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Discrepancies of Abortion Methods and Values Between Japan and the World

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Abstract

In this paper, the discrepancy in abortion methods between Japan and overseas and the discrepancy in attitude toward abortion between CEDAW and Japan were considered. Today, the global standard for first-trimester abortion is the use of MA and VA without the help of GA. However, in Japan, the 'obsolete' D&C and un-recommended GA remain used for early abortion, whereas neither MA nor VA has seen full adoption. This lagging of abortion technology is due to several reasons: the customary use of current methods, doctors' lack of concern and desire to maintain an advantageous status quo, the stigmatization of abortion, 'apathy and disdain' toward women and a lack of correct information, which this paper attempts to mitigate. The MHLW's suspicious notice and the Japanese government's reluctance to improve women's condition due to 'fetus over women' ideology demand more examination. We should turn our eyes to the real suffering of Japanese women and the possibility for MA to save them from agony. Women's reproductive health and rights are human rights that are their natural rights. We should then find a way to realize this pledge in Japanese society.

1. Introduction

On October 23, 1971, at the Symposium on Clinic and Office Abortion Procedures held in Madison, Wisconsin, USA, "the reign of the Dilatation & Curettage (D&C) over early abortion¹ had finally come to an end".² Symposium participants made this claim because clinical research studies conducted by respected organizations called for the adoption of electrical vacuum suction abortion, using the Karman cannula, as "standard medical practice".³ The newly adopted method and other aspiration techniques, such as the later-developed Manual Vacuum Aspiration (MVA), were integrated into a single category and are now known collectively as Vacuum Aspiration (VA). In

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¹ In this paper, only early abortions will be focused on because they occupy approximately 95% of all abortions in Japan. The issue of abortions due to prenatal diagnosis is important, but it is beyond the scope of this paper and should be discussed otherwise.

² Tunc, 2008, pp.82-83.

³ Ibid.

2003, the United Nation's World Health Organization (WHO) announced VA as the recommended technique of surgical abortion for pregnancies up to 12 to 14 weeks of gestation.⁴

On the other hand, abortion has been deeply associated with D&C in the minds of the Japanese. Even now, the jargon 'kakidasu (scraping out)' is often used to ironically implicate the curettage abortion frequently performed in this country. This association is made among not only lay people but also professionals. In 1998, a professional magazine article written by an OB/GYN doctor described the D&C procedure in detail as the abortion method for early pregnancies up to 12 weeks (LMP)⁵, whereas there was no mention of VA on the issue.⁶ In 2008, the Japan Society of Obstetrics and Gynecology included a chapter of "Dilation and Curretage [*sic*]"⁷ in its training materials for residents, but, again, VA was missing.

In this paper, such differences between Japan and other countries in terms of abortion methods and policies as well as their effects on women are discussed. The purpose is to unveil the obscured abortion problems that are latent and ignored in Japanese society and culture and to consider their consequences for women's lives. First, the perplexing reality of Japanese abortion healthcare is demonstrated, compared with the world's standards, and the reasons for discrepancy are discussed. Next, we review the jeopardized debate concerning women's health and rights between the United Nations' Committee on the Elimination of Discrimination against Women (CEDAW) and the Japanese government. Then, the vicious cycle created and supported by these medical and political conditions is examined in light of stigma and disempowerment. Finally, we seek a breakthrough to resolve the abortion problems and to end the 'apathy and disdain'⁸ plaguing Japanese women.

Background

The Japanese government has a history of policy changes to control its population by intervening in women's reproduction. In 1880, the government

⁴ WHO, 2012, p.2.

⁵ Kimura, 1998. LMP is the last menstrual period, which is commonly used by Japanese OB/GYNs but approximately two weeks longer than the actual gestational period.

⁶ Kitamura, 1998.

⁷ This kind of odd spelling suggests the indifference and distance of Japanese OB/GYNs on this topic, especially those written in English.

⁸ Grimes et al., 2006, p.2.

outlawed abortion with the newly introduced Penal Code and began a “give birth and multiply” policy. However, after its defeat in World War II, Japan partly legalized abortion by enacting the Eugenic Protection Law (EPL) in 1948 to curb the explosion of the population. Pro-natal policies eventually returned amid the rapid economic growth and shortage of workers in the 1960s. The government attempted to abolish EPL twice in 1970 and 1982 but was unsuccessful due to strong resistance from women. Japan is currently facing acute anxiety over a falling population, and signs of pro-natalism are returning.

Abortion has basically been prohibited for over one century now, but since the Second World War, almost all early abortions have been allowed by EPL and its revised version of Maternal Protection Law (MPL)⁹ with a catch-all excuse of “economic hardship”. Such hardship is assumed to be below the poverty line, so most women who want an abortion do not truly fit into this category. Moreover, the “economic indication” is not truly stipulated in the law in the strictest sense. However, the MPL-designated OB/GYN doctors¹⁰ take the law loosely and practically admit almost any women to have an abortion on demand if the pregnancy is early enough. This situation creates a gap between the law and reality, making almost all abortions appear legally as well as morally questionable and accordingly making abortion a social taboo.

On the other hand, abortion is generally regarded in society as a woman’s sin or as a sign of bad motherhood.¹¹ Abortion is often equated with a mother’s killing of her baby.¹² Such stigmatization of abortion is supported and strengthened by widely acknowledged and often chiefly Buddhist rituals for the aborted fetus, called ‘Mizuko Kuyo (literally “Water-baby Mass”)', introduced to the country by some religious and political leaders in approximately 1970.¹³ “Abortion and the rituals surrounding it are—emphatically and thoroughly—gendered phenomena”.¹⁴ Usually in Japan, only women are held responsible for abortion. Therefore, abortion should be among the very critical problems targeted by efforts to end gender discrimination in this country, but this importance is rather unacknowledged among the Japanese people.

⁹ EPL was revised in 1996, deleting all of the sections related to eugenics. See Kato, 2009. MPL’s direct translation is “Mother’s Body Protection Law”, which is an embodiment of the government’s view that treasures women’s bodies but not their minds.

¹⁰ They are the only people authorized to perform legal abortion in Japan.

¹¹ This perception underlies the rituals for the dead fetuses.

¹² Tama, 2001, p.162.

¹³ Several authors write books on the subject in English including: Hardacre, 1997; LaFleur, 1992.

¹⁴ Hardacre, 1997, p.11.

2. Discrepancy in Abortion methods

Japanese Dependency on D&C

Many Japanese OB/GYN doctors are very proud of their D&C technique. In a medical textbook of 1980, a Japanese OB/GYN doctor boasted: “As for the surgery (of artificial abortion), the Japanese designated doctors for the EPL are leading the world in respect to their experiences and techniques”.¹⁵ Apparently, he believed that their art of curettage was superior to other unfamiliar methods. However, accidents with D&C are not rare, as an article in the JSOG reports:

D&C is the most frequently performed minor surgery in daily OB/GYN practices which takes a rather short time, but medical accidents in relation to D&C are repeatedly reported. The analysis of 1,687 OB/GYN medical accidents collected by JAOG (Japan Association of Obstetricians and Gynecologists) during 1983 to 2002 shows the incidents in the process of D&C is 8 % of all the OB/GYN medical accidents. The most common accident caused by D&C was uterus puncturing [...]. Among all, the puncturing amounts to 40 % in all of the D&C operation errors.¹⁶

However, the author strangely never considers the possibility of switching from D&C to another safer method to prevent another accident.

Kiyoshi Uchide has reported¹⁷ a similarly baffling example of an actual medical accident by curettage¹⁸ in 2003, in which an abortion patient died after experiencing the perforation of her uterus and intestine during an abortion surgery at a prestigious university hospital in Japan. The hospital admitted the medical error, but both the comment of apology released from the hospital and the verification report of the accident by the third party failed to detect the real problem: the dependence on curettage, despite the repeated citations of the risk of perforation posed by this approach.¹⁹

¹⁵ Sugiyama, 1980, p.152.

¹⁶ Makino, 2009, pp.N435-N438.

¹⁷ Presented at a workshop of the 31th Congress of the Japanese Association for Philosophical and Ethical Researches in Medicine on 17 November 2012 in Kanazawa.

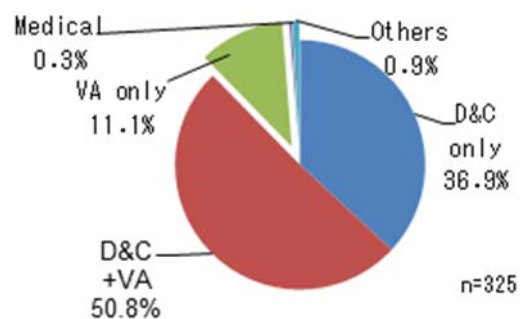
¹⁸ From the presentation material provided by Dr. Kiyoshi Uchide for the above-mentioned workshop on 17 November 2012. According to Uchide's report, the accident occurred at one of the leading medical schools in Japan, Jikei University School of Medicine Hospital in December 2003.

¹⁹ Nakamura & Okamura, 2009; Kimura and Saito, 1998. Kimura and Saito noted cervical

Typical Abortion Surgery in Japan

Our 2010 nationwide survey²⁰ has proved for the first time that D&C is the method of choice for terminating early pregnancy among Japanese OB/GYN doctors. In total, more than 88% of respondents continue to use D&C for abortions for pregnancies less than 12 weeks LMP (the breakdown was as follows: D&C alone was 37%, the combination of D&C and VA was 51%²¹, and VA alone (without the help of D&C) was only 11%²²). (Figure 1)

Figure 1. Principal Method for 1st Trimester Abortion



In addition, most OB/GYNs preferred general anesthesia (GA) for their surgery (Figure 2). The survey also revealed that 83% of the respondents have used D&C at least once in their lives, compared to the 49% who have never used VA at all.

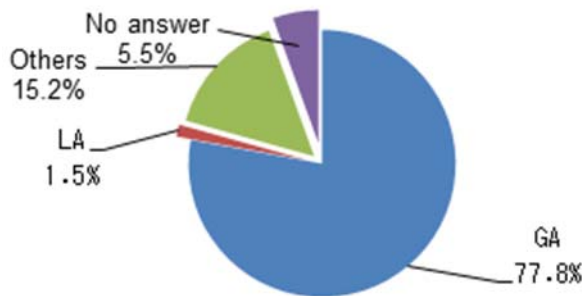
lacerations, inflammation and other complications besides perforation.

²⁰ Kinefuchi, 2011. This survey was conducted by Mieko Kinefuchi, Maki Mizuno and Kumi Tsukahara for the Grant-in-Aid for Challenging Exploratory by Research Japan Society for the Promotion of Science (JSPS) contributed to Dr. Kiyoshi Uchide of Kanazawa University in 2010 FY. The results were reported on Nov. 29, 2011 in Kyoto. In this study, we sent a self-administrated questionnaire by mail to Japanese doctors in 932 designated OB/GYN clinics and hospitals in listed up from the Yellow Pages and obtained 343 responses (collection rate of 36.8%).

²¹ The breakdown of combinations of D&C and VA was as follows: 28% of them applied “VA before D&C”, and 23% “D&C before VA”.

²² In the Japanese questionnaire, we used the term “souha”, which literally means “curettage”, but dilation is necessary before the curettage. Therefore, “souha” is equated to D&C in this paper.

Figure 2. Anesthesia Used with the Principal Method



The result appears surprising because D&C is a rather invasive and intricate technique, as a caring Japanese female OB/GYN doctor describes below:

The patient lies on an operating table and opens her legs widely to be strapped each of them on the clasp. Usually, it is operated under general anesthesia by intravenous drip infusion. Therefore, the surgery will be over while the patient is asleep. First, use the speculum to fix the opening of the vagina firmly. Next, pull away the laminaria rod or other dilators having been inserted one day before to dilate the uterus. Then, clean and sanitize the affected area before use forceps to fix the opening of the uterus firmly, and insert uterine sound in order to probe the interior of the uterus. [...] After this examination, use a set of cervical dilators (such as Hegar type) to stretch out the uterus opening little by little.[...] After the uterus opening becomes wide enough, insert the placental forceps into the uterus, and pull out the uterine contents. In case of early pregnancy, most of the removed contents are villus and some endometrial membrane [...] there will be some bleeding. [...] After pulling out the villus, use the curette to scrape the deciduous membrane in order to clean up the inside of the uterus. During the above process, administer oxytocic to stimulate uterine contraction. [...] This is the abortion surgery for pregnancy in early gestation. Usually, the operation itself takes about three to five minutes.²³

²³ Kono, 1999, pp.110-112.

Note that all the medical apparatus and such intervention will be gone only if the doctor uses abortion pills instead. This surgery method also involves the risk of perforation mentioned earlier, which the author explains as follows:

The process seems simple and easy, but the surgery is performed in a blind way since doctors cannot see the inside of the uterus. Doctors feel their way to scrape out the villus, fetus and endometrial membrane as well as blood. [...] any experienced doctor cannot help perforate the uterus at least one time in her or his life. Sometimes uterine perforation causes peritonitis with acute stomachache and high fever, requiring an additional abdominal operation.²⁴

Such a painful and dangerous image of ‘the abortion’ is more or less shared among the Japanese.²⁵ Partly due to the media frenzy of ‘Mizuko Kuyo’ from the 1970s to 1990s and popular novels and even in sex education, abortion is associated with blood, cruelty and harrowing episodes²⁶ in many people’s minds. Therefore, the stigma of abortion deepens, strengthening ‘apathy and disdain’ toward women.

Safe Abortion as Women’s Rights in the World

In contrast to the common Japanese view of abortion, the image of abortion in the women’s reproductive health framework is completely different. An article on a WHO report proclaims the following:

Access to safe, legal abortion is a fundamental right of women, irrespective of where they live.²⁷

In such a framework, abortion is defined as an innate right of women—that is, not as a charity or offering given from authority. Under this framework, an unsafe abortion is considered a threat to women’s health as well as rights. Consequently, safer and more decent abortion methods have been aggressively explored in the world.

²⁴ Ibid, pp.112-113.

²⁵ This depiction also attests to the fact that curettage in abortion surgery is usually performed without the help of ultrasound in Japan.

²⁶ This shared image may be related to the discourses in rituals for aborted fetuses.

²⁷ Grimes et al., 2006, p.1.

After all the scrutiny and comparisons, the international community has decided on standard abortion methods that are completely different from Japanese doctors' preference. As we mentioned earlier, in the 2003 1st edition of "Safe Abortion", the WHO recommended not to apply D&C unless a safer method, either VA or Medical Abortion(MA)²⁸, is unavailable, citing the vast mass of scientific evidence in favor of this approach²⁹. In the 2nd edition of "Safe Abortion" published in 2012, WHO's attitude toward D&C became harsher.

Dilatation and curettage (D&C) is an obsolete method of surgical abortion and should be replaced by vacuum aspiration and/or medical methods.³⁰

In a similar manner, not only for early abortions but even for D&E³¹ in the second trimester, the WHO negated the regular use of GA,³² which remains standard for first-trimester abortions in Japan.

On the other hand, the WHO recommended MA as one of the primary first-trimester methods along with VA. MA is a non-surgical method that essentially uses two drugs: mifepristone³³ and misoprostol. This method may be used immediately after the woman confirms the intrauterine pregnancy³⁴ or throughout the first trimester. Mifepristone and misoprostol are now included in the WHO's essential drug list, and a combination of these two drugs is known as "both safe and effective" for the purpose of the early termination of pregnancy.³⁵

After all, both of the WHO-recommended safe early abortion methods, VA and MA, have not yet been fully adopted in Japan.³⁶ In this context, we may say that Japanese abortion healthcare is lagging and that the cause of such a lag should be determined.

We are not suggesting that replacing D&C with other "superior" methods is indispensable. Rather, it may be that Japanese doctors are obligated to prove the superiority of Japanese methods, if they believe in them, for the improvement of

²⁸ MA will be fully discussed later.

²⁹ WHO, 2003, p.20.

³⁰ WHO, 2012, p.31.

³¹ Dilution and evacuation is an OB/GYN surgery to be used for second-trimester abortions, which are not common in Japan. This paper will not cover this topic due to space limitations.

³² WHO, 2012, p.49.

³³ Also called as Mifeprex, RU486 etc.

³⁴ WHO, 2006, p.11.

³⁵ WHO, 2012. P.49

³⁶ Karman cannula has not been adopted in Japan and metal cannulas are commonly in use; in this way, the Japanese VA differs from international standards.

world technology. However, at present there is no evidence that Japanese D&C is superior to MA and VA. In addition, MA and surgical methods are very different. “Women should be given a choice of method”.³⁷ Japanese doctors must acquire more variations in their repertoire.

It is unjust for Japanese women to live with a possibly less effective and unsafe method without any alternatives simply because we live in this country.

Reasons for this Underdevelopment

There must be reasons why a highly technological country such as Japan is underdeveloped in terms of abortion technology compared to world standards. There are several possible explanations for this phenomenon.

First, Japanese OB/GYN doctors began to use D&C very early when other countries prohibited abortion. In other countries, even when abortion was illegal, D&C was used as an emergency treatment to save the life of the mother or in a clandestine procedure. When Japan legalized abortion in the 1940s, 20 or 30 years prior to other Western nations, D&C played the primary role of curbing the population by hundreds of thousands of people per year. Therefore, Japanese OB/GYN doctors were highly accustomed to the method by the time other countries started legalizing abortion.

Second, the designated doctors are secured by and benefit from the designation system itself. For example, these doctors are virtually monopolizing the Japanese abortion market. In addition, they are free to set their price and quality of their services because abortion is a private practice not covered by medical insurance. Consequently, abortions are a lucrative procedure in Japan³⁸. The average price per abortion is approximately ¥100,000³⁹ (\$833: \$1=¥120) for a first-trimester abortion, a level much higher than in other countries. It is likely that these facts discourage the doctors from challenging the status quo.

Third, the doctors may be uninterested because there are no claims from abortion patients. The silence is supposedly primarily due to the abortion stigma, which is defined as “a negative attribute ascribed to women who seek to terminate a pregnancy that marks them, internally or externally, as inferior to ideals of womanhood”.⁴⁰ The abortion stigma makes a woman who has had an

³⁷ Berer, 2005, p.9.

³⁸ Brasor and Tsubuki, 2012.

³⁹ Kinefuchi, et al., 2011.

⁴⁰ Kumar, Hessinia and Mitchell, 2009, p.4.

abortion feel ashamed, valueless and disempowered and blame herself.⁴¹ If she remains silent, the abortion healthcare will not change, and she will have the same experience again, or another woman will be stigmatized again. Once this vicious cycle is set, nothing will change within the cycle; instead, the number of stigmatized women will increase, and their collective scar will deepen.

Another problem is that Japanese women who have had an abortion have no idea how they were treated because of GA. These women thus lose not only the chance to recognize the poor service and place blame but also the chance to gain agency and become stronger, experiencing empowerment. For this reason alone, abortion poses a very critical problem to be targeted by efforts to end discrimination against women.

Finally, another possibility is that doctors have lost the chance to notice the preeminence of MA in the world. Language barriers are behind this problem. For most Japanese people, especially busy doctors, crossing language barriers is not easy. Even in the Internet age, people tend to turn to information from translated materials and obtain a quick impression of the news, and if this news fails to catch their concern, they will save themselves the trouble of searching further. For them, online news as translated by a reliable party is convenient insofar as the translation is good; otherwise, there is a risk of being misinformed. The following section will present how the information on mifepristone (RU486) provided by the Ministry of Health, Labour and Welfare (MHLW) of Japan is insufficient and biased.

MHLW's Misinformation

At first glance, the MHLW's notice⁴² appeared dubious because the issue in October 2004 contains the FDA's announcement from November of that year. After my inquiry on the phone to the MHLW, the notice was revised. However, several problems remain, as we observe below. Before we continue, recall the fact that the Japanese government has not approved mifepristone.⁴³ It may be that this policy reflects the MHLW's peculiar notice on the pill, which appears to

⁴¹ Hase, 2003, p.14.

⁴² The notice was issued from the Compliance and Narcotics Division of Pharmaceutical and Food Safety Bureau in the MHLW.

⁴³ As for Misoprostol, which also may be used alone (that is, without mifepristone, although the success rate is slightly lower) has been already approved in Japan as a drug to treat gastric ulcers. However, the company selling misoprostol in Japan limits the usage of the medicine to the originally intended purpose, strictly prohibiting the use by pregnant woman because "it may cause miscarriage". Therefore, there is no possibility of using misoprostol to terminate pregnancy.

have been strangely manipulated.

The objectives of the two-page notices are essentially identical: to alert people to the danger of online shopping of “oral abortifacient unapproved in our nation” and to alert the public about the risk of mifepristone (Mifeprex).

One of the MHLW’s notices (issue date is unknown) partly quotes from a few items from “2005 and 2006 FDA Alerts and Updates on Mifeprex”. When we read these excerpts in Japanese (translated below), each of them appears as though the entire sentence was copied:

*You should not buy Mifeprex over the Internet.

*Mifeprex has special safety restrictions on how it is distributed to the public.⁴⁴

In fact, the first sentence in the pertinent page of the US Food and Drug Administration (FDA) ends with the following phrase:

... because you will bypass important safeguards designed to protect your health (and the health of others).

Likewise, the second sentence is followed by another informative sentence:

... Also, drugs purchased from foreign Internet sources are not the FDA-approved versions of the drugs, and they are not subject to FDA-regulated manufacturing controls or FDA inspection of manufacturing facilities.⁴⁵

The FDA’s intention is clear: it aims to alert to the risk of foreign drugs purchased through the Internet and to suggest the merits of buying the FDA-approved drugs on the safeguarded regular route. The fact that Mifeprex is sold in USA is missing from the MHLW’s notice. This analysis leads us to the following suspicion: “Does the MHLW deliberately cut the above passages in order to hide the fact that the Mifeprex (mifepristone) has already approved and sold on regular sales channel in the USA?”

Let us analyze another MHLW notice on 25 October 2004, which alerts to

⁴⁴ MHLW, 2013.

⁴⁵ US FDA, 2011a.

the danger of the oral abortion pill by stating the following:

In November 2004, the latter messages are added to the [US FDA's] alert section of product document [of Mifeprex]: serious bacterial infections and sepsis, rupture of fallopian tube after administered to a patient to ectopic pregnancy.⁴⁶

In fact, this was 'news' in the United States and the product label was corrected accordingly when several accidents became known. However, in the US, these "accidents" were quickly and thoroughly investigated, and the cause was soon determined. The FDA immediately announced the newly found information, and the label was corrected again in 2005 to explain that such accidents are "atypical" and caused by very rare bacteria called *Clostridium sordellii*, providing an explanation of how to identify the signs of infection in the unlikely event of occurrence.⁴⁷ The current label as of 2011 no longer mentions sepsis.⁴⁸ The old label excerpted by the MHLW may now be found on the page of "Approval History".⁴⁹ On the other hand, even 9 years after the first reports of these accidents, the MHLW has continued to ignore the additional information supplied by the FDA.⁵⁰

The MHLW also announced in its notice that the government had begun to strengthen surveillance of the agencies for private importation and to limit individual imports of the pill as well. An obvious loophole for this restriction was presented. The notice added the following: the import of the pill is possible "when the director of the Local Bureaus of Health and Welfare has confirmed that the pill was imported in pursuance to a doctor's prescription".⁵¹

However, such importation does not seem to be feasible. Because, as we will see, doctors have such a biased view regarding abortion pills, it should be difficult to find a doctor who willingly writes the prescription.

⁴⁶ MHLW, 2004.

⁴⁷ Because the tubal rupture is a result of ectopic pregnancy (EC), and EC is one of the contraindications to the medication, the MHLW's alert appears both incorrect and inflated.

⁴⁸ US FDA, 2011b.

⁴⁹ US FDA, 2011c.

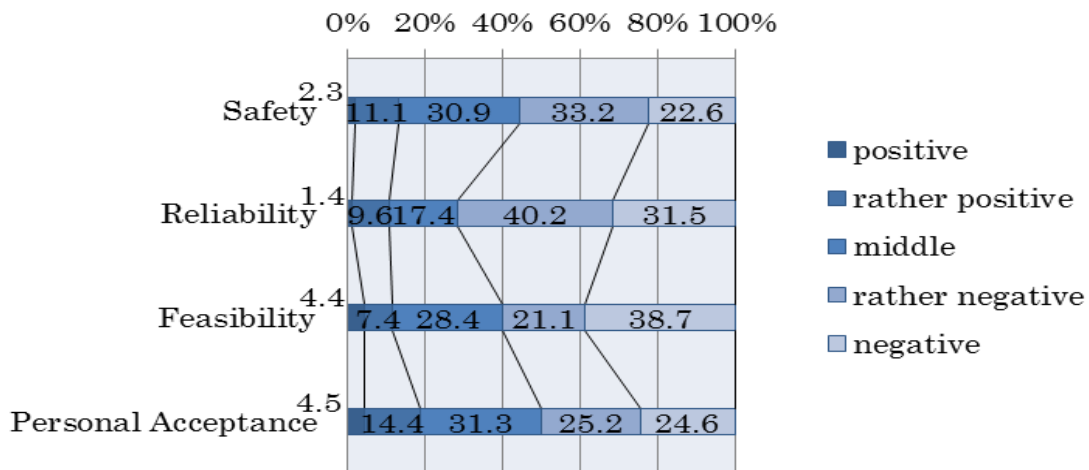
⁵⁰ Similarly, the statement appears to be too sensational, if not plainly false: "The oral abortifacient unapproved in our nation is known as to cause hemorrhage which sometimes requires surgery to cure, and the prescription and the follow-up of the doctor is required for the medicine in the other western countries. Thus, this drug should not be imported by individuals nor used easily in order to prevent health hazards." MHLW, 2004.

⁵¹ Ibid.

OB/GYN Doctors' Attitude toward Mifepristone

One of the most viable alternatives for early abortion continues to be MA, which appears to be unappealing to Japanese OB/GYN doctors. The results of our 2010 survey⁵² show that less than half of OB/GYN doctors are interested in the use of RU486 (mifepristone) and MA, with 10% being “very interested” and 34% “somewhat interested”. In addition, doctors did not have favorable impressions of RU486. Answering questions concerning the safety of RU486, those responding positively amounted to a mere 13% in contrast to those responding negatively, who amounted to 56% of all respondents. Likewise, with regard to the reliability of RU486, those responding positively amounted to a mere 11%, but those responding negatively amounted to as much as 72%. These bad impressions, which are likely due to a lack of correct information about RU486, led almost 60% of responding doctors to feel negatively about the feasibility of introducing RU486 to the Japanese clinical setting. Finally, almost half of doctors responded negatively about their personal acceptance of RU486. (Figure 3)

Figure 3. Images of RU486 among OB/GYN Doctors



Overall, Japanese OB/GYN doctors are observed as having a rather biased view on the abortion pill, which may be partly due to the MHLW's (or, we

⁵² Kinefuchi, et al., 2011.

should rather say, the government's) biased information, as we will demonstrate later. Our next question then concerns what is behind the government's anti-MA attitude.

3. Discrepancy of Abortion Views

The Sixth Periodic Report to CEDAW

Let us see the Japanese government's seemingly biased attitude toward women observing in depth the course of debates with a UN body. The Committee on Elimination of Discrimination Against Women (CEDAW) is a United Nation's committee that monitors and recommends to the contracting parties the implementation of the International Convention on the Elimination of All Forms of Discrimination against Women (the Convention).

CEDAW has shown concern about Japanese women's health problems, as is evident in the recent negotiation on the sixth periodic report from Japan to the UN committee. CEDAW has repeatedly cited two particular concerns regarding Japanese women's health. The first is to change the law to decriminalize abortion performed by women to themselves, and the second is to inquire women's psychological and mental healthcare.

In its General Recommendation No. 24 (20th session, 1999) on women and health, CEDAW called for the UN member states to amend legislation to decriminalize abortion, as shown below.

When possible, legislation criminalizing abortion could be amended to remove punitive provisions impose on women who undergo abortion.⁵³

All of the ratified nations including Japan should have complied with these general recommendations. However, as if in response to this recommendation, the Japanese government revealed its position in the additional statement on women's contraception in the paragraph 362 of the sixth periodic report of States parties on 8 September 2008;

Regarding artificial abortions, [...] any measures or changes related to abortion within the health system can only be determined at the national or

⁵³ UN WOMEN, 2009.

local level according to the national legislative process. Since artificial abortions in Japan are regulated under the Penal Code and the Maternal Protection Law, it is illegal to have an artificial abortion when it is in violation of either of these laws.⁵⁴

This statement is outrageous. The government ignored the fact that the convention should supersede national laws, and there is an obvious reluctance to promote women's wellbeing. Here we observe an example of 'apathy and disdain' toward women.

Japan's Stand on Criminalization of Abortion

Before we continue, let us observe Japan's Penal Code. Article 212 of the Penal Code states the following: "When a pregnant woman causes her own abortion by drugs or any other means, imprisonment with work for not more than one year shall be imposed." The current MPL technically exempts abortion for very limited reasons: (1) A mother whose health may be affected seriously by the continuation of pregnancy or by delivery for physical or economic reasons; (2) a mother in question whose pregnancy was conceived from fornication by violence or threat or while unable to resist or refuse.

Consequently, Japanese laws only allow abortions when there is a serious physical health problem, serious life-threatening poverty, or a sexual offence in a strict sense. Needless to say, these exemptions are not enough to attain the goal of reproductive health that WHO strives for.

Within the framework of WHO's definition of health as a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, reproductive health addresses the reproductive processes, functions and system at all stages of life.⁵⁵

Accordingly, these drawbacks, the continued criminalization of abortion in the nation and the lack of prioritization of women's mental health are sufficient to constitute violations of the Convention.

Moreover, the government justified its position on abortion by appealing to the nation's autonomy. To the direct question from CEDAW, "does the

⁵⁴ Government of Japan, 2008.

⁵⁵ WHO, 2014.

Government plan to decriminalize abortion?”, the government replied negatively on 14 April 2009 and emphasized its position as follows:

The Penal Code of Japan defines abortion as a crime, recognizing the life and physical safety of a fetus as the primary interests and the life and physical safety of a pregnant woman as the interests protected by law. Under the Maternal Protection Law (Law No. 156 of 1948), abortion is allowed only when it is performed by a doctor who has been designated under the provision of the first paragraph of Article 14 of the Maternal Protection Law from the perspective of protecting the life and health of the mother.⁵⁶

Here, the government finally reveals its “fetus before women” ideology; that is, its pro-natalism. This ideology may somehow explain the MHLW’s incongruous notices. From the pro-natalist perspective, MA is a dangerous drug that may entice women to abort their fetus easily due to its convenience as well as its physical and mental safety. However, if they take the women’s perspective, less risk and a less stigmatizing means of addressing an unwanted pregnancy is not bad at all. We will return to this theme later.

To the above-mentioned government’s fair-faced but non-compliant attitude, CEDAW again admonished the government on 7 August 2009 to change its policy by recommending that:

[T]he State party amend, when possible, its legislation criminalizing abortion in order to remove punitive provisions imposed on women who undergo abortion, in line with the Committee’s general recommendation No. 24 on women and health and the Beijing Declaration and Platform for Action. The Committee requests the State party to include in its next report information on the mental and psychological health of women.⁵⁷

This statement was the final position of their last debate on the 6th report. We are not sure yet when and where the two parties will reach an agreement, which may be a long way away, but we should continue to watch their maneuver such as providing misinformation, changing the subject, and stigmatizing and

⁵⁶ Government of Japan, 2009.

⁵⁷ CEDAW, 2009.

disempowering women, as we have seen on the notices of abortion pills and insincere responses to CEDAW over the legalization of abortion.

Another important topic presented by CEDAW is women's mental and psychological health. The criminalization of abortion may cast a large shadow over women's mental health. It is arguable that we need it because in the world, there are countries that do not criminalize abortion at all, such as Canada. In addition, we may reconsider why we 'must' criminalize all abortion by laws even when the product of conception remains an 'embryo', which has a good chance of being naturally aborted if let alone.

Making Early Abortion Earlier

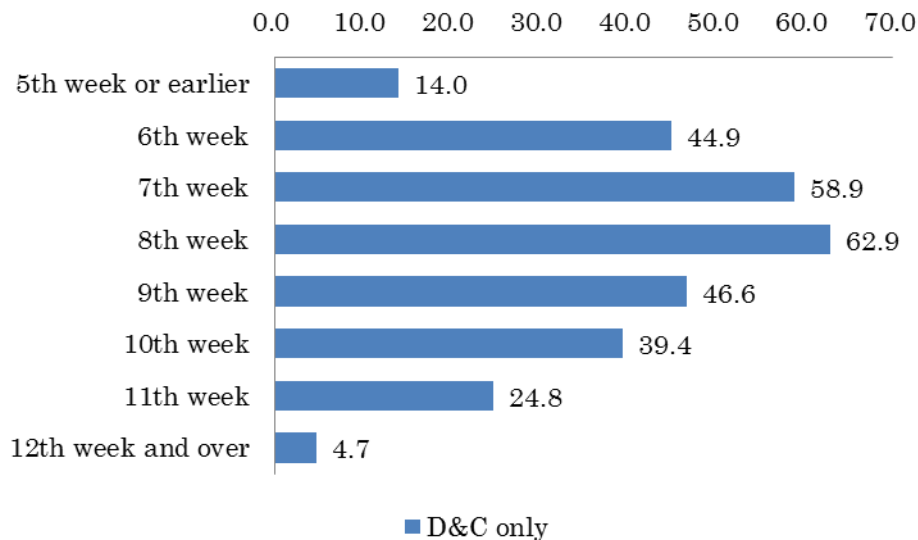
Now, let us consider the fact that MA may be performed much earlier than D&C. Our 2010 study found that over 60% of Japanese OB/GYNs are confident in performing abortion with D&C after 8th weeks of pregnancy, but those confident in perform in if on 5th weeks or less decreases dramatically to less than 20%.⁵⁸ (Figure 4) However, MA may be used if the woman so demands as soon as the intrauterine pregnancy is confirmed, which occurs on the 5th or 6th week of pregnancy.⁵⁹ In the US, "Patients commonly present for abortion services at or after the first missed menses, which in a typical cycle corresponds to 4 weeks' gestational age".⁶⁰ If MA is adopted in Japan, doctors may confidently perform an abortion much earlier, while the product of conception is still a gestational sac or embryo and not yet a fetus. This finding should dramatically change people's view on abortion, lessening the stigmatization of abortion and alleviating women's suffering.

⁵⁸ Kinefuchi, et al., 2011.

⁵⁹ Due to space restrictions, here we simply indicate that the same was true to MVA.

⁶⁰ Paul and Lichtenberg, 1999, p.40.

Figure 4. Weeks of Pregnancy (LMP) Doctors Feel Confident to Abort with D&C Only



4. Conclusion

In this paper, the discrepancy in abortion methods between Japan and overseas and the discrepancy in attitude toward abortion between CEDAW and Japan were considered.

Today, the global standard for first-trimester abortion is the use of VA and MA without the help of GA. However, in Japan, the ‘obsolete’ D&C and un-recommended GA remain used for early abortion, whereas neither VA nor MA has seen full adoption. This lagging of abortion technology is due to several reasons: the customary use of current methods, doctors’ lack of concern and desire to maintain an advantageous status quo, the stigmatization of abortion, ‘apathy and disdain’ toward women and a lack of correct information, which this paper attempts to mitigate. The MHLW’s suspicious notice and the Japanese government’s reluctance to improve women’s condition due to ‘fetus over women’ ideology demand more examination.

We should turn our eyes to the real suffering of Japanese women and the possibility for MA to save them from agony. Women’s reproductive health and rights that are their natural rights are already theirs. We should then find a way to realize this pledge in Japanese society.

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