RESEARCH ESSAY

Women and Health in Japan: The Rise and Obstacles of Gender and Sex-Specific Medicine

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ABSTRACT

In this article, the author first overviews the state of affairs concerning reproductive health/rights in Japan. The spread of HIV/AIDS and STIs (Sexually Transmitted Infections) in Japan are then examined, followed by a discussion on promotion of gender and sex-specific medicine. Finally, the author examines causes of death in Japan and their implications from the perspectives of gender equality.

Keywords: AIDS, Gender and Sex-Specific Medicine, Health, HIV, Japan, Sexually Transmitted Infections (STIs)

1. INTRODUCTION

The Constitution of Japan in Article 25 stipulates that “All people shall have the right to maintain the minimum standards of wholesome and cultured living. In all spheres of life, the State shall use its endeavors for the promotion and extension of social welfare and security, and of public health” (Prime Minister of Japan and his Cabinet, 1946). However, the policies introduced by the Japanese government under the LDP (Liberal Democratic Party) Cabinet have been sending the message to the people that “it is the citizen’s duty, instead of basic human rights, to maintain good health and high cultural standards, by issuing many laws and ordinances.” After the Democratic Party came to power there has been no significant change in government policies or philosophy when it comes to the fundamental issues of health and welfare.

Incidentally, the Basic law for a Gender-Equal Society in Japan (enacted in 1999) has no provision on women’s health. In contrast, the term “reproductive health/rights” was introduced in the first Basic Plan for Gender Equality endorsed by the Cabinet on December 12, 2000, the Second Basic Plan for Gender Equality endorsed by the Cabinet on December 27, 2005, and the Third Basic Plan for Gender Equality endorsed by the Cabinet on December 17, 2010. What is more, the Second Basic Plan lists “the sex-specific medicine” as one of its 10 most important agenda items. That is, “to promote ‘sex-specific medicine,’ or medicine appropriate for each individual which takes sex differences into full consideration, in an effort to maintain and enhance life-long health.” Furthermore, the Third Basic Plan claims that surveys and research projects in this field
should be promoted, that the importance of “the sex-specific medicine” should be known to the general public, that the total medical system should be geared to “the sex-specific medicine,” and that the preventing measures for mental and physical health on the basis of sex differences. Of course, these moves by the government are most welcome.

In this article, I will first overview situations concerning reproductive health/rights; then I will discuss spread of HIV/AIDS and STIs in Japan, followed by a discussion on promotion of gender and sex-specific medicine. Finally, I will examine causes of death in Japan and their implications from the perspectives of gender equality.

2. REPRODUCTIVE HEALTH AND SEXUAL HEALTH/RIGHTS

In Japan, the maternal mortality rates have dropped over the course of time, and the technological level of obstetricians/gynecologists and midwives is high. Yet, nationwide the number of obstetricians/gynecologists and midwives shows a tendency to fall. Among the causes are: long work hours demanded of obstetricians/gynecologists and greater financial burden incurred by low wages and an increase in medical suits (insufficient lawsuit insurance) (Ministry of Health, 2007, p. 45). Similarly has the number of maternity clinics run by private midwives gone into decline (Welfare and Medical Service Agency, 2007, p. 6). For this reason, it is not easy for pregnant women to make an appointment for their delivery. In some cases, they change their residence to other municipalities in order to reserve a bed for their delivery. No significant countermeasures have been taken and in recent years, there have been medical accidents in child delivery shaking the nation. When pregnant women exhibited a symptom of a brain hemorrhage or other serious symptoms, they were sent to several other large hospitals by ambulance but each time they were refused to be accepted for reasons ranging from occupied beds to absence of doctors and doctors in operation. At the final hospitals that did accept them, babies were delivered by Cesarean section, which either cost the life of the pregnant women or put them in a coma in a critical condition. There are exceptions, though quite small in number; where an appropriate network has been built among public hospitals, university hospitals, medical practitioners, and fire departments in charge of ambulances in order to minimize the occurrence of such accidents.

Turning to contraception, thanks to the efforts of women’s NGOs and concerned Diet members, the Ministry of Health and Welfare officially approved low-dose pills in June 1999, almost nine years after receiving the first application in 1990. Nevertheless, medical products that are permitted for use are limited to those listed at the time of application to the Central Pharmaceutical Affairs Council back in 1990. Starting in 2008, a kind of low-dose pills that has already been approved to treat dysmenorrhea contracted as a complication of endometriosis is covered by public medical insurance, but is not allowed to be used as a contraceptive. Japan is one of a few nations, which was slow in officially approving emergency contraceptives. At last, on March 24, 2011, Japanese Government approved the sale of Levonorgestrel as “Norlevo pill” (developed by HRA Pharma, France). Induced abortions are legalized only if the conditions stipulated in Article 3 of the Mother’s Body Protection Law are met: doctors judge that continuation of pregnancy is undesirable for the health of the maternal body or for economic reasons, and the couples give consent. However, deleting the clause on “economic reasons” entails “revival” of “illegal abortion” in the Penal Act, which is currently regarded as an exception on the ground of the Mother’s Body Protection Law. Under the Penal Act, women who have had abortions and medical doctors and midwives who have operated women for abortion are penalized for “illegal abortions,” but the provision that frees men who made women pregnant against their will from any punishment remains intact. Even rape victims who have undergone induced abortions are considered for penalization. While
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