously provide individualized care in the in-hospital midwifery clinic. 3. Able to play an instructive role in the in-hospital midwifery clinic. 4. Able to autonomously provide care in the in-hospital midwifery care unit. <em>Able to detect transition from low risk to high risk symptoms in the early stage and to intervene when necessary.</em></td>
<td>1. Able to provide creative midwifery care. 2. Able to play an instructive role in the in-hospital midwifery care unit. 3. Able to play an instructive role in the in-hospital midwifery clinic. <em>Able to provide instruction to staff in both low and high risk cases.</em></td>
</tr>
</tbody>
</table>

### Table 4: Clinical Ladder for Continuing Education

<table>
<thead>
<tr>
<th>Novice level</th>
<th>Level I</th>
<th>Level II</th>
<th>Level III</th>
<th>Level IV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goals</td>
<td>1. Able to understand information required for healthy living behavior diagnosis and pregnancy progress diagnosis in pregnancy/child delivery/puerperum/newborn period with support. 2. Able to gather information using the fixed form. 3. Know the lacking information and able to gather the additional necessary information with guidance. 4. Able to record using correct terms and appropriate expressions.</td>
<td>1. Able to autonomously gather information required for healthy living behavior diagnosis and pregnancy progress diagnosis in pregnancy/child delivery/puerperum/newborn period. 2. Know the lacking information and be able to gather the additional information. 3. Able to sort out information required for assessment with guidance. 4. Able to make records using the correct terms and appropriate expressions.</td>
<td>1. Able to gather all information required for implementing individualized midwifery care among the information for healthy living behavior diagnosis and pregnancy progress diagnosis in pregnancy/child delivery/puerperum/newborn period. 2. Able to sort out information required for assessment.</td>
<td>1. Able to get the picture of overall situation concerning the target including individuality, mental/social aspects, family background, and selectively gather information focused on the required area.</td>
</tr>
</tbody>
</table>

*Midwifery in Japan 11*
### Midwifery in Japan

#### 3. Continuing Education

The JNA offers 2-3 day off-the-job training programs for midwives, such as human resource development training concerning establishment and conduct of an in-hospital midwifery clinic and in-hospital midwifery care etc. Similarly, educational programs are also offered by prefecture nursing associations and other organizations.

Since FY2011, JNA has put a priority on enhancing practical competency of midwives amongst midwifery related agendas. In 2012, JNA formulated a continuing education tool that can be applied nationwide, "Guidelines for Applying Practical Midwifery Competency Ladder (Clinical Ladder)" that links the training for novice midwives to in-service professional development provided afterwards.

#### 3. Number of Midwives

The number of midwives employed in 2012 was 35,185, or 0.28 per population of 1,000. About 62% of midwives work at hospitals and 25% at clinics. Additionally there are midwives who are currently unemployed, or working as public health nurses or nurses.

### Midwifery Competency Ladder

<table>
<thead>
<tr>
<th>Level I</th>
<th>Level II</th>
<th>Level III</th>
<th>Level IV</th>
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</thead>
<tbody>
<tr>
<td>i) Able to make an appropriate diagnosis by analyzing information on healthy living behavior and pregnancy progress with support. i) Able to make an appropriate diagnosis by analyzing information on healthy living behavior and pregnancy progress with support as needed. i) Able to make an appropriate diagnosis by analyzing information on healthy living behavior and pregnancy progress. i) Able to share the given details of the diagnosis with other members of the medical care team including the pregnant/puerperant woman. ii) Able to make a midwifery plan concerning maternal, social, and family conditions of the pregnant/puerperant woman and the newborns. ii) Able to make a plan and revise it during the conditions. ii) Able to make a midwifery plan with the participation of the pregnant/puerperant woman and their family members. ii) Able to make a plan using an appropriate method considering the priorities of the pregnant/puerperant woman and the newborns and their midwifery problems. iii) Able to make a midwifery plan with the participation of the pregnant/puerperant woman and their family members, and revise it. iii) Able to make an appropriate plan using the SWTH framework. iii) Able to make a midwifery plan with the participation of the pregnant/puerperant women and their family members. iii) Able to make an appropriate plan. iv) Able to make a specific plan using the SWTH framework. iv) Able to make a midwifery plan with the participation of the pregnant/puerperant women and their family members. iv) Able to make a plan including the collaboration with other related health/medical care staff and revise it.</td>
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### Planning

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<tr>
<td>i) Able to select a problem according to the needs of the pregnant/puerperant woman and the newborns. i) Able to make a specific plan using the SWTH framework. i) Able to make a midwifery plan with the participation of the pregnant/puerperant women and their family members. i) Able to make a plan using an appropriate method considering the priorities of the pregnant/puerperant woman and the newborns and their midwifery problems. ii) Able to make a midwifery plan concerning maternal, social, and family conditions of the pregnant/puerperant woman and the newborns. ii) Able to make a plan and revise it during the conditions. ii) Able to make a midwifery plan with the participation of the pregnant/puerperant woman and their family members, and revise it. ii) Able to make a plan including the collaboration with other related health/medical care staff and revise it. iii) Able to make a midwifery plan with the participation of the pregnant/puerperant woman and their family members, and revise it. iii) Able to make an appropriate plan using the SWTH framework. iii) Able to make a midwifery plan with the participation of the pregnant/puerperant women and their family members. iii) Able to make an appropriate plan. iv) Able to make a specific plan using the SWTH framework. iv) Able to make a midwifery plan with the participation of the pregnant/puerperant women and their family members. iv) Able to make a plan including the collaboration with other related health/medical care staff and revise it.</td>
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### Practice

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<th>Practice</th>
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<tbody>
<tr>
<td>i) Able to provide basic midwifery skills with support. i) Able to provide the targeted midwifery care safely and surely following the standards and procedures according to the midwifery care plan. i) Able to provide basic life support and advanced life support in an emergency (including neonatal resuscitation). i) Able to conduct practice following the clinical pathway when using it. ii) Able to conduct practice following the clinical pathway when using it. ii) Able to conduct practice following the clinical pathway when using it. ii) Able to conduct practice following the clinical pathway when using it. iii) Able to provide midwifery care with various approaches. iii) Able to provide midwifery care with various approaches. iii) Able to provide midwifery care with various approaches. iii) Able to provide midwifery care with various approaches. iv) Able to assess the variances of the diagnosis. iv) Able to provide midwifery care with various approaches. iv) Able to provide midwifery care with various approaches. iv) Able to provide midwifery care with various approaches. v) Able to accurately report the result of the midwifery care provided by herself and give guidance. v) Able to accurately report the result of the midwifery care provided by herself and give guidance. v) Able to accurately report the result of the midwifery care provided by herself and give guidance. v) Able to accurately report the result of the midwifery care provided by herself and give guidance.</td>
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### Evaluation

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<th>Evaluation</th>
<th>Evaluation</th>
<th>Evaluation</th>
<th>Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>i) Able to ask questions regarding the midwifery practice and solve them. i) Able to assess the result of the midwifery care provided by herself on reasonable grounds. i) Able to assess if the midwifery care provided by herself met the needs of the pregnant/puerperant woman and the newborn. i) Able to assess if the midwifery care provided by herself met the needs of the pregnant/puerperant woman and the newborn. ii) Able to assess the extent to which the goal was achieved, and to revise the plan. ii) Able to make records using clinical pathways. ii) Able to make an educational/instructive role during the condition. ii) Able to make an educational/instructive role during the condition. iii) Able to assess the variances when using clinical pathways. iii) Able to make an educational/instructive role. iii) Able to make an educational/instructive role. iii) Able to make an educational/instructive role. iv) Able to analyze the care provided by other staff and give guidance. iv) Able to make an educational/instructive role. iv) Able to make an educational/instructive role. iv) Able to make an educational/instructive role.</td>
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4. Evaluation of the Quality of Midwifery Care

Since 2000, the Professional Committee on Midwifery of JNA has considered indicators and measurements for evaluating the quality of midwifery, taking into account “Essential Competencies for Basic Midwifery Care (ICM. 1999).” To grasp the current situation in Japan and compare it with other countries, the committee conducted a survey of 2,000 midwives in terms of core competencies listed by the ICM. In line with its findings, evaluation criteria of midwifery in the phases of pregnancy, delivery, and puerperium were set in 2003 from the standpoint of the level of midwifery care how midwives should be able to practice. The second version of evaluation criteria was drawn up in 2007 in line with the survey results in 2005. For the new criteria, competency levels were integrated and the description of each level was simplified. If these criteria are used in maternity facilities nationwide, they are expected to become more standardized and to contribute to assuring the quality of midwifery care.

Table 5: Evaluation of the Quality of Midwifery Care at Medical Facilities (Partly excerpted)

| Level 1 | Able to perform with advice / under instruction |
| Level 2 | Able to provide care independently / Able to do independently according to the manual |
| Level 3 | Able to provide individual care by using various methods to achieve the goal / Able to give guidance to students and junior fellows / Able to lead and coordinate a team |
| Level 4 | Able to objectively grasp the situation with a few clues and identify the core of problems / Able to coordinate care, including by other than a nursing team, to set ambitious target |

Diagnostics and care in the intrapartum period
Aim: To provide appropriate midwifery care in respond to the progress of delivery for a mother to have a baby safely and for her and her family to be satisfied with their experiences

<table>
<thead>
<tr>
<th>113 To understand and respond to the course of delivery for a parturient woman and her family</th>
<th>Answer at the item level</th>
<th>Answer at the sub-item level</th>
</tr>
</thead>
<tbody>
<tr>
<td>113.1. Able to understand the course of delivery for parturient women and their families in the facility</td>
<td>4</td>
<td>3 2 1 Not applicable</td>
</tr>
<tr>
<td>113.2. Able to explain the course of delivery to a parturient woman and her family</td>
<td>4</td>
<td>3 2 1 Not applicable</td>
</tr>
<tr>
<td>113.3. Able to respond to a parturient women and their family according to the course of delivery</td>
<td>4</td>
<td>3 2 1 Not applicable</td>
</tr>
</tbody>
</table>
5. Midwifery Practice

1) Importance of Care by Midwives

Midwives must respect the wishes of the pregnant women and their families, and support them so that they can enjoy good health, safe delivery, and successfully transition to parenthood. Therefore, midwives must be able to make accurate diagnosis and offer appropriate care, and empathetically share both joy and sorrow together with their patients. In addition, besides supporting women during delivery, with respect for women’s reproductive health rights, it is vital that midwives continue to provide comprehensive measures to support women’s health throughout their lifetime.

JNA is developing a project with an aim to “providing midwifery care to all pregnant women, those in the puerperium, and newborns.” As part of this project, the “Guidelines for Applying a Practical Midwifery Competency Ladder (Clinical Ladder)” was developed as a tool for midwives to evaluate their own midwifery capacity. Using the tool, midwives can objectively evaluate their own midwifery experience, and understand their own level on the Clinical Ladder.

Up until now, only a few hospitals have created their own clinical ladders. However, developing a standardized version of the Clinical Ladder to help evaluate the midwifery competency level of Japanese midwives anywhere in Japan, has been a revolutionary movement. It is of hope that the use of Clinical Ladder will spread ubiquitously to improve midwives’ skills in the future.

2) Roles of Midwives in Re-modeling of Perinatal Medical Service System

Following the recent decrease in the number of facilities dealing with childbirths and obstetricians/gynecologists, ensuring safe and secure childbirth places is an urgent issue. Under such circumstances, midwives are expected to play more important roles than ever.

The MHLW formulated the “Vision for Securing Safe and Desired Medical Care” in June 200825), stipulating that physicians and nursing staff should more closely cooperate, and that under such cooperation midwives can exercise their expertise for safe and secure childbirth. Since 2008, the Ministry has been operating the grant project for trainings for midwives etc., and facility improvement for the purpose of establishing the “in-hospital midwifery care” and the “in-hospital midwifery clinic” as a system in which midwives provide midwifery care on their own initiative.

In the past, the outpatient system in which midwives take the initiative in providing health check-ups and health guidance for pregnant women and the In-Hospital Midwife-Led Care System

The in-hospital midwife-led care system is a system to effectively utilize midwives. The “in-hospital midwifery clinic” and the “in-hospital midwifery care” make up the nursing/midwifery system in which midwives take the initiative in providing antenatal health check-ups, childbirth support, and health guidance at hospitals and clinics.

◆ In-hospital Midwifery Clinic
An outpatient service where midwives provide health check-ups and health guidance to pregnant and postpartum women.

◆ In-hospital Midwifery Care
The method and the system allow midwives to provide independent midwifery care to pregnant women admitted for delivery, and to mothers and children after delivery, especially for low-risk deliveries which can be assisted by midwives.

Japanese Nursing Association, February 2009

Fig. 7: In-Hospital Midwife- Led Care System
system in which midwives provide birth assistance services in hospitals and medical clinics as they have usually been doing in maternity homes were operated depending on pregnant and parturient women’s risks. JNA has placed these two systems as “in-hospital midwifery clinic” and “in-hospital midwifery care” respectively under the “In-hospital midwife-led care system”. In this system, midwives provide the necessary care to pregnant and parturient women depending on their risks in cooperation with physicians at medical institutions.

3) The System Implementation at Facilities

The number of facilities implementing the in-hospital midwifery clinic and the in-hospital midwifery care tends to increase following the trends toward re-modeling of perinatal medical care system. The increase of these facilities is also led by the national government’s financial support concerning improvement of facilities/ equipment for implementation of the in-hospital midwifery clinic or in-hospital midwifery care and conduct on training.

In each facility, midwives, physicians, and the relevant staff are preparing for the in-hospital midwifery clinic and the in-hospital midwifery care in cooperation so that they can be operated depending on the community needs and the roles of the facility. Midwives are providing proactive care mainly to low risk pregnant/ parturient women. Regarding high risk pregnant/ parturient women, they are providing midwifery care in cooperation with physicians depending on their conditions. The criteria of reporting to the physician for changes in pregnant/ parturient women’s risk level is set through discussion by midwives and physicians in the facility based on the guidelines indicated by Health and Labour Sciences Research Grant.
Midwifery in Japan

- Maternal Check-ups at In-Hospital Midwifery Clinic
- Midwife Performing Ultrasound
- Midwife Counseling Mothers
- Childbirth Support at In-Hospital Midwifery Care
1. “Guide for Protocol Development for Delivery Facilities During Disasters”

In order to share the lessons learnt from the Great East Japan Earthquake in 2011, JNA visited the affected areas and conducted an investigation to grasp the conditions of the delivery facilities of the affected areas, and held a symposium to present our findings. Survey results of the delivery facilities suggested that only a few facilities had manuals for dealing with child delivery during disasters. Since such manuals were intended for the entire medical facility, they only dealt with general, unspecialized procedures for how a hospital should act during an emergency. JNA created a “Guide for protocol development for delivery facilities during disasters” in 2013, to provide specific ideas and guidance to delivery facilities when they prepare a disaster management manual.

2. Temporary Transfer System of Midwives

JNA proposes a temporary transfer system of midwives as a system that contributes to correcting the uneven distribution of midwives, and possibly strengthening midwives’ practical skills.

In the temporary transfer system of midwives, a midwife is transferred to a remote facility as a midwife for approximately half a year to one year while being under the employment contract with the original employer. In addition to amending the uneven distribution of midwives, the system can contribute to the local community by providing midwifery care to all pregnant/postpartum women in need. Strengthening midwives’ practical skills through practice in normal child delivery assistance is another one of the system’s objectives.

Fig.9: Utilization of Temporary Transfer System of Midwives
3. Other Topics

1) Gestational Diabetes Mellitus

Since the International Association of Diabetes and Pregnancy advocated the global criteria for diagnosing gestational diabetes mellitus in 2009, the definition and diagnostic criteria for gestational diabetes mellitus were also revised in Japan in July 2010.

The introduction of the new diagnostic criteria is said to have increased the incidence of gestational diabetes mellitus 4-fold, from 2.92% to 12.08%. Considering the risks of gestational diabetes mellitus on the fetus, however, the new diagnostic criteria are important for safer perinatal management of the mother and child. Since midwives are professionals who can provide appropriate assistance during each period of pregnancy, they can promote both maternal health as well as the health of the babies to be born, making their contribution to society significant.

2) HTLV-1

“HTLV-1” is a virus called “Human T-cell Leukemia Virus Type 1.” It is considered to cause adult T-cell leukemia, HTLV-1-associated myelopathy, and other diseases. Although the presence of the virus is not necessarily accompanied by visible symptoms, one in every 1,000 persons develops adult T-cell leukemia. In Japan, approximately 1% of the population are said to be carriers of the virus.

It was found that when a mother has HTLV-1, her baby can also be infected with HTLV-1 through breast milk. The possibility of infection in case of long-term breast feeding is 15% - 20%, and even for babies who are not breastfed a possibility of infection is approximately 3%. Although a preventive method of freezing breast milk at -20°C before feeding has been proposed, there are still no absolute preventive measures.

In Japan, the HTLV-1 Antibody Test has been added to the standardized test items of health check-ups for pregnant women since 2012. Accordingly, there are women who find out that they are carriers for the first time when they are pregnant. Midwives are expected to provide HTLV-1 carrier mothers with various assistances, including consultation on feeding methods and supporting their mental health.

3) “Handbook for Introducing Unit Management of a Mixed-Divisions Ward for Maternity and Other Patients”

The number of child delivery facilities is decreasing, partly due to the decrease in the number of children born and the lack of obstetricians. Medical institutions handling fewer cases of child delivery are forced to hospitalize maternity patients with patients from different divisions in the same ward (Mixed-divisions ward). Accordingly, newborns are facing a higher risk of infection. JNA formulated a “Handbook for Introducing Unit Management of a Mixed-Divisions Ward for Maternity and Other Patients” in September 2013, and it suggests that the staff should form isolated clusters to take care of maternity patients in the mixed-divisions ward. The handbook was distributed nationwide to approximately 2,700 institutions handling child delivery. Through exchange meetings between obstetrics managers and seminars on the basics of obstetrics management, the idea of forming isolated clusters for maternity patients has spread. The association will make further efforts to familiarize a wider range of people with the idea, so that it can contribute to improve the current system to provide a better child delivery environment.
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*Resources listed above are available only in Japanese.
*Data are accessed in and valid as of March, 2014.
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