
Chapter 4

Family Planning

As a result the first two inter-governmental conferences concerning population issues, the World Population Conference held in Bucharest (1974), and the International Population Conference (1984) held ten years later in Mexico City, many developing countries concluded that a rapid population increase created a strain on resources, hampered economic development and hindered their affluence, leading them to introduce government-led family planning programs as a means of limiting population growth.

However, family planning programs are closely involved with personal lifestyles, and if they are introduced to control national population growth, they are often unable to achieve satisfactory results. Accordingly, at the International Conference on Population and Development (ICPD) in Cairo in 1994, reproductive health/reproductive rights¹ became the central concept. Government representatives from 179 countries adopted a “Program of Action” that strongly shifted the focus of population policy from the macro (national level) to the micro (individual level), from population policy driven by the government to the individual, in other words, individual women. The transition from family planning aimed at population control to a reproductive health/reproductive rights program has not been smooth, however, and many countries have not fulfilled the needs of women who want to use contraception or defer pregnancy.

The contraception prevalence rate in developing regions for all contraception methods is 59% on average, while it is 69% in advanced countries, with the difference continuing to shrink.

There still remain large differences between nations: 4%–40% in Sub-Saharan Africa (excluding South Africa), 5%–75% in South and Central Asia, 24%–75% in Southeast Asia. Even within the same country, differences between the affluent and poor strata have been pointed out as another problem².

Like many developing countries now, Japan was economically weak after the Second World War, and in addition to lagging behind dramatically in the fields of maternal and child health and public health, the population increased explosively. With almost no capital available, health workers and the people fully utilized their knowledge and ideas and made steady progress in family planning and maternal and child health. By combining the fields of family planning and maternal and child health, local residents, particularly women and mothers, received guidance from public health nurses and participated in community activities, with multi-dimensional activities expanding from maternal and child health to family planning, and then to community-based health.

Examples of the various experiences and strategies in the field of family planning in Japan include the fact that family planning was promoted as part of maternal and child health, with the fundamental concept that reproductive self-determination is an individual right. The experiences also include the involvement of community organizations through midwives and public health nurses, and close cooperation between bureaucracy and the community. These are considered meaningful examples of the shift from family planning aimed at controlling

¹ Health and rights relating to sex and reproduction. The situation where everyone has the right to determine the number and birth timing of their own children without being subject to social pressures such as convention, or mental or physical pressures.

² United Nations Population Fund (2002) State of World Population Report 2002.

population growth, to family planning based on the concept of reproductive health/reproductive rights, suitable for application by developing countries in implementing the Cairo "Program of Action."

For that reason, in this chapter we will focus on trends in Japanese initiatives in family planning, particularly after the Second World War, and then discuss the results and challenges arising from these initiatives. We will then summarize Japan's experiences that may be applicable to the challenges faced by developing countries. Furthermore, as examples of international cooperation in the family planning field using Japan's experience, in an appendix at the end of the chapter we will introduce the record of Integration Projects (IP) of the Japanese Organization for International Cooperation in Family Planning (JOICFP).

1. Trends in Family Planning

1-1 Pre-war and Wartime "Birth Control" (1920~1945)

After the First World War (1914~1918), from about 1920 in Japan, people started proclaiming the necessity of birth control (translated into Japanese as "restriction or regulation of the numbers of children"), and a birth control movement was born.

An economic depression followed the First World War, and as the labor movement started to gain prominence, socialists began to urge the need for birth control as part of a program to improve the life of workers. Furthermore, influenced by Margaret Sanger, the forerunner of the birth control movement, the birth control movement started among women's liberation movement members (e.g. Shizue Kato) aiming for health and happiness at the individual level. Although Sanger visited Japan from the USA in 1922, the Japanese government imposed an entry condition completely prohibiting activities promoting family planning. Despite this, reports in the newspapers and other

media had a strong impact in Japan at that time, and family planning became a popular topic in women's magazines. Shizue Kato and others founded the Japan Birth Control Research Association in Tokyo, and contraceptive methods such as the Ogino Rhythm Method (1924) and the Ota Ring (1932) were developed. In 1932, Shizue Kato also underwent training for 3 months at the Sanger Clinic in New York, and after returning to Japan established a birth control clinic in Tokyo.

The rise of militarism in the 1930s led to a policy of "Fukoku Kyohei," or enhancing the wealth and military strength of the country, that called for population increase. The birth control movement was accordingly suppressed as a philosophy contrary to the national interest, and the birth control clinic was closed in 1938. In 1941, the government prohibited contraception, lowered the marriage age, and promoted an average of five children per married couple.

1-2 From Post-war Baby Boom to Promulgation of the "Eugenic Protection Law" (1945~1948)

Following the end of the war in 1945, Japan's population increased sharply due to the demobilization of the armed forces, repatriation from former colonies, leading to a Baby Boom in the 3 years from 1947 to 1949. (From 1945 to 1955, the population increased from 72,150,000 to 90,780,000, while the average annual population increase was at 3.1% in 1950.) Amidst the post-war devastation, living conditions in Japan were extremely poor, with unavoidable shortages of clothing, food and shelter. At that time, there was a lack of accurate knowledge about contraception, and no contraceptive devices available, so there were many unwanted pregnancies. The old Penal Code promulgated in 1880 penal code on abortion crimes³, forcing women to undergo illegal abortions. Many women died, or suffered from complications, as a result of illegal abortions performed under very poor conditions.

³ Abortion is still applicable as a crime now.

In this situation, a movement of diet politicians arose to protect women from dangerous illegal abortions, and in 1948 the Eugenic Protection Law was promulgated, permitting abortion by a medical specialist under specified conditions. In 1949, the Eugenic Protection Law was amended to add “economic reasons” to the conditions for widening the indications for induced abortions. In the same year, the manufacture and sale of contraceptive pharmaceuticals, previously prohibited, was permitted.

1-3 From Rapid Increase in Abortion to the Widespread Use of Family Planning (1949~1959)

Following the 1949 amendments, further revisions to the Eugenic Protection Law in 1952 allowed abortions to be performed in accordance with the judgment of the supervising doctor, without having to wait for the hitherto complicated evaluation by the official institution. As a result, the number of abortions increased markedly from 1949 to 1955, with the number of applications for induced abortion reaching a historical high of 1,170,000 in 1955.

In response to this situation, a “Cabinet Decision Regarding Popularization of Family Planning” was issued in 1951, stating that “Induced abortion is necessary in some cases from the viewpoint of protecting the mother’s body, but the current high frequency of induced abortions is not good for the mother, so a changeover to family planning is desirable.” The government then began to address family planning in earnest. Following this Cabinet Decision, the Eugenic Protection Law was again amended in 1952, making it mandatory to provide a “Eugenic Protection Counseling Center” in all public health centers throughout Japan, and a system of family planning workers was established, comprising

former midwives, public health nurses and general nurses. Training sessions were held in each prefecture for accreditation as family planning workers that provide family planning counseling as well. In addition to such human development programs, family planning promotion activities were also commenced centered on the Eugenic Protection Counseling Center. This can be said to be the start of Japanese government initiatives in the field of family planning. In many prefectures, however, the infrastructure was not ready and preparation was delayed, so in the four years from 1952-1955 the foundations were laid for later activities, and activity began in earnest in the latter half of 1955⁴.

In October 1955, the Fifth International Conference on Planned Parenthood sponsored by the International Planned Parenthood Federation was held in Tokyo. It was attended by about 500 people from Japan and overseas, including representatives from 16 countries. It was the first international conference to be held in post-war Japan, and was reported extensively by the mass media at the time. This Conference provided a strong stimulus to the family planning movement in Japan, and was the catalyst for a variety of movements concerning family planning.

First, organizations involved in family planning in Japan linked up to prepare for the conference, and in 1954 the Family Planning Federation of Japan was formed, and has since fulfilled the function of the family planning organization representing Japan⁵. Furthermore, this conference promoted cooperation between the government and the private sector, producing strong results as both parties complemented each other’s functions. At the international conference, many doctors, midwives, health workers and

⁴ Kon, Yasuo (2000) “*Waga Kuni no Kazoku Keikaku Undo no Ayumi* [The History of Family Planning Movement in Japan],” *Kazoku Keikaku Binran 2000 - Shoshi Korei Shakai to Ripro Health* [Handbook on Family Planning 2000 - Low Birthrate, Aging Population, and Reproductive Health], Japan Family Planning Association, Inc.

⁵ The Japan Family Planning Promotion Association (described in more detail later) is a representative body belonging to the Family Planning Federation.

Table 4-1 History of Family Planning

Year	Policy, Movement, etc.	Societal Trends
1876	Introduction of Malthus's "Population Theory" to Japan	
1880	Old Penal Code enacted (abortion made a crime)	
1914		· Commencement of First World War
1918		· Armistice ends First World War
1922	Margaret Sanger visits Japan. Family planning movement flourishes.	
1923		· Kanto Daishinsai (Great Kanto Earthquake). Enter age of pressure to limit population growth
1937	Promulgation of Public Health Center Law	
1938	Promulgation of Maternal and Child Protection Law Establishment of Ministry of Health and Welfare	
1939		· Commencement of Second World War
1940	Promulgation of National Physical Strength Law	
1941	Promulgation of National Eugenic Law Population policy establishment regulations decided	· Enter period of "Give Birth and Multiply"
1942	Public health nurse system commenced Mother's Handbook System commenced	
1945		· Japan defeated in the Second World War
1947	Maternal and Child Health Handbook replaces Pregnant Mother's Handbook	· First Baby Boom (1947-49)
1948	Promulgation and enactment of Eugenic Protection Law Population Association of Japan established	
1949	Eugenic Protection Law amended (Some abortions permitted for economic reasons) Cabinet creates "Council on Population Committee"	
1950	National Institute of Public Health commences system of "Family Planning Model Villages" (~1957) Cabinet "Council on Population Committee" abolished Mainichi Newspaper Population Problems Research Council starts "National Family Planning Public Opinion Poll" (thereafter conducted annually)	· United Nations Children's Fund (UNICEF) provides material assistance (~64)
1951	"Cabinet Decision Concerning Extension of Family Planning" announced	
1952	"Family Planning Extension Guidelines" announced Eugenic Protection Law amended (creation of Eugenic Protection Consultation Clinics, creation of Family Planning Worker System) New Life Movement started by business group	· Government launches population policy
1953	Institute for Research on Population Problems established as an advisory group to the Minister of Health and Welfare Institute for Research on Population Problems announces "Proposal concerning Quantitative Population Adjustments"	
1954	Japan Family Planning Promotion Association (now the Japan Family Planning Association) established Family Planning Federation of Japan formed Japan invited as representative of developing countries to World Population Conference in Rome (Aug-Sept)	
1955	IPPF Fifth International Conference on Planned Parenthood held (October, Tokyo) Special measures to allow sale of contraceptives by family planning workers. "Family Planning Special Project" commenced for low-income earners (cost of contraceptives paid by government) "Home Life Research Association" formed	· Number of abortions peaks nationally
1956	"Family Planning Research Committee" created First Annual Family Planning National Conference held	· Economic White Paper "It's not post-war any more"
1959	Institute of Research on Population Problems publishes first "Population White Paper" Family Planning moves from Public Health Department to Children's Department, integrated into maternal and child welfare policy	
1960	Ikeda Cabinet formed. "National Income Doubling Plan" Institutional delivery exceed 50% of all births	· Around 1960, the contraception prevalence rate reached 43%, and overtook abortion rate · Institutional delivery exceed 50% of all births · Against a background of a shortage of young labor and the depopulation of rural villages, the "No need for family planning" theory emerged, and family planning policy rapidly weakened and was entrusted to the private sector
1968	Japanese Organization for International Cooperation in Family Planning (JOICFP) established	
1972	Second Asian Population Convention (Tokyo)	
1973	Population Problem Cooperation Association formed.	
1974	Ota Ring (IUD) approved globally	
1977	Two new types of IUD approved.	
1994	International Conference on Population and Development held (Cairo)	
1996	Eugenic Protection Law revised, becomes Mother's Body Protection Law	
1999	Low-dosage oral contraceptive (Pill) approved	
2000	Institute for Research on Population Problems eliminated in reorganization of government ministries and departments	
2002	Family Planning Federation of Japan disbanded (Absorbed into Japan Family Planning Association)	

community activists interested in family planning gathered from all over Japan for enthusiastic lectures and discussions. As a result, in 1956 the First National Conference for Family Planning Promotion was organized and sponsored jointly by the Ministry of Health and Welfare and the Family Planning Federation of Japan, since which time the conference has been held once a year. The Family Planning Federation of Japan represents Japan's family planning bodies on the International Planned Parenthood Federation, and also participated in the World Population Conference held in Rome in 1954.

The family planning program launched under government leadership since 1952 started to develop from the second half of 1955 as described above. As a result of this, the abortion rate began to decline after peaking in 1955 when the family planning program was undertaken in earnest (see Figure 4-1).

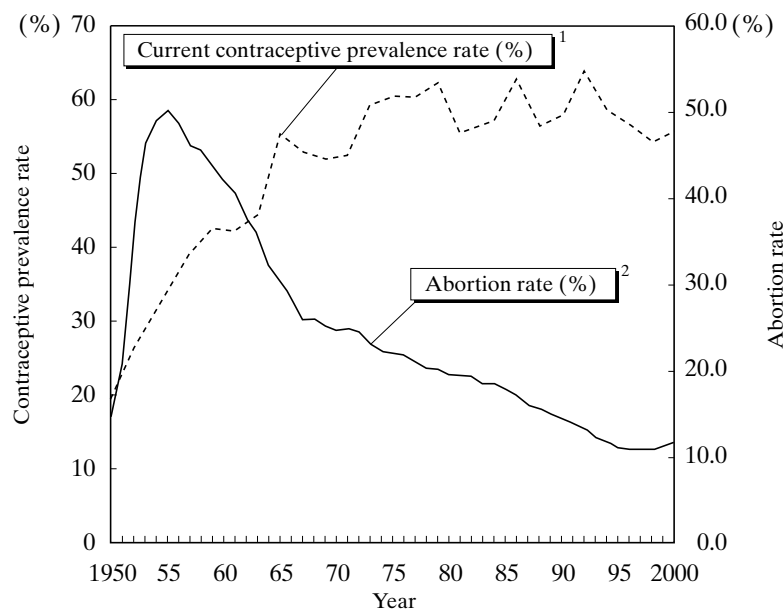
1-4 The Popularity of Family Planning and Present Challenges (1960~present)

(1) Spread of Family Planning and the Start of Reproductive Health/Reproductive Rights

As a result of the above mentioned activities, the contraceptive prevalence rate reached 43% around 1960, overtaking the abortion rate, and Japan's initiatives in the field of family planning began to show definite results (see Figure 4-1).

The Ikeda Cabinet was formed in 1960 and the "National Income Doubling Policy" was proposed. As the government gave first priority to the economy and began to focus on strengthening export-related industries, it rapidly lost enthusiasm for family planning policy. Furthermore, when a shortage of young workers emerged around 1965 accompanying Japan's rapid economic development, the "No need for family planning" theory started spreading among the business world and mayors of towns and villages, stating that there was no need for the administration

Figure 4-1 Contraceptive Prevalence Rate and Abortion Rate



N.B.:1) The current contraceptive prevalence rate is the ratio of females using contraceptives at the time of the survey to the total respondents to the survey, which targeted married women under the age of 50.

2) The abortion rate is the number of abortions per thousand women between the ages of 15 and 49 (according to the Maternal Health Protection statistics).

Data: Population Problems Research Council of the Mainichi Newspaper, Statistics and Information Department, Cabinet Secretariat, Ministry of Health, Labour and Welfare.

Source: National Institute of Population and Social Security Research

to promote “family planning” that might lead to “population reduction.”

When males left rural villages to look for cash income in the cities, their wives were burdened with the farm management in addition to housework and child-raising. If they became pregnant during the farming season, it was a large drain on the household income, so abortions were unavoidable. For public health nurses and midwives working in rural villages, contraception guidance was therefore a pressing problem that could not be divorced from their other duties.

As a result, since the government's family planning policy was largely weakened, the officials provided contraception consultation and guidance when necessary as part of maternal and child health guidance. The main family planning activities shifted toward activities by non-governmental organizations. In 1977, “family planning special consultation services” (genetic counseling) were entrusted to the Japan Family Planning Association as a new project for the Ministry of Health and Welfare. In 1984 a budget was allotted for an Adolescent Counseling Project as part of the “Healthy Motherhood Promotion Project,” and the Japan Family Planning Association began to train adolescent counselors, thus creating a national network that continues to the present.

In the light of the low birth rate and the above mentioned socioeconomic changes, proposed amendments to the Eugenic Protection Law to apply stricter conditions for abortions were repeatedly submitted to the diet (1972~73 and 1982~83), citing such reasons as “the indications for abortions are too broad” and “the low birth rate is a problem.” Advocacy campaigns led by the Family Planning Federation of Japan have opposed these amendments on the grounds that it was illogical to

severely restrict abortions when family planning guidance and services were inadequate. The indications for abortions in the Eugenic Protection Law have therefore remained unchanged⁶.

From around this time, even in Japan, women began to assert that if the Eugenic Protection Law was going to be amended, then it was about time that the law as a whole should be reviewed from a woman's perspective. Similar women's movements developed at a global level after the Program of Action received international approval at the International Conference on Population and Development held in Cairo in 1994⁷. Reproductive health/reproductive rights became the central concept there, and the focus of population policy shifted sharply from the macro (national level) to the micro (personal). The main driver of population policy shifted from governments to individuals, namely women, and family planning assumed significance, not for population control, but as a part of reproductive health/reproductive rights, i.e. the right of people (especially women) to make their own decisions concerning pregnancy and childbirth⁸.

(2) Current Challenges

While Japan has achieved a certain level of results in the field of family planning as described above, from the viewpoint of reproductive health/reproductive rights, many challenges still remain to be tackled as described below.

In Japan, condoms are overwhelmingly utilized as the most popular contraceptive method (see Box 4-4, Table 4-2), with the current range of alternatives still limited. (For example, the low-dosage oral contraceptive pill was finally approved in June 1999, the copper-coated IUD approved in July

⁶ The concept of eugenic protection enshrined in the Eugenic Protection Law has attracted criticism from the time it was promulgated. In 1996 the law was extensively revised, eliminating all eugenic concepts, and renamed the “Mother's Body Protection Law.”

⁷ Muramatsu, Minoru (2002) “*Sengono Kajo Jinko to Sanji Seigen* [Surplus Population and Family Planning after WWII]” Population Association of Japan ed. *Jinkou Dai Jiten* [Encyclopedia of Population], pp. 905-910, Baifukan Co., Ltd.

⁸ Institute for International Cooperation, Japan International Cooperation Agency (2003) “Second Study on International Cooperation for Population and Development - New Insights from Japanese Experience” Japan International Cooperation Agency.

1999, and the female condom was approved in November 1999, but usage has been slow.) Despite the fact that the emergency contraception pill is an effective method for preventing undesired pregnancy, it still has not been approved.

The number of abortions is increasing in the under-twenty age group, as are sexually transmitted diseases (STDs), necessitating new reproductive health/reproductive rights policies for youth (see Box 4-2). In general, there has been little public discussion of reproductive health/reproductive rights, and the concept is not widely known.

Challenges that still need to be tackled include the right to sexual self-determination, sex education for youth, and gender-free education.

Between 1947 and 2002, life cycles of Japanese women have changed, so that their average life expectancy has increased from 53.96 to 85.23 years, and the average number of children they bear has declined from 4.54 to 1.32 children. In order to deal with such changes, it is necessary to understand each individual's needs concerning reproductive health/reproductive rights, and enhance the system to deal with these needs.

Table 4-2 Main Methods of Contraception Used in Japan (Mainichi Newspaper Survey) ¹⁾

	1st (1950)	5th (1959)	9th (1967)	11th (1971)	14th (1977)	17th (1984)	20th (1990)	22nd (1994)	24th (1998)	25th (2000)
Condoms	35.6	58.3	65.2	72.7	78.9	80.4	73.9	77.7	77.8	75.3
Ogino Rhythm Method	27.4	40.4	37.4	32.9	27.0	11.8	7.3	7.1	8.4	6.5
IUD, Pill	—	—	6.1	9.6	12.4	8.5	5.7	4.3	4.2	4.2
Sterilization	—	6.3	3.6	3.9	5.3	10.5	9.8	7.0	5.9	6.4
Douching, withdrawal ²⁾ , spermicidal jellies, diaphragm, contraceptive sponge	55.0	43.0	26.4	21.0	15.2	6.0	9.0	8.6	9.3	27.5
Basal temperature rhythm method	—	6.1	—	—	—	8.4	8.0	6.8	8.2	9.8
Other, no reply	15.0	5.3	4.2	4.3	3.2	5.4	2.5	3.1	2.6	2.4

N.B.:1) The figures for the 1st to 14th surveys are the proportion of women with contraceptive experience, whereas for the 17th–25th surveys they are proportion of women currently using contraception. Multiple answers were permitted, so totals may exceed 100%.

2) Includes tablets.

Source: Population Problems Research Council of the Mainichi Newspaper (2000)

Box 4-1 Condoms are the Most Popular Form of Contraception in Japan—Why are Condoms So Popular?

Most foreigners are surprised if you tell them that the use of condoms accounts for 75% of all contraception in Japan. The condom is not only a contraceptive method, but also an indispensable method of preventing sexually transmitted diseases. Many overseas countries are working very hard to improve condom usage rates to prevent sexually transmitted diseases such as HIV/AIDS. For this reason, overseas workers in the field of reproductive health/reproductive rights are interested in the situation in Japan and want to know the secret behind this high level of condom usage. It is thought that a number of factors, such as special conditions in the militaristic period starting in the Meiji Era, have combined to contribute to the high level of condom usage rate of 75% in Japan. Here we will put forward some possible reasons based on Japan's family planning experience.

1) Familiarity

During war in the militaristic era, the Japanese Government issued condoms to the armed forces to prevent sexually transmitted diseases and promoted their use, so men were familiar with using

condoms. Much effort was put into producing high quality condoms, and the production technology is now at the top level globally (thickness 0.02 mm).

2) Lack of Choice

After the end of WWII, when people considered family planning with the aim of reviving the economy and improving lifestyles, the only choices were illegal abortions and condoms. From the latter part of the 1960s to the 1970s, the Pill (oral contraceptive) and IUD were in common use in various foreign countries, and there were moves toward obtaining approval for the Pill in Japan. The government expressed concerns about the Pill's side-effects and the possible effect on sexual morals, however, and withheld approval. The low-dosage contraceptive pill was finally approved in 1999.

3) Easy to Use, Easy to Obtain

In 1952, when the government commenced its family planning project, the main contraceptive methods were condoms, the Ogino Rhythm Method and the diaphragm. Of these, the condom is simple and easy to use on the spur of the moment, and unlike the contraceptive pill, the sperm is seen to be caught in a sac, providing visible reassurance. The condom was also popular because it was comparatively cheap (and was distributed free to low-income earners) and could be obtained without needing to consult a doctor.

When the family planning movement started, various initiatives were introduced to make condoms easy to obtain. Women's community groups cooperated with family planning workers to sell and distribute condoms (circular condom boxes known as a "Love Box"), and family planning workers made home visits to provide guidance and sales. Industry groups had family planning networks, and condoms were available by mail order and from pharmacies. They later became easy to obtain through door-to-door sales, vending machines, and convenience stores.

4) Market Forces

When the system of family planning workers selling condoms was approved, the profit margin from distributing condoms became an incentive for family planning workers. Once people had to pay to obtain condoms, they became more critical in their evaluations, leading to the development and marketing of high quality condoms to meet the demands of consumers. (In many developing countries, cheap condoms are distributed free in family planning programs as assistance materials.)

5) Improved Image of Condoms

In Japan, condoms have been used for preventing transmission of sexually transmitted diseases since before the war. In other countries as well, condoms now have a stronger image as a means of preventing transmission of sexually transmitted diseases than as a contraceptive method, making it difficult to popularize them as a contraceptive method. In Japan's case, it is believed that the promotion of condoms as a means of family planning, by trusted family planning workers such as midwives and public health nurses, has been useful in promoting the image of condoms as a contraceptive method. Condoms have also been attractively packaged (like chocolate), are of high quality, come in different styles and quantities (1 dozen, 40, etc.), and are manufactured to meet the demands of consumers and family planning workers.

[Challenges concerning condoms]

In Japan, condoms are often used together with the Ogino Rhythm Method, and abortions are

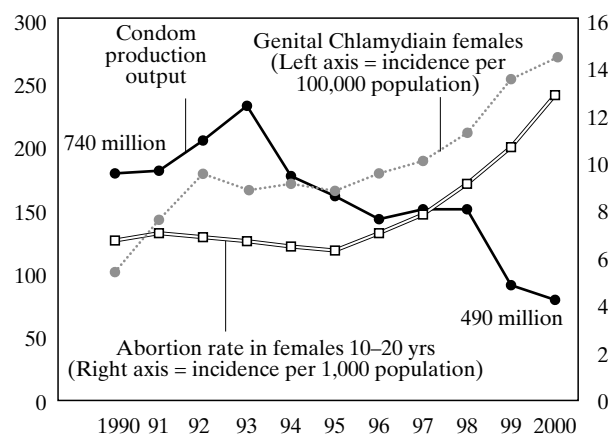
still frequently required to deal with the failures. Studies show that fears by gynecologists that their incomes will be reduced if the numbers of abortions decline have hindered the spread of modern contraceptive methods in Japan⁹. Condoms are easy to obtain and easy to use, so as in various foreign countries, there is little demand for them at family planning clinics or counseling facilities. In Japan these facilities are almost non-existent.

Box 4-2 Reproductive Health and Reproductive Rights among the Japanese Youth

Since the mid-1990s, unprotected sexual intercourse has increased sharply among the younger generation in Japan. According to the “Survey of Youth Sexual Activity” conducted by the Japanese Association for Sex Education almost every 6 years from 1974 to 1999, the first sexual intercourse experience is consistently happening earlier for senior high school students and university students, with the number of sexually active female university students in particular exceeding 50% in the 1999 survey (The Japanese Association for Sex Education home page). In contrast, the number of condoms sold has declined since 1993. Compared with other developed countries, where unwanted pregnancies and sexually transmitted diseases are declining among youths, the numbers are increasing in Japan. For example, since 1996 the incidence of sexually transmitted diseases such as chlamydia and gonorrhea, and the abortion rate, has increased in the 10–20 age groups, with the abortion rate doubling in the past 5 years (see the graph below).

It is therefore a matter of some urgency that the rates of unwanted pregnancies, abortions, and sexually transmitted diseases among Japanese youth are reduced. In order to bring about rapid improvements in these problems, it will be necessary to provide adequate facilities and personnel to provide services (including counseling) that are easily accessible to young people, and also provide education in reproductive health/reproductive rights that provides awareness of the self-determination right to give birth/not give birth, and to improve the social environment to achieve this.

Annual Change in the Abortion Rate, Incidence of Chlamydia and Condom Production Output in Japan



Source: Kihara, Masahiro (2003) “Discussion: The Current Situation and Prospect of the Spread of HIV/AIDS in Asia-Pacific Region,” International Medical Center of Japan, Center for AIDS Research Development (<http://www.acc.go.jp/kenkyu/ekigaku/2003ekigaku/001.htm>)

⁹ Coleman (1983)

2. Main Participants in Family Planning

As described above, the peak of Japanese initiatives in family planning was between 1955 and 1960. The most important characteristic of these initiatives was cooperation between the government and the community, inspired by the Fifth International Conference on Planned Parenthood held in Tokyo in October 1955. In this section, we will mainly introduce the various initiatives during that period, of the government and the community.

2-1 Government Initiatives in Family Planning

(1) Government Initiatives—from the Viewpoint of Protecting the Mother's Body

The following are examples of specific initiatives by government administrative bodies in family planning: (1) The 1949 amendments to the Eugenic Protection Law provided for Eugenic Protection Clinics to be set up at health centers to provide birth control guidance (although this system in fact saw very little use at all); (2) In May 1949, the manufacture and sale of contraceptive pharmaceuticals, that were previously prohibited, was approved; (3) Following a Cabinet resolution in 1951, the Eugenic Protection Law was again amended in 1952, making it mandatory to provide "Eugenic Protection Clinics" in all public health centers throughout Japan, and midwives, public health nurses and nurses created a system of Family Planning Workers, who spread awareness of family planning; (4) In 1955 the Eugenic Protection Law was further amended, allowing Family Planning Workers to sell contraceptive devices and

medicines. (5) From the latter part of 1956, a Family Planning Special Program provided individual guidance and contraceptives at public expense to low-income earners (households on welfare, and borderline cases)¹².

Concerning these government initiatives, Muramatsu wrote that "What is noticeable about this sort of government programs is that from the start they tried to downplay as much as possible the significance of population policy, and pushed public health and maternal health protection to the forefront. From the end of the war to the 1950s, public debate was overwhelmingly about "population," but Muramatsu points out that the government chose "health" as the foundation for its ideology, as an approach that was unlikely to attract criticism¹³.

(2) Debate about Population Problems

At that time, Japanese Government initiatives were mainly concerned with "Maternal Health Protection," but the nature of the population problem was often debated. In simple terms, we will introduce below the debate over the population problem within Japan. In the "Proposal concerning New Basic Government Population Policy" submitted in 1946, some interesting points were made, such as "Birth control should be done of one's free will," and "abortions and sterilization require careful consideration." The important points were, however: (1) In order for the population carrying capacity to recover¹⁴, factors such as international trade, reconstruction of domestic industry, adoption of full employment policies, and overseas migration must be considered; and (2) Adjustment of the population itself is necessary, producing a need for legislative

¹² Muramatsu, Minoru (2002) "*Sengono Kajo Jinko to Sanji Seigen* [Surplus Population and Family Planning after WWII]" Population Association of Japan ed. *Jinkou Dai Jiten* [Encyclopedia of Population], pp. 905-910, Baifukan Co., Ltd. and Kon, Yasuo (2000) "*Waga Kuni no Kazoku Keikaku Undo no Ayumi* [The History of Family Planning Movement in Japan]," *Kazoku Keikaku Binran 2000 - Shoshi Korei Shakai to Ripro Health* [Handbook on Family Planning 2000 - Low Birthrate, Aging Population, and Reproductive Health], Japan Family Planning Association, Inc.

¹³ Muramatsu, Minoru (2002) "*Sengono Kajo Jinko to Sanji Seigen* [Surplus Population and Family Planning after WWII]" Population Association of Japan ed. *Jinkou Dai Jiten* [Encyclopedia of Population], pp. 905-910, Baifukan Co., Ltd.

¹⁴ The industrial, land and resource capacities required to support a certain population.

maintenance of popularization of family planning. Since not much could be expected from item (1), item (2) was considered more important.

In 1949, the “Institute for Research on Population Problems” was established by the Cabinet. Its basic recommendations were contained in the “Recommendations for a New Basic Population Policy,” which contained not only recommendations for population control, but also for increasing the population carrying capacity.

In 1953, the “Institute for Research on Population Problems” was made an advisory body to the Minister of Health and Welfare, and in 1954 delivered its “Recommendations Concerning Quantitative Population Control.” These stated that from the viewpoint of the population problem, it was necessary to strongly promote family planning. As a result, at the National Health Managers Conference in 1954, the Minister for Health and Welfare, Takamaru Kusaba, stated in his opening speech that family planning popularization should be pushed strongly in view of the population problem. Debate then arose as to whether it should be “family planning for the purpose of solving the population problem” or “family planning to protect the maternal health,” and this question also became the center of debate at the Fifth Annual International Planned Parenthood Convention in 1955. As a result of these debates, a national consensus was formed that “family planning should be promoted as part of maternal and child welfare, with population problems regarded as completely separate.” In 1959, family planning was transferred within the Ministry of Health and Welfare to the “Maternal and Child Health Department, Children’s Bureau,” a move that can be considered symbolic of this policy decision¹⁵.

However, in 1960, with the release of the Income-doubling Plan, interest in family planning suddenly faded.

(3) Research and Educational Activities by Public Research Organizations

In 1949, the National Institute of Public Health designated 3 villages as “Model Villages for Family Planning,” and guidance in family planning and birth control commenced in 1950. The objective of these activities was to halt the sharp increase in the number of abortions and eliminate potential damage to maternal health. Specialists from the Institute of Public Health visited the villages regularly, and working in coordination with the local public health nurses and midwives, they conducted education sessions to groups and home visits to provide individual guidance. This program was an experiment to determine which birth control methods suited Japan, and see how many abortions could thereby be avoided, through providing actual guidance to the Model Villages and then applying the effective methods on a national scale. Using modern terminology, such a scheme would be called an operation research method. The selection of (1) a village in rice-growing country, (2) a village in a dry-field farming region, and (3) a fishing village, as the 3 Model Villages illustrates this.

Actual guidance was conducted in the following 3 stages: (1) Firstly, education for the overall people in the community; (2) Selection of people wanting to use birth control from the general population, and providing them with group education; and (3) Providing periodic individual guidance to each couple. Method (1) is effective in gaining the understanding of people surrounding the woman, such as village leaders, husbands, and parents-in-law. Method (2) instills confidence along the lines of “We can do it too,” arising from the group dynamics. Method (3) is indispensable for dealing with problems of family planning and contraception requiring sensitive and private handling.

Based on the idea that lasting effects cannot be achieved simply by piecemeal peddling of

¹⁵ Muramatsu, Minoru (2002) “*Sengono Kajo Jinko to Sanji Seigen* [Surplus Population and Family Planning after WWII]” Population Association of Japan ed. *Jinkou Dai Jiten* [Encyclopedia of Population], pp. 905-910, Baifukan Co., Ltd.

technology, an effort was made to have people understand what family planning involved, and why it is necessary. People were convinced by the argument that “Many abortions are performed in this village, adversely affecting the woman’s health, and family planning is necessary to prevent this.” “Protecting the health of the mother” became the keyword of the family planning movement.

The Model Village experiments continued for 7 years from 1950. As a result, the contraceptive prevalence rate increased and the birth rate (per thousand population) declined from 26.7 before guidance started, to 14.6 in the third year, reaching as low as 13.6 in the final year. The decline in the overall birth rate for Japan during the same period is considered to be mainly due to abortions, whereas in the Model Villages, due to family planning, the birth rate declined while the number of abortions fell.

Due to the success of the Model Villages for Family Planning, various corporations started family planning guidance for their employees. After a basic survey, contact was made with Wives Associations, labor supervisors, and labor unions. Actual guidance commenced covering a wide range of activities, including lectures, discussion meetings and film shows, and advertising through pamphlets and newspapers, then progressing to guidance for small groups, and finally to individual guidance. Methods utilizing experiences from the Model Villages, such as employing midwives, were used to institute a system of regular home visits. Apart from a reduction in abortions, these programs achieved additional benefits for the corporations, because an increase in the number of employees’ children would necessitate higher family allowances and the preparation of larger company housing.

A well-known example of a leader in corporate initiatives in family planning is the Joban Coalfield Co. in Fukushima Prefecture, which started its involvement in 1952. Dr. Hideo Hayashi of the Obstetrics and Gynecology Department of the Joban Coalfield Hospital, wanted to protect women from the complications that commonly resulted from abortions, and he also strongly believed in the

need for family happiness, so he started providing guidance from a doctor’s standpoint. From 1953, with the cooperation of three specialists from the National Institute of Public Health, that had provided guidance for the Model Villages, a model zone (716 households, population 3,632) was established within the coalfield, and guidance was started in earnest. A local midwife was employed for home visit guidance. The program focused on independent participation by women, and guidance was requested by 94% (352 people) of women in the model zone who thought that birth control was desirable. This shows the high level of interest held by women at that time.

Japan was invited to represent developing countries at the First International Conference on Population held in Rome in 1954 Reports on the Model Villages for Planned Childbirth and the abovementioned case of the Joban Coalfield attracted strong interest.

(4) Popularization Activities Mainly by Practicing Midwives

As mentioned above, the 1952 amendment of the Eugenic Protection Law established the family planning worker system. After careful consideration by the Ministry of Health and Welfare as to who should be appointed as family planning workers, midwives were added to public health nurses and nurses. Births at that time mainly occurred at home, so there were midwives in each community who were trusted by the mothers. Midwives were a good choice for the popularization of family planning, as it is “something directly involving the women’s bodies, and there are no provisions for the use of models or oral explanations.” Midwives were the persons most concerned about the health of the mother at that time, and they took the initiative in taking the accreditation course and becoming Family Planning Workers. A system was gradually established whereby the midwife would instruct mothers individually on how to use a contraceptive device, and the public health nurse would provide health education to groups, at the same time imparting

Box 4-3 Real-life Activities of Family Planning Workers

The example of Fumie Kikuchi, a practicing midwife in Tokyo. “In childbirth after the war, unexpected things would occur like an unusual delivery of the placenta or postpartum hemorrhaging. I tended to interpret it as probably being the result of an earlier curettage. This was because I knew that before the war, curettage was performed as a treatment for infertility. I was struck with it and realized that controlling pregnancy is the first priority. I attended to learn about family planning in the first lecture in 1952. Once I got my qualification, I soon bought slides, a projector and condoms, etc., and provided guidance for groups of 3-5 women whose homebirths I had supervised. It was easy to gather people here, but it was difficult to gather borderline people (welfare recipients) who were booked through the public health center. It was often said, ‘The four islands of Japan are filled with children; quick and careless manufacturing is a problem. Quality rather than quantity,’ just like being ejected from a machine.”

The example of Sakiko Kubota, who was a family planning worker with the New Life Movement at Nippon Kokan (steel company). Twenty midwives were employed as consultants. They underwent training for 3 months from the start of 1953, and then provided counseling for the families of employees at the Kawasaki plant for 1 year. The results were good after the 12 month test period, so the following year we split up and went to different companies. I was in charge of the Asano Dock in East Kanagawa. At the start, it wasn't easy; before getting to discussion of family planning, I'd have to spend time discussing personal and lifestyle problems. Initially, there was strong resistance from the employees, with them saying things like, “I don't want you to come to my house,” or “I don't want anyone to know that you're visiting, so don't leave your bicycle in front of the house.” In order to first get people together without resistance, I conducted cooking and all sorts of other classes, created housewife groups in each district, decided on committees with leadership potential, and then started individual consultations using them as my point of contact. Once a year, I would hold a thank-you party for the committee members in the factory gymnasium. In the Keihin District alone, about a thousand housewife committee members gathered. The counselors also gathered once a year, at a health resort in Izu. Newspapers labeled this movement as being in the “pioneer spirit,” and the Iwanami Movie Company made a movie called “Japan is Full.”

The example of Misao Nagata who worked as a midwife from 1930 at Mikkabi-cho, Inasa-gun, Shizuoka Prefecture. From around 1952, most people were aware of the term “birth control” from newspapers and magazines, but didn't know about actual methods of birth control, and contraceptive devices were difficult to obtain. It was an era when pregnancy commonly led to abortion. Nagata personally appealed for the necessity of family planning. Housewives whose babies Nagata had delivered visited the Nagata Maternity Clinic to access contraceptive information and techniques. Yoshiko Ohishi, who started a birthing center in the same town in 1946, spoke to the people who gathered there about matters such as the effects of abortion and the establishment of pregnancy. After she obtained the family planning worker qualification in 1952, in the evenings she visited gatherings of supporters in each small hamlet for talks, taking with her rather thick condoms, and various types of diaphragms, borrowed from the pharmacist. This guidance was provided to women of childbearing age, but family planning is not possible without male cooperation. Guidance through the Wakakusa-kai was aimed at men, and mothers-in-law who control agricultural families. I also visited fire brigades, manufacturing companies, bus companies and mines, etc., to impart accurate information about sex and the birth cycle (e.g. half of puerperal fever is caused by neglect of the mother's health because of

men's tyrannical demands). Because we were instructed in use of the diaphragm at training classes, more wives were recommended to use a diaphragm than condoms, but the wives were often averse to using a diaphragm that was like a rubber membrane stretched across a round rim of piano wire. There was even someone who said, "If I insert that thing, it'll go deep inside my stomach." The usage rate failed to grow nationally for the following reasons: women had to be measured to fit the appropriate size, diaphragms could not be used suddenly if needed, and cleaning them after use was troublesome. Proper use of condoms was not properly understood either, however, and instruction was required about the correct method of application and removal, and handling afterward (there were many problems, such as those who washed condoms for reuse, or threw them away in rivers, and condoms thrown into toilets that ended up in fields together with the night soil).

Sources: Nishiuchi, Masahiko and Mother and Child Health History Publication Committee (1988) *Nihon no Boshi Hoken to Moriyama Yutaka* [Maternal and Child Health in Japan and Moriyama Yutaka], Japan Family Planning Association, Inc., and Ohbayashi, Michiko (1989) *Josanpu no Sengo* [About Midwives after the WWII] Keiso Shobo pp. 208-221

accurate knowledge and information about family planning and mother and child health. It is said that (such an effective mutual collaboration between midwives and public health nurses made throughout Japan was one of the keys to the success of the family planning movement in the post-war period in Japan. Family planning promotion activities throughout Japan combining both of these aspects was an important key to the success of family planning in Japan's post-war period. Despite the fact that the income of midwives as a profession would fall if the number of births declined due to family planning guidance, they vigorously conducted activities, closely coordinated with the local community, due to a strong sense of purpose to protect women from abortions, and gradually achieved good results.

In 1955, sale of contraceptives by family planning workers was approved, so it became common to sell condoms at the time of consultation. At that time, as it was usual for men to buy condoms at the pharmacist, women were embarrassed about buying them. The new system delivered contraceptives to individuals upon request. Midwives retained the profit margin on the

condoms as instruction fees, providing increased incentive for instruction.

2-2 Private Sector's Initiatives in Family Planning

(1) Activities of Non-governmental Organizations Immediately After the Second World War

After 1950, more than 20 family planning associations were established as public bodies, but their principles and views varied greatly, similar to the rivalry of local barons. To improve this situation, the Family Planning Federation of Japan was formally inaugurated in April 1954 as an umbrella organization to oversee all these groups, with the aim of increasing lobbying power towards the government and overseas. Around the same period, in 1952, family planning activists established the International Planned Parenthood Federation (IPPF). In October 1955, the IPPF held its Fifth International Conference on Planned Parenthood. The Family Planning Federation of Japan worked to host the Convention in Japan, where it was highly successful¹⁶.

¹⁶ Kon, Yasuo (2000) "Waga Kuni no Kazoku Keikaku Undo no Ayumi [The History of Family Planning Movement in Japan]," *Kazoku Keikaku Binran 2000 - Shoshi Korei Shakai to Ripro Health* [Handbook on Family Planning 2000 - Low Birthrate, Aging Population, and Reproductive Health], Japan Family Planning Association, Inc.

(2) Japan Family Planning Promotion Association Initiatives

Representative of public initiatives were the activities of the Japan Family Planning Extension Association, which was established in 1954 and changed its name to the Japan Family Planning Association in 1962. The Japan Family Planning Extension Association was created in 1954 by Mr. Chojiro Kunii (now deceased), and from that time continued to cooperate with the government and experts in this field to promote family planning in Japan in the post-war period. The Association's policy is to "promote a humanistic family planning movement while aiming for economic independence through its own efforts"; to cooperate with the government in family planning initiatives by

utilizing its own strengths as a non-governmental organization; to provide information about family planning; to train family planning workers; to develop and promote education material; to provide contraceptives; to provide midwives with low cost condoms through special contracts with condom makers; and to develop local organizations.

The Japan Family Planning Extension Association poured its efforts into training of public health nurses and midwives involved in family planning, creating various types of training projects. The Japan Family Planning Extension Association First Annual National Conference was held in 1956 in association with the Ministry of Health and Welfare and the Family Planning Federation of Japan, and has been held every year

Box 4-4 Public Information and Awareness Campaigns by the Japan Family Planning Extension Association

Soon after its creation, the Japan Family Planning Extension Association issued its own monthly publication called the "Family Planning Newspaper" (changing its name to "Family and Health" in 1982). This aimed to popularize family planning and increase awareness, and was distributed to municipalities, organizations and individuals, providing family planning information and increasing knowledge and awareness. In addition the staff visited practicing midwives and others in community organizations, public health centers and municipalities that were promoting family planning, conducting seminars and conferences with local residents to advance the family planning movement. They also distributed contraceptives (mainly condoms) at special prices based on special contracts with condom manufacturers, providing services as part of the awareness campaign¹⁷. Educational materials for the use of family planning workers in promoting their work were developed based on feedback from their experiences with families. Specialists helped with these research and text development activities, and family planning programs were conducted with constant cooperation with administrators, academics and the private sector. The wide range of educational materials produced over many years includes textbooks, pamphlets, educational materials for distribution, panels, audiovisual materials, and items for health guidance and health checks. These educational materials were introduced in catalogs distributed each year to municipalities and interested parties.

In 1978, the Medical Committee (with Seiichi Matsumoto as chairman) was established, with the aim of improving the quality of training activities and information and educational materials, under the guidance of professionals including Committee members.

¹⁷ Compared to clinic-based family planning promotion activities in various countries, this method of providing contraceptives to the community was regarded as highly original by Dr. Malcolm Potts, head of the medical section of the International Planned Parenthood Federation, who monitored family planning in Japan in the 1970s and promoted internationally "Community-Based Distribution of Contraceptives," modeled on Japan's experience.

since, providing lectures about family planning and maternal and child health, presenting awards to persons of merit, and contributing to boosting the vigor of the national movement.

A major contribution of the Japan Family Planning Extension Association was its significant impact on policy formulation by providing a link between government, academics and the private sector. In 1955, the Association created the Family Planning Study Group. At the time of its creation, the Committee included representatives from the Ministry of Health and Welfare, the National Institute of Public Health (NIPH), public health center directors and regional government administrators. At the monthly meetings, there was enthusiastic debate about the theoretical construction and interpretation of family planning and population problems, as well as the popularization of family planning, focusing on effective strategies and tactics. A wide range of topics were discussed, including grass-roots community participation, development of community organizations, particularly mothers' organizations, and the effective use of midwives and public health nurses (group instruction by public health nurses, individual instruction by midwives). There was also discussion concerning the training curriculum, and the transfer of projects to towns, cities and villages. Discussions here were reflected in policy at the national and local government levels.

(3) New Life Movement by Corporations

While family planning workers provided guidance locally, the "New Life Movement" to spread family planning among industry started in 1952 (see Box 4-5). This initiative spread rapidly, because family planning guidance could be easily provided to corporate employees gathered as a group. It was taken up by those involved in shipbuilding, coal, electricity, telecommunications, chemical manufacturing, paper manufacturing, national railways, Nippon Telegraph and Telephone Public Corporation, transportation companies, police and firefighters. It was painstakingly explained that the objective of this

project was not to reduce the family allowance paid to company employees, but to improve the health and welfare of the individual and family.

(4) Other Initiatives

In December 1934, the "Imperial Gift Foundation Aiiku-kai" was established as an Imperial initiative to improve health and welfare for mothers and children. In Japan at that time, neither the Ministry of Health and Welfare nor public health centers were yet in existence, so the Aiiku Survey Society was first established to conduct scientific research into maternal and child health issues. These early surveys showed that the infant mortality rate in Japan was extremely high (125 deaths per 1,000 births in 1934), particularly in farming and fishing villages.

In an attempt to reduce the infant mortality rate, Aiiku-Groups (Married Women's Voluntary Groups for Mother-Child Health and Welfare) were established to tackle the problem at the village level. These were set up so that one group covered a primary school zone or old village area, with one member of each group covering about 10 households, and subgroups allocated to village sections or neighborhoods. The main activity involved each member visiting homes to hold discussion meetings (subgroup leader meetings and subgroup member meetings). Prior to the war, there were more than 1,200 designated model Aiiku villages in 46 prefectures nationwide, and after the war the Aiiku movement was linked with the maternal and child health program by the Ministry of Health and Welfare, contributing to strengthening of local organizations concerned with maternal and child health.

Family planning was also taken up by the mass media. The Mainichi Newspaper established the Population Problem Research Council in July, 1949, and from 1950 onward conducted a "National Family Planning Survey," as a rule every 2 years. It was unprecedented for a general newspaper company to set up an organization devoted to surveying population problems, and the resulting surveys have provided valuable data that is without

Box 4-5 Family Planning Movement by Corporate Programs

In addition to government family planning projects focused on cities, towns and villages, from about 1952 family planning promotion by businesses became common. From around 1951, the so-called “New Life Movement,” based on the three pillars of family planning, household budgeting and family morals, started with guidance and support from the Institute for Research on Population Problems (established in 1933 as a half-public, half-private sector research organization). Funding for this program was supplemented by instruction fees from companies. Complementing the Livelihood Improvement Movement of the Ministry of Agriculture and Forestry focusing on agricultural villages, the Institute for Research on Population Problems focused on companies. In 1955, the wives of directors of major companies started up a “Family Living Research Association,” contributing to the corporate family planning movement. A central aim of the New Life Movement was planned parenthood through popularization of family planning, but at the same time they aimed to empower women in the household. Their ultimate aims were for happy household management through management of household finances, encouragement of saving, promotion of health and hygiene in the home, childcare and education for children, improved education and for life to be culturally enriched. Through this movement, many Japanese housewives developed the custom of keeping the household accounts.

The trigger for this movement was when the personnel manager of Nippon Kokan consulted the Ministry of Health and Welfare about labor practices and employee welfare, and met the director and staff of the National Institute of Population Problems. Representing the Institute for Research on Population Problems, the Institute conducted a 2 year trial of the New Life Movement using Nippon Kokan as a model. Based on the trial results, the New Life Movement formally started at the Nippon Kokan Kawasaki Steelmaking Plant from 1953. A Family Page was provided in the company newspaper to improve dissemination of information, and group guidance was provided by a family planning worker to groups each comprising five households, centered in company housing. The family planning worker would then visit each household to provide individual guidance in contraceptive methods. Individual consultation also provided the benefit of being able to purchase cheap contraceptives that the company had obtained in bulk. As a result, after only one year, the following remarkable results were reported: the family planning prevalence rate had jumped from 40.7% to 70.8%, the birth rate had declined by 47%, and the abortion rate declined by 79%. Before guidance, condoms were overwhelmingly the most common form of contraception, but as a result of individual consultations, the proportion of female-centered methods such as spermicidal jellies and the diaphragm had increased markedly. Following this success, aiming at a target of 100 companies and 1 million people, centered in major corporations and government corporations, employees in shipbuilding, coal, electricity, chemical manufacturing, paper manufacturing, national railways, private rail companies, Nippon Telegraph and Telephone Public Corporation, transport companies, police and firefighters also participated. At the peak, a record 55 companies and 1.24 million people participated in the project.

For companies, the New Life Movement produced great economic benefits. The lower birth rate meant a reduction in family allowance and childbirth costs, reduced company housing costs, and also reduced medical allowances. These savings were channeled into the activities of the New Life Movement. There were also numerous side-benefits, such as reduced employee absenteeism, improved family health management, and fewer accidents, and relations were strengthened between

company employees. However, as societal demands related to population changed, the movement faded, until in 1971 only 8 companies remained involved in the Kanto Region, and in 1982 the last company, a transportation company, discontinued the movement, marking the end of the New Life Movement.

Sources: Nishiuchi, Masahiko and Boshi Hokenshi Kanko Iinkai (1988) *Nihon no Boshi Hoken to Moriyama Yutaka* [Maternal and Child Health in Japan and Moriyama Yutaka], Japan Family Planning Association, Inc.

Kubo, Hidefumi (1997) *Nihon no Kazoku Keikakushi - Meiji/Taisho/Showa* [History of Family Planning in Japan; Meiji/Taisho/Showa Era], Japan Family Planning Association, Inc.

Population Association of Japan ed. (2002) *Jinkou Dai Jiten* [Encyclopedia of Population], Baifukan Co., Ltd.

parallel globally for the length of time covered. According to the first survey, the proportion of “persons currently using contraception” was 19.5%, and the proportion of “people who have never used contraception” was 63.6%¹⁸.

3. Family Planning in Developing Countries in the Light of Japan's Experience

3-1 Factors in the Outcomes of Family Planning Measures in Japan

After the government became seriously involved in the family planning program in 1952, private sector and businesses became involved in a wide range of initiatives, with results improving each year. As the contraceptive prevalence rate rapidly increased, the abortion rate sharply declined, so that in the 1960s the contraceptive prevalence rate reached 43%, overtaking the abortion rate. After reaching the highest peak at 1.17 million in 1955, the number of abortions declined every year thereafter, and the contraceptive prevalence rate increased (see Figure 4-1).

After the hardships of the Second World War, lifestyle and health needs increased for the Japanese

people as a whole, and with cooperation from the government, non-governmental organizations, specialists and community organizations, the constructive efforts of those involved in family planning created a synergistic effect to achieve such good results in only a decade. Next, we will consider whether the main factors contributing to the success of family planning in Japan are applicable to developing countries.

(1) Approach Emphasizing the Existence of Needs and the Individual

From the end of the Second World War until the start of the family planning project in 1952, many people with unwanted pregnancies had induced abortions out of sheer necessity, and the number of these people suggested a strong demand by individuals in society to control the size of their families. Abortions also had serious adverse consequences for women's bodies, so there was a strong undercurrent of demand for birth control from the additional viewpoint of protecting women from physical harm. This formed the backdrop for moves to reduce the number of abortions through family planning, not as a means for population control, but in order to stop the harm caused to the health of mothers and children by abortions.

¹⁸ Kubo, Hidefumi (1997) *Nihon no Kazoku Keikakushi - Meiji/Taisho/Showa* [History of Family Planning in Japan; Meiji/Taisho/Showa Era], Japan Family Planning Association, Inc.

Emphasis was placed on the perspective of the individual, and with the adoption of “the health of the individual and human happiness” as its philosophical basis, family planning was promoted as part of maternal and child health, and public health. This approach was appreciated by most people in the community, and family planning activities spread rapidly. At the same time, based on the concept that “the individual reflects the community, so the community can assist the individual,” the view was put into practice that involvement and action by the local community was also essential, since the benefits of protecting the health of the individual extended into the community as well, and it was necessary to improve the public health standards of the entire community.

The situation today in developing countries, with low levels of contraception use, is that their governments lack a coherent family planning philosophy, and end up vacillating between a “population policy” and “protecting the health of mothers and children.” Choosing the route of protecting the health of mothers and children, Japan stressed the health and happiness of the individual, a philosophy for family planning that met with general public acceptance. In light of Japan’s experience, in an area such as family planning that is so closely tied to an individual’s life choices, the key to success may well be an approach that addresses issues through the community as a whole with local resident participation, but at the same time emphasizes on the particular needs of the individual.

(2) Establishment of System of Cooperation between Government, Academia and the Private Sector

One factor that can be cited as contributing to the success of family planning in Japan was the efficient division of responsibilities that took place

between government, academia, and the private sector (NGOs and practicing midwives), producing an efficient system of cooperation. In Japan, a private sector agency, the Japan Family Planning Association (an NGO), played both a pacesetter role and a coordinating role, thus enabling effective cooperation between government, academia, and private sector organizations. While the government devised policies and put infrastructure and systems in place on the ground, professional bodies provided specialist information based on research and surveys they conducted. They also provided guidance and constantly developed new techniques. Being closest to the public on the other hand, local governments and public health centers served as links to NGOs and other private sector groups, who for their part acted as end providers of family planning services to the public. This system was a major force in the growth and continuation of a family planning industry¹⁹.

(3) Use of Midwives, Public Health Nurses and General Nurses, Trusted by the Public, as Family Planning Workers

Family planning guidance, an issue concerning people’s personal sex lives, was nevertheless implemented smoothly in Japan by employing as family planning workers health services personnel who were already trusted by the public. For many years midwives and public health nurses alike had performed work that involved raising the general level of health of the residents in their local community, so they were well acquainted with people’s personal lives, and had come to be deeply trusted by the local residents, who accordingly felt comfortable with them. Since it was these same practicing midwives and public health nurses who were assigned the task of providing family planning guidance in the local community, family planning met with acceptance by Japanese people and became an entrenched feature of their lives. Since

¹⁹ Institute for International Cooperation, Japan International Cooperation Agency (2003) “Second Study on International Cooperation for Population and Development - New Insights from Japanese Experience” Japan International Cooperation Agency.

family planning is an issue with a deep connection to an individual's personal life, the personnel assigned to provide family planning guidance must enjoy the people's trust.

(4) Active Non-government Organizations and Community Groups

During the post-war period when abortions were banned, many women suffered from health problems resulting from unlawful abortions. With the aim of remedying this situation, non-governmental organizations were founded to promote family planning, along with other community groups aiming to improve maternal and child health. Leading organizations of this kind included the Family Planning Federation of Japan, the Japan Family Planning Association (JFPA), and the National Institute of Population and Social Security Research. The JFPA made a particularly large contribution, mapping out a path for the family planning movement in Japan, developing methods to expand the wider use of family planning. From the 1960s onwards, the JFPA served as the entity formally charged by the government with the task of implementing family planning guidance. JFPA initiatives applicable to developing countries are listed below:

- It set up a study group that served as an umbrella organization bringing together government, academia and the private sector; it laid out a direction as well as promotion strategies for family planning in Japan; and it assisted with government policy formulation. This sort of coordinating role is perfectly suited to an NGO, which does not have vested interests.
- It made full use of the network of practicing midwives and public health centers around the country. For example, while communicating government and global trends to those frontline workers, it would also gather data from those workers and convey it back to the government, thereby playing a central role in the collection and dissemination of information. This data served as important raw

material when the government came to determine its policies.

- It provided technical and practical support for lectures by family planning workers.
- It prepared educational materials for lectures, and audiovisual teaching materials for information, education and communication activities.
- It supplied contraceptive devices and pharmaceuticals for sale using the "social marketing" method. (This method is discussed below.)

As this list of activities demonstrates, the campaign to increase the use of family planning required a high level of expertise. Since the government could not simply force people to use family planning by legislation or decree, the process would require both an expansion of the relevant non-governmental organizations and their active involvement.

Initiatives taken by Japanese industry to meet the challenge of family planning (such as the New Life Movement) were without parallel in the world. Some aspects of these measures may be instructive for developing countries where companies and businesses play a central role in people's lives.

Family planning, embraced by Japanese society for its part in protecting the health of mothers and children, was also an issue of deep concern to women, and therefore found a natural audience in local women's groups in Japan. Existing maternal and child health organizations (such as the Aikku-kai) had also been tackling family planning program in earnest, with the guidance and the cooperation of public health nurses, and contributed greatly to the success of family planning programs in Japan.

(5) Importance of Information, Education and Awareness

For the purpose of expanding the use of family planning in Japan, extensive education activities were conducted, imparting information and knowledge to the community. These activities altered community awareness, leading to a decline

in the abortion rate and an increase in the contraception prevalence rate.

(6) Introduction of the Contraceptive “Social Marketing” Method

In Japan, special contracts were signed with the manufacturers of contraceptive devices (and medicines) for bulk purchases at cheap prices by NGOs that were promoting family planning. These organizations were then able to provide these devices at wholesale prices to family planning workers around the country, who could in turn offer safe yet inexpensive products to local residents at the same time as they handed out family planning materials. This arrangement had two advantages: it provided family planning workers with a financial incentive to promote family planning, and it made it easy for members of the general public to gain access to contraceptive devices and drugs. In addition, by buying stocks of contraceptive devices (mainly condoms) at inexpensive prices and selling them, the NGOs administering this system could gain their own source of revenue, thereby enabling them to conduct their own self-supporting operations as NGOs.

This method corresponds to the concept of “social marketing,” now being applied to assistance programs, and provides hints on how this method can be utilized in developing countries. For the public health systems in developing countries which espouse “free medical treatment” but whose services do not in fact function properly, owing to a shortage of funds and other factors, some lessons can be derived from this “social marketing” method employed in Japan.

3-2 Lessons Learned from Problems Encountered—the Importance of Reproductive Health and Reproductive Rights

As a result of initiatives in the field of family planning, the contraception usage rate in Japan began to rise from around 1960, and abortion rates fell considerably. The contraception prevalence rate failed to grow much beyond the 50-60% level, however, and the abortion rate among young people has showed signs of increasing. Condoms are easy to obtain, and by far the most popular method of contraception in Japan. In the case of condom failure, it is still acceptable to have an abortion. This is because in the chaotic conditions that arose in Japan immediately following the war, people tended to address any health-related issue after it occurred and not before. There were also few opportunities during that period to pursue any significant discussion of family planning from the viewpoint of reproductive health, the debate then prevailing being a choice between “Population control? Or protection of the maternal health?” This was one of the causes of the leveling off in the contraception prevalence rate, as well as the increase in abortion rates among young people. This experience demonstrates the need to promote further public discussion of family planning issues and the importance of a comprehensive approach to family planning that matches each individual’s needs from the viewpoint of reproductive health and rights. Such an approach would suit a woman’s life choices from cradle to grave, and encompass an expansion of available contraceptive options, individual counseling, and publicity campaigns and education.

Appendix. Family Planning/ Prevention of Parasitic Diseases Integration Project (IP)

With the aim of introducing “humanistic family planning,” including social marketing methods as well as self-supporting and sustainable family planning programs based on community participation, since 1974 the Japanese Organization for International Cooperation in Family Planning (‘JOICFP’) has been conducting an integrated family planning/parasite control project (Integration Project, or ‘IP’). This IP has run for more than twenty years in many countries, principally in Asia, based on Japan’s experience in family planning and parasitic disease control programs.

IP activities have been embraced by the people in these countries. These programs have raised people’s interest in health issues and their attitudes towards improving their lives, and have also brought about advances in parasite control, improved nutrition, and family planning. Time and again these IP programs have demonstrated that they can develop into “community development movement,” embracing maternal and child health, preventive medicine activities, and lead to improvements in sanitation and living standards. For that reason we will now discuss this IP in more detail, as an example of how Japan’s experience has been put to good use. We will present an overview of this IP and its background, and then the experience in Nepal as a concrete illustration of its operations in the field.

1. Background

People living in rural areas comprise 70-80% of the population of developing countries. In rural communities, religion and traditions continue to exert a strong influence, and the level of education is generally low. In addition, the villagers’ lives are poor, and infant mortality is high. It is difficult to

persuade people who live in such farming communities of the need for family planning, and to get them to put it into practice. It is accordingly important to gain people’s understanding and trust, by adding another element to family planning that wins people’s trust and encourages them to adopt it willingly.

So what sort of elements can be added to family planning? The idea was raised of combining it with maternal and child health programs, that have a natural connection to family planning. Maternal and child health has a number of its own issues, such as antenatal and postnatal guidance, immunizations, feeding and nutritional guidance, and guidance in mothering skills. Another factor was that many developing countries had few doctors, public health nurses, or midwives, and was also lacking in relevant infrastructure, such as clinics. In these circumstances it would have been difficult to use maternal and child health programs as an opening to implement family planning. JOICFP therefore realized that it needed to come up with a program that did not require doctors, complicated technology, or sophisticated medical facilities; that would deliver fast results that local communities would welcome; and that could be combined with family planning. It was at this point that JOICFP turned its attention to parasite control.

Parasites such as roundworms and hookworms afflict some 70-80% of rural populations in developing countries, and cause a variety of illnesses. If family planning workers brought with them some knowledge of parasite control that they could use to treat families and children in particular, the results would be almost instantaneous. Once that happened, housewives and their families would approach the family planning workers to show their appreciation,

Box 4-6 Why Parasite Control is an Appropriate Partner for Family Planning

- 1 It can be implemented on a small budget without the need for sophisticated technology or expensive equipment.
- 2 The medicines are effective and safe.
- 3 Parasite eggs can be seen with a microscope, and the worms that are expelled following treatment can be seen with the naked eye. People can see results immediately for themselves.
- 4 Parasites often infect children, causing their parents much concern.
- 5 Parasite testing and treatment can serve as effective tools in hygiene education.
- 6 By getting villagers to appreciate that they won't be able to improve their health through parasite control activities unless the whole community plays a part, people can be encouraged to become involved in such collective activities.
- 7 Parasite control can build relationships of trust with the people living in the community. This in turn allows workers to earn people's understanding and cooperation when it comes to a personally sensitive issue like family planning.
- 8 Parasite control includes such activities as mass parasite control examination and treatment, enhanced hygiene education, and community organization. This experience can be translated into preventive medicine and primary health activities.
- 9 In developing countries that lack a strong government parasite control policy, Japan's experience of encouraging the private sector in taking a lead role can be of particular use.

thereby laying the basis for a relationship of trust. If the villagers came to trust the family planning workers in this way, would they not then also naturally become receptive to the workers' promotion of family planning ideas? These factors lead to the concept of integrating family planning with parasite control. The success of JOICFP's world-first "collective parasite control campaigns" were made possible by the full use of Japan's post-war experience, where government, academic and private sector organizations joined forces in parasite control initiatives, with significant community participation.

2. Outline of the Integration Project (IP)

A steering committee is established as the IP's highest policy-making organ to oversee each

individual project. The steering committee has a tripartite structure, comprising government-related agencies²⁰, academics and specialists, and non-governmental organizations (usually the family planning association from the country in question). The committee selects field sites, secures funds, material resources, and facilities, and plans logistics. It is also responsible for the training of personnel such as field workers and laboratory technicians, and the project managers responsible for implementation of the program both at the central base and out in the community. The steering committee also produces and distributes teaching materials, liaises and coordinates with governments, universities, and relevant domestic organizations, and conducts negotiations with the responsible organizations at the Japanese end. The training of project personnel, in particular, is essential for

²⁰ The purpose of involving government officials is to get them to know the experimental process from the start, earn government support, and make it easy to get the project adopted as a government program, the ultimate objective.

Box 4-7 Application of Japan's Experience in Integration Projects

The following aspects of the above-mentioned Japanese experience described earlier were put to good use in this IP:

- **Approach of Placing the Emphasis on the Individual**

Based on the experience in Japan that family planning must be something people really feel is necessary if it is to become widely accepted, health of people is emphasized and activities that meet people's needs are developed instead of family planning for the purpose of population control.

- **Building a System of Cooperation between Government, Academia and the Private Sector**

Japan's experience was that government, academia and the private sector best contribute their respective strengths when each played its own particular role under an umbrella of cooperation. Japan established such a system of cooperation by having tripartite cooperation which experience was applied on the IP steering committee.

- **Appointing Staff Trusted by the Local Community**

In order to make family planning more widespread based on its experience, Japan knew that it was first necessary to build a relationship of trust between the community and public health and family planning workers. JOICFP aimed to do this by first embarking upon parasite control, a program that would produce fast results and be easy for people to understand.

- **Making Effective Use of Local Community Groups; Promoting Community Participation (In Particular by Women)**

Based on Japan's experience, public health activities (including family planning) have maximum effect when the local residents themselves (and the local women in particular) are responsible for the relevant activities. Along with the appointment of public health workers from among the local population, people were encouraged to set up their own community organizations and to develop public health projects for which they themselves were responsible, based on their needs. As much as possible, JOICFP encouraged women to take part in that process, and devised means that made it easier for women to participate.

- **Emphasis on Information, Education and Communication**

JOICFP aimed to increase awareness and knowledge in the community, and achieve sustainability in the activities it helped to launch. It therefore did not simply dispense drugs, but instead placed priority on health education, enabling local people to learn about public health issues through parasite control activities.

- **Charging for Drugs and Services**

Japan learned that charging for drugs both strengthened the sustainability of programs and raised community awareness and the sense of ownership of public health programs. In keeping with that experience, JOICFP charged for drugs and community health services.

achieving progress with project activities.

The IP steering committee normally selects two field sites in each country. The criteria by which field sites are selected are as follows:

- 1) Geographic criteria: one site must be a farming village on the outskirts of the capital. Both sites should have inadequate family planning programs. The public health situation of the region must also be poor, with high levels of roundworm and hookworm infestation. The sites must have good transport and communication links, however. A suitable population for a field site is around 10,000 to 30,000.
- 2) Personnel criteria: the region of the field site must have public health workers, family planning workers and health outreach workers, and there must be people with authority such as government officials, educators and religious leaders who can be counted on to provide cooperation with projects.
- 3) Base facilities: clinics or health posts are needed to advance the project.

These IPs tend to follow a basic pattern. First, parasite control activities are initiated, in order to gain the local people's understanding of the importance of public health issues, as well as their trust in the community health workers. Second, once that has been achieved, local residents are encouraged to organize community public health activities for which they themselves are responsible. Finally, family planning and maternal and child health activities are then gradually incorporated into the initial community projects. So that the public health activities are "owned" by the community, JOICFP both fosters and draws on the full potential of community organizations, and it selects and trains local residents to lead community health projects.

Because family planning and maternal and child health are issues of particular importance to women, JOICFP came up with ways to boost their participation, for example by placing as many women representatives as possible in community

organizations, and by employing women as public health workers. In addition, in order to secure the sustainability of community health activities, as a general rule JOICFP charged for medications and parasite control examinations. (Another expected benefit from charging for medicines and services is an increased awareness and sense of ownership of the programs by the local residents.)

These programs were developed initially based on Japan's experience, so it will sometimes be necessary to make appropriate modifications in order to suit local conditions. Following a trial period using the Japanese model, strategies may need to be modified in the light of preliminary results. Sharing information and exchanging ideas with colleagues with similar experiences is very useful in facilitating progress in an IP. To that end, international conferences, where information is exchanged on each country's particular IP experiences, are held on a regular basis, inviting principally members from the steering committee of participating countries. These conferences assist in the efficient advancement of field projects, as well as in resolving particular problems.

3. Example in Nepal: Integrated Project of Family Planning, Nutrition and Parasite Control—the Development from Parasite Control to Reproductive Health/Reproductive Rights

(1) A Summary of the Project, and Japan's Experience

The Nepalese maternal mortality rate is around seventy times greater than that of Japan, making Nepal one of the few countries where the average life expectancy at birth is shorter for females than for males. In the 1970s the Nepalese government promoted family planning with the aim of controlling the country's population increase, but in 1976 Nepal's contraception prevalence rate was just 2.9% for married people, and 69% of which had undergone sterilization operations. In light of this situation, in 1979, with the financial assistance

of the United Nations Population Fund (UNFPA) and in cooperation with the Nepal Family Planning Association, JOICFP decided to promote family planning and mother and child health projects in village communities that lacked medical services.

The projects began as an integrated project (IP) of family planning and parasite control, after which activities were gradually developed and the target communities expanded. With the particular aim of promoting family planning and maternal and child health with participation by local residents, members of the local community were encouraged to form their own organizations. Public health workers and local residents were also given training, after which they went out on regular rounds to provide guidance and services to the villages where the family planning and maternal and child health care projects were to be implemented.

As a result, under the lead of local residents in 26 villages without medical services, simple public health facilities (called "primary health care posts") were established to provide guidance in primary health care and to dispense basic drugs for payment. In addition, meeting a long-standing wish of local residents and thanks to a grass-roots grant-in-aid from the Japanese Embassy, birthing centers were built in Kavre District (the Panchkhal Family Health Center, 1997) and in Sunsari District (the Itahari Family Health Center, 2000), that are now providing safe childbirth services for local women. Midwives from Japanese Overseas Cooperation Volunteers have also been playing an active role with local workers, providing technical assistance for the centers' midwifery services.

Based on the experience in Japan, the following approaches were adopted in this IP in Nepal:

- Approach emphasizing the individual: integrating family planning with collective parasite control, "individual health and happiness" was adopted as the guiding principle for family planning.
- Building a system of cooperation between government, academia and the private sector:

by forming a steering committee at the outset of the project comprised of government officials, private sector agencies and specialists, JOICFP created a system for advancing projects based on cooperation between the three sectors.

- Building up relationships of trust with the community: through the favorable impression that the parasite control activities had on the local people, a relationship of trust was built up between them and the family planning workers.
- Making the best use of community organizations and promoting participation by the local population (women in particular): JOICFP boosted involvement by women by forming mothers' clubs in each village covered by the project. In addition, while building materials (such as cement and tin) used in the construction of the elementary community health centers were covered by project funds, the land, construction costs and labor involved were all provided by the villagers. This strengthened the local community's self-help efforts and its sense of ownership in the project.
- Emphasis on information, education and communication: from the field office located in the center of the Panchkhal Project region, public health workers went out on rounds to nearby villages, where they provided medical services as well as practical information and educational guidance. A simplified version of Japan's Maternal and Child Health Handbook was developed and distributed widely to female volunteers so that they could use the handbook as maternal and child health teaching materials that used photographs to explain information.
- Dispensing medicines for payment: the sustainability of the activities was boosted by devising ways to help pay for their cost, such as charging for medications dispensed and midwifery services provided.

We will now examine in detail how the project in Nepal has developed, based on these approaches.

(2) The State of Family Planning and Maternal and Child Health at the Start of the Nepal Project

In 1979, when JOICFP began its joint project with the Nepal Family Planning Association, it targeted three villages (Panchkhal, Bhagawatti and Baruwa) in the Panchkhal Region, with a population of around 9,000, in Kavre District, a mountainous region 40 kilometers east of the capital Kathmandu. Nepalese women at that time married young, commenced bearing children at a young age, gave birth to many children, had dangerous abortions, and were undernourished and overworked. In addition, owing to factors such as poverty and a lack of public health services and education, the average life expectancy at birth was shorter for females than males, and the maternal mortality rate was one of the highest in the world.

(3) Project Development Process—From Parasite Control to Integrated Project (IP) with Family Planning

1) Gaining Understanding and Trust Through Parasite Control Activities

The rate of parasite infestation in Nepal was extremely high at 90%. The project activities began with a collective parasite control program, at first targeting school-children. Children in the project community were gathered together and tested as a group for parasitic infestation, and anthelmintics were given to any child who was found to have worm eggs. The villagers, who were initially embarrassed to present a stool sample for examination, also slowly came to understand the worth of this particular project. It was then noticed that in order to prevent re-infection, there was a need for the villagers to have access to suitable communal sites for drawing water, for environmental sanitation improvements such as building toilets in schools, and for reforming the hygiene habits of

individuals. Understanding of the importance of family planning and maternal and child health spread, and trust in the community health workers slowly strengthened.

2) From Parasite Control Activities to the Community Initiated Self-supporting Public Health Activities

Parasite control therefore functioned as a basis for forming public health committees in each of the villages that in turn developed into activities whereby the local residents constructed their own simple public health facility, or “primary health care post.” All the buildings were basic, usually just two rooms. So that the activities would be self-supporting and sustainable in the long term, only cement and sheets of tin for the roof were supplied by the project—land, construction costs and labor were all provided by the villagers working together. Public health workers would be needed to manage these facilities, so people from the village who had completed senior high school were given two months of community health education and training, after which two of them were appointed to manage each center. Because these workers would be handling maternal and child health and family planning issues, JOICFP looked for women candidates for the community health worker positions. There were few women in the villages with the requisite level of scholastic attainment, however, so men came to be trained as public health workers. Consideration was given to ensure that the health posts would meet the needs of women by appointing female villagers as volunteers to assist the workers. Furthermore, although the members of the villages’ public health committees were also exclusively men, a path was opened for women to become involved through the formation of mothers’ clubs in each village, and the appointment of club representatives to the public health committees. These health posts raised income to meet IP activity costs by charging for medications.

These had been purchased at wholesale prices, allowing the health posts to sell them to local

residents at a market discount of around 20 percent. The health posts offered private consultations on contraceptive devices, and also provided basic medical services. In addition to those day-to-day activities, each month the village would be visited by a nurse and a midwife from the project's field office. Working together with the public health worker and a female volunteer, this visiting team would check the health of infants, pregnant women, and nursing mothers, and also provided guidance on family planning. Although the project was initially launched in three villages, demand for its programs arose from villages in the surrounding area, and by 1993 the IP had been extended to fifteen villages (a total population of 60,000), with a primary health care post established in each village. In the three villages where the project was first begun, the number of toilets increased from one in 20 buildings to one in five, and the rate of parasite infection in the Project region had fallen from 90% to 46%.

3) Spread of Activities to Other Villages

Based on the experience gained in the Panchkhal Villages, in 1993 the project was launched in the Sunsari District, 550 kilometers east of Kathmandu. Under this project, a team comprising a nurse and midwife would go out on regular rounds, where they would provide guidance, offer basic medical treatment, and dispense medicines. Women volunteers in the project region were organized into community groups, and by helping with reception duties and measuring infants' vital statistics, these local volunteers worked in concert with the public health workers. This program had been in operation only five months when it was expanded into five villages in the neighboring Morang District. Considerable effort was also put into campaigns to improve nutrition. In order to redress a lack of balance in people's diets, each village was supplied with large pots and frying pans, and on their regular visit the team of health workers would provide nutrition education as well as conduct cooking sessions, using vegetables and rice contributed by the local women.

Although initially these women were rather reluctant to apply new methods of cooking, as their children came to enjoy the food, the sessions became popular, and at several villages these developed into meals programs for children.

4) Start of Midwifery Activities

In 1988, a Family Health Center was established in Panchkhal with the support of a grassroots grant-in-aid from the Japanese Embassy. The center housed both a field office and a maternity clinic, which had been the dream of the villagers for many years. The Center had a grand debut, with the opening ceremony attended by more than 100 people, including the Japanese Ambassador, the President and the Director General of the Nepal Family Planning Association, and members of public health committees and representatives of mothers' clubs from the fifteen villages.

Although small-scale midwife projects had commenced in 1996, project midwives received further training in Japan to upgrade their skills. The use of an emergency vehicle was arranged, and in cooperation with hospitals, hygienic and safe midwifery services were launched, operating 24 hours a day. Besides providing midwifery services on fee charging services to help fund expenses, the center undertook a variety of activities, including lectures on safe childbirth for villagers, the collection of maternal and child health data, and supplying medicines at cost to the elementary public health post in each village. Workers from the center also visited villages to provide guidance and supervision, and coordinated projects between the fifteen villages. It lived up to its name as a center for protecting the health of mothers and children in the Panchkhal Region. As a result of twelve days' live-in training given to 75 traditional midwives recruited from the project region, there has been an increase in the early detection of at risk pregnancies, more and more pregnant women and nursing mothers have undergone health checks, and there have been almost no cases of infant or maternal deaths in the project region. In addition, in order to meet the costs of giving birth at the project family health

center in the Panchkhal Project, village women have started to form pools to save the money

needed (on average the fee per delivery at this center is ¥2,000.)