Contraception choices in Japan: Why Japanese women refuse to adopt oral contraceptives as their primary form of birth control

by Allix Hillebrand
American University
School of International Studies and University Honors Program Senior Capstone
May 6th, 2013

I. Introduction

Prior to 1999, induced abortion was legal in Japan under almost any circumstance. However, oral contraceptives were not approved by the Japanese Ministry of Health, Labor, and Welfare.[1] It wasn't until Viagra became available in Japan and outside foreign pressure pointed to the hypocrisy of legalizing Viagra but not oral contraceptives that the pill became available.[2] The Eugenics Protection Law of 1948 largely legalized abortion in Japan under many circumstances such as economic reasons in the family or danger to the health of the mother or infant. This law was revised in 1996 to be called the Maternal Health Protection Law, allowing further access to induced abortion by requiring only the consent of the mother and father, if the father was present.[3]

In 1995, the abortion ratio in Japan was 289 abortions per 1000 live births. In 2007, nearly 10 years after the legalization of oral contraceptives, only 657,000 women (2.2%) were reported to be using the pill while 80% of women preferred to use condoms. The abortion ratio remained at 235.5 abortions per 1000 live births.[4] Although the risks associated with abortion are

[1] Miho, O. (1999). ""You Can Have Abortions, But No Oral Contraceptive Pills": Women and Reproductive Control in Japan." Asian Journal of Women's Studies **5**(3): 99-99.
[2] Ibid.
[3] Jitsukawa, M. and C. Djerassi (1994). "Birth Control in Japan: Realities and Prognosis." Science **265**(5175): 1048-1051.
[4] Johnston, R. (2013). Historical abortion statistics, Japan. Abortion statistics and other data.

much greater than those of taking oral contraceptives, Japanese women still had not adopted oral contraceptives as a primary form of birth control. Kazakhstan saw similar changes to their contraception repertoire after women had already grown accustomed to utilizing abortion as a form of birth control.

Kazakhstani women used abortion as their primary form of birth control under Soviet Russia due to the lack of availability of other forms of contraception as well as skepticism concerning domestically produced contraception. The USSR was the first country to legalize induced abortion in 1920, and the availability of abortions carried through to many of Soviet-bloc countries, including Kazakhstan.[5] Following the increase in availability of oral contraception and several family planning initiatives by the Kazakhstan Ministry of Health, the abortion ratio decreased from 1026 abortions per 1000 live births in 1992 to 288.4 abortions per 1000 live births in 2010. In addition, between 1991 and 1998, the proportion of women using modern forms of contraception (condoms and oral contraception) rose from 26 percent to 39 percent.[6]

Although oral contraceptives became available in both countries after abortion became a widely accepted practice of birth control, Kazakhstani women quickly changed their contraception choice while Japanese women did not. By comparing the implementation of oral contraceptives as a family planning method in Japan and Kazakhstan, this research aimed to determine why Japanese women have not more readily utilized oral contraception as a primary method to prevent pregnancy. A historical analysis of each country in was carried out to identify

[5] Agadjanian, V. (2002). "Is "Abortion Culture" Fading in the Former Soviet Union? Views about Abortion and Contraception in Kazakhstan." Studies in Family Planning **33**(3): 237-248.
[6] Johnston, R. (2013). Historical abortion statistics, Kazakhstan. Abortion statistics and other data.

a causal mechanism as to why only two percent of Japanese women today use oral contraceptives.

II. Literature Review

Plentiful published scholarship has researched why women make certain reproductive choices, including the use of contraception and abortion. There are fewer studies, however, which have looked into the reasons for why a woman or population of women may choose one form of contraception over the other, or the preferences between abortion and other forms of contraception.

Data has shown the primary form of contraception used in a country varies across the world. There is no ideal "method mix" defined by any public health organization or voice of authority. Sullivan, et. al published a study in 2006 which sought to investigate why some countries predominantly use one form of contraception over the other. They define "method skew" as a single contraceptive method being responsible for 50% or more of national contraceptive use. They found 34 countries that fit this definition – 16 which used mostly traditional methods, 4 which use forced sterilization, and 14 which used the pill, IUD, or injections as a principle method. Reasons for method skew were varied. Government policy was found to influence the predominance of forced sterilization in India and the IUD in Egypt. The authors point out that although a method may have come to be used predominantly due to abundant supply, in the cases of Morocco and Dominican Republic they eventually became a societal preference. In Central Asia, they found the predominant use of IUD is due to the efforts of the new governments after the collapse of the Soviet Union to promote women's health when

their primary form of birth control was abortion. However, Soviet society's negative attitudes toward oral contraception posed difficulties for making the pill a more utilized method.[7] In a comprehensive study of Asian countries and the U.S. Bulatao found that the choice of contraceptive methods was influenced by contraceptive goals, contraceptive competence, contraceptive evaluation or assessment and contraceptive access.[8]

The recommendations of international public health bodies have also historically had effects on the funding and structure of reproductive health programs. Following the International Conference on Population and Development in 2004, many health programs across the world which previously emphasized a specific, usually underutilized, contraceptive method began promoting a balance of methods. The conference also encouraged client-focused services of contraception, which may be responsible for the rise of one method over the other when individuals are given the method they prefer as opposed to being pressured into another.[9]

There are many individual case studies which investigate how other measures are related to women's reproductive choices. Contraceptive use, which includes all kind of contraception, is generally associated with higher levels of education. Logically, the knowledge and information attained from receiving education results in contraceptive use.[10] In addition, higher education attracts women away from a life of family and childbearing.[11] In Uganda, it was found that

---

[7] Sullivan, T. M., J. T. Bertrand, et al. (2006). "SKEWED CONTRACEPTIVE METHOD MIX: WHY IT HAPPENS, WHY IT MATTERS." Journal of Biosocial Science **38**(4): 501-521.
[8] Bulatao, R. A., J. A. Palmore, et al. (1989). Choosing a Contraceptive: Method Choice in Asia and the United States. Boulder, Colorado, Westview Press.
[9] Sullivan, T. M., J. T. Bertrand, et al. (2006). "SKEWED CONTRACEPTIVE METHOD MIX: WHY IT HAPPENS, WHY IT MATTERS." Journal of Biosocial Science **38**(4): 501-521.
[10] Alsaawi, M. and D. J. Adamchak (2000). "Women's status, fertility and contraceptive use in Kazakhstan." Genus **56**(1/2): 99-113.
[11] Westoff, C. F. and R. Potvin (1967). College Women and Fertility Values. Princeton, NJ, Princeton University Press.

secondary or higher education, discussion about family planning with partners and living in an urban area were strong indicators of contraceptive use.[12] Similar results were published about Ghana.[13] An analysis of 25 countries yielded the conclusion that the higher the level of education of women, the greater they utilize contraception. The correlation was stronger in industrialized and educated countries than poor and illiterate ones, indicating that the trend between education and contraceptive use is not universal.[14]

Employment and discussion of family planning choices with the spouse or partner also increases the likelihood that women will use contraception.[15] Overall, indicators of development are associated with contraceptive use. However, these studies do not differentiate between the types of contraception used. A distinction is sometimes made in data between temporary and permanent forms of contraception. Temporary forms include oral contraceptives and condoms, while permanent contraception is usually surgical sterilization. A similar distinction is sometimes made between traditional and modern forms of contraception, definitions which vary but typically distinguish between celibacy, abstinence, and the rhythm method versus oral contraceptives, condoms, IUD, and sterilization.

For example, Jayaraman, et. al found that in Nepal, India, and Bangladesh, the strong preference for sons results in higher contraceptive use once the number of sons in the family

---

[12] Chaudhury, R. H. (1984). "The influence of female education, labor force participation and age at marriage on fertility behavior in Bangladesh." Social Biology **31**(1-2): 59-74.
[13] Tawiah, E. O. (1997). "Factors Affecting Contraceptive Use in Ghana." Journal of Biosocial Science **29**(2): 141-149.
[14] Rutenberg, N. e. a. (1991). Knowledge and Use of Contraception. Demographic and Health Survey.
[15] Salway, S. (1994). "How attitudes toward family planning and discussion between wives and husbnads affect contraceptive use in Ghana." International Family Planning Perspectives **20**(2): 44-47, Schuler, S. R. and S. M. Hasheni (1994). "Credit Programs, Women's Empowerment and Contraceptive Use in Rural Bangladesh." Studies in Family Planning **25**(2): 65-75.

increases. In addition, permanent methods of contraception were increasingly used as the number of sons increased.[16]

Other research has also studied the relationship between contraceptive use and abortion. In most of Africa, women have high fertility levels around 6 children per woman due to low use of contraception. Abortion has restrictions in all of Africa except for South Africa, causing some women to resort to unsafe illegal abortions when faced with unplanned pregnancies. Abortion is also used in South America and Southeast Asia where contraceptive access is less than ideal. In developing countries where abortion is restricted, women will sometimes use unsafe abortion as a means to space pregnancies before undergoing sterilization when the desired number of children is met.[17]

Developing countries overall have higher rates of abortion and unsafe abortion coupled with lower use of modern contraceptives. In contrast, developed countries have lower rates of abortion and higher modern contraception use. Although this is trend is easy to revert to when attempting to explain reproductive choices, the story is truly much more complicated. The profound number of factors that have been thought to influence reproductive choice make it impossible to generalize across regions or even countries. The trends in contraceptive use and method choice vary so widely that it warrants analysis on a national or even local level. The analysis of reproductive and contraception choices over time in Kazakhstan and Japan will allow

[16] Jayaraman, A., V. Mishra, et al. (2009). "The Relationship of Family Size and Composition to Fertility Desires, Contraceptive Adoption and Method Choice in South Asia." International Perspectives on Sexual and Reproductive Health **35**(1): 29-38.
[17] Ãhman, E. L. and I. H. Shah (2006). "Contraceptive use, fertility, and unsafe abortion in developing countries." European Journal of Contraception & Reproductive Health Care **11**(2): 126-131.

for more specific and concrete conclusions to be drawn as opposed to relying on extrapolating other results. The public health impacts of this strategy will also be more productive.

III. Methodology

This research consisted of qualitative analyses was by comparing the histories of oral contraception introduction and abortion utilization in Kazakhstan versus Japan in order to come to a conclusion as to why Japanese women have been so reluctant to adopt oral contraceptives as a more primary form of birth control. Both Kazakhstan and Japan developed a societal preference toward using abortion as a form of birth control following their legalizations in 1920 and 1949, respectively. However, following the introduction of oral contraceptives in each of these countries, Kazakhstani women more significantly altered their contraception choices to utilize oral contraceptives compared to Japanese women. In addition, this was paralleled by a much greater drop in the abortion ratio in Kazakhstan compared to Japan.

The independent variables were defined as:

1. The country-wide change in utilization of oral contraceptives since their introduction

2. The country-wide change in use of abortion as a form of birth control since the introduction of oral contraceptives

The dependent variables were wide-ranging and included the policy, structure, timeline, and other historical particulars of the introduction of oral contraceptives. This encompasses the changes in access and availability to oral contraceptives over time. An additional dependent variable was any cultural dispositions or influences which could affect reproductive choices after

a change in available options: namely, the Soviet abortion culture carrying over to Kazakhstan and the Japanese value of tradition and established convention.

By assessing the dependent variables for the two countries and comparing them to the outcomes in the independent variables, the goal of this method was to explain a causal mechanism between them to identify why Kazakhstan's outcomes are so different compared to those of Japan.

IV. Japanese contraceptive use over time

Before World War II, all contraceptives except condoms were illegal and the "bear and multiply" policy was encouraged.[18]As a result, illegal abortions were rampant.[19] The Diet passed Eugenic Protection Law in 1948 which legalized abortions, and "economic hardship" as a suitable reason for an abortion was added in 1949. However, abortion as a punishable offense remained in the penal code. The original Eugenic

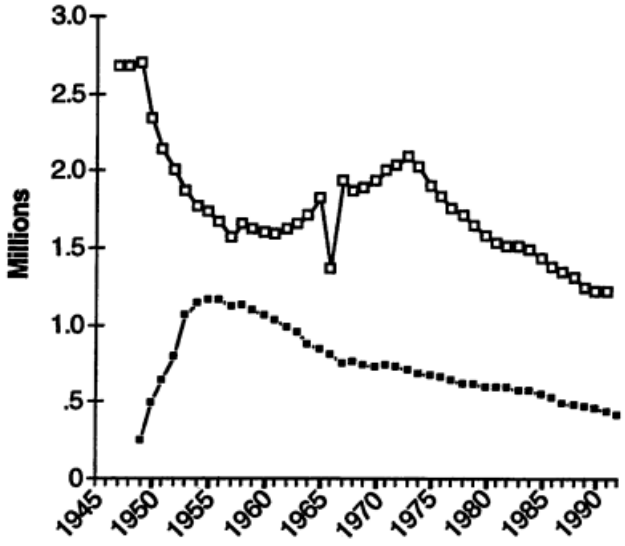

Figure 1. Number of births and abortions in Japan following World War II and the passage of the Eugenic Protection Law. Births are indicated by unfilled boxes, while abortions are indicted by filled boxes.[1]

[18] Jitsukawa, M. and C. Djerassi (1994). "Birth Control in Japan: Realities and Prognosis." Science **265**(5175): 1048-1051.
[19] Ibid.

Protection Law allowed for abortion for eugenic or health reasons as well as rape. Protest by those with disabilities resulted in the removal of the eugenics clause 1996 and its name was changed to the Mother's Body (Maternal Health) Protection Law. Following the initial passage of the EPL, the increase in number of abortions mirrored the decrease in birth rate (Figure 1). During the 1960's, this relationship became less clear due to the increase in use of other contraceptive methods such as intrauterine devices (IUDs) and the rhythm method.[20]

Four years passed until the Japanese government passed new regulations for contraceptives in 1952, resulting in a four year lag where Japanese women became accustomed to using abortion as a form of birth control.[21]Abortions reached a peak of 1.17 million in 1955 and declined thereafter.[22]

The Daily Mainichi Committee on Population Problem conducted a survey every two years since 1950 on contraceptive use and family planning among Japanese women and couples. In 1961, a year after oral contraceptives became available in the United States, 60.5 percent of Japanese women said they used condoms as their principle form of contraception. This increased to 78 percent in 1998, as compared to other methods such as sterilization, IUDs, and the rhythm method. Some women use condoms in coordination with the rhythm method, using condoms only on "dangerous days", namely when the women is ovulating.[23]

V. Japanese contraceptive availability and utility

[20] Miho, O. (1999). ""You Can Have Abortions, But No Oral Contraceptive Pills": Women and Reproductive Control in Japan." Asian Journal of Women's Studies **5**(3): 99-99.
[21] Jitsukawa, M. and C. Djerassi (1994). "Birth Control in Japan: Realities and Prognosis." Science **265**(5175): 1048-1051.
[22] Miho, O. (1999). ""You Can Have Abortions, But No Oral Contraceptive Pills": Women and Reproductive Control in Japan." Asian Journal of Women's Studies **5**(3): 99-99.
[23] Ibid.

After the pill was released in the United States in 1960, it was available on drugstore shelves in Japan as an over-the-counter treatment for irregular menstruation and other menstrual disorders. Its ability to serve as a contraceptive, however, was unknown at the time.[24] Following an international stir on oral contraceptives in the 1960's and its introduction into many industrialized countries, in 1962 the Japanese Ministry of Health banned the manufacturing, importation, and distribution of oral contraceptives due to cultural fears of sexual promiscuity as well as the feared side effects of synthetic hormones.[25] In 1972, the Ministry of Health revoked the over-the-counter status of the pills meant for non-contraceptive purposes and from then on women required a prescription for the pill from their obstetrician-gynecologist. The pill was not approved for its contraceptive purposes until 1999, but nothing stopped doctors from prescribing it as contraception well before that date. However, compared to oral contraceptives elsewhere in the world, this drug was very high in concentration of synthetic hormones, resulting in stronger side effects. Before its approval as a contraceptive, one estimate purports that 200,000 women annually used the synthetic hormone pills as contraceptives.[26] Other data suggest that as many as 500,000 to 800,000 women used the dangerous high-dose pills.[27] The 1998 Mainichi Committee on Population Problem survey found that only 1% of women used the pill as a form of contraception.[28]

[24] Ibid.
[25] Oddens, B. J. and A. Lolkema (1998). "A scenario study of oral contraceptive use in Japan: Toward fewer unintended pregnancies." Contraception **58**(1): 13-19.
[26] Miho, O. (1999). ""You Can Have Abortions, But No Oral Contraceptive Pills": Women and Reproductive Control in Japan." Asian Journal of Women's Studies **5**(3): 99-99.
[27] Jitsukawa, M. and C. Djerassi (1994). "Birth Control in Japan: Realities and Prognosis." Science **265**(5175): 1048-1051.
[28] Miho, O. (1999). ""You Can Have Abortions, But No Oral Contraceptive Pills": Women and Reproductive Control in Japan." Asian Journal of Women's Studies **5**(3): 99-99.

The struggle to approve oral contraceptives in Japan spanned several decades and was due to many different reasons – among them were the fear of dangerous side effects, a culture which stigmatized any sexual promiscuity, the acceptance of abortion as a failsafe form of birth control, political lobbies and influences of physicians and industries, and the AIDS pandemic.

The fear of possible dangerous side effects of the oral contraceptives was prominent especially after the thalidomide crisis. During the 1950's and 1960's, Japanese women witnessed the thousands of babies born with birth defects following the mothers taking the drug thalidomide for morning sickness.[29] Suspicion of pharmaceutical companies was growing. Although the high-dose contraceptives purportedly had much stronger side effects than the recommended low-dose pills, Japanese feminists still cited disruption of a woman's "natural rhythm" as a side effect of the low-dosage.[30] Education on the low-dose contraceptives was also limited due to the Ministry of Education is reluctant to promote any sex education or information on family planning. As a result, the media was the only source of information on oral contraceptives for Japanese women, and the mass media, as expected, only reported on the dangerous negative side effects of the high-dose pills.[31] The media went as far as to report the negative side effects of the high-dose pills on the environment.[32]

However, there were a group of women during the 1970's led by Enoki Misako who called for the legalization of oral contraceptives and the removal of the abortion law. The Japanese media labeled these women as radical activists. Other feminists such as Akiyama Yoko viewed

[29] Ibid.
[30] Ibid.
[31] Jitsukawa, M. and C. Djerassi (1994). "Birth Control in Japan: Realities and Prognosis." Science **265**(5175): 1048-1051.
[32] Miho, O. (1999). ""You Can Have Abortions, But No Oral Contraceptive Pills": Women and Reproductive Control in Japan." Asian Journal of Women's Studies **5**(3): 99-99.

the pill as “in no way a good thing” and women should utilize other forms of contraception if they are available. Another main reason cited for the disapproval of the pill was the unnaturalness of regulating a woman’s body with synthetically produced substances. These views pervaded feminist ideology well into the 1990’s.[33]

In 1986, a committee was created under the Ministry of Health to investigate the low-dose contraceptive pill and study its efficacy and safety. Cardiovascular side effects of the pills were the most feared.[34] It was expected that the pill would be legalized during the 1990’s. Opposition was heavy from feminist activists, doctors, and women alike. Women’s health write Jansson Yumiko contended that women should not potentially forgo their health for “overwhelming efficacy” of the pill. A women’s health clinic in Osaka published a book titled ‘The Pill: We Don’t Choose It’, arguing that the pill perpetuates the lack of women taking control of their own decisions. By using the pill, a woman’s place in life will not improve due to the burden of contraception being placed on the woman as opposed to condoms which place some of the responsibility in the man’s hands. By using condoms in combination with the rhythm method or a diaphragm, the responsibility to protect pregnancy is shared between partners. The authors contend that although the efficacy of the pill is enticing, it is only one factor that is considered in their decision to disapprove of the pill.[35]

The same women who published the book ‘The Pill: We Don’t Choose It’ theorized why the state was taking steps to legalize the pill even though there were few women demanding the availability of the pill and so many more who were fighting against it. They believed the

---

[33] Ibid.
[34] Goto A, R. M. R. A. I. (1999). "Oral contraceptives and women's health in Japan." JAMA: The Journal of the American Medical Association **282**(22): 2173-2177.
[35] Miho, O. (1999). ""You Can Have Abortions, But No Oral Contraceptive Pills": Women and Reproductive Control in Japan." Asian Journal of Women's Studies **5**(3): 99-99.

Japanese government was making up for the fact that it was becoming more and more difficult to control the sexuality of women by providing the pill to prevent an increase in babies born out of wedlock. They also believed that the state was offering the pill with the hidden intent to restrict the abortion law, since theoretically once the pill is available and being used correctly, abortions would no longer be necessary. These women were highly suspicious of the government's motivations, and these suspicions did materialize when there were two movements to remove the economic clause from the Eugenic Protection Law. Because 99 percent of abortions were performed under this clause, removal would have essentially be a ban on abortion.[36]

Two movements organized by a nationalistic religious organization aimed to remove the economic clause from the Eugenic Protection Law believed that the clause allowed sexually immoral and irresponsible women access to abortion. The amendment almost passed the second time around in 1983 but was narrowly rejected by the Liberal Democratic Party.[37] Feminists did not see the legalization of the pill as any sort of liberalization, but instead an attempt by the government to further control women and their sexual autonomy.[38]

Others suspected that the government was so reluctant to push forward the liberalization of contraception in hopes of preventing the reduction in birth rate. However, there has been no industrialized country where the introduction of oral contraceptives noticeably reduced the birth rate.[39]

---

[36] Ibid.
[37] Jitsukawa, M. and C. Djerassi (1994). "Birth Control in Japan: Realities and Prognosis." Science **265**(5175): 1048-1051.
[38] Miho, O. (1999). ""You Can Have Abortions, But No Oral Contraceptive Pills": Women and Reproductive Control in Japan." Asian Journal of Women's Studies **5**(3): 99-99.
[39] Jitsukawa, M. and C. Djerassi (1994). "Birth Control in Japan: Realities and Prognosis." Science **265**(5175): 1048-1051.

The AIDS epidemic also resulted in significant opposition to the legalization of the pill. The HIV rate in Japan was and has always been significantly lower than its industrialized country counterparts. This has been theorized to be due to the high condom use in Japan.[40] Other data suggest that the Japanese did not use condoms in the correct manner which would prevent the spread of sexually transmitted diseases.[41] By 1991, the Ministry of Health and Welfare's medical advisory committee had recommended approval of the pill and the required clinical studies among 5000 Japanese women had already been completed. The results of the studies replicated those obtained internationally, which was that the pill was a safe and effective way to prevent pregnancy. However, in 1991 the Ministry released a report which documented 238 new cases of HIV-positive individuals in Japan.[42] As a result, the Ministry of Health froze the project on legalizing the pill in 1992 and was met with little opposition.[43]

The Ministry was criticized for using the AIDS epidemic as a front for fears that the liberalization of contraceptives would result in a further decrease in the Japanese birth rate and increase in the number of aging individuals.[44] The press reported these allegations to be true, even though the Japanese birth rate had already been decreasing from 3.65 to 1.43 between 1950 and 1966, and the introduction of oral contraceptives in other industrialized nations resulted in no measurable decrease in the birth rate.[45] Following investigation, Health and Welfare minister

[40] Miho, O. (1999). ""You Can Have Abortions, But No Oral Contraceptive Pills": Women and Reproductive Control in Japan." Asian Journal of Women's Studies **5**(3): 99-99.
[41] Jitsukawa, M. and C. Djerassi (1994). "Birth Control in Japan: Realities and Prognosis." Science **265**(5175): 1048-1051.
[42] Ibid.
[43] Miho, O. (1999). ""You Can Have Abortions, But No Oral Contraceptive Pills": Women and Reproductive Control in Japan." Asian Journal of Women's Studies **5**(3): 99-99.
[44] Oddens, B. J. and A. Lolkema (1998). "A scenario study of oral contraceptive use in Japan: Toward fewer unintended pregnancies." Contraception **58**(1): 13-19.
[45] Goto A, R. M. R. A. I. (1999). "Oral contraceptives and women's health in Japan." JAMA: The Journal of the American Medical Association **282**(22): 2173-2177.

Yuuya Niwa announced there was no link between oral contraceptive use and the prevalence of AIDS. However, his initiatives to quickly approve the pill were foiled in July of 1993 when the Liberal Democratic Party lost control in Japan.[46]

The pharmaceutical companies were subsequently required to provide proof that no link existed between the use of oral contraceptives and the contraction of HIV, a task which some argued would require extensive unethical experiments.[47] The effects of the AIDS epidemic were not all negative, however, as the Ministry of Education initiated changes in sex education curriculum to include information on HIV/AIDS as well as the serious discussion of sex by Japanese journalists.[48] The Cairo Conference on Population and Development instilled interest in the pill once again following the introduction of the phrase 'reproductive rights'. Family planning clinic doctor Kitamura Kunio believed that by not offering the low-dose pill, it put women in danger by forcing them to either take the riskier high-dose hormone pills or acquire an abortion, both methods of contraception which are far more dangerous than the pill itself.[49] Clinic doctors, unlike Kunio, traditionally had been against the legalization of birth control while the leaders of their professional organizations supported the change.[50] The clinical trials performed on 5000 Japanese volunteers were even spearheaded by the Japan Association of Obstetrics and Gynecologists and the Japan Society Obstetrics and Gynecology.[51]

---

[46] Jitsukawa, M. and C. Djerassi (1994). "Birth Control in Japan: Realities and Prognosis." Science **265**(5175): 1048-1051.
[47] Ibid.
[48] Ibid.
[49] Miho, O. (1999). ""You Can Have Abortions, But No Oral Contraceptive Pills": Women and Reproductive Control in Japan." Asian Journal of Women's Studies **5**(3): 99-99.
[50] Jitsukawa, M. and C. Djerassi (1994). "Birth Control in Japan: Realities and Prognosis." Science **265**(5175): 1048-1051.
[51] Goto A, R. M. R. A. I. (1999). "Oral contraceptives and women's health in Japan." JAMA: The Journal of the American Medical Association **282**(22): 2173-2177.

In contrast, the revenue from performing abortions provided significant income for the clinic doctors, presumably giving them a vested interest in making sure that oral contraceptives were never legalized. However, as the Japanese population began to age and the birth rate declined, professional gynecology began to take a more logical approach to their business and doctors such as Kunio began to support preventative care.[52] Feminists responded, and the legalization of the pill was soon to be seen a symbol of female autonomy as opposed to patriarchal control. Although the pill may not have been believed to be the best contraceptive method, feminists conceded that the decision should be in the hands of the woman as opposed to the state. 'Reproductive rights' now encompassed the right of the woman to choose her form of contraception as a part of a woman's right to self-determination.[53]

However, most Japanese women still would not use the pill if it were made available. Positive attitudes toward the legalization of the pill according to the Mainich I survey declined from 35.4% in 1986 to 22.7% in 1992, and the number of respondents who said they were interested in taking oral contraceptives following legalization dropped from 12.9% to a mere 6.9%. However, women who had previously had an abortion were more supportive of the legalization of the pill (27.7% in 1992) and were also more likely to utilize the pill (5.2% in 1992).[54]

Discussion of the pill following the Cairo conference recommenced in 1995, and legalization of the pill was expected by 1997. However, the project was postponed yet again, this time to the

[52] Jitsukawa, M. and C. Djerassi (1994). "Birth Control in Japan: Realities and Prognosis." Science **265**(5175): 1048-1051.
[53] Miho, O. (1999). ""You Can Have Abortions, But No Oral Contraceptive Pills": Women and Reproductive Control in Japan." Asian Journal of Women's Studies **5**(3): 99-99.
[54] Jitsukawa, M. and C. Djerassi (1994). "Birth Control in Japan: Realities and Prognosis." Science **265**(5175): 1048-1051.

concern that the hormones may disrupt the environment and wildlife following the excretion of the drugs in women's urine. The media widely publicized changes in the sea ecosystem as well as increasing female and male infertility rates, causing a stir among women and raising questions again as to the safety of the pill. At the same time, the right to life movement began gaining momentum in Japan. Pro-life activists opposed both the legalization of the pill as well as the Eugenic Protection Law, disregarding both as obstacles to "the right of children to be born."[55]

It has been speculated that the approval of the pill by the Health and Welfare Ministry was expedited following the approval of Viagra, a treatment for male impotence. The project to approve Viagra only took 6 months within the Ministry to complete, as opposed to the nearly three decades that efforts had been taken to legalize the pill. Outrage by feminists followed, describing a strong double-standard between men and women by the Japanese government and Japanese society in general. Although the approval of Viagra spearheaded more support for the legalization of the pill, the number of women demanding the liberalization of contraception was still highly outnumbered by the women who either disapproved of oral contraceptives or were ambivalent on the topic. Only 7.2 percent of respondents to the 1998 Mainichi survey said they would use the pill if it were made available, compared to a stark 54.2 percent of women who said they would definitely stick to traditional methods such as condoms and the rhythm method.[56]

Nevertheless, the Subcommittee of the Central Pharmaceutical Affairs Council announced that oral contraceptives were safe and effective on February 25, 1997, and the Special Committee of the Council followed suit on October 28, 1997and Special Committee of the Ministry's Central Pharmaceutical Affairs Council. A third approval needed to come from the Executive

[55] Miho, O. (1999). ""You Can Have Abortions, But No Oral Contraceptive Pills": Women and Reproductive Control in Japan." Asian Journal of Women's Studies **5**(3): 99-99.
[56] Ibid.

Committee and then the Ministry of Health would finalize the legalization of low-dose oral contraceptives.[57] The Ministry presented its findings to the Public Health Advisory Committee, neither supporting nor opposing the approval of oral contraceptives. They contended that although the relationship between oral contraceptives and STDs was blurry, STD rates would likely increase following the approval of the pill unless if the approval was doubled with measures to educate the Japanese on STDs and condom use.[58] After several further delays due to more environmental concerns, the risk of cervical cancer, and debate over prescription guidelines, 10 different types of low-dose oral contraceptives were approved.[59] The final liberalization of contraceptives came on June 16, 1999 after almost four decades of wrestling with the issue.[60] The contraceptives became available to Japanese women later on September 2, 1999.[61]

Following the approval of low-dose contraceptives in Japan in 1999, there were many speculations about how women would alter their primary source of contraception. Access to abortion was still protected under the Maternal Health Protection Law. The number of abortions performed annually prior to the legalization of contraceptives was estimated at 0.5 million or 18.6 per 1000 women aged 15-44. However, this data is thought to be less than a third of the actual abortion rate due to underreporting.[62] Clinic doctors commonly did not report the number

[57] Oddens, B. J. and A. Lolkema (1998). "A scenario study of oral contraceptive use in Japan: Toward fewer unintended pregnancies." Contraception **58**(1): 13-19.
[58] Goto A, R. M. R. A. I. (1999). "Oral contraceptives and women's health in Japan." JAMA: The Journal of the American Medical Association **282**(22): 2173-2177.
[59] Ibid.
[60] Ibid.
[61] Ibid.
[62] Oddens, B. J. and A. Lolkema (1998). "A scenario study of oral contraceptive use in Japan: Toward fewer unintended pregnancies." Contraception **58**(1): 13-19.

of abortions they performed in order to avoid taxes.[63] The number of unintended pregnancies and abortion rate in Japan has been higher than its industrialized nation counterparts. In addition, the trends of abortion rate among different age groups are different from other nations – the abortion rate in Japan does not decrease until well past age 40, as compared to other countries such as the United States where the abortion rate is highest for women in their 20's and significantly decreases thereafter.[64] A study published in *Contraception* in 1998 utilized complex prediction scenarios in order to estimate that oral contraceptive use rates of 15% would decrease the number of unintended pregnancies in Japan by 13-17%, while a higher use rate of 25% would decrease the number of unintended pregnancies by 22-29%.[65] This suggests that the strong Japanese reliance on condoms and the rhythm methods alone resulted in unintended pregnancies that were terminated via abortion.

Although the pill was finally legalized in Japan, Japanese women were reluctant to make the switch from more traditional methods of birth control such as condoms and the rhythm method to oral contraceptives. This was expected considering the results of the Mainichi surveys which still showed single-figure percentages of respondents indicating that they would utilize the pill if it were available.[66] In 2007, a study was conducted among women who visited a clinic to determine the impact of oral contraceptives on their quality of life after a 3-month period of using the pill. While values for the physical domain increased among users who were taking the pill as a form of contraception, their social, psychological, and environmental domain values

[63] Goto A, R. M. R. A. I. (1999). "Oral contraceptives and women's health in Japan." JAMA: The Journal of the American Medical Association **282**(22): 2173-2177.
[64] Ibid.
[65] Oddens, B. J. and A. Lolkema (1998). "A scenario study of oral contraceptive use in Japan: Toward fewer unintended pregnancies." Contraception **58**(1): 13-19.
[66] Miho, O. (1999). ""You Can Have Abortions, But No Oral Contraceptive Pills": Women and Reproductive Control in Japan." Asian Journal of Women's Studies **5**(3): 99-99.

decreased. This indicated that while they accepted oral contraceptives as an effective form of contraception, it had negative effects on the relationship with their partners.[67]

Cost also proved to be a significant barrier to the utilization of oral contraceptives following its legalization. Guidelines written by six obstetrical and gynecological organizations which accompanied the initial approval of low-dose oral contraceptives required the prescription of the pills by a gynecologist and a gynecologist visit as well as various other tests every three months. Neither the pills nor the visits were to be covered by insurance.[68] Today, these visits are required at a much lower frequency, however the pill is still not covered by National Health Insurance scheme unless if prescribed for irregular menstruation.[69] The cost of the pill is cited as one of the main reasons Japanese women do not adopt oral contraceptives.[70]

Research published by the Japan Society of Obstetrics and Gynecology in 2011 indicated that most women in Japan gather their information about oral contraceptives primarily from the media, and take oral contraceptives for regulating menstruation. Only 0.5% of women reported using oral contraceptives, compared to 16% and 24.5% in the United States and France, respectively. The overwhelmingly number one reason for not using oral contraceptives was the difficulty in obtaining a prescription from their gynecologist. The amount of accurate information available to women about oral contraceptives is highly limited, so they fear the

---

[67] Matsumoto, Y., S. Yamabe, et al. (2007). "Impact of use of combined oral contraceptive pill on the quality of life of Japanese women." Journal of Obstetrics & Gynaecology Research **33**(4): 529-535.
[68] Goto A, R. M. R. A. I. (1999). "Oral contraceptives and women's health in Japan." JAMA: The Journal of the American Medical Association **282**(22): 2173-2177.
[69] Matsumoto, Y., S. Yamabe, et al. (2011). "Perception of oral contraceptives among women of reproductive age in Japan: A comparison with the USA and France." Journal of Obstetrics & Gynaecology Research **37**(7): 887-892.
[70] Matsumoto, Y. and S. Yamabe (2010). "After 10 years: has approval of oral contraceptives really decreased the rate of unintended pregnancy in Japan?" Contraception **81**(5): 389-390.

possible side-effects and low very little about the true benefits of oral contraceptives beyond their function as treating disorders such as irregular menstruation.[71] Japanese women see oral contraceptives as a treatment for menstrual and hormonal abnormalities as opposed to an effective measure to prevent pregnancy.[72]

VI. Kazakhstan before independence

To effectively analyze the use of contraceptives in Kazakhstan over time, one must begin in the Soviet Union before Kazakhstan gained independence. The principal method of birth control in the Soviet Union was abortion due to its legal status and wide availability in government hospitals. Modern contraception, particularly oral contraceptives, was unavailable in government hospitals due to the health ministry's opinion that Western oral contraceptives were dangerous. Condoms and IUDs were manufactured domestically but were of poor quality. Importing these and other modern methods were expensive to import.[73] A 1974 Decree by the Ministry of Health of the Soviet Union titled "On the Side Effects and Complications of Oral Contraceptives" effectively banned the use of oral contraceptives.[74] Data on contraceptive use in

[71] Matsumoto, Y., S. Yamabe, et al. (2011). "Perception of oral contraceptives among women of reproductive age in Japan: A comparison with the USA and France." Journal of Obstetrics & Gynaecology Research **37**(7): 887-892.
[72] Matsumoto, Y. and S. Yamabe (2010). "After 10 years: has approval of oral contraceptives really decreased the rate of unintended pregnancy in Japan?" Contraception **81**(5): 389-390.
[73] Westoff, C. F., A. T. Sharmanov, et al. (1998). Replacement of Abortion by Contraception in Three Central Asian Republics. Calverton, Maryland, The Policy Project and Macro International Inc.
[74] Popov, A. A., A. P. Visser, et al. (1993). "Contraceptive knowledge, attitudes, and practice in Russia during the 1980s." Studies in Family Planning **24**(4): 227-235.

the Soviet Union is sparse. National statistics did not even include contraception. It is estimated that between 1-3% of the few contraceptive users utilized oral contraceptives in 1990.[75]

Independence for the Central Asian states resulted in a host of political, economic, and social reforms. These reforms included changes in the healthcare system and reproductive health policy, growth of private healthcare, and improvements in medical training and practice.

The "abortion culture" which perpetuated the population of Soviet women is well documented. An overall decrease in the number of desired children coupled with lack of access to contraceptives resulted in the highest abortion rate in the world. Pregnancy and abortion were medical matters and therefore under the control of the state, while family planning was a household decision. The Soviet state maintained control over fertility and population growth by providing wide access to abortion but restricting information and access to other forms of contraception. Women became accustomed to using abortion as a form of birth control, hence the development of the Soviet abortion culture. The collapse of the Soviet Union allowed women to explore the reproductive and family ideas of the West, which included the use of contraception.[76] Abortion is still legal in Kazakhstan during the first 12 weeks of pregnancy, and can be acquired after 12 weeks if there are other complications that could affect the mother or the child. Abortion is provided for free in most cases.[77]

---

[75] Popov, A. A. and H. P. David (1999). From Abortion to Contraception: A Resources to Public Polices and Reproductive Behavior in Central and Eastern Europe from 1917 to Present. Westport, CT, Greenwood Press.
[76] Ibid.
[77] Westoff, C. F. (2000). The Substitution of Contraception for Abortion in Kazakhstan in the 1990s. DHS Analytical Studies. Calverton, Maryland, ORC Macro. **1**.

VII. Kazakh health reform after dissolution of Soviet Union

During the first years of Kazakh independence, the health care system was set up to be a public service provided by the state where all health professionals were state employees. It was a highly centralized, standardized, and bureaucratic system. Healthcare was guaranteed to all Kazakh citizens for free and was financed by the state. Kazakhstan began by maintaining the structures set up by the Soviets. While the system was effective in the Soviet Union, Kazakhstan found that they no longer had the means to finance such an extensive network. The healthcare system was in shambles in 1991 and continued declining in the wake of an economic downturn in Central Asia. Funding allocated for health was decreasing each year, resulting in a significant decline in public health indicators such as life expectancy and morbidity. A new system needed to be implemented, especially after the 1995 Constitution of Kazakhstan guaranteed healthcare to all of its citizens. A mandatory health insurance program was set up in 1995, but quickly collapsed in 1999 due to mismanagement and corruption. A series of reforms quickly followed which created a network of family group practices with the intent of expanding and improving primary care. A large World Bank loan in 1998 supported the successful program.[78]

Part of Kazakhstan's healthcare reforms included a distancing from the Soviet focus on providing all care in hospitals, and instead employing general practitioners as a delivery for primary care. The definition of primary care was extended to include family planning, and oral contraceptives were added to the essential drugs list of the basic health care package guaranteed to all Kazakh citizens.[79] Order 33 issued by the Kazakh government in February 1994 approved a country-wide family planning program which required all hospitals and clinics to provide and

[78] Ibid.
[79] Grant, G. (2005). Toward a Framework for the Analysis of Abortion Culture. United Kingdom, Southampton Statistical Sciences Research Institute.

expand family planning services.[80] Kazakhstan has increasingly allocated money toward the Ministry of Health since 2003, where the amount of money being allocated each year is greater than the country's increase in GDP. The outpatient drug benefit plan includes oral contraceptives, 3-month injectables, and IUDs for inpatient facilities.[81]

The establishment of a two-tiered healthcare system consisting of both public healthcare and private healthcare in Kazakhstan opened up many doors for the satisfaction of family planning needs. The distinction between public and private healthcare allows for the identification of individuals who do or do not need government assistance for their reproductive health. The creation of a private healthcare market allows women who can afford family planning services to acquire them elsewhere besides the limited state supply.[82] Primary healthcare institutions such as polyclinics, delivery hospitals, central rural hospitals, and doctor's assistants posts are responsible between 500 and 3000 households. The physician or doctor's assistant at each of these facilities is responsible for counseling and assisting women with their contraception choices.[83]

In addition, the pharmaceutical sector is now almost entirely privatized and free of government interference, allowing for a wide availability of oral contraceptives. Oral contraceptives sold in Kazakhstan include both monophasic and multiphasic pills and at least one

[80] Population Policy DataBank. U. Nations, Department for Economic and Social Affairs.
[81] Armand, F., B. O'Hanlon, et al. (2006). Contraceptive Security in the Central Asian Republics Kazakhstan, Kyrgyzstan, and Tajikistan. Washington, DC, Private Sector Partnerships-One Project, DELIVER Project, USAID.
[82] Grant, G. (2005). Toward a Framework for the Analysis of Abortion Culture. United Kingdom, Southampton Statistical Sciences Research Institute.
[83] Westoff, C. F., A. T. Sharmanov, et al. (1998). Replacement of Abortion by Contraception in Three Central Asian Republics. Calverton, Maryland, The Policy Project and Macro International Inc.

type of progestin-only pill. Generic versions of oral contraceptives are available as well. However, high-dose oral contraceptives are not available for purchase.[84]

As a result of these reforms, the fertility rate in Kazakhstan dramatically decreased following independence. The Soviet fertility rate in 1924 was 7.7, and by 1999 the fertility rate in Kazakhstan was 2.05. Kazakhstan made the "low fertility transition" – a process evident across the histories of many countries. Increased education, income, urbanization, and weakening of traditional authority generally leads to decreased fertility rates. High fertility is associated with underdeveloped or developing countries while low fertility is associated with more developed nations.[85]

Substantial international funding for family planning was injected into the former Soviet states. A conference held in Georgia in 1990 titled "From Abortion to Contraception" raised attention to the extremely high abortion rates in the Soviet Union. The Tbisilisi Declaration was published as a result, which called upon the world to improve reproductive health and family planning programs. USAID, UNFPA, and the World Bank led the way in funding healthcare programs in Central Asia. Recently, the Private Sector Partnerships-One (PSP-One) was funded between 2004 and 2009 by USAID to assist with the delivery of high quality family planning and reproductive health services in developing countries, including Kazakhstan.[86]

---

[84] Armand, F., B. O'Hanlon, et al. (2006). Contraceptive Security in the Central Asian Republics Kazakhstan, Kyrgyzstan, and Tajikistan. Washington, DC, Private Sector Partnerships-One Project, DELIVER Project, USAID.

[85] Westoff, C. F., A. T. Sharmanov, et al. (1998). Replacement of Abortion by Contraception in Three Central Asian Republics. Calverton, Maryland, The Policy Project and Macro International Inc.

[86] Armand, F., B. O'Hanlon, et al. (2006). Contraceptive Security in the Central Asian Republics Kazakhstan, Kyrgyzstan, and Tajikistan. Washington, DC, Private Sector Partnerships-One Project, DELIVER Project, USAID.

VIII. Contraceptive use in Kazakhstan over time

Changes in the use of contraceptives and abortions was seen as early as 1995 in the Demographic and Health Survey conducted in Kazakhstan. Between 1992 and 1994, 38% of all pregnancies ended in abortion. A dramatic decrease in abortion in Kazakhstan during the 1990's was more prominent in urban areas and women with a higher level of education.[87] Abortion

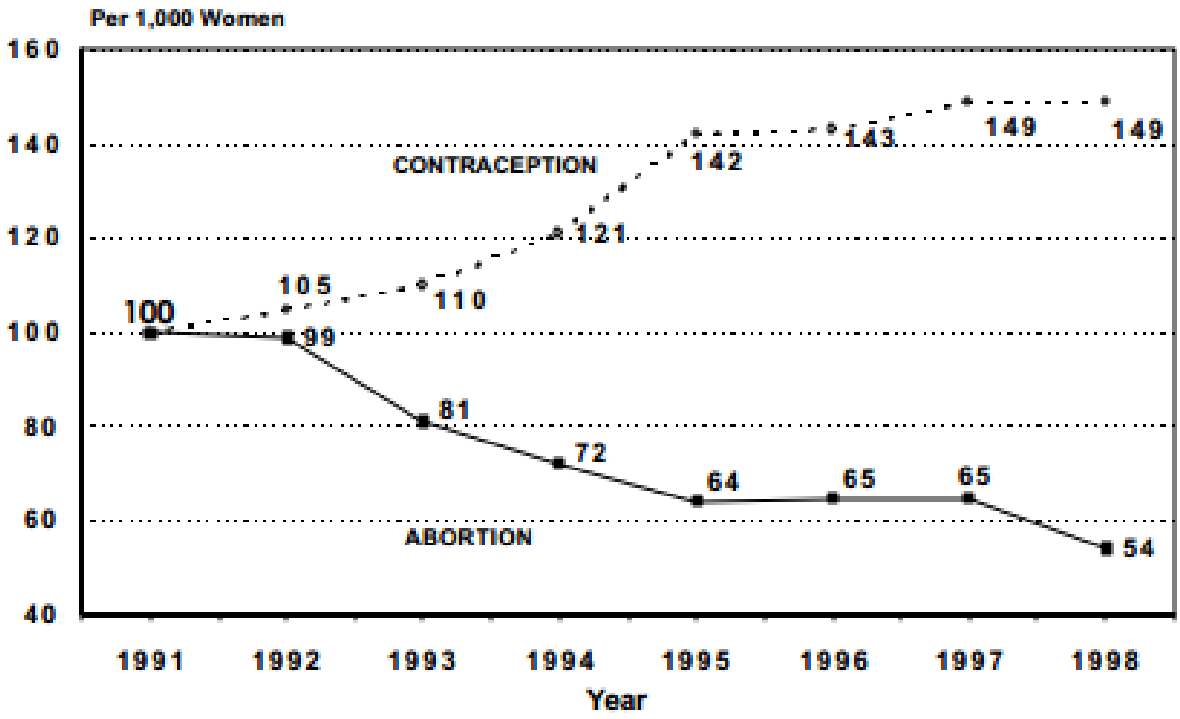

Figure 2. Trends in contraception and abortion in Kazakhstan, 1991-1998. Contraception includes the pill, IUD, spermicides, and injectables.[77]

began to be gradually replaced by the use of modern contraception. During the first half of the 1990's, contraception use increased by 25%. The IUD remains to be the most popular form of

[87] Westoff, C. F., A. T. Sharmanov, et al. (1998). Replacement of Abortion by Contraception in Three Central Asian Republics. Calverton, Maryland, The Policy Project and Macro International Inc.

contraception.[88] The increased number of women utilizing contraception was coupled with a decrease in the number of women acquiring abortions (Figure 2).

Interviews conducted with health professionals as well as abortion and contraception users in Almaty, the largest city in Kazakhstan, yielded interesting information about how Kazakhs characterize abortion and contraception. Although abortion is widely available and takes only a few hours, it is seen by both healthcare providers and women as a dangerous procedure that can result in complications. Oral contraceptives are also thought of as a potential danger, but with different kinds of risks such as hormonal imbalance or headaches. Another survey found that abortion is regarded as the most harmful out of all of the contraceptive methods.[89] Oral contraceptives are expensive and typically out of reach for poor rural residents. At the time this study was conducted, the clinics in Almaty had long run out of free contraceptives for their patients. Abortion was even less affordable.[90] More than 98% of women who acquire abortions in Kazakhstan are unmarried, and it was found in a survey that about half of the participants' husbands had problems with abortion and condoms, but not other forms of contraception.[91] A study funded by the World Bank in 2006 found that health providers are most likely to recommend oral contraceptives as opposed to other forms of contraception. After an abortion, more than 90% of providers would recommend oral contraceptives to their patients.[92]

---

[88] Ibid.
[89] Ibid.
[90] Agadjanian, V. (2002). Understanding the Dynamics of Abortion and Contraception in Armenia and Kazakhstn, Arizona State University.
[91] Westoff, C. F., A. T. Sharmanov, et al. (1998). Replacement of Abortion by Contraception in Three Central Asian Republics. Calverton, Maryland, The Policy Project and Macro International Inc.
[92] Rani, M., S. Chao, et al. (2006). Fertility Regulation in Kazakhstan: The Role of Providers and the Public Financial Cost. Health, Nutrition, and Population Family, World Bank Human Development Network.

In summary, a stark decrease in the number of abortions in Kazakhstan has been met with an increase in the utilizations of contraception. More specifically, oral contraceptives are more likely to be recommended to women by healthcare providers.

IX. Politics of contraception in Japan

In addition to initiatives which cited women's health as the main basis for the legalization of oral contraceptives, there were also several political arguments both in favor and against the changes. One of the arguments in favor for a more varied contraceptive repertoire in Japanese society is the responsibility that the Japanese government has to the rest of the world to maintain a reasonable domestic population policy. During the 1990's, Japan was becoming a leader in international development assistance and was second behind the United States in the amount of aid it contributed toward sustainable development. In January 1994, the Japanese government promised no less than 3 billion dollars towards "the most urgent problems facing developing nations", most notably population problems. Japan was criticized for taking such initiatives when its domestic policies on population control were misaligned with those that were taking shape in the rest of the world. Industrialized and developing countries alike were promoting family planning initiatives which included a woman's choice to several kinds of contraceptives. At the time, Japan was funding development population initiatives through multilateral channels due to the obvious ethical questions that could arise if Japan provided bilateral aid that went towards oral contraceptives: How could Japan provide a developing nation with a form of contraception that was illegal in Japan itself? Questions were raised as to whether Japan could effectively implement development initiatives through the sharing of knowledge and expertise if its own

domestic population programs were subpar and potentially detrimental to the health of the female population.[93]

In addition, clinic doctors and physicians designated to perform abortions were an important lobby against the legalization of the pill. Abortion doctors earned large incomes from performing abortions – it was estimated that private gynecologists, who perform the greatest number of induced abortions in Japan, to earn a total of 400 million dollars annually prior to 1998. Some family planning organizations as well as condom manufacturers disapproved of the legalization of the pill as well due to the revenue that they would lose to condom sales.[94] Another important point to be brought up here was that only a small fraction of physicians in Japan were women (13.6% in 1996).[95] Although gender gap statistics are frequently cited whenever feminist initiatives are stalled, the few number of female physicians resulted in an important voice being lost in the scuffle. As the Japanese population continued to age and the birth rate declined after the second Japanese baby boom during the 1970's, any adverse economic effects of the legalization of oral contraceptives did not pose as much as a threat. Instead, obstetrician-gynecologists saw the legalization of the pill as a potential source of revenue after the Ministry of Health revoked the over-the-counter status of high-dose hormone pills in 1972, and doctors now could sell the prescription to their patients. Preventative women's healthcare and the use of oral contraceptives looked to be a new business venture, especially since the abortion rate was declining during the 1960's and 1970's.[96]

---

[93] Jitsukawa, M. and C. Djerassi (1994). "Birth Control in Japan: Realities and Prognosis." Science **265**(5175): 1048-1051.
[94] Goto A, R. M. R. A. I. (1999). "Oral contraceptives and women's health in Japan." JAMA: The Journal of the American Medical Association **282**(22): 2173-2177.
[95] Ibid.
[96] Ibid.

An additional important lobby in favor of the legalization of oral contraceptives was the Japanese professional groups and organizations. As described earlier, while individual clinic doctors may have directly benefited from the continuation of the ban of the pill, their leaders of professional organizations generally supported the approval of the pill. In 1993, the Japan Association of Obstetricians and Gynecologists, the Japan Society of Obstetrics and Gynecology, the Japan Family Planning Association, and the Family Planning Federation of Japan all recommended to the Ministry of Health to expedite the approval of low-dose oral contraceptives. The Ministry responded by setting up yet another committee to look into the safety and efficacy of the pill.[97]

X. Cultural predispositions to contraceptives in Japan and Kazakhstan

In both Japan and Kazakhstan, culture-specific predispositions affected the way oral contraceptives were initially viewed and utilized in each country. Beginning with Japan, Japanese culture has always had strong favoritism towards the traditional. Even in common Japanese society, individuals prefer already established norms as opposed to new methods or even ideas. This quality of Japanese culture can be assumed to influence women's contraception choices. Because women used condoms as their main form of birth control for many decades prior to the availability of birth control, they were not interested in the new method and preferred to utilize the traditional methods. This can be seen in the Mainichi Family Planning surveys

[97] Ibid.

which showed a large segment of the female population that was ambivalent to the prospects of a new effective form of birth control.[98]

In addition, Japanese women believed that oral contraceptives repress their sexuality by forcing them into a daily medication regimen.[99] This is compounded by the fact that many married Japanese couples have a low coital frequency, making the prospect of taking a daily birth control pill very unattractive. Instead, these couples prefer to use condoms for the few times a year that they have intercourse.[100]

Conservative Japanese women feared being sexually liberated and sexual disorder that could be caused by the legalization of the pill. The first official talks of approving the pill began in the 1960's by the Central Pharmaceutical Council of the Ministry of Health. The case was quickly dropped for political reasons, as it was rumored that the wife of Prime Minister Sato "strongly opposed the pill's official approval because it would encourage sexual promiscuity." This view was refuted by the Mainichi surveys in 1986 and 1990 which revealed that 33 to 35 percent of women did not approve of the legalization of the pill due to "promoting of sexual immorality". Although the figure dropped to 22 percent in 1992, this belief still permeated Japanese women's sexual conscience.[101] Women feared to be labeled *sukimono*, or sex maniacs, as a result of using oral contraceptives. Female sexuality was a taboo in Japanese society and women were willing to

[98] Miho, O. (1999). ""You Can Have Abortions, But No Oral Contraceptive Pills": Women and Reproductive Control in Japan." Asian Journal of Women's Studies **5**(3): 99-99.
[99] Jitsukawa, M. and C. Djerassi (1994). "Birth Control in Japan: Realities and Prognosis." Science **265**(5175): 1048-1051.
[100] Ibid.
[101] Miho, O. (1999). ""You Can Have Abortions, But No Oral Contraceptive Pills": Women and Reproductive Control in Japan." Asian Journal of Women's Studies **5**(3): 99-99.

risk their health in order to maintain their image.[102] Similar opinions are shared by Japanese women concerning visits to the gynecologist. A survey among 107 Japanese women in 1999 showed that 26% of respondents would not visit the gynecologist even if they had a pressing subject to discuss with their doctor. Other embarrassment is evident among women when asked about cervical cancer screening and annual pap-smears.[103]

In Kazakhstan, elements of the abortion culture of the Soviet era perpetuated well into the independence of Kazakhstan. There were no ideological or moral qualms with abortion in the Soviet Union. This coupled with the widespread access and no cost of abortion to citizens of the USSR resulted in a societal preference and reliance on abortion as a form of birth control. Soviet families also were preferring smaller families and lower fertility, increasing abortion use. Women were much more comfortable when talking about the number of abortions they have had over their lifetime, allowing for relatively easy collection of data about abortions. This is in contrast to the culture of other nations such as the United States, where there is a stigma and alienation associated with women who make it known they have acquired an abortion.[104]

The abortion ratio was particularly low among the Muslim indigenous population compared to the Russians and people of other European descent due to their preference for larger families. However, the abortion ratio in Kazakhstan today is still one of the highest in the world despite its dramatic decline the past two decades. In 1995, the total abortion rate was 2.7 among Russian women compared to 1.1 among ethnic Kazakhs. A large emigration of Russians out of

---

[102] Jitsukawa, M. and C. Djerassi (1994). "Birth Control in Japan: Realities and Prognosis." Science **265**(5175): 1048-1051.
[103] Goto A, R. M. R. A. I. (1999). "Oral contraceptives and women's health in Japan." JAMA: The Journal of the American Medical Association **282**(22): 2173-2177.
[104] Agadjanian, V. (2002). "Is "Abortion Culture" Fading in the Former Soviet Union? Views about Abortion and Contraception in Kazakhstan." Studies in Family Planning **33**(3): 237-248.

Kazakhstan following independence may have had an effect on national abortion rates due to their higher use of abortion. Ethnic Russians are more accepting of abortion overall.[105]

Younger Kazakhstani women, regardless of ethnicity, are more likely to disapprove of abortion, which may be a contributing factor to the ease at which modern contraception has been introduced by the government into Kazakhstan. Any disapproval of abortion decreases with age, which aligns with the abortion culture of the Soviet era remaining in the older generations but disappearing in newer generations.[106]

XI. Analysis

There are several key differences between the introduction of oral contraceptives in Japan and Kazakhstan that could plausibly be responsible for the disparity in oral contraceptive use between women of the two countries.

First, the long and intense political resistance to the introduction of birth control pills in Japan was an obstacle to promoting different methods of contraception that was not a problem in Kazakhstan. The decades-long battle between the Ministry of Health, reproductive rights activists, and pharmaceutical companies created a societal reliance on abortion and other forms of contraception while the pill was not available. In addition, fears of potential side effects of the pill were perpetuated among Japanese women as a result of the constant concerns of the Ministry of Health and refusal to approve the drugs.

[105] Ibid.
[106] Ibid.

In contrast, the only time a government authority denounced oral contraceptives due to alleged dangers in Kazakhstan was early in 1974 when the Soviet Ministry of Health completely restricted their use. Funding for family planning programs and reproductive health programs in Kazakhstan by organizations such as USAID and UNFPA also worked to qualm any fears regarding the dangers or side effects of the pill. There was little to no political resistance in Kazakhstan to the introduction of the pill – instead, all forms of contraception were encouraged in order to reduce the astonishing abortion rate. While fear and resistance plagued the introduction of oral contraceptives to Japan, they were encouraged and welcomed with more or less open arms into Kazakhstan.

Second, an important distinction between the two countries was the heavy involvement of Japanese physicians during the legalization process as opposed to Kazakhstan. Multiple physician societies and organizations made recommendations as to the potential legalization of oral contraceptives in Japan. These societies did not exist in Kazakhstan because all of the health workers were state employees and had no opportunity to collectively organize or unionize. The coziness between Japanese physicians and the Ministry of Health had significant impact on the delays: Obstetricians and gynecologists were reluctant to be in support of oral contraceptives due to the potential revenue cuts they would encounter if they weren't providing as many costly abortions to their patients. This not only had an effect on the timeliness of legalization, but also in the aftermath of the introduction of oral contraceptives. It was already established that physicians were weary of the pills, and once they had access to them, were less likely to recommend them to patients in consideration of the potential consequences on their income.

This is the direct opposite of Kazakhstan, where physicians and health workers are more likely to recommend oral contraceptives compared to abortion and other forms of contraception.

This contrast in provider attitudes toward oral contraceptives has directly reflected in the reproductive choices of women in Japan and Kazakhstan: Japanese women are less likely to utilize oral contraceptives.

Third, the context in which the oral contraceptives were introduced could plausibly have resulted in the difference in pill use we see today. Kazakhstan was already under a host of other political, economic, and social reforms when healthcare reform was underway and the pill was introduced. The entire region was evolving quickly following the breakup of the Soviet Union. Introduction of oral contraceptives was just another small change in the mix. In contrast, the changes taking place in Japan were one of only a few other reforms under contest at the time. It was a high-visibility reform and consistently appeared in the media, drawing attention to the issue and encouraging Japanese women to develop and opinion on the topic.

Birth control pills in Kazakhstan were not newsworthy whatsoever. This difference in context upon the introduction of oral contraceptives resulted in an intense debate in Japan where women could synthesize different arguments on the subject and reach an opinion on whether or not they would utilize birth control pills when they became available. They were exposed to false information about the dangers of birth control pills. In Kazakhstan, this was not the case.

XII. Final Thoughts

Today, a very small fraction of Japanese women utilize oral contraceptives as a form of birth control. Although both Japan and Kazakhstan saw decreases in the abortion ratio since the introduction of oral contraceptives, Japanese women increasingly utilized condoms as opposed to the birth control pill. This trend could logically be due to many reasons, but upon analysis of the

history of each country's introduction of the pill, several themes stand out that differentiate Japan and Kazakhstan. Intense political resistance in Japan over several decades and fear-mongering among the Ministry of Health and Japanese physicians resulted in Japanese women being fearful of the drugs once they were legalized. This is in contrast to Kazakhstan, where there was no political opposition. Health workers in Kazakhstan also had no opportunity to voice their opinion on the pills given the Soviet command environment, while Japanese physicians had avenues to express their concerns. When women had the opportunity to use the pills, Japanese physicians were less likely than Kazakhstani physicians to recommend oral contraceptives. Logically, this has resulted in fewer Japanese women using birth control pills. Finally, the turmoil during which oral contraceptives were introduced into Kazakhstan made it a trivial reform. This is in comparison to the intense debate which reigned in Japan and encouraged women to discuss the subject as a result of the media reporting on the potential reforms. These three clear differences between the introduction of oral contraceptives in Japan and Kazakhstan could plausibly be responsible for the minimal use of birth control pills by Japanese women. Public health implications include the need to cater reproductive health and family planning programs to these unique characterizations of the reproductive health environment in each country. Programs in Japan should address the false fears women have of oral contraceptives and attempt to navigate the Japanese custom of practicing traditional practice. In the future, perhaps family planning programs will take this into account in order to more effectively promote the use of oral contraceptives in Japan.

References

Population Policy DataBank. U. Nations, Department for Economic and Social Affairs.

Agadjanian, V. (2002). "Is "Abortion Culture" Fading in the Former Soviet Union? Views about Abortion and Contraception in Kazakhstan." Studies in Family Planning **33**(3): 237-248.

Agadjanian, V. (2002). Understanding the Dynamics of Abortion and Contraception in Armenia and Kazakhstn, Arizona State University.

Ãhman, E. L. and I. H. Shah (2006). "Contraceptive use, fertility, and unsafe abortion in developing countries." European Journal of Contraception & Reproductive Health Care **11**(2): 126-131.

Alsaawi, M. and D. J. Adamchak (2000). "Women's status, fertility and contraceptive use in Kazakhstan." Genus **56**(1/2): 99-113.

Armand, F., B. O'Hanlon, et al. (2006). Contraceptive Security in the Central Asian Republics Kazakhstan, Kyrgyzstan, and Tajikistan. Washington, DC, Private Sector Partnerships-One Project, DELIVER Project, USAID.

Bulatao, R. A., J. A. Palmore, et al. (1989). Choosing a Contraceptive: Method Choice in Asia and the United States. Boulder, Colorado, Westview Press.

Chaudhury, R. H. (1984). "The influence of female education, labor force participation and age at marriage on fertility behavior in Bangladesh." Social Biology **31**(1-2): 59-74.

Goto A, R. M. R. A. I. (1999). "Oral contraceptives and women's health in Japan." JAMA: The Journal of the American Medical Association **282**(22): 2173-2177.

Grant, G. (2005). Toward a Framework for the Analysis of Abortion Culture. United Kingdom, Southampton Statistical Sciences Research Institute.

Jayaraman, A., V. Mishra, et al. (2009). "The Relationship of Family Size and Composition to Fertility Desires, Contraceptive Adoption and Method Choice in South Asia." International Perspectives on Sexual and Reproductive Health **35**(1): 29-38.

Jitsukawa, M. and C. Djerassi (1994). "Birth Control in Japan: Realities and Prognosis." Science **265**(5175): 1048-1051.

Johnston, R. (2013). Historical abortion statistics, Japan. Abortion statistics and other data.

Johnston, R. (2013). Historical abortion statistics, Kazakhstan. Abortion statistics and other data.

Matsumoto, Y. and S. Yamabe (2010). "After 10 years: has approval of oral contraceptives really decreased the rate of unintended pregnancy in Japan?" Contraception **81**(5): 389-390.

Matsumoto, Y., S. Yamabe, et al. (2007). "Impact of use of combined oral contraceptive pill on the quality of life of Japanese women." Journal of Obstetrics & Gynaecology Research **33**(4): 529-535.

Matsumoto, Y., S. Yamabe, et al. (2011). "Perception of oral contraceptives among women of reproductive age in Japan: A comparison with the USA and France." Journal of Obstetrics & Gynaecology Research **37**(7): 887-892.

Miho, O. (1999). ""You Can Have Abortions, But No Oral Contraceptive Pills": Women and Reproductive Control in Japan." Asian Journal of Women's Studies **5**(3): 99-99.

Oddens, B. J. and A. Lolkema (1998). "A scenario study of oral contraceptive use in Japan: Toward fewer unintended pregnancies." Contraception **58**(1): 13-19.

Popov, A. A. and H. P. David (1999). From Abortion to Contraception: A Resources to Public Polices and Reproductive Behavior in Central and Eastern Europe from 1917 to Present. Westport, CT, Greenwood Press.

Popov, A. A., A. P. Visser, et al. (1993). "Contraceptive knowledge, attitudes, and practice in Russia during the 1980s." Studies in Family Planning **24**(4): 227-235.

Rani, M., S. Chao, et al. (2006). Fertility Regulation in Kazakhstan: The Role of Providers and the Public Financial Cost. Health, Nutrition, and Population Family, World Bank Human Development Network.

Rutenberg, N. e. a. (1991). Knowledge and Use of Contraception. Demographic and Health Survey.

Salway, S. (1994). "How attitudes toward family planning and discussion between wives and husbnads affect contraceptive use in Ghana." International Family Planning Perspectives **20**(2): 44-47.

Schuler, S. R. and S. M. Hasheni (1994). "Credit Programs, Women's Empowerment and Contraceptive Use in Rural Bangladesh." Studies in Family Planning **25**(2): 65-75.

Sullivan, T. M., J. T. Bertrand, et al. (2006). "SKEWED CONTRACEPTIVE METHOD MIX: WHY IT HAPPENS, WHY IT MATTERS." Journal of Biosocial Science **38**(4): 501-521.

Tawiah, E. O. (1997). "Factors Affecting Contraceptive Use in Ghana." Journal of Biosocial Science **29**(2): 141-149.

Westoff, C. F. (2000). The Substitution of Contraception for Abortion in Kazakhstan in the 1990s. DHS Analytical Studies. Calverton, Maryland, ORC Macro. **1**.

Westoff, C. F. and R. Potvin (1967). College Women and Fertility Values. Princeton, NJ, Princeton University Press.

Westoff, C. F., A. T. Sharmanov, et al. (1998). Replacement of Abortion by Contraception in Three Central Asian Republics. Calverton, Maryland, The Policy Project and Macro International Inc.