Published in final edited form as:

Nurs Hist Rev. 2016 ; 24: 41–64. doi:10.1891/1062-8061.24.41.

Midwife and Public Health Nurse Tatsuyo Amari and a State-Endorsed Birth Control Campaign in 1950s Japan

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Abstract

Mrs. Tatsuyo Amari, a qualified midwife and nurse, served Japan's state-endorsed birth control campaign as a "birth control field instructor" in rural Minamoto Village of Yamanashi Prefecture just west of Tokyo. Her work sheds light on the role of female health care workers in health and population governance in 1950s Japan. Amari not only facilitated the "top-down" transfer of the state-sanctioned idea of birth control and contraceptives, as did other birth control field instructors, but also enabled the "bottom-up" flow of knowledge about people's reproductive lives through her participation of in the policy-oriented birth control research called the "three model-village study." Contextualizing Amari's engagement with the study elucidates how the state relied on the established role of female health care workers as intermediaries between state and people. Finally, Amari's contribution to the scientific aspect of the campaign may motivate historians to recognize the politics around female health care workers' participation in the science of birth control.

Keywords

Japan; public health nurse; midwife; birth control; twentieth century

Introduction

Today the Japanese government expresses concerns over its declining birth rates, but half a century ago it proudly proclaimed that its birth control policy had tamed population growth. In 1951, the Japanese Cabinet decided that the government should set out to popularize birth control, and a state-endorsed birth control campaign followed.¹ Coinciding with the policy, birth rates declined dramatically over the 1950s. The government took credit, suggesting that the policy was reducing the birth rates. In practice, however, community-based midwives and public health nurses played a critical role in implementing the policy in the lives of millions of Japanese people. Many of these women took on the role of "birth control field instructors" (*jutai ch setsu jicchi shid in*) to teach married men and women the new idea of contraception and to distribute contraceptives. Birth rates declined partly because of the "on the ground" work of these female health care workers.

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This article illustrates the important role of these health care workers in the state-endorsed birth control campaign by analyzing and contextualizing the activities of Mrs. Amari Tatsuyo (1928–), a qualified midwife and public health nurse who served as a birth control field instructor in rural Minamoto Village of Yamanashi Prefecture, just west of Tokyo.² In many ways, Amari was a typical such instructor, so her story reflects the experiences of many midwives and public health nurses employed in the birth control initiatives.³ At the same time, she was one of a small minority of midwives in Japan who took part in the policy-oriented “three model-village study” and this made her particularly distinctive. Launched in 1950 and conducted by the National Institute of Public Health (NIPH) in Tokyo, the study was charged to test the policy’s practicability, with a pilot project to investigate whether contraception reduced birth rates.⁴ The study employed Amari for the pilot initiative to present a model to deploy nationwide, so for the most part what she did for the study can be considered representative of the activities of other field instructors. However, she also stood out from the other field instructors because of her contribution to the scientific aspect of the project.⁵

Amari’s embodying both typical and atypical features provides us with a powerful lens through which to analyze the significant position midwives and public health nurses occupied in the birth control campaign and, more broadly, in state-led population governance during the 1950s when the campaign was at its peak. In contrast to the United States, for example,⁶ central authorities in Japan have actively intervened in population and reproductive health since the Meiji period (1868–1912), as the politics surrounding life became an increasingly intricate part of Japan’s modernization process.⁷ The state assigned the role of purveyor of its health policy to midwives and public health nurses. As groups whose *raison d’être* included protecting people’s health on behalf of the state, these health care workers were in close proximity to the state and were expected to communicate government messages to the people.⁸ Despite the change in sociopolitical climate after the Second World War, the government continuously exercised power over citizens’ reproductive health, partly for the sake of stable demography. As such,, midwives and public health nurses could most efficiently support the government mission because of their established ability to connect the state to the people.

On this stage, Amari worked for the “three model-village study” as a birth control field instructor. On the one hand, her actions illustrate the critical role of the majority of these instructors in the state governance of population; they were expected to transfer new contraception knowledge and technology from the central government to the citizens by applying their moderator position. Instructors such as Amari facilitated the flow of state-sanctioned ideas and goods from “top” to “bottom,” or – in terms of population governance – from the governor to the body of people subject to governance. On the other hand, by taking part in the scientific activities of the study – specifically by collecting information on the reproductive history and behavior of local villagers and passing it on to her medical collaborators at the NIPH – Amari helped facilitate the “bottom-up” flow of information, which also supported population governance. Thus, she assisted the bidirectional flow of knowledge and goods between state and people, so her contribution to the birth control campaign was doubly significant. Because of her extensive participation in the campaign, analysis of her activities and the wider context in which she became a birth control field

instructor gives a fuller picture of the mechanism of governing reproductive health and population in 1950s Japan.

That Amari was among the very few female health care workers engaged in the policy-oriented birth control research should not distract us from recognizing the value of her story for the history of nursing and midwifery. Thus far, historians of nursing and midwifery have generally overlooked their contribution to birth control initiatives, depicting them as tangential characters.⁹ Moreover, studies specifically dealing with nursing, midwifery, or health governance in postwar Japan, despite the centrality of birth control initiatives and related research, have focused chiefly on the practical aspect of these women as “birth control field instructors” and failed to notice their engagement with the science of birth control. Reasons for this omission vary. One obvious explanation could be that nurses and midwives who participated in the research/initiative were so few that historians have not seen the significance of studying them. Another might be that they rarely appear in historical materials on birth control research.

I argue that this lack of visibility reflects less the absence of contribution of female health care workers to a scientific endeavor than the gendered power relations in medical research during the period that obscured their contribution. It is important that historians of nursing and midwifery consider the possibility that nurses and midwives were, in the terms of Adele Clarke, “silenced” or rendered only “implicated” by the power relations naturalized in the specific setup of the research.¹⁰ From this perspective, the case study of Amari sheds new light on historiography. There is no doubt that Amari played a critical role in the three model-village study, but its significance becomes even more apparent when we consider that the study galvanized both the state birth control campaign and private family planning initiatives in later years and gained international acclaim among population experts.¹¹ Thus, an examination of Amari’s activities makes visible a group of actors whose contribution to population and health governance was critical but silenced or implicated by the hierarchical gender power relations in the population governance exercise.

While considering the position of midwives and public health nurses vis-à-vis the modern state, I stress categorically that these health care workers were not pawns of the state, but agents in their own right. They adopted or resisted the ascribed mediator role as birth control instructors depending on their personal circumstances and professional motivations. Even when they embraced the role, they were neither docile nor transparent assistants to the state. They did not merely pass packaged messages between the government and local people, but made their own judgments based on professional knowledge and skills, and adapted the policy to the needs of the people they were serving. To demonstrate these points, I use sources that broadly reflect the voices of midwives and public health nurses who worked as birth control instructors, alongside the specific materials that elucidate Amari’s role in the three-village study.

Both the state birth control campaign and the three-village study emerged from the health politics that unfolded under the U.S.-led Allied Occupation of Japan (1945–52). Therefore it is useful to explore health reform in Occupied Japan as it affected nurses.¹² To offer background and context to postwar birth control initiatives in which midwives and public

health nurses played a more pervasive role than clinical nurses, I focus on the impact of the reform on midwifery and public health nursing.

Reform of Nurses in Occupied Japan: Change and Continuity

When considering the history of nursing and midwifery in Japan over the twentieth century, many scholars regard the Occupation as a watershed because it subjected nurses and midwives to dramatic reform.¹³ The reform was possible because of the unchallenged U.S. political power in the Occupation. Americans influenced the reform in three primary ways. First, Americans serving the administrative body, General Headquarters (GHQ), initiated the reform. Brigadier General Crawford F. Sams, chief of the GHQ Public Health & Welfare Section (PH&W), employed Captain Grace Alt, a graduate of the Johns Hopkins School of Nursing with a Bachelor of Science degree from George Peabody College in Nashville, Tennessee, to head its Nursing Affairs Division and lead the reform. Second, under Alt's leadership, nursing education was based on the American model.¹⁴ On 11 April 1946, Alt instructed Japan's Nursing Education Council (*kango seido kenkyu kai*) to draft a new curriculum for nursing education based on that of American nursing schools.¹⁵ Third, the reform Alt proposed reflected an American view of the profession.¹⁶ At that time, nurses, midwives, and public health nurses in Japan were independent professional bodies due to their distinctive histories. Alt worked toward a system similar to what she was familiar with in the United States: a single regulation and organization governing all groups.¹⁷ To carry out the reform effectively, she actively liaised with leading Japanese nurses who were familiar with or sympathetic to American nursing. On 22 November 1946 a meeting was held to deliberate the launch of the Midwife, Public Health Nurse, and Nurse Association, and on 3 July 1948, the Public Health Nurse, Midwife, and Nurse Law 203 was issued. Both reflected American influence: the former was modeled on the constitution and bylaws of the American Nurses Association, while the latter defined public health nursing and midwifery not as an independent group but as a branch of nursing. Thus, under the Occupation, American nursing shaped development of female health care professionals in Japan.¹⁸

What specific changes did the reform of nursing bring to midwives and public health nurses? For the leaders of midwives, the reform meant weakening their professional autonomy.¹⁹ At the onset of the Occupation, midwifery was a well-established profession.²⁰ Its professional border had been clearly demarcated by the Midwives' Ordinance of 1899, which defined midwives as trained and registered health practitioners and specialists in normal births, familiar with anatomy, physiology, gynecology, and pediatrics, who complemented obstetrician-gynecologists charged with abnormal births. Since 1927, midwives had had their own nationwide professional organization, the Japan Midwives' Association. Toward the end of the Second World War, midwifery was an educated and organized professional body with more than 34,000 registered practitioners.²¹ According to historian of Japanese nursing Reiko Shimazaki-Ryder, Alt was suspicious of the midwives because she thought they retained a "taint of militarism and nationalism" due to their involvement in the aggressive pronatalist policy of the wartime government.²² Alt, as a member of the Occupation forces with the mission to democratize and demilitarize Japan, found the wartime cooperation problematic and tried to mitigate the power of the organization. Nevertheless, while the reform might have had political consequences for midwifery as an

organization, from the perspective of day-to-day work, it changed little. Many midwives simply continued to attend normal births. Changes eventually occurred, triggered not directly by the postwar nursing reform, but by factors such as the hospitalization of childbirth beginning in the mid-1950s.²³ Thus, it is fair to argue that the reform changed some aspects of midwifery while retaining others.

Nursing reform had a similar impact on public health nursing, in that one could observe elements of both change and continuity. The reform attempted to dissociate public health nursing from the discourse of health in the wartime regime, as it had done for midwifery. Public health nursing expanded in the 1920s, and initially intersected with the burgeoning humanist and socialist thinking that regarded ill-health as a manifestation of social ills and considered public health nursing a solution to the phenomenon.²⁴ The wartime climate fueled by the Second Sino-Japanese War (1937–45) transformed the position of public health nurses. With the logic that war “requires healthy soldiers to man a conscript army” and “Mobilization of the civilian economy for war requires welfare measures to secure a healthy, stable workforce,”²⁵ public health nurses were mobilized to protect and promote people’s health for the sake of the war. Under the April 1937 Public Health Law, they became core personnel in public health centers across Japan, identified as “providers of health guidance to improve physical fitness for war.”²⁶ From 1938 on, public health nurses responsible for the health of mothers and babies became even more valued, when the Ministry of Health and Welfare established in January that year stressed maternal and infant health in terms of its contribution to creating “healthy soldiers, healthy people” (*kenpei kenmin*).²⁷ Finally, the 1941 Public Health Nursing Regulation was aimed to professionalize the occupation for the sake of wartime mobilization. Thus public health nurses occupied a position in the health regime that, according to historian Yutaka Fujino, promoted fascism.²⁸ With the postwar reform infused with the ideology of democracy, public health nurses were actively encouraged to transform their profession to distance themselves from the wartime regime.

To provide a sharp ideological break from the prewar period, the postwar nursing reform changed the definition of public health nursing. The 1941 Regulation and its 1945 amendment – both part of the wartime effort – defined public health nurses and their professional duties. A public health nurse was an expert in guidance on disease prevention and health promotion, a promoter of health and hygiene for mothers and babies, and an assistant in patient care. Under the postwar Public Health Nurse, Midwife and Nurse Law 203, the definition was simplified; public health nurse was now a specialty licensed by the minister of health and welfare and dedicated to health guidance.²⁹

Despite the change, similar to midwifery, postwar public health nursing was built on prewar and wartime practice and infrastructure. One example is that at Kyobashi Health Center, one of the first urban health centers in Japan. The center opened its doors in 1935 as a training institution of the American-influenced and Christian-inspired St. Luke’s Nursing School, which, with support from the Rockefeller Foundation, had been a leader in developing public health nursing in Japan since the 1920s. Throughout the war, Kyobashi Health Center offered a model for public health nursing in cities and an avenue through which public health nurses developed expertise. In the postwar era the center continued these established

practices, though in new political, ideological, and administrative frameworks. In 1952, public health nurses conducted 12,551 home visits to oversee care of tuberculosis patients and infant diseases, and 40,353 consultations on a wide range of subjects from nutrition to mental hygiene.³⁰ There were also elements of continuity in public health nursing in rural areas. Analyzing the development of the model of public health nursing that flourished in rural Kochi Prefecture, historian Tetsuya Kimura argues that the presence and experience of public health nurses in the prewar era shaped the so-called Kochi method in the postwar era.³¹ Thus, in tandem with nursing reform, prewar infrastructure provided a foundation for development of public health nursing in the postwar period.

Aspects of change and continuity also existed in the expected role of public health nurses and midwives as agents of health for the state. In the prewar period, they had acted as intermediaries between state and people, and this continued as the state continued to intervene in people's health. However, the drastic sociopolitical changes after the war compelled the government to reconsider the tone of the rhetoric in its campaigns, and with it the articulated mission of midwives and public health nurses. The process of making the birth control policy and the state-endorsed birth control campaign attests to this point.

Postwar Japan's Population Problem and "Birth Control Instructors"

In addition to nursing reform, population growth was another concern of the GHQ.³² Between 1945 and 1948, birth rates rose and mortality declined, and the population increased by some 8 million people.³³ This phenomenon, coupled with the 1945 food shortage, fueled the argument that Japan was facing a population problem.³⁴ Americans working for the Occupation debated an imminent population crisis.³⁵ Partly due to U.S. involvement, the issue quickly became high on the agenda in Occupied Japan.

In the dispute over the population problem, the prevailing views with regard to high birth rates prompted the government quickly to establish infrastructure aimed at fertility reduction.³⁶ On 30 April 1946, the Ministry of Health and Welfare set up the Institute of Population Problems (*jink mondai kenky jo*, IPP) to investigate the problem and supply data analysis to government officials, politicians, and other interested parties for developing effective countermeasures. Based on Institute studies, the government adopted a series of reproductive policies to suppress birth rates. The 1949 amendment to the Eugenic Protection Law widened opportunities for women seeking induced abortions.³⁷ Also in 1949, the Pharmaceutical Law lifted the ban on use and sale of condoms and diaphragms. Finally, on 26 October 1951, the Cabinet decided on a fundamental policy to popularize birth control.³⁸ In response, the Eugenic Protection Law was amended in May 1952, with a clause that mandated establishment of "birth control field instructors" dedicated to popularizing birth control through guidance at the grassroots level. Also in 1952, the NIPH launched training courses in birth control for doctors and public health service leaders, and thereafter health centers across Japan were encouraged to launch a birth control campaign. Starting in 1954, the semiprivate, semigovernmental Study Group on Population Problems (*jink mondai kenky kai*), in which the IPP's Nobuo Shinozaki played a critical part, promoted birth control in private corporations via its New Life Movement.³⁹ Thus, during and immediately

after Occupation, the perceived population problem quickly became seen in terms of birth control policies and campaigns.

Public health occupied center stage in the birth control campaign because the government had initially advanced birth control as a means to protect maternal health rather than a solution to the population problem.⁴⁰ Maternal health in this context referred to reproductive health, which the government deemed had deteriorated quickly due to the 1949 Eugenic Protection Law amendment that led to rising abortion rates. With the 1951 policy, the government proposed contraception as an alternative to abortion.⁴¹ State public health agencies – responsible for maternal health since the prewar period – were entrusted to deploy the birth control campaign nationwide. Thus, the maternal health argument gave the public health sector the role of popularizing birth control across Japan.

The authorities nominated nurses, midwives, and public health nurses as birth control instructors. Midwives were regarded as best suited for the task because of their direct contact with women.⁴² At that time, nearly all childbirths in Japan took place at home attended by midwives, so they had the opportunity to advise women directly on matters linked to reproductive and sexual health, which could well include birth control. Thus, in 1952, when local authorities began training for the qualification “birth control field instructor” under the auspices of the central government, they targeted midwives, who became the majority of instructors. Public health nurses also formed a sizable part of the pool. Since the state campaign was also deployed via local health centers, public health nurses based at local centers and working for improving maternal health were singled out as instructors. Midwives and public health nurses who obtained the certificate had the right to sell contraceptives directly to the public. They collaborated with local doctors and health centers and taught local men and women – though mostly women – the benefits of birth control. They also made contraceptives available in marriage counseling,⁴³ home visits, and workshops.

How did midwives and public health nurses respond to their new role? Limited data preclude a full analysis, but fragmented sources indicate that some public health nurses carried out the task with a strong sense of mission. Kiwako Kodama, in Okuna Village in Ehime Prefecture, is a good example. Kodama, who since 1942 had “dedicated all her youth” to improving the health of the “poor village,” claimed, in the mid-1950s, that birth control was “something that left the biggest impact” on her career as a public health nurse. She developed an interest in birth control sometime between 1947 and 1949, when she noticed a sudden drop in village birth rates and heard a rumor that more and more women were having abortions. She suspected the declining birth rates had something to do with the incidence of abortions. Fearing that abortions damaged mothers’ health, from 1951 on she spent many nights doing research on birth control, frequented the local public health center to lobby for birth control, and integrated it into her own work. Kodama “preached, with fervor, on the sinfulness of abortion, its negative impact on maternal health and her talk even extended to child education and the future of the village.”⁴⁴

In February 1953, Kodama voluntarily attended a birth control training course organized by Ehime Prefecture and the health center, and persuaded the lecturer to visit the village. The

lecturer gave a seminar to 200 local women and an evening workshop with technical guidance to 25 local health practitioners. According to Kodama, by 1954 70 percent of the village women of childbearing age, 300 households, had participated in the birth control movement, and she was very proud that the village was nominated for the title “model ward in maternal and infant hygiene” (*boshi eisei moderu chiku*), in July 1953.⁴⁵

Others’ reactions were mixed. Most midwives were freelance at that time, and some resisted the government policy as they thought birth control would deprive them of their source of income.⁴⁶ Tamae Maeda, who practiced in Kobe, recalled that many midwives expressed frustration at a meeting sometime in the spring of 1953. At the gathering, intended to train midwives to become birth control instructors, many protested and heckled local public health personnel and the lecturer: “Who do you think we are!?” “Are you planning to snatch jobs away from us!?” “If we [go along with the policy] my business will suffer. Why do we have to do something that we know for sure will damage us? Who decided on this stupid policy? No, I won’t cooperate.”⁴⁷

Despite their misgivings, many midwives seemed eventually to agree to cooperate with the authorities. However, the motivations behind their decisions varied. Some, like Kodama, were driven by a sense of duty to protect mothers’ health. For instance, Fumie Kikuchi from Tokyo voluntarily took the training course in 1952, the first offered in the area, because she had observed an increased incidence of health problems in women and believed the deregulation of induced abortions triggered them. According to Kikuchi, “after the war, I began to witness cases where the placenta came out in a strange way or where bleeding unexpectedly occurred after labor. I interpreted that these occurred due to abortions... I felt, ‘that can turn into something serious; I need to put priority on controlling pregnancies.’” For this reason, she chose to become a birth control instructor.⁴⁸ Kakui Aoyanagi, who also practiced in Tokyo, embraced birth control from a moral standpoint: “With fervor, I instructed [women to practice] birth control so that precious lives would not be wasted,” although acknowledging the “contradiction inherent in midwives’ instructing birth control [when they should be promoting births instead].”⁴⁹ Other, more business-oriented midwives may have seen a benefit because instructors could benefit from sales of contraceptives.

The majority, however, simply followed policy, accepting it as inevitable. Midwife Sumi Nagasawa, practicing in a poor area of Adachi Ward in Tokyo, was initially skeptical, but it seemed she and her colleagues eventually went with the policy, concluding that it was yet another order “from the top.” She recalled: “During the war, midwives were constantly told that ‘quantity over quality’ was the state policy and so we were pressed to cooperate with the state to increase birth rates. And then, we were told it was the state policy [to reduce birth rates. Despite the contradiction]... still, we tried our best to comply with the state policy. ‘How naïve, sincere, and good-natured we are; we must be so easy to deal with’ – that’s the kind of conversation we were having back then among ourselves. We ridiculed ourselves, but we still cooperated.”⁵⁰

These testimonies vividly depict how midwives and public health nurses negotiated their role in the birth control campaign as intermediaries connecting state and people. However, it is crucial to note that this role was not introduced with the campaign, but had long

characterized their quality as female professionals. Since before the war, the state had expansively participated in social management and heavily depended on women's groups as intermediary actors.⁵¹ Midwives and public health nurses were one such group. They taught modern notions of hygiene to birthing women and their families, and through such work became quickly integrated into the network anchored by the state that aimed to transform Japanese people into a body of disciplined, civilized, and above all modern subjects.⁵² Their position remained largely unchanged in the postwar period, and the state made full use of it for its birth control campaign.

The voices of birth control instructors, however, simultaneously highlight that they were not just pawns of the state: their decisions to embrace or reject the role depended on their motivations. Whereas Nagasawa's testimony suggests that some midwives might have been "easy to deal with" from the government perspective, Maeda illustrates that others initially made it difficult for the authorities to implement the policy because they did not see financial incentives in the role.⁵³ Kodama and Kikuchi felt compelled to comply with the policy more from an acute concern over women's health than from allegiance to the elusive entity of the state. Thus, complex negotiation between female public health practitioners and the state characterized what at a glance appeared to be a straightforward "top-down" process of diffusing birth control across Japan. The reaction of the workers to the title "birth control field instructor" was mixed, yet many eventually embraced the new role, and accounts in later years praised their contribution to the dramatic fall in birth rates over the 1950s.

Tatsuyo Amari, a full-time midwife/nurse, served as a birth control field instructor in her rural community of Minamoto Village, so educating villagers on birth control and giving contraceptives were already part of her daily work. But she came to play an even more active role in the state birth control campaign when she became involved in the policy-oriented birth control research project called the "three model-village study."

Conduit Between State and People: Midwife/Nurse Amari

While government officials were drafting the birth control policy at the beginning of the 1950s, NIPH director Yoshio Koya (1890–1974) planned studies on contraceptive use to be conducted by his research team at the nascent Department of Public Health Demography, in the creation of which he had a major role. Koya was an elite medical researcher specializing in biostatistics who had combined research with policy-making since the prewar period. During the war, as a researcher promoting racial hygiene and an officer at the Ministry of Health and Welfare, he was instrumental in drafting the National Eugenic Law.⁵⁴ After the war, he remained an important scientific advisor to the government. He successfully persuaded minister of health and welfare Ryugo Hashimoto to lobby for a birth control bill, and as a member of the Population Problem Council he prepared a draft that culminated in the 1951 decision to adopt a birth control policy.⁵⁵ Koya's authoritative positions as Japan's leading medical researcher, racial hygiene advocate, and advisor allowed him to oversee the direction of reproduction policies in Japan.

The so-called three model-village study (*sanson moderu-mura kenkyu*) was the first part of Koya's research. It was an epidemiological/demographic study conducted by the NIPH

research team between 1950 and 1957 in three villages in the vicinity of Tokyo. In 1950, 1,161 families or 6,936 men and women participated in the study; in 1957, a total of 7,133 participated.⁵⁶ The chief objective was to evaluate the feasibility of the state-led birth control campaign. Because the campaign intended to suppress birth and abortion rates by promoting contraception, the study assessed whether there was a correlation between use of contraceptives and declining abortion and birth rates. It was also a pilot project for future nationwide birth control initiatives. In other words, the study was a preparatory exercise for implementation of the 1951 policy.

Mountainous Minamoto Village in Yamanashi Prefecture was selected as one of the three test villages because it had a well-established branch of the Imperial Gift Foundation Aiiku-kai, one of the few and very influential philanthropic organizations in infant and maternal health in rural areas.⁵⁷ Aiiku-kai was a particularly attractive collaborator because it was embedded in the network of politicians, health officials, and doctors based in Tokyo that churned out health-related policies and was integrated in rural communities via its branches. It thus had the capacity to enable the NIPH, part of the central network, to reach out to the rural communities, the target of the study.⁵⁸

Minamoto Village had one of the oldest Aiiku-kai branches. Kimiyo Yasaki, wife of a former mayor of the village, had long been committed to improving maternal and child health in her village and lobbied for a branch there. Minamoto Village Aiiku-kai opened in 1937.⁵⁹ It established itself as a core organization in the village by offering at an affordable price antenatal and midwifery services, health checkups for infants and babies, child care advice, and other public health services.⁶⁰ By the time the NIPH recruited it, the branch had close connections with the local health service, so it would be able to interact effectively between the NIPH research team and the local test participants.

The Aiiku-kai branch indeed acted as a local liaison, so day-to-day research activities occurred in conjunction with the branch. The office hosted meetings where NIPH researchers, prefectural health authority representatives, and Aiiku-kai personnel deliberated on study deployment. Aiiku-kai also recruited married members (mostly female) as research participants, and organized lectures on reproductive anatomy and birth control by Hiroshi Ogino, the NIPH obstetrician-gynecologist charged with the Minamoto experiment.⁶¹ Aiiku-kai set up consultation opportunities with Ogino, and distributed to the research participants contraceptives of their choice, such as condoms, diaphragms, jelly accompanied with syringes, sponges,⁶² and, later, foam tablets, along with information about the “safe period” method and sterilization.⁶³ It also facilitated periodical home visits. For local participants, Aiiku-kai was thus the most visible reference point of the study framework.

Within Aiiku-kai, full-time midwife/nurse Tatsuyo Amari was the most indispensable for the study. Originally from Minamoto Village, she began her training in 1944 at the prestigious nursing training school affiliated with Japan Red Cross Hospital in Tokyo. Her training was interrupted by the turmoil of the war so she only graduated in 1946, but immediately after graduation she got a job at the Minamoto Village Aiiku-kai via an introduction by the principal of the primary school. Aiiku-kai was looking for a midwife but could not find one and hired Amari because she was the closest they could find. Shortly thereafter Amari's

superior – the secretary of the local branch – recommended that she obtain a license in midwifery and in public health nursing because Aiiku-kai specialized in infant and maternal health. Amari obtained the two licenses in March 1947 and June 1948. Thus, by the time the three model-village study began, she was one of the health care workers qualified in nursing, public health nursing, and midwifery and well integrated in the local community.⁶⁴

Amari was in charge of the day-to-day running of the study, while Ogino visited the village every two weeks to supervise the project. In Ogino's absence, Amari conducted consultation sessions and handed contraceptives to participants from the stock the NIPH left at Aiiku-kai.⁶⁵ She learned from Ogino how to fit diaphragms and fitted women when he was not around, and led home visits on the NIPH's behalf. Thus, she maintained the link between researchers and subjects.

Amari's attributes worked favorably for the study. First, her employment at the local Aiiku-kai branch made her an attractive liaison. Because of her affiliation with the branch, she had regular contact with the NIPH team, in particular Ogino, who used the office as a local base. As an Aiiku-kai midwife/public health nurse, she was familiar with the research participants because she had been serving them as Aiiku-kai members. Second, Amari's personal background availed her when she was forging links between the NIPH and local people. As mentioned above, she was originally from Minamoto Village but had been based in Tokyo for part of her life. Because of her career choice she moved between the village and the capital, and between the lay and medical communities, and her ability to link the two disparate social and geographical domains helped her appear credible and trustworthy to both village participants and NIPH doctors.

More important, Amari was an invaluable birth control instructor. Because the study was as a pilot project, she was effectively a birth control instructor prototype. Her performance could affect the policy-making process in which the exact tasks of instructors were determined. For this reason, her day-to-day activities for the study should mirror a model practice. Amari lectured on how women could use contraceptives to avoid the adverse effects of abortions, in line with the argument supporting the 1951 policy. She fitted diaphragms, the contraceptive sanctioned by the 1949 Pharmaceutical Law. Through her "enlightenment" activities – to borrow Koya's term – Minamoto villagers would learn the benefits of birth control and eschew abortions, so birth and abortion rates would decline over time.⁶⁶ In other words, Amari represented the majority of birth control instructors commissioned to facilitate the flow of goods and knowledge about contraception from central authorities to people.

At the same time, in this setting Amari helped the bottom-up flow of knowledge, and this made her unusual as a birth control instructor. This aspect of her performance was manifested most tangibly in home visits. During these visits, Amari checked whether participants correctly filled in the postcard-sized calendar given to them at the beginning of the study to record their menstrual cycles. She interviewed all the participants and noted details such as choice of contraceptives, number of children, children's approximate age, and future family plans. These were cursory memos but contained personal information, for

instance: “Name: Mr. and Mrs. A [the memos noted their full names]; Number of Children: 3; Current Methods of Contraceptives: diaphragm and jelly; Notes: the youngest child in school this year. Planning to stop with three children.”⁶⁷ If a participant became pregnant, Amari tried to find out whether the pregnancy was due to failure in the use of contraceptives. For instance, she noted that Mrs. B, who chose to use a condom, was found to be pregnant between January and June 1930, and scribbled, “sometimes [Mrs. B and her husband] didn’t use [a condom] because they couldn’t be bothered.”⁶⁸

Amari passed the notes and the menstruation calendars on to the local Aiiku-kai branch office, which collated her data and made biweekly reports to the NIPH with lists and charts. ⁶⁹ Based on the reports, the NIPH team did a more sophisticated calculation on contraceptive use as well as birth, fertility, and abortion rates among test participants. Finally, Koya used the statistics to validate the state policy and state-sponsored birth control campaign he himself had promoted. Thus Amari was the first point at which data on Minamoto villagers’ reproductive habits and contraceptive use entered and traveled toward the “top.” Despite her seemingly insignificant “bottom” position, her contribution to the study was immeasurable: she generated and made accessible to NIPH researchers and Koya sensitive personal data that were absolutely essential for the study but would have been highly unlikely to be obtained without her involvement.

How did Amari react to the role? Unlike some of the abovementioned midwives and public health nurses, who actively decided to become birth control instructors, she was given the role was automatically because she worked for the Aiiku-kai. Moreover, birth control (“family planning,” the literal translation of *kazoku keikaku*) was just one of many jobs she had to attend to along with her routine midwifery work; therefore the NIPH work could easily be labeled low priority. Evidence suggests that Amari diligently carried out her tasks and was proud that she singlehandedly did the legwork for the study. On the records of the participants’ menstrual cycles, Amari said: “[I gave each woman] a card like [the size of] a postcard with dates of the year written on it, and we asked them to record the dates of menstruation, when it happened.... It was I who went around and visited the 100 people every month, and checked whether or not they ticked the dates of menstruation.”⁷⁰ Thus, although Amari did not choose initially choose to work for the NIPH, her professionalism drove her once the study began.

Moreover, although Amari generally followed NIPH instructions, she was not entirely passive. For instance, describing consultation sessions with research participants, she said:

[If a woman] wanted, for instance, the rhythm method, then I taught things like “from this day to that day is dangerous,” and to those who wanted a diaphragm... . Dr. Ogino taught me directly how to fit it, so I invited them to come to the Aiiku clinic and measured the size.... If [a woman] did not wish to use a diaphragm, I passed a sponge over to her.⁷¹

On the surface the quote seems to confirm Amari’s loyalty. The study made it a rule that participants should choose the contraceptive because Koya considered their autonomous decisions key to positive results. The quote seems to illustrate that Amari followed the rule, diligently allowing participants to use their own initiative. Nevertheless, it also suggests she

may have potentially influenced the study's direction. Recommending the sponge as an alternative to the diaphragm alludes to her power in changing participants' opinions on choice of contraceptives. Because participants' autonomy mattered greatly to the study, Amari's consultation sessions, in which women were encouraged to choose one contraceptive over another, could have had a tangible effect on the results.⁷²

There is no doubt that Amari's influence in the study was limited. Ogino regularly visited the village to check progress and even at times accompanied Amari on home visits, so it would be fair to say her activities were conducted under the watchful eyes of the NIPH. Nevertheless, one could argue that Amari was not an entirely transparent agent, and, subtle though her influence might seem, she might have contributed to shaping the three model-village study as a medico-scientific enterprise.

Amari's case points to the important role of Japanese public health nurses and midwives in the state-endorsed birth control policy and campaign. As the three model-village study maintained a symbiotic relationship with the state policy and acted as a model case for later initiatives, her position as a test birth control instructor illuminates state determination to use the mediating role of public health nurses/midwives to its full potential to actualize its policy. But Amari, and a very few public health nurses and midwives who took part in similar pilot projects, were not the mere "assistants" they were often portrayed to be, but had influence. Amari was an essential moderator for the pilot initiative and a producer of knowledge. As a result of her involvement, goods and knowledge pertaining to birth control traveled from both top to bottom and bottom to top. By taking part in the study and making herself useful to both parties, Amari expanded communications between state and people.

Conclusion

Amari's story underscores the significance of female health care workers' intermediary role in the birth control research and governance exercise. This view urges us to reappraise their position in current historiography, which has largely ignored their quality as research assistants or their position in larger social projects such as population control. The study also hints at a provocative message in the role of Japanese health practitioners in governing world population, in particular, the role nurses and midwives such as Amari might have had with Koya's birth control research. Although this article chiefly points out the critical role of midwives and public health nurses in the domestic context, perusal of the world history of population control might sustain a role beyond the national framework, especially when we consider that the Japanese experience became molded into the global discourse of population control in the 1960s as Koya broadcast the result of the three model-village study to the international community. In this context, the image and practice of Japanese public health nurses and midwives as birth control instructors may have had a role in a diffused global network working toward surveying and intervening in the reproductive lives of people in the "Third World," the target of the transnational population control movement that emerged in the 1960s from the narrative of overpopulation. In order to assess critically the achievement of nurses in an increasingly globalized period of modern history, we may want to critically explore the complexities in the activities of community-based health care workers not only

in the national framework, but also in the sites built on the nexus of local, national, and global health politics.

Acknowledgments

This work was supported by the Wellcome Trust [085926/Z/08/Z]. I am grateful to Mrs. Tatsuyo Amari for the interviews,¹ and to Ms. Seiko Koya and Mrs. Sayuri Arino for making my research in Minamiarupusu City productive. Special thanks to Professor Osamu Saito and Dr. Naoko Yoshinaga for sharing their materials on Aiiuku-kai, to Dr. Elizabeth Toon for stimulating dialogue, and finally to Professor Christine Hallett, Professor Rima Apple, and two anonymous reviewers of *Nursing History Review*, who kindly gave their time to read an earlier version.

Notes

1. As did English terms, Japanese terms referring to fertility control underwent changes throughout the country's history. Roughly speaking, jutai ch setsu, sanji ch setsu, and sanji seigen correspond to "birth control," whereas kazoku keikaku is a direct translation of "family planning." I adopt the term "birth control" following the terms used by Japanese officials at that time, but it must be noted that the above phrases were used interchangeably, and kazoku keikaku was used in the three-village pilot study that is the focus of the article. For details of the use of these terms, see Obayashi, Michiko. Sengo nihon no kazoku keikaku fuky katei ni kansuru kenky . Ochanomizu University 2006 Ph.D. dissertation For details of the birth control policy, see Obayashi, Michiko. Sengo no gyosei shido no jutai chosetu. Josanpu zasshi. 1987; 41:84–92. [PubMed: 3644034]
2. I was very fortunate to secure interviews with Mrs. Amari, as she is one of the few midwives or public health nurses involved in the study. According to the extant record, she was the only local midwife/public health nurse who supervised the study in Minamoto Village on a regular basis. Given that the study took place in only three villages in Japan, it is possible that fewer than ten midwives/public health nurses participated. However, it should be noted that Koya's research team conducted similar studies elsewhere, so the number in the birth control research led by the NIPH is sure to be greater than speculated here. Hereafter, following academic convention, I omit the title when mentioning Mrs. Amari.
3. Historians of various fields have taken an interest in the history of birth control in postwar Japan: Toyoda, Maho. Sengo nihon no b su kontor ru und to kurarensu gyanburu: dai 5 kai kokusai kazoku keikaku kaigi no kaisai wo ch shin ni. Jend shigaku. 2010; 6:55–70. Ogino, Miho. "Kazoku keikaku" eno michi. Tokyo: Iwanami shoten; 2008. p. 182–83. Obayashi, Sengo no. Tama, Yasuko. "Kindai kazoku" to bod poritikkusu. Kyoto: Sekaishisoshu; 2006. p. 29–30. p. 49p. 61p. 185–93. Obayashi, Michiko. Josanpu no sengo. Tokyo: Keiso shobo; 1997. p. 208–9. Although the majority of the works recognize the critical role midwives and nurses played in postwar Japanese birth control initiatives, few have adopted it as a central focus. The exception is Kayo Sawada's work, which aptly describes the role of midwives in birth control in postwar Okinawa. Sawada, Kayo. Beigun t chika Okinawa no josanpu niyoru hinin fuky katsud to sono heny : 'ripurodakutibu herusu/raitsu' no h ga kara 'kazoku keikaku' e. Jend shi kenky . 2005; 8:55–78. This focus does not negate the presence of active birth control initiatives outside the government domain. But, it should be noted that in Japan, even if many of these campaigns appeared independent of the state sector, they were often integrated into the network of body politics in which the state occupied an indispensable and far-reaching position. See Tama. Kindai kazoku. :231–66. for an insightful discussion on the layered meanings of the birth control movement in postwar Japan. For specific case studies, see Takeda, Hiroko. The Political Economy of Reproduction in Japan: Between Nation-State and Everyday Life. London RoutledgeCurzon 2005 Gordon, Andrew. Managing the Japanese Household: The New Life Movement in Postwar Japan. Gendering Modern Japanese History. Molony, Barbara; Uno, Kathleen, editors. Cambridge, Mass: Harvard University Asia Center; 2005. p. 423–51. Fujime, Yuki. Sei no rekishigaku. Tokyo: Fuji shuppan; 2005. p. 343–77. Ogino, Miho. Kazoku keikaku eno michi. Shiso. (2003); 925:169–95.

¹The author has exchanged consent forms with Ms. Amari in which both signed consent to publish.

4. On the relationship between birth control policies and population sciences in East Asian states, see Greenhalgh, Susan. *Just One Child: Science and Policy in Deng's China*. Berkeley: University of California Press; 2008. is insightful
5. A comparison can be made with the activities of female fieldworkers employed to carry out eugenic research by the U.S. Eugenics Record Office (ERO) at Cold Spring Harbor, New York, in the early twentieth century. The biggest difference between the American fieldworkers and Japan's Amari, which reiterates the central argument of this article, is that Amari had influence on both researchers and research subjects while the contribution of the American fieldworkers remained unidirectional. On the American fieldworkers, see Bix, Amy Sue. *Experiences and Voices of Eugenics Field-Workers: 'Women's Work' in Biology*. *Social Studies of Science*. 1997; 27:625–68. [PubMed: 11619412]
6. Examples of birth control projects deployed in the U.S. public health service are given in Schoen, Johanna. *Choice and Coercion: Birth Control, Sterilization, and Abortion in Public Health and Welfare*. Chapel Hill: University of North Carolina Press; 2005. For the history of U.S. public health nursing, see, e.g., Apple, Rima D. 'Much Instruction Needed Here': The Work of Nurses in Rural Wisconsin During the Depression. *NHR*. (2007); 15:95–111. Buhler-Wilkerson, Karen. *No Place like Home: A History of Nursing and Home Care in the United States*. Baltimore: Johns Hopkins University Press; 2001. Buhler-Wilkerson. *False Dawn: The Rise and Fall of Public Health Nursing in America*. New York: Garland; 1983. and Hamilton, Diane. *The Cost of Caring: The Metropolitan Life Insurance Company's Visiting Nurse Service, 1909–1953*. *Bulletin of the History of Medicine*. 1989; 63:414–34. [PubMed: 2686780]
7. See, for example, Früstück, Sabine. *Colonizing Sex: Sexology and Social Control in Modern Japan*. Berkeley: University of California Press; 2003
8. Homei, Aya. *Birth Attendants in Meiji Japan: The Rise of a Medical Birth Model and the New Division of Labour*. *Social History of Medicine*. 2006; 19:407–24. Nishikawa, Mugiko. *The Modern Midwife (Sanba) and the Transformation of Childbirth at the Local Level in Japan*. *US-Japan Women's Journal*. 2003; 24:82–101. Terazawa, Yuki. *The State, Midwives, and Reproductive Surveillance in Late Nineteenth- and Early Twentieth-Century Japan*. *US-Japan Women's Journal*. 2003; 24:59–81. Steger, Brigitte. *From Impurity to Hygiene: The Role of Midwives in the Modernisation of Japan*. *Japan Forum*. 1994; 2:175–87.
9. An exception is the works that deal with Margaret Sanger, a former district nurse who became one of the chief figures in the U.S. birth control movement during the early twentieth century. Another is Johanna Schoen's work, which details the practice of female health care workers such as nurse Lena Hillard, who played a critical role in birth control experiments in southern United States in the 1930s. Schoen. *Choice and Coercion*. :29–71.
10. Clarke, Adele E. *Disciplining Reproduction: Modernity, American Life Sciences, and the "Problem of Sex"*. Berkeley: University of California Press; 1998. p. 259
11. Obayashi underlines the importance of the three-village study in the history of birth control in postwar Japan. Obayashi. *Sengo nihon*. :43–57.
12. Nishimura, Sey. *Promoting Health in American-Occupied Japan Resistance to Allied Public Health Measures, 1945–1952*. *American Journal of Public Health*. 2009; 99:1364–75. 1371–72. [PubMed: 19542032]
13. For instance, see Tanaka, Sachiko. *Senryoki ni okeru nihon no kango kaikaku – hokenfu josanpu kangofu ho wo megutte –*. *Nihon ishigaku zasshi*. 2012; 58:106–7. Tanaka. *Senryoki ni okeru hokenfu josanpu kangofu ho no rippo katei*. *Kanagawa h gaku*. 2001; 34:117–81. Shimazaki-Ryder, Reiko; Ooishi, Sugino. *Sengo nihon no kango kaikaku*. *Nihon kango kyokai shuppansha*; 2003. Shimazaki-Ryder, Rieko. *Nursing Reorganization in Occupied Japan, 1945–1951*. *NHR*. 2000; 8:71–93. Hiraoka, Keiko. *Senryoki nio keru kango seido kaikaku no seika to genkai – hokenfu josanpu kangofu ho no seitei katei wo toshite –*. *Kangogaku togo kenkyu*. 2000; 2:11–27. Yufune, Sadako; Sadaoka, Minobu; Nishimura, Masako. *Transition of Nursing in Japan*. Niimi koritsu tanki daigaku kiy . 2001; 22:65–71. Endo E, Kato B, Kamisaka Y, Sakamoto M, Takahashi M. *History of Nursing in Japan*. 15. *Nursing Innovation in Postwar Japan*. *Kango kyoiku*. 1988; 29:624–31. [PubMed: 3060635]
14. For details, see Shimazaki-Ryder, Ooishi. *Sengo nihon*. :89–132.

15. The Council, established 25 March 1946 to organize the reform, consisted of GHQ officials, Japanese doctors, and leaders of nursing in Japan. For more details on the process, see Shimazaki-Ryder. *Nursing Reorganization*. :84.
16. Obayashi. *Josanpu no sengo*. :145–65.
17. As Obayashi argues, these were the “main aspects of the reform envisioned by the PH&W,” *Josanpu no sengo*, 6. However, it should be noted that the development of midwifery in the United States was very different from that in Japan. In Japan, midwifery established itself as a profession in the Meiji period independent of nursing, whereas U.S. development of professional midwifery kept close proximity to nursing, as the establishment of “nurse-midwives” attests. See Ettinger, Laura E. *Nurse-Midwifery: The Birth of a New American Profession*. Columbus: Ohio State University Press; 2006. Dawley, Katy; Burst, Helen Varney. *The American College of Nurse-Midwives and Its Antecedents: A Historic Time Line*. *Journal of Midwifery & Women’s Health*. 2005; 50:16–22.
18. Assessing nursing reform, Hiraoka argues that it did not lead to professionalization of nurses because: (a) the circumstances in the immediate postwar period required quantity of nurses rather than quality in nursing and this resulted in a structure whereby nurses were fragmented; and (b) the leaders from the old system, fearing the nurses trained under the new one might supplant them, hampered professionalization. Hiraoka. *Senryoki ni okeru*. :11.
19. Obayashi details the frustration of midwifery leaders for the occupation’s campaigns for the reform of nursing. See Obayashi. *Josanpu no sengo*. :5–23.
20. See note 12.
21. For instance, in 1943, a total of 34,702 midwives were registered across Japan. Kiyoko, Okamoto. *Josanpu katsudo no rekishiteki igi: Meiji jidai wo chushin ni*. *Josanpu zasshi*. 1981; 35:21–43. 40.
22. Shimazaki-Ryder. *Nursing Reorganization*. :87.
23. Obayashi. *Josanpu no sengo*. :242–63.
24. Okuni, Michiko. *Hokenfu no rekishi*. Tokyo: Igaku shoin; 2008. p. 16-70. Takahashi, Aya. *The Development of the Japanese Nursing Profession: Adopting and Adapting Western Influences*. London: RoutledgeCurzon; 2004. p. 133-42.
25. Kasza, Gregory J. War and Welfare Policy in Japan. *Journal of Asian Studies*. 2002; 61:417–35. 429–30.
26. During the period, the number of public health centers rose quickly, from 49 in 1938 to 770 by 1944. These centers each served a clientele of 100,000–130,000. Aldous, Suzuki. *Reforming Public Health*. :55.
27. A classic work showing how provisions for infant health were improved in times of war is Deborah Dwork, *War Is Good for Babies and Other Young Children: A History of the Infant and Child Welfare Movement in England 1898–1918*. London: Tavistock; 1987. For the Japanese context, see Shinmura, Taku. *Ken no shakaishi: y j , eisei kara ken z shin e*. Tokyo: Hosei daigaku shuppankyoku; 2006:229–44. Fujino, Yutaka. *K seish no tanj : iry wa fashizumu wo ikani suishin shitaka*. Kyoto: Kamogawa shuppan; 2003.
28. The number of public health nurses also expanded. According to Aya Takahashi, in 1940, 18,000 women were known to be working as public health nurses (*hokenfu*, “health women”). However, Takahashi assesses, “public health nursing did not develop in tandem with the public health project, but was caught in a black hole of administration.... [P]ublic health nursing was mainly a ‘public’ development. It was the passivity of nurses’ public role and the state-led development of public health nursing in Japan that explained the psychological weakness of nursing professionalism, and the almost complete absence of nursing politics in pre-war Japan.” Takahashi. *The Development of the Japanese Nursing Profession*. :155–56.
29. Sugawara, Kyoko. ‘Kokka shikaku’ toshite no hokenfu no sh en 2 – senry ki ni okeru hokenfu josanpu kangofu h no seitei katei wo otte –. *Gendai shakai bunka kenkyu*. 2002; 24:125–42.
30. Hishinuma, Michiko; Naruse, Kazuko; Yoko Oshikawa, Yoshiko Sakai; Mori, Akiko; Tashiro, Jyunko. History of a Health Center’s Activities in an Urban City in Japan: from 1935 to 1999 in Chuo-ku, Tokyo. *Seiroka kango daigaku kiyu*. 2002; 28:1–17. 4.
31. The Kochi model referred to a system of district nursing whereby a public health nurse employed by a prefecture or smaller administrative unit resided in a district and conducted health guidance. It

- was considered unique, as it was based on the district police system. Kimura, Tetsuya. *Ch zai hokenfu no jidai 1942–1997*. Tokyo: Igaku shoin 2012:46–66.
32. Oakley, Deborah. American-Japanese Interaction in the Development of Population Policy in Japan, 1945–52. *Population and Development Review*. 1978; 4:617–43.
 33. *Ibid.*, 619.
 34. O'Bryan, Scott. *The Growth Idea: Purpose and Prosperity in Postwar Japan*. Honolulu: University of Hawai'i Press; 2009. p. 146–48.
 35. Sato, Jin. Formation of the Resource Concept in Japan: Pre-War and Post-War Efforts in Knowledge Circulation. *Sustainability Science*. 2007; 2:151–58. Dinmore, Eric Gordon. Princeton University: 2006. *A Small Island Nation Poor in Resources: Natural and Human Resource Anxieties in Trans-World War II Japan*; p. 125–32. Ph.D. dissertation
 36. Shinozaki, Nobuo; Shokury kiki to sanji seigen. *Jinko mondai kenkyujo kenkyu shiryō No. 3. Sei to seishoku no jinken mondai shiryō shusei*. Ogino, Miho, editor. Vol. 8. Tokyo: Fuji shuppan; 2001. p. 92–94. 1 July 1946
 37. As Yasuko Tama contends, the de facto legalization of abortion by the Eugenic Protection Law was part and parcel of the government population policy aimed at curbing population growth. Tama, *Kindai kazoku*, 31. However, as the name of the law suggests and Ogino and Matsubara point out, the law's primary purpose was to control the quality of the Japanese population, and it had its roots in the prewar National Eugenics Law that legalized coercive practices such as involuntarily sterilization. Ogino. *Kazoku keikaku*. :159–71. Matsubara, Yoko. *The Enactment of Japan's Sterilization Laws in the 1940s: A Prelude to Postwar Eugenic Policy*. *Historia Scientiarum*. 1998; 8:187–201. Also see Norgren, Tiana. *Abortion Before Birth Control*. Princeton, N.J. Princeton University Press 2001
 38. There is no precise name for the policy; here I use such terms as “1951 policy” to refer to the Cabinet decision.
 39. The New Life Movement (*shin seikatsu undō*), which began in the late 1940s, was a network of initiatives triggered by cooperation among government ministries, private firms, and women's organizations and built on prewar and wartime campaigns to improve daily life by morality, frugality, household efficiency, and hygiene. For the promotion of birth control in the New Life Movement, in addition to the works listed in note 4, see Tama, Yasuko. *Sh sanko to kazoku seisaku*. Inoue, Shun'ya. *Iwanami kōza gendai shakaigaku 19 “kazoku” no shakaigaku*. Tokyo: Iwanami shoten 1996:159–88. Kimiko, Kimoto; *Kazoku. jendō, kigyō shakai – jendō – apurichi no mosaku*. Kyoto: Mineruva shobo; 1995.
 40. The government move to eschew the population control argument was based on the concern that it might be criticized for being draconian against the tide of democracy. However, it was not long before the government explicitly defined birth control as a means for population control. In 1953, the Ministry of Health and Welfare re-launched the Advisory Council on Population Problems (*jinkō mondai shingikai*), with an explicit mandate to endorse birth control to control Japan's population. As detailed below, Koya's political lobbying and scientific activities was pivotal to the move within the government. Tama. *Kindai kazoku*. :35–53.
 41. Koya, Yoshio. *The Program for Family Planning in Japan*. Series III, Box 94 [hereafter CGP-CLM Japan files], Folder 1539. Countway Library of Medicine; Harvard Medical School, Boston: 1952. n.d. c
 42. Obayashi. *Josanpu no sengo*. :219–21.
 43. The amended Eugenic Protection Act of 1952 also mandated that all prefectures and cities with public health centers be equipped with “eugenic protection consultation clinics.”
 44. In Japan, induced abortion became discussed in terms of religious sins around the end of the 1950s in part due to the anti-abortion campaign deployed by the religious organization *Seichō no ie*. See Tama, Yasuko. *Boseiai to iu seido: kogoroshi to chō zetsu no poritikusu*. Tokyo: Keiso shobo 2001:123–24.
 45. 644 Unit E1277 Slip no. 0377, Folder no. 200-0424-0432. *Jutai chōsetsu to tomoni aru hokenfu no kiroku*. Minamoto Aiku-kaikan hozon shiryō shū; Minamiarupusu City, Yamanashi Prefecture, Japan: 1956. n.d., c. [hereafter Minamoto Archives]
 46. Inoue, Ritsuko. *Sanba-san, 50-nen yarimashita Maeda Tamae monogatari*. Tokyo: Chikuma shobo; 1996. p. 167–68.

47. Inoue. Sanba-san. :165–66.
48. Obayashi. Josanpu no sengo. :209.
49. Nakamoto, Atuko. Kitto ii osan samba Aoyanagi Kakui to 16,000 no seimei. Tokyo: Seiryu Shuppan; 1998. p. 194
50. Nagasawa, Sumi. Sanba no Osumi-chan ichidaiki. Tokyo: Soshisha; 1995. p. 167 Obayashi. Josanpu no sengo. :220.
51. Sheldon, Garon. Molding Japanese Minds: The State in Everyday Life. Princeton, N.J.: Princeton University Press; 1997. p. 115–45.
52. See note 12.
53. Aya Homei elaborates the business aspect of midwifery in 1920s Japan. Homei, Aya. Midwives and Medical Marketplace in Modern Japan. Japanese Studies (Australia). 2012; 32:275–93.
54. The law, issued in 1941, was modeled on the equivalent law in Nazi Germany. On Koya's contribution to fascist Japan, see Matsumura, Hiroyuki. 'Kokub kokka' no y seigaku: Koya Yoshio wo ch shin ni. Shirin. 2000; 83:102–32.
55. Koya, Yoshio. Whither the Population Problem in Japan. Bulletin of the Institute of Public Health. 1951; 1:2–4. 2.
56. Koya, Yoshio. Seven Years of a Family Planning Program in Three Typical Japanese Villages. Milbank Memorial Fund Quarterly. 1958; 36:363–72. [PubMed: 13589726]
57. The Aiiku-kai was established in 1934 by an imperial gift to commemorate the birth of the crown prince Akihito in 1933. For a critical history of Aiiku-kai, see Saito, Osamu. Senzen nihon ni okeru ny y ji shib mondai to aiiku-son jigyo . Shakai keizaishigaku. 2008; 73:33–55. Yoshinaga, Naoko. The Modernization of Childbirth and the Indoctrination of Motherhood in Prewar Japan: The 'Aiiku-Son' Project of Imperial Gift Foundation 'Aiiku-Kai'. Tokyo daigaku daigakuin kyoikugaku kenkyuka kiyo. 1997; 37:21–29.
58. Obayashi. Sengo nihon. :45.
59. Saito, Osamu. Bosei eisei seisaku ni okeru ch kan soshiki no yakuwari – Aiikukai no jigyo wo ch shin ni. Senkanki nihon no shakai shudan to nettow ku – demokurash to ch kan dantai. Inoki, Takenori, editor. Tokyo: NTT Shuppan; 2008. p. 359–79.
60. Prefecture, Yamanashi, editor. Yamanashi-ken shi. Vol. 6-2. Kofu: Yamanashi nichinichi shinbunsha; 2006. p. 257–68.
61. Showa 30-nen nissai, Minamoto-mura boshi aiikukai. 1955. Unit A1214, Folder number 0300, 0129–0198, Files 030-0164-0165, Minamoto Archives
62. The sponge-and-salt method, in which a woman dips a sponge into a 10 percent salt solution and then inserts it into her vagina, was Koya's invention. She believed this method would be suited to farmers in Japan as salt was cheap and accessible even in rural areas and therefore could be an alternative to more expensive methods such as condoms and diaphragms. Koya, et al. Seven Years. :365–66.
63. Contraceptives such as condoms were initially distributed without cost, with a subsidized payment after the third year. Sterilization was "recommended only when the family was very poor and already had four or more children, or for reasons the Eugenic Protection law would permit." Koya, et al. Seven Years. :365.
64. Tastuyo Amari interview, Minamiarupusu City, Yamanashi Prefecture, Japan, August 17, 2012.
65. Tatsuyo Amari interview, Minamiarupusu City, August 4, 2013.
66. The three-village study demonstrated that both abortion and birth rates in the test villages plummeted over the period of experiment. While Shuji Kubo, a member of the NIPH team charged with the village of Fukuura, was skeptical that the guidance of the test birth control instructors truly caused the phenomenon, Koya, as mentioned subsequently, interpreted the result as bolstering the 1951 policy. See Obayashi. Sengo nihon. :46.
67. Kazoku keikaku. n.d., Unit E1298, Folder number 0200, 0601-0673, Files 0200-607, Minamoto Archives
68. Ibid., Files 0200-620.
69. Ibid., Files 0200-622-636.
70. Tastuyo Amari interview, 17 August 2012.

71. Ibid.
72. Ironically, however, the specific quote in the text could also be interpreted as confirming her docile nature. By recommending the sponge instead of the diaphragm, Amari might have, though inadvertently, assisted Koya, who wanted to try the sponge as a “simple” contraceptive method replacing the more “complicated” diaphragm, which he deemed less appropriate for the country people. However, my interview with Amari suggests that her professionalism as a health care worker also affected the ways she instructed the research participants. Koya, et al. Seven Years. : 366. Yoshio Koya (?), ‘Family Planning Practice in Three Test Villages (as of June 1, 1955),’ 1955, folder 1553, CGP-CLM Japan files; Kokuritsu k sh eiseiin eisei jink gakubu, “3 moderu-son ni okeru kazoku keikaku jisshi j ky ,” May 1954, Unit E1141-0241, Folders 190 0235-0294; Kokuritsu k sh eiseiin eisei jink gakubu, “3 moderu-son ni okeru ninshin j ky ,” 1 January 1954, Unit E1141-0241, Folders 190 0295-0298, Minamoto Archives.