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Dr. Melissa Dale

ARTICLES

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BOOK REVIEW

Empires of Panic: Epidemics and Colonial Anxieties ~ Robert Peckham, editor
Dr. Eric Tagliacozzo

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We are pleased to announce the publication of the Fall 2016 issue of *Asia Pacific Perspectives*. This special issue presents five papers focused on themes related to the social history of medicine and contemporary cultural understandings of disease and patient’s lived experiences in the Asia Pacific.

The idea for this issue originated with the planning for the University of San Francisco Center for Asia Pacific Studies’ fall 2015 conference, *Bodies, Healing and Culture: A Social History of Medicine in East Asia*. Inspired by the research presented at the conference and reminded of the benefits of scholars sharing research with one another beyond their particular area specialty, we decided to broaden our scope and time period to include the Asia Pacific from the past to the present and devote an entire issue to the topic.

Within this issue, you will find five papers that represent the diversity of topics currently being researched in the fields of medical history and contemporary studies in medical anthropology. These articles range in time from the 16th c. to the early 20th c. to the present. They also represent breadth in terms of topic – from the development of medicine as a profession and access to medical care, to cross-cultural exchange and encounters over issues linked to discourses on modernity such as birth control and domestic science, to patient narratives chronicling their responses to life-threatening diseases in contemporary Asia.

We begin the issue with *Soyoung Suh*’s study of surgical treatments of breast cancer in South Korea from 1959-1993. Suh begins her article by historicizing the discourse on breast ailments and notes records as early as the 1600s discussing the topic. In the 1930s, Suh notes how traditional treatments became replaced by surgical intervention as Korean medicine increasingly viewed Western medical techniques as superior. One of the highlights of Suh’s study is her discussion of the patient-physician relationship and patient’s family-physician relationship. The last section of Suh’s article is particularly poignant as it gives voice to the lived experiences of breast cancer patients and their attempts to negotiate a path to treatment and palliative care through surgery, activism and a search for alternatives.

*Pamela Runestad*’s article on narratives of people living with HIV/AIDS (*yōseisha* 陽性者) in Japan continues the theme of patients becoming active participants in the framing of their illness narratives. Combining field work among *yōseisha* participating in events such as the AIDS Bunka Forum and an examination of accounts of life with HIV/AIDS published by Place Tokyo, Runestad finds that *yōseisha* strive to achieve normalcy in their lives while also advocating for acceptance. Runestad argues that the utilization of ‘flexible kata’ (型), allows *yōseisha* to speak publicly about topics once considered taboo in Japan.

With *Andrew Goble*’s article we turn our focus to the development of medicine as a profession and women’s access to medical care in late 16th century Japan. Examining the Honganji Religious Community in Ōsaka and Kyoto through the diary of physician Yamashina Tokitsune, Goble adds to our understanding of medicine and community in pre-modern Japan. Chronicling the treatment of patients often over the course of years, Yamashina’s diary reveals a proactive attention to health,
continuity of care, the complexity of medical prescriptions, and the ability of patients to receive access to care at practically all hours of the day and night. Goble’s section on Yamashina’s treatment of women during pregnancy is particularly interesting and provides important insight into female health support networks at the time.

In the next article, Mirela David uses the occasion of Margaret Sanger’s visit to China as a lens to study cross-cultural exchange regarding birth control during the 1920s. Sanger, an American birth-control activist and founder of Planned Parenthood, traveled to China in 1922 to lecture on the topic. While there, Sanger expressed her views that birth control could help solve China’s social problems caused by overpopulation and lack of resources and also help improve women’s health. During her visit she engaged with and stimulated discourse with Chinese journalists and intellectuals on the eugenic potential of birth control. By focusing on the translation of Euro-American discourses in China, David’s work adds to our understandings of eugenics in China and more broadly to the worldwide social movement and ideology.

In the final article, René Alexander Orquiza Jr. provides our readers with an understanding of the introduction and teaching of domestic science in the Philippines from 1906-1932. During this period, Orquiza finds that kitchens became classrooms that were designed to achieve widespread cultural change though the promotion of Western ideas of hygienic practices and healthier eating and expanded roles for Filipinas. Orquiza argues that in practice these classrooms and publications that promoted the teaching of domestic science in the Philippines created contradictions and reminded Filipinos of American cultural hegemony.

We end this issue with a book review by Eric Tagliacozzo of Robert Peckham’s edited volume, Empires of Panic: Epidemics and Colonial Anxieties.

On behalf of the journal and our authors, I would like to thank Dr. Leslie Woodhouse (Assistant Managing Editor) for the time, energy, and expertise she has put into bringing this issue to publication.

- Melissa S. Dale, Editor
Rethinking Breast Mountain (Yuam): Surgical Treatments of Breast Cancer in South Korea, 1959–1993

by Soyoung Suh, Ph.D., Dartmouth College

Introduction

Women in South Korea have faced rapidly increasing rates of breast cancer for the past ten years. According to a special report by the Korean Breast Cancer Society, the crude incidence rate in 2012 marks 70.7 cases per 100,000 women, including cases of ductal carcinoma in situ. This rate is two times higher than the 29.5 cases reported in 2002.1 When calculated by including only incidents of invasive cancer, the number amounts to 60.1. The statistical report by the (Korean) National Cancer Center shows a similar trend, displaying 68.2 cases per 100,000 women in the year of 2013.2 This number is lower than the 125 new cases per 100,000 women in the United States in the same year, yet South Korea presented the highest incidence rate in Asia in 2013.3

Paralleling the sudden rise of breast cancer, discourses about successful prevention and control have also emerged. Through early detection and advanced treatments, breast cancer is now deemed a curable disease. The government statistics present that the five-year survival rate has increased from 78.0% in 1993–95 to 91.5% in 2009–2013 – an overall increase of 13.5% over 20 years.4 Innovations in radiology, pathology, histology, and genetics have effectively developed diversified treatments, and specialized surgeons not only perform “breast conserving” surgeries but also undertake breast reconstruction, thereby meeting patients’ individual needs more fully.

The majority of popular reports of breast cancer since 2000 have been shaped by a narrative trajectory in which the “sudden emergence” of the disease is followed by “successful control.” For example, Dr. No Tong-yŏng, one of the most well-known breast cancer specialists in South Korea, expressed his professional confidence in controlling the disease. When one is diagnosed with breast cancer, s/he can treat it well with the help of advanced surgery and chemotherapy. Breast cancer, even in the case of metastasis, can be cured. If you are in one of the earlier stages, hope is unquestionable. More to the point, cancer in general is no longer a rare, incurable, and life-threatening disease. According to Dr. No, every Korean with a prolonged life expectancy is now susceptible to cancer.5 Yet we can prevent and control cancer successfully, as we have done with breast cancer.6

The South Korean conceptualization of breast cancer as a “suddenly prevailing yet properly controllable epidemic” manifests the promise of biomedical development, thereby conjuring up a brighter future for Korean women. However, this forward-looking portrayal of breast cancer often discounts past experience, thereby ignoring the origins and evolution of the disease. Contrary to the conventional understanding, women in Korea have long suffered from a range of breast ailments, some of which appear similar to today’s breast cancer.7 Although the term “breast cancer” gained circulation only in the twentieth century, a rich understanding of what we may now call “breast cancer” previously existed. This essay thus aims to historicize the changing connotations of breast ailments, which have created textual (dis)continuity for patients seeking to interpret the ontology of breast cancer in postwar South Korea. When did Koreans first come to terms with breast cancer? Before the current terminology was introduced, what terms did Koreans use to describe
symptoms similar to today’s definition of carcinoma in the breast? In what ways does the premodern understanding of breast ailments shape or ignore the current interpretations of breast cancer?

Following such inquiries about the origins of Korean medicine’s understanding of breast cancer, this paper examines the Korean adoption of William Stewart Halsted’s (1852-1922) radical mastectomy. Halsted’s technique removed the breast, the two underlying chest-wall muscles, and the lymph nodes of the axilla as a major treatment of breast cancer. Halsted’s surgical method reflects his understanding of the physiology of the disease as well. According to Barron H. Lerner, “Halsted believed that breast and other cancers began as small foci that then enlarged in a slow, orderly, centrifugal manner before spreading to local lymph nodes.” By eliminating the entire site en bloc, Halsted aimed to cure the disease and to avoid the possible impacts of surgical dissection on local recurrence: the liberation of cancer cells, and the contaminated knife’s introduction of cancer in the operative site.

The existing scholarship has well documented the origins, development, and decline of Halsted’s radical mastectomy in the United States. Once adopted by American mainstream surgeons, the Halsted method remained the most authoritative treatment for breast cancer. American surgeons remained loyal to Halsted more tenaciously than their European and Canadian counterparts. Although condemned as “barbaric” by female activists, the Halsted method was hardly challenged by American surgeons. The technique became obsolete in the late 1970s, only through contested interactions among different causes, such as the introduction of novel statistical methods, patient activism, a few surgeons’ own criticism, and the changes in American popular perceptions about women’s health. Employing a “war” metaphor, Lerner persuasively demonstrates how inextricably surgical innovations were associated with the clinical and cultural specificities of Cold War America.

What, then, caused the embrace and subsequent termination of Halsted’s method in South Korea? To what degree does the changing surgical technique of breast cancer illustrate attributes of Korean medical culture? Through these questions, this paper also analyzes the Korean medical professionals’ attitude toward American medical authority, which also impacted the well-being of Korean female patients. Last but not least, this paper questions the extent to which Korean women became agents, and not merely passive objects, of surgical innovation.

In considering the aforementioned questions, I analyze three types of documents. Breast ailments depicted in premodern medical treatises provide textual labels and contents through which both physicians of traditional medicine and some patients reasoned the causes and cures of breast cancer in postwar South Korea. Second, I examine case reports published in the Journal of the Korean Surgical Society between the late 1950s and early 1990s, which exhibit the mode of professional evaluation of Halsted’s radical mastectomy. Given that the nationwide statistics of cancer became available only in the late 1990s, the clinical cases published between 1959-1993 allow us to explore the early stage of Korean accommodation of breast cancer surgery. Third, I scrutinize a patient’s memoir to balance professional male elites’ perspectives on surgical treatments. Although the patient’s voice is limited in terms of circulation and her socio-cultural background, her struggle with breast cancer and eventual death helps us contemplate the meaning of surgery outside of professional narratives.

Tales about breast cancer have an Anglo-American origin. A variety of patients’ memoirs, biographies of the disease, research on changing modes of surgery, radiotherapy, chemotherapy, and analysis of different trajectories and meanings of prevention, to name a few, mainly focus on the United States and Britain. In so doing, the stories about those who “radically transformed breast cancer’s epidemiological, clinical, and personal meanings” have largely reflected the fear, hope, struggle, and confusion of American and European societies. Recently, anthropologists have called for more attention to be focused on cancer as a “transnational condition involving the unprecedented
flow of health information and technologies as well as people across national borders,” soliciting strands of local analyses in a global context.

Building up the geographically expanded research on cancer, my analysis aims to benefit from a long-term perspective, which demonstrates the “unnatural” attributes of experiencing breast cancer. As Robert A. Aronowitz points out, whereas the “natural” history of breast cancer, the doomed destruction of the body, seems hardly to have changed, the way an individual, or a society, experiences the fear of breast cancer and hope for its cure has been radically evolving over the past centuries. The changes from “isolated, private fears of breast cancer to immense individual and collective concern over the risk of breast cancer” reflects the “unnatural” socio-cultural vicissitudes that have shaped the language and mode of patients’ experience in American society. In a similar vein, this paper examines the “unnatural” manifestation of the disease in patients on Korean soil, which may or may not disclose the same degree of dynamics and contestations, compared to the United States, on Koreans’ own terms. Far from a linear progress, the surgical treatments of breast cancer in history reflect moments of ruptures and resonance. At the core of the “unnatural” evolution of breast cancer lie the changing techniques of surgery. The meaning of surgical treatments had changed in postcolonial South Korea because of the pre-existing understanding of breast ailments in East Asia, Korean surgeons’ pro-American upbringing under the Cold War contestation, and patients’ yearning to find every means possible for a cure. In search of the evolving meanings of surgical treatments, I begin by tracing the origins of a Korean term for breast cancer or carcinoma— breast mountain, yuam (乳巖).

**Treating Breast Mountain (yuam) without Surgery, from 1600-1945 C.E.**

The scholarly tradition of Korean medicine recognizes breast mountain (yuam 乳巖) as a major disease category of female breast ailments, yet does not suggest a surgical intervention as an effective clinical solution. The Korean translation of breast cancer today is yubangam (乳房癌), yet until the 1990s, the *Journal of Korean Surgical Society* did not differentiate yubangam from yuam. In the textual repertoire of Korean traditional medicine, yuam, the combination of yu (breast, 乳) and am (rock or mountain, 癌), signifies a non-lactational breast illness, which literally implies the rock-shape dent or a mountain-shaped boil on breasts. No source has yet identified when, exactly, the character am (癌) was applied as a label for cancer in Korea. Yet, given that am was interchangeable with many characters, such as 岩, 巖, 岫, and 嵖, which all sound like am, it is not exaggerating to say that using the label of yuam for modern breast cancer resonated with the pre-existing understanding of breast mountain, that is, a hard, stone-shaped lump visibly growing in the breast.

The traditional understanding of breast mountain did not recommend a surgical treatment, as the cause of the disease was thought to be rooted deeply in a woman’s way of life and her entire bodily circulation. Hŏ Chun (1539–1615), the best-known physician/scholar in the Korean history of medicine, detailed the breast mountain category by selecting three medical texts from Yuan and Ming China: Zhu Zhenheng’s (1282–1358) *Danxi’s Methods of Mental Cultivation* (Danxi xinfa 丹溪心法, 1481), Li Chan’s (active 1573–1619) *Introduction to Medicine* (Yixue ruwen 醫學入門, c. 1575), and the *Orthodox Transmission of Medicine* (Yixue zhengzhuan 醫學正傳, 1515). Hŏ Chun titled his composition “An Old Lump Becomes Breast Mountain.”

If women (puin 婦人) accumulate concerns, anger, and depression for a long time, the qi of the spleen becomes weak, and the qi of the liver deviates from the way it should be. Without knowing it, the woman grows mass-like stones or a small, soft-shelled turtle in the breast. This mass neither causes pain nor itching; then, after ten years, it festers, and becomes retracted. This is called breast mountain. The shape of the sore part was dented like a caved-in rock. If this happens, the disease cannot be healed. The lady can be cured...
A lump grows in the breast when a lady accumulates worries and anger. The lump neither pains nor itches, yet after five to seven years, the skin becomes swollen, then gets dark, and the inside of the lump festers to a head. This is called breast mountain. If the woman exhausts her qi and blood, she would perish. Sixteen-Ingredient Drink for Qi Flow and Decoction of Steamed and Dried Peal of Unripe Mandarin should be prescribed quickly. If the lady’s qi is depleted, prescribe only Clear the Liver and Thrust-out Constraint Decoction. If the lady clears her mind and rests and replenishes, then she may survive for a couple more years. (Introduction to Medicine)

In the beginning of breast mountain, the disease can be treated if a patient takes medicine that helps her qi run and blood circulate, and the patient’s emotions and thinking are not in conflict. This disease mostly arises from depressive thoughts and accumulated anger, particularly among middle-aged women. If the breast mountain did not fester, then it can be treated. But if the lump festered, it cannot be treated. (Orthodox Transmission)

By selecting these references, Hŏ Chun underlines four major attributes of breast mountain. First, the disease originated from accumulated emotional disturbance, particularly among middle-aged women. Lifetime concerns, anger, resentment, and depressive thoughts, which had no expression, led to sunken and festered breasts. Second, Hŏ Chun notes that the rock-shaped breast dent has to do with the circulation of the entire body. The blocked qi and blood directly aggravate the swelling breast. The strength of the liver qi or the weakness of the spleen qi determines the size and state of the lump. Third, Hŏ Chun highlights that timely intervention at an earlier stage may yield positive results. If the mass is too large or festered, then the patient cannot be treated at all. For recovery, Hŏ Chun uses nuanced expressions, such as “prolonging the life” or “getting back to the way it should be,” instead of simply indicating “complete cure” or “full recovery.” Fourth, as Yi-li Wu carefully demonstrates with her analysis of the Qing medical classic’s identification of female breast disease,16 Hŏ Chun reveals a flexible understanding of the gender of breast mountain: Hŏ Chun put the above passage in the chapter on “breast” (yu 乳) in External Forms (oehyŏng外形), the second volume of his five-volume encyclopedic compilation, indicating a universal application of the disease category. Other breast diseases were put under the chapter of “women” in Miscellaneous Diseases (chappyŏng雜病), the third volume. Although Hŏ Chun viewed breast mountain as a gender-neutral category, he also clearly differentiated male from female causes and portrayed breast problems in general as a part of female reproductive complications or a female disease resulting from accumulated emotional disturbance. Breast mountain both challenges and retains Hŏ Chun’s normative understanding of breast ailments as women’s diseases.

As Hŏ Chun did not diagnose breast mountain as a locally developed lump, he prescribed only decoctions aiming to rejuvenate the patients’ qi. Hŏ Chun mentioned a surgical intervention for breast abscesses, yet only as an example of failure. Quoting a Chinese source, Hŏ Chun highlighted that a 70-year-old female who tried a surgical intervention eventually passed away. The passage implies that the patient could have lived longer if she did not do anything.17

Understandings of breast mountain or breast illness in general remained largely consistent with Hŏ Chun’s framework in subsequent centuries.

As Table 1 summarizes, Hŏ Chun’s contemporary, Yi Sŏk-kan (1509–1574), for instance, listed breast abscesses, yu昂(乳癌), and breast boils, yuch’ang(乳瘡), under the category of yujong(乳腫), although he did not mention breast mountain explicitly in his Experienced Prescriptions by Yi
Suk-kan (李碩幹經驗方, sixteenth century). Kang Yi-o’s (1788–?) Essential Prescriptions of Abscesses by Yaksan, the Antiquer (若山好古腫方撮要, c. 1799–1857) followed Hŏ Chun in categorizing breast diseases under “External Section” (oegwa 外科), and briefly summed up effective treatments for breast abscesses and other child-birth-related complications. Another edited volume of prescriptions, Divine Prescriptions from Chingyang (晉寓神方), which was well circulated in late-eighteenth-century southeastern provinces, described breast mountain in light of Hŏ Chun’s framework, highlighting the emotion-related and non-lactational causes of the disease.

To sum up, there was no surgical treatment recommended for breast mountain in the scholarly tradition of Korean medicine. Given that the disease was thought to be caused by accumulated emotions and major constraints of the entire body’s circulation, treatments focused mostly on calming the mind, controlling the patient’s attitude, and administering medicine during the early stage. Breast mountain was primarily perceived as a women’s illness, yet unlike other breast ailments categories, it was not directly related to lactation or post-partum issues. Once the lump grew and festered, the physician held no hope for a cure.

In the eighteenth and nineteenth centuries, a couple of renowned practitioners who specialized in treating abscesses, chongŭi (腫醫), gained recognition in an elite compilation of medicine. However, performing surgical techniques had in general meant a lower status for medical specialists. While scholarly physicians, yuŭi (儒醫), were expected to freely discuss the entirety of the body in relation to seasonal changes and human affairs, technicians of abscesses, chongŭi, were supposed to merely remove pesky boils. Extant cases scarcely testify to the extent to which female patients suffering from breast mountain embraced surgical treatments wholeheartedly. Scattered textual records only briefly addressed manual intervention into the abscesses, yet did not replace the existing decoction-centered therapies. Yu Yi-t’ae (1652–1715), for instance, suggested “break by needle” (ch’imp’a 針破) to treat breast mountain or boils (yujong 乳腫) in his Experienced Simple Prescriptions (實驗單方, 1709). During the Japanese colonial reign (1910-45), the practice of mastectomy appears to have been introduced to Korea in tandem with other advancements of Western medicine. The official history of the Korean Surgical Society states that breast cancer surgery was carried out in Korea during the 1930s. However, we know little about the operating surgeons or the female patients beneath the scalpel. No details of the surgical technique are known, yet the term “surgery” (susul 手術) for breast ailments gains visibility in the 1930s. In 1917, Maeil sinbo published an advertisement of the

### Table 1

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<tr>
<th>Author</th>
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<th>Introduced Categories</th>
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<tbody>
<tr>
<td>Yi Sŏ-kan</td>
<td>Experienced Prescriptions by Yi Sŏ-kan 李碩幹經驗方</td>
<td>16th century</td>
<td>Breast abscesses, breast boils, yuch’ang (乳瘡)</td>
</tr>
<tr>
<td>Yu Yi-t’ae</td>
<td>Experienced Simple Prescriptions 實驗單方</td>
<td>Late 17th century-early 18th century</td>
<td>Breast mountain</td>
</tr>
<tr>
<td>Unknown</td>
<td>Divine Prescriptions from Chingyang 晉寓神方</td>
<td>Late 18th century</td>
<td>Breast mountain</td>
</tr>
<tr>
<td>Kang Yi-o</td>
<td>Essential Prescriptions of Abscesses by Yaksan, the Antiquer 若山好古腫方撮要</td>
<td>c. 1799-1857</td>
<td>Breast abscesses, yuong (乳癰)</td>
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Cho family’s plaster (Cho koyak 趙膏藥) only by underlining its remedial efficacy for breast boils, yujong. Yet, in 1934, the revised advertisement added that the plaster could heal yujong, “without any surgical intervention.” The idea of surgical intervention as a clinical solution for breast ailments becomes visible in printed advertisements in the 1930s.

When viewing available information from the end of World War II, it is not entirely clear to what extent Korean women suffered from breast mountain. The official history of the Korean Surgical Society, which prioritized pyloric stenosis caused by ulcers during the 1940s and 50s, delayed cancer research until after the Korean War (1950-53). However, the aforementioned analysis demonstrates that elite medical practitioners since the sixteenth century had elaborated the causes, prognoses, and treatments of breast mountain by navigating through Chinese medical texts and folk remedies. The holistic understanding of breast mountain did not support surgical intervention, particularly when the lump grew large and was aggravated. Breast mountain at its core defies any idea of a “local” disease. If the root cause of the lump resided in the patient’s lifestyle, the blockage of qi circulation in the entire body, and pent-up emotion accumulated for years, amputating the breast to merely remove the lump did not make any sense.

Surgery for National Rejuvenation and New Identities, from 1945 to the 1950s

Surgery and surgeons began to emerge as emblems of innovation and infallible medical authority around the turn of the last century. Paralleling the introduction of Western medical education and the establishment of the modern license system, surgery arose as the most efficacious cure for Koreans’ desperate health issues. Anecdotes of privileging surgery and surgeons abound in modern Korean history. When Min Yŏng-ik (1860-1914), a high-ranking official from the powerful Queen Min family, was stabbed during the Kapsin Coup in 1884, an American physician, missionary, and officer, Dr. Horace Newton Allen (1858-1932) successfully treated Min’s wound. Neither hospitalization nor a serious surgical operation was carried out. Rather, Dr. Allen’s skillful management of Min’s hemorrhage and pyosis was sharply contrasted with the incompetence of fourteen surrounding physicians of traditional medicine. Running about in confusion, those doctors wanted to apply pitch to the wound to stop the bleeding, according to the narrative of the Korean Surgical Society. It was the “superior technique of Western surgery” that saved the life of Officer Min in the emergency.

Not surprisingly, Allen was allowed to establish the first Western-style medical clinic, House of Extended Grace (Kwanghyewŏn 廣惠阮 광혜원), in 1885 with royal support. In the 1930s, surgery as the symbol of Western medicine’s supremacy gained further recognition. Even the passionate advocates of traditional medicine, who publicly debated with doctors of Western medicine, willingly acknowledged the prowess of Western surgical techniques.

In the 1930s, surgery as the symbol of Western medicine’s supremacy gained further recognition. Even the passionate advocates of traditional medicine, who publicly debated with doctors of Western medicine, willingly acknowledged the prowess of Western surgical techniques. Cho Hŏn-yŏng, a talented graduate of Waseda University in Japan, gained a reputation as the best-known Korean advocate of traditional medicine. Even Cho acknowledged that, by definition, “Eastern medicine is internal medicine whereas Western medicine is surgical intervention... Western medicine is all about the technique of surgery.” To Cho, the core virtue of Western medicine lay in its aggressive yet efficacious manipulation of the body.
Paralleling the changing popular conception of surgery, the cultural and economic status of the newly trained surgeons was distinguished from that of other Korean medics. Paek In-je (1898-1950?), for instance, successfully solidified the identity of a surgeon as cosmopolitan professional and committed, patriotic intellectual. He served as the first Korean faculty member at the Professional School of Medicine in Keijō (Kyŏngsŏng ŭihak chŏnmun hakkyo) from the late 1920s to 1945, and successfully ran his own clinic, which has become today’s Paek Hospitals and Inje University. Paek’s financial success and clinical achievement under Japanese colonialism illustrates the growing pride and authority of Korean surgery during its fledgling period.

The Japan-centered education of Korean surgeons faced a crisis at the end of the World War II. When the U.S. Army Military Government in Korea (USAMGIK, 1945-48) occupied Korea below the 38th parallel, higher education became a significant stage of development for Cold War propaganda. Korean elites noticed that the language and culture of surgical studies would soon follow the American standard.

The American impact on Korean surgical education and networking became clear with the formation of South Korea (Republic of Korea) in August 1948. The newly founded Korean Society of Surgery (1947) established two years of pre-medical courses followed by four years of regular medical college. Those who completed twelve years of elementary, junior-high, and high school education were allowed to apply for the pre-medical courses. The revised education system invalidated the pre-existing vocational school, the Professional School of Medicine in Keijō established under the Japanese authority. Additionally, the formation of pro-U.S. and anti-communist South Korea broadened the influx of textbooks, terminologies, mentors, and training opportunities coming from the U.S.

The Korean War (1950-53) accelerated the American impact on the Korean Surgical Society. No substantial research has analyzed the role of the civil war in innovating the Korean medical system. Yet the Korean official narrative confidently recognizes the “radical” changes in surgical studies during the war. “The development of the discipline of surgery after the Korean War is the most eye-opening progress in the entire history of surgical studies.” Like a double-edged sword, the war created both tragic loss and unprecedented opportunities for Korean surgeons. The official history of the society points out that “[i]t is well known in history that the study of surgery has radically been developed through wars. The experience of treating numerous wounded soldiers substantially contributed to the advancement of Korean surgery.”

After the war, the United States continued to shape Korean surgeons’ yearning toward successful professionalism. Leftover American radiation instruments became a significant resource for Koreans. Interpersonal contacts nurtured Korean interest in the American system: Koreans envied Americans’ generous administration of sedatives, anti-parasitics, digestives, diuretics, and antibiotics. A variety of postwar aid agents, such as the American-Korean Foundation (AKF), foreign missionary societies, and Scandinavian medical aid, provided opportunities for exchange programs and short-term training for Korean surgeons. As Dr. Howard Rusk, who played a significant role in establishing the AKF in 1953, succinctly put it, the medical training of South Koreans would turn the nation into a “bulwark of freedom.” As a response to Dr. Rusk, Dwight D. Eisenhower said, “When young physicians from overseas receive specialized training in the United States, it gives them an opportunity to become familiar with our history, government, and cultural activities. When these physicians return home, they will be trained in the latest techniques of rehabilitation and also serve as interpreters of the American way of life.” Given the symbiosis of medical aid and Cold War ideology, no other field of medicine better demonstrated American prowess than surgery. The radical removal of tumors or body parts and creative reconstruction epitomized the yearning for recovery in postwar South Korea.
Not surprisingly, the postwar Korean Surgical Society embraced the nation-centered and pro-American virtue of surgery. The leaders of the society aimed to sustain the “radical advancement” that the bloody civil war endowed on their profession. Strengthened during the war, the Korean Surgical Society in the early 1960s assessed that “paralleling the economic revival of motherland, the young and talented surgeons, who absorbed advanced Western medicine, have driven eye-opening progress without a pause.”

To sustain the rapid pace of development during this early phase of adopting Western medicine, Koreans longed for a more complete absorption of American surgical techniques. The Society hoped to overcome language and research confusion caused by the sudden transition from Japanese-German medicine to American medicine after World War II.

What remained crucial to Korean elite surgeons was catching up with American standards at the fastest pace. In the Society’s new journal, the preface by the president advocated that they should “summarize then disseminate the advanced American medicine in a short time period.”

We still cannot pinpoint when exactly Korean surgeons authorized Halsted’s radical mastectomy. The aforementioned brief history of Korean surgery, however, hints that the socio-political vicissitudes in South Korea after 1945 – liberation from Japanese colonial governance, division, American military occupation in the South, postcolonial contestation between two Koreas, the Korean War, and South Korea’s state-building under the cultural and political rubric of Cold War tension – created a surgical authority that valued English-language, American-style, rapid achievement and patriotic rhetoric. In this milieu, as long as the imported American surgical textbooks explicitly authorized radical mastectomy as the most effective treatment, no other alternative would have even occurred to a Korean surgeon when faced with a patient suffering from cancer of the breast.

Given the aforementioned context, it is necessary to analyze a two-page article published by the Journal of the Korean Surgical Society in 1966. This article reported a case of a bleeding breast found in a 73-year-old, unmarried woman, Ms. Kim. The short report stated that, although the biopsy failed to show malignancy, “Halsted’s retrograde radical mastectomy” was deemed necessary. Referring to American scholarship from the 1920s and 1940s, the authors viewed the hemorrhagic discharge from the nipple as evidence of invasion of cancer into the milk ducts. Accordingly, the authors carried out the removal of the entire right breast, underlying chest muscle, and axillary lymph nodes. The post-operative histological diagnosis of the surgical specimen turned out to be adenocarcinoma. The authors confidently reported on their correct judgment and timely intervention.

Interestingly, the aforementioned report did not discuss the female patient’s post-surgical situation. The case only stated that the patient, Ms. Kim, without any noticeable medical problem, was frail yet had good nutrition. A mung-bean-sized mass was palpated at the bleeding part of her milk duct, yet she did not have any pain when the lump was pressed, and there was no swelling in
her armpit. Aside from these personal notes, the authors did not present any possible after-effects, complications, or the survival period of the patient. The two-page report thus raises several questions that cannot be entirely investigated through available sources: How long did Ms. Kim actually survive after the operation? To what extent did the surgeons consider that the patient’s response or opinions were important to include in their reports? Was the surgeons’ lack of what we now call “narrative competence” overcome as the surgical technique was improved over time?

No simple answer is possible examining the existing documents. Yet the aforementioned twofold attributes of the 1966 case – the heavy reliance on American references and the insufficient attention to the female patient – should be further investigated as we move on to Korean surgeons’ embrace of Halsted’s radical mastectomy.

**When Did Korean Surgeons Discard Halsted’s Radical Mastectomy?**

Extant records testify to Korean surgeons’ research on breast cancer as early as the mid-1950s. Although the disease was rare, surgeons fully recognized breast cancer and regularly updated their references from Anglophone academic sources. For instance, the first article in the first volume of the *Journal of the Korean Surgical Society* discussed hormone treatment for breast cancer in 1959. Brief analyses of Korean breast cancer patients were published in the following years, demonstrating professional attention to the disease. In the journal, almost 40 case reports detailed the clinical observation of mammary carcinoma, breast mass, lesions, and cancer among Korean women between 1959 and 1992. These case analyses provide a valuable window on the manifestation of breast cancer among Korean women before a nationwide statistical survey launched in 1999. The reporting surgeons were mostly affiliated with major hospitals in Seoul, yet local institutions joined in time. Each clinical report examined from dozens to hundreds of patients. The largest case study researched a total of 1,012 patients. Survival rates were tracked in three-, five-, or ten-year blocks. These clinical reports specified patients’ age, gender, pathological identification of carcinoma, time between first recognition of the lump and first outpatient visit, location of the palpated lump, metastasis, and the method of treatment.

Compared to post-1990s reports, clinical cases in the 1960s more frequently addressed untreated patients. For instance, 98 patients with carcinoma were selected from 258 patients with breast disease who visited the Seoul National University hospital between January 1959 and June 1962. Among the 98 patients with malignant carcinoma, 53 were treated with radical mastectomy. Among the remaining 45, 25 were not treated at all, and 20 received other treatments, such as radiation or hormone therapy.

The 1960s reports viewed radical mastectomy as the most effective and qualified treatment of breast cancer. The first article in the first volume remarked that “hormone treatment alone cannot heal breast cancer. As of now, the best treatment is early detection and early radical mastectomy. Hormone therapy is only an auxiliary method.” The privileging of radical mastectomy over other therapeutic methods can also be found in another clinical report investigating 129 cases between 1955 and 1965. The author stated that “pre- or post-operative radiation, removal of endocrine organs, and the recently introduced chemotherapy is being discussed, adding more confusion.” Given that none of the auxiliary methods had successfully improved patient survival rates, the Korean surgeons found no reason to depart from practicing Halsted’s radical mastectomy.

In the mid-1960s, the researchers found it difficult to track five-year or ten-year survival rates. Data in published articles was often incomplete, and the authors themselves admitted there was a lack of long-term analyses in their research of breast cancer. They ascribed this shortcoming to the comparatively recent history of the disease in South Korea and the “uniquely Korean social environment.” The authors did not specify what the cultural impediments implied, but it can be
conjectured from other reports from the journal that Korean women and their family members feared publicizing the disease.

Due to their familiarity with and admiration of American medicine, Korean surgeons trusted in what the 1956 edition of *Christopher’s Textbook of Surgery* described in its Chapter 14, “The Breasts.” This text explicitly argued that “until more effective, physiologic or chemotherapeutic methods become available, conventional radical mastectomy remains the definitive measure for operable, possibly curable cases.”53 The author, Canadian Ian MacDonald aimed to balance two “extreme” viewpoints: he rejected both simple mastectomy combined with radiotherapy and more extended types of mastectomy. For instance, Robert McWhirter and his Edinburgh associates challenged the Halsted technique as early as the 1940s, reporting that 43% of all cases of breast cancer in 1941 and 1942 had survived for five years when they were treated with a combination of simple mastectomy and radiotherapy to the axillary, supraclavicular, and internal mammary node areas. As a comparison, 32% of patients had survived five years between 1935 and 1940 when radical mastectomy was the major treatment.54 The other “extreme” approach contemplated an even more extensive operation than the Halsted procedure: Owen Wangensteen’s super-radical mastectomy dissected four more sets of lymph nodes than Halsted’s mastectomy. In a similar vein, Jerry Urban’s extended radical mastectomy “removed several ribs and split the sternum with a chisel,” to remove the same mammary nodes Wangensteen hoped to get rid of.55 Although the procedure gained limited converts among American surgeons, surgeons at Memorial Sloan-Kettering in New York City performed 900 extended radical mastectomies by 1978.56 Following in MacDonald’s footsteps in synthesizing contradicting approaches, Korean surgeons writing in the 1960s continued to retain Halsted’s authority while partially recognizing the latest challenges to his method.

During the 1970s, the privileged status of Halsted’s radical mastectomy continued. Compared to the 1960s, the number of examined cases increased, and ten years of patient data had accumulated. Mostly relying on the American quantitative data of the five-year survival rate, Korean surgeons continued to authorize the Halsted technique. However, it should be stated that Koreans did acknowledge the latest criticism of Halsted’s method, and often commented on George B. Crile’s argument for simplified mastectomy.57 In general, though, Korean surgeons hesitated to try the alternative technique. The journal maintained that “most surgeons still preferred radical mastectomy. The reason is not because the method is the best, but because we cannot be sure which method is best.”58 Given the Korean ambition to catch up to the American standard at its fastest pace, American debates over complicated issues only created Korean confusion, reserve, and hesitance.

The 1970s witnessed a range of innovations in both understanding and treating breast cancer. A few Korean surgeons predicted that more extensive use of mammography would detect breast cancer sooner.59 The significance of pathological and histological diagnosis was highlighted. Overall, 30-40% of clinical diagnoses turned out to be corrected by advanced biopsy. Approximately 30% of reported surgical breast diseases turned out to be carcinomas. Use of chemotherapy increased. More innovations in radiology and pathology, however, did not challenge Korean surgeons’ understanding of cancer as a locally developed malignant mass, which should be removed from the body as soon as possible.

Under the framework of cancer as a localized phenomenon, early detection gained support among the medical community. Following MacDonald’s positive remarks about the American Cancer Society’s role in publicizing periodic self-examination,60 Korean surgeons took for granted the rationale of self-surveillance. More to the point, they implicitly blamed female patients for their ignorance. Compared to Western counterparts, according to surgeons, Korean women lacked awareness of cancer.61 The reason why relatively few operable cases were found was that most patients reported their symptoms too late.62 The professional report ascribed patient refusal of surgical operation to “old age, poverty, and ignorance.”63
It was not until the mid-1980s that a few clinical reports began to address attempts to modify
mastectomies. Still, a 1983 article reflected the prevalence of the conventional method; it reported
40 cases out of 71 patients received radical mastectomies. However, in a 1991 clinical report
examining 60 patients, only five underwent a radical mastectomy, while 50 patients had either a
simple or modified radical mastectomy. Halsted’s authority was not explicitly challenged, yet elite
surgeons began to officially pronounce their changed views about radical mastectomy in the early
1990s: “The radical mastectomy or extended radical mastectomy which was quite dominant in the past...is now rapidly out of mode. And modified radical mastectomy has become the trend.”

The prolonged dominance of radical mastectomy until the mid-1980s prompts the question
of what motivated Korean surgeons to abandon the method. We find that Korean surgeons had become
aware of Anglo-American criticism of radical mastectomy. For instance, a 1960 article discussed the
“latest” Western challenges to the Halsted method. Later, Korean authors frequently mentioned
the combination of simple mastectomy and radiotherapy, along with Crile’s alternative approach to
breast cancer. However, the Koreans ultimately remained loyal to Halsted. Additionally, Korean
surgeons’ biased perspective retained a more conservative attitude. Given that the breast was not a
“life-threatening organ,” its removal was considered a “comparatively safe surgery.” In retrospect,
the surgeons themselves confessed that their understanding of breast cancer was simplistic: the
treatment was nothing but an “excision.” In light of this limited understanding of breast cancer as a
local mass grown in an expendable body part, a “more thorough and clear removal of the (possibly
metastasized) lymphatic nodes” was understood as the most appropriate therapeutic choice. If the
total removal of a once indispensable – yet now “unnecessary” – female organ was safe, simple, and
already authorized by a renowned American surgeon, why should Koreans risk a new technique?
The clinical case reports repeatedly state that “if no radical difference is found between radical and
modified mastectomy, the former seems an appropriate and reasonable solution.” In 1995, Korean
surgeons themselves remarked that “an outdated conservatism, the lack of surgeon’s confidence
[in a new method], fear for the outcome [low survival rate], and the small size of the Korean breast
compared to the Western breast” limited their dissemination of the breast-conserving technique.

How, then, did Korean surgeons come to abandon Halsted’s radical mastectomy? They
recognized a rapid transition in their field in the early 1990s. “Recently, the number of breast cancer
patients who visit hospitals is increasing, and so is Korean society’s attention to this disease. The
treatments aiming at stages I and II of breast cancer are changing fast enough to embarrass our
surgeons.” The innovations in radiology, genetics, and endocrinology made clear that cancer is not
merely a disease with an abnormal mass. The discourse about cancer’s complexity and individuality
began to emerge in the journal in the late 1980s. More to the point, Korean surgeons sensed that
American statistics from the National Cancer Institute in the late 1980s no longer validated the
efficacy of radical mastectomy. When Koreans noticed that mainstream American surgeons had
mostly discarded the radical approach, Koreans also abandoned their long-time loyalty to Halsted.
As passionate followers of the American model under the Cold War mentality, and as latecomers to
the breast cancer epidemic, Korean surgeons had little choice but to carefully follow in the footsteps
of American mainstream surgeons.

Unlike their American counterparts, Korean surgeons and cancer specialists were able to
avoid the fierce debate around surgical management, randomized controlled trials (RCTs), and the
efficacy of mammography. The South Korean medical community, as a latecomer to treatment of
the disease, had largely observed – rather than actively engaged in – innovations in the surgical
technique. Korean surgeons, viewed from the Society’s documents, carried out a delayed yet swift
transition to breast-conserving surgery, beginning in the early 1990s. The prompt adaptation to the
American mainstream standard was carried out at the expense of remaining largely as a bystander
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rather than a subject – of surgical innovation. The American National Cancer Institute’s statistics provided an authoritative data for Korean surgeons’ clinical judgement. Koreans also wholeheartedly embraced the obsession with early intervention, drawing on the war metaphor to take initiative, and on narratives of survivorship as a therapeutic resource.

One interesting feature of South Korea’s termination of Halsted’s method is the invisibility of patient activism. Compared to their American counterparts, Korean female patients seem to have remained voiceless about their clinical choices, or the loss and side-effects of radical mastectomy. Does this imply that breast cancer up to the 1990s was not a major health problem among Korean women? What were Korean women’s responses to Halsted’s radical mastectomy? To consider those questions, the following section analyzes one patient’s memoir, published in the 1980s.

A Patient’s Experience of Breast Cancer Surgery

Yi Hyo-suk’s To Those Who Are Suffering from Cancer and To Their Family Members is unique in the genre of Korean breast cancer patients’ narratives. It is not an exaggeration to say that patients’ own voices are rare in South Korea. Catherine Jieun Kim, a Korean-American breast cancer patient, commented in the early 2000s that no monographs of Korean or Korean-American survivors were available, whereas “more than 2,000 books about breast cancer are found via the internet in the U.S. and more than 500 memoirs were written by American survivors.” After 2000, Korean patients began to organize associations in major hospitals: the mass media initiated a program featuring a patient who had lived with breast cancer since the 1990s. An increasing number of interviews and surveys have since been carried out to facilitate sociological and anthropological research about breast cancer in Korea. Still, a patient’s own monograph, with her name and image on the cover, is more of an exception than the rule in South Korea. Furthermore, Yi and her family shared not a success story of survival, but the long and painful process of encountering, treating, and succumbing to cancer.

Reflecting the rapidly industrializing South Korea, the memoir displays the hopes and despairs of an educated middle-class family. Yi was a nurse who graduated from the prestigious private Yonsei University, and her husband ran a promising business after graduating from a top university. Their financial and cultural resources enabled them to try every means possible to cure the disease. Yi’s husband attempted to understand cancer more fully, pursuing every “natural diet, fast, yoga, dietary treatment, negative treatment, folk remedy, cutting-edge diagnosis, and treatment at the most prestigious general hospital, surgery and radiation treatment, and chemotherapy.” Encountering all types of healers and every means of cure, Yi and her family came to critically reflect on the culture of surgery and biomedicine and eventually opined about cancer’s ontology, which finds resonance with Hŏ Chun’s understanding of breast mountain.

Interestingly, both Yi and her husband had a relationship with the U.S. army. As a licensed nurse, Yi worked at a field hospital associated with the 121st American Army base in Pup’yŏng between 1967 and 1974. Yi’s husband was a civilian partner of an American army station in South Korea. Both showed competence in English, and their linguistic prowess and cultural affiliation helped them pursue American resources for treating the disease. They sent a letter to the American Cancer Society in 1978–79, asking for “foreign pamphlets [and] foreign journals’ reports about recovery from cancer.” Not only Korean surgeons but also the patient maintained a pro-American attitude and pursued a more concrete connection in their search for therapeutic solutions.

Finally, yet importantly, Yi’s record exhibits how evangelical Protestantism, which was rapidly growing in postwar South Korea, helped Koreans accept an incurable disease and death. Having lost her parents early in life, Yi was educated by Christian missionaries from Canada. Moreover, Yi’s father-in-law, an evangelical Protestant pastor, had ministered to Koreans in Manchuria in the early twentieth century. During Yi’s unexpected encounter with breast cancer, the couple deeply searched
their Christian faith for the meaning of health, life, and death. In desperation, Yi actively joined Korean-style revival meetings, fasting, and early morning prayers, which were gaining popularity in 1980s South Korea. Anticipating a miraculous healing, however, the couple tried to balance belief and reason: they refused to consult the Philippine “healers of holy spirit,” who advertised their technique of removing cancerous lumps without surgery. Yi’s Christian faith, ultimately, motivated her to reach out to other female breast cancer patients.

As Aronowitz describes in the case of Susan Dilwyn Emlen (1769-1819), the medical explanation of an illness alone does not help the patient to unravel the questions around “why me?” and “why now?” The natural history of cancer, which has evolved over millennia, gains meaning through time- and culture-specific spiritual resources. As Emlen’s breast cancer progressed, she increasingly sought solace in spiritual resources and Quaker faith,79 as did Yi and her husband in the rapidly growing Protestantism in South Korea.

In summary, Yi’s memoir succinctly displays a patient’s perception of cancer’s nature, surgery, and the meaning of alternative healings. Given the rarity of Korean female patients’ voices captured before the 1990s, I take her memoir as a vignette that balances the aforementioned professional discourses on breast cancer. Yi and her family’s memoir helps us flesh out the patient’s agency, even if the voice was feeble.

Initial Detection

In early September 1978, Yi felt minor pain in her breast. Overall, she was a healthy homemaker, so she never examined her breasts regularly. Having chills and a fever, Yi first called her obstetrician acquaintance, who relieved her by saying that one cannot contract cancer overnight. However, Yi decided to contact a recommended surgeon when she found an unusual nodule in her breasts: they had hardened, with a bit of nipple retraction. After clinical diagnosis, Yi’s first surgeon simply suggested removing her breast as she had completed breastfeeding. Startled, Yi looked for a second opinion from a renowned surgeon at Severance Hospital of Yonsei University.80 After her mammogram (yubang sajin 유방사진), the surgeon urged an operation.

It took almost two months for Yi to finally decide to get the surgery. What annoyed her most was the lack of confidence in surgical operation. Yi’s husband, after referring to the medical primers and textbooks available at that time, believed that the surgical intervention of a malignant tumor (malignant neoplasm) would only aggravate the surrounding tissues. Yi’s sister-in-law, a flourishing physician of traditional medicine, prescribed an internal remedy, which softened Yi’s breast a bit. Yi consulted two more major institutions before making her final decision: Korean Cancer Center Hospital81 and the Catholic University of Korea St. Paul’s Hospital.82

Yi’s anxiety was mollified after being introduced to a “foreign woman” who had survived breast cancer surgery and was working in South Korea at that time. Yi’s husband, in retrospect, reported
that “my wife was relieved a lot and [was] persuaded to receive a surgery after getting to know the survivors’ stories in the U.S. or other advanced countries.”83 “Seeing” a foreign survivor actually persuaded Yi to trust in surgery. As Alison Macdonald argues, “it is through corporetic visual apprehension that disease affiliation and the therapeutic work of sharing has productive and virtuous value.”84 The foreign woman Yi met did not involve her in any activism at that moment, yet in seeing and talking to the foreign survivor, Yi immediately formed an imagined connection and found solace in the foreign survivor’s rejuvenation.85

On November 2, 1978, Yi underwent the operation, and she was discharged on November 12. She received five to ten minutes of radiation five days per week for six weeks beginning on December 27 of that year. Around March of 1979, she regained confidence in her health, and from that moment on, she attempted to reach out to other breast cancer patients. Yi tried every possible therapy to get back to “normal” life as a mother and wife. The first part of her diary ends in June 1979, as she reveals her hope of sharing her experience with future breast cancer patients.

Yi seemed to become aware that her cancer had returned in early 1980. On March 27, 1981, she felt pain in her other breast, which had not been operated on. In the diary entry of September 21, 1981, she complained of pain which awoke her a couple times during the night. She suffered from a cough, pain in her chest, and pain in her sacrum. She also detected a lump in her throat.86 In her prayers, Yi hoped to “go where no pain exists.”87 For fear of alarming her two young sons and her husband, however, Yi did not want to fully expose her pain to them. During the winter of 1981 and spring of 1982, Yi and her family sensed the impending end of her life. She was briefly hospitalized at Severance when she lost digestive functions. The hospitalization escalated her disappointment, as the staff recommended a higher level of radiation and chemotherapy after an exhausting examination. Weakened and dispirited, Yi insisted on going home. Her husband tried his best to manage her pain until she died on June 17, 1982.

Surgery: The Path to A Cure?

Yi and her husband’s negative attitude toward surgery contrasts sharply with the elite surgeons’ framing of mastectomy as “simple,” a mere removal of a cancerous lump. Yi’s fear of surgery partly resulted from a lack of proper information. The diagnosis of cancer by the surgeon was brief and decisive, yet no more follow-up was provided by any hospital staff. Yi’s husband wanted to know more about the size of his wife’s cancerous lump, hoping to further understand the prognosis and obtain individualized therapy. Yet Yi’s memoir indicates that the hospital staff did not provide necessary information to the patient and her family before the surgery. Without knowing an approximate survival rate or the prognosis of her stage of cancer, Yi herself had to look for available resources, such as other patients’ experiences or other references about cancer in general. More to the point, Yi and her family doubted surgery was the ultimate cure for cancer. Her husband questioned: if cancer did not form in a moment, how could a one-time surgery cure the disease completely? Yi’s family’s familiarity with traditional medicine also enhanced their skepticism about surgery. Probably, Yi’s sister-in-law was familiar with the millennium-old explanation of breast mountain and other ailments, although no direct comments are found in the memoir.

The earlier part of Yi’s memoir fully elaborated on the unexpected pain that followed surgery. Although Yi was a woman of strong will who hoped to put up with the post-surgical pain without painkillers, she nonetheless “bawled my head off” when doctors “pushed without mercy the hose inserted under my armpit.”88 She regretted her decision to be operated on. The knife-stabbing pain, itchiness around the compressed bandage surrounding her chest, and her ultimately powerless arm were more situations that the patient alone needed to endure. Yi eventually felt recovered four months later, but the lingering pain still awoke her during the night. The actual experience of surgery
left a deep scar on Yi’s mind. She decided not to receive any kind of surgery again, even in the case of metastasis, and Yi in fact did not undergo additional surgery when her condition worsened.

In April 1980, seventeen months after her surgery, she felt discomfort in her hipbone. Considering it a symptom of metastasis, Yi consulted with the operating surgeon. Although the surgeon recommended a bone scan, she refused his advice. She thought, “Now, if the cancer is found in any other parts of me, I do not want to receive another surgery. If I have to die, then I will die. If there is any cancer in me, I will co-exist with the cancer cells until I die.”89 Yi’s husband also expressed his negative impressions regarding the medical professionals’ advisement of surgery. Not accepting his wife’s cancer in the beginning, he blamed the surgeon as a quack with cruel techniques. “The doctor, a disastrous jerk! Although cancer is [now] prevalent [in our society], yet by recommending surgery, he is going to do an innocent person an injury for his profit. The [surgeon] is a bastard worse than a thief. A robber!”90

Communication and Trust

Yi and her husband frequently regretted the lack of fuller communication with the surgeons and other staff in large general hospitals. From the first moment she consulted with a surgeon, Yi was repulsed. After a brief diagnosis, the surgeon lightly recommended, “Wouldn’t it be all right for you if your breasts get removed? They have already played their role.” By suggesting a removal, the surgeon alluded to cancer, without saying it explicitly.

To what extent did the surgeons and medical staff Yi met reveal the truth to her, and what did Yi and her family expect? After being diagnosed by the surgeon in Severance, Yi accepted her cancer. Yet, even in this case, the patient did not receive any exact information about her stage or the size of the lump. Yi expected a more detailed explanation, but “[t]he surgeon was known to be comparatively quiet, and he only said that the diagnosis from the mammography urged a surgery.”91 When Yi and her husband sought a second opinion from a well-known cancer specialist at the Catholic University of Korea St. Paul’s Hospital, the doctor hid his opinion from the patient, instead clearly confirming her cancer to her husband. Although both the doctor and the husband feared directly notifying the patient, both failed to perfectly hide it from Yi.

After surgery, Yi was informed that it had gone well. However, it did not take long for her to realize that the operation was more serious than expected. On the contrary, the operating surgeon informed Yi’s husband of her state in a bit more detail. Right after the surgery, the surgeon mentioned, “It went well, but the tumor was very large; hence, we removed a lot of it. It will be OK.” Her husband wanted to ask more, but the operating surgeon and his assistants “passed by quickly.” On the day of discharge, the operating surgeon suddenly stated, “Take good care of your wife, as she won’t survive long.” In retrospect, Yi’s husband described the moment as sudden and surreal. Startled, he did not even ask the surgeon how long his wife could actually survive. The communication between the surgeon and the patient was carried out on the fly, without any comprehensive guidelines for future care.

Neither Yi nor her husband openly challenged a surgeon’s authority nor had a strained relationship with any of doctors they consulted. The couple rather generously understood the surgeons’ lack of communication skills. Facing Yi’s tears over her post-operative pain, the surgeons responded only with a “stiff look.” Yet Yi understood that because “they have come across exactly the same complaints from so many patients, the surgeons cannot gently comfort me.”92

Nevertheless, the absence of interpersonal communication between patients and doctors eventually exacerbated Yi and her husband’s distrust in the biomedical system. Yearning for more information from all kinds of domestic and foreign references, the couple came to reconsider the biomedical definition of health and disease. The husband elaborated:
I and my wife gradually came to distrust Western medicine. From the beginning, I was suspicious of Western medicine, which focuses only on symptomatic treatment. On the contrary, I trust traditional medicine, as it aims to cure the root of disease. My wife is a nurse trained in biomedicine, but is now drawn to discredit Western medicine as well. . . . I believe that the cause of a disease lies in one’s mind in 80% [of all cases]. Administering medicine is surely important; so is the attitude of the mind or mental therapy. But if I come to a hospital [with my wife], a patient only sees a doctor for one or two minutes after hours of waiting. How can a patient even fully inform the doctor of her symptoms? I frequently doubt how one’s disease can be cured by merely receiving prescribed medicine. More to the point, I assume cancer does not occur in one day. That being said, how can Western medicine easily cure the disease [cancer] in a short time? I came to believe that a disease can only be cured by renewing one’s mind and correcting one’s dietary habits.93

The short and insincere dialogue between a doctor and a patient, according to Yi’s husband, was caused by inadequate definition of diseases and healing. Standardized diagnoses and prescriptions for treatment silenced the individuality of human beings, thereby failing to capture the complex interactions between mind and body. The Yi family’s memoir underlined focused, interpersonal communication as the central building block of trust in clinical encounters.

A Patient’s Activism

As soon as Yi completed radiation therapy, she desperately wanted “to do something” for other breast cancer patients. Yi herself greatly benefited from other survivors’ experiences. For instance, Yi was introduced to the work of an American activist, Teresa Lasser, who founded the Reach to Recovery support program of the American Cancer Society.94 When Lasser visited Korea in 1974, she brought in sample bras for mastectomy patients. Emulating Lasser’s example, Yi sent a special order to the Nam Young Company to manufacture bras for Korean mastectomy patients. Most importantly, during Yi’s radiation therapy, she and her husband were shocked by the sheer number of breast cancer patients who they encountered at the hospital, who were also depressed, disappointed, and discouraged.95 Without nationwide statistics, we cannot verify their statements. Yet the couple was both surprised and encouraged by the fact that they were not the only victims of breast cancer.

When the 50 bras were delivered in September 1979, Yi solicited a list of patients from Severance Hospital, then sent out 75 letters of invitation. On the 20th of the same month, ten patients gathered at Yi’s house, sharing their own experiences. The memoir highlighted this moment with unprecedented empathy and hope. Connecting with other patients opened a new chapter in Yi’s life as a religious and professional nurse-patient, a suffering healer. Yi’s activism, although limited in scope, provided her a novel framework through which she experienced “overjoy and fullness.” As long as she felt connected with other patients, she “forgot about her own disease.”96

After a year of Yi’s activism, Yi’s husband noticed a pattern emerging from the list. “My wife’s list that was collected from many hospitals [in Seoul] detailed name, age, operation date, address, and telephone number.”97 When Yi’s mood fluctuated due to the deaths of other patients, he contacted other patients on her behalf. From his firsthand observations, he came to realize that at least half of the patients who received surgical operations (mostly radical mastectomies) passed away within six months. Regarding the prognosis, he also clarified that “after nine months or a year, many recurrences tend to occur. If relapses happen, then the patient is hospitalized again. Re-surgery only prolongs life a couple of months. [Relapse] means a serious metastasis. Two-thirds of these cases would perish soon.”

Yi’s husband sarcastically contrasted the survivors with the dead. Those who passed away within six months after surgery, ironically, were from affluent families. Economically and culturally,
they had the resources to fully conform to a hospital’s therapeutic solutions: they received radiation treatment and endured chemotherapy, yet rarely survived more than six months. On the contrary, those who lacked financial resources often deviated from the hospital’s course of treatment. In desperation, they often committed themselves to religion, folk therapy, traditional medicine, and natural treatments - which sometimes helped them survive more than six months.

It is not my purpose to measure the authenticity of Yi’s husband’s statement based on supposedly objective data. The data about breast cancer treatment became a locus of serious debates among American and European surgeons in the 1960s, and it was only at the 1970 meeting of the American College of Surgeons that a renowned surgeon, Bernard Fisher, called for more organized and definitive randomized and controlled trials to measure surgical outcomes. Although resistance was also obvious, Lerner assesses that Fisher’s remarks convinced many among his colleagues. Given the uncertainty of the “scientific” data of surgical treatment, Yi’s husband’s own portrayal of “patterns of post-mastectomy” defies a linear progress model based only upon five-year survival rates. Whereas elite discourse in the 1970s and 1980s depicted breast cancer as a surgically controllable malignant lump, the caregiver of a patient carefully captured the complicated process of post-operation. Yi’s husband cautiously conjectured that at least half of the patients who received surgical treatments (mostly Halsted’s radical mastectomy) “passed away in six months.” Even in a limited way, this observation can be contrasted with the ever-increasing survival rate during the 1970s and 80s. To Yi’s husband, blind conformity to the guidelines of the surgeon, biomedicine, and the hospital could not guarantee a full recovery.

The Search for an Alternative

Yi found solace in prayer. She testified, “I’ve experienced the enormous power of prayer. I have sincerely prayed for a month, then now, I reached a conviction that this radiation therapy would surely heal me.” By the summer of 1980, Yi was praying for a full recovery. However, as she felt her cancer advancing, she decided to offer a prayer that might better prepare her for approaching death. At this point, Yi wanted to go to the “Mountain Prayer House” (kidowŏn 기도원) to deepen her spiritual realization.

Fast-growing Korean Pentecostalism celebrated divine healing as one of the most explicit signs of God’s intervention. The Yoido Full Gospel Church, which was established by Ja-shil Choi and her son-in-law, David Cho, in Seoul, provided solace to the fatigue of the urban poor, promising material success and health in addition to the salvation of one’s soul. Accordingly, the church exploded from a tent gathering with less than thirty people in the early 1960s to one of the largest megachurches in the world, boasting 800,000 members in 2012. Putting her last hope in spiritual realization and miraculous healing, Yi planned an eight-day fast with prayer at the Mountain Prayer House run by the Yoido Full Gospel Church.

The prayer house first reminded Yi’s husband of a refugee camp during the Korean War. The hall was crowded with ill people who were laying about unsupervised, and the bad smell was mixed with sounds of prayer and coughing. Abhorring the miserable situation, her husband begged the guard for a better place if he paid an extra fee. When Yi found a spot in a women’s-only room with a Korean-style heating system, she stayed there for eight days, joining main worship twice a day and praying alone in a small underground tunnel. Overall, Yi and her husband expressed having had a positive experience at the prayer house. After eight days, Yi not only felt recovered physically, but also a rejuvenated hope to survive. The couple left the prayer house filled with gratitude, confidence, and new hope for the future.

After the fasting, the couple committed themselves to natural dietary and other alternative therapies. Yi ate only a small amount of vegetables, brown rice, and unshelled whole grain adlay,
refusing any meat or fish. Therapeutic cupping turned out to be particularly effective for the pain in her spine. The entire family tried it regularly. Acupressure therapy also relieved Yi’s physical fatigue. Yi’s family moved into a new house, looking for fresh air. Yi’s husband ordered an air purifier, which was not widely known among Koreans then. He also purchased a water purifier to avoid acidification. While pursuing every means of a cure except another surgery, the couple met Dr. No, a licensed internal medicine physician and a passionate advocate of vitamin B-17 therapy. According to Dr. No, the lack of vitamin B-17 causes all kinds of cancer. It was scientifically proven by “many experiments and statistics, and clinical trials,” yet the therapy was still awaiting the FDA’s authorization. Yi’s husband did his best to obtain B-17 shots from the U.S. and Germany. Yi experienced remarkable improvement, although not a complete cure, but she had to terminate the therapy due to the lack of B-17 shots in Korea.

Among other therapies, according to Yi’s husband, the patient best benefited from the made-in-Japan instrument of “visible ray therapy.” The principle was simple. Conventional wisdom taught that the sun’s warm rays cure various abscesses or incurable diseases. A Japanese inventor made an electric spark using two carbon rods, then directed the rays onto the soles of the feet of terminal-stage cancer patients. The Japanese inventor advertised its efficacy for “all kinds of cancer treatment in addition to chronic hepatitis, trouble in the liver, rectum, throat, lung, heart, kidney, myopia, far-sighted eyes, bruises, and boils.” The visible ray therapy did work in controlling Yi’s pain in her final stage.

According to the memoir, after the spring of 1982, all Yi’s husband could do was soothe his wife’s pain. As medical morphine was illegal in South Korea, Yi’s husband reached out for help to secure a sufficient pain reliever. The patient needed the pain reliever every six hours in addition to the visible ray therapy. While her husband worked in his office, a hired caregiver gave Yi a shot. Soon, Yi needed the shot every two hours, and the hired “shot-lady” requested extra money for the more frequent service. From the beginning of May to Yi’s last day on June 17, 1982, what soothed the terminally ill breast cancer patient were “shots of pain reliever every two hours, visible rays, vitamin B-17, germanium, forcefully given vegetable juice and water, the cool air generated by a negative ion cleaner, a respirator, the audio sermons by Pastor Kwak Sŏn-hee of So Mang Presbyterian Church and Pastor Yi Ch’ŏn-sŏng, and the hymns sung by a soloist, Kim T’ae-yŏng.”

**Conclusion**

The scholarly medical tradition represented by Hŏ Chun since the seventeenth century had rarely recommended a surgical intervention, as the root of breast mountain was deeply associated with regimen, emotion, and the bodily circulation of qi. Hŏ Chun’s explanation of breast mountain, which was derived from a millennium-old textual tradition in East Asia, is surely consonant with the current sensitivity to hormone-related therapies and etiological awareness of environmental factors. However, the biomedically-trained surgeons of the twentieth century ignored the past understanding of breast mountain, authorizing only Halsted’s radical mastectomy as the most effective treatment until the mid-1980s. Under the Cold War framework of medical training, South Korean surgeons embraced American surgical authority without hesitation, and, accordingly, viewed American mainstream medicine as an infallible source of medical innovation. By the early 1990s, South Korean surgeons, as a group, were not in a position to question or debate the established American authority – Halsted’s radical mastectomy.

Yi Hyo-suk’s memoir primarily testifies to the patient family’s desperate trials of all kinds of therapies in the early 1980s. Although Yi first relied on surgery, she and her family came to agree more with Hŏ Chun’s explanation of breast mountain. The patient’s testimony and surgeons’ terminologies disclose a dissimilar understanding of cancer’s ontology and possible treatments.
Whereas surgeon-authors often came to terms with the “simple removal” of unnecessary body parts, the female patient Yi loathed the surgery as a life-threatening anathema, which hardly secured a cure. Not merely due to physical pain, but rather to the insufficient reasoning about cancer’s etiology, Yi and her husband rejected the operating surgeon’s advice to have another surgery for her metastasis.

Needless to say, Yi’s narrative as an individual patient should not be generalized. Yi and her husband’s portrayal of clinical encounters between 1978 and 1982, however, encourages us to further historicize issues around the patient-doctor relationship in treating breast cancer, moral grounds of secrecy, the possibility and limitation of a patient’s activism, and the religious and commercial meaning of seeking alternative medicines in Korean soil.

Although popular discourse in today’s South Korea often celebrates the rapidly increasing five-year survival rate, the National (Korean) Statistics Office states that 8.9 per 100,000 women died of breast cancer in 2014. This number is surely lower than 18.3 who died of lung cancer, 14.2 of colorectal, and 12.4 of stomach cancer. However, when compared to 6.1 in 2004 and 2.0 in 1993, the 8.9 in 2014 demonstrates a steady increase of breast cancer deaths among Korean women. As Aaron E. Carroll well points out, the increased survival rate, which is mostly based on early screening, does not necessarily imply that fewer women are dying of breast cancer. In a similar vein, H. Gilbert Welch has criticized the culture of over-diagnosis in the American health care system, which demonstrates an obsession with the idea of complete control, yet rarely pays attention to the quantity and quality of breast cancer deaths. If translated into the Korean context, Carroll’s and Welch’s research reminds us that despite the increased survival rate and the successful cases of breast-conserving surgery, more women in South Korea died of breast cancer in 2014 than in 1993. Rethinking the manifold narratives about surgical intervention in a transnational and trans-temporal context, therefore, urges us to begin a dialogue that can raise hope beyond an increased survival rate.

NOTES
4. See the national statistical report in note 2.
5. Ch’oi, “Ch’oi Po-sik i mannan saram.”
6. Dr. No’s remarks hint at what Kristen Bell calls the “breast-cancer-ization of cancer survivorship,” a criticism about breast cancer’s normalizing impact on other types of cancer. See Bell, “The Breast-Cancer-ization of Cancer Survivorship.”
7. Breast cancer’s history is already well documented by many historians. For instance, see Aronowitz, Unnatural History. For a more popular version, see Mukherjee, The Emperor of All Maladies, 46–59.


13. “Am (암),” in *Han’guk chŏngsin munhwa yŏn’guwŏn, Han’guk minjok munhwa tae paekkwa sajŏn*, vol. 4.

14. For a detailed analysis of breast ailments in Chinese medical classics, see Wu, “Body, Gender and Disease,” 83-128.

15. Hŏ Chun, *Tongŭi pogam, oehyŏng 外形 [External Forms], yu 乳 [Breast], kyŏraek kusŏng ǒ yuam 結核久成於乳巖 [An old lump becomes breast mountain].


17. Hŏ Chun, *Tongŭi pogam, oehyŏng, yu, yuong nyŏngo pulch’i 乳癰年高不治 [If breast abscesses become old, they are difficult to cure].


20. *Chinu sinbang [Divine Prescriptions from Chingyang (Area)], yu 乳 [Breast].

21. Regarding chongŭi, see Kim, *Hanŭihak e mich’in Chosŏn chisigin dŭl.

22. Regarding breast山, see Kim, *Hanŭihak e mich’in Chosŏn chisigin dŭl.

23. Yu Yi-t’ae, *Sirhŏm tanbang [Experienced Simple Prescriptions]*, yubu 乳部 [breast section].

24. For more details, see Paek In-je paksa chŏn’gi kanhaeng wiwŏnhoe, *Sŏngakcha Paek In-je.*

25. The exact number of surgeons produced by 1945 is not available. However, approximately 4,000 Korean doctors were trained in biomedicine under Japanese colonialism (1910-45). The number increased from less than 100 in 1910 to 2,600 in 1943. Kim, “Ilche kangjŏmgi chosŏnin tŭl ŭi ŭisa toegi,” 429-468.

26. Although surgeons had been removing breast tumors since antiquity, surgical removal of breast tumors was rare in early-nineteenth-century America and Britain. Surgeons viewed cancer in the breast as a local and specific disease, although humoral theory provides an alternative approach. Aronowitz detailed the cultural, clinical, and spiritual meaning of breast surgery in the U.S. by analyzing Susan Dillwyn Emlen’s (1769-1819) struggle with cancer of the breast. Aronowitz, *Unnatural History*, 21-50.


29. *Chosŏn ilbo*, May 9, 1934.

30. To a certain degree, the Americans continued to rely on the Japanese colonial system. Koreans kept using Japanese textbooks to train surgeons, and clinical apprenticeship was carried out according to the Japanese unit of a classroom. Neither a medical board system nor specialization in anesthesiology, cardiothoracic surgery, neurosurgery, orthopedics, or plastic surgery had yet been established. However, U.S.-centered medical education was imminent, and surgeons themselves were aware of the challenge.


Rethinking Breast Mountain

– Suh


40. Taehan oegwa hakhoe, Taehan oegwa hakhoe 50 nyŏnsa, preface.


42. Ibid.

43. The first volume of Taehan oegwa hakhoeji [The Journal of the Korean Surgical Society] was published in 1959. The monthly journal was retitled Annals of Surgical Treatment and Research in 2014, and publishes only in English now.


47. Given that Korean women’s life expectancy in the 1960s did not exceed 65 years, the patient Ms. Kim received a strenuous surgical operation at an old age. In today’s terms, the operation was like a radical mastectomy upon an 85-year-old woman, which many surgeons would oppose.


52. K. S. Min, “Clinical Experiences of the Mammary Carcinoma with Special Reference to Late Result.” JKSS 8, no. 3 (1966): 142.

53. Davis, Christopher’s Textbook of Surgery, 380.


55. For Owen Wangensteen and Jerome Urban, see Lerner, The Breast Cancer Wars, 74–79.

56. Ibid., 80–81.

57. For George B. Crile, see Aronowitz, Unnatural History, 322–323, or Chapter Eight.


60. Davis, Christopher’s Textbook of Surgery, 349.


62. Ibid.


69. For George Crile Jr, see Lerner, The Breast Cancer Wars, 61-64.

70. Ibid., 159.


74. Yi Hyo-suk, Amŭro kot’ong pannŭn yi.

75. Kim, Syain, 117.

76. For a recent ethnography, see Nelson, “Diagnosing Breast Cancer in South Korea.” For a recent review of patient-interview–based research in South Korea, see Suh, “The Impact of Cancer Diagnosis and Its Treatment.” Today, we can trace patients’ voices through breast cancer patients’ organizations (Hwanuhoe) both on- and off-line, published survivor stories, and media interviews.

77. Yi Hyo-suk, Amŭro kot’ong pannŭn yi, 12.

78. Regarding the growth of Evangelical Protestantism as the most influential religion of South Korea between 1885 and the 1990s, see Lee, Born Again. For the rapid growth between 1953 and 1988, see Chapter 3.


80. As a graduate of Yonsei University, Yi chose the surgeon because he was the husband of Yi’s old friend from the university.

81. This institution was established in 1963.

82. This institution originated from a clinic founded in 1944, and then became affiliated with Catholic University in 1961.

83. Yi Hyo-suk, Amŭro kot’ong pannŭn yi, 78.


85. Yi Hyo-suk, Amŭro kot’ong pannŭn yi, 130.

86. Ibid., 214.

87. Ibid., 207.

88. Ibid., 18.

89. Ibid., 113. From Yi’s diary in July 1980.

90. Ibid., 10.

91. Ibid., 14.

92. Ibid., 18-19.

93. Ibid., 111-112.

94. Regarding Lasser, see Lerner, The Breast Cancer Wars, 102-103.

95. Yi Hyo-suk, Amŭro kot’ong pannŭn yi, 92-93.

96. Ibid., 95-96.

97. From today’s point of view, it is unthinkable for major hospitals in Seoul to share patients’ records with another patient. However, Yi was once a nurse, hence she was probably understood as “one of us” by some medical staff at that time. In addition, Yi’s intention to organize a voluntary patient meeting might be considered positively by other medical staff. The first breast cancer patients’ organization, Korea

98. Lerner, The Breast Cancer Wars, 139-140, or chapter 6.
100. Regarding divine healing, see Kim, “Reenchanted.”
101. For the church’s history from an insider’s perspective, see Lee, The Holy Spirit Movement in Korea, 93-110.
103. Ibid.
105. Welch, “When Screening is Bad for a Woman’s Health.” For more of his argument, see Welch et al., Making People Sick in the Pursuit of Health. Carroll, “Why Survival Rate Is Not the Best Way to Judge Cancer Spending.”

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Walking the Walk, Talking the Talk: Narratives that Challenge HIV/AIDS Taboos in Japan

by Pamela Runestad, Ph.D., Creighton University

‘Any given day, someone faces it.
Any given day, someone is informed they have it.
Any given day, someone makes the decision to live with it.

HIV—
A small, small virus in an electron microscope
This big shadow thrown into everyday life

It’s been 20 years since HIV/AIDS appeared in the world.
This book contains notes by people living with and affected by HIV/AIDS.

LIVING TOGETHER.
If you can find yourself in the sentences of this book,
We’ll be grateful.’

- From ‘Living Together: Our Stories,’ a 2005 booklet about living with HIV/AIDS edited by Ikegami Chizuko and Ikushima Yuzuru of Place Tokyo, Japan’s first and most influential HIV/AIDS support organization. Translation by the author.

Introduction

HIV/AIDS in Japan

Japanese infectious disease specialists know the pathogen Human Immunodeficiency Virus (HIV) as hito men’eki fuzen uirusu (ヒト免疫不全ウイルス). Acquired Immune Deficiency Syndrome, or AIDS, which is the syndrome caused by HIV, is known as kotensei men’eki fuzen shoukougun (後天性免疫不全症候群). However, both HIV and AIDS are referred to collectively by the general public by a katakana name derived from the English acronym AIDS – eizu (エイズ). The most common route of infection in Japan is through sexual transmission: male-male sexual contact constituted almost 70% of all cases in 2015, while heterosexual sex accounted for approximately 20% of cases. General efforts have been made to prevent the spread of HIV since the first reported case in Japan in 1985: condoms are readily available; sterilization of medical equipment, screening of organ and blood donors, and heat treatment of blood products are standard practices; and HIV screening of pregnant women is mandatory. However, prevention efforts at the individual level (such as barrier use during sex and HIV testing rates among members of high risk groups such as Japanese men)
have been adversely affected by problems stemming from conservative sex education programs and policies that ignore sexual practices that go beyond family building, general perceptions of HIV/AIDS as a “foreign” rather than domestic disease, the perception that HIV=AIDS and AIDS=death, and sexual morals in which women are expected to be chaste wives and mothers (who can thus be blamed for the nation’s poor sexual health if they deviate from these ideals) while there is some expectation that men engage in extramarital sex (and are less likely to be held accountable for polluting the body politic).8

Treatment of HIV/AIDS includes a strict regimen of anti-retroviral (ARV) medication prescribed by a physician. These are available to Japanese patients on the national health insurance plan. However, two key points must be made here. First, almost none of the members of the HIV negative general public I interviewed in 2011-12 knew there was medication for HIV. Rather, in the words of one male interviewee, “when you get eizu, you die.”9 The second point is that ARVs are expensive even with insurance and require registration of one’s HIV status to get the discounted rate. Furthermore, several people living with HIV/AIDS, or yōseisha (陽性者) I interviewed pointed out that professionals such as pharmacists can determine a yōseisha’s HIV status based on their prescriptions, and even medical practitioners make assumptions about their sexuality and behaviors based on their HIV status. Mr. T, for example, stated in an October 2011 interview that although he is now on good terms with his doctor, he was taken aback when he was diagnosed a few years prior because his physician followed his diagnosis with the comment, “Oh, so you must be gay, then.” In other words, newly diagnosed yōseisha are likely to think that they are going to die upon hearing their HIV diagnosis (a fear highlighted in narratives below) because few Japanese know about ARVs, and they are vulnerable to discrimination and stigmatization even by those who are supposed to help them once they are diagnosed and begin treatment.

Misconceptions about HIV/AIDS such as these may be at the root of HIV/AIDS incidence and prevalence in Japan: there have been about 25,000 cases of HIV/AIDS reported cumulatively (about 0.1% of the population)10. There are about 1,000 new cases of HIV and 400 new cases AIDS annually, and these new cases of AIDS represent people who were NOT previously diagnosed as having HIV (ibid). This phenomenon is called ‘suddenly, AIDS’ or ikinari eizu (いきなりエイズ). Although these numbers are much smaller than prevalence and incidence in other countries, the general upward trend is troubling for a society with a relatively high literacy rate and a socialized healthcare system. Those living with HIV/AIDS and working with yōseisha populations are interested in breaking these misconceptions about the illness by challenging the taboos surrounding it through direct discussion of HIV/AIDS in various narrative formats, discussed below.

Illness narratives: Forms and Uses

Researchers from disciplines such as literature, history, psychology, and anthropology have all discussed uses of illness narratives in some form, and each of those perspectives are useful for the discussion of HIV/AIDS narratives in Japan. Regarding narrative forms in general (both written and spoken), Ochs and Capps describe narrative as a method of making sense of experience through the ordering of events that may seem disparate; it is also a resource for socializing emotions, attitude, and identities, developing personal relationships, and constituting membership in a community.11 They further assert that narrative and self are inseparable because narratives are born out of and give shape to experience.12 In other words, experience shapes narrative; but being able to order events through culturally appropriate narratives allows a person to assign meaning to an experience, serves as a mode of self-expression, and functions as an assertion or sign of one’s position in a community.

Narratives have been an anthropological staple since the early 1900s but W.H.R. Rivers’ use of illness narratives (spoken narratives converted to written format as ethnographic data) at that
time was among the earliest to argue that the healing practices of others were not random but rather exhibited a coherent, internal logic. In this way, illness narratives have been considered ways of ‘finding out’ about cultural systems for the listener. In the same way that Rivers learned about Melanesian societies by studying massage there, we can learn about Japanese culture and concepts of illness through analysis of how the Japanese narrate HIV/AIDS. Additionally, it has become well-known that illness/wellness narratives are not medically inert for the writer-speaker or the reader-listener. In other words, narratives are not just about health practices – they can influence individual health by providing catharsis, and public health through audience education. Recognition of these benefits began with Freud, and is apparent in the work of psychiatrist-anthropologists Allan Young and Arthur Kleinman.

An early example of this that is particularly germane to written illness narratives of infectious disease in Japan is historian Kathryn Tanaka’s analysis of leprosy/Hansen’s Disease (HD) literature in Japan, in which she illustrates that rationale for writing about illness is dynamic and dependent on social, cultural, and technological landscapes. She asserts that once Promin was developed as a treatment and cure for leprosy in 1946, there was a shift from ‘leprosy literature’ in which narratives were a heavily censored phenomenon that grew out of hospital administrators urging patients to come to terms with their incurable illness and quarantine policies, to ‘HD literature’ in which narratives became a politically engaged literature insistent on the restoration of human rights. The rise in writing about HD experiences in Japan during the twentieth century signals a change in focus from illness narratives as therapeutic literature to a form of activism.

As discussed by Tanaka, written illness narratives like those by leprosy/HD patients highlighted above can be considered a genre in their own right. Writing specifically about HIV/AIDS, literature specialist Ann Jurecic draws attention to the fact that writing as well as speaking about illness publicly in general is a relatively new trend that was fostered by the HIV/AIDS epidemic in the United States. Written HIV/AIDS narratives in English exceed the quantity of writing about flu, tuberculosis, polio, cancer, and other illnesses combined, and these narratives have proliferated due to increased distances between patients and practitioners in the medical profession, improvements in modern health care and understanding of HIV etiology in which a treatment or cure appears feasible, women’s liberation, gay liberation, and the ‘inability of master narratives to give meaning to suffering in the modern era... [as well as] the technological advances that promote self-publication and the global distribution of information.” In other words, the socio-cultural, technological, and medical climate in the United States has allowed for illness narratives, particularly written HIV/AIDS illness narratives, to become very public there – just as leprosy/HD narratives did in Japan (although the timeframe is not the same). In addition, even though the HIV/AIDS narratives in Japan I discuss below have not attained the same status or recognition as the Japanese leprosy/HD literature described above, the distinction between ‘before treatment’ and ‘after treatment’ conditions for writing (i.e., preparing for disfigurement and a slow death as opposed to learning to live with the stigma of having been infected) fits both illnesses.

Similar to Jurecic’s assertion that the proliferation of public discussions of illness is a relatively new phenomenon in Anglophone media, direct discussion of illness appears relatively recent in Japan when considering the issue of disclosure in self-help groups versus patient disclosure and disclosure to friends, family, and coworkers. Paul Christensen’s work on Alcoholics Anonymous (AA) in Japan is particularly instructive here: he describes how members of AA in Japan disclose to the group but keep their status as alcoholics and AA members secret in daily life, indicating inability to fully ‘come out’ or speak publicly about alcoholism as a social problem for fear of stigmatization or harassment not just as individuals, but as family members or company workers. But ramifications are further complicated when the person in question is experiencing an infectious disease and
the medical community is involved due to differences in who is disclosing to whom, and what the perceived risks are for the individual and for society. For example, as Susan Long has illustrated, medical practitioners may disclose a terminal cancer diagnosis to the family of a Japanese patient rather than the patient themselves as a form of kindness or mercy.\textsuperscript{21} The patient is usually able to ascertain the diagnosis indirectly; this type of disclosure preserves the humanity of the patient by allowing the family to focus on continuing with daily life rather than focusing on the person’s approaching death. But for people with illnesses that the general population may associate with ’deviant’ or ’abnormal’ behavior, disclosure by patients to others is more about avoiding stigma and discrimination whereas disclosure by medical practitioners to patients’ families is about avoiding psychological trauma to the patient. In fact, early in the epidemic, the medical community feared disclosing an HIV diagnosis to patients who had been exposed to HIV through medical treatment and indeed failed to disclose to them, while publically disclosing the HIV status of sex workers.\textsuperscript{22} Once this was discovered, it became a patient rights issue; the infectious nature of HIV essentially forced the Japanese medical community to re-think the family model of disclosure because of risks to public health and family relations if HIV/AIDS patients were not informed of their HIV status but family members were.\textsuperscript{23} In short, the emergence of HIV/AIDS issues made illness a topic of conversation (as it did in written form in the U.S.), but the context in which this happened was rife with stigma and discrimination against those perceived to be polluting the body politic – problems that, as presented below, yōseisha still experience.

With regard to spoken illness narratives in particular, these may have roots in self-help groups such as AA in the United States in the 1930s.\textsuperscript{24} Rooted in Protestantism, AA incorporates characteristics of religious witnessing, including public (or semi-public) statements about personal experiences, confirmation of faith in the group and invitations to others to join, confirmation of solidarity of the group, a learned, patterned form of experience narrative, and re-writing of personal history according to experience with the group.\textsuperscript{25} These characteristics, having been secularized to some degree, are also apparent in non-religious self-help groups; as indicated above, AA itself is also active in Japan and its presence may have influenced the proliferation of self-help groups. In fact, the tendency for yōseisha to speak about their status in peer support groups may look similar to disclosure in AA meetings in that yōseisha tend to give a brief introduction and are encouraged to talk about what is bothering them. However, unlike alcoholism, HIV status is often tied up with other tabooed topics such as homosexuality. For example, one of my interviewees, a Japanese civil servant from Kansai, stated, ‘it’s harder for me to tell my parents that I’m gay than I’m HIV positive.’\textsuperscript{26} He continued to say that he had not told his parents about his HIV status because he would have to tell them how he got it (through sex) – and that he is gay. Interestingly, these are things he is willing to disclose anonymously in public. It is precisely these differences – the association with supposed ‘abnormal’ sexuality and the willingness to speak out (albeit anonymously) about it – that make HIV narratives different from other illness narratives in
Japan. The pressure that some yōseisha feel from other members of society that somehow they are ‘not normal,’ often doubly stigmatized due to their illness and perceived means of transmission, has inspired them to write and speak about the realities of living with HIV in the hopes that they can increase public understanding and thus decrease stigmatization. They narrate their experiences with HIV in public ways not just to give order to their own experiences, but to encourage discussion of the feared and tabooed topics of HIV/AIDS and sex – things that are omnipresent due to various mass media representations and entertainment industries, but are considered ‘inappropriate’ for polite conversation or education.27

In addition to the variety of written and spoken illness narratives produced for various reasons and audiences, illness narratives may also be performed in various settings.28 Some of the most studied versions of such performances are clinical encounters, where patients and medical practitioners play particular roles (or refuse to play particular roles); otherwise, there is little literature that describes the significance or the embodied, performed illness narrative – particularly in conjunction with written and spoken illness narratives. Moreover, it appears that attention to these topics provides us the chance to see the emergence of new forms of Japanese narrative as well as the opportunity to see how some Japanese not only combat tabooed topics, but also reject the premise of similarity inherent in the often-heard phrase, ‘we Japanese’ (ware ware nihonjin 我々日本人).

**Flexible kata**

*Kata* (方) is a form or a way of doing something such as the stroke order of writing a Chinese character, the placement of flowers in a flower arrangement, the motions in tea ceremony, or even moves in martial arts. Although often used in reference to fine arts and martial arts, it can be applied to everyday or professional tasks as well, such as making a dish, filling in forms, or even talking on the telephone. In the analysis of narratives below, I discuss how the *way* of telling about life with HIV/AIDS, or *kata*, is on one hand fairly consistent in terms of the components they include regardless of the mode of presentation, but adapted to the needs of individuals, audiences, and events on the other. In this way, the *kata* of HIV/AIDS narratives in Japan is quite flexible when compared to the *kata* of tea ceremony, calligraphy, and flower arrangement. Drawing from Yano’s assertion that one must have mastered *kata* in order to break *kata* – and thus push forward a form of art – I consider the narrators of HIV/AIDS as masters: having perfected their own versions of HIV/AIDS narrative, they (not the general public, mass media, or medical profession) are the masters of explaining what it is to live with HIV/AIDS.29

**Methods**

The narratives discussed here were gathered by the author between 2010-2012 during ethnographic research conducted with NGO/NPOs that support yōseisha in Kyoto and Tokyo. The author translated several excerpts from the popular booklet, ‘Living Together: Our Stories’ which was published by Japan’s first and foremost HIV/AIDS community-based organization, Place Tokyo.30 The author conducted 75 semi-structured interviews (including yōseisha as well as HIV-Japanese)31 and conducted participant observation at several events including the AIDS Bunka Forum and PLANET Candle Parade described below. The data from the AIDS Bunka Forum Yokohama talk by Ms. Ishida and Dr. Iwamuro are derived from notes taken by the author (recordings were not permitted) as an audience participant in 2011. The data from the PLANET Candle Parade were collected through participant observation of the parade in which the author walked alongside and amidst other participants in 2011.

**Talking the Talk: Written HIV/AIDS narratives in ‘Living Together: Our Stories’**

Place Tokyo is Japan’s first, most established, and arguably most far-reaching HIV-related
support organization. Place Tokyo has been working to provide support for yōseisha since 1994; the organization pre-dates UNAIDS by two years. Founder Ikekami Chizako was inspired to start Place Tokyo after spending several years working with sexologist Milton Diamond from the University of Hawai’i and staff at the Life Foundation in Honolulu. The mission of the Life Foundation is “To stop the spread of HIV and AIDS. To empower those affected by HIV/AIDS and maximize their quality of life. To provide leadership and advocacy in responding to the AIDS epidemic. To apply the skills and lessons learned from the AIDS epidemic to other related areas of public health or concern.” The idea was to create an atmosphere that stymied stigma and discrimination while also providing social support, testing, and information on medical care and services. Thus, The Life Foundation created a comprehensive support system that included telephone help lines, a buddy system, AIDS education programs, and research. These foci are clearly visible at Place Tokyo, which offers telephone counseling and peer group meetings and events and also creates educational materials and conducts research. Place Tokyo also emphasizes the importance of fostering a positive environment with regard to HIV.

The importance of ‘living positively’ was also carried over from the Life Foundation to Place Tokyo: “Place” stands for Positive Living And Community Empowerment. “Positive Living” refers to “living as yourself;” “Community” refers to a group of people who collectively and actively engage in activities to create a healthy environment and foster interest and concern for others in daily life; “Empowerment” represents learning how to channel one's inner power, whatever it is and in whatever way is best for an individual. Ms. Ikekami further notes that empowerment starts at an individual level, but is necessary on the societal level for social change. In this way, empowerment is considered multi-dimensional and interactive. Ms. Ikekami describes the timing and the start of the organization this way:

Place Tokyo has been functioning as a research network since 1995. The World AIDS Conference was held in Yokohama in 1994. At that time, NGOs and CBOs played a really effective role, so the administration for the first time recognized that NGOs and CBOs also provide valuable input in HIV policies. And then, they also realized that if those groups want to do research, it should be considered. Up until then, “HIV/AIDS research” was something that was only done by scientists and physicians. But there is research that really only CBOs are able to do.

The first real research that we did was an assessment based on HIV+ people’s input. For this research, of course we included someone who could act as an HIV representative and participate in the research team and checked everything from choosing the topics on. Until then, there had been no research like that. In particular, there was nothing but notifications from yōseisha through doctors who did this and that in their own offices. And we thought, “Is it OK to keep doing it like that? And how does how it’s done influence what kind of information is considered desirable? Maybe we should make sure the information given by the yōseisha benefits the yōseisha”... From getting the people who are affected involved, to focusing on prevention, and now care, that has been our trajectory.

In addition to research and publication, other activities were simultaneously taking place to keep both yōseisha and the general public tuned in to HIV issues: peer support groups, newsletters, and telephone hotlines provided spaces for dialog about living with HIV. Research informed how these activities were executed, and activities shaped research. In other words, the relationship between outreach and research is dialectical in nature. Essentially, Place Tokyo has grown from a group of people that collected and digested information for the public and for yōseisha prior to 1994 into an organization that conducts research alongside yōseisha that not only contributes to understandings
of HIV/AIDS in Japan but facilitates education, counseling, and improvement in the quality of life for people in the community.

“Living together. If you can find yourself in the sentences of these pages, we’ll be grateful.”

So begins Place Tokyo’s booklet, “Living Together, Our Stories,” which is about living with HIV/AIDS. Notice how the editors, from the first page, deftly encourage readers to “find themselves” as a way of “living together.” Self-reflection and self-care are means to understanding others and building a positive environment or society. I will not reproduce the lengthy discussion about individualism versus groupism that has permeated discussion of Japan by academics and is also present in everyday discourse there; but I do want to highlight the significance of this perspective. This philosophy of actively making a positive environment everyone can live in by understanding and caring for the self is a response to what Place Tokyo founder Ikegami Chizuko recognizes as an “environmental problem” in which Japanese, particularly young Japanese, have been passive participants in society who leave decisions – even decisions about safer sex – up to others. Focusing on how social problems and public health issues like HIV and other sexually transmitted infections (STIs) are perceived by young people as “not their problem,” she asserts that this attitude perpetuates blame and stigmatization because the spread of infectious disease is something others should “not spread” rather than something they themselves should protect themselves from. One of Place Tokyo’s goals, then, is to change the environment (society) by encouraging frank discussions about sex and sexual health so that individual and public health is improved. It is important to point out that according to Place Tokyo, improving public health is not limited to decreasing the incidence and prevalence of STIs like HIV; rather, it includes building a supportive (positive) environment for everyone – but particularly for people who have experienced some form of discrimination. One way to do this is to foster communication – to break the taboos against speaking honestly and openly about sex. Ms. Ikegami describes their campaign to encourage couples to talk about sex and condoms this way:

> Just getting information doesn’t connect to preventative behavior. What is obstructing preventative behavior with regard to sexually transmitted HIV in Japan? ... In the case of female students, they hesitate with regard to their male partners, and find it difficult to strongly say for themselves that they want to use protection, or convince them to use it... In male students the same age... it’s that they’re not used to using them. They think they’re uncool or don’t feel good or destroy the mood. [So we want to tell them], if you’re not used to it, you should get used to it, right? About the relationship factors in the females, girls think that if they strongly assert themselves, it’s not ladylike or it leaves a bad impression, but we want to tell them, you’ve got the wrong impression. Boys don’t actually think that. But if the partners communicate beforehand, these misconceptions clear up, and they should think about that. If we change the image to make it positive, that preventative behaviors are cool, whether you’re male or female you can protect your sexual health – we want to spread that message widely. “It’s YOUR problem.” They think it’s not their problem but someone else’s. But it is their problem. It’s “our” problem, is what we want to say...”

“Living Together: Our Stories” is an example of how Place Tokyo combines research, education, counseling, and outreach in a single publication. Through this first poem, readers are drawn into...
experiences of living with HIV/AIDS – for those infected, for their friends and family members, for their partners (many of whom do not have HIV). Through the assertion that someone “faces it... is told they have it... decides to live with it” everyday, and the invitation to find themselves in the booklet, readers are also encouraged to think of themselves as that “someone,” to see HIV as an issue they can own through becoming more knowledgeable and taking charge of their own sexual health. To facilitate this, the stories are interspersed with columns by Ikegami and Ikushima Yuzuru, a medical social worker who counsels people living with HIV/AIDS at Place Tokyo. Readers also find the Place Tokyo website at the end of the booklet, and are encouraged to visit it so that they can find out more about the organization, its research and resources, and HIV/AIDS in general.

Through the inclusion of narratives from various types of narrators, this booklet serves as a resource for readers who may be drawn in by the drive to “find out” about the lives of “real people” living with HIV; readers who may be searching for the words of someone else to comfort them, to feel that they are not alone in their diagnosis; readers who may be searching for information about how to interact with a loved one living with HIV; or readers who simply want to know more about HIV and where to get “good” information. Here, I focus on the narratives by yōseisha because these written narratives provide us with some insight about the typical structure of HIV/AIDS narratives in Japan.

“At First, I Just Thought of Suicide” By KN

Even now sometimes when I think back on when I found out, my chest hurts. I never felt so panicked and full of despair. I just felt death was so real. Of course, I had some knowledge of what HIV/AIDS was, but at the moment when I found out, it just evaporated.

At first, I thought of nothing but suicide. I’m going to die anyway, so it might as well be now... there’s not going to be a cure in my lifetime... But the people around me wouldn’t accept that, and the days went by.

Before I found out, I didn’t like myself at all and I was really careless. I wasn’t good at my job or being with others, and I had lost all confidence. And then I started feeling really bad, and I wondered, “I can’t really have THAT...” but I went and got a test.

Actually, I’d had a test two years before. Then I was negative, and the way I was treated at the test center was very business-like. But the day I found out, I was treated totally differently. I was taken to a room with no window, and I could hear other people being told they were negative through the door. “Why am I being made to wait here this time?” “Maybe...” “No, it can’t be...” As I thought, my throat got dry and my hands were wet with sweat. After a short while, I was taken into another room again and I was told the result. I started to panic and broke down and cried.

This time, the results of the blood test showed I needed to start taking medication right away, but that I wasn’t showing symptoms of AIDS. The doctor said, “That’s really lucky!” But at the time, I couldn’t understand that.

For me, the courage to live with HIV came when the attending physician said, “I can help you.” Before that, I hoped for “a death” from everyone around me.

Living with HIV, I’ve rebuilt my self confidence and started over. In the last 2 years plus, I’ve thought, “I can’t do it anymore!” many times. But recently, something about me is different... I’ve been able to like the self that chose to live with HIV a bit more than before. So now when I think “I can’t do it!” or when I’m faced with something over and over, I’ve
become able to think, “I can definitely get through this.” So, I like myself, the me that thinks like that, better.

I don’t know how many years I’ll live. I don’t know what ordeals are waiting for me. I’ve only rebuilt myself part-way. But maybe that is “living.”

That’s what I think now. “HIV is a big chance to re-think my life, myself.”

So, “no matter how hard it is, I can overcome it.”

KN begins the narrative with the panic and despair that accompanies disclosure. For this yōseisha, such feelings were so intense that suicide seemed like the only way out since they were “going to die anyway.” In fact, HIV negative members of the Japanese general public I interviewed nearly always linked an HIV diagnosis to death: “When you get eizu, you die,” a middle-aged Japanese salaryman told me. Perhaps this is because HIV and AIDS are elided in the Japanese term eizu (as noted above) and also because HIV is only visible to the naked eye when it progresses to the point that people experience lesions and wasting, the hallmarks of AIDS and signs that suggest imminent death. These links with death, paired with the tendency for HIV in Japan to be transmitted primarily through sex, have made it a taboo topic that people find it difficult to discuss openly in serious contexts.

Next, KN goes back in time, describing their lack of self worth and the lead up to the test. This provides a point of comparison for the self evaluation at the time of writing (discussed below), and admission that the positive test followed a negative test a few years before allows them to compare what it is like to be given both negative and positive results. Noting that they could hear people being told they were negative and the sense that this time was different, KN describes breaking into a sweat and finally breaking down in tears upon hearing the HIV test was positive this time. Because of the trauma of diagnosis, they were unable to comprehend the doctor’s assessment that although they needed medication, they had not progressed to AIDS. Many yōseisha, both in writing and in interviews with me, stated that because they associated HIV with death and because they considered it “someone else’s problem” prior to diagnosis, they were filled with self-blame upon diagnosis and that such ideas were barriers they had to overcome in being able to accept their HIV status. Another writer, K, put it this way:

When I was told I was positive, my heart was filled with fear and humiliation… When directly faced with various hard facts at the hospital, I felt… as though I was guilty of a terrible sin. The image of this illness that has been presented up until now is that it’s something not worthy of consideration or encouragement. Even I, myself, someone with HIV, had this strong, discriminatory view.

Returning to KN’s narrative, they move on to describing the decision to live with HIV, stating that that became possible when the doctor made it clear that treatment and care could improve their condition. Finding support was the turning point. From there, KN describes taking charge of their life, and realizing that “I like myself… better” now than they did before the HIV diagnosis. This was also a common theme in my interviews with yōseisha. For example, a retired accountant in his 60s who had been living with HIV for 25 years stated, “HIV is only part of me” when discussing his acceptance of HIV. These messages, when made available to others, serve as reassurances to newly diagnosed that they are not alone and that they can live a good life with HIV. In other words, the writings of yōseisha make them part of a peer network even if they never meet their readers face to face, and such writings aim to tell readers that HIV is not a death sentence.

To summarize, the framework, or kata, for the written yōseisha narratives in Place Tokyo’s booklet includes 1) pre-diagnosis and the diagnosis, 2) difficulty with acceptance and disclosure, 3) finding...
support, 4) becoming part of the peer support network, and 5) final comments about life with HIV.

This is the general trajectory in the 2005 booklet as well as the narratives included, but the order
and emphasis of these components is flexible and varies from writer to writer. The overall style of
writing is colloquial and confessional, highlighting each writer’s voice and feelings, thereby lending
authenticity to each story while also giving readers the sense that the writers are speaking to them.
Moreover, the disclosure of intimate feelings and experiences allows readers to feel that they know
someone like KN or K or they are like them somehow, even though the identities of the
writers have been protected. In fact, it is even difficult to ascertain the gender of most (but
not all) writers. Essentially, the style and framework allow the writers to reach out to
others and not only share their stories, but create an opportunity for Japanese to talk
about HIV/AIDS as a domestic problem – to break the taboos surrounding it. Use of
this flexible kata, which allows for a delicate balance of intimate sharing while protecting
one’s identity, is also discernable at the
HIV/AIDS events described below in which
yōseisha speak publicly about life with HIV/
AIDS. Considering the steady support Place
Tokyo has provided for yōseisha since 1994,
perhaps this is not coincidence.

Talking the Talk: Performing HIV/AIDS Narratives at the AIDS Bunka Forum in
Yokohama 2011

AIDS Bunka Forums are two-day, conference-style public events held annually across Japan.
Anyone can attend and admission is free. They are widely publicized and students in particular are
encouraged to come. Activities include workshops, guest speakers, concerts, red ribbon manicures,
and art exhibits; NGOs/NPOs generally have booths set up in common areas. The longest running
Forum is the AIDS Bunka Forum in Yokohama. Participants include people interested in learning
about sexually transmitted infections, sexuality and gender spectrums, and groups that support
sexual minorities. The list of guest speakers usually includes those who agree to speak about
their experiences with HIV in such public venues. Such yōseisha are, importantly, different from
most yōseisha in that they are comfortable in their diagnosis, willing to talk about it with others,
and also able to speak with large groups. Unlike the truly anonymous yōseisha who writes about
their experiences, there is the added risk for guest speakers that they may be recognized if an
acquaintance opts to attend. It is a risk they accept. But other risks, such as being asked questions
they are not willing or ready to answer, for example, are carefully managed by the structure of the
narrative and the settings, which include the presence of a supporter. Similar to written narratives,

a key strategy is to give the audience just enough details about a yōseisha’s personal life so that
they see the human face of HIV, but not enough to open the speaker up to stigmatization and
discrimination. Another way to put this is that the kata of the HIV/AIDS narrative is expanded to
include the physical presentation of self as a method to help the audience learn about HIV/AIDS by
challenging its status as a tabooed topic.

At the 2011 AIDS Bunka Forum in Yokohama, Ms. Ishida took the stage and Dr. Iwamuro
introduced her, giving the audience time to take in both participants visually. Ms. Ishida’s hair was
stylishly bobbed. She looked vibrant and beautiful in her flowing blue tunic, black leggings, and sandals: there was nothing to separate her from any other Japanese women in the audience in terms of her fashionable appearance. Her doctor, Dr. Iwamuro, is well-known for his role in founding the forum and appeared to be a typical middle-aged professional with glasses and graying hair. The only thing that made him stand out was his famous condom-print tie; but this probably went unnoticed by many in the audience.

The two began a conversation about her life and experiences with HIV, noting that she could not speak for all yōseisha. Dr. Iwamuro asked Ms. Ishida about how she found out that she was HIV+, the circumstances surrounding her infection, the symptoms she experienced, the difficulties of disclosure, the care she was offered, and her daily life. Through this interaction, the audience learned things about Ms. Ishida that Dr. Iwamuro already knew. She is married and has a child. All pregnant women in Japan are tested for HIV, and that is how she found out she is living with HIV. She got a tattoo several years ago and experienced flu-like symptoms (fever, swollen glands) afterwards but thought she had just gotten a bug that was going around. She was shocked to find out she was HIV+ during a prenatal exam, commenting that the tattoo parlor had probably re-used their needles. She told the audience that she had a lot of difficulty telling her family, but her doctor helped her by being there when she told her mother. She couldn’t bring herself to tell her father; her mother told him for her. At the clinic she visits, the staff all know her and are very friendly to her – she said they notice whether or not she has gained or lost weight and whether she appears happy or not. Before opening the session up for questions, she noted she is living an everyday life taking care of her child, but that it is sometimes hard because there is still a lot of discrimination.

Together, Ms. Ishida and Dr. Iwamuro constructed a narrative that guided the audience through her experiences with HIV/AIDS. Importantly her kata, though spoken on a stage and performed in collaboration with an interlocutor, is similar to the written narratives described above. Like KN, Ms. Ishida describes her diagnosis, various traumas she experienced related to this diagnosis (such as inability to tell her father her HIV status), and finding support from the medical community. During the question and answer session that followed, Ms. Ishida described her decision to live with HIV and taking responsibility for the choices she made that lead to her infection: as she answered questions about her feelings – such as whether or not she regretted getting her tattoo – her doctor answered medical questions. Dr. Iwamuro also exhibited great skill in unobtrusively steering the audience away from questions that may have been too personal for Ms. Ishida, such as those about her family life or sex life. Rather than answer questions about her sex life and the birth of her child, for example, Dr. Iwamuro discussed safer sex and ways to prevent transmission between serodiscordant couples and from mother to child. To use Goffman’s theory of presenting the self, they crafted a careful impression that would not embarrass Ms. Ishida or others in front of the audience; however, their collaboration was more protective than Goffman’s theory intends because the goal the organizers had was not for the audience to get to know Ms. Ishida or Dr. Iwamuro. The goal was to get them to know HIV through Ms. Ishida’s and Dr. Iwamuro’s narrative. While the audience learned about what it is like to be tested, to disclose to family members, and to get treatment through her narrative, most of Ms. Ishida’s personal identifiers were carefully and purposefully omitted.

Thus, Ms. Ishida’s narrative gave the audience a specific image of someone living with HIV: a beautiful, articulate young woman with a son, someone not much different from the audience members, perhaps. This encouraged the audience members to see that HIV can infect and affect anyone in Japan, and contrasts sharply with mass media portrayals of HIV+ Japanese women (who are a small minority of Japanese cases in the first place) as selfish and dangerous. Rather, this educational narrative crafted by two seemingly “normal shakaijin (社会人)” provided the audience
a chance to learn about safer sex, mother-to-child transmission, and personal responsibility for self preservation. For example, when asked about whether she was angry with the tattoo parlor, Ms. Ishida was adamant that she had chosen to go there in order to pay less than she would have if she had gone to a “regular” shop. Although she said she sometimes regretted all the trouble she had experienced for such a trivial thing, she claimed responsibility – and asserted that the audience members needed to do the same thing when making choices. In this way, in addition to providing a “yōseisha face and experience” that they want to see or “consume,” and providing an introduction to living with HIV, Ms. Ishida was able to use her narrative and questions from the audience to challenge the audience to think about their choices and take responsibility for the consequences. This challenge echoes Ms. Ikegami’s goals of encouraging young Japanese to take charge of and be responsible for their own sexual health. It also creates not just an opportunity (as is the case for the written narratives) but also a space for those living with HIV/AIDS to assert their normalcy as Japanese and to contradict the oft-heard claim that HIV is a “foreign” problem, or a problem of “deviants.” In addition, her healthy appearance literally shows audience members that HIV does not equate to death.

There are a few points to summarize regarding public, oral disclosures like these. First, speakers such as Ms. Ishida are not alone when they speak: peers or support staff join the speakers on stage, and form part of the audience. This arrangement provides emotional support and allows for the redirection of questions that speakers may not be ready or willing to answer. Second, speakers use pseudonyms or professional names that they themselves have selected. This gives them the power to select the personal information they are willing to share in that specific setting. A speaker at another event asserted that HIV is only five percent of his life, of himself. Amongst his friends, of course he uses his given name; some people in his everyday life know he is a yōseisha, but his HIV status is not the defining element of his identity to him or the people closest to him. However, when he speaks publically as a yōseisha, he is Mr. Y: he highlights that five percent because that is what is asked of him, and he reminds the audience that they are only seeing part of him. For yōseisha, it is safer – both in terms of an individual’s mental health and in terms of avoiding discrimination – to highlight these experiences rather than personal details when speaking to the general public about being HIV+. Third, although there is an element of performance involved in the telling of such narratives (discussed below), this does not extend to making changes in appearance – either to embellish or hide certain individual attributes. Their narratives cast them as yōseisha, and their clothing and comportment cast them as members of the general public. This is important because many people who have no personal experience with yōseisha tend to imagine them as outside the general public and as belonging to special groups. Therefore, one of the take-home reminders of these sessions is that yōseisha are members of the general public. Fourth, the narratives are physically regulated by several means: by the placement of the sessions at the end of the day so people are unlikely to linger afterwards; holding sessions in large rooms so people are more likely to self-monitor their questions; structuring the session to fit a specific time frame with a clear end time; contextualization of the session within a larger event; planning for the speaker to enter after the audience is convened and leaving before the audience departs (if the speaker so desires); and including key supporters (such as friends or physicians) in the audience.

These interactions make it clear it is not just Ms. Ishida and Dr. Iwamuro who shape the narrative: by the end of the session, it was obvious that the audience and the organizers had roles in shaping it, too. To use Kleinman’s terminology, Ms. Ishida, Dr. Iwamuro and the audience all worked together to develop an “explanatory model” of HIV that they could all understand and use to share information – all without making any specific references to Ms. Ishida’s personal life or allowing the audience to approach her alone prior to or following her session. This is yet another example of flexible kata: while components of the narrative are relatively constant, strategic disclosure, the
steering of audience members’ questions, the control of the room and of Ms. Ishida’s entrance and exit, all work to protect her as she describes living with HIV. Another way to think of this is to say that the flexible kata set on paper with the Place Tokyo booklet in 2005 is now being adapted for stage. In fact, as I describe below, the use of flexible kata is also discernible at HIV/AIDS events where the role of speaker/participant has less emphasis on audience education and more emphasis on memorialization and activism.

Walking the HIV/AIDS Narrative: The PLANET® Candle Parade 2011

“There are many people in Japan living with HIV. I am one of them. Stigma and discrimination are not going away. We cannot forget that eizu is a social disease...” began Hunky, a Kyoto resident who lives with HIV. Moments before, he had walked up the stone steps of City Hall at dusk, and taken the microphone from Ms. Odagiri, one of the event organizers. As he talked about continuing to fight against prejudice and stigma, his voice waivered just enough for me to notice. But his message about the importance of talking openly about HIV was as clear as the thick, white letters inked on his blue t-shirt that read, “I am HIV positive.”

When he finished, it was almost dark. Parade participants organized into a line behind a large, white banner that featured a red ribbon and the name of the event written in large, black letters. Hunky took one corner and gestured for me to take a section next to him. We all walked from City Hall to Gion, and the procession was a relatively quiet one (particularly compared to the protest against nuclear energy that walked the opposite route that night). People talked in low voices with loved ones or walked alone – all carrying flickering candles in paper cups that sometimes dribbled hot wax down their hands. Someone played a flute as we walked, and Ms. Odagiri’s voice rang out over the loudspeaker: “We are from PLANET, an organization that remembers people lost to eizu and promotes awareness of HIV. Won’t you walk with us?” This was punctuated by stops in front of shops displaying red ribbons on their facades; in the days before, several of us had visited the shop owners along the parade route and asked if they would put up a red ribbon in their window to show their support. Every time we passed such a shop, Ms. Odagiri would thank them over the loudspeaker and there was an exchange of bows – often through the shop’s windows. When we reached the park, people were invited to give their impressions of the walk. No one spoke as a yōseisha, but several people remarked about the power of being part of the walk itself.

Unlike Ms. Ishida’s narrative above, Hunky did not talk about the circumstances of his infection or his everyday life. He did not tell the audience about his progression from diagnosis to acceptance, or tell them they had to be responsible for their actions. He did not have to do any of these things because the participants – despite being open to the general public – was a much more specific one than the crowd at the Bunka Forum. Although anyone can attend PLANET’s candle parades, participants tend to be those who have personal experience with HIV/AIDS, either as yōseisha, through loss of a loved one, or through professional experience (i.e. medical practitioners or

Lighting candles at dusk just before the start of the 19th candle parade. (Photo by author)
Speaking to a sympathetic, even empathetic, audience who had their own experiences with HIV, Hunky focused on the importance of talking about HIV openly as a tool to fight discrimination rather than talking about his experiences as a yōseisha.

Although Hunky’s speech does not fit the kata we see in the written narratives of KN and K or in Ms. Ishida’s spoken narrative at the Bunka forum, his actions at the parade do. From the beginning of the event, Hunky announced his HIV status, both verbally and through his clothing. During the parade, he carried the banner; but he also passed it off to others and mingled with the crowd. Walking with other yōseisha and people who have lost loved ones to HIV/AIDS expresses solidarity of shared diagnosis, shared experiences of living with HIV/AIDS, and shared support. At the end of the walk, Hunky joined the rest of us in the park – dark but for our candles – and listened to people give their impressions of the walk. He joined the organizers for dinner, popping his ARVs in his mouth, and washing them down with beer and battered fish between bits of conversation. Hunky’s participation – speaking, walking, sharing opinions and food – simultaneously signaled his acceptance of his HIV status, his role as a peer and public activist, and his comfort with himself as someone who lives positively with HIV.

Mattingly has argued that “narratives may be acted rather than told,” stating that such “living narratives” suggest the possibility of healing. Further, she notes that such performed narratives are similar to healing rituals in that 1) heightened attention to the moment gives the event legitimacy, 2) a number of sensory cues express/create meaning, 3) aesthetic, sensuous and extralinguistic interactions are highlighted, 4) the experience is socially shared, 5) the people involved reflect on the past, present and future, situating themselves in a particular history, as a method of healing, and 6) participants can be transformed. Each of these criteria is met by the event: all participants exhibited a heightened attention to HIV/AIDS, whether individual focus was on personal loss or grief, efforts to raise social consciousness, or a combination of the two. Some people dressed up in kimonos, some dressed “smart” as though out on a date, and many wore red ribbons. Everyone carried candles. People walked together, grouped together, listened to the flute and Ms. Odagiri’s voice as we moved steadily up the street and towards Gion. This was the nineteenth annual parade, and posters showed pictures of some of the first marchers who were now deceased.

There are three key differences between the Bunka Forums and Parade that demonstrate yet more flexibility with the HIV/AIDS narrative kata. First, participants at the Bunka Forums are all voluntary participants – people who chose to learn about some aspect of HIV/AIDS and/or gender and sexuality – whereas the members of the general public present at the Parade were crowds of people shopping in Gion. This meant that the latter were not nearly as engaged as the audience members at the former; yet, this parade made HIV/AIDS visible to members of society unlikely to attend events like the Bunka Forums and unlikely to consider HIV/AIDS their problem. And although some carried photographs of those lost to HIV/AIDS, yōseisha like Hunky were part of the parade and demonstrated their vitality. Thus, the Candle Parade is an important avenue not just
for memorializing the dead and supporting yōseisha (as opposed to education, the purpose of the Forums), but also for HIV/AIDS activism.

Second, the ways in which participants created the narrative at the parade was different. Although the audience members were drawn into the narratives at the Bunka Forums through the question and answer sessions, they were relatively passive participants during the narrative construction between those onstage at the beginning of each session. In comparison, parade participants who walked the route were active participants throughout the event. For example, as noted above, Hunky walked, talked, ate, and drank his way through the parade and the events afterwards. Because he was asked to speak and helped organize the event, his actions stood out. But in reality, all the participants walked their narratives – some without saying a word. It is possible that the power that people said they felt during the procession was this sense of walking narratives together, in an atmosphere where the goals and the rules were shared by everyone. Moreover, this event provided an opportunity to examine how illness narratives can be embodied and performed. The people who saw the parade from the sidewalks cannot really be described as “participants” because few of them made any effort to engage with parade participants: some accepted education packets and condoms from student participants, but many either took quiet notice or seemed to ignore the parade completely.

Third, although the parade moving through Gion seems open and porous compared to Bunka Forum sessions in closed rooms, there were still several factors that functioned to control the setting. Those with shared experiences – membership in the same peer support group, those who suffered the loss of a common friend or loss of a child, for example – tended to walk together. Moreover, the pace of the walk, the darkness, the holding of candles, and the solemn mood discouraged interactions between strangers – with the exception of students who had been recruited to hand out condoms as the parade moved down the street. In Hunky’s case, this meant that although his shirt constantly announced his status as a yōseisha, he could vacillate from his “public yōseisha” role as a speaker and banner-carrier to other versions of himself as he moved around and talked to friends and acquaintances. In this way, not just Hunky’s privacy, but that of the other participants as well, was protected by the structure of the event – the darkness, the candles, the pace, the intimate groups. When people take part in this very public event, they are still able to maintain a sense of quiet privacy, all the while being supported by the presence of fellow participants. These three points highlight how the kata of telling (or walking) HIV/AIDS narratives is, again, flexibly used by participants to assert the importance of HIV/AIDS as a domestic issue of everyday Japanese and to challenge its tabooed status.

Conclusions

Producing HIV/AIDS narratives in Japan, like leprosy/HD narratives before them, is a means for yōseisha to order their experiences, educate the general public, and engage in activism. Written, oral, and performed HIV/AIDS narratives produced for public consumption conform to a “flexible kata” that serves to introduce the general public to issues of testing, diagnosis, disclosure, and acceptance in a way that suits the narrator’s storytelling style and the mode of delivery, all the while protecting the narrator through controlled disclosure of private information. This is relatively easy on paper, where writers can choose pseudonyms or initials and can easily omit personal identifiers since they do not come face to face with the audience. When speaking in public, the narrative kata is expanded to include an additional set of organizer controls. Limits of the narrative are set as organizers control the speaking time (length of narrative, and position in the program), the entrance and exit of the speaker (orchestrated to avoid the speaker being cornered by someone from the audience), contextualization of the narrative (such as at a Bunka Forum, where the audience expects to hear about the topic), and embedding speaker support either by providing a moderator (such as
Dr. Iwamuro) or by including friends in the audience. Speakers also prepare what will and will not be disclosed. Much like the written narratives, these “performed” narratives are carefully crafted so that audiences can learn about HIV through the speakers, but the audience actually learns very little about the personal lives of the speakers. In addition, narrators hope that their physical presence defies the stereotype that HIV=death, and that the audience becomes able to see yōseisha as everyday Japanese as they learn about HIV/AIDS. In the case that speakers seem to be different from audience members, speakers rely on their ability to convey their humanity, what it felt like to find out one’s HIV status for example, to push for acceptance and acknowledgement of a diverse population in Japan. Diversity even amongst yōseisha is stressed by the common assertion that “I cannot speak for all yōseisha” that I heard at each one of the public talks and was repeated in private interviews. This is very different from the common phrase, “we Japanese” that often crops up in conversation. This subtle, but very purposeful attempt at activism is just one example of how the educational atmosphere at events like Bunka Forums is blended with activism.

In instances in which yōseisha actions can be understood as embodiment of the HIV narrative form, such as participation in an AIDS walk, the activist elements are clear. Hunky’s assertion that “Eizu is a social disease” was made through a loudspeaker from the steps of City Hall. He wore a shirt that asserted his HIV status, and carried an HIV/AIDS memorial banner down the main street of Kyoto along the same path that people protesting nuclear power took. Unlike the Bunka Forums where people chose to set aside time and learn about various issues related to sexual health, the goal for the “audience” at the AIDS walk – the people walking down the street – was to increase visibility and bring the issue to people who perhaps rarely, if ever, thought about HIV. It was a method to bring HIV/AIDS, if not to people’s doorsteps, then literally to Main Street (Gion). It was a strategy not unlike Ms. Ikegami’s, to encourage local people to think about HIV as “your problem... our problem.”

Although all three types of narratives above utilize what I have termed “flexible kata,” the spoken and embodied narratives by Ms. Ishida and Hunky differ from the written narratives regarding what I have referred to as a performative element. The significance of this element cannot be ignored because it is what sets them aside from the many, many people living with HIV in Japan. To put it plainly, Ms. Ishida and Hunky are not typical yōseisha. They represent just a small percentage of yōseisha who have the ability to stand in front of an audience and talk about their lives as HIV+ people. They have known about and been accepting of their status for several years. They received guidance and support (but no formal training) in public speaking. They are active in organizations that support people living with HIV/AIDS. They participate in spreading information about HIV by speaking in public, running peer group meetings, participating in HIV/AIDS events, and helping to prepare education materials. Thus, they are different from the vast majority of yōseisha who do not do these things. In fact, one yōseisha pointedly mentioned at an event that, “Not everyone can do peer support.” To elaborate, not everyone living with HIV is physically, mentally, socially, or financially able to make HIV activism a part of their lives.

Second, the desire to be active in HIV movements does not equate to being a “performer.” There are countless people who work in research, prevention, and counseling who never take center stage. Rather, these speakers’ personalities, experiences, access to resources, and imbedded-ness in social networks combine in such a way that they are able to tell their stories as “public yōseisha.” Quite simply, they are good at being on stage; they might not have started out this way, but they had the drive and the support necessary to do what they do.

Third, there is an element of preparation that is essential to public speaking. As discussed above in detail, there is a specific time, place, and target audience for each narrative. Neither Hunky nor Ms. Ishida read from a prepared script or had memorized what to say. But they did think about
what they were going to say (and not say) before they came. The settings of the events required it, although it is easier to see in some cases than others. In Ms. Ishida’s case, for example, it was evident that the two speakers had agreed upon what would be asked and how they would respond to audience questions beforehand. Again, these public narratives about living with HIV are planned and carried out by people with all the resources they need to do so. These performances were not something that someone did spontaneously, without prior thought, in a public place like a park or the train station. They were performed at specific venues, with the assistance of specific agents, and with specific goals.

Although these characteristics sound similar to theatric performance and that “performance” is often associated with actors, characters, and works of fiction, I want to be clear that in discussing Ms. Ishida and Hunky as performers, I am not referring to them as actors. They do not perform shows or portray characters. The performances they give are not fiction. What they do when they are onstage is highlight the presence of HIV in their lives for the benefit of the audience – and to some degree, for themselves and their fellow yōseisha. To reiterate one yōseisha’s comment, “HIV is only part of me.” Thus, rather than actors on the stage who follow a script written by someone else, who portray a character by allowing that character to blend and bleed into themselves, public yōseisha formulate their own scripts and perform specific parts of themselves. Given this distinction and my use of kata, it seems more appropriate to say that the narrators described here are masters of HIV/AIDS narrative. Further, these masters have not only rejected erroneous assumptions of what it means to have HIV that perpetuated by the mass media, the general public, and even the medical profession, but have also rejected the assumption of Japanese sameness through their narratives. Thus, the narratives included here are examples of how yōseisha have been working to challenge existing taboos about sex and HIV/AIDS, and even what it means to be Japanese. In Ms. Ikegami’s terms, they are trying to change the environment by encouraging the audience to re-think their impressions of HIV/AIDS and sex, and see HIV and other STIs as something that they can take the responsibility to prevent. To put it another way, the masters described here have redefined the talk and the walk of living with HIV in Japan.

NOTES

1. Ikegami Chizuko and Ikushima Yuzuru, eds., Living Together: Our Stories (Tokyo: Place Tokyo, 2005). This was originally published in 2005, so 20 years was accurate at the time it was written. The title of the booklet is in English although the contents are in Japanese. There are six stories of living with HIV and 5 sections on sexual health. The booklet concludes with a summary message and resources.

2. See Ikegami and Ikushima, Living Together. Translation by the author.

3. Modes of HIV transmission include intimate exposure to HIV-infected blood or blood products (such as Factor 8 which is used to treat hemophiliacs); vaginal, seminal, or rectal secretions; and breastmilk. Behaviors that facilitate infection include oral, anal, and vaginal sex without a barrier (such as a condom or dental dam); intravenous drug or vitamin use with communal, unsterilized needles; blood or organ transfer using unsterilized equipment or infected blood or organs. Mother-to-child (MTC) transmission can occur in utero, during birth, or through breastfeeding.


5. The cause of about 9% of 2015 cases are listed as “unknown,” and another 2% are listed as “other” (厚生労働省 2015). Although intravenous drug accounts for a large percentage of HIV transmission in the US, there were only 2 cases in Japan in 2015; moreover, Japanese women have high testing rates and low infection rates that led to exactly one case of mother-to-child transmission rates that year (ibid).
6. Much like in the United States, a large percentage of hemophiliacs in Japan contracted HIV through use of HIV-infected blood products – products that were imported from the U.S. See Seki et al 2002 and 2009 for details.

7. It’s possible to further prevent MTC by prescribing ARV treatment to HIV+ pregnant and post-partum women, followed by anti-retroviral (ARV) prophylaxis for infants born to HIV+ mothers. There is also a pre-exposure prophylactic (PrEP) ARV that can be prescribed for high-risk populations.


10. 厚生労働省 (Kouseiroudousho) 2015.


14. See Kathryn Tanaka, “Through the Hospital Gates: Hansen’s Disease and Modern Japanese Literature” (PhD diss., University of Chicago, 2012). Leprosy is now called Hansen’s Disease (HD) and is named for the man who discovered the bacteria that causes it. Promin was the first antibiotic treatment to successfully treat HD; efficacy was demonstrated in the United States in 1941, but was not available in Japan until 1946.

15. Tanaka, 5.


18. Jurecic, 10.


25. Personal communication July 2011.


29. I used the actual names of the organizations, per requests from those organizations.

30. I use the actual names of professionals, per their requests. Names of yōseisha are either pseudonyms they themselves use when speaking in public (full names), or author-assigned pseudonyms (known by an initial).

31. The Life Foundation was started in 1983 by sexologists and epidemiologists who recognized HIV would become a problem in Hawai‘i due to the transience of the population and its relatively large gay population.
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33. The buddy system pairs people who have been recently diagnosed with HIV with a “buddy” who has been living with the diagnosis for some time and is comfortable acting as a mentor. It is similar to the sponsor model of Alcoholics Anonymous.
34. Personal communication, September 2011.
36. Personal communication December 2010. Translation from the Japanese by the author.
37. Ikegami and Ikushima 2005.
40. Personal communication December 2010, translation by author. Note: Ms. Ikegami’s assertions are based on research conducted by Place Tokyo.
41. Names are as they appear in the booklet. Translation by author.
42. Ikegami and Ikushima 2005, 6.
43. Personal communication July 2011.
44. Mother-to-child transmission in Japan is very low because pregnant women are screened and treated. Infection through intravenous drug use is also low because this type of drug use is relatively low in Japan.
45. Ikegami and Ikushima 2005, 8.
46. Personal communication August 2011.
47. This is a very common statement amongst yōseisha. All of my HIV positive interviewees emphasized this when they spoke with me, and the men who spoke at the AIDS Bunka Forum in Kyoto said it, too. They emphasized that similar things may have happened to them and that some may have commonalities, but were careful to say that everyone is different and that no one person’s voice could represent everyone with HIV.
48. In this particular case, getting HIV through being tattooed is probably less stigmatizing than getting HIV through sex or drug use but still more than stigmatizing than being infected through medical treatment because of the association between tattoos and the yakuzza.
49. Interestingly, she did not discuss disclosure to her partner and did not discuss him during her talk.
52. This term literally means “person of society” and is used to refer to someone who is living in and contributing to society by working, being married, and having children. For many, being chronically ill suggests that one cannot be a Shakaijin. Failing to contribute to society in these ways, particularly for women, is considered by conservatives as selfish and wasteful – especially if one contracted a ‘bad’ illness like HIV through ‘deviant behavior.’
53. Similar strategies were also apparent at the AIDS Bunka Forum in Kyoto, where three male yōseisha spoke at a similar type of session with a moderator. There were, however, major differences between the two sessions. First, the Kyoto session was clearly not as scripted as the Yokohama session, and yōseisha were clearly more comfortable speaking for themselves. Second, the moderator was not a medical doctor and his role was solely to ask the pre-determined questions. Third, yōseisha at the Kyoto session were eager to speak to audience members individually: in fact, this is how I made a number of contacts. This just goes to show that each session is really managed to a different level depending on the participants.
55. PLANET stands for People Living with AIDS NETwork. The A is generally written so that it also looks like an H to emphasis life with both HIV/AIDS. Unlike Place Tokyo, this group doesn’t do research and they don’t have an office – it exists IN people, and through the events like AIDS walks and participation at the Bunka Forum.
56. PLANET has been doing AIDS walks in May annually since 1991. They always follow the same route. The goals of the PLANET Candle Parade are to remember those who were lost to AIDS, raise awareness about HIV/AIDS, and to fight to end discrimination of those living with HIV/AIDS.

57. Ms. Odagiri keeps records of all the business along the parade route and which ones agree to display a red ribbon. When distributing red ribbons, she reminds store owners who have hung them in the past of this, and she points out which neighbors have agreed to display them. From year to year, one-third to one-fourth of the shops on the route agree to display red ribbons.

58. It’s not really possible to ascertain a participant’s HIV status unless, like in Hunky’s case, it’s literally written on their clothing.


60. Ibid., 76.

61. Personal communication September 2011.

Bibliography


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For pre-modern Japan, the area of medicine and community has been largely overlooked in previous scholarship. The field of medical history has benefitted from some valuable surveys of premodern medicine, but scholarship otherwise has tended to focus on broadly-defined textual and theoretical issues. Until recently little attention has been paid to medicine in its social context. The field of urban history, while producing engaging material, and benefiting from new approaches to using visual sources such as the genre of Kyoto-centric paintings known as Scenes Within and Without the Capital (Rakuchū Rakugai zu 洛中洛外図), has tended to focus on topics related to such things as architecture, spatial morphology, and male spheres of political and economic activity. Little sustained attention has been given to aspects of material culture, or fundamental constituent elements of urban life such as the experiences of families, women, and children.

This essay, part of a larger project on the medical culture of Japan in the late sixteenth century during the transition period between the late medieval and the early modern eras, will break new ground. It will explore the place of medicine in urban communities, paying particular attention to both female adults and children. We will examine their afflictions, their medicines, their provision of care and access to treatment for family and acquaintances, and their social networks.

The primary source for this study is the diary of the physician Yamashina Tokitsune (山科言経). An aristocrat banished from the Imperial capital of Kyoto, Tokitsune found refuge in the Honganji Pure Land temple urban districts (jinai) in Ōsaka (Tenma) and Kyoto (Rokujō). He resided in them for at least fifteen years (1586-1591, and 1591-1601 respectively), and while he had a broad range of interests and connections, his primary activity was as a physician serving the commoner population. Tokitsune provides extensive details on the lives, families, health issues, and medicines of his patients, and offers a level of detail (including hundreds of personal names, and information on family and neighborhood relationships) that is unmatched in any source prior to this time. Yet, Tokitsune’s medical activity has been little studied, and the only in-depth discussion of his life does not focus on his role as a physician. In short, this rich record has barely been examined for its central value as a source on medicine and community.
1. Context

Historical Background

In the last decades of the sixteenth century a multi-polar civil war – which had been raging for nearly a century – was brought to a close. The process of unification involved massive military campaigns and battles, extensive economic and commercial development, and an epochal wave of urbanization based around warlord castles (jōka machi 城下町) and, especially in the central Kinai region (location for Ōsaka, Kyoto, Nara, etc.), commoner-run temple districts (jinai machi 寺内町)\textsuperscript{11}.

The era also was one of pronounced social change and social mobility, extensive internal migration and displacement, formation of new urban communities, and the explosive growth of specialized occupations and professions.

The Honganji Pure Land community was enmeshed in the fabric of these changes. Based in what is now Ōsaka – which was, in fact, established by Honganji – the organization was a nationwide network of faith communities asserting independence and autonomy from the warlords who claimed regional and local hegemony. Honganji asserted itself powerfully, as readily seen by its decade-long resistance in the 1570s to the transformational hegemonic warlord Oda Nobunaga. Honganji and Nobunaga reached a peace agreement in 1580, one condition of which was that Honganji abandon Ōsaka. In 1585 the successor national hegemon Toyotomi Hideyoshi relocated it to the Tenma district of Ōsaka. In 1591, as part of a project to transform the city of Kyoto, Hideyoshi relocated Honganji to the Rokujō area of Kyoto, where its headquarters have remained to this day.

Ethos of the Honganji Jinai

The Honganji jinai (寺内) in Tenma and in Rokujō were self-governing communities of 4000 to 6000 people located in larger urban environments (respectively, Ōsaka and Kyoto). Residents shared faith in the saving grace of the Amida Buddha, but otherwise the jinai were economically and socially diverse communities. The jinai were home to the Honganji leadership, administrators, religious groups responsible for ceremonial activity, priests and nuns, merchants and artisans (we can identify at least 50 different occupations and trades), day laborers, householders, homeowners and renters. While the community was a sedentary one, it was not static. There was some amount of in-migration and out-migration, and a steady stream of sojourning pilgrims from provincial congregations. There were, however, few transients, and in principle samurai warriors were banned.

The community existed on the bedrock of consociation and faith. An equally important consideration for residents was the promise of refuge and stability in turbulent and unpredictable times. Accordingly, building and maintaining a sense of community derived from shared bonds and a concern for the well-being of others. Those aspirations built upon a fundamental commonsense associated with belief in the Amida Buddha, namely the notion of the assistance of the other (tariki 他力); by extension, helping others was inherent in the ethos of daily life. Moreover, the Honganji jinai community’s self-identity was reinforced by a sense of insiders and outsiders. How these elements might play out is attested in the immediate aftermath of a devastating earthquake (the most destructive in a century) in 1596. As Tokitsune noted: “All the women and children are gathered in the inner areas. At night we are on guard against thieves (from outside). Within the jinai precinct it is rare for anyone to sleep at night.”\textsuperscript{12}

The Locus of Health Care

In pre-modern Japan, and certainly at the end of the sixteenth century, hospital, hospice, or inpatient facilities were essentially non-existent. Patients visited doctors, or doctors made house calls, but the actual tending to the ailing took place in private residences (a home, rented accommodation,
etc.). As far as we can tell, within the household women were responsible for care and nursing. And, since within the jinai many buildings functioned both as residences and places of business, and since renters could also be employees (apprentices, junior assistants), then women also provided care for non-family who were in practice members of a larger household.

Concomitantly, and also bearing in mind that caring for children was a long-term enterprise, it was likely the case that health care was not only a daily concern of women, but that it was an integral part of their daily routines. In that sense, health care was given more attention by women than it was by men. This would seem to suggest that matters of medicine and care played a more important part in women’s lives than they did in men’s lives.

2. Availability of Treatment and Medicines

Spatial and Temporal Elements

The spatial arrangement of the Honganji jinai in Tenma and Rokujō (Ōsaka and Kyoto) facilitated access to medical treatment, making it readily available to women in the Honganji community. Both areas were compact urban areas crisscrossed by streets and laneways, which enabled ready and unproblematic movement within them. The named wards into which the jinai were divided, and, particularly in Kyoto, the presence of well-known street names, also meant that it was relatively easy to find one’s way to a given location. It is also clear from Tokitsune’s record that either the doctor or patient might be guided and accompanied to the other by intermediaries (neighbors, acquaintances, adults and children) familiar to both. At the maximum, doctor and patient would have been separated by no more than one kilometer distance or (allowing for age and physical condition) at most a thirty minute walk. For practical purposes, and based on the approximate location of Tokitsune’s known residences, the distance and time was closer to half that distance: 500 meters, or fifteen minutes.

Treatment was also available throughout the day. For example, the wife of Kurō Emonnojō (who owned a bathhouse) on one occasion came in the night to get medicine for her husband’s ailment, and on another occasion in the early morning (understood as anywhere between 0400 and 0700) brought her young daughter, who had fallen in the house, banged her head, and was “near death” (zesshi絶死) to receive urgent treatment. More generally, Tokitsune mentions interactions with patients at sunrise, in the early morning, at dusk, at twilight, in the evening, and in the middle of the night (which extends to the early AM). He also notes more specific periods, such as hour of the tiger (0300-0500), hour of the serpent (0900-1100), the hour of the rooster (1700-1900), or portions of such. Overall, it appears that medical treatment was available at almost any time of the day or night. In fact the only times that Tokitsune seems not to have been available (unless he was attending a patient, or occasionally staying overnight) was between about 0100 and 0400, and in the early- to mid- afternoon.

Two Case Studies: The Shimozuma Daughter and Nishi Onkata

Let us now look at two examples of treatment over an extended period. The first case is that of a young girl, the second that of an adult woman and mother. The first example is that of a six year-old girl, a member of the Shimozuma family which appears in Tokitsune’s diary over a fifteen year period (1587-1602). She had first received treatment from Tokitsune in the eighth month of the preceding year, 1596, at which time he had treated her for such things as abdominal pain and diarrhea, and given her pulse diagnoses on several occasions. In any event, Tokitsune notes that on Keichō 2 (1597).7.11, a sunny day (Tokitsune records the weather almost every day), the Shimozumas
sent someone to inform him that their daughter was suffering an attack of (the always unpleasant and often fatal) sunstroke kakuran (霍乱), and wanted Tokitsune to come and give her a pulse diagnosis. He did, and also compounded three packets of a five-ingredient (dolochos bean 白扁豆, aromatic madder 香薷, magnolia 厚朴, field mint 薄荷, and loquat leaf 桃杷葉) medicine for them. He continued treatment for the next few days, and felt that her condition was getting better. Two weeks later the daughter was sent to him to have her pulse diagnosed and to get medicines. Two weeks after that she was sent again, so clearly the family was monitoring her condition. She came again two weeks later, but the following day developed a slight fever and had diarrhea. Tokitsune compounded two packets of medicine for her. Unfortunately, the diarrhea heralded the onset of a serious intestinal problem. They called for Tokitsune to give treatment the next day, and the day after that, as Tokitsune records:

Early dawn, second half of the hour of the tiger (0300-0500, thus 0400-0500). I heard from Shimozuma Saishō that his daughter had vomited twice during the night. They had come to get medicine. I compounded one packet of shiitake mushroom (香菇), dolochos bean, magnolia, coptis (黃連), Korean mint (藿香), white plum flower (白梅花), loquat leaf, and gave it to them. At the hour of the serpent (0900-1100) two attendants came to meet me so I went there. I did a pulse diagnosis. From the middle of the night she had vomited three times. Her diarrhea was a little better. Further I gave one packet of this morning's medicine to which I added cloves (丁香) and white atractyloides (白朮), and five doses of Kaiki-san. In the evening two attendants came so I went again. I did a pulse diagnosis. [This time I compounded] nutgrass, Korean mint, dwarf lilyturf, white plum flower, aloeswood, magnolia, tuckahoe mushroom (茯苓), cloves, and loquat leaf.

(Later) Someone came from Shimozuma Saishō and asked for a pulse diagnosis for the daughter, and two attendants came, so I compounded Korean mint, dwarf lilyturf, aloeswood, magnolia, tuckahoe mushroom, cloves, white plum flower, and loquat leaf.

For the next eleven days the daughter received continuous treatment. Until the final entry for the episode she alternated between being diagnosed as seeming better, with symptoms that included abdominal pain, vomiting twice and “her stomach making a noise,” discharging white diarrhea, a slight fever and a slight cold (風入), heart heat (心熱) and diarrhea, and being terribly afflicted. The Shimozumas were obviously very concerned, and contacted Tokitsune as often as they felt necessary. Every day they either sent someone to meet Tokitsune and bring him to their residence (sometimes providing a litter for him), and several times they sent someone to pick up medicines, or to give a report on her condition. Tokitsune was routinely asked to give a pulse diagnosis (eleven times), and while he was at their residence he either compounded medicines (five times, using as many as fourteen ingredients) or (five times) gave a prepared packet which was sometimes a repeat of a formula that he had prescribed previously. Charmingly, on one visit he gave the daughter a clay toy dog to play with. Tokitsune only declined to go on one occasion, apparently because it was too late at night, at which time the Shimozumas contacted another eminent physician, Ichōken (一鷗軒 Nanjō Sōko 南条宗虎) who prescribed medicine. The next day he consulted with Tokitsune about her condition, and then later that day Tokitsune made two more visits to the girl, examining her pulse and compounding medicine. Unfortunately there is only one more entry on this patient, so we do not know the ultimate outcome.

Our second example is that of Lady Nishi Onkata (西御方) (1562-1616), a key figure in the Honganji movement (and Tokitsune’s sister-in-law). Mother of six children, three of whom died in childhood, her medical record is extensive (well over 4000 entries over a twenty year period). Here we shall look at one instance, treatment for at least two attacks of malaria over a seven-week period
(24th day of the fifth month to the fifteenth of the seventh month). This instance is a useful guide to the possible rhythms of activity of both doctor and patient in the treatment process. And, even though this paper is focused on the use of medicines, the case also provides a glimpse into ways in which both patients and doctors accessed religious forces as a supplement.20

On the twenty-fourth day of the fifth month of 1595, Tokitsune visited Lady Nishi twice – once with his wife, Kitamuki, Nishi’s sister – giving her pulse diagnoses and determining that she had malaria. The following day, Tokitsune and other family members witnessed a performance by a priest who claimed to have special healing powers. The priest, Ise Fukuin (伊勢福院), claimed that the paper that he wiped over his body was thereby imbued with the power to heal any ailment. Tokitsune, Kitamuki, her other sister Oharu, and his son Acharmu bought paper, and wrote on each piece the ailment for which they and others were seeking relief: For Lady Nishi, her various problems; for Tokitsune and his son, that there be no illnesses; for Kitamuki her female ailments; and for Reizei Tamemitsu his elevated qi. They also obtained a number of blank sheets, which presumably were to be distributed to others. Upon returning Tokitsune gave one sheet to Lady Nishi, and another to an attendant, Akoko, who had an eye affliction.21

Unfortunately for Lady Nishi, her malaria attack worsened. Three days later, on the twenty-eighth, her fever was so “terrible” that Tokitsune visited her four times, giving a combination of medicine and pulse diagnosis. On the first day of the sixth month, when she was “terribly afflicted,” she requested medicine that would bring down the malaria. Her condition, and the possibility that the medicines he was providing were not effective, prompted Tokitsune to seek unusual medicines. He provided some pellets of a pill medicine that he had concocted, and then the next day:

I went to Lady Nishi before I went to Monzeki and did a pulse diagnosis. It is improved. Since I was informed that the dust washed off (a statue of) the bodhisattva Jizō (地蔵菩薩) by rainwater is a bringing-down medicine ochikusuri for malaria, I had someone get it and bring it here. Next I asked Yamato San’i (Sōjo) about Monkey Wolf Frosting (猿狼霜) and he told me about it by letter. Next I went to Monzeki. At dusk I again went [to Lady Nishi] and did a pulse diagnosis. It is greatly better. Further she wanted medicine. I forwarded Kakkō shōki-san to which I had added flavors, and also ten pellets of the bringing down medicine.22

The next day Tokitsune stayed with Lady Nishi all day, and determined that the malaria was about half as bad as it had been the day before. Perhaps the special medicines had helped. But then two days later the malaria recurred, and with varying degrees of severity continued relapsing and recurring until about the middle of the seventh month.

During this extended episode of malaria lasting some 52 days, Tokitsune visited her on 42 of those days, and on another five days sent medicines but did not visit her. On those 42 days he made a total of 58 visits (nine at the specific request of the patient), on one occasion staying with her all day;23 the most number of visits that he made in any one day was four.24 He gave her a pulse diagnosis on 46 occasions. Lady Nishi also requested that Tokitsune ask Yamato Sōjo to come and give her a pulse diagnosis, which he did on two occasions.25 Sōjo also supplied her with a decoction medicine, some unspecified medicines, and he supplied Tokitsune with a special medicine Myōkō-en which he administered to Lady Nishi; as noted above, Tokitsune also asked Sōjo about another special medicine, the aforementioned Monkey Wolf Frosting (猿狼霜).26 Tokitsune also consulted, by correspondence, with Sōjo about Lady Nishi’s condition.27

During the period of treatment Lady Nishi was supplied with medicines a total of 59 times. Tokitsune supplied her with medicines on 32 occasions, and of those medicines twelve were named
formulas (Yōki-tō 養気湯, Kakko chōki-san 香藿正気散, Jakō-gan 麝香丸, Kaiki-san 快気散, Kōju-san 蓬香丹, Senkyū chachō-san 川芎茶調散, Chachō-san 茶調散, Shimotsu-tō 四物湯, Hōshin-tan 豊心丹, Hakkai-san 八解散, Anshin-san 安神散, and Myōkō-en 妙香円), and three were generic medicines (one was a mouth medicine, the other a decoction medicine, the other a malaria-bringing down medicine). Not infrequently he added various ingredients to the standard formula. Separately from those occasions, Lady Nishi herself asked to be supplied with medicines on at least 27 occasions, and she requested seven named formulas (Yōki-tō, Kakkon chōki-san, Jakō-gan, Kaiki-san, Kōju-san, Senkyū chachō-san, and Anshin-san), a decoction, and, as we have seen, malaria bringing-down medicine.

Finally, while during her illness Lady Nishi was tended primarily by those in her immediate household, she also received visits from siblings, who were sometimes accompanied by Tokitsune. He records Nishi’s sister Kitamuki visiting six times, usually in the evening, but on one occasion staying until the hour of the tiger (0300-0500), and on another staying – along with her brothers and her son – until dawn. Nishi’s brothers, and Tokitsune’s son, visited at least three times, and when she suffered a bout of sunstroke they visited as a group.

As we can see from these two cases, the Shimozuma family’s daughter and Lady Nishi, women at the higher levels of the jinai community could receive extensive medical care. However, Tokitsune’s diary also enables us to see that people of virtually any background and social status in the jinai had access to essentially the same resources and treatment.

Various Elements Influencing Access to Treatment and Medicines

Medical services were ubiquitous and accessible to residents of the Honganji jinai. Let us first take the example of children. It was not uncommon for children visiting the doctor to be accompanied by adults: a father bringing a daughter who had boils on her feet, or a mother (wife of a needle-maker) bringing her daughter who was suffering from dysentery. But, with the apparent exception of infants and the very young, it was also not uncommon for children – both male and female – to visit the doctor unaccompanied by adults, whether by themselves, or with siblings or other neighborhood children. Children might visit for initial treatment (such as one small girl who came to have her eye problem examined, or the daughter of a rice-merchant suffering from boils on the face), to receive a check up and get further medicines (the Shimozuma daughter), to pick up medicine and sometimes wait for it to be compounded (the daughter of the small-bell maker), or to pick up medicines on behalf of others (such as the child from the Tsutsura-ya shop located near the intersection of Shijō and Muromachi streets who took medicines to an old nun). One by-product of visits to the doctor by children was, no doubt, the inculcation of a lifelong commonsense that medical treatment and medicines were part of the fabric of everyday life.

Another aspect of general access to medicines is illustrated by Tokitsune’s frequent practice of, when visiting a household, not only giving treatment to the designated patient, but also distributing medicines and giving check-ups to other people present. That is, even people who may not have been ailing might have their general health monitored. For example, when treating the fever of Lady Nishi’s youngest daughter, who
was then four years old, he also gave pulse diagnoses to three of the wet-nurses in the household, and to four other women present; he also distributed a “standard number” of ten doses of different medicines to five women there (all the formulas were ones used to fortify the body). \(^{37}\) When visiting the Itami household to treat one of the sons in the household, he gave a check-up and distributed medicines to the family’s three other young children: daughters aged two, five, and ten. \(^{38}\)

People also had indirect access to medical information. One form of this was when others sought medical assistance on a person’s behalf, as when the wife of Rokushōya went to Tokitsune to inform him that the wife of a carpenter was ailing, and then accompanied him as the doctor went to her home. \(^{39}\) Another form of indirect access was via written communication, either directly to the doctor (a letter describing a daughter’s symptoms and asking for medicine), \(^{40}\) or through third parties, as in the following case: \(^{41}\)

>I was told that the mother of the Itami’s younger wet-nurse is in Harima (province). A record of her symptoms arrived (所労一書). ‘She feels feverish inside; during the night she vomited up worms at least six times; it was the same during the daytime; vomiting blood; unable to eat etc.’ I compounded and sent to them fifteen packets of nut-grass (香附子), peony (芍薬), coptis (黄連), balloon flower (桔梗), Sichuan lovage (川芎), Chinese angelica (当帰), dwarf lilyturf (麦門冬), and ginseng (人参).

Strangers, too, benefitted from treatment, even for extended periods, as in the case of an old nun who was taken under the wing of the rice merchant Mago Zaemonnojō (孫左衛門尉) and his family. For a period of three weeks in 1587 they cared for an “unattached” elderly nun from the Honganji’s Bungo province congregation who was visiting Kyoto. Mago initially informed Tokitsune that they had a “sick person,” and asked Tokitsune to come and give her a pulse diagnosis. An hour after his departure, Mago came to report that she was a little better, and got some medicine for her. Her treatment continued nearly every day for the next three weeks. Mago came, sometimes at early dawn, to get medicines and report on her condition (such as “lower blood, a headache, a tightness of the chest, and affliction of her ki”), or else he sent people to get medicines for her. Tokitsune likewise visited the nun. Sometimes he was asked to do so, other times he simply went; he visited at early dawn and at other times of the day. The nun received pulse diagnoses and medicines. Tokitsune also provided medicine at least once even while he was laid low by a week-long malaria attack and was getting acupuncture treatment. \(^{42}\) The nun recovered, provided 500 mon as payment for the medicines, and returned to her home province. \(^{43}\) We learn no more of the nun, and we have no idea of what connections she may have had in Tenma/Ōsaka, but it is clear that even as a visitor she had access to medical care no different from what residents of the jinai enjoyed.

Finally, and as suggested by some of the above examples, women had access to medicine as a result of their associations with women in other households for whom Tokitsune had provided treatment. In the case of the serving woman Matsu (松), who served in Tokitsune’s household, he provided medicine and treatment not only to her, but to her mother, and even to the daughter of one of her acquaintances. \(^{44}\) Relatives of two other serving women \(^{45}\) were also provided with medicines. \(^{46}\) Likewise, Tokitsune gave long-term medical attention to the family members of the wet-nurses in Lady Nishi’s household, and in one case he gave treatment to three generations in one wet-nurse family (mother, three daughters, and at least one granddaughter). \(^{47}\) In another example, at Lady Nishi’s request, Tokitsune treated a pregnant woman identified as the “younger wet-nurse” (also the wife of a shrine priest), over a period of two months for such things as phlegm, fever, coughing, diarrhea, and general post-partum recovery. \(^{48}\) The preceding discussion demonstrates that women of all ages and classes had access to treatment for a wide range of symptoms and conditions.
3. Pregnancy and Post-partum Ailments

Reproduction was central to the continuity of family and community. Yet, reproduction was not unproblematic: lack of contraception meant that pregnancies were frequent; miscarriages, stillbirths, and unexpelled placenta were always a concern; the rate of infant mortality was high; mothers could die in childbirth. Within Tokitsune’s immediate orbit, his sister-in-law Lady Nishi bore six children, three of whom died of illness before the age of ten; one of Tokitsune’s children and several of his nieces and nephews died of illness before the age of five; and others of his sisters-in-law died of illness and accidents in their twenties. In a non-trivial sense life was fragile.

Naturally enough their health during pregnancy and post-partum was of great concern to women. But beyond the obvious, we might usefully observe that, allowing for the natural concerns of male family members, all the evidence we have for this era at least suggests that prenatal and post-partum care of women was an overwhelmingly female sphere. Advice, knowledge and experience of such matters resided with women rather than with men. As far as we can tell, births were supervised and attended primarily by women, some of whom were recognized as something like specialist midwives (parenthetically, and no doubt at least reflecting the availability of space in an urban environment, there is no mention of the stereotypical birthing huts). Doctors appear not to have been directly involved in childbirth, and indeed, Tokitsune provides no information at all about births in his diary. Having said that, doctors did have their knowledge and role, and it is apparent from Tokitsune’s case that a doctor must have acquired a wealth of relevant knowledge and experience from his interactions with his female patients. In any event, in the Honganji jinai at least, it appears that the challenges of women’s medicine were met proactively by women, and the availability of treatment and medicines was a significant factor in this.

The experience of pregnancy and birth was, naturally enough, a continuum, as is suggested by the example of Kiku. A woman who had already given birth to at least two children, Kiku first contacted Tokitsune in the eighth month of 1589, when she was probably in the fifth or sixth month of her pregnancy. She received a pulse diagnosis and some doses of the tonic medicine Aisuyaku (愛洲薬).

In the middle of the ninth month she received some Aisuyaku, and a few days later received medicine for her daughter’s sores. Then from the middle of the tenth month and for a two-week period she received first some Aisuyaku, and then a combination of a pulse diagnosis and medicines from Tokitsune. At the end of the eleventh month four weeks later, upon learning that Kiku had given birth (danzan) a couple of days earlier, Tokitsune sent her some medicine. Three days later Kiku visited him and received some medicine, and every day for a week thereafter Tokitsune gave her a pulse diagnosis and some medicines to help with her recovery.

Prenatal Care

What prenatal problems did Tokitsune observe? Sometimes he notes a specific concern: being four months pregnant and discharging blood; seven to eight months pregnant and discharging blood; eight months pregnant and experiencing abdominal pain; pain because the area below the abdomen was distended, and tendons on one hand were sore; or, having abdominal pain and discharge, as it transpired, two weeks before the anticipated birth of a daughter. But most of the time the reference is to a woman being afflicted by unspecified prenatal ailments.

Though few specifics were reported to Tokitsune, people were in little doubt that the condition of pregnancy was an important one to note when reporting symptoms. And, it appears that it was not uncommon for women to monitor closely, and keep a record of, their bodily condition. Some women maintained records of their own illnesses and prenatal conditions that were furnished to assist the physician in prescribing medicine. Others kept lists of foods that were prohibited...
or allowed (impermissible or permissible, not recommended or recommended 禁好物) during pregnancy.\textsuperscript{62} It was also common for women to monitor their overall health by requesting pulse diagnoses. Naturally, these elements could be combined: one patient asked for a pulse diagnosis, tonic medicine, and a list of foods that were prohibited or allowed; when she developed a temperature, she then asked for a pulse diagnosis and a prescription for medicine.\textsuperscript{61}

Women prepared in advance of the birth, and presumably hoped for as easy a birth as possible. No doubt many prayed for a safe birth. And on one occasion at least Tokitsune provided Shimomura Koshôshô (who was expecting her second child a month or so later) a benjigetsu (反支月) amulet which would protect her during a month that was considered a taboo time (based on yin-yang divination theory) to give birth.\textsuperscript{64} But more concrete preparation involved medicines.

Sometimes Tokitsune was simply asked for medicine. More commonly he was asked to provide medicines that would induce birth, promote delivery, and facilitate the expulsion of the placenta. Tokitsune was often requested to provide medicines both generic, as in the case of hayame gusuri, or expeller medicine (for which Tokitsune provides no specific formula), and specific formulas, such as Saisei-san (催生散) Birth Inducing Powder, and some other named formulas. Allowing for some “double counting” and the fact that Tokitsune prescribes medicine even when he doesn’t specifically say that the people reporting the symptoms asked for medicine, families requested unspecified medicine thirteen times, expeller medicine twelve times, and a named formula twelve times; Tokitsune gave expeller medicine twenty-four times, and a named formula twenty-five times.

Sometimes the medicine was requested well in advance of the birth, which suggests that women took it for granted that such medicines more likely than not would be needed during the birthing process. It might also be the case that this timing reflects, in addition to early preparation, the fact that the general period when a birth was likely to take place was known with greater certainty than was the precise date when it would occur. For example, in preparing to give birth to her fifth child (her fourth daughter), Lady Nishi requested ten packets of hayame gusuri nearly five weeks prior to the actual birth.\textsuperscript{65} In the case of the first birth to Ito, the daughter of Nishi’s wet-nurse, they asked for medicines (including one to promote delivery) one month prior to when they thought the child might be born; from a couple of days prior to when they thought she was about to give birth they asked for medicine to help expel the placenta; when the birth did not take place they continued asking for medicines; a week later when again the mother thought that birth was imminent (and in fact occurred that same day) they again requested medicine.\textsuperscript{66}

Others made their requests closer to the time of birth, as in the case of a family that requested medicine for a woman who was expected to give birth in four days (she was provided with Saisei-san),\textsuperscript{67} or the family that requested it once labor had commenced.\textsuperscript{68}

\textit{The wife of Kichi Emonnojô (吉衛門尉), an acquaintance of Shinkyûrō (新九朗), is in labor. They wanted hayame gusuri. I gave them three doses. Finally it was born. I was then told that the placenta had not been expelled. I gave three doses of the same formula to which I added Aisuyaku, and one large packet of Kaiki-san, and three doses of Aisuyaku.}

And, as we may expect, hayame gusuri was also requested when the birth took longer than anticipated. In one case, where the woman had felt for four days that she was about to give birth, the husband went to Tokitsune for hayame gusuri, was given three doses and a packet of Kaiki-san, and the child was born safely shortly thereafter (after which the husband came to express his thanks, and was given three doses of Aisuyaku).\textsuperscript{69} In another case, where the labor had lasted for three days, Tokitsune was informed by a wet-nurse who served Nishi, that one of her renters was having a difficult birth (nanzan 難産). Tokitsune first prescribed three packets of Saisei-san; the next day the wet-nurse informed him that the woman had still not given birth so he gave three packets
of Shimotsu-tō to which he added realgar (雄黃); she gave birth early the next morning. A week later, after the wet-nurse had informed him that the patient was having post-partum difficulties, Tokitsune dropped by to give a pulse diagnosis and medicine.70 Another case of nanzan required less attention: the wife of Shin Emonnojō (新衛門尉) came in the early morning to tell Tokitsune that the neighboring house was having a difficult birth, and since it was overdue they wanted medicine, and so he gave two packets of inducing medicine (we learn no more of the case).71

Post-Partum Care

Post-partum was referred to by two terms. The first was danzan (断産), literally meaning “at the cessation of the birth.”72 The second was sango (産後) “post-partum,” which is the more familiar term. There is some overlap in their usage: for example sometimes it appears that danzan is used when sango could be used (in an instance of unexpelled placenta). And one might feel that danzan would be subsumed under sango. However, the terms are used distinctly. In general, it seems that danzan refers primarily to the fact that the birth process has been completed; while sango is a general reference to post-partum. Below I will engage them separately, though my narrative references to “post-partum” may cover information subsumed under both terms.

With respect to danzan completion of birth, Tokitsune lists 32 instances where medicines and treatment were sought, and lists the medicines he prescribed. Allowing for multiple prescription and different ones prescribed on different days, we find that Aisuyaku was prescribed in at least thirteen instances, Shimotsu-tō (四物湯) in eighteen, Kaiki-san in six, saisei-san (催生散) in four. Decocting the herbs is prescribed twice; four named formulas are noted once each; a compounded medicine is noted once; and simply “medicine” is noted once.

Among the symptoms we learn the following: abdominal pain or bleeding as a result of the completion of birth might continue for 30 to 42 days after birth;73 in another case a woman’s painful symptoms were associated with the fact of her having given birth danzan three months earlier.74 The treatment process involved furnishing medicine, perhaps making house calls to examine the patient, and while there usually giving a pulse diagnosis and prescribing further medicine. The process could range from a one off-provision of medicine (Yosan’s wife Maa マア),75 to treatment being given over a period of three days (the daughter of Suke Zaemonnojō 助左衛門尉) or four days (the wife of the artist Hikoshirō 彦四郎),76 or for a week or more (the wife of Ichisuke 市助).77

One poignant description of a woman suffering post-partum danzan comes from 1597 (and also illustrates a chain of connections that brought treatment to her):78

One of the town administrators (nakai) Shin Zaemonnojō (中居新左衛門尉) came from the wet-nurse of On’ue [Lady Nishi’s eldest daughter], with the message that seven or eight days previously [the woman of] the Monzeki’s [Koshō, ie Junnyo] town administrator Tanba had had a completion of birth (danzan); she was in a lodging, and her affliction was very serious, and they wanted a pulse diagnosis and some medicine. Accordingly I went with him to the lodging. Since they asked for medicine, I made various surmises, and made two packets, compounding nut-grass, Sichuan lovage, peony (芍薬), Chinese angelica, bitter orange (枳穀), fragrant angelica (白芷), tuckahoe mushroom, bidentate achyranthes (牛膝), verbena (馬鞭草), and wild ginger (細辛).

[Later] Someone came from Tanba asking for some additions to this morning’s medicine, as she had vomited it back up (吐逆心有). I added Korean mint (藿香) and Japanese plum (烏梅) and gave it to them. They also had come to tell me that recently she had vomited some medicine back up; they didn’t know whose medicine it was. I gave them the additions.
In the evening I went there again and took her pulse.

[Later] Later that night someone came from Tanba again wanting [medicine]. She was suffering, and they had come to ask me (for more medicine). I gave them one packet of the addition from the previous hour.

With respect to sango post-partum, many times we learn simply that the woman was post-partum, and that people were requesting some medicine; no particular problem is noted. Indeed, in some cases immediately after a birth people simply requested restorative medicine (気付薬) or tonic medicine (養生薬). On occasion people also requested that Tokitsune give a pulse diagnosis, at which time he also generally prescribed a medicine. Other times we learn that a woman is suffering from a post-partum ailment, but the specific problem is not identified. And on one occasion a woman was described as suffering post-partum symptoms some 60 days after giving birth.

But we also learn of specific concerns. Abdominal pain is mentioned many times, and it could occur as much as 30 days after giving birth. Sore bottom and abdomen; breast carbuncle, and fever and liquid oozing; dizzy and chest hurts; head hurts after thirty days; dizziness; dizziness and fever; dizziness and sore chest; bad feeling in chest; chest pains; diarrhea; swelling, and swollen belly; not eating; eyes dancing, and trembling; abdominal pain and diarrhea, and fever and trembling; bad blood not coming out; blood leakage; wind of the blood; chills in the lower portions, heat on the higher portions; sore head, and bleeding in the lower portions; nose bleed; fever, headache, and vomiting; or ailing, delirious, urinating and defecating, swollen, profuse urination, and then unceasing urination.

Stillbirths are noted only a few times. In one case the birth was a little earlier than anticipated and the child emerged dead. On another occasion, after a difficult labor which had lasted for over a day, and during which Tokitsune visited in the night to give a pulse diagnosis, the child was born dead; the mother (the wife of a candle-maker) seems to have recovered quickly. On another occasion however the mother of a stillborn child required at least nine days to recover. The birth was not referred to as a difficult one, but the people around the mother were sufficiently concerned at the length of time that she was in labor that they requested medicine from Tokitsune. The woman remained afflicted following the stillbirth; and the day after, when the woman was still speaking deliriously, they asked for and received further medicines. The following day her condition was slightly improved. Over the course of the following week she experienced swelling, and the amount of her stool and urination were of some concern. The family was then provided with medicine that, Tokitsune instructed them, had to be decocted, and while she had largely returned to normal at the end of the treatment period she was still experiencing profuse urination.

Unexpelled placenta seems to have been a perennial concern. Expeller medicines, as well as formulas that promoted recovery, were most frequently employed to deal with this problem. Sometimes people asked for a generic medicine for expelling the placenta; other times they asked for a medicine by the formula’s name. Sometimes Tokitsune sent a packet or two without specifying details; other times he sent a specific named medicine. It seems that when requests for placenta-expelling medicine came fairly soon after the problem was noticed, the placenta was expelled fairly soon thereafter – usually the same or next day, as in the case where Hōshunken’s wife requested medicine from Tokitsune for her tenant, who had not expelled her placenta; it was expelled the next day. In other cases we learn that a placenta had not been expelled and thus medicine and treatment was sought, but do not have further reference to the problem, even though the context suggests that it must have been expelled successfully, as in one case where medicine was provided to a woman whose placenta had not been expelled, and she received medical attention.
for a time thereafter. Some cases were more alarming. On one occasion we learn of one woman whose placenta had still not been expelled five or six days after giving birth, and so Tokitsune gave her two packets of Shimotsu-tō to which he added flavors; two days later payment was brought on the young woman’s behalf, indicating (since it appears that payment, frequently described as a token of appreciation, was not made if treatment was not successful) that the placenta had been safely expelled.

The above section elucidates the medical challenges facing, and the support and treatment available to, women during their pregnancy and after giving birth. While women in general may have experienced a broader range of symptoms, and medical texts no doubt address a broader range as well, the information in Tokitsune’s record tells us directly the symptoms and challenges for which actual women, his patients, sought treatment. No doubt individual experiences were different, but I believe that we are on safe ground in concluding that during the continuum of pregnancy, parturition, and post-partum, women in the Honganji jinai had ready access to treatment, and that their health was constantly monitored. It is also clear that women received support from those around them.

4. Women’s Medical Support Networks

Tokitsune’s records regarding pregnancy and post-partum ailments that we discussed in the previous section also provide information on who contacted him on behalf of the female for whom medical treatment and medicines was provided. Many entries note only that a matter involving a person or household had been mentioned to Tokitsune, without necessarily specifying which member of a household conveyed the information. In other cases, someone other than a family member is identified as the conveyer of the information. A tabulation of all these instances provides insight into the contours (I may have missed a case or two, but the overall order of magnitude of the breakdowns is clear).

On the 45 occasions when prenatal concerns were reported to Tokitsune (see Table One, below), 23 times the report was made by the family (including the principal), and on the other 22 the report was made by an acquaintance or a neighbor. Of the at least 32 instances of completion of birth danzan, on fifteen occasions someone from the immediate family reported it, and on the other seventeen occasions an acquaintance or neighbor reported it directly or referred the family to Tokitsune. For the 60 occasions when sango post-partum concerns were reported, on 35 of them the report was made by the family, and on 25 of them the report was made by neighbor or acquaintance. Or, for all of the 92 post-partum instances, on 50 occasions reports were made by family members.

### Table One: Prenatal and Post-partum Concerns Reported in Tokitsune’s Diary

<table>
<thead>
<tr>
<th>Type</th>
<th>Total</th>
<th>By family</th>
<th>By non-family</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prenatal sanzen</td>
<td>45</td>
<td>23</td>
<td>22</td>
</tr>
<tr>
<td>Post-partum danzan</td>
<td>32</td>
<td>15</td>
<td>17</td>
</tr>
<tr>
<td>Post-partum sango</td>
<td>60</td>
<td>35</td>
<td>25</td>
</tr>
<tr>
<td>Post-partum concerns combined</td>
<td>92</td>
<td>50</td>
<td>42</td>
</tr>
</tbody>
</table>

TOTAL combined Prenatal and Post-partum concerns: 137 73 64
and on 42 occasions by an acquaintance or neighbor. All in all, of the total 137 reports for all categories, on 73 occasions reports were made by family, and on 64 occasions by acquaintances or neighbors.

Let us now look further at some random examples of how women gave assistance to each other. The first examples seem to have been urgent requests, and were conveyed on behalf of other women to Tokitsune by women who were already his patients. We do not know the precise relationship between the requester and the principal on whose behalf the request was made, but it is useful to note that the requester was able to ensure treatment for someone with whom Tokitsune had, as far as we can tell, no previous contact. Thus, one Akoko (アコ) who was in service with Lady Nishi (a piece of information she felt it important to convey) told Tokitsune that the widow of one Kawabayashi Echigo no kami (河林越後守) who lived in Kawaramachi in Ōsaka-chō (大阪町瓦町) was suffering from a menstruation-related symptom, so he immediately hastened to give treatment. Having treated her, Tokitsune then took this opportunity to go and check on the condition of, and give further medicines to, another woman, who also lived across the river in the Nakagawa section of Ōsaka’s Aiyacho (大阪藍町中川). He had visited this woman two days earlier, at the entreaty of another of his patients, Shimomura Koshōshō (下村小少将). As he recorded on that occasion:

_Someone came from Shimomura Koshōshō to state that the wife of Osaka Aiyacho’s Nakagawa Kusakai Ukon Sā Emonnojō (大阪藍屋町中川内草筰右近惣衛門尉) was ailing, so I went there and did a pulse diagnosis. Her blood is down, her chest is clogged, her head hurts, she is not eating, and her ears are ringing. I sent three packets of Shimotsu-tō to which I added astragalus (黄耆), aloeswood, ginseng, nut-grass, fragrant angelica, baikal skullcap (黄芩), and Japanese catnip. Next I went to Koshōshō’s place, and (her husband, Shimomura) Yosuke treated us. There was a meal._

Koshōshō assisted others as well. As we may expect, she sought treatment for her infant son’s ailments, such as foot sores; smallpox (疱瘡) and a minor fever; diarrhea; and coughing (しわぶき). But she is also noted over the years as seeking treatment for such people as: an acquaintance whose hair was falling out; a serving man afflicted with diarrhea; another acquaintance who was experiencing a difficult labor; and another one of her serving women who had post-partum fever and a sore head.

Other cases of women giving assistance involve older women who, judging by their personal names, were past child-bearing age (likely their children had grown to adulthood) and, as was not uncommon, had decided to enter a new phase of their lives and become lay nuns. As such, they became members of a distinct female space that constituted yet another social network for them. As senior women in the _jinai_, one of their roles (or avocations) was to lend their services to others, and as lay nuns they operated across many social boundaries. Their cumulative individual activities constituted a decentered but ever-present collective network.

One such example is that of Myōgen (妙玄), also referred to in the diary as Kurikaka (クリ母), that is, the mother of Kuri (one of Lady Nishi’s serving women). Myōgen appears repeatedly in Tokitsune’s records, reporting items such as a seven-year-old acquaintance’s son having bloody diarrhea, or referring an old nun who was an acquaintance of hers in order to receive a pulse diagnosis (in each case Tokitsune prescribed medicine). Another example is that of Myōtoku, who we earlier saw arranging for Tokitsune to provide treatment for the unexpelled placenta of an acquaintance’s daughter. Myōtoku, a patient and a family friend who seems to have been close to Tokitsune’s late mother, is also recorded for such things as: being an intermediary who took medicine to a child suffering diarrhea and also accompanying the child for treatment the next year; introducing a mother and child for treatment, and then serving as intermediary to bring Tokitsune
their thanks payment;\textsuperscript{128} being an intermediary to get medicine for another child, and again being the intermediary bringing the thanks payment;\textsuperscript{129} coming to get medicine on behalf of the wife of an indigo-dyer;\textsuperscript{130} introducing the wife of an acquaintance who had nausea;\textsuperscript{131} introducing the young daughter of an acquaintance to get treatment;\textsuperscript{132} taking medicine to a wet-nurse suffering abdominal pain;\textsuperscript{133} or acting as an intermediary for and accompanying a four-year-old girl for treatment.\textsuperscript{134}

There is one woman, whose identity Tokitsune noted only as the wife of Hikoshirō (彦四郎), who we can follow helping neighbors and friends to receive treatment and medicines over many years. Her case provides texture, especially with respect to children and mothers, and is worth pursuing in some detail. We can trace her health-related activities between 1591 and 1599. She seems to have been in general good health, but since Tokitsune was not the only physician around, it is possible that her interactions with Tokitsune do not represent her full medical history. Like Myōtoku she was a long-term acquaintance of and close to Tokitsune’s family.\textsuperscript{135}

The first contact between Hikoshirō’s wife and Tokitsune occurred in late 1591 when, having just given birth she requested medicines from him, which he provided on three occasions over a four-day period.\textsuperscript{136} It appears that Hikoshirō’s wife was satisfied with the treatment, for she brought a wider group of people into contact with Tokitsune. A sequence of diary entries from a month later provides a look at this process.

Late in the first month of 1592 she brought a tray of sweets to Tokitsune, and also brought along her acquaintance Yojūrō (与十郎) and his child, both of whom received a pulse diagnosis and some medicines.\textsuperscript{137} A few days later, early in the second month, Hikoshirō’s wife accompanied that child who brought, as thanks, some fish, and also received some decoction medicine. She also brought along with her on this visit two other children of ward residents, who Tokitsune also examined, and for each of whom he gave moxibustion treatment.\textsuperscript{138} One week later, early in the morning, Hikoshirō’s wife came to Tokitsune to ask him to give a pulse diagnosis to the post-partum wife of the nearby pharmacist Sōritsu (宗立) (owner of the Sumiyoshi-ya pharmacy 住吉屋), which he did, and also provided medicines twice that day. Then, later that day, Tokitsune was asked to provide medicine to Hikoshirō’s wife herself, who was “near death” (絶死) and was in great abdominal pain, a problem that she had had since her baby’s birth.\textsuperscript{139} Then, six days later Hikoshirō’s wife came to ask that Yokitsune give a pulse diagnosis for the ailing wife of Yojūrō (whose ailment was noted as a “little better” in Tokitsune’s diary two days later).\textsuperscript{140}

These episodes provide a guide to the interactions of Hikoshirō’s wife over the following seven years. With respect to her own condition, the problem with the abdominal pain continued, though it appears that this was due to her having become pregnant again, rather than as a result of the earlier birth. Hikoshirō’s wife received pulse diagnosis and medicine for abdominal pain in the fifth, sixth month, and tenth months of 1592.\textsuperscript{141} On the last occasion Tokitsune was accompanied by the mother of Ima, a wet-nurse responsible for Lady Nishi’s oldest son. There is no mention of why Ima’s mother came along with Tokitsune, and we do not know what relationship she had to the wife of Hikoshirō. However, and while Tokitsune makes no reference to Hikoshirō’s wife being pregnant (though his records note her receipt of some Saisei-san birth-inducing medicine), and that she gave birth to another child during the first month of 1593),\textsuperscript{142} we might speculate that, as an older woman familiar with pregnancy and childbirth, it was in order to give assistance and advice to both Tokitsune and the wife of Hikoshirō.

When Hikoshirō’s wife’s pregnancy came close to term, she referred another woman, also approaching birth, to Tokitsune for treatment in the twelfth month of 1592.\textsuperscript{143} As we know, it was not uncommon for women who were expecting or who had recently given birth to assist other pregnant women.\textsuperscript{144} For the wife of Hikoshirō, such involvement appears to have been a regular part of her neighborhood activity. She is noted as an intermediary for pregnant women on a number
of occasions. From 1592 to 1597 we find that: the wife of the artist Hikoshirō came to say that the neighboring woman had post-partum discomfort in her chest (胸アシキ), and requested medicines on her behalf; an acquaintance of Hikoshirō’s wife requested hayame gusuri expeller medicine from Tokitsune, and had a successful birth; Hikoshirō’s wife requested Saisei-san on behalf of a woman in the neighborhood; Hikoshirō’s wife informed Tokitsune that Yojūrō’s wife was in labor and wanted medicine; an acquaintance of Hikoshirō was provided with medicine to expel his wife’s placenta; and a woman who was a friend of Hikoshirō’s wife, who was suffering symptoms post-partum, came to Tokitsune for a pulse diagnosis, and was given medicines that Tokitsune compounded for her seven times over the following ten days.

We might also note the occasion in the fourth month of 1596 when the wife of Hikoshirō came to Tokitsune to pick up post-partum medicines that had been requested for the elder sister of the wife of Minoya Yojūrō (美濃屋与十郎). It turns out that the elder sister was physically in the province of Mino, and given that it was a trip of at least several days to get there from Kyoto, they must have been acquiring the medicines some time in advance of the birth, rather than asking for them after the birth. Post-partum matters were not casual ones, and it is evident that Hikoshirō’s wife enjoyed great trust from her contemporaries.

Hikoshirō’s wife also acted as an intermediary for her acquaintances’ children when they needed medical care. She once accompanied a man and his daughter who needed a pulse diagnosis; another time she recommended that a woman take her son to Tokitsune for treatment. Other references between 1592 and 1597 suggest that she took particular interest in the health of the children of Minoya Yojūrō. On at least two occasions Hikoshirō’s wife accompanied Minoya’s son when he brought Tokitsune a gift for medicines they had received from him (on one occasion she also brought two other neighborhood children along with her). When Yojūrō’s wife was ailing on one occasion Hikoshirō’s wife came to get Tokitsune and accompanied him as he made a house call; in two successive years when the son went at the New Year to thank Tokitsune for the treatment the previous year, Hikoshirō’s wife accompanied him; on another occasion she brought two of Yojūrō’s sons for treatment; and on one occasion when one of the sons was “near dead” and needing treatment, she came and informed Tokitsune of the situation, and he went there immediately. All in all, while we do not have a large number of entries regarding the wife of Hikoshirō, they extend over many years, and are consistently related to involvement in the medical concerns of others (which, no doubt, reflects the focus of Tokitsune’s diary). We might posit that she provides an example of long-term female acquaintances whose interactions in part constituted a female family medicine network.

Families and households appear to have been a major locus of support networks. That said, there was no standard size or composition for a household. Lady Nishi’s household was made up of close to 30 people, adults and children, virtually all of whom were female. In the Itami household there were perhaps a dozen people spanning three generations. And in the household of a tatami-matting
maker there were two parents and two children. Yet, irrespective of composition, no household in the Honganji jinai seems to have lived in isolation. With mothers, wet-nurses, people of different generations, and neighbors, all enjoying their varied and overlapping circles of acquaintances, which could cut across lines of status and social position, information regarding medical matters in any one household could readily be disseminated. The information in these networks was an accumulation of information from many women’s experiences over time and was added to constantly. It is also important to bear in mind that it was unlikely that information was withheld, and more likely that information was shared readily.

There are three larger points regarding the rhythms of those female support networks. Firstly, the networks that disseminated medical knowledge and support were managed by women on a sustained, long-term basis, and as an integral component of general social activity and bonds. And, while no doubt males talked about medicines and there is ample evidence that males too assisted and referred others, I have been unable to discern a comparable pattern of activity sufficient to identify something like a male support network in which there was any significant component related to medicine. Secondly, particularly in the areas of pregnancy and post-partum, and by extension to the health of children, the network support given to women seems to have been almost exclusively provided by other women; that is, a network of support for women provided by women. Thirdly, and reflecting the web-like nature of networks, we may identify three chains of connection, which may have overlapped, in terms of the way in which support was provided. Namely: one patient introduces someone else to the physician; a chain of connections links a person in need to the doctor, but always the key introduction is provided by a female, especially in areas of women’s health; finally, long-term associations and friendships of acquaintances and neighbors, in which mutual assistance was no doubt an integral component, constituted something close to a permanent medical support network.

We may take an additional point from the preceding information. Namely, pregnant and post-partum women appear to have been beneficiaries of a multi-component support network that was made up of immediate family and household, the surrounding physical community of neighbors, and a virtual community of acquaintances and intermediate third parties. And, we might add, the family itself was the beneficiary of that support network.

5. Concluding Comments

Tokitsune’s diary makes possible a granular engagement of the medical experiences over an extended period of time of actual women and their families prior to the seventeenth century that is not possible from any other sources. What are some larger points we may take away from our initial exploration of aspects of family medicine in the Honganji community as recorded in there? First, it is clear that people in the Honganji community had ready access to medicine and to medical treatment. Patients and doctors were in close physical proximity, and the dimensions of the Honganji jinai likely meant that a visit to or from the doctor required no more than fifteen minutes travel. As we have seen, this also meant that medical attention was available at almost any time of the day or night. Medical attention was available in more or less the same way to any member of the community irrespective of occupation or status. All of these elements were, as far as we can tell, new phenomenon in the final decades of the sixteenth century.

Second, knowledge of medicines was widespread. Not only were people aware of medicines by name (Aisuyaku and Ninjin chōkō-san, for example), they were aware of different varieties of general medicine (such as tonic medicine or restorative medicine), and they were aware that medicines were available for any number of symptoms or needs (prenatal and post-partum ailments, or bringing down malaria, for example). Additionally, it is apparent that the availability of medicines made it
possible to take a proactive approach to health management. This not only meant keeping track of the condition of people around them (most obviously, within families) on the assumption that medicine would be acquirable in timely fashion, it also meant that it was possible for patients to keep track of individual health over an extended period by maintaining their own records.

Third, especially in the context of the Honganji community with its strong sense of identity and concern to build and maintain strong internal bonds, it appears that attention to the health of family and of neighbors provided a new element in community bonding. Beyond simply taking note of health and illness, women in particular seem to have been able to build long-term bonds based upon their personal reproductive experiences and, a slightly different but inextricable element, their concern for the survival of their children in an age when such could not be taken for granted. Thus, we have strong evidence of female health networks that provided information sharing and support.

Fourth, women had shared experience of illness (of their own and of others), an awareness of the medical condition of neighbors and their children, and ready access to medicines and to specialists. Certainly in the Honganji, and no doubt more generally in the new urban environments of the late sixteenth century, this detailed knowledge and web of connections propelled issues of medicine and health to the forefront of daily life in a way that had not been possible prior to this time.

Finally, let me suggest two further items. First, on a larger historiographical note, exploration of issues of community health and survival, bonding and networks, and attention to the family (or household) unit, and thus of issues which we can show were of fundamental interest to women, particularly in this turbulent period in Japanese history, promises a wider appreciation of women’s historical experience than is gained from privileging attention to politics and conflict. Second, with respect to the role of medicine in society, women appear to have had greater daily interest in matters of health and medicine than men, and it appears that greater attention was paid to the treatment of medical issues of particular concern to women (their own symptoms, and those of their children, families, and acquaintances) than to those of any particular concern to males. Accordingly, we may speculate that study of women and medicine provides our most important portal into the role of medicine in society, and is key to understanding the development of Japanese medical culture in the immediately succeeding early modern era (1600-1868 C.E.).

NOTES

I wish to dedicate this essay to the memory of my mother, Beth Perry Goble (1921-2015), a midwife and pediatric nurse.

1. See Hattori Toshirō, Muromachi Azuchi Momoyama jidai igakushi no kenkyū; Shinmura Taku, Nihon iryō shakai shi no kenkyū.


3. For example, Mary Elizabeth Berry, The Culture of Civil War in Kyoto.

4. For example Kojima Michihiro, Egakareta Sengoku no Kyōto Rakuchū rakugai zu byōbu wo yomu; Kuroda Hideo, Rakuchū rakugai zu Funaki bon o yomu.

5. One notable exception is Lee Butler’s “Washing Off The Dust: Baths and Bathing in Late Medieval Japan.”

6. See Andrew Edmund Goble, “Rhythms of Medicine and Community in Late Sixteenth Century Japan: Yamashina Tokitsune (1543-1611) and His Patients;” Goble, “Shokuhō ki ni okeru Manase ke no iryō bunka no tenkai – Mōri daimyō ke to no kankei o rei ni;” Goble, “Yamashina Tokitsune nikki (Tokitsune kyōki) no
shinryōroku teki kisai – Igaku tenshōki o haikei ni;” Goble, “Physician Yamashina Tokitsune’s Healing Gifts.”

7. *Tokitsune kyōki* (hereafter *TTK*). The diary covers the period 1576 to 1608. For a number of the years before 1586 the diary is, however, not fully extant. For a useful overview of the diary, see Hanada Yūkichi, “*Tokitsune kyōki* kō.”

8. For useful information on the Tenma and Rokujō Honganji jinai, see: Hashizume Shigeru, *Seto naikai chiiki* shakai to Oda kenryoku 274-291; Itō Takeshi, “Tenma no seiritsu - Settsu Tenma Honganji jinai chō no kōsei to Tenma gumi no seiritsu katei;” Kitai Toshio, *Chūsei kōki no jisha to keizai*, pp. 227-249. For “street directory” type maps of the two locations, see Takahashi Yasuo et al, *Zushū Nihon toshi shi*, pp. 96-97. More broadly on Ōsaka in this period, see Minami Hideo and Mametani Hiroyuki, “Toyotomi jidai no Ōsaka jōka machi.”


10. See Yoshida Hajime, *Nihon no shoku to sake*, pp. 95-135. See also the Goble studies referred to in note 6 above.

11. For a comprehensive introduction to jinai, see Niki Hiroshi, Ōzawa Ken’ichi et al., *Jinai chō no kenkyū*.


13. Zesshi is a vexing term that at first glance seems to imply that someone had died, but is used in contexts when the person so described receives treatment and (usually) survives the event. Thus it seems to indicate a colloquial sense of someone suffering so much that they seem to be “near death” or “dying,” rather than “has died.”


15. The case unfolds between Keichō 2 (1597).7.11 (8:14) and Keichō 2 (1597).8.27 (8:51). On the Shimozuma clan, the long-term main administrative family serving Honganji, see Kinryū Shizuka, “Sengoku jidai no Honganji naishū Shimozuma shi.”

16. For a gripping visual depiction of sunstroke (*kakuran* 霍乱), see the medieval illustrated scroll *Yamai no sōshi* (*病の草紙*, *Scroll of Afflictions*). The commentary to the scene reads: “There is an affliction called kakuran. In the stomach there is pain like being stabbed; from the mouth one vomits liquid, from the backside one leaks diarrhea. One lies prostrate in convulsions, and it is truly agonizingly unbearable.” For an explication of the 22 scenes in the *Scroll of Afflictions*, and of the 37 scenes in the later *Ihon yamai no sōshi* (*異本病の草紙*, *Scroll of Gross Afflictions*), see Andrew Edmund Goble, “Images of Illness: Interpreting the Medieval Scrolls of Affliction.”


19. Nishi Onkata (西御方) (1562-1616), whose posthumous Buddhist name was Hōjuin Yūshin ni (宝壽院祐心尼) was a high-ranking member of the cultural, political, and religious elite. She was born into the aristocratic Reizei family. She served as consort to Imperial Prince Sanehito (誠仁親王) (1552-1586), by whom she had two children. In 1582 she was married to Kenson Sachō (顕尊佐超) (1564–1599), second son of the Honganji Pure Land movement head Kennyo (頗如) (1543-1592), and head of the Kōshōji branch of the Honganji. She had four children by Kenson, three of whom (one son and two daughters) became leading figures in Honganji in the turbulent years which witnessed the split of Honganji into the two factions which are rivals to this day.

20. Yamashina Tokitsugu, Tokitsune’s father, noted that healing had at least two components, one being medicine (*iryō* 医療) and one being prayer (*kiryō* 祈療). See *Tokitsugu kyōki*, Eiroku 12 (1569),5.13 (4:332). Tokitsune and his family on occasion requested that prayers be said to alleviate their medical problems. One example comes from their requests at Sumiyoshi Tsumoridera Yakushi 住吉津守寺薬師 that prayers be offered for such things as: the alleviation of his wife Kitamuki’s eye ailment *TTK*, Tenshō 18 (1590).2.12 (4:21); his son Achamaru’s cough *TTK*, Tenshō 18 (1590).3.10 (4:33); Tokitsune’s various
ailments, on which occasion he also paid for prayers for three months TTK, Tenshō 18 (1590).5.28 (4:52); or Tokitsune’s swollen foot TTK, Tenshō 18 (1590).11.12 (4:132). For an overview of prayer healing in the medieval era, see Shinmura Taku, Nihon iryō shakai shi no kenkyū, pp. 335-374.

28. For example, TTK, Bunroku 4 (1595).6.6 (6:283): “Since someone came from Nishi Onkata to get medicine I forwarded two packets of Kakkō shōki-san to which I had added aloeswood (沈香), wild ginger (細辛), nut-grass (香附子), mandarin orange peel (陳皮), dwarf lily-turf (麦門冬), etc. At the shadow of evening I went there to see how she was doing and did a pulse diagnosis.”
31. TTK, Tenshō 16 (1588).5.17 (3:70).
32. TTK, Keichō 1 (1596).6.30 (7:110).
33. TTK, Bunroku 3 (1594).11.16 (6:175); TTK, Bunroku 4 (1595).12.7 (6:397).
34. TTK, Keichō 2 (1597).7.15 (8:19).
35. TTK, Tenshō 18 (1590).9.23 (4:111). The daughter received treatment from the twenty-ninth of the eighth month through the twenty-fifth of the eleventh month, and was provided with a variety of formulas and compounded medicines.
40. TTK, Keichō 2 (1597).2.6 (7:308).
42. Tokitsune’s bout of malaria laid him low between 5.16 and 5.22. He received acupuncture treatment from a moxibustion specialist キウカ (灸家) on three successive days: TTK, Tenshō 15 (1587).5.20 (2:279), 5.21 (2:279), and 5.22 (2:279).
45. TTK, Tenshō 18 (1590).7.4 (4:78), 7.6 (4:79).
46. TTK, Tenshō 18 (1590).2.18 (4:24).
47. The mother is Uwa On Menoto ウワ御乳人, one daughter is Tokumatsu 徳松, another daughter is Fuku
福 (who also was a wet-nurse), another daughter is Ito イト (who also was a wet-nurse), and then Ito’s daughter. For examples of treatment for each: Uwa TTK, Tenshō 18 (1590).12.21 (4:148); Tokumatsu TTK, Bunroku 2 (1593).7.16 (5:334), Keichō 2 (1597).5.15 (7:383); Fuku TTK, Bunroku 1 (1592).4.9 (5:50); Ito TTK, Bunroku 3 (1594).7.27 (6:118); Ito’s daughter TTK, Bunroku 3 (1594).7.28 (6:118).


49. For a strong critique of the scholarly construct of the birthing hut, see Hitomi Tonomura, “Birth-giving and Avoidance Taboo: Women’s Body versus the Historiography of Ubuya.”


51. TTK, Tenshō 17 (1589).8.20 (3:270).


60. For more on this, see Goble, “Rhythms of Medicine,” pp. 23-26.


64. TTK, Keichō 2 (1597).4.18 (7:361).

65. TTK, Tenshō 18 (1590).2.3 (4:17).


69. TTK, Tenshō 18 (1590).2.3 (4:17).


73. TTK, Bunroku 4 (1595).2.5 (6:219).

74. TTK, Tenshō 17 (1589).6.17 (3:238).

75. TTK, Tenshō 17 (1589).12.1 (3:315).

76. TTK, Tenshō 16 (1588).1.25 (3:12), 1.26 (3:13), 1.27 (3:13), 2.4 (3:16).

77. TTK, Tenshō 14 (1586).4.8 (2:126).

78. For a strong critique of the scholarly construct of the birthing hut, see Hitomi Tonomura, “Birth-giving and Avoidance Taboo: Women’s Body versus the Historiography of Ubuya.”

79. For more on this, see Goble, “Rhythms of Medicine,” pp. 23-26.


81. TTK, Tenshō 18 (1590).2.3 (4:17).


84. TTK, Tenshō 18 (1590).2.3 (4:17).


delivered at a joint meeting of the medieval and early modern sections of Nihonshi Kenkyūkai in Kyoto on June 11, 2016.

73. TTK, Keichō 2 (1597).12.25 (8:147); for the wife of Hikoshirō the artist, see: TTK, Tenshō 19 (1591).12.19 (4:313) and TTK, Bunroku 1 (1592).2.8 (5:22).

75. TTK, Tenshō 17 (1589).2.28 (3:189).
77. TTK, Tenshō 14 (1586).7.3 (2:156) through 7.10 (2:160) when the wife has recovered.
80. TTK, Bunroku 4 (1595).6.6 (6:281).
81. TTK, Keichō 3 (1598).7.30 (9:23); TTK, Keichō 3 (1598).9.28 (9:66); TTK, Keichō 3 (1598).10.23 (9:79); TTK, Keichō 3 (1598).12.29 (9:120).
82. TTK, Tenshō 15 (1587).3.11 (2:248); TTK, Tenshō 15 (1587).6.18 (2:290). In both of these cases, however, other symptoms manifested a few days later. TTK, Keichō 3 (1598).6.28 (8:276).
83. TTK, Tenshō 17 (1589).7.25 (3:257).
85. TTK, Keichō 9 (1604).intercalary 8.21 (13:36), noting treatment for the daughter of Iwatsuru, his kawaramono “outcast” odd-jobber.
87. TTK, Keichō 3 (1598).9.10 (9:54-55).
89. TTK, Tenshō 17 (1589).4.3 (3:207); TTK, Tenshō 17 (1589).7.3 (3:245); TTK, Keichō 2 (1597).10.23 (8:93).
91. TTK, Keichō 3 (1598).9.10 (9:54-55).
92. TTK, Bunroku 2 (1593).5.7 (5:421).
94. TTK, Bunroku 1 (1592).8.24 (5:135); TTK, Keichō 3 (1598).5.3 (8:242); TTK, Keichō 4 (1599).7.23 (10:13).
95. TTK, Keichō 2 (1597).7.24 (8:27).
98. TTK, Keichō 1 (1595).8.28 (7:207).
104. TTK, Tenshō 15 (1587).11 (2:225). Wind of the blood 血かせ（血風）is likely an abbreviation for 血虚生風, 'internal wind due to deficiency of blood,' resulting from profuse bleeding, marked by such symptoms such as dizziness and trembling.


110. TTK, Tenshō 16 (1588).4.8 (3:51), 4.9 (3:52), 4.27 (3:63).


119. TTK, Tenshō 16 (1588).5.7 (3:66).

120. TTK, Tenshō 16 (1588).6.9 (3:91).


122. TTK, Tenshō 17 (1589).10.29 (3:304).


124. TTK, Tenshō 14 (1586) (2:201).

125. TTK, Tenshō 15 (1587).7.3 (2:296).

126. See TTK, Tenshō 18 (1590).2.21 (4:26) also providing seven packets of Chōchū-san 調中散, TTK, Bunroku 4 (1595).3.18 (6:239) also providing ten doses of Kaiki-san 快気散, for which she paid ten mon.

127. TTK, Bunroku 3 (1594).7.3 (6:100); Bunroku 4 (1595).4.7 (6:253).


130. TTK, Keichō 1 (1596).3.16 (7:53).


132. TTK, Keichō 1 (1596).10.21 (7:238).

133. TTK, Keichō 2 (1597).2.27 (7:368).

134. TTK, Keichō 2 (1597).5.9 (7:379).

135. She was a member of Tokitsune’s Aromatic-Madder-powder gift group [see TTK, Bunroku 1 (1592).6.13 (5:85); for this gift group, see Andrew Edmund Goble, “Physician Yamashina Tokitsu...prior to a family memorial services], such as the seventeenth anniversary of the death of Tokitsu’s father, and the 25th anniversary of the death of his wife Kitamuki’s father [TTK, Bunroku 2 (1593).4.17 (5:266); TTK, Bunroku 3 (1594).8.23 (6:132)].


138. TTK, Bunroku 1 (1592).2.8 (5:21-5.22).
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140. TTK, Bunroku 1 (1592).5.12 (5:68); TTK, Bunroku 1 (1592).6.3 (5:80); TTK, Bunroku 1 (1592).10.23 (5:164).
143. TTK, Tenshō 15 (1587).8.28 (2:319): “From Baian’s wife [who had given birth to a son eleven weeks earlier: TTK, Tenshō 15 (1587).6.5 (2:285)] I received word that a nearby woman had post-partum abdominal pain and diarrhea. I gave two packets of Shimotsu-tō to which I added nut-grass and nutmeg 肉豆冠.” TTK, Tenshō 15 (1587).9.7 (2:323): “From Baian’s wife word that [the person] in the neighborhood has post-partum temperature and shakes. They asked me to help. I sent the medicine from the other day. It is better. Further it is like this. I did a pulse diagnosis. I gave two packets of Shimotsu-tō to which I added ginseng, and astragalus. At the late evening they came again to get medicine so I gave one packet of what I had given at an earlier hour to which I added beefsteak plant 柿蘇, and one packet of restorative medicine Kitsuke yaku 気付薬.” TTK, Tenshō 15 (1587).9.10 (2:325): “I did a pulse diagnosis for the post-partum [patient] near Baian. I gave 3 packets of Shimotsu-tō to which I added ginseng, magnolia, nutmeg, and nut-grass.”
144. TTK, Bunroku 2 (1593).11.2 (5:421).
147. TTK, Bunroku 4 (1595).8.16 (6:334).
148. TTK, Keichō 1 (1596).1.3 (7-6).
149. TTK, Keichō 2 (1597).11.26 (8:120), 11.27 (8:120), 11.28 (8:121), 11.29 (8:121), 11.30 (8:122), 12.3 (8:126), 12.5 (8:127), 12.6 (8:128), 1.3 (8:158).
151. TTK, Bunroku 2 (1593).6.6 (5:299).
156. TTK, Keichō 1 (1596).3.16 (7:53).

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“The Task is Hers: “ Going Global, Margaret Sanger's 1922 Visit to China

by Mirela David, Ph.D., University of Saskatchewan

Bodily diseases such as syphilis, alcoholism, mental illnesses such as dementia, erotomania can all harm one’s descendants, and even more than our children and grandchildren, can harm our society. Eugenics [the science of racial betterment, or renzhong gailiangxue 人種改良學] advocates the use of national power to forbid reproduction of this kind of men and women, suffering from these diseases. Men and women – or one party, if they are afflicted with such illnesses – should resign themselves that they do not have the qualifications of becoming parents and should restrict their reproduction until they do not reproduce anymore. To restrict sons and daughters is to improve the race, to better the bodies of our children, regardless whether it’s about mental or physical health, this is the parents’ responsibility and it constitutes the basis of advancement. If parents are not in a strong position and do not have the ability to rear numerous children, then they should practice birth control.

– Gai Zun (丐尊), “Control of Reproduction,” 1921

Such was the discourse on the eugenic potential of birth control following the 1922 visit to China of its most ardent global proponent, Margaret Sanger. A former nurse, Margaret Sanger coined the term “birth control,” and founded The American Birth Control League, a precursor of Planned Parenthood. Inspired by her mother’s recurring pregnancies Sanger become the foremost advocate of contraception with a global reach. Sanger controversially opened the first contraceptive clinic in the U.S. in 1916, and was tried for violating the Comstock obscenity laws through her birth control advocacy. If eugenics was the goal, birth control was seen as a means to an end. Both Sanger and Chinese intellectuals approached biological reproduction as social, national and racial reproduction. The perceived problem was the perpetual breeding of key diseased segments of the population identified by eugenicists as people plagued by mental diseases or syphilis, and its detrimental and degenerating effect on national health. Journalist Gai Zun (丐尊) explicitly linked birth control with race improvement (shanzhong 善種), especially in view of the multitude of ailments that can affect the quality of descendants. Gai Zun developed some of the themes suggested in Sanger’s speech at Beijing National University, in particular the imposition of restrictions on the reproduction of the mentally ill through the use of national or army power. Sanger had also emphasized the benefits of birth control to allow a higher quality education for children in smaller families. The description of dysgenic births and the prescription of coercive measures of inhibiting reproduction of alcoholics, criminals, and the feeble-minded implied a concept of Mendelian laws of heredity, whereby for these categories there was no possibility of improvement in society other than stopping their social and biological reproduction. Birth control for less-than-perfect people was seen as a measure of racial improvement and of controlling the quality of the offspring. Eugenics (youshengxue 優生學) proposed a veto on the reproduction of biologically deviant social categories.

Margaret Sanger’s trip to China held a double meaning: it reinforced images of China as a global example for the necessity of birth control because of overpopulation and insufficient resources, and it also sparked an intriguing debate in the Chinese press around the eugenic quality of birth
control. Sanger’s correspondence shows her efforts in forming a global birth control movement, and the enthusiastic responses from Chinese journalists, intellectuals, and expatriates to the social possibilities of contraception (shengyu jiezhi 生育節制). In the 1920s China’s birth control movement was in its nascent phase.

Part of the birth control work was translating birth control theories and methods, debating their uses or inadequacies for the Chinese situation, and disseminating that information through the booming print media cultural industry, in particular in women’s journals in cities such as Beijing and Shanghai. This engagement with birth control remained mostly at a theoretical level in the early 1920s. Sanger’s visit to China acted as a catalyst in the birth control debates in China. Sanger’s influence did not end with her visit: she continued to correspond with Chinese intellectuals and female gynecologists, leading to the 1930s openings of Chinese birth control clinics modeled on Sanger’s New York clinics. In this article I explore Sanger’s interactions with Chinese intellectuals of the New Culture Movement (1915-1921), and the initial reception of Sanger’s birth control activism in 1922. To this end I examine the contents of Sanger’s speeches in China and the translation of these and others of Sanger’s works into Chinese, to assess which of her ideas were prevalent in Chinese women’s magazines. Disenchanted with Chinese traditional culture, young intellectuals during the New Culture Movement turned their attention towards Western concepts of science and democracy as a means to help China through its transition. Eugenics was one of the popular sciences at that time.

Ultimately eugenics as a worldwide social movement and ideology was also translated into the Chinese situation. Here, I understand translation not in the sense of transmission, but in a historical and cultural vein as enabling the emergence of new ideas – both in China and globally regarding the relationship between women’s reproductive bodies, population control, politics and activism. Through this approach one can uncover the potential of eugenics for social change, which might explain why in view of national dangers some intellectuals were arguing about solving China’s social problems in eugenic terms. Chinese intellectuals did not just uncritically adopt western theories of eugenics and birth control. Instead they selectively translated western scientific, cultural and social studies emphasizing what resonated locally, namely approaches to poverty stemming from overpopulation.

Moreover, some radical liberal intellectuals agreed with Sanger’s eugenic argument for birth control to improve women’s health. Women’s reproductive health was considered in light of the prominence of feminism and individualism in the decentralized journalistic open period of the 1920s. I find that while Sanger’s feminist and eugenic ideas were well received, few shared her exclusive focus on birth control as a panacea for China’s social ills. This was mostly on account of the philosophical tensions between Sanger’s eugenic line of argumentation for birth control and leftist and nationalist understandings of economic realities. At the height of the global popularity of eugenics, Chinese intellectuals demonstrated agency in their rejection of eugenics. Some Chinese leftist intellectuals disagreed with Sanger’s criticism of the lower classes and her preference for the fit and talented upper classes, claiming instead that birth control only distracted from economic inequality and imperialist oppression.

Gender also played a role in the perception of birth control. Socialist women unlike socialist men believed birth control and socialism are compatible. In 1920s China women’s reproduction was perceived to be the task of modernizing male intellectuals, as men – sometimes using female pseudonyms – wrote the overwhelming majority of the articles on contraception. This bothered Sanger, whose hopes of finding female counterparts in China were initially dashed by the different political persuasions of the male-dominated intellectual scene. Sanger’s insistence on restricting population was incompatible with some nationalists’ views, according to which population was vital for national survival. This was also the reason why the Japanese government censored Sanger upon
the occasion of her visit there in 1922. Nonetheless, Sanger’s concern with the population question was the primary reason why she enjoyed substantial coverage in the Chinese press, given the prominence of Malthusian theories of overpopulation in China.

Juliette Chung explores the split in the Chinese eugenics movement between those who embraced birth control and those who saw it as racial suicide. My study, however, focuses on the translation of Euro-American eugenic discourses in China, as well as with the cultural encounters between Western activists and writers, and Chinese intellectuals. In her consideration of Lamarckism versus Mendelism, Chung – like Dikötter – argues that Lamarckism exerted a substantial influence in China and Japan because it allowed for race improvement by means of social reform. My research suggests that Chinese intellectuals’ belief in Lamarckism, which stressed the influence of the environment for the development of future generations, did not preclude their acceptance of hereditary inheritance inspired by Galton or Mendel’s genetic research, which they advocated in certain instances. I want to complicate this Lamarckian emphasis by also focusing on the Mendelian version of eugenic thought in conjunction with birth control, according to which heredity and biological factors are determinative, which effectively disavows any formative social action apart from predetermining who is allowed to procreate. Chung also collapses radical intellectuals’ engagement with sex to a “sexuality versus morality” opposition. I show that the sexual ethics they professed was undoubtedly eugenic.

Tani Barlow finds that eugenics flourished precisely at the intersection of natural and social sciences, and that scientific racism was a core element of progressive feminism. Woman as a concept could no longer be thought of without science. Barlow’s research centers on the eugenic health of modern women redefining themselves and being redefined in scientific terms as units of reproductive physiology in connection with commodity advertisement in 1920s China. My study, like Barlow’s, acknowledges the pervasive presence of eugenic ideology in the cultural sphere in Republican China. Frank Dikötter’s focus on medical discourses of eugenics as a means of reducing birth defects in China posits continuities between interwar eugenic views and the framing of China’s One Child Policy in the 1980s. According to Dikötter eugenics was not institutionalized in Republican China, but was popular among modernizing elites. My investigation pushes beyond his argument, and inquires into the reasons for the popularity of eugenics.

Ann Farmer emphasizes the scientific rationale for actual prejudice against the poor, disabled, and criminals and the quest for a biological solution to all social ills. According to Farmer, tying eugenics to sexual education gave British intellectuals an aura of progressiveness; however, their emphasis was on eugenic reproduction. Minna Stern analyzes the institutionalization of the eugenics movement in California, a frontrunner state, from analyzing print media such as the column on “Social Eugenics” in the L.A. Times, quarantine policies at the Mexican border, eugenic sterilizations, Sinophobia, deportation, faulty IQ tests, and race suicide anxieties. My study connects explicitly through translation the Chinese eugenic debates to global eugenics.

1. Margaret Sanger’s Visit to China

In 1922 Sanger decided to visit Japan and China. Sanger was amazed that on the streets of Beijing she saw thousands of men, but very few women. “Dust, dust, dust and walls within walls” is her recurring depiction of Beijing. She was obsessed with cleanliness and hygiene and wanted to bathe all the time. Sanger had come with a letter of introduction from Jiang Menglin, who was studying in the U.S. Chen Da, a famous population specialist who studied at Columbia University, had met Sanger in the U.S. and also invited her to China.

Sanger’s journey to China and her lectures challenged the traditional free birth ethic. Hu Shi (胡適), a famous Chinese writer acted as her translator and invited Sanger to speak at the National
University, Cai Yuanpei (蔡元培), the chancellor of the National University gave a dinner in her honor. Sanger observed that all of the men had larger families than they desired; she was also impressed with Hu Shi’s assessment of the population question. Hu Shi, a leading figure in the New Culture Movement portrayed Sanger as the foremost advocate of birth control: “She is a brilliant orator, very few women can display such an arrangement of ideas in their speeches.” Hu Shi’s comment revealed a concern shared by his contemporaries about women’s lack of personality. Hu estimated that almost 2000 participants attended the lecture, which he promoted in the following ad:

*Unrestricted birth causes population increase to surpass the capacity of raising children. On a small scale it can cause every person and every family to fall into poverty, on a wider scale it is a crisis of world culture and world peace. In the West ever since Malthus many scholars have advocated birth control, but society has viewed this as immoral. In reality to give birth and not be able to raise a child, to give birth and kill because of disease, would it not be better if one limited this in advance, and only gave birth to excellent children?*

Hu Shi contemplated the benefits of contraception, from its implication for the individual, the family and global culture. Here Hu made a eugenic argument to give birth only to “exceptional” babies. Hu praised Sanger’s dedication and sacrifice, relating how Sanger even went so far as going to prison for her cause. Hu further mentioned the establishment of the American Birth Control League, which numbered more than 50,000 members. Because of the translation difficulties she had experienced in Japan, Sanger showed Hu her speech prior to her talk. Hu advised Sanger to speak on contraceptive methods, as that would interest students.

Hu Shi’s translation of Sanger’s lecture at Beijing University was published in its entirety in two women’s magazines: *The Ladies’ Journal* and in *The Women’s Review*, which issued special editions on birth control. Sanger linked civilization with birth control on a global scale and approached contraception as a cultural and biological issue. She further equated the birth control problematic with population pressure, and disavowed infanticide and abortion. For Sanger birth control was a solution to poverty, women and child labor, dementia, and crime. Decrying the fact that there were studies to improve sheep, cows, and pigs, but not to improve humans, Sanger stressed the centrality of contraception for race advancement and population suppression: “Now we need to advocate birth control to improve the race. I dare say mankind’s increase is sufficient.”

Sanger further made a paradoxical and intriguing statement that encapsulated the internal tension of her beliefs: although she had always advocated for the freedom of the individual – and women in particular – Sanger argued for restricting the individual freedom to procreate, in view of the urgency of population increase. Sanger even promoted forced sterilization for both sexes enforced with the aid of military action to curb the reproduction of the mentally disabled. For Sanger, eugenic concerns trumped women’s rights. Sanger’s position here was quite clear: reproduction was not necessarily a matter of individual choice. Apart from the coercive aspects, even liberal Chinese intellectuals partly agreed with this stance.
Numerous eugenicists relegated the mentally disabled to a different category: flawed and perhaps not fully human. Given their perceived lack of control, Sanger argued to take away the reproductive ability of people with mental health problems: "people afflicted with dementia, could not inhibit their desires, and one has to use sterilization surgery to force them not to procreate." The eugenic discourse problematically marginalized all people with mental disabilities in the quest for a perfect human being and for the greater good of the society. Such arguments placed disabled people in a vulnerable position. Even while a mother’s body was to be protected on humanistic grounds, the bodies of disabled people were refused their full humanity. Sanger’s view on the use of sterilization for racial regeneration was also shared by Pan Guangdan, the most prolific eugenicist in China, and by population specialists such as Chen Changheng and Chen Da.

Sanger further provided practical scientific contraceptive methods for both genders which caused quite a stir: from describing the best time to engage in sexual relations according to a woman’s cycle, to sterilization by means of x-ray, to the withdrawal method and the use of condoms. Moreover, Sanger decried the gendered double standard embedded in the Chinese partiality for boys as the embodiment of society’s hopes for the next generation. Sanger hoped to integrate Chinese intellectuals interested in revolution and social betterment into the global birth control movement.

Chinese intellectuals were particularly receptive to Sanger’s explicit link between birth control and eugenics, which Sanger believed would unravel racial, political and social problems: “Birth Control is practically identical in ideal with the final aims of Eugenics.” Thus Sanger not only underlined affinities between the birth control movement and the eugenic movement, but also collapsed the two in their aspirations by suggesting birth control could be a form of eugenics in praxis: “Birth Control Propaganda was thus the entering wedge for the Eugenic educator.” Sanger wanted to improve education in prophylaxis, sexual hygiene and infant welfare.

According to Sanger the unequal birth rates between eugenic population categories of “the unfit and the fit” represented “the greatest present menace to civilization,” a crisis unresolvable by competition between the classes: “the example of the inferior classes, the fertility of the feeble-minded and the mentally defective, the poverty-stricken classes, should not be held up for emulation to the mentally and physically fit yet less fertile parents of the educated and well-to-do classes.” Despite Sanger’s crusade to help improve the quality of life and health of lower-class women through contraception, this passage demonstrates a certain class bias, in her assignment of unfitness solely to the lower classes. This position explains some Chinese leftist intellectuals’ outright rejection of Sanger’s ideas. Additionally, by warning against emulation of such unfit behavior in the upper classes, she seemed to want to preserve the upper classes intact. Lastly, for Sanger birth control could only solve future problems, but it could not address the effects of present and past dysgenic breeding.

Despite the convergence between eugenics and the birth control movement, there were also significant philosophical differences that Sanger wanted to circumvent to convince eugenicists of the necessity of contraception for the eugenic project. While eugenicists emphasized, “producing healthy children” and “sterilization of the unfit,” the birth controllers advocated stopping all reproduction where economic means were scarce. Conservative eugenicists’ belief that a woman’s responsibility was to deliver children for the state did not sit well with Sanger, who also disavowed eugenic mating as insufficient to tackle the problem of unlimited reproduction of the deprived and sick. Instead Sanger wanted to convince eugenicists to support contraception for the working class as a means to preserve eugenic aspirations of race improvement.

Eugenics without Birth Control seems to us a house built upon the sands. It is at the mercy of the rising stream of the unfit. It cannot stand against the furious winds of economic
pressure, which have buffeted into partial and total helpfulness a tremendous proportion of the human race. Only upon a free, self-determining motherhood can rest any unshakable structure of racial betterment.40

For Sanger contraception was uplifting to the race, and necessary to curtail the “unfit,” a eugenic euphemism used to connote the diseased population. Whether Sanger herself was a eugenicist or just an ardent birth control activist who appealed to the most convincing scientific argumentations of the time, is debatable. Despite her empathy for the most unfortunate, her statements about the lower classes were extremely controversial. Her commitment was to birth control and she clearly employed eugenic arguments to further the cause of birth control globally.

During the same 1922 trip Chen Haicheng (陳海澄), a journalist from China Times, invited Sanger to Shanghai.41 Despite Shanghai’s Europeanized appearance Sanger was dismayed by the rickshaw men’s appalling working conditions.42 Chen accompanied Sanger to visit a cotton-spinning mill employing over 5,000 women as well as to the crowded worker shacks: “It was a shock to see sick little children at work; thousands of little girls who could not possibly have been over eight or nine years of age.”43 Sanger was horrified at the abysmal working conditions for women and girls: thus the children got ten cents a day for twelve hours of work, while mothers were compelled to bring their babies to work and keep them in baskets by the machines. Sanger was outraged at what industrialization brought to Chinese women in China, and proclaimed that China, like the Western world, would learn the consequences “of abusing womanhood for this machine labor.”44 Despite her insight that Western imperialism had been detrimental to China, Sanger believed Western contraceptive methods could work efficiently there, because of their potential to effect social change: “And Birth Control must precede any great permanent change in her social systems.”45 Sanger’s one-dimensional vision of social progress was not very convincing to Chinese intellectuals.

Sanger even ventured to see the slums46 and wrote harrowing descriptions in her diary of people “limping in the streets, begging” and “lepers hanging in the street.”47 Sanger’s experiences in Chinese factories and slums, in seeing the abysmal everyday living conditions of women and children, and her empathy for rickshaw pullers informed her opinion of China’s social problems. Rather than seeing poverty as a problem of unequal distribution of wealth, Sanger considered it to be an issue connected to unchecked reproduction. These impressions provided her with more descriptive ammunition for her crusade of promoting birth control to curb these social sufferings. Sanger confessed that China “represents the final act in the national tragedy of overpopulation.” 48

In the Birth Control Review, the American journal Sanger edited, China and Japan figured prominently on the list of countries where overpopulation had become acute, and were given as examples for the necessity of implementing eugenic measures and birth control.”49 This was one of the reasons for Sanger’s Asian tour. Chen Haicheng compared Sanger’s experiences in China with her visit in Japan, where the Japanese government had prohibited her from lecturing publicly. Publicized as forbidden, Sanger’s talk, entitled “Population and War,” attracted Japanese educators, editors and scientists.50

In a speech at the Shanghai National Association of Vocational Education, Sanger emphasized repeatedly the necessity of the science of birth control – as opposed to natural population control through war and disease – to obtain better babies.51 Here her highlighting the quality of descendants and her message of race improvement expressed her eugenic views. Sanger dismissed her detractors, who apocalyptically predicted the disappearance of mankind or racial suicide as a result of contraceptive practices, and argued instead that contraception improved health.52 This scientism embedded in medical and physiological knowledge, functioned as a sign of modernity and legitimation by implicitly appealing to science’s claim to truth.
In this speech Sanger focused on promoting the idea of the small family: one that included no more than three or four children. New Culture intellectuals conceived of the conjugal family (小家庭 xiao jiating) as a redemptive move away from the bonds of the traditional family that enabled individuals to hone their talents, so that they, in turn, could contribute to the nation’s future. Chinese intellectuals did not unquestioningly replicate the western model of the small family, because in China, unlike in the West, civil concerns were at the core of the nuclear family. After Sanger’s visit, many Chinese journalists addressed the issue of selective marriage choice, which followed a eugenic logic. Sanger endorsed what could be termed eugenic marriage by advising women to refuse to marry men suffering from tuberculosis, venereal disease, and mental illness. In a move to convince her male audience of the economic benefits of contraception, Sanger argued that a woman who gave birth ten times not only endangered her health, but encumbered the husband as well.

Sanger was puzzled that during her stay in Shanghai she had yet to meet with Chinese women. Sanger’s feminist approach to birth control fueled her desire to attract more women into this global movement. It is apparent that Sanger had no choice but to place her hopes in Chinese male intellectuals to help spread her message. Finally, Sanger met Yu Qingtang, a Chinese female professor recently returned from studying in the U.S., who became Sanger’s translator for the speech sponsored by The Kiangsu Educational Association, The National Association of Vocational Education of China and the Association of Family Reformation of China. However, a translation problem precluded Sanger from making any meaningful connection to Chinese female intellectuals: Yu felt too shy to translate the technical aspects of practicing birth control and told Sanger she would ask a doctor to say that. Sanger wrote in her diary about the translator’s lack of courage. This further lowered Sanger’s opinion of some of the women in the audience, regarding their inability to engage with topics such as sexuality and references to the female body. This incident underscores the radicalism of Sanger’s advocacy in a time when sexual matters remained very much taboo in China as well as in the West.

2. The Reception of Margaret Sanger in the Chinese Press

Sanger was enthralled with the coverage of her visit in the Chinese press. Pictures of Sanger in Japan, or in Beijing in the company of Hu Shi and Zhang Jingsheng (張競生), appeared in several newspapers. Zhang, a well-known advocate of sexual education and contraception, accompanied Sanger as one of her translators. However, their motivations for advocating contraception diverged: Sanger was animated by feminist concerns such as women’s self-determination, whereas for Zhang sexual freedom was central – a radical position for that time. A controversial sexologist and philosophy professor at the time, Zhang was quite taken aback by the fact that the Chinese press was so interested in Sanger’s ideas even though he had shared similar views several years prior to her visit. In his “Aesthetic Outlook of Life,” Zhang wrote:

Three years ago [in 1921] I saw how the people of my country bred like pigs and dogs, fathers and mothers only knew about ejaculation and conception, there was no proper education and upbringing, and thus the boys became criminals and the girls became prostitutes. Back then I attempted to promote methods of population control widely, but received nothing but curses and abuses from society. Within less than a year [in 1922] Mrs. Sanger from the United States came to China and promoted exactly the same ideas, and the newspapers, which lambasted me, suddenly welcomed Mrs. Sanger’s views. In fact, my theories were more profound than Mrs. Sanger’s. But I was insulted, and she was praised and enjoyed a great reputation. The reason for this difference was because Sanger was an American woman, and I was just a Chinaman! 62
Zhang prided himself in advocating birth control in a eugenic fashion, and on his theories that connected eugenics, reproduction and sex. He also pointed to the double standard that some ideas were more convincing if they were coming from a Westerner. Suffering from an identity crisis of racial inferiority also evidenced in his other writings, Zhang criticized the wholesale westernization of ideas surrounding sex and reproduction.

2.1 The Coverage of Margaret Sanger in Women’s Magazines such as Women’s Review and Women’s Voice

In an article from the “Special Edition for Birth Control” of the Women’s Review, published on the occasion of Sanger’s visit, Chen Dewei (陳德微) praised Sanger’s concern for women’s suffering as well as the contribution of her birth control advocacy to the incipient women’s movement in China. Chen underscored the future-oriented optimism of this movement. To promote birth control effectively Chen believed one had to:

*Investigate the situation of the mother, assess the difficulties of promoting birth control in different places, research maternal and infant mortality rates and illnesses, promote motherhood training for future mothers, as well as publicize the equal aptitudes method to forbid the union of sick marriages, and of people with sick children.*

Chen agreed with Sanger’s rejection of marriage for people afflicted with genetically transmitted diseases. This was in line with the Mendelian approach, whereby dysgenic marriages were condemned. Many other Chinese intellectuals such as Chen Da, Pan Guangdan, Zhou Jianren, and Chen Jianshan also subscribed to this viewpoint. The article ended with three eugenic measures: first to research the method of non-marriage for those suffering from hereditary diseases; second “to unite the birth control societies in every country” and third to make use of the slogan “to advance people’s declining base and to raise the racial base!” Whereas the first measure addressed the possibility of forbidding marriage on eugenic grounds, the last two measures brought in the possibility of racial advancement as the ultimate goal not just for a national-scale movement, but for a global movement. Chen argued that the Birth Control Research Society should investigate the possible implementation of eugenic laws with the following goals: “to prevent China’s decline into a health crisis; to save and protect the Chinese nation from illness and insanity.” Chen conceived of national sanity and the possibility of national survival in eugenic terms. Chen echoed Sanger’s scientific emphasis, viewing “scientific theory as point of departure to support the birth control society.”

Science’s appeal as a topic of study here stems from its application in China as the dominant vision of modernity due to its social potential. The appeal of science in the interwar period can be attributed to its claims to objectivity and universality; one of the reasons why eugenics was so popular was because of its claims to scientism through its linkages with genetics. Stressing the need to diminish the reproduction of people plagued by hereditary diseases was also part of Gai Zun’s eugenic platform.

Gai Zun, like his contemporary Chen Dewei, addressed racial preservation in view of disease as a global human predisposition, to which he added the issue of quality versus quantity of descendants in the Chinese case: “In the past the emperor had many sons and grandsons. Nowadays people still embrace polygamy and marrying early as well as leaving behind countless descendants. Irrespective of whether the product’s quality is good or bad, they only care if the number is sizable.”

In his critique of the traditional family system, Gai was referring to peasants’ penchant for numerous sons. Furthermore, Gai was in implicit alignment with Sanger addressing the problem of large families. In her speech at the Association of Family Reformation of China in Shanghai
Sanger had criticized those who believed that a large family would increase the likelihood of a great personality being born in the family. To Sanger large families were plagued by disease, poverty, and crime; genius did not arise out of a quantitative probability. On the contrary: population quantity had many potentially devastating dysgenic effects.

Gai contemplated two distinctive methods of restricting reproduction. The first method was the Malthusian method of restricting sexual desire and thus reproduction, which he dismissed as an effective means, because he doubted people’s ability to inhibit their sexuality. Secondly Gai considered the neo-Malthusian doctrine, which advocated the use of birth control. Like Sanger and Zhang Jingsheng, Gai believed humans have a natural sexual instinct that should not be suppressed, whereas Malthus advocated its suppression. Nonetheless, Gai shared the Malthusian concerns of overpopulation: “If population surpassed the material limits available to everybody, poverty must occur, and society would not be safe.” Gai made the case for a eugenic solution as exemplified by the newest contraceptive methods:

In most civilized countries contraception is openly endorsed. From a social viewpoint, from a eugenic point of view or of race improvement, it is an issue after Malthusianism. Presently because of the scientific advances regarding pregnancy prevention, there are already methods that do not harm the health of men and women.

Here Gai remarked on the cultural and civilizational dimension of birth control. From Gai’s rejection of Malthusians’ ascetic method one can infer that for him contraceptive methods also allowed for sexual exploration. Such eugenic methods were seen as salient both for their social significance, and for the protection they offered to women’s health. Gai further made the case for quality to replace quantity as a measure of success: “China’s population is the first in the world, but apart from a few rich ones, most live in poverty. A people’s strength lies not in its numbers.”

Gai assented to global eugenic criticism of undesirable reproduction for “syphilitics, alcoholics and perverts,” and demanded local regulations to strengthen the Chinese nation. Chinese intellectuals’ preoccupations with the poor physical quality of the population – and by extension the angst of racial extinction – were exacerbated by their belief that this represented China’s backwardness. Race improvement was connected with national survival and the reproductive potential of the individual. In this sense, discussions of individuality were never about the individual alone, but were framed in the individual/nation dialectic.

Not all authors praised Sanger’s promotion of birth control for China’s national future. Ke Fu criticized Malthusianism, especially the idea that poor people who could not feed their children should practice birth control. He believed that Malthusianism’s insistence that insufficient resources stemmed from unchecked population only strengthened Western imperialism by reducing the large Chinese population. Moreover, Ke was convinced that in the long run birth control could only harm China. Despite confusing Malthus’s abstinence solution with birth control, Ke’s was a leftist critique of the suitability of birth control as a solution for China’s difficulties.

For female socialist journalists, however, there was no incompatibility between birth control and socialism. One of the first women leaders to rise out of the Communist movement, editor of Women’s Voice Wang Huiwu (王会悟), and female journalist Wang Jianhong (王剑虹) both wrote articles supporting birth control. Women’s Voice was the first Communist party-sponsored journal that presented female voices, and not merely male writers writing under female pseudonyms.

In an article entitled “Birth Control for the Preservation of Love,” Wang Jianhong stressed the liberating characteristic of birth control for women that would allow them to reclaim their humanity, an idea shared by Sanger. Writing from a woman’s experience, Wang argued that not practicing birth control led to inequality within marriage, as the woman shouldered more burdens. In addition, she
highlighted how reproduction hindered economic independence for women:

> Wedged tightly under the control of men’s heels, women are the tools that satisfy male carnal desire...Women constantly raise small children for men and aside from this role are nothing but ignorant animals. Chinese society is built upon this kind of slave system that lacks any compassion and human character.81

Here Wang Jianhong articulated a powerful critique of women’s traditional roles as merely procreative figures, and confronted the sexual objectification of women. Wang did not argue against motherhood per se, but for a better-quality motherhood by focusing on fewer children. Wang challenged Sanger on only one issue: that socialists and Marxists generally opposed implementing birth control, since she was both a socialist and a supporter of birth control. However, male socialist Mao Dun contested birth control as a distracting issue for women, who he argued should engage more in politics instead. In his view, unequal distribution of wealth – not overpopulation – was the root of all China’s social problems.

Many intellectuals were dissatisfied with the view of China’s population as its main source of poverty, which they considered to be part of a larger, systemic imperialist oppression resulting from unequal treaties that gave unfair trade advantages to foreign powers in China. Others were optimistic that China’s resources were sufficient to feed its burgeoning population and rejected contraception out of fears of racial destruction. Instead writers like biologist Zhou Jianren (周建人), one of the editors of *The Ladies’ Journal*, proposed improving food production to solve the reproductive dilemma: “The unchecked population problem has become a hardship as it pertains to food distribution. Some advocate restricting blind population growth. However, they have not thought of food distribution methods.”82 Zhou refers to the unequal distribution of wealth – a fundamental problem in socialist thought – where resources including food are concentrated in the hands of a small wealthy minority, at the expense of the underprivileged majority. Zhou dismissed some aspects of Malthusian theory, such as restricting sexual desire to avert reproduction, as irrational.83 Zhou thought the focus should be on improving existing – if imperfect – contraceptive methods.

Zhou addressed the tension between advocating birth control on individualist grounds and as a total solution to China’s problems. Zhou’s feminism informed his opinion that women as individuals had a right to access contraception, while his socialist bent led him to view reproduction as work: “Regarding the private personal domain, women shoulder the task of childbearing by far more than men. They are pregnant around 280 days, followed by a similar period for breastfeeding. This kind of work is extremely tiring and hard.”84 Similar to many socialist reformers of the time, Zhou also advocated communal childrearing to ease a mother’s sufferings. Zhou had a utopian socialist vision of childbearing, since he considered it to be “a great benefit to a future society.”85

Despite Zhou’s advocacy of contraception, and his belief in its compatibility with socialism, he criticized the wider social relevance of birth control as an absolute solution to universal social ills: “Using birth control to solve a few difficulties was thought to be able to resolve many problems, but it is all wrong. In theory birth control is in my opinion very healthy. The mistake of many past discussants is not related to birth control per se, but in trying to employ this method as a solution to all social problems that cause inequality.”86 Zhou, unlike Sanger, rejected birth control as a panacea to economic inequality. Instead, his support for contraception was spurred by his feminist concern with women’s health and the effects of pregnancy on women’s bodies.

Shan Yongjun (山用均) also addressed the convergence between the “health of the mother’s body” and contraception.87 Shan started from popular dichotomies that contributed to criticism of birth control: moral/immoral, natural/unnatural, whereby birth was presented as natural and contraception as unnatural. Shan employed the following eugenic arguments, to which he saw no
possible objection: the goal of the advancement of human society, limiting reproduction of mentally defective people, and the right of doctors to induce abortion to protect a mother’s weak body and preserve her health. Birth control was also thought to improve the quality of life of the offspring, so that “children are not given the worse quality clothes, food, and shelter; in short life necessities.”

Shan like Gai was familiar with the neo-Malthusian doctrine of birth control, which sought to lessen social decline. Shan identified three possible causes for this: corruption and poverty, excessive human fertility, or economic organization. Shan deemed that Malthus addressed all of these issues: mankind’s corruption and poverty arose from overpopulation and fertility. People’s fertility was situated above economic organization in Shan’s view, having the power to destroy it. Thus “poverty is not the fault of economic organization, but it is the liability of human fertility.” Echoing Sanger, Shan was frustrated that the working class was indifferent to human fertility. Ultimately, for Shan, fertility as a problem seemed to override and determine other economic concerns.

2.2 “The Task is Hers”: Translation and The Ladies’ Journal Special Edition on Birth Control

Excessive fertility was also the target of Sanger’s critique in “Woman’s Error and Her Debt,” which represented Margaret Sanger’s call to women to take responsibility in accepting their inferior status and causing overpopulation. The Special Edition on Birth Control in The Ladies’ Journal contained an approximate translation with commentary on Sanger’s Woman and the New Race, translated by Wu Jing under a different title: “Inspecting the History of Birth Control.” The purpose of this article was to present the book. The translation started with an excerpt from the first Chapter of Woman and the New Race, which corresponded to the beginning of the first chapter “Woman’s Error and Her Debt,” and continued with a short presentation of Sanger followed by a second chapter “Women’s Struggle for Freedom.”

In “Woman’s Error and Her Debt” Sanger ridiculed the League of Nations, and what she saw as the futile attempts of weak statesmen to “carve out spheres of influence.” Sanger stated that women had the power to destroy their efforts by “producing explosive populations” and “converting these pledges into the proverbial scraps of paper.” This passage was the beginning of the Chinese version presenting Sanger’s Woman and the New Race. The more radical call to voluntary motherhood that followed, however, was missing from the Chinese translation: “or she may, by controlling birth, lift motherhood to the plane of a voluntary, intelligent function, and remake the world. When the world is thus remade, it will exceed the dream of statesman, reformer and revolutionist.” Sanger’s opinion that free motherhood had the potential to change the global situation was emphasized in the Chinese version, which also contained an explanation of Sanger’s activities in the Neo-Malthusian League, and the “race improvement” results in countries such as Germany, Italy, France, Belgium, Spain, Sweden, Australia, Brazil, Cuba, Switzerland, and Mexico, where the organization had local unions similar to the one in New York.

A closer look at “Woman’s Error and Her Debt” is necessary since Chen Haicheng published his own translation of Woman and the New Race, which he entitled Jieyuzhuyi (節育主義 [Birth Control] (Shanghai: The Commercial Press, 1925). This Chinese translation of the book was republished in 1928. In the original English version Sanger made a very sarcastic and emphatic argument for woman’s acquiescence to her inferior status. For Sanger, the ties of motherhood that established women’s social roles represented “chains” that “bind her to her lot as a brood animal for the masculine civilizations of the world.” In this Sanger established a direct link between reproduction as women’s dominant social role and their plight. The animal metaphor only reinforced the notion of the burden women had thrust upon them in a patriarchal world.

Sanger went even further by blaming prolific mothers for plagues and famine. In what follows Sanger articulated a strong eugenic disparagement of women:
While unknowingly laying the foundations of tyrannies and providing the human tinder for racial conflagrations, woman was also unknowingly creating slums, filling asylums with insane, and institutions with other defectives. She was replenishing the ranks of the prostitutes, furnishing grist for the criminal courts and inmates for prisons. Had she planned deliberately to achieve this tragic total of human waste and misery, she could hardly have done it more effectively.98

In this passage Sanger condemned women for reproducing all that eugenicists hoped to reduce: the feeble minded, prostitutes, and criminals. For Sanger undesired children represented metaphorically “clogs and destroyers of civilization.”99 The convergence of reproduction, health and culture is a frequent motif for both Sanger and Chinese intellectuals, the only difference being that Sanger was thinking globally, while Chinese intellectuals were thinking locally about how these Western concepts would further China's national future. Sanger believed that birth control enabled the fundamental freedom for woman that could “uproot the evil she has wrought through her submission.”100 Sanger emphasized that women's negative impact had been unconscious, while birth control epitomized a conscious means of action. This was a call to action for women to assume responsibility for their reproductive capabilities: “the task is hers. It cannot be avoided by excuses, nor can it be delegated. It’s not enough for woman to point to the self-evident domination of man, nor does it avail to plead the guilt of rulers and the exploiters of labor.”101 Here Sanger suggested that the ubiquitous feminist criticism of patriarchy, autocracy, and labor exploitation were insufficient if birth control as women's empowerment was not practiced.

Sanger felt that woman's error lay in her submission. Her debt was the limiting of her reproduction: “War, famine, poverty and oppression of the workers will continue while woman makes life cheap. They will cease only when she limits her reproduction and human life is no longer a thing to be wasted.”102 In establishing that life was devalued by uncontrolled reproduction, Sanger made a qualitative assessment. She also recognized a causative link between poverty, famine, and overpopulation. Interestingly Sanger’s rhetorical strategy and argumentation combined eugenic arguments with feminist criticism.

Wu Jing’s selective translation of Woman and the New Race also gives us insights into Sanger’s reception in 1922 China. Wu focused on the chapter “Women's Struggle for Freedom,” which discussed infanticide, because of its relevance to the long-standing practice in China. In particular female infanticide was often practiced in China. Western discourses on infanticide reiterated arguments of China being “stagnant” and “uncivilized.”103 Sanger assessed infanticide globally, noting its practice by the native tribes of North America, Australia, New Zealand, and Africa, Japan, India, China, early Greece and Rome. Sanger remarked that despite the advent of civilization, and regardless of religious and intellectual condemnation, infanticide was still practiced, and that “Chinese midwives are extremely skillful in producing early abortion.”104 Se Lu (瑟盧) also praised Sanger’s use of the scientific method to prevent infanticide, abortion, and other inhumane methods of reducing undesired births.105

Sanger encapsulated woman’s desire for freedom in the expression “feminine spirit.” A woman rebelled, according to Sanger, when her spirit was inhibited by unwanted pregnancies and caring for too many children: “Where laws, customs and religious restrictions do not prevent, she has recourse to contraceptives. Otherwise, she resorts to child abandonment, abortion and infanticide, or resigns herself hopelessly to enforced maternity.”106 These violent means of curtailing reproduction appeared – according to Sanger – only under great economic pressure. However, the last sentence in the above passage – about resignation to enforced maternity – is missing from the Chinese translation.

Perhaps, as Yun-chen Chiang points out, this was merely a loose translation of Sanger’s notion of voluntary motherhood. Or perhaps it reflected the reluctance of The Ladies’ Journal – which preferred
the contemporary Ellen Key’s motherhood movement\textsuperscript{107} – to fully endorse Sanger’s message. Ellen Key promoted motherhood in connection with race-regeneration. The Chinese translation ends with a discussion of the right of the mother to determine when pregnancy occurred, but omits Sanger’s more radical position on “the right of marriage without maternity.”\textsuperscript{108} Chinese authors only endorsed Sanger’s recommended exemption from motherhood for certain dysgenic categories of people. Indeed, what was missing entirely from the Chinese version in the last two paragraphs, was the possibility of not choosing motherhood at all, an option suggested by Sanger in the original version as a way to free women from their reproductive burden:

\begin{quote}
Society, in dealing with the feminine spirit, has its choice of clearly defined alternatives. It can continue to resort to violence in an effort to enslave the elemental urge of womanhood, making of woman a mere instrument of reproduction and punishing her when she revolts. Or, it can permit her to choose whether she shall become a mother and how many children she will have. It can go on trying to crush that which is uncrushable, or it can recognize woman’s claim to freedom, and cease to impose diverting and destructive barriers.\textsuperscript{109}
\end{quote}

The Chinese translation states only that: “There is another way to give a mother freedom: to ensure she has a legal right to contraception.”\textsuperscript{110} A translator’s choice and a slight change or omission of a sentence or word enables new meanings to emerge; in this case the translator whittled Sanger’s radicalism down to fit in the more dominant view on eugenic motherhood inspired by Ellen Key preferred by the editors of The Ladies’ Journal. Wu, like many Chinese translators of her time, demonstrates a high degree of creative license in an attempt to ease the cultural differences between Sanger’s message and Chinese practices and culture.

Other new scientific discourses were emerging in Republican China at the same time as Sanger’s. Tani Barlow argues that appropriated western paradigms took on “a different discursive force” in the treaty ports of China, and that this appropriation of western knowledge was conditioned by the local political context. Barlow contends that Chinese intellectuals “redeployed and excessively privileged modernist discourse from social and biological science that acted as a sort of universal knowledge.”\textsuperscript{111} This appropriation of modern western scientific knowledge gave Chinese intellectuals legitimacy as modern scholars. However, as Lydia Liu points out, processes of cultural translation are quite complex, and besides appropriation and domination resistance are also observable.\textsuperscript{112} Wu Jing’s selective translation also reveals this type of resistance to a particular kind of radical thought, and also reflects Liu’s assertion that ideas were converted by their new uses in China.

The opening article of the Special Edition on Birth Control in The Ladies’ Journal highlighted Sanger’s advocacy of a mother’s freedom to choose when she wanted to have a child.\textsuperscript{113} Sanger’s ideas from Woman and the New Race, where she stressed “voluntary motherhood” and decried woman’s role as an “incubator” are echoed here: a mother’s freedom is depicted as an important responsibility to the development of the new race. The unknown author likened people to animals and plants, who delivered “fine and healthy” (\textit{youliang} 優良) offspring for a better mankind.\textsuperscript{114} In Woman and the New Race Sanger herself remarked upon the continuities between the animal and human kingdoms, describing traits of mothers that “stand out also as the characteristics by which the progress of species is measured.”\textsuperscript{115} The Chinese article contained Sanger’s call for “better babies, better education and better political and international organizations.” The author praised Sanger’s commitment to liberating poor women from bondage, a major racial theme for Sanger: “Womanhood shakes off its bondage. It asserts its right to be free. In its freedom, its thoughts turn to the race.”\textsuperscript{117}

Feng Qiao (風峰), who explored Sanger’s impact on birth control in Japan, also discussed woman’s liberation or a mother’s freedom. While “Feng Qiao” had been used before as a female
pseudonym by writer Zhou Jianren, in this case it was employed by Chen Wangdao, the editor of Women’s Review. Male feminists frequently crossed gender boundaries by using female pseudonyms to mask their own gender and to assume a female voice. The impersonation of female writers allowed male authors to promote their feminist agenda more efficiently among female readers. The affective performance of a gendered voice functioned as a sort of legitimacy. But in effect this was still a male perspective reflecting a man’s view of feminism.

This article also promoted contraception to women by appealing to their desires for self-realization and liberation. One can see that for Chen Wangdao, as for Sanger and Chen Dewei, individualism, women’s choice, and self-help were all significant values. Chen echoes Sanger’s urgency in her plea to women, and like Sanger also criticizes mothers. Chen Wangdao published five articles on birth control around the occasion of Sanger’s visit. Even before Sanger’s arrival, Chen had shown himself in favor of neo-Malthusianism over Malthusianism, and warned that one should not attempt to preserve chastity by rejecting birth control. For him contraception was necessary for several reasons: hygiene, eugenics and free love. The comparison with the animal world gave Chen the ammunition he needed to uphold his philosophy of love: while the sole purpose of sex for the “inferior” animals was reproduction, human sexual contact had an additional function: a love that was evolved. Liberal writers like Chen Wangdao, Zhang Xichen and Zhou Jianren believed that love elevated humans. Chen was critical of the Japanese government’s censorship of Sanger’s visit disputing its prohibitive policies relegating contraception advocacy to “an offense” and “a conspiracy to endanger the country.” Japan’s pro-natalist policies were especially troubling for Chen, who remarked on the vicious cycle between population and war: “for war one needs a numerous population, for population one needs war.”

Sanger’s promotion of birth control found resonance mostly in intellectual circles in both Japan and China, since those were the types of people she came into contact with during her Asia tour, and because they were more likely to employ contraception. Other writers disputed the eugenic fear of diminishing offspring of intellectuals as symptomatic of the entire state of China’s population:

*They name this a great crisis for China, because they believe that the offspring of intellectuals are youzhong (優種) “the superior race.” If the eugenic race diminishes, is it not a great loss for the nation? We believe that in order to consider the weakness and strength of a nation one has to see how the majority of the population is. If one only focuses on a minority, this disregards the majority of people. Thus it is unavoidable that it unsettles people to think of the privileged class that people utterly detest. All traitors come out of the intellectual circles. Considering all this, to give birth to fewer candidates to become traitors, is definitely a good idea.*

This critique showcases class-based fears of racial extinction and privileges certain groups of people as more eugenically fit than others. It can be understood as a leftist criticism of the elitism embodied in eugenics. The article criticizes birth control as a distracting solution from China’s problems:

*The majority of Chinese say infant mortality is so high. Many of the suffering folk endure diseases, calamities that destroy the deficient; there are hundreds of diseases and thousands die of natural causes. They really don’t need birth control, as it cannot solve their problems. The marrow of the fruits of hard toil of many grieving folk is being greatly extorted and exhausted. The social economic system that makes radical trouble in some circles is the aggression of imperialism. It is the oppression of warlords, bureaucrats, and landlords and of despotic gentry that wreaks havoc nowadays. Not to be radical, but to superimpose birth control on common folk’s beliefs is superfluous.*
The author rejected contraception as a cure for China’s ills, and found that people were subjected to multiple forms of oppression: the oppression of the economic system, of imperialism, of landlords, and of warlords. Certainly the implication was that a change in the economic system would bring about change in people’s lives. For many leftist intellectuals, there was a clear incompatibility between the tenets of eugenics – with its emphasis on the talented people – and its targeting of the lower classes for the implementation of eugenic measures, considering that the necessary radical change could only emerge through revolution from below.

Lastly, the editor of The Ladies’ Journal, radical liberal intellectual Zhang Xichen (章錫琛) debated the eugenic quality of birth control with biologist Chen Jianshan (陳建山) who feared actively implementing birth control would amount to race suicide. Chen’s eugenic concern was that only the upper class practiced contraception, which resulted in diminishing the superior race.

While acknowledging that initially “superior people” would practice contraception while the “multiplication of those without reason” continued, Zhang postulated that the practice of birth control could trickle down to the lower classes, where it would acquire a “greater social value.” Zhang also agreed on restricting the reproduction “of the social status that is genetically predisposed not to give birth to good elements,” meaning “[the] sick.”

Zhang also inserted race into his attack on Chen Jianshan. Chen had echoed “white pessimists,” who predicted that the birth rate of the white population would regress, while the yellow and black populations increased. Chen assented to this logic according to which “more people, meant more excellent people, while less people meant less excellent people. White people preserved an unnatural state. We people of color should return to a natural state.” Reproduction was an intrinsic part of racial survival theories that were taken as valid scientific facts and transcended racial boundaries to extend to the yellow race.

Following an anticolonial logic, Zhang countered emphatically: “Does the world only belong to white people? Not also to black and yellow people?” Indeed, there was little relevance to the Chinese situation in rehashing statements of European anxiety about the unrestricted reproduction of other races. Zhang also dismantled ideas of Chinese superiority based on clan lineage: “As we can see the races that have produced more children are not necessarily superior.” Eugenic arguments about quality over quantity undermined theories where racial survival lay in the propagation of a race’s numerous descendants. Witnessing the domination of Europeans – who did not have large populations – both globally and at home, convinced Chinese authors to accept these discourses. Zhang (aka Se Lu) asked emphatically: “Why is it that great nations such as England, France have small populations?” Like Sanger, he emphasized quality over quantity of the population. His solution was to rely on eugenics (renzhong gailiangxue 人種改良學), “the science of racial betterment” to implement birth control for the benefit of the nation. According to Se “racial strength does not lie in great numbers, but in their superiority” (youliang 優良). Se also disagreed with the nationalists, who opposed birth control, out of their fear that “if the population shrinks, the nation will weaken,” and could ultimately be destroyed. Se stressed that neo-Malthusian practices contributed to both “personal happiness and social health” by preventing venereal disease and crime. This is an instance in which a selective combination of Sanger’s radical ideas and Ellen Key’s notion of individual happiness coexisted in the arguments of Chinese liberals.

Other strands of eugenics discourse conflicted directly with traditional Chinese culture. Se Lu saw an incompatibility between Malthusianism and the Chinese traditional marriage system of taking multiple wives. Se’s critique of polygamy and early marriage showed how eugenics could be deployed as a critique against patriarchal and Confucian structures. The use of eugenics as a scientific tool to demolish Confucian elite structures stood in marked contrast with Western eugenic emphasis of the talented class and racial apprehensions. Responding to Confucian chastity...
defenders, Se showed the double standard of two different moralities divided according to gender lines in China that ascribed chastity only to women. Instead Se advocated sex education for both sexes. He contended that birth control was unrelated to chastity, thus downplaying conservative critiques of sexual liberation.

Lastly Se was a feminist concerned with how reproduction encumbers women’s economic independence. He lamented the recurrent cycle of pregnancies and births that young mothers endured. He saw a choice for women: “either be an organ for making babies,” or take the chance to get an education, serve society, and be economically independent. Though unattributed, this was a direct reference to the two choices espoused by Sanger in *Woman and the New Race*. Se, like Sanger, advocated birth control for women’s liberation and racial improvement, and deemed racial suicide theories ridiculous. He felt that women should have the freedom to decide their own reproduction, as well as freedom of love and marriage. In particular Sanger’s feminist ideas appealed to Se. Se was aware that reproduction greatly affected gender hierarchies and ideologies, especially in terms of economic independence, where he decried the slave-like state of women.

**Conclusion**

There are two temporal components to the debates on birth control in China. First they ensued as a result of Sanger’s highly publicized visit. In this sense the debates in China were occurring simultaneously with the debates elsewhere around the world animated either by direct contact with Sanger or through translation. The other temporal component relates to the theoretical issues embedded in these debates: the use of Malthusian and eugenic arguments gave the birth control movement an aura of future-oriented progressivism. But this is precisely the point where the disagreements occurred. Even though many Chinese intellectuals saw the wisdom of implementing birth control for improving women’s health, they did not believe that birth control could be an effective solution to other pressing social issues in the future. The interest in birth control in the early 1920s among prominent intellectuals such as Hu Shi, Zhang Xichen, and Zhou Jianren did not translate into practice at that moment, the reality of which sexologist Zhang Jingsheng – who urged the implementation of birth control measures – was fully aware.

I contend that while Chinese writers translated, they also debated birth control in view of China’s social and political challenges of the time and inflected new meanings onto these concepts that served as vessels. Thus, eugenics was not a timeless concept whose meaning is uniform in time and across space. Its meaning becomes embedded in the particular local historical circumstances in the interwar warlord period in China, which allowed for heated intellectual debates through the lack of centralization and censorship that was more formalized after the Nationalists came to power in 1927.

These debates also form a key moment in women’s reproduction becoming salient to China’s national future, and its social and political development. Chinese radical intellectuals, initially fascinated by the power of individualism, were now linking women’s reproductive bodies to class, as well as national and racial improvement schemes, which eventually displaced individual choice altogether in the 1930s and beyond. This particular displacement of women’s rights to make their own reproductive choices becomes evident once women’s reproduction becomes subsumed in eugenic arguments for population control. This enabled most intellectuals to involve women’s reproduction in a dialectic move: they understood advocating birth control for a woman’s individual bodily well-being and race improvement, while simultaneously agreeing that birth control could be a part of solving dire social ills – but not the only solution, as Sanger proposed. The social, racial and national dimensions of reproduction elided the fact that reproduction was a matter of the individual, because the intellectuals agreeing with Sanger did not just make an argument for women’s benefit, but also for the social and national benefit. Sanger had some ardent supporters in China that
internalized the eugenic underpinnings of her birth control advocacy. As for her political-minded detractors, Marxism and nationalism seemed more convincing means than birth control to shape China’s future. Most Chinese intellectuals agreed that China needed to make progress, but they could not agree how to achieve it. While socialists hoped redistributing wealth would improve the overall social environment including disease and poverty, nationalists saw population as a resource for racial continuation. Finally the displacement of women’s reproductive rights by class politics was mostly made possible by the fact that most Chinese intellectuals who debated birth control were male feminists. The few women’s voices on these issues saw no incompatibility between socialist activism and advocating contraception. However, ironically, these very women were the ones with whom Sanger – much to her disappointment – was not able to connect during her visit.

NOTES
2. Xia, Gai Zun (1886-1946) was the editor in chief of Kaiming Shudian from 1926. Xu Youchun and et al. ed., Minguo renwu da cidian [Dictionary of Figures of Republican China] (Hebei: Hebei Renmin Chubanshe, 1991), 658. Xia Gaizun also edited two journals Wenxin (1934) and Yuebao (1937). Sometimes the articles do not contain the full name of their authors, as was the case here. I have identified Gai Zun as Xia Gai Zun a renowned editor and contributor to Women’ Review. Another example of this practice is when Zhou Jianren is only mentioned as author by his first name Jianren, omitting his last name.
4. Ibid., 74.
6. Ibid., 62.
9. Ibid., 104-112.
11. Ibid., 12.
14. Hu Shi, Riji quanpian [Complete Diary] (Anwei: Anwei Jiaoyu Chubanshe, April 15, 1922), 627-628. Jiang Menglin (1886-1964) , an educator and politician was to become the president of Peking University. Jiang obtained his Ph.D from Columbia University under the guidance of John Dewey.
15. Yu Lianshi, “Minguo shiji chengshi shengyujiezhi yundong de yanjiu- yi Beijing, Shanghai, Nanjing wei zhongdian” [“Research on Republican Urban Birth Control Movement- with a Focus on Beijing, Shanghai and Nanjing”] (Ph.D Diss. Fudan University, 2008), 80.
16. Ibid. (np ., April 16-19, 1922), 105-108. Hu Shi (1891-1962) was a professor at Beijing University who promoted the use of vernacular and western learning.
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18. Ibid., 112.
20. Ibid.
21. Ibid.
25. Ibid., 2.
26. Ibid., 2-3.
27. Ibid., 3.
28. Ibid.
29. Ibid.
32. Ibid.
34. Ibid.
35. Ibid.
36. Ibid.
38. Ibid.
39. Ibid.
40. Ibid.
43. Ibid., (April 30th 1922), 121.
44. Ibid.
46. Irene Corrbally to Margaret Sanger, May 1, 1922, LCM, MSPP.
47. Margaret Sanger, *World*, (April 27th 1922), 120
50. Chen Haicheng, “Huijian Shanke” [“Memories from Meeting Mrs. Sanger”].
52. Margaret Sanger, “Sanggeer Füren zai” [“Mrs. Sanger’s Lecture at”], 14953.
54. Margaret Sanger, “Sanggeer Füren zai” [“Mrs. Sanger’s Lecture at”], 14953.
55. Ibid.
56. Chen Haicheng, “Huijian Shanke” [“Memories from Meeting Mrs. Sanger”].
57. Yu Qingtang (1894-1949) was a graduate of Columbia University, and a student of John Dewey’s. 1922 she returned to China and became a professor at Daxia University in Shanghai advocating mass education. Xu Youchun and et al. ed., Minguo renwu [Dictionary of Figures].
58. Huang Youpei to Margaret Sanger, April 24, 1922, MSPP.
63. Chen Dewei was part of Funü Wenti Yanjiuhui [Research Society for Women’s Problems], along with other journalists, editors, such as Zhou Zuoren, Zhou Jianren, Xia Gaizun, and Zhang Xichen. The members of this society met every month to discuss women’s issues starting with 1921. Li Zongwu, Wu Juenong, “Funü wenti yanjuhui jianzhuang,” Jiande Chufanhui Yuekan [Research Society for Women’s Problems Periodical] 3, no. 5 (1921).
64. Chen Dewei, “Ye ge linshi de dongyi” [“A Provisional Motion”], MGRB [Republican Daily], Shengyu jiezhi wenti hao [Special Number on Birth Control] 40 (1922): 4.
66. Frank Dikötter, Imperfect Conceptions, 110-111.
68. Chen Dewei, “Ye ge linshi de dong e” [“A Provisional Motion”], 4.
69. Ibid.
70. Ibid. Two Chinese birth control societies appeared in 1922: the first one, Chaner Zhixian Yanjiuhui [“Birth Control Research Society”] was organized by students at Beijing University who were inspired by Sanger’s lecture. Frank Dikötter, Imperfect Conceptions, 110-111. This was the organization mentioned by Chen. The second organization was founded in Suzhou, Zhonghua Jieyu Yanjiuhui [“Chinese Research Society for Birth Control].
73. Margaret Sanger, “Sanggeer Füren zai Shanghai Jiating ri xin hui de jiangyan” [“Mrs. Sanger’s Lecture at the Association of Family Reformation of China”], 14953.
75. Ibid.
76. Ibid.
77. Frank Dikötter, Imperfect Conceptions, 69.
78. Ibid.
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84. Ibid., 88.

85. Ibid.

86. Ibid., 89.


88. Ibid.


90. Shan Yongjun, (1922).


96. Chen Haicheng to Margaret Sanger, April 15, 1922, LCM, MSPP.


98. Ibid.

99. Ibid.

100. Ibid.

101. Ibid.

102. Ibid., 8.


107. Ellen Key (December 11, 1849 - April 25, 1926) was a Swedish feminist activist, educator and writer. In her promotion of the Women's Movement, Key viewed mothers as future of the race, being a believer in evolution and eugenics. Louise Sofia Hamilton Nyström, *Ellen Key, Her Life and Her Work* (New York and London: G. P. Putnam’s sons, 1913), xii.


110. Sanger, “Tonger zhixian” [“Inspecting the History of Birth Control”], 14936.


113. Ibid.


115. “Ying Sangeer” [“Welcoming Mrs. Sanger”], 14817.


118. Chen Wangdao was a Marxist and New Culture writer who opposed the old morality and advocated the new morality. Between 1920 and 1923 he was the editor of *Funü Pinlun [Women's Review]*, a supplement to *Minguo Ribao [Republican Daily]*, where he published many articles regarding women's liberation. Beginning with 1920 he was a literature professor at Fudan University. Chen Wangdao, *Chen Wangdao Wenji [The Collected Works of Chen Wangdao]* (Shanghai: Shanghai Renmin Chubanshe, 1979).


122. “Shangge Füren judi zhongyou” [“The Important Trip to a Once Visited Place by Mrs. Sanger”], *Dazhong Shenghuo [People’s Life]* 1 (n.d.): 003.

123. Ibid.


125. Chen Jianshan was a biologist in Republican China. In his book *Taijiao [Antenatal Training]* (Shanghai: Shangwu Yinshuguan [Commercial Press], July 1925) Chen contemplated the influence of mother’s heredity on the fetus, congenital heredity, and the quality of reproduction. Chen Jianshan, like Cai Yuanpei, was interested whether fetal education could hypothetically contribute to the quality of the future race. Chen Jianshan favored eugenic theories stressing heredity.

128. Zhang Xichen, “Du Chen Jianshan Xiansheng “Youshengxue he ji ge xing we wenti” [“Reading Mr. Chen Jianshan’s ‘Eugenics and Some Problems Related to Sex’”], *Minduo Zazhi* 6, no. 2 (1925): 8.

129. Ibid.

130. Chen Jianshan, “Youshengxue he ji ge” [“Eugenics and Some Problems”], 60.

131. Zhang Xichen, “Du Chen Jianshan” [“Reading Mr. Chen Jianshan’s”], 8.

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135. Ibid.

136. Ibid., 14825.

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“The Task Is Hers”: Margaret Sanger’s 1922 Visit to China – David

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Kitchen as Classroom: Domestic Science in Philippine Bureau of Education Magazines, 1906-1932

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This paper explores the contradictory messages on domestic science from three magazines published by the Philippine Bureau of Education between 1906 and 1932. *Philippine Education*, *Philippine Craftsman*, and *Philippine Public Schools* explained official educational pedagogy and policy to teachers and administrators throughout the Philippines, and each described the challenges of introducing domestic science to classrooms and communities. Inspired by Progressive Era American ideals and successes in the US, the Bureau of Education’s magazines regularly offered guidelines, testimonials, lesson plans, and advice for the application of domestic science in the Philippines. Yet they contradicted themselves and the ideals of domestic science.

A close examination of the Bureau of Education’s official magazines reveals four significant contradictions. First, they promoted domestic science as a tool for enlarging the role of Filipinas in society. But the magazines presented domestic science goals that reinforced the subservient position of Filipinas to Filipino men. Instead of expanding women’s opportunities outside of the home, the magazines presented a version of domestic science that limited self-expression and civic engagement to the kitchen. Second, the magazines claimed domestic science recipes and procedures would appeal to all Filipinos. They predicted domestic science’s message of modernity and improvement would guarantee an easy sell to rich and poor, young and old. But the magazines also acknowledged that some Filipinos found western recipes and ingredients too expensive, and others simply shied away from foreign and unfamiliar foods. Third, the magazines repeatedly claimed the higher nutrition and cleanliness standards of domestic science would strengthen Filipino bodies and improve Filipino lives. But their discourse also contained paternalistic assessments of the physical and mental limitations of Filipinos, revealing the racial prejudices of their authors and the hypocrisy of their promises. Finally, the magazines based their promotion of domestic science on the supposed superiority of American cuisine and culture. Yet they also conceded that in order to purchase imported western goods, Filipinas ironically needed to sell exportable arts and crafts, or sell foods that they learned to prepare in their domestic science classes. Together, these contradictions revealed how advocates struggled to introduce domestic science to the Philippines. They had hoped to replicate the changes that domestic science brought to the US. Instead, these publications demonstrate conflicting impulses within the Bureau of Education about the shape and scope of domestic science in the Philippines, as well as the most effective way to teach domestic science to a diverse and disparate population.

Manila fruit market, ca. 1899. American educators advised Filipino students to consider nutrition and hygiene in their daily lives when purchasing produce at these markets. Stereograph image, Library of Congress.
Note on Sources and Historiography

Before examining the magazines, it is helpful to contextualize the era and authorship of their publication. *Philippine Education, Philippine Craftsman, and Philippine Public Schools* were the three most widely distributed monthly magazines of the Philippine Bureau of Education, the government organization in charge of the public school system. Formed in 1901, the Bureau of Education replaced the temporary educational system that the United States Army erected after the end of the Spanish-American War in 1898. Because the Philippines was a colony of the United States until 1942, Americans administered the Bureau of Education and introduced policies on race and pedagogy popular among Progressive Era American educators. They modeled much of their approach to teaching in the Philippines on the domestic science, vocational, and trade education at Native American boarding schools and African American vocational schools. Coordinating and updating these policies across the archipelago required the continuous distribution of information to teachers. The Bureau released its own official documents in the form of bulletins and circulars. But these three magazines were more approachable because they featured long essays, detailed photographs and illustrations, and news about fellow teachers. The oldest and longest running of the magazines was *Philippine Education*. From 1906 until 1926, *Philippine Education* shared a wealth of information for teachers such as personal announcements, administrative policies, book reviews, recaps of teaching conferences, administrative policies, lesson plans, and classroom accounts. Its successor, *Philippine Public Schools*, appeared from 1928 to 1932 and primarily released lesson plans. It was easily the most technical of the three magazines and because of its later publication run, it featured the most Filipino authors. By contrast, *Philippine Craftsman* contained longer pieces, more advertisements, and high quality artwork that made it more like a popular magazine than an educational journal; it had a shorter run from 1912 to 1917.

This paper also builds upon the scholarship of three distinct fields on the American Period (1898-1946) in the Philippines: domestic science, the feminine ideal, and textbooks. By focusing on the Bureau's magazine articles on domestic science, the piece places these different bodies of scholarship that rarely interact with each other in conversation. For example, most scholarship on Philippine domestic science has focused on two approaches: First, that of domestic science as a lens for examining technology and modernity, or the successful cultivation by American teachers, businessmen, and government officials to equate kitchen technology with prestige, status, cosmopolitanism, modernity, and urbanity. Second, scholars have also viewed domestic science as a lens for atomizing the larger obsession with disease, health, and race in the age of empire, placing kitchens as the first line of defense against the weakening of Filipino bodies. In a more general sense, most studies on Philippine domestic science largely ignore the impact of American imperialism on Filipino cuisine, choosing instead to focus on the impact of trade with China or the three centuries of colonialism under Spain. City planning and urban studies scholars have tangentially touched on domestic science as well, focusing on the improvements of infrastructure and their effect on Philippine food systems. But relatively little work has been done on the debates about teaching domestic science in the public schools. This lack of study on educational dialogue is all the more surprising considering the wealth of scholarship on *Philippine Public Schools* and their promotion of American ideals through literature. A cottage industry on the Thomasites, the first American teachers in the Philippines in 1901, has repeatedly drawn the connection between education and American missionary work. Scholars have even examined the irony that promoting allegiance to the American empire in Philippine schools actually fueled Filipino nationalism and independence. Understanding the Bureau of Education’s promotion of domestic science is especially important because American reformers viewed the discipline as an effective tool for individual self-empowerment, social uplift, and the advancement of women. Scholarship on the
connection between domestic science and the Filipina ideal has mostly focused on white American female missionaries teaching Filipinas the basics of home economics and housewifery. Even if this interpretation made Filipinas secondary actors in the narrative, at least they were closer to economic and political power during the American Period than the three preceding centuries under the Spanish when Filipino men relegated Filipinas to the sidelines of revolutionary movements. Debates about domestic science in the Bureau of Education magazines revealed that the Americans, too, questioned whether they could truly expand the role of Filipinas from the home into substantial civic power. Finally, this article builds on the scholarship of Filipino textbook literature. Scholars have examined how the Bureau’s standardized texts promoted American civic ideals while simultaneously weaving a narrative of stunted Filipino historical progress, justifying American imperialism. Yet there has been little scholarship on the Bureau’s magazines. Mindful of this previous work, this article examines how the Bureau’s magazines debated the role of domestic science in transforming how people ate, how Filipinas viewed their own role in society, and how teachers used texts in the classroom.

In the minds of these educators, the first priority of domestic science was convincing generations of Filipina schoolgirls that these methods could improve their lives. But many writers in the Bureau’s magazines claimed that improvement was incremental at best.

Promise and Limits for the Filipina

The Bureau’s magazines repeatedly claimed domestic science would open up new opportunities for generations of Filipina schoolgirls. They presented cooking, cleaning, and housekeeping as ways of figuratively contributing to the nascent Philippine democracy. Yet a close examination of these magazines shows that domestic science quite literally meant Filipinas would remain in subservient positions to Filipino men. Furthermore, domestic science created an even stronger tie to the home for the Filipina.

Many authors connected specific characteristics of the Filipina ideal to domestic science. These descriptions built upon the Spanish Period Filipina ideal, a set of activities which historian Marya Camacho says was intended “to prepare girls and women for their primary social function of spouse-mother-homemaker or, to a lesser extent, for religious community life” with “new feminine values with emphasis on purity, modesty, and seclusion.” Domestic science in the American Period, by contrast, promised to expand the available routes for Filipinas. For example, Silva M. Breckner wrote in *Philippine Craftsman* in 1914 that domestic science empowered Filipinas to take care of their own children, freeing them from the need for nursemaids and caregivers. She cited the story of a young Filipina mother who had previously taught domestic science but was now an empowered, self-reliant mother. “She has no one to care for her baby and wants no one, for she knows how to take care of it herself.” Two years later, Genoveva Llamas wrote in *Philippine Craftsman* that women were preconditioned to be better at home management than men. Filipina women thus had a duty to apply their innate skills for the betterment of their communities and Philippine society. She claimed women “use better judgment in buying things for the house,” “employ a greater variety of food,” “use better taste in the choice and arrangement of home decorations,” and “have learned to take care of the babies, a matter that is sure to raise the standard of vitality throughout the Islands.” These natural abilities bound women to the home. Llamas also encouraged Filipinas to perform their domestic duties with grace by replacing the drudgery of home management with a noble sense of national purpose. “To the one who ennobles the task and performs it with becoming dignity, it is a source of real pleasure and a means to health for herself and those around her.” Maria Paz Mendoza-Guazon, a Filipina professor of pathology and bacteriology at the University of the Philippines, elevated the importance of domestic science in *The Development and Progress of Filipino Women* (1928), a book endorsed by the Bureau of Education. Mendoza-Guazon claimed domestic science contributed to town life and the sense of community. “We can judge how charity has been
firmly implanted into the heart of the Filipino woman and how much she has contributed, with her
cookies and home-made cooking, to the entertainment of the people of the town where she was
born.”18 She argued that exceptional Filipinas had drastically changed the definition of the Filipina
ideal as well. “The Filipino woman of the modern type cares less for flattery, but demands more
respect; she prefers to be considered a human being, capable of helping in the progress of humanity,
rather than to be looked upon as a doll, of muscles and bones.”19 Mendoza-Guazon asserted that
education also helped Filipino men to better appreciate Filipinas, daring to believe education also
forced Filipino men to consider gender equality. “Higher education erases the difference of interests,
aims, and views of men and women, and demands recognition of equal rights for both.”20 For these
proponents, domestic science started a process of empowerment—first in the kitchen, then outside
the home—that culminated in reducing gender inequality in Philippine society.

Yet a closer look at the education of Filipina schoolgirls shows domestic science was the only
subject where many Filipina schoolgirls felt they could be creative and empowered at school.
Multiple Bureau magazines described how Filipina schoolgirls took risks in classroom kitchens,
but they did not voice the same enthusiasm in other subjects. In other words, the kitchen was the
only place for change. Breckner offered apocryphal evidence that her fourth-graders in Tarlac and
Palawan were noticeably different on the days they had domestic science. “The days when they
are to have their cooking lessons are their happiest days. They sometimes tell me that they get
something good to eat at that time.”21 She herself was happiest when domestic science lessons
made a direct impact on cooking at home. “One mother was delighted to have her daughter make
hoecake to eat with fried meat. She prized it as a choice dish. If our cooking is done along right lines
it will interest the mothers.”22 Another American educator praised domestic science classes for
allowing Filipinas to practice originality and friendly competition. Hugo H. Miller, the Chief of the
Industrial Division for the Bureau of Education, wrote in Philippine Craftsman in 1914 that domestic
science helped Filipina schoolgirls find their own voices and develop a stomach for criticism. “If
one of our girls suggests a recipe (and there is quite a rivalry in this) she is given the opportunity
of preparing it for the class; and when it is served, judgment is passed. The recipe may be rejected
as not conforming to the best rules for diet, or may be accepted as presented, or altered to suit the
class criticisms.”23 Domestic science classrooms measured success according to food. A Filipina
could start to find her identity through the creation, competition, and the judgement of her peers.

But connecting individual pride to food was a subtle way of equating a Filipina’s importance
in society to her ability to feed and please Filipino men. This was a view Philippine Public Schools
asserted that it was the responsibility of Filipina schoolgirls to prepare ingredients from produce
the boys had grown. This would give the boys a sense of their own importance while reinforcing
the pleasing, subservient role of the girls. “When home-economics girls prepare and serve food to
garden and poultry-club boys, the point is missed if the lesson is made simply an activity in feeding
a large group...Whatever values may result, and there should be others, such an activity should not
fail to bring the boys to understand and appreciate (in an elementary way) the food values of their
garden products. It should acquaint them with the taste (if not the deliciousness) of the food, which
may be a new vegetable or a common one prepared in a new way.”24 Domestic science instruction
required Filipina schoolgirls to prepare dishes for Filipino schoolboys so that the boys would both
eat the benefits of their own work and register the values of agricultural science; nowhere in this
description is there a consideration of the work, values, or sacrifices of the Filipina. Domestic science
may have empowered Filipina schoolgirls with new skills, but reinforcing their self-worth through
food and demoting their voices in order to feed the boys was hardly an empowering experience. The
role of women still largely meant preparing food and pleasing men.

Proponents of domestic science, however, were confident that more than just students would
end up eating western dishes. They envisioned Filipinos of all ages ultimately embracing western
cuisine and culture. Yet the Bureau’s magazines also debated the true breadth of adoption of
domestic science, as many authors argued their efforts ignored or excluded the poor and the elderly.

**Appeal and Underwhelming Adoption**

The Bureau’s magazines insisted domestic science would entice Filipinos regardless of class or
location. With pragmatic benefits to health, as well as aspirational promises of better lives, many
authors argued Filipinos would embrace American dishes and food methods. Yet their promotion of
domestic science overlooked a few factors. First, imported ingredients in western recipes were too
expensive for many Filipinos. Second, some Filipinos simply liked the foods they had always eaten
and resisted change. Authors in the Bureau’s magazines disagreed on the best way to promote
domestic science in the future and to overcome these obstacles to change.

For some authors, domestic science was synonymous with the modern progress of the
Philippines. As Miller wrote, “what can be more important to a
home-loving people, as are the Filipinos, than improvement in
home conditions?” Miller and others believed social improvement
began at home, and domestic science was the key to home
improvement—particularly for a population that was just learning western standards of cleanliness and hygiene. Connecting
civilization to health, or elevating cleanliness to the level of
godliness, had completely transformed the importance of domestic
science in Native American and African American schools in the
US; these precedents served as a model for teaching domestic
science in the American-run Philippine public schools. George
Kindly, an American teacher in Lumbago, made this connection
explicit by quoting former president Theodore Roosevelt’s words on
Native Americans in 1914 in *Philippine Craftsman*: “The girl should
be taught domestic science, not as it would be practiced in a first-
class hotel or a wealthy private home, but as she must practice
it in a hut with no conveniences, and with intervals of sheep-
herding.” Inspired by Roosevelt’s words, the Bureau’s teachers
sought the best way to promote western cuisine and cleanliness
to Filipinos. Breckner believed Filipinos would respond best to humility, arguing Filipinos would listen
to new ideas if the Americans were humble. “Sometimes I have been led to wonder whether some
American teachers do not lack in real sympathy with our educational problem, in that we too often go
at our work in the spirit that drives rather than leads...[Filipinos] should see in us and our ‘customs’
ways which we would want them to imitate.” Breckner also believed Filipinos would pay attention
if Americans demonstrated the best practices and behaviors of domestic science. “We can do as
much in teaching by our example and manner as we can by words alone.” In Breckner’s eyes, seeing
earnest Americans practice domestic science would be an irresistible lure for many Filipinos.

Other American educators believed community outreach would win over Filipinos. While
teachers could proselytize to Filipina schoolgirls, there were skeptics in the community that domestic
science advocates needed to convince. Llamas encouraged teachers to welcome older Filipinos into
their kitchen classrooms to see domestic science for themselves. “Opposition to innovations is often
overcome by inviting the old folks to visit the school and get in touch with housekeeping as there
taught. If step by step is explained to them and the finished product in cooking is sampled or taken
home, clearer ideas of the Bureau’s point of view will be obtained.” She argued that older Filipinos
were even more important than Filipina schoolgirls because families ultimately shaped everyday
Philippine life. “Not only daughters but parents ought to be trained in domestic science, for upon them rests the happiness and prosperity of the home.”31 The Bureau’s magazines believed they could win over Filipinos by bringing domestic science demonstrations into the home. Reinforcing classroom concepts when cooking at home would spread knowledge to non-students, and it would free up time in the classroom. Students, parents, and teachers would all benefit. Philippine Public Schools in 1931 described how this scenario would help teachers. “If home activities soon followed, if they were closely connected with classroom activities, and if some satisfactory device were worked out for giving a girl help and credit or at least recognition for preparing and serving at home recipes ones prepared in class, considerable school time now spent in ‘practice’ of simple techniques could be saved for purposes more profitable in the education of the girl.”32 Ideally, teachers would convert both young and old Filipinos behind domestic science simply through exposure.

The most popular message in the Bureau’s magazines to convince Filipinos to cook and eat like Americans, however, was the appeal to science. Public outreach and promises of progress were good, but hard evidence in the form of nutritional science would supposedly win over Filipinos with objective truth. Nutritional science would also disabuse Filipinos of antiquated superstitions about food that actually did more harm than good. Elvessa A. Stewart, an American who taught in the Philippines from 1912 to 1957, asserted in a 1929 article in Philippine Public Schools that “Scientific reading is the mortal enemy of superstition...Such false beliefs as ‘that fruit may not be eaten for breakfast because it will give a stomach ache’ or ‘that milk is not the proper for people beyond infancy’ have no basis in fact and must be overcome before we can reach the goal of optimal nutrition which will help make vital health a reality instead of an ideal.”33 Stewart also believed developing a thorough understanding of nutritional science in the present would have long-term benefits in the future. Educators needed to make nutritional science literature easily accessible in schools. “Every library, whether the library of the school or the private library of the teacher, should be supplied with this material.”34 Similarly, Philippine Public Schools argued in 1928 that if a Filipina schoolgirl understood the theory behind nutritional science, she would continue applying domestic science methods for the rest of her life. “She has enough training in manipulation that if in later years she may have reasons to do more extensive work in cooking she will be able, after some practice, to prepare a meal that is well-balanced and palatable and satisfactory in every way.”35 Science would win over the skeptics and implant itself into the Philippine future.

Other Americans argued that the way to convince Filipinos to adopt domestic science was to show them the wonders of a modern classroom kitchen. Domestic science stressed order, hygiene, and cleanliness in physical space, resulting in school kitchens unlike those in most Filipino homes. They emulated domestic science kitchens in the US with multi-purpose spaces for sewing and studying as well as cooking. These classroom kitchens featured chimneys that funneled smoke out of the house, as well as low hoods with ventilators because, as Philippine Public Schools wrote in 1931, “a class cannot do its best work in a smoky room.”36 Carrie L. Hurst boasted about her space in Misamis in Philippine Education in 1907. She had the best building on campus because it featured a fresh coat of white paint, eight white curtains at the windows, a light colored wooden cupboard, and a small linen closet ingeniously fashioned from discarded soap and milk boxes. Together, they created what she described as “quite a ‘homey’ feeling when our table is set and we are partaking of a meal prepared in our own kitchen.”37 Philippine Public Schools noted in 1928 that classroom kitchens were designed with “working quarters and conditions which are as nearly as possible like a model home,” with the intention of inspiring Filipina schoolgirls to recreate these spaces at home.38 If they could maintain the same standards of the classroom in their kitchens at home, they would practice domestic science throughout their lives.

This praise for Philippine classroom kitchens inevitably inspired many Bureau magazines to critique the average Filipino home kitchen. Critics such as Llamas blamed the shoddy state of
Philippine home kitchens on the lack of attention to sanitation and hygiene during the Spanish Period. “Before the coming of the Americans, the sanitary system was so poorly organized that thousands of people died every year from preventable diseases. People knew little of importance of cleanliness.”\(^{39}\) Mendoza-Guazon also deplored the omnipresence of smoke and dirt in Philippine kitchens, even in the homes of the elite. She recounted how cooks prepared banquet meals in modest, dirty kitchens. “As there was no gas range, an iron oven or, in many instances, the earthen ovens or kalan were lined on top of a long wooden table with strong legs.”\(^{40}\) Furthermore, Miller lamented that the average Filipino kitchen was “not sufficiently planned for in the mind of the house builders” and was “cramped and ill-equipped and impossible to clean.”\(^{41}\) Naturally, seeing what was possible in classroom kitchens would inspire Filipinos to adopt domestic science – spaces, dishes, ingredients, customs, and all.

Although the Bureau’s magazines maintained a rosy belief that the adoption of domestic science was inevitable, they also conceded some of their own promotion had backfired. Indeed, Philippine Public Schools wrote that some of the procedures of western domestic science were ill suited for the Philippines. In 1928, Philippine Public Schools claimed the obsession with technology of domestic science had caused some Filipinos to decrease their consumption of fresh fruits. “Fresh fruits not only are cheaper than canned ones but they also have greater nutritive value,” it said. “Canning should be confined to seasonal fruits which are in such abundance that all cannot be used while in season.”\(^{42}\) Philippine Public Schools also argued that Filipinos were consuming too many imported foods instead of healthier, indigenous alternatives; celebrating imported canned goods in Bureau promotional literature and photographs perpetuated unhealthy habits. “A picture showing an elementary cooking class working at a table which has on it bottles of mixed pickles, catsup, and other sauces illustrates a wrong idea of plain elementary cooking. These ingredients are expensive and add little to the diet.”\(^{43}\) Filipinos were readily adopting western domestic science, but they were adopting the less nutritionally valuable aspects of it.

But the biggest hurdle to the widespread adoption of domestic science was the price of imported western ingredients. Items such as canned milk were simply too expensive for many Filipinos, despite their supposed health benefits. The Bureau’s magazines repeatedly claimed that canned cow’s milk was superior to indigenous milk sources such as carabao (water buffalo) milk and coconut milk. Eusebio B. Salud even connected western milk consumption to the progress of western civilization: “The achievement of any race of people in science, art, and literature depends more on the milk consumption of that people than on any factor...a nation that consumes milk liberally is bound to be a healthy, virile, and prosperous nation.”\(^{44}\) He also highlighted the importance of milk in child development. “The children who drank milk showed, in general, brighter faces and were more active at play than those of the control group who had no milk.”\(^{45}\) Other milk advocates explicitly connected the increase in milk consumption in public schools to domestic science. José C. Munoz, a supervising teacher in Negros Occidental, stated that teachers had a direct impact on the popularity of cow’s milk. “Of course the teachers’ influence over the children has had something to do with this change of attitude toward milk...Records now show that sixty percent of the pupils in the central school drank milk. Less than ten percent drank milk last July.”\(^{46}\) The Bureau’s magazines made imported canned milk synonymous with better nutrition and healthy bodies, even though it was an item many Filipinos could barely afford. Munoz himself describes how milk was an aspirational product. “Desires for the good of our health must be met...When the need for milk is finally realized, the people will always provide funds for this very important food.”\(^{47}\) Milk was an important but pricey ingredient that not everyone could afford.

The Bureau’s publications also described skepticism of domestic science among older Filipinos. In Cotabato, Anna Pinch Dworak complained that all of her work promoting domestic science in
classrooms and public markets had ultimately made “little or no impression in the line of adoption of new dishes.” Miller similarly lamented that while students embraced domestic science, parents did not always follow suit. “Anything that has been made in the cooking classes has been eaten with relish,” he wrote, “but the results have evidently failed to penetrate the home. It is a matter of difficulty for one member of a family to cause a foreign food to become a part of the family’s diet.” Promises of progress, community outreach, and advances in science could neither put money in the pockets – nor remove the skepticism – of all Filipinos.

The Bureau’s magazines, however, also claimed domestic science would have tangible effects on Filipino bodies and minds. In another plea to win over Filipinos, the Bureau promised western foods would lead to stronger physiques and sharper thinking. Yet their claims of the inherent inferiority of Filipinos caused one to question whether these American authors even believed their own promises of domestic science’s effects on the opportunities available to Filipinos.

Bodies, Minds, and Race

The Bureau’s magazines also promoted domestic science by claiming western foods and health standards would strengthen Filipino bodies and better lives. But Bureau magazine articles undermined their own message by presenting a racist belief that many Americans held in the early-1900s – namely, that Filipinos were inherently weaker and less intelligent than white Americans. The same Bureau magazines that offered the promise of domestic science simultaneously mocked Filipinos as childlike, imitative, dependent on Americans, and incapable of complex thought. The Bureau’s perpetuation of these stereotypes made the goal of improving Filipino lives ring hollow.

The Bureau’s magazines contended that western standards of domestic science would inevitably improve lives. Indeed, taming the tropics and improving Filipino resistance to disease became a main justification for American imperialism. Many authors claimed that domestic science, by bringing a higher standard of nutrition to a large number of Filipinos, would make for a healthier nation. Miller described how Filipina schoolgirls were adapting basic domestic science recipes for home use. “We have in all classes little kitchen lovers who develop their cooking into an art; but these must have individual training...We have learned that the dishes to which the girls are accustomed are cheap, and that a balanced diet may easily be evolved from them.” He stressed cleanliness was the most important value of domestic science food instruction. “Our work lies mainly in lessons of cleanliness, to have the girls form habits of preparing their dishes in a clean and wholesome way, basing their procedure on what they have learned concerning personal and household hygiene and sanitation.” Llamas reiterated the importance of bringing cleanliness to all Filipinos regardless of economic class. She criticized domestic science cookbooks for catering primarily to well-to-do families by featuring American recipes for preserved fruits and breads that were “seldom served at the Filipino table.” Llamas insisted that domestic science stress clean, nutritious foods drawn from both Filipino and American cuisines. “Whether

![Diagram of model domestic science building, p. 393, Philippine Public Schools Magazine, 1928.](image-url)
Filipino or American dishes are served,” she wrote, “they are beginning to be served in the safest and the most healthful way.” More, she believed the procedures of domestic science ought to carry over to the more humble Filipino dishes in the future because “the extravagance of imported foods is gradually giving way to the use of foods obtainable from the home markets or in the home garden.” For Stewart, the key to transforming health was convincing Filipinos to look at food as more than just fuel. “Just as health is more than mere freedom from disease, so nutrition is more than satisfying hunger of filling the stomach.” Llamas also believed domestic science classes were essential to eradicating germs and disease from cooking. “When the excellent interest shown in school cooking takes form and produces results as home cooking, an important problem will have been solved, and a long step will have been taken toward the elimination of the sale of poorly prepared food from germ-laden baskets on streets and in the market.”

Most Bureau magazines agreed that school lunch counters were the most effective place to introduce this focus on cleanliness and improving Filipino bodies to the largest number of people. At public schools throughout the archipelago, Filipina schoolgirls sold the dishes they prepared in their domestic science classes to students, teachers, and the general public. Filipinos could eat at school lunch counters and sample the benefits of food that met western standards and was prepared under the watchful eyes of actual domestic science instructors. Multiple authors praised the food at school lunch counters as superior to the food at public market stalls. Florencia Bonifacio, a teacher at the Meisic School in Manila, mentioned the quality of her students’ cooking in Philippine Craftsman in 1915. “The food sold by the schools is prepared under the supervision of a trained domestic-science teacher and is served in dishes which are washed and scalded. All the pupils who prepare or handle food for sale are clean.” She remarked that this was a stark contrast to the food prepared in public market stalls because “the less one knows about the preparation of the food sold by the street vendors and the markets, the less difficult it is for him to eat it.” She used the example of cakes and ice cream to elaborate on the difference in quality between school lunch counters and public stalls. “The cakes made by the schools are much richer than those which can be bought at the shops. The ice or ice cream sold by the schools contains milk, while that sold by the street vendors is made of water and the white of eggs.” There simply was no comparison. Munoz claimed Filipino parents also preferred that their children eat at school lunch counters instead of market stalls. “They were glad that a good substitute was found at last for the dirty cakes and candies that are usually sold on the road by local vendors.” School lunch counters were serving meals that met the standards of western domestic science, not the suspect imitations that failed to strengthen bodies and minds. Munoz also boasted that school lunch programs led to a sharp decrease in the number of below-average pupils. Over the course of four months, he claimed meals from school lunch counters helped to lower the percentage of below average pupils from 65 percent in July to 42 percent. “The best result of the of school lunch program is the increase in grades and aptitude of the children.” With proper nourishment, Filipino students could focus on their studies and prepare themselves for better opportunities in the future.

School lunch counters also had an additional benefit for Filipina schoolgirls of teaching them how to reinvest in their communities and how to run small businesses. Bonifacio described the joy Filipina school girls felt as they decided where to redirect the profits they earned selling food into purchasing athletic supplies, industrial material, and books for the school library. Other Filipina schoolgirls set up their own home catering businesses, selling their expertise in cooking many of the recipes they learned in their domestic science courses. Llamas praised a home caterer in Leyte who offered an impressive menu of domestic science staple items—sandwiches, biscuits, corn muffins, lye hominy, pickles, jams, jellies, fruit butters, cookies, gingerbread, layer and loaf cakes, doughnuts, ice cream, and candies. These catering businesses, by replicating the same high standards of domestic science classrooms, would expose the average Filipino to nutritious foods at affordable prices.
Nevertheless, the Bureau’s magazines also included plenty of passages that stated Filipinos were inherently weaker and less intelligent than whites. Considering the popularity of Social Darwinism and ethology on conceptions of race in the early-twentieth century, it is not surprising that these views affected the writing of American Progressive reformers in the Philippines. These views shaped the thinking of a number of authors in the Bureau’s magazines. Edna A. Gerken wrote in *Philippine Public Schools* in 1930 that Americans should practice patience while Filipinos developed good nutritional habits and healthy bodies. “With persistent effort, the desired results in changed living habits will come even though it may not be evident until the present school child has become the parent in the home of tomorrow.” Llamas asserted a similarly benign belief in the adoption of domestic science by stating “housekeepers and cooks are not made in a single day, and experts in these lines find that a large measure of their success is the result of patient, persistent practice.” But others believed patience could not compensate for the innate physical and mental limitations of Filipinos. For example, Kilmer O. Mos, an American teacher working in Central Luzon, wrote in *Philippine Craftsman* in 1914 that the men who were working Philippine fields were naturally weaker than the white pioneers who settled the American West. “The early pioneers in America had at least the advantage of having the work accomplished by strong, able-bodied men,” he wrote. In the Philippines, the work was done instead by “immature schoolboys” who “got discouraged and left” because “there was nothing stronger than a moral suasion to hold them.” W.J. Cushman, an American teacher at the Villar Settlement School, asserted in *Philippine Craftsman* in 1914 that Filipinos were incapable of helping themselves because they were immature and indecisive. “The Negrito is but a child and changes his mind with every change of the moon, if not oftener, and that change of mind may mean a change of location or something else just as detrimental to the best interests of the school.” With American help, Cushman claimed there was “a marked effect on the working capacity of the pupils...now it is possible to get quite satisfactory work out of the older pupils, at least ten to twelve times the amount accomplished at first.” American instruction—and diet—had supposedly made Filipinos surpass their natural abilities. Yet their ceiling of potential still lay within the inherent limitations of their race.

The supposed difference in physical and mental abilities between Filipinos and Americans was an expression of the belief in the superiority of the west. To convince Filipinos domestic science was worth adopting, the Bureau’s magazines encouraged teachers to repeat the narrative of western superiority in many ways.

**Promotion of the West**

Domestic science’s supposed advantages relied largely on promoting the superiority of western cuisine and culture. The Bureau’s magazines included plenty of accounts claiming domestic science originated from countries with higher standards of cleanliness and sophistication. Connecting western foods with cultural superiority thus developed a desire for imported goods among Filipinos. But the Bureau’s magazines also pointed out that Filipina schoolgirls paid for western goods either by making traditional Filipino arts and crafts for export, or by selling food within their communities. Thus, domestic science in the Philippines perpetuated the East-West dichotomy both by creating consumer demand for western goods among Filipina schoolgirls, and by supplying foods catering to Filipino communities. Domestic science thus consistently elevated western cuisine to Filipinos and caught them in a cycle of producing and consuming western foods.

Many domestic science instructors reinforced the supposed superiority of western food by making Filipina schoolgirls prepare banquets of western dishes on special occasions. The Bureau’s magazines recounted how public schools around the country welcomed visiting government bureaucrats and dignitaries with meals demonstrating a command of domestic science. Hurst wrote that her students prepared elaborate meals for Governor General James F. Smith. “The girls
entertained several times at luncheon and dinner, setting the table, cooking, and serving as well as many more experienced people.”71 She praised her students for adapting basic domestic science recipes to their specific locale because “they seem to have mastered the art of good cake baking to the extent of taking any new recipe and adjusting it to suit the conditions here.”72 Similarly, Alice M. Fuller, the Bureau’s national director of domestic science, praised students who prepared western recipes in Cagayan Province. She listed an impressive set of dishes that her students prepared in *Philippine Education* in 1907. For lunch, they made hot cakes with melted sugar and coffee; and for dinner, they made *arroz Valencia*, lettuce salad, beets from the school garden, and dessert of biscuit doughnuts, and fudge.73 Visitors were so impressed with the meal that Fuller boasted, “some members asked that we might have such a dinner each year and this proposition was greeted with great enthusiasm.”74 Fuller then described a year later in *Philippine Education* that her students had mastered a range of western recipes that changed through the year. All year round, they were prepared tomato catsup, creamed cod fish, salmon croquettes, and coconut custards.75 During Christmas, they added coconut cream candy, penotchie, and lemon cream.76 Filipina schoolgirls prepared western foods that symbolized western sophistication in order to reassure American visitors that domestic science instruction was effective and that the civilizing influence of domestic science was reaching Filipinos around the country.

The most widely embraced cooking technique from domestic science was baking and the Bureau’s magazines were flush with accounts of Filipina schoolgirls making breads, cakes, and pastries. The magazines presented baking’s growing popularity as evidence of domestic science’s positive effect in the country. For example, Miller described how hot cakes and doughnuts were now available across the country. “They have achieved an almost complete invasion. No home is without them...In the local market you may purchase doughnuts ‘a la Americana’ from a woman who learned the art from her schoolgirl daughter.”77 He noted that the custom of taking tea in the afternoon had spread as well. “The serving of tea with sandwiches and biscuits has become quite common and invitations to five o’clock tea parties to celebrate birthdays among both girls and boys are to be expected at almost any time.”78 Llamas focused on the explosion of baked goods at Leyte High School. “It has been interesting to watch the trend of these lunches from doughnuts to peanut candy, which were about the only articles that had ready sale at the beginning of the year, to cookies, gingerbread, and cup cake, and later to biscuits and corn muffins, which at present time are popular.”79 Dworak mentioned about teaching Filipina Muslim schoolgirls in the southern islands how to bake at the Moro Girls Industrial School in Cotabato. “Bread is furnished for the early breakfast; rice and fish, dried as a rule, at 11 o’clock; and for supper a kind of stew made of fish and vegetables. Frequently the stew is supplemented by salmon or sardines.”80 She also boasted that the girls always finished their lunches, and that they ate better at school than at home because lunch “was well prepared and in abundant quantity.”81 The growth of baking was one of the proudest accomplishments of domestic science.

Some advertisements for western imported foods in the Bureau’s magazines attributed the growth of western cuisine in the Philippines to the supposedly higher standards of western canned
goods. These ads claimed products from the US and Europe inherently had higher standards of cleanliness, hygiene, and nutrition. For example, a 1907 ad for Mellin’s Baby Formula in *Philippine Education* boasted it had won the prize for high quality and nutrition at the 1904 Saint Louis World’s Fair. The ad copy said Mellin’s excelled not only in the US, but was also better than conventional milk sources in the Philippines because “it is specially adapted for use where fresh milk is either unavailable or of doubtful quality.” The ad then appealed to an even wider audience by promising benefits for invalids and convalescents. Other magazine ads also focused on the variety of imported western food items. Armour’s Meat claimed Filipino consumers should crave different kinds of beef. “It is especially important to have variety, not only in the kind of meat but in the way it is served. Many people grow weary of sitting down day after day to fried, boiled, or roasted meats, until they declare ‘don’t care for meat.’” Different kinds of canned meats brought a variety of items that ensured consumers ate properly. Ads for restaurants in Manila also seized on the appeal of western cuisine. *Philippine Education* ran an ad for the Imperial Hotel in 1907 that boasted it served “The Best of Australian Meats and Butter” as well as a “First-class American Table-Board.” Trading on the supposed benefits of western cuisine only reinforced the importance of Filipinos embracing domestic science.

Yet in order to pay for the imported goods and ingredients, Filipina school girls resorted to creating arts and crafts for export, or selling prepared foods in their communities—thus using their domestic science skills to pay for domestic science demands. Filipina schoolgirls made trinkets as well as exportable high-priced commodities such as baskets, lace, and textiles that appealed to American consumers. Miller described how a Filipina schoolgirl used her domestic science training to pay for these purchases. “She has been taught in her domestic science class to crochet, embroider, or sew. She makes a pretty article and offers it for sale. With the money she received she learns that she has earning power.” Items beyond the kitchen appealed to her as well. “Formerly in our town a girl with shoes and stockings was very rare and girls cared little for such things,” wrote Miller. “Now they long for pretty shoes and stockings, a scarf, some other pretty article.” Domestic science classes enabled the Filipina to buy these items because “she needs no longer sit apathetically and long for pretty things that others wear...she can get many things which otherwise she would be compelled to do without.” Munoz stated that while domestic science had created a desire for imported items, it also encouraged Filipino families to raise money and increase their standard of living. “Another outstanding result that is bound to come on account of the school lunch is the raising of the standard of living and the encouragement of production and labor.” The desire for new products supposedly also drove their parents to work harder to afford these items, too. Munoz continued, “In a parent-teachers gathering held some time ago in connection with the mothers’ day celebration, an intelligent farmer and father of school children told me that his tenants were working hard to get money to buy [canned cow’s] milk for their children. To increase one’s earnings is a matter of desire.” Domestic science thus inspired both the purchase of imported western goods by Filipinas, as well as the labor to pay for their purchase. While not everyone could afford to buy these imported goods at first, the Bureau’s magazines promotion of domestic science both fueled and supported the determination to incorporate them into Philippine society end.

**Conclusion**

Examining *Philippine Education*, *Philippine Craftsman*, and *Philippine Public Schools* helps us understand how American cultural imperialism worked in the Philippines at the start of the twentieth century. With the amount of coverage these magazines devoted to domestic science, it is clear that the Bureau of Education viewed its dissemination as a priority for changing Philippine culture. Transforming how people ate would remind all Filipinos, regardless of economic class, geographic region, or religious faith, that an American system governed the archipelago from the bottom up.
Yet the differing views contained within these magazines also created contradictions that ultimately limited the spread of domestic science and the transformation of the Filipino diet. The inability to reach older generations, as well as the expensive price of imported ingredients, proved difficult hurdles for domestic science to overcome. Conflicting messages on achievable goals and ultimate objectives of domestic science made uniform implementation across the country impossible. Because domestic science largely consigned Filipina schoolgirls to the kitchen, the lofty promises of domestic science failed to resonate even with those it most directly targeted. These factors—along with others too numerous to discuss in this essay—resulted in the persistence of Filipino cuisine and, indeed, a decline in the consumption of American cuisine after the formal end of American colonialism in the Philippines in 1946.

Despite the failure of the Bureau to implement domestic science to the Philippines on a national scale, an examination of these magazines can reveal important insights into twentieth century Filipiniana. These magazines are rich cultural sources and records capturing the transmission of Progressive Era ideas from the US to the Philippines. They reflect the consumer habits and taste preferences of teachers, educators, and students for more than thirty years. As magazines published during the golden age of advertising and the rise of the Philippine popular press, they also illustrate the biases of their authors, as well as the aspirations of their Filipino students who they described. Disagreements within these magazines about the size and shape of domestic science showed a healthy and constructive debate about how to pitch messages that would resonate with newly educated Filipinos eager to perform an American-style middle class identity. Finally, these magazines reflected the importance the Bureau of Education placed on transforming future generations of Filipinos. Sharing approaches to domestic science that worked in different parts of the country meant teachers could read about examples that worked and emulate them in their own schools. After all, stories on domestic science shared space in these magazines with discussions about agricultural science, writing, economics, civics, politics, math, and arithmetic. These magazines made domestic science part of a Filipino student’s core curriculum regardless of whether he or she was destined for a future in classical, trade, or vocational education.

Most importantly, depending on one’s view, domestic science was either an insidious agent or a benevolent instruments of change. Whether one ate Filipino or American food, domestic science brought a new American frame to how one ate, cooked, and thought about one of the most basic human needs. Food thus became a subtle but unescapable expression of imperialism and the constant efforts at America’s constant efforts to enforce its cultural hegemony in the Philippines.

NOTES


17. Ibid., 609.


19. Ibid., 44.
20. Ibid., 46.
22. Ibid.
23. Hugo Herman Miller. “Results from Domestic Science.” *Philippine Craftsman* 2, no. 7 (January 1914): 444.
25. Miller, “Results from Domestic Science,” 441.
29. Ibid.
31. Ibid.
34. Ibid.
41. Miller, “Results from Domestic Science,” 442.
42. “Photographs for Publication Showing Home-Economics Activities,” *Philippine Public Schools*, February 1928, 27.
43. Ibid., 27.
45. Ibid.
47. Ibid., 50.
49. Miller, “Results from Domestic Science,” 458.
50. Ibid., 442-3.
51. Ibid.
53. Ibid.
54. Ibid., 526.
58. Ibid.
59. Ibid., 211-212.
61. Ibid., 49-50.
62. Ibid., 50.
70. Ibid., 558.
72. Ibid.
74. Ibid.
75. Fuller, “A Course in Domestic Science.” *Philippine Education* 5, no. 6 (November 1908): 29.
76. Fuller, “Cooking-Sewing.” *Philippine Education* 5, no. 10 (March 1909): 34.
77. Miller, “Results from Domestic Science,” 458.
78. Ibid.
81. Ibid.
82. “Mellin’s.” *Philippine Education* 4, no. 4 (September 1907): 3.
83. Ibid.
84. “Armour’s Meat.” *Philippine Education* IV, no. 3 (August 1907): 12.
88. Ibid., 450-451.
89. Ibid., 451.
90. Munoz, 49-50.
91. Ibid., 50.
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Empires of Panic: Epidemics and Colonial Anxieties (Hong Kong University Press), edited by Robert Peckham, is an intriguing volume. There are not many books on a topic as diffuse as this one – the idea itself is unusual, and worthy of a volume. And the book once in hand does not disappoint – though slim, the study punches above its weight in sketching out some of the parameters of this notion across a wide ambit of time and space. This is not history for the faint of heart. It is, however, history that shows how epidemics have spread and caused havoc in various places, and how this phenomenon in turn has been processed and explained by states, and by the human actors that make up the “public,” as well as the sinew of these same states. Most of the action in the volume takes place in Asia, broadly construed; parts of it also jump later on to other geographies, beyond the world’s largest continent.

Directions are laid down in the Introduction, “Panic: Reading the Signs.” Here, Peckham as editor usefully tells us that the vastness of Asia has episodically caused feelings of great anxiety in the West. It’s not just the vast extent of the territory that is “Asia,” but also the immense number of people living there that is potentially hazardous, if things should go wrong. And epidemics are about as “wrong” gets in this scale of danger. How could pathogens and the people carrying them be controlled, if the distances covered across Asia were so large? How could the immense flow of humans be staunched, when the numbers of people being talked about in imperial terms dwarfed the Western administrators and colonial officials charged with such a daunting task? Peckham shows us some of the calculus at work here, in different climes and in various places, and looks for themes in common among the examples. Despair and a sense that Western science had better move quickly were a near-constant in this equation. This was true in India, for example, vis-à-vis the millions ruled in the “jewel in the crown” of the British Empire. But it was also true in Dutch Indonesia, and in a nineteenth-century China that was being carved to pieces by many avaricious powers, all of them taking territory for themselves as putative spheres of influence.

Five of the chapters fit very well together in showing some of the breadth and scope of the ideas on offer in this book. Chapter 2 (by John Carroll) takes Canton as its “site”: here, in factories across a crowded, hemmed-in anchorage, Western merchants confronted the multitudes of China from a solitary base for several hundred years. The notion of the crowd here was seen as dangerous from
the beginning, because of disease (assuredly) but also because of the dangers of fires inherent in such a small space. Chapter 3 (by Joao Rangel de Almeida) examines the Sanitary Convention of 1851, when initial ideas about a pan-European response to epidemic disease spreading on the wings of colonial trade and migration began to circulate in administrative circles. Chapter 4 (by James Beattie) then looks at the scene just a few years after this, but in India, where the 1857 Mutiny changed the landscape of dissent in the sub-continent to one presaging outright rebellion, partially as a result of disease and over-crowding. The tendrils of migration in the wake of the disturbances then stretched all the way to the Antipodes, showing the repercussions of instability as they moved along colonial British pathways. Chapter 5 (by David Arnold), who has written widely elsewhere on disease and public health vectors, then deepens this story further by looking at the plague and influenza as a pan-Indian and supra-Indian phenomena just a few decades later, in the late nineteenth and early twentieth centuries. Finally, in Chapter 6 (by Robert Peckham himself), these patterns are linked to the astonishing stretch of telegraph wires around the colonial world, both inside and between colonies, and also back to the metropoles in distant Europe. How pandemic was “seen” by the West was of course conditioned by the speed of such reporting, and this vector changed rapidly after telegraph wires started to increasingly connect the globe, especially after the Suez Canal was dug in 1869.

Chapters 7 and 8 (by Amy Fairchild and David Johns for the former, and Nicholas King for the latter), are good essays, and both present interesting material. They do not, however, connect quite as well as the former essays, partially because they move further away temporally from the “Age of Empire” proper, and also because they begin to move further away from Asia itself in their overall scope as well. Chapter 7 does this through a broad-based analysis of public perception of panic and epidemics, mostly over the long twentieth century, and Chapter 8 looks at visual culture and spreading disease from the 1930s, all the way up until our own time. Again, both are useful and well-supported essays, but they do not jibe as well with the overarching theme of the book as earlier chapters do, which fit together more naturally as a set. In an Epilogue chapter, Alison Bashford ties together the eight treatments before her own, and does a nice job of explaining the arc of this research as a coherent “project,” looking back into the past, but also forward into the future as well. It should become clear to anyone reading this volume that the subject-matter at hand is important: we’ll likely live or terminate ourselves as a species based on how we handle such pandemics in the future, given the terrifying speed with which the planet has now knitted itself together. In this respect, Empires of Panic is a real service to the field, both in showing that the past is prologue, as the saying goes, and also in warning us that not to take such lessons seriously would be foolhardy indeed.