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**The Reverence for Life Movement - A Community-based
Primary Health Care Movement in Kumamoto, Japan**

BY

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THESIS

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This thesis is dedicated to my mentor, Beverly J. McElmurry, Ed.D., RN, FAAN,
without whom this project would ever have existed.

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ATK

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LIST OF ABBREVIATIONS

ACNHCK	Association for Creating New Health Care in Kumamoto
CBPAR	Community Based Participatory Action Research
CBPR	Community Based Participatory Research
JA	Agricultural Cooperatives
JAWG	Agricultural Cooperatives Women's Groups
JRCS	Japanese Red Cross Society Student Volunteer Program
JSRM	Japan Society of Rural Medicine (Currently: Japanese Association of Rural Medicine (JARM))
KHAC	Kumamoto Health Administration Center
KHACTF	Kumamoto Health Administration Center Task Force
KHMA	Kumamoto Health Maintenance Association
KMA	Kumamoto Medical Association
KOAA	Kumamoto Organic Agriculture Association
KSRM	Kumamoto Society of Rural Medicine
KSSM	Kumamoto Student Settlement Movement
NATV	National Association of Towns and Villages
NHK	Japan Broadcasting Cooperation
PAHO	Pan American Health Organization
PHC	Primary Health Care
RLM	Reverence for Life Movement
WHO	World Health Organization

SUMMARY

The purpose of this historical case study was to provide such a rich and thick description of the Reverence for Life Movement (RLM) - a community-based Primary Health Care (PHC) movement in Kumamoto, Japan from 1962 to 1980 - through synthesis of historical documents and oral histories collected from participants. Based on a postmodern orientation, this case study not only focused on the objective historical facts of the movement, but also emphasized the voices of both leaders and participants of the movement. The oral histories presented a slice of lived experience and conveyed what this community-based social movement meant to the speakers, whose words impart the sense of meaning, motivation, and passion that facilitated their strong commitment to this sustainable social movement.

Contextual information included a review of the development of Japan's health care system and of its standards of rural health practice as pioneered by Dr. Toshikazu Wakatsuki. Along with the history of the RLM, the researcher attempted to analyze the RLM through the theoretical framework of a PHC-based health system as defined by the Pan American Health Organization and World Health Organization in 2007. Set against the PHC-based healthcare framework, the RLM appears as a community-based PHC movement that recruited community support and intersectoral efforts in improving health and healthcare infrastructure in Kumamoto, and impacted health policy nationally.

The RLM created a conceptual framework for health that encompassed healthcare, safe food and good eating practice, and agriculture. With a new conceptual framework, strong leadership, and broad community engagement, the movement expanded its activities

SUMMARY (continued)

beyond the traditional health care framework. The RLM, securely rooted in endemic community values, contributed to the development of a comprehensive PHC movement that collaborated across social sectors. Over the 40 years of continuous activities, the RLM has become a leading example of a sustainable social movement that not only facilitated the health of citizens and communities, but also strengthened the health care infrastructure and modeled the kind of success that grounds good national policy.

Chapter 1

“A small group of thoughtful people could change the world. Indeed, it’s the only thing that ever has.”

Margaret Mead

A Phenomenon of Interest

Now more than ever, achieving better health for all is a critical global health issue as well as a critical community health issue. In 1978 the World Health Organization (WHO) declared Primary Health Care (PHC) as its philosophical framework to deliver comprehensive health services to the population (World Health Organization, 1978). PHC is a strategy for organizing healthcare systems and society to promote health. It is important to recognize that both the country and the community participate in the processes to develop an accessible and equitable health care system that meets the health needs of the population. To build an acceptable health care system, health care services need to be congruent with the cultural, geographical, historical, and economical contexts as well as the health profiles of the community. The WHO has identified the ultimate goal of PHC as better health for all, and presented five key elements to achieving that goal:

1. Eliminating social disparities in health and ensuring universal coverage;
2. Organization of health services around the population’s needs and expectations;
3. Integrating health into all sectors;
4. Facilitation of inter-sectoral collaboration; and
5. Increasing stakeholder participation (World Health Organization, 2011).

Over the 30 years since the WHO presented PHC, various programs have been implemented throughout the world; however, developing a sustainable comprehensive PHC program have been a challenge (Lawn, et al., 2008). Researchers have identified that the weakest strands in the development of PHC were community participation and inter-sectoral engagement (Lawn, et al., 2008).

The Reverence of Life Movement (RLM) is a sustained community-based social movement which has successfully addressed those five key elements of PHC. It was initiated in Kumamoto, a state of Japan, where the primary industries have been farming and fishery. The movement emerged from a small group of physicians in 1962 with the formation of the Kumamoto Society of Rural Medicine (KSRM), inspired and mentored by Toshikazu Wakatsuki, M.D., a pioneer physician who had established a community-based agricultural and rural medicine practice in Nagano, Japan. Those visionary young physicians in Kumamoto spearheaded a community-based social movement with other concerned citizens and facilitated development of a mechanism to provide comprehensive health services for Kumamoto's population. Through the social movement, the concerned citizens of Kumamoto successfully transformed the traditional provision of health care to a new healthcare approach through community mobilization with a community-based interdisciplinary, inter-sectoral citizens' organization, the Association for Creating New Health Care in Kumamoto (ACNHCK) which, by the early 1970s, included more than 4,500 memberships. (Takekuma, & Koyama, 1978).

The focus of this social movement was not only on transforming the provision of health care; but it embraced reverence for life, which included a broad definition of health

and well-being. As the movement progressed, a new conceptual framework emerged, one that approaches health by connecting medicine/healthcare, foods/eating, and farming/agriculture. Through this new conceptual framework, the social movement was expanded beyond a traditional medical / health care framework; it facilitated organic farming and sustainable agriculture with the member farmers and promoted the development of consumer network to distribute organically grown local produce to the urban market by the consumer members. The movement continued to advocate importance of safe foods, organic farming, and sustainable agriculture for the health and well-being of the population and the environment (Takekuma, 1983; Takekuma, & Koyama, 1978).

Under this unique conceptual framework, strategies for facilitating healthcare have broadened from the traditional medical model to a more comprehensive health promotion model which included annual health checkups; disease prevention and screening programs; primary care; provision of Oriental medicine; wellness promotion; lifestyle change; environmental health; chronic illness management; as well as extensive education on eating, nutrition, and environmental safety; facilitation of sustainable agriculture; and production of safely and locally grown foods. The integration of these approaches in healthcare services and daily lives has facilitated healthy life styles and helped the people take ownership of their health and well-being.

The Reverence for Life Movement (RLM) is a sustained community-based social movement in Kumamoto, Japan, which reflected original values and visions of the comprehensive PHC defined by WHO. Over the past 40 years, with participation and commitment of the community members, and with the distinct leadership of visionary

leaders, RLM has continued and is still evolving despite the societal changes that had occurred since the 1960s. Some of the outcomes are:

1. Establishment of the Kumamoto Health Maintenance Association;
2. Revitalization of the Kumamoto Red Cross Hospital as an area trauma and emergency medical center that provides advanced tertiary care to the urban and rural populations, as well as a top rated teaching hospital and disaster relief expert in the nation;
3. Development of the Kumamoto Health Maintenance Center that provided health screening outreach programs to rural communities in Kumamoto by a health screening mobile;
4. Establishment of the Kumamoto Red Cross Health Maintenance Center;
5. Establishment of Kumamoto *Koseiren* (Kumamoto Prefectural Federation of Agricultural Cooperatives for Health and Welfare);
6. Establishment of the Kumamoto Organic Agricultural Association;
7. Establishment of the Kumamoto Organic Produce Distribution Center;
8. Establishment of the Reverence for Life and Food, a consumer organization; and
9. Provision of physicians to the rural hospitals and clinics (Oguni City Hospital, Kikusui City Hospital, Kikuchi Yojo-en Clinic, and Kumamoto City Hospital).

Such system coincides with, and even predates, the stated ideals of Primary Health Care as Margaret Chan, the Secretary General of WHO explained, “With an emphasis on local ownership, PHC honored the resilience and ingenuity of the human spirit and made space for solutions created by communities, owned by them, and sustained by them” (Chan,

2008, p. 866). RLM has demonstrated a successful implementation of key elements of comprehensive PHC prior to the establishment of the definition of PHC by WHO in 1978.

Significance of the Study

Documenting, describing, and analyzing The Reverence for Life Movement (RLM) is meaningful and historically significant. As noted above, PHC's weakest strands have been community participation and inter-sectoral engagement (Lawn, et al., 2008). RLM successfully pursued every key element of PHC. A historical case study of RLM not only presents thick and rich description of RLM and the stories of individuals who engaged in the movement, but also provides information that other communities worldwide can use to facilitate sustainable PHC programs.

Purpose

The purpose of this historical case study is to provide such a rich and thick description of the Reverence for Life Movement (RLM) – a community-based PHC movement in Kumamoto, Japan from 1962 to 1980 - through synthesis of historical documents and oral histories collected from the individuals who had participated in the movement.

Theoretical Context

Stemming from a postmodern orientation, the study is theoretically informed by several related literatures that form a compelling interdisciplinary intersection: studies of PHC, the history of health care of Japan, and studies of social activism and leadership. The study has drawn from inquiries in these literatures. Through the historical case study, the researcher aimed to describe the phenomenon of interest beyond an objective truth and

reaching to the perspectives of the people who lived and experienced the movement. The researcher collected and recorded evidence from historical documents, records, archives, oral histories, personal narrative accounts, eyewitness accounts, audiovisual files, and photos, in order to understand the past and impose meaning upon the past. The study aimed to describe a case of a community-based social movement that has promoted health and well-being of the population and the communities in Kumamoto, Japan: therefore, the study did not aim to draw any generalizable findings or conclusions.

Background - the Researcher's Connection with the Phenomenon of Interest

It is important to acknowledge the researcher's connection with the phenomenon of interest. During the course of The Reverence for Life Movement (RLM), the researcher was privileged to witness the life and work of one of the visionary leaders of the movement, Yoshitaka Takekuma, M.D., Ph.D., as one of his children. From a child's perspective, having an accurate comprehension of the whole picture of RLM was rather difficult. Growing up inside of the phenomenon of interest not only hindered the researcher from obtaining objective reference points for evaluating the movement, it also impeded understanding of traditional health care in Japan. However, as a child of an activist leader, the researcher was privileged to participate and witness many of the historical events related to the movement.

As a child of an activist leader, the researcher had developed personal connections with many of the community stakeholders and other individuals who had contributed to RLM. It was a part of the daily life of the researcher to witness, observe, and participate in the phenomenon of interest since 1970 to 1986, when the researcher spent her childhood in Kumamoto, Japan. It took almost 20 years for this researcher to recognize the role of RLM

and of the social activism in the community. In 2006, during a course on the PHC, the researcher had an opportunity to share RLM with fellow classmates and Dr. Beverly J. McElmurry, a nurse scholar who is specialized in PHC research and implementation of the PHC programs in urban communities in Chicago (McElmurry, Tyska, & Parker, 1999). Despite the reluctance of the researcher, Dr. McElmurry strongly recommended the researcher to consider describing RLM in scholarly manner by using the PHC framework. Dr. McElmurry's passion for PHC and her recommendation did encourage the researcher to revisit RLM as a nurse scholar. As the daughter of a leader, the researcher was privileged to access to public documents and reminiscences from the community stakeholders and the private archives of individuals who had engaged in the movement.

Parameters

The Reverence for Life Movement (RLM) is a sustained community-based social movement in Kumamoto, Japan initiated in 1962. Over the past 40 years, the movement has continued through numerous societal changes and transitions. Of course, capturing a social movement with over 40 years of history requires time and a wealth of data. In this study, due to time limitation, the researcher has given special emphasis on the period from 1962 to 1980, which includes historical events that influenced the making of the prefectural level political decisions regarding healthcare provision in Kumamoto, Japan.

Design of the Study and Research Questions

Preliminary research questions were formulated to guide the investigation. They encompassed several aspects of the phenomenon of interest:

1. Development of the Reverence for Life Movement (RLM);

2. Roles of the participants of RLM in promoting health and well-being of the Population in Kumamoto, Japan; and

3. Meanings and outcomes of RLM.

The four questions below were designed to encompass key elements required for historical analysis and interpretation: who, what, when, where, how, and why.

1. What was the role of the Kumamoto Society of Rural Medicine (KSRM)?
 - a. How did KSRM emerge?
 - b. Who were the members and what were their roles in RLM?
 - c. What were the objectives of KSRM?
 - d. What did KSRM do?
 - e. Why did the group conduct an epidemiological study?
 - f. Why did KSRM move forward into social movement rather than staying as a research group?
 - g. How did KSRM expand their activities in relation to the establishment of the Association for Creating New Health Care in Kumamoto (ACNHCK), and why?
2. What was the role of the Association for Creating New Health Care in Kumamoto (ACNHCK)?
 - a. How did ACNHCK emerge?
 - b. Who did become members and what were their roles in RLM?
 - c. What were the objectives of ACNHCK?
 - d. What did ACNHCK do?

- e. How was ACNHCK managed and who contributed leadership?
 - f. How did the new conceptual framework of health care that connects medicine/health care, food/eating, and farming/agriculture emerge through the movement? What did they do with the new conceptual framework? And why?
 - g. How did ACNHCK deal with opposition and obstacles?
 - h. How did ACNHCK deal with political negotiations? And why?
 - i. What organizations collaborated with ACNHCK?
 - j. How did ACNHCK contribute in improving health of the population in Kumamoto?
 - k. What were the outcomes of ACNHCK?
 - l. How did ACNHCK come to a closure in 1980? And why?
 - m. What happened to RLM after the closure of the Association for Creating New Health Care in Kumamoto?
3. What were the roles of the participants of RLM?
- a. Who were the key contributors to RLM to achieve its goals? And what did they do?
 - b. What were the roles of women in RLM?
 - c. What were the roles of farmers in RLM?
 - d. What were the roles of academicians in RLM?
 - e. What were the roles of nurses in RLM?
 - f. What were the roles of physicians in RLM?

- g. What were the role of journalists and media in RLM?
 - h. What were the roles of politicians in RLM?
4. What were the meanings and outcomes of RLM in improving health and well-being of the population in Kumamoto, Japan?
- a. What were the outcomes of RLM from 1962 to 1980?
 - b. What were the short comings of RLM from 1962 to 1980?
 - c. How have these early years of the movement influenced Kumamoto society in 2010?
 - d. How have the early years of the movement influenced Japanese national policies in 2010?

Historical Sources

Over the 40-year of history of the RLM, it accumulated many primary and secondary sources in forms that included oral history interview recordings, magazine articles, newsletters, newspaper articles, audio tapes, reports, original copies of the documents produced during the process of RLM, published books, broadcast media features, private media files, published scholarly articles and abstract, and official statistical data.

The primary repositories of the documents are in Kumamoto, Japan at the Kikuchi Yojoen Clinic & Health Center, the Yojo Densho Kan Community Center, and the private residence of Dr. Yoshitaka Takekuma. Other sources included archives in Kumamoto in the private collections of the community members. With consent of owners of the documents, when needed, copies and/or digital images of the primary and secondary documents were obtained. The majority of the oral sources were collected during June 2010 to December 2010.

Additions to the oral histories that were collected in 2010, and previously archived interviews and audio-visual tapes by public broadcast medias were reviewed as a part of the data.

Oral History

Oral history, in comparison with other forms of primary source materials, is a unique source in that it is solely created for historical purposes. Oral history can preserve life stories that would otherwise be lost. By collecting testimony from many on a single topic, the oral historian can fill the gaps left by formal documents. Oral history can convey personality, explain motivations, and reveal personal perceptions and perspectives. Oral history is based on persons' recall or memories, which is make it vibrant and descriptive, however, it needs to be interpreted in context. Oral history does offer rich, intimate, personal testimonies and stories about historical events and the course of life experiences. Researchers can integrate oral histories with other source to describe history from diverse perspectives.

In the study, by oral history interviews, the researcher obtained stories about the experiences and perspectives of the people who have participated in RLM through their unique roles. Oral history interviews were planned with other individuals who participated in the RLM to obtain stories and perspectives their roles and engagement in the movement. The oral history interviews were guided by a list of core questions and several individually tailored questions that aimed to discover the individuals' roles and engagement in RLM (Appendix A).

With consent of the interviewee, each interview was digitally audio-recorded. The oral history interviews were conducted mainly in Kumamoto, Japan.

Data Collection – Technical Matters

During the oral history interview, I used a digital audio recording device (Zoom H2 handy recorder). Audio files were saved in two independent hard drives: one as a primary and another one as a backup. With permissions, other documents such as reports, photos, newspapers, journal and magazine articles, book sections, and original manuscripts and letters were scanned, digitized, and saved as digital files, and /or photocopied for review purposes.

Data Synthesis

The data obtained through the methods described above were synthesized based on thematic categories:

1. Overview of the development of RLM from 1962 to 1980;
 - a. Development and activities of the Kumamoto Society of Rural Medicine (KSRM) from 1962 to 1970.
 - b. Development and activities of the Association for Creating New Health Care in Kumamoto (ACNHCK) from 1970 to 1980.
2. Roles of the participants of RLM in promoting health and well-being of the population in Kumamoto, Japan; and
3. Meanings and outcomes of RLM.

With synthesis of the data, the researcher provide description include the context (when and where), the actors (who had engaged in the stage of the movement), what happened, how did it happen, and why. Data from oral histories relevant to the thematic

categories are also introduced in relation to the roles of the individuals who had engaged in RLM.

Language Competency

The majority of the documents I intended to examine and archive were in Japanese. The oral history interviews were conducted in Standard Japanese or in Kumamoto dialect, a local language spoken in Kumamoto, Japan. Japanese is my primary standard language, and Kumamoto dialect is one of my native languages. Language competency and translation accuracy of the data were examined and verified by multiple individuals who have knowledge of the topic and are professionally credible in English, Japanese and Kumamoto dialect.

Ethical Consideration

For this study, the University of Illinois at Chicago, Office for the Protection of Research Subjects reviewed my application for “Determination of Whether an Activity Represents Human Subjects Research”: protocol number, 2010-0499. That office determined that this research did not meet the definition of human subject research as defined by 45 CFR 46.102(f). Specifically, the study was considered an oral history project in which there was no intent to produce generalizable knowledge or conclusions. However, a signed consent and copy right release form for oral and other historical data was obtained from each interviewee and/or donor (Appendix B). The documents were prepared in both English and Japanese.

The Overview

The remaining seven chapters of this study discuss the development and roles of the Reverence for Life Movement (RLM) in promoting health and well-being of the population

in Kumamoto, Japan. In Chapter 2, I provide information to contextualize the study: 1) a sketch of how health care in Japan has developed, and 2) a short history of agricultural medicine and rural health. The importance of such contextualization is well described by the historian Berkhofer:

Human activities and institutions are to be understood in relation to the larger network of behavior or social organization and structure of which they are said to be part. Social, political, religious, economic, family, philanthropic, and other institutional practices make sense only when placed in their proper social and cultural contexts (Berkhofer, 1995. p. 31).

Development of agricultural medicine and rural health in Japan is information that is critical to understand the phenomenon of interest. In the beginning of RLM, a group of visionary young physicians were inspired and mentored by Dr. Toshikazu Wakatsuki, who was a pioneer physician of agricultural medicine and rural health in the post-World War II, Nagano, Japan. Thus, learning about Wakatsuki's philosophical position and strategies for rural health practice in Nagano, Japan, is critical to understanding the initiation of RLM.

The next five of the chapters following chapter 2 provide thick and rich description of RLM from 1962 to 1980. The chapter 3 and 4 describe the development and activities of the Kumamoto Society of Rural Medicine (KSRM) and the Association for Creating New Health Care in Kumamoto (ACNHCK). These two groups became the major vehicles to carry out the Movement agendas

The chapters 5, 6, and 7 focus on the actors in the movement. The chapter 5 concentrates on women in relation to RLM. One of the driving forces was women's issues such as women's health status in the rural area. There were women leaders who took significant roles in building the movement to critical mass. And women used the movement

to mobilize an initiative for a new consumers' movement for safer food, clean and safe water, and better eating.

The chapter 6 features farmers and their role in RLM. Farmers' health issues and provision of health care in rural communities were a significant part of the Movement's agenda. Rural farmers joined the movement, and later on, some member farmers established an initiative to facilitate organic farming to promote sustainable agriculture, better health of farmers, environmental health, and provision of safe produce to urban communities in Kumamoto. Farmers were keys to implementing the three components of healthcare/medicine, food/good eating, and agriculture/farming bringing that conceptual connection to practical fruition.

The chapter 7, describes other contributors to RLM. The movement was remarkably successful in mobilizing a diversity of participants in the communities and forging an interdisciplinary approach. In this chapter, I describe what I learned of the roles of nurses, physicians, journalists, academicians, and politicians. Under the stories of politicians, I discuss politics in more details. During the course of the movement, its leaders successfully communicated political agendas and issues that required political decision making at the prefectural level.

The chapter 8 balances the achievements, outcomes, and shortcomings of the movement and analyzes RLM from the perspectives of a PHC-based health care system. In particular, it describes what RLM accomplished during the period of 1962 to 1980. In 1980, the Association for Creating New Health Care in Kumamoto (ACNHCK) closed, and the movement branched out to develop in several different areas as such as healthcare, consumer

empowerment, environmental health, and promotion of organic farming. This chapter puts the movement in perspective, describing its accomplishment by 1980, and challenges it faces in the years to come.

In the middle of the chapter, the researcher updates the trends on the movement as of 2010. In that light, the researcher reflects on that RLM has meant in improving the health of population and the communities of Kumamoto. Finally, I analyze RLM from the perspectives of a community-based social movement and contemplate its meaning for comprehensive Primary Health Care around the globe.

Chapter 2

Contextual Information for the Phenomenon of Interest

Every movement evolves within a context. So we begin by surveying, first, how modern Japan developed its health care system and, second, how agricultural and rural health were shaped by Toshikazu Wakatsuki, M.D., who inspired and mentored the leaders of the Reverence for Life Movement (RLM). This dual context will give depth to the stories that RLM stakeholders tell.

Japan began rapid industrialization in the late 1860s. After the Meiji Restoration in 1868, a new imperial government ruled - a dynasty that would include the Meiji, Taisho, Showa, and Heisei periods. Under this new regime, Japan accelerated both industrialization and the modernization of its social system. That accelerated modernization was the background for the confluence of social and healthcare issues that over the 50 years post-World War II shaped the development of Primary Health Care (PHC) in rural Japan. By the late Showa period, PHC in Japan would come to include annual health screening and health promotion programs.

Historically, Japanese in rural farming communities had the greatest needs for health care. Until the 1960s, these communities suffered from poverty, unsanitary environments, and poor access to health care. Farmers were severely impacted by anemia, chronic hypothermia, cold injuries, arthritis, tendonitis, parasites, tuberculosis, malnutrition, pain, injuries, high blood pressure, and pesticide poisoning. Such needs inspired several pioneers in the field of agricultural medicine and rural health in Japan, whose life-long commitments

and collaborative efforts with these communities led them to become exemplars for nationwide preventive care policies and programs.

Historical Overview of Development of Health Care System in Japan

In recent decades, Japan has been known as a country where people are born with the world's highest life expectancy (82 years old) (World Health Organization, 2006). Driving that expectancy have been highly regulated health insurance systems and the privatized health care delivery systems. Thus Japanese people have equitable access to health care, while maintaining freedom of choice in selecting health care providers. Older Japanese citizens obtain long-term care services based on the degree of their care needs. As of 2000, these services are funded by a long-term care insurance system that is mandatory for every citizen aged 40 years and older. Despite the rapid increase in cost of health care, Japan's public and privatized health systems still offer its citizens equitable access to health care services, preventive care, and health promotion.

Health care developed at varying rates during Japan's modern political periods:

1. The Meiji, Taisho, and early Showa periods, (1868 -1945);
2. The middle Showa period, post-WW II (1946 - 1960), which includes seven years of occupation under the Allied Powers; and
3. The late Showa and early Heisei periods (1961 - 2000).

For one thing, governmental systems changed both before and after WW II; for another, industrialization and economic development progressed; and finally, Japanese people's health needs changed.

Meiji, Taisho, and Early Showa Periods (1868 - 1945)

After Japan's 250 years of isolation, the leaders of the Meiji government realized that dramatic changes had taken place. Not only had the Industrial Revolution occurred, but the Western countries were also in the midst of aggressive colonization. The Japanese government coined the slogans *Fukoku Kyohei* (Wealthy Country, Strong Military) and *Shokusan Kougyo* (Facilitation of Industry and Development of Engineering) (Drennan, 1998). The slogans illustrate the main focus of the country's policies, which aimed at national advancement. Health care and social welfare systems were gradually established in the context of Japan's economic/industrial development and expansion of military power as a response to western colonialism in Asia.

In the Meiji period, health care was generally considered a personal responsibility. In the case of deteriorated health conditions or need for continuous care, assistance was expected to be provided by the family members, friends, and neighbors. In 1874, the Public Assistance Law (*Juk kyu Kisoku*) was established, the first law to provide assistance for the poor, sick, minor children, and the frail elderly. While this law is considered an equivalent to the Poor Law in England, this law did not ensure the right of citizens to receive services, but was more system that provided identified citizens with a very limited amount of monetary funds as gifts (Social Insurance Agency of Japan, 2009). There was no concept in the law that health care was to be funded publicly. In 1873, the Japanese government established the Treatment for the Poor in Epidemics Act (*Akubyō ryūko no setsu hinkon no mono shōbun gaisoku*), the first law to state that under special circumstances such as an epidemic, the government provides physicians and treatment for the poor.

As the Japanese government aggressively promoted industries, they demanded more and more workers. The majority of workers were drawn from poor farming communities to the cities where many of the factories were located. These factory workers were exposed to long working hours and harsh working conditions without adequate safety measures (Drennan, 1998). The government responded to such inadequacies with the Mining Regulations (*Kougyo Jourei*) of 1890, which included Miner Protection Rules (*Kofu Hogo Kitei*). However, it limited its meager safety and health provisions to miners (Drennan, 1998). The Factory Act (*Koujo Ho*) of 1911 also created a workers' compensation system, which was similar to the Miner Protection Rules. The Miner Protection Rules and the Factory Act were significant laws that addressed worker's compensation. The system was greatly compromised because it required that workers prove that an injury or a health condition was not caused by the worker's own fault. This rule put the burden on the injured workers. In this period, compensation was perceived as voluntary assistance, which illustrated the Confucian-based paternalism that prevailed in Japanese industrial relations.

In the late Meiji period, in 1905, a mutual aid society of employees of the Yahata Steel Mill started to offer health care services to its employees. At that time, health care services for the general public were limited, and subsidizing health costs was unknown. Japanese institutions did not yet serve public health, and for a long time health care services lagged behind industrial development. However, in 1922, during the Taisho period, the Health Insurance Law (*Ken Kou Hoken Hou*) was passed, and implemented in 1927 (Drennan, 1998). The aim of the Health Insurance Law was to provide health care insurance coverage to workers and miners. Despite its shortcomings in services covered,

implementation of the Health Insurance Law was a significant milestone in improving access to health care in Japan.

Since the Meiji period, Japan's health care delivery has relied heavily on physicians' private practices. Except for nationally governed hospitals such as university and military hospitals and hospitals owned by foundations, physicians themselves administered most hospitals and clinics in the country. By 1898, there were 136 government hospitals and 518 private ones (Anesaki, 2008, pp. 55-72). In 1937, 95% of outpatient clinics were operated and owned by physicians (Committee of Health Research Foundation of Japan, 1988a).

The provision of health services was based on fee for service, and patients were required to pay the entire cost—a heavy burden on citizens and one that limited access to health care. Even after Japan established health insurance, its limited coverage did not increase revenue for physicians, and many of them encountered financial challenges in running private practices. For financial reasons, physicians sought a more secure practice environment in urban settings, creating a severe shortage of physicians in rural communities. For example, in 1935, one third of the 12,000 townships in Japan were without a physician. Another one third had only one private practice physician (Committee of Health Research Foundation, 1988). Thus, in Japan's rural areas, health declined.

Rural communities had been suffering for decades from poverty, and epidemics. From the beginning of the twentieth century, epidemics of tuberculosis consistently broke out in rural farming communities. In 1913, Ishihara conducted an epidemiological survey on female factory workers and tuberculosis, and he hypothesized that those female textile workers, who became infected with tuberculosis under horrendous living and working

conditions, spread tuberculosis into rural communities. Suffering with TB, they could not work; so they were laid off from the factories and returned to their villages. In the survey, Ishihara estimated that tuberculosis killed 5,000 female workers annually (Anesaki, 2008, pp. 55-72).

By 1930, the Japanese government's policy "Wealthy Country, Strong Military" had stretched rural communities thin enough to make the government aware of their deterioration; the countryside was home to 60% of Japan's population (Takekuma, 2000). The rural communities were the source of soldiers and factory workers. However, as the government aggressively promoted industrialization and expansion of its military power to establish an empire in Asia, the rural communities lost their resources to provide for the country. In 1932, the annual mortality rate in rural Japan was 19.40 per 1,000 versus 13.78 per 1,000 in Japanese cities, which clearly showed that Japan had health disparities (Yoshihara & Wada, 1999).

The deterioration of rural communities made the government aware of the need to improve rural health. Thus, in 1933, the government appointed a taskforce to develop a health insurance system for the general population. It took five years to establish the National Health Insurance Act (*Kokumin Kenkou Hoken Hou*), a voluntary municipality-based health insurance system. Significantly, the insurance not only covered a majority of the population, but also allowed the municipalities to reimburse for midwifery services, health promotion programs, cremation, and funeral costs (Committee of Health Research Foundation, 1988b). From a health care system perspective, this new law improved access to health care dramatically.

The demands for military power further reinforced the need for a mandatory national health insurance program. As Japan took a path of military expansion in Asia and further involvement in World War II, the military was concerned about the poor health of soldiers and demanded that a Ministry of Health and Welfare be established to produce “healthy and strong soldiers” (Anesaki, 2008, pp. 55-72). In 1941, the government intended to set up a mandatory municipality-based health insurance system nationwide within three years. By 1943, 95% of the municipalities in Japan had established a health insurance program. However, this program was not able to reach 100% of residents. After 1944, when the war intensified and some cities were destroyed by bombings, health care delivery became dysfunctional due to the shortage of health care professionals and medical supplies (Committee of Health Research Foundation, 1988b). While not accomplishing its initial goals, the National Health Insurance program did set a blueprint for the universal national health insurance system in postwar Japan.

Middle Showa Period / Post World War II

The end of WW II introduced a new “world view” in Japan’s health care policy, one that was built into the new constitution, which came into force in 1947. Article 25 states, “All people shall have the right to maintain the minimum standards of wholesome and cultural living. In all spheres of life the state shall use its endeavors for the promotion and extension of social welfare and social security and public health” (The Constitution of Japan, 1946). For the first time, the new constitution mandated the state’s responsibility in promoting social security, welfare, and public health and it guaranteed the right to life.

The main focus of this period in health care was to recover from the war, prevent extreme poverty, control infectious diseases, and reestablish infrastructures. When the war was over, Japanese economic and social systems were in a state of exhaustion. Food, housing, and energy shortages hit the country severely, as did high unemployment, which was exacerbated by the repatriation of soldiers and over six million civilians who had settled in the former colonial territories during the previous eighty years. Epidemics of acute and non-acute infectious diseases and parasites were major health problems, and considerable efforts were made to control them.

Reestablishment of the health care delivery system progressed gradually. During the occupation by the Allied Powers, in 1948, the Medical Service Act, the Medical Practitioners Act, the Dental Practitioners Act, the Nurses Act, and the Dental Hygienists Act were passed (Anesaki, 2008, pp.59-60). These Acts provided definitions of each health care profession and explained its scope of services, roles, and legal obligations. The legislation aimed at improving standards of health services and effectiveness of health professions (Anesaki, 2008, pp.55-72). During this period, Virginia M. Ohlson, PhD, RN, FAAN, a founder of Global Health Leadership Office (formally the office of International Studies) at University of Illinois at Chicago, College of Nursing, served as a chief of the Public Health and Welfare Section of General MacArthur's headquarters, the Supreme Command of Allied Powers (University of Illinois at Chicago, 2001). As a public health nursing consultant, Ohlson contributed to the establishment of the law that regulated the practice and education of the

public health nurses (Fondiller, 1999). The national economy stabilized in the early 1950s with the economic benefits of the Korean War, and occupation by the Allied Powers ended in 1952.

By 1955, the reestablishment of national health insurance became a major political agenda and the National Health Insurance Act was established, being implemented in 1958 (Drennan, 1998). In 1961, every municipality in Japan introduced a mandatory municipal-based health insurance program to the residents. The municipal-based health insurance program covered residents such as farmers, self-employed individuals, retired seniors and their family members, who were not covered under an insurance program offered through employers. The insurance premium for the health insurance was determined based on the income level so that health insurance became available and affordable for anybody. Each municipality managed the health insurance program based on the collected premiums contributed by the participants. Japan finally achieved a ‘universal health insurance system’ to ensure the citizens equitable access to health care.

Late Showa and Early Heisei Periods (1961 - 2000)

From 1961 to 2000, Japan achieved the highest life expectancy in the world for a number of reasons. Japan enjoyed accelerated economic development until 1974. Also, the government further contributed to improvements in the health care system and established generous coverage under its universal health insurance. Japan improved maternal and child health, school health, occupational health, and health care of the elderly. As the country developed and lifestyles became more westernized, health issues among the population changed. Chronic diseases replaced infectious diseases as the main causes of deaths.

In 1973, the government started free health care services to adults over 70 years old. However, without control, the free health care was overused, and health expenditures increased dramatically. The fee-for-service reimbursement system also contributed to the rise in health care expenditures (Committee of Health Research Foundation, 1988b). In 1977, the annual cost of health care per one older adult was 20,000 Japanese yen, four times higher than the young-adult counterpart (Yoshihara & Wada, 1999). With the decline of economic development and an aging population, rapid increases in health care expenditures became a serious political issue and required that the government increase out-of-pocket payments.

The Health Service System for the Elderly Act, passed in 1982, modified the payment system for health care services for the elderly by implementing a cost-sharing arrangement with other insurers. The law also established a mechanism to provide preventive measures such as annual health checkups and health promotion programs for adults over 40 years old. Until this law passed, health insurance only paid for health care services for illnesses and injuries. Integrating preventive care into the health care system promoted disease prevention and disease management and contributed greatly toward containing health care costs.

While Japan achieved the highest life expectancy in the world, the country also faced a rapidly aging population: the birth rate declined and older adults were living much longer. In response, in 1997 Japan passed the Long-Term Care Insurance Act for the Elderly. Like the National Health Insurance Act, this act required municipalities to be insurers, and persons 40 years and older had to contribute to the program based on their income. Services were granted to persons over 65 who needed long-term care (Anesaki, 2008, pp. 55-72).

The late Showa and early Heisei periods clearly illustrated recovery from World War II, rapid economic and technological development, and maturation of the health care system; but these periods also displayed the drawbacks of that rapid prosperity. Societal and economical aspects of aging presented a challenge to the country. As aging continues, the Japanese health care system is under periodic evaluation and modification.

The preceding overview contextualizes our exploration of Japanese rural health. We saw that Japanese health care legislation sprung largely from the need for healthy soldiers and factory workers. Before about 1960, health in the countryside attracted study only when it spread urban epidemics. In rural Japan the scene was set for a Primary Health Care movement. Dr. Toshikazu Wakatsuki, a leader and pioneer physician in rural health practice in Japan, created a school of thought and defined agricultural medicine and rural health in Japan. The work of Dr. Wakatsuki, as a result, inspired the leaders of the Reverence for Life Movement (RLM).

Toshikazu Wakatsuki, M.D and Development of Agricultural Medicine and Rural Health

Toshikazu Wakatsuki, M.D., established and defined agricultural medicine and rural health in Japan. He established three fundamental principles of rural health practice: 1) Democratization of health care; 2) With people; and 3) Practice in the community (Saku Central Hospital Archive, 2010). Wakatsuki oriented his practice as a movement to democratize healthcare. He believed in equity and universal access to quality healthcare regardless of wealth and place of residence. Wakatsuki postulated that to democratize healthcare, the community itself must be democratized, and the main actors of the process

should be the residents themselves. He facilitated community participation in healthcare; he initiated use of community health workers to create a personable and accessible channel where villagers could consult health workers (also their neighbors) about health problems.

One of the goals of democratization of healthcare was to educate people to take responsibility for their own lives and health. In rural areas, extreme poverty had forced people to accept and endure illnesses. Wakatsuki explained:

For farmers, to see a doctor was equivalent to luxury such as throwing a feast with a geisha. Why would a poverty-stricken farmer do such thing? The farmers do not come to see doctors when they need a doctor; for the majority of them when they see a doctor, it was their time to die. Health was something that you sacrifice to survive as a peasant. These deeply rooted mentalities, social norms, and environments forced farmers to endure illnesses that were the true enemy. (Wakatsuki, 1994, p.127)

Wakatsuki devoted tremendous efforts to fighting the deep-rooted mentalities among farmers, as he strongly believed that if the farmers could change their way of thinking, ownership of health would be in their hands. Therefore, one of his earliest objectives was to creating moments when rural people would reorient their attitudes to their own life and health. He considered this reorientation essential to democratizing healthcare (Saku Central Hospital Archive, 2010).

Wakatsuki had realized that his initial attitude to rural medicine was wrong. In one of his works, Wakatsuki wrote about his feelings when he arrived at Saku on March 6, 1945:

There were B29s flying over the sky of Tokyo. Here I came, ran away from Tokyo, with my wife and my little son. I vividly remember when I stepped on to the platform

of the Komoro station, the cold mountain air struck my nose... I thought, now, I can survive for a while; anyway, in the midst of the mountains, I will try my best and work hard *for* [emphasis added] the health care of the farmers. (Wakatsuki, 1971, p.2)

But by the early 1950s, his idea of working hard “for the farmers” transformed to working hard “with the farmers.” After he had worked in the farming villages in Nagano, Japan, he gained this strong conviction: a rural health movement was only possible when physicians work with the people, but not for them (Saku Central Hospital Archive, 2010).

Wakatsuki visited rural villages often, which at that time was very untraditional for a physician; however, he believed that by seeing rural families where they live, one could determine true problems and potential solutions. He became aware of villagers’ illnesses, health conditions, characteristics, and patterns throughout the seasonal and agricultural calendars. Once he became familiar with culture, diet, living conditions, farming practices, geographical characteristics, people’s belief systems, family and community structures, and politics in the areas, he was convinced that he had to change his approach to improve the health of the villagers. He carefully observed the series of illnesses and collected extensive data. Wakatsuki not only took an epidemiological approach to compile data on rural illnesses and disease characteristics, but also applied qualitative research approaches, which led him to an in-depth understanding of the villagers’ life and health problems. He visited their homes, ate with them, talked with families, observed how they worked and lived in the harsh environment of mountainous regions. For example, he hypothesized that the major cause of *Hie* (chronic hypothermia, coldness, and cold injuries), a common health problem among villagers, and especially women, in the region, was caused by the poorly insulated, poorly

heated housing under harsh mountainous environments, as well as the women's role, status, and chores in the household (Wakatsuki, 1994, pp. 219 - 220; Nagi, 1994, p. 99).

Wakatsuki's detailed, in-depth observation and evidence-based scientific approach to investigating health problems of the farmers further transformed his health care practice into an ecological approach that encompassed outreach, health screening, and education. Soon, Wakatsuki started to think that the responsibility of a rural doctor was to combat "latent diseases," which he conceptualized as "diseases that require treatment which is not sought due to social reasons, and /or diseases of which the person is not aware" (Wakatsuki, 1994, p. 128).

Wakatsuki did not hesitate to deliver health care to the villagers despite severe criticism by other physicians who followed the social norm: "a physician is supposed to treat patients who come to him" (Wakatsuki, 1994, p. 127). Wakatsuki was convinced that to investigate more about "latent diseases," he must go out into the community and perform physical assessments of the residents where they lived. By December 1945, an outreach healthcare program was started by volunteer doctors, nurses, and clinic clerks on Sundays and holidays. The unique feature was that the program also delivered entertainment for the villagers: the group of health care professionals performed an educational drama in relation to health problems such as stomachache (parasites, and appendicitis) and tuberculosis (Nagi, 1994, p.101). Wakatsuki wrote the scripts. He was influenced by Kenji Miyazawa, a poet, author of children's literature, and social activist in the early *Showa* period. Miyazawa encouraged artists to perform drama in villages in their own neighborhoods (Nagi, 1994, p.101). Integration of health care and performing arts was a great success and well accepted

by the villagers who craved entertainment in their daily lives. The volunteer health care activities were very well accepted among the communities and contributed to the development of the total village health management program in Yachiho village in 1959, and further to the Nagano prefecture-wide health screening and management program in 1973 (Nagi, 1994, p. 104; Wakatsuki, 1994, p. 205).

Yachiho Village Total Health Management Program

The Yachiho village total health management program was a good example of creativity and collaboration with a local municipality. In 1958, Japan implemented the National Health Insurance Program, a municipality-based health insurance program. All residents who were not covered under employer-based insurance programs were mandated to join the National Health Insurance Program. Thus the nation established a mechanism to cover the entire population under health insurance; however, many municipalities suffered from deficits due to uncollected premiums and co-payments. For a small village like Yachiho village, where most of the residents were low-income farmers with very limited cash flow, managing a sustainable health insurance program was a challenge. For financial reasons, the residents stopped seeking health care, which contributed to increased “latent diseases” (Wakatsuki, 1994, p.207). Kokichi Ide, the mayor of Yachiho village in 1959, was the first mayor in the Saku region to show an interest in Wakatsuki’s approach to health care. Ide agreed to implement the total village health management program, Wakatsuki’s new system to protect the health of the farmers (Wakatsuki, 1994, p. 207). Collaboration with the municipal leadership was a significant step in expanding the health screening and health promotion programs among the farming villages in the region.

With a small budget of 100 yen per resident, the program started with very limited health screening. However, the program approached health issues in creative and comprehensive ways. The program emphasized: 1) Utilization of a health notebook and creation of the health record system; 2) Utilization of community health workers and their development; and 3) Health screening and health promotion of the population (Wakatsuki, 1994, p. 212). It was significant that the program established a health record system for the entire population and distributed health maintenance notebooks for individuals to use for health reference and to track personal health information (Wakatsuki, 1994, p. 210).

From a PHC perspective, training and deploying community health workers, Eisei Shidoi, was critical to creating and sustaining the program. Wakatsuki had learned that strategy from the Dispanser program, a PHC movement in Kiev, USSR, in 1947 (Wakatsuki, 1994, p. 211). The community health workers brought a very positive effect to the Yachiho village. Wakatsuki described this effect as “democratization of the rural village,” which facilitated motivation, engagement, and commitment of the villagers to protect and promote their health (Wakatsuki, 1994, p. 212). These community health workers were recruited from Yachiho village and called “health promotion activists” (Wakatsuki, 1994, p. 212). As villagers themselves, the community health workers had in-depth understanding of the life and culture of the village and the context behind health problems. Physicians and nurses collaborated with them by educating the community health workers, screening villagers for disease, and accepting referrals (Wakatsuki, 1994, p. 212; Saku Central Hospital, 2009). Development of the community health workers helped to create a new concept among the villagers: “Who is going to protect the health of the community? Who is going to make the

community healthy? It is the people of the community themselves.” (Wakatsuki, 1994, p. 212) The community health workers of the Yachiho village went beyond their official duties to learn and self-direct a series of health promotion dramas to educate their own villagers. They hosted annual health fairs to build awareness of health among the villagers. The tradition of the Yachiho community health workers continues today (Saku Central Hospital, 2009).

The total health management program in Yachiho village was a critical stepping stone toward a prefecture-wide health screening program in Nagano. Those annual screening programs, which served 22 neighborhoods in the village during the winter, detected diseases and health problems in early stages, and helped reducing health care costs to the municipality (Nagi, 1994, p.143). For ten years, the Yachiho screening programs’ epidemiological data enabled comparisons with other municipalities’ health data. The comparison showed clearly that the program was cost effective and prevented disease and injuries (Nagi, 1994, p. 130, p.143; Wakatsuki, 1994, p. 212). Nearly 50 years later, Nagano Prefecture’s health data have proven that, despite geographic disadvantages, Nagano became one of the healthiest prefectures in Japan—and on a low budget:

1. The lowest annual health care cost for the elderly (687,128 yen/capita compared to national average of 832,373 yen/capita);
2. The highest life expectancy for males (79.84 years old);
3. The fifth highest life expectancy for females (86.47 years old);
4. The shortest average hospital stays in the nation;
5. The lowest age-adjusted mortality for males;

6. The second lowest age-adjusted mortality for females;
7. The lowest age-adjusted mortality for cancer in males; and
8. The second lowest mortality for females in the nation (Nagano Prefecture, 2009).

A School of Thought: the Japan Society of Rural Medicine (JSRM)

Wakatsuki pursued his passion for rural health to the next level. On August 20, 1947, Wakatsuki and his colleagues hosted the first conference of the Nagano Society of Rural Medicine at the Saku Hospital. The conference participants included not only physicians, but also public health nurses, nurses, officers from national health insurance system, farmers, and members from the Nagano farmers' cooperative. Since WW II had just ended, the conference welcomed two participants from the Allied Powers and one of them made a speech to celebrate success of the conference (Wakatsuki, 1971, p. 108). At the conference, issues related to agricultural medicine and rural health were actively discussed from the farmers' perspectives. Gradually, health professionals in other parts of Japan began cooperating among sectors and disciplines; they copied the problem/need-based and evidence-based approaches toward health issues in other rural communities. In July 1952, the first conference of the Japan Society of Rural Medicine (JSRM) took place in Nagano with 200 participants. At the conference, Wakatsuki made a keynote speech and stated:

The Japan Association of Rural Medicine was established in response to meet the need of health issues of farmers and rural farming villages. In reality, health and hygiene issues of rural communities and populations had been severely ignored. The environment of farming communities presents unique characteristics such as a long-inherited conservative family system, traditional values and culture, and severe

poverty. To properly intervene for health issues in a community with such unique characteristics, strategies ought to be unique. Our association was born because villagers had strongly appealed to us for their better health and improved health care. At the beginning of the conference, I would like to address the uniqueness of our organization. First of all, our study does not exist for the sake of study. Our study is aimed to improve the quality of life of the villagers, improve their productivity, and protect their lives from harm. We are not conducting research for the sake of research; we do not practice medicine for profit. We hold humanism highly and challenge the conservative academic tradition. Secondly, we have run this organization with democracy. We do not accept such thing as an academic sect. We owe no allegiance to any chief. Our organization was established based on the appeals from farmers and health professionals who work with farmers; therefore, we all work together hand in hand. Doctors, nurses, midwives, hospital administrators, health promotion professionals, and everyone who works for the health and welfare of rural communities in Japan—we work together and raise the quality of this academy. We embrace interdisciplinary studies and our approaches are pragmatic and action-oriented (Wakatsuki, 1971, pp. 110-111).

The keynote speech characterized the nature of JARM and its tradition. The establishment of JSRM promoted the influence of this new approach to rural medicine. The leaders of the RLM movement were a few of the health professionals who became connected with JARM and were mentored by Wakatsuki. They adopted JSRM's principles.

Discussion

We have seen the history of Japanese health systems from societal and political perspectives and the development of agricultural health and rural medicine. It is clear that Japan's concept of health, including rural health, changed over the years, in ways that reflected political agendas. From the early Meiji period to the early Showa period, the health of the population and health policies closely followed the country's industrial development and the expansion of colonialism in Asia. People's health was considered not for the people themselves, but for the country's industrial development and military expansion. After over 260 years of an established caste system under the feudalistic Tokugawa shogunate, there were very limited opportunities in society to nurture a concept of "rights." Under the patriarchal family system, a human life was often considered a commodity; often the rights of individuals were sacrificed for the family. In this social context, health was not yet a priority of individuals, but health was used for the sake of the family, the society, and the country. However, despite these politico-social reasons for the development of health care systems, it is significant to acknowledge that Japan established a system to offer health insurance to the entire population before the end of World War II. This health insurance program became the foundation for postwar Japan's National Health Insurance, a municipality-based health insurance program for all.

The loss of WW II brought the Japanese people a new view of health. The new constitution defined health as "a basic human right," and it also described the role of governments, including municipal governments, in protecting and promoting the health of the population. As we have seen, there were financial problems. Under the new National

Health Insurance Act, the local municipality's responsibility was to manage a health insurance program for the local population, which often challenged financially unstable small municipalities. For example, Yachiho village in Nagano, one of the poorest farming villages in Japan, found maintaining a health insurance program was a burden. However, the law mandated the maintenance of the insurance program despite the village's financial status. It was into this gap that Wakatsuki and his team stepped.

Health care policy and a mandated system alone did not make health care functional or delivery feasible. Creativity, passion, patience, efforts, diplomacy, and right timing were required for Yachiho village to launch its "total village health management program." That successful program developed when the health needs of the population met the nation's new health policy and health care system, acquired support from stakeholders, recruited community participation, and drew strong visionary and pragmatic leadership from Wakatsuki and the health care team from the Saku General Hospital. Yachiho people grasped the opportunity to try a new idea that produced new ways to improve community health, based on the efforts of the villagers themselves.

The case of Yachiho village illustrates four critical philosophical components of Primary Health Care and Wakatsuki's approach to rural health: social justice, equity, solidarity, and participation. Wakatsuki's approach to rural medicine was rooted in the principle that society must meet the health need of the population, a principle that rooted all efforts in social justice. When Wakatsuki implemented an outreach program to the villages in Saku region, health services were offered to the villagers regardless of wealth, which equalized opportunities and further promoted equality of health outcome. The community

was able to maximize collective rewards by developing mutually respected health services systems: access to healthcare, a health management program, and development of community health workers from the community itself. The community was united: the community leaders, the villagers, and health care professionals came together in solidarity to work toward achieving better health. In addition, standards were set for the prefecture-wide health promotion programs. The Yachiho program illustrated participation at every level: voluntary *participation* of health care professionals in the initial outreach programs for rural villages, participation of villagers in outreach programs and health screening programs—from passive participation initially to active participation later on. Participation of villagers especially encouraged a sense of engagement and responsibility for their health.

It is important to note that the Yachiho program and its principles called for consistently intersectoral and interdisciplinary efforts. Intersectoral and interdisciplinary approaches are also key components of Primary Health Care. To reach out to villagers, Wakatsuki recruited available volunteer health care professionals and non-healthcare staff. To implement the Yachiho village total health management program, Wakatsuki worked closely with numerous sectors such as local political leaders, agricultural cooperatives, and local municipalities to put the program in place. Of course, Wakatsuki faced disagreements, differences in political affiliations, lack of resources, and local power struggles among community stakeholders. As a result, he hammered out compromises that reshaped his “ideal practice.” (Wakatsuki, 2000, pp.177-181). Yachiho was in Saku region, and in Saku, Nagano, Japan, Wakatsuki’s and his team’s principle was the imperative of “meeting the health need of the population.” That principles matches WHO’s slogan “Health for All.”

Even though no WHO existed to define PHC when Wakatsuki started his practice in 1945 in Saku, his practice shared philosophical and strategic principles of PHC. The revolutionary aspect of this rural health program was that, in villages like Yochiho, health was not purchased as a market commodity. But it was a state that all villagers would achieve, with help from local health professionals, working together within their own community.

Chapter 3

Reverence for Life Movement



Figure 1. Map of Japan and Location of Kumamoto (Wikipedia, 2008)
(Retrieved from:
http://en.wikipedia.org/wiki/File:Map_of_Japan_with_highlight_on_43_Kumamoto_prefecture.svg)

Kumamoto

Kumamoto is located in the center of Kyushu Island, one of the four major islands of Japan, which located in south west region of the country and currently has a population of 1,842,140 (Kumamoto Prefecture, 2011). In land area, Kumamoto is ranked 16th largest prefecture among the 47 prefectures of Japan, and it is about the half size of Northern Ireland, UK (Kumamoto Prefecture, 2011). The land area includes small islands and the shores of the Ariake Sea in the southwest. In the northern part, there is a wide range of highland area that includes Mt. Aso, the world's largest caldera volcano. Forests cover 63% of the land; Kumamoto has many valleys, hills, and mountains (Kumamoto Prefecture, 2011). Geographically, Kumamoto belongs to the temperate zone with characteristics of

humid monsoon climate. Its primary industries have been agriculture, forestry, and fishery. In 2005, Kumamoto held the second highest number of licensed agriculturists registered, and its farmland area ranked seventh in the nation. Kumamoto takes a leading role of the nation's food production (Kumamoto Prefecture, 2011). The capital of Kumamoto is Kumamoto City, located in the central part of the prefecture with a population of about 730,000 (Kumamoto City, 2010).

During 1960s to 1970s, Kumamoto had about 1,700,000 residents. Like other parts of Japan, it was going through post-WWII recovery and rapid economic development. Laborers migrated to urban areas to reconstruct Japan's infrastructure. Many men, who were heads of households, migrated to the urban areas seeking higher-wage jobs to support their families back home. Construction and economic development proceeded rapidly; however, there was a lack of attention to the environmental health and safety. During the time period, Japan experienced a new onset of environment-related health problems. The new types of health problems related to industrial wastes and air pollutions, created concerns and awareness about environmental health in the Japanese society.

Among those environmental related health problems, Kumamoto was severely hit by outbreak of Minamata disease. Minamata disease was first identified in 1956, in Minamata City around the Minamata Bay in Kumamoto. A patient was suffering from neurological symptoms with unknown cause (National Institute of Minamata Disease, 2011). Scientists and physicians at Kumamoto University conducted further investigation on the health problems in the area, and it was identified that the health problem was caused by a certain heavy metal poisoning transmitted via fish and shellfish. In 1968, after extensive

investigation and research, the Japanese government announced its opinion that Minamata disease was caused by consumption of fish and shellfish contaminated by a methyl mercury compound discharged from a chemical plant (National Institute of Minamata Disease, 2011). The disease affected central nervous system and presented various symptoms such as sensory disturbance in the four extremities, ataxia, and concentric contraction of the visual fields. Minamara disease caused a severe birth defect when parents ate fish that was contaminated by methyl mercury from the industrial wastes. The outbreak of Minamata disease became an overriding concern to citizens of Kumamoto. When daily food could poison them with an incurable disease, they became sensitized to the importance of safe food and a safe environment.

Health of Kumamoto Citizens

In the shadow of rapid industrial development, people in Kumamoto were struggling for health. Its health status was among the worst in Japan. In 1967, Kumamoto's perinatal mortality was 33.1 per 1000, which ranked the worst among the 46 prefectures in Japan. In 1968, prevalence of tuberculosis was 290.4 per 100,000, again the worst in the nation. Mortality by cancer, at 124.2 per 1000 exceeded the national average of 114.6. Among cancer surgeries, 70 % were identified as "not fully effective" due to advanced stage cancer. Cancer screening in general was performed in only 5% of the adult population. Mortality by stroke was 219.2 (per 100,000) much higher than national average and was trending upward (Creating New Health Care in Kumamoto Archive, 1970).

Kumamoto suffered from a shortage of nurses and physicians. According to the Ministry of Health, Labor, and Welfare of Japan, in 1965, number of Registered Nurses (RN)

in Kumamoto was 2,673. The rest of the nursing workforce was provided by Licensed Practical Nurses, primarily at clinics and hospitals owned by private practice physicians. Kumamoto had only 248 Registered Public Health Nurses, RNs who received an additional six to twelve months of training in community health; they were critical to guarding Kumamoto's public health, but they barely covered its needs (The Ministry of Health, Labor, and Welfare of Japan, 2010). About 23 local municipalities had no public health nurses (Creating New Health Care in Kumamoto Archive, 1970). Skilled workers such as RNs naturally sought higher wages and better technology in cities such as Fukuoka, Osaka, Nagoya, and Tokyo. The number of registered physicians and surgeons in Kumamoto in 1965 was 2,157, of whom many practiced in urban areas in Kumamoto (The Ministry of Health, Labor, and Welfare of Japan, 2010). In 1969, 160 rural communities were identified as rural areas without a physician in residence. This number was twice the national average, which indicated that Kumamoto citizens were severely hindered from accessing healthcare services by licensed health professionals (Creating New Health Care in Kumamoto Archive, 1970).

Prologue to the Reverence for Life Movement

It is important to acknowledge that there was a prologue to the RLM. The RLM was initiated by several young physicians who participated in the Kumamoto Society of Rural Medicine (KSRM) which was established in 1963. But where did these young doctors come from and how did they get interested in rural medicine? Further investigation revealed that the many of the young doctors who participated in the KSRM were former members of the

Kumamoto Student Settlement Movement (KSSM), and some also served in Japanese Red Cross Society student volunteer program (JRCS) (Takekuma, 1983, pp.151-152).

In July 1957, the KSSM, an intercollegiate student volunteer organization was established in Kumamoto. The organization had about 400 student members from medicine, law, nursing, social work, and education from colleges, universities, and post-secondary vocational schools in Kumamoto. The KSSM received strong support from the faculty members of Kumamoto University, Kumamoto College of Business, Kumamoto Women's College, and Kumamoto School of Nursing. It was strongly supported by Dr. Reiju Fukuda, a former president of Kumamoto Medical Association (KMA) and a former member of the Oxford House Settlement (Abe, 2000, pp. 26 - 27). The student members provided health screenings, legal support services, social services, childcare, and tutoring programs for civilians and their family members returning from the former colonized territories in other Asian countries. The KSSM members served in an urban community where there were not enough social and health services during the late 1950s and 1960s (Abe, 2000, pp.26-27; Takekuma, 1983, p.152).

Yoshitaka Takekuma, M.D., PhD, one of the leaders of the KSSM and later the RLM, recollected that support from faculty members from the colleges and universities in Kumamoto strengthened the KSSM and its credibility. Dr. Tokichi Rokutanda, professor of microbiology at Kumamoto University, and Dr. Mamoru Uchida, professor of Kumamoto Junior College, were present at the first assembly of the KSSM to support this intercollegiate student movement. Takekuma described the mentorship and support that the students received from the faculty members as “a wonder of life”: both Dr. Rokutanda and Dr. Uchida

later joined the RLM as board members when the Association for Creating New Health Care in Kumamoto (ACNHCK) was established in 1970 (Takekuma, 1983, p.152). Takekuma identified the KSSM as the root of his engagement in social action. The KSSM network became an important foundation for the development of the RLM (Abe, 2000, pp.25-pp.27).

Wasaku Koyama, MD, PhD, a former director of the Japanese Red Cross Health Maintenance Center, recollected his experience as a KSSM leader this way:

We were fearless. We were warned by the Kumamoto city officials that students like us should not step into such place like the *Aoba-jutaku* (the *Aoba* apartments). They said it was dangerous for young students to get involved. The *Aoba* apartments were a ghetto. But we went there anyway. There were many Okinawan people there. The leader of the residents was also an Okinawan gentleman. Initially, people were quite suspicious about us at the beginning, but after we consistently visit the apartments, they gradually opened up their hearts and welcomed us. We were able to gain their trust. We did many things: students from early childhood education did some programs for children such as story time, sing-along time, craft, and so on. Nursing students delivered hygiene education. They sanitized bathrooms and toilets, and other unsanitary areas. Law students did some legal consultations.

We were students; therefore, we were not qualified to diagnose illness. One day, we noted a sick person and he was coughing. His face was pale and looked quite weak. Lung sounds were suspicious. So, we begged Dr. Rokutanda if he was able to take a look at this gentleman. At the beginning, he was reluctant to go to the *Aoba* apartment. You know, Dr. Rokutanda was a microbiologist. He was a physician, but

clinical diagnosis was not his cup of tea. He said, “I haven’t used a stethoscope for a while.” Anyway, we dragged him over to the apartment, and let him listen to the gentleman’s lung sounds. Dr. Rokutanda said “It doesn’t sound good; we need to send him to the hospital!” So we did. The patient was diagnosed with active tuberculosis (TB) and pleurisy. Later, the condition of the *Aoba* apartments gradually improved – as things got better at the apartments, we started looking into rural health issues, because Kumamoto’s rural areas were still poor and there were many problems. (Wasaku Koyama Interview, 2010)

Hideobu Matsukane, M.D., an executive board member of Japanese Red Cross Society (JRCS), recollected his experiences as a student volunteer for JRCS and KSSM:

I was a JRCS student volunteer. JRCS was very active during the summer break. We went to many rural villages to help. I was assigned as a chief of the entertainment department, so I learned how to operate a movie machine – so that we could entertain villagers. I carried heavy movie equipment and went to the villages. You know, I really liked to serve since I was very young. When I was in middle school, the school nurse was a Japanese Red Cross trained nurse who had served in WWII. She suggested that I organize a student volunteer group in the middle school. I really liked the spirit and mission of the Red Cross. I liked to help people. So I was active with the Red Cross, but I also joined the KSSM. With KSSM, I was able to engage in community service year-round – something to engage with. And of course, my classmates were there, too. (Hideobu Matsukane Interview, 2010)



Figure 2. Dr. Toshikazu Wakatsuki and former Kumamoto Student Settlement Movement Members. From left: Hidenomu Matsukane, Wasaku Koyama, Toshikazu Wakatsuki, and Yoshitaka Takekuma (Yoshitaka Takekuma Archive, 2010)

Kumamoto Society of Rural Medicine

On November 9, 1963, Kumamoto Society of Rural Medicine (KSRM) was formed. Young physicians from Kumamoto University College of Medicine, public health nurses, dietitians, and community life consultants from the Agricultural Cooperatives also joined the KSRM, and the total membership was approximately 150 (Abe, 2000, pp. 46-47; Nagao, 1972, p. 28). Many of the KSRM member physicians were former members of KSS. After the young physicians graduated from medical school, they joined the Department of Internal Medicine and Hematology and the Department of Public Health at Kumamoto University for internship and research. The KSRM included noted physicians Shigeru Nomura, M.D., Ph.D., professor in the Department of Public Health, and Haruo Kawakita, M.D., Ph.D., professor in the Departments of Internal Medicine and Hematology, Kumamoto University School of Medicine; they joined the KSRM to develop a program of research on rural health and rural populations (Yoshitaka Takekuma Interview, 2010).

Yoshitake Takekuma, M.D., PhD recollected the process of forming KSRM:

We were very much aware that something needed to be done about the rural population of Kumamoto. In those days, many of the rural areas in Kumamoto were so isolated due to mountains, distance, and lack of good transportation, etc. Many villagers had very limited access to health care. Also, during the rapid economic development period in 1960s, the structure and environment of rural area had dramatically changed. We wondered what we could do about it. We had heard about Dr. Toshikazu Wakatsuki from the Saku Hospital in Nagano. Dr. Yukio Hashimoto, one of my classmates, suggested us to form a group to learn more about rural medicine. He offered us his mother's home in Kumamoto to have the first meeting of the KSRM. We also invited Dr. Wakatsuki to Kumamoto for the first official KSRM meeting. We received much good advice, and of course, encouragement. Dr. Wakatsuki was very inspirational, but at the same time he was instrumental and very pragmatic. His philosophy—practice in the community, work with people, and democratizing healthcare—made sense to me. He recommended that we try an epidemiological investigation on the health status of rural population to know the baseline. Later, the epidemiological study on the health of farmers of Kumamoto revealed unbelievably shocking results. But the evidence did contribute to push the movement into the next level. (Yoshitaka Takekuma Interview, 2010)



Figure 3. Dr. Toshikazu Wakatsuki (center) and Members of the Kumamoto Society of Rural Medicine. (Back from left: Makoto Futatsuka, Wasaku Koyama, Makoto Takamatsu, Katsuyoshi Iwanaga, Yoshitaka, Takekuma. Front left: Shigaru Nomura. Front right: Yasuo Kawakita) Photograph taken on November, 9, 1963 in Kumamoto. (Yoshitaka Takekuma Archive, 2010)

Epidemiological Study on Health of Farmers in Kumamoto

“Moms in farming villages are light blooded.” That news headline raised concern among women in rural Kumamoto. From 1962 to 1963, the Red Cross Society had campaigned for blood donation; however, this campaign was not as successful as expected. It revealed shocking news about a trend in the health status of women in Kumamoto. It was described as “light blood”: iron deficiency anemia. Over 40% of the adult woman donors were not qualified to donate blood because their hemoglobin levels fell below $< 12\text{g Hb/dl}$. Specifically in rural areas, the proportion of women with these low hemoglobin counts exceeded 50% of potential donors (Nishinippon Newspaper, 1972, pp.168-169).

In response to this shocking statistic, in 1967, KSRM initiated an epidemiological study on the health status of farming women in Kumamoto. The study was a prefecture-wide five-year long study, and it was conducted in partnership with Kumamoto Central

Agricultural Cooperatives, local Agricultural Cooperatives (JA), and Kumamoto Agricultural Cooperatives Women's Groups (JAWG). From 1967 to 1969, only adult women were the subjects of the study. In 1970 and 1971, women and their spouses were invited to the study to make comparisons. The participants were selected based on stratified sampling. The subjects were age 20- to 59-year-old women/ housewives/farmers, and their spouses (1970 and 1971), who perceived their health as "healthy" and were actively involved in farming activities. Each regional JA selected 100 subjects based on age and type of farming / agricultural business (Association for Creating New Health Care in Kumamoto Archive, 1971).

This epidemiological study was carried out diligently, and the disciplines collaborated in it. Data were collected as health checkups were performed in local communities during the summer months. A team of healthcare professionals included: 5 to 6 physicians, 12 to 16 nursing staff, 15 to 20 lab technicians, 4 to 6 dieticians, and 8 to 10 JA staff; such teams visited each farming community together by bus. Prior to the data collection, a JA community life improvement consultant performed a baseline community assessment, and collected demographic information from each participant. Three days prior to the data collection, each participant was asked to document what she/he had eaten in a meal diary; this nutrition information was integrated with the analysis of overall health status (Nishinippon Newspaper, 1972, pp. 168-169). The assessment was performed over 20 categories that included: complete blood counts, basic metabolic panel, vital signs, electrocardiogram, urinalysis, occult blood tests, parasite screening, life style assessment, and assessment for farmers' syndrome: such symptoms included chronic back and joint pain, scoliosis, peripheral neuropathy, frequent urination and incontinency originated in hard

labors and postures in relation to farming. At the end of the day, nursing staff provided individual counseling for each participant based on the results available at that time (Nishinippon Newspaper, 1972, pp.168-69).



Figure 4. A Photo from Epidemiological Study on Health of Women in Farming Communities data collection (location unknown) The banner reads, “Kumamoto Society of Rural Medicine Health Assessment Group” (Association for Creating New Health Care in Kumamoto Archive, 1971).

Participating in this study were 14 JAs in 1967, 13 JAs in 1968, and 12 JAs in 1969, according to the Kumamoto Agricultural Cooperatives Men’s Group’s special report on health status of farmers (1970). This midterm report revealed a severe crisis in women’s health in the rural communities. All the recruited participants had perceived themselves as “healthy” prior to the study; however, the results revealed that only 15.2% (1967), 9.2% (1968), and 6.8% (1969) were “healthy/normal” (Kumamoto Agricultural Cooperatives Men’s Group, 1970). Over 80% of participants had some sort of latent health issues (Appendix D).

The follow-up survey and focus groups that followed data collection revealed that only one out of six participants who had received an evaluation of 4 “needs further investigation”, or 5 “treatment required”, actually sought to see a physician after they received a referral letter from a KSRM physician (Association for Creating New Health Care in Kumamoto Archive, 1971; Nishinippon Newspaper, pp164). Participants stated, “I have the letter in my dresser as a keepsake,” “I lost the referral letter somewhere,” “I have been like this for a long time, and I was OK. So why do I need to see a doctor?” Some responded, “Once I went to the health check-ups, I felt that I was treated by a doctor!” or “The doctor here said, ‘If you take so many lab tests, something will come up abnormal. Nothing to worry about!’ So he sent me back home.” The findings from the follow-up survey and focus groups illustrated that rural women were still far from health and healthcare. They also indicated that one-time health check-ups were not enough (Creating New Health Care in Kumamoto Archive, 1971).

Strong voices from community members challenged the KSRM’s work as lacking systematic follow-up for those who needed further intervention. “The study only created problems and fears among the community. There was no hope of resolving the issues if the study presented only problems” (Nagao, 1972). “Frustration and criticism surged against KSRM,” remembered Yoshitaka Takekuma, MD, PhD, a member of KSRM:

After the study, there were some criticisms, and sometimes anger was expressed. I remember that one of the leaders of a JA women’s group said, ‘Where can we go from here? You doctors just came, and checked us up and dumped such

bad test results on us, and that was it. Where could we find a solution? No resources around. We are far from the city. No one has time to take a day off from farming. There is no doctor around. I wish at least we could get a check our health status, like the one we did, once a year. It was really nice that all the doctors came over to see us.’ Then, people were still struggling with poverty and money was tight. For many people, going to see a doctor for one’s own health was such a luxury! For many farmers, by the time they were really sick and needed to see a doctor, it was already too late to treat. Going to see a doctor without being sick? No one could even imagine it. The concepts of disease prevention and health promotion were so foreign not only to doctors, but to the population in general. However, when we discovered how sick these rural farming moms were, we had to do something to break through the traditional medical model and create new healthcare—and systemize it— so that health management, health promotion, disease prevention, treatment, and emergency intervention could be done smoothly.” (Yoshitaka Takekuma Interview, 2010)

Kumamoto Health Administration Center Task Force

In January 1970, based on the work of KSRM, Kumamoto Health Administration Center Task Force (KHACTF) was formed to tackle the unresolved issues of rural health in Kumamoto (Kumamoto Health Administration Center Task Force, 1970; Nagao, 1972). A farmers’ cooperative, the Kumamoto Central Agricultural Cooperative, formed a Health Improvement Initiative, which also called on the KSRM to work on a tangible solution for the health crisis (Abe, 2000, p. 49). KHACTF members researched successful health promotion programs in other parts of the country. They visited Saku Central Hospital in

Nagano to learn more about the total health management program in Yachiho Village in Nagano (Abe, 2000, p. 49). By the summer of 1970, KHACTF drafted a proposal to establish Kumamoto Health Administration Center, a center that would manage community health in systematic manner. The task force published a proposal in November 1970. Its introduction described three fundamental principles:

1. The Health Administration Center provides healthcare by the citizens for the citizens from the point of view of health, not disease.
2. The Center reevaluates roles of healthcare providers and healthcare facilities in the communities, and aims to systemize provision of healthcare services in Kumamoto.
3. The Center would establish linkages among prevention/health promotion, health check-ups/disease screenings, treatments, and rehabilitation, so that no one would be lost in the healthcare system.

(Kumamoto Health Administration Center Task Force, 1970, p. 1)

In the same proposal, the KHACTF traced its motivation:

We often heard “Our healthcare is so disorganized and corrupted!” Rapid changes in the societal structure and chaos in healthcare left behind those of us in rural prefectures and rural communities. The crisis of healthcare is the crisis of our lives. The frustrations of citizens concerning healthcare are now almost unbearable. What made the healthcare so dysfunctional? Healthcare and health insurance reforms are discussed far from our presence. Is that really fair? This proposal of a Kumamoto Health Administration Center was carefully drafted with contributions from doctors

from local communities, to current healthcare issues, and social and cultural characteristics of Kumamoto. The Health Administration Center must have participation and support from local private physicians in the communities, from local municipalities, government bodies, the Japanese Medical Association, and most of all, from the citizens of Kumamoto. Healthcare matters for us all. Healthcare is for our lives (Kumamoto Health Administration Center Task Force, 1970, p. 1).

The proposal presented three conceptual models:

1. Conceptual model that described network/linkages of healthcare services in Kumamoto and beyond (Figure 6)
2. Kumamoto Health Administration Center Organizational Conceptual Model (Figure 7)
3. Conceptual blueprint for the annual health screening unit (Figure 8)

The conceptual models and the proposal presented a futurists' vision for a comprehensive management system. It laid the foundation for today's integration of advanced technology such as computerized health information and diagnostic features, and an electronic medical record system with one medical record for one person throughout life, which can be shared with multiple health care providers/institutions. The model proposed the seamless provision of health care to citizens in a cost-effective manner. Ultimately, a computer network and linkage with a central diagnostic center would incorporate their aspiration to provide the most advanced and quality medical services to rural citizens (Figure 6, Figure 7, and Figure 8).

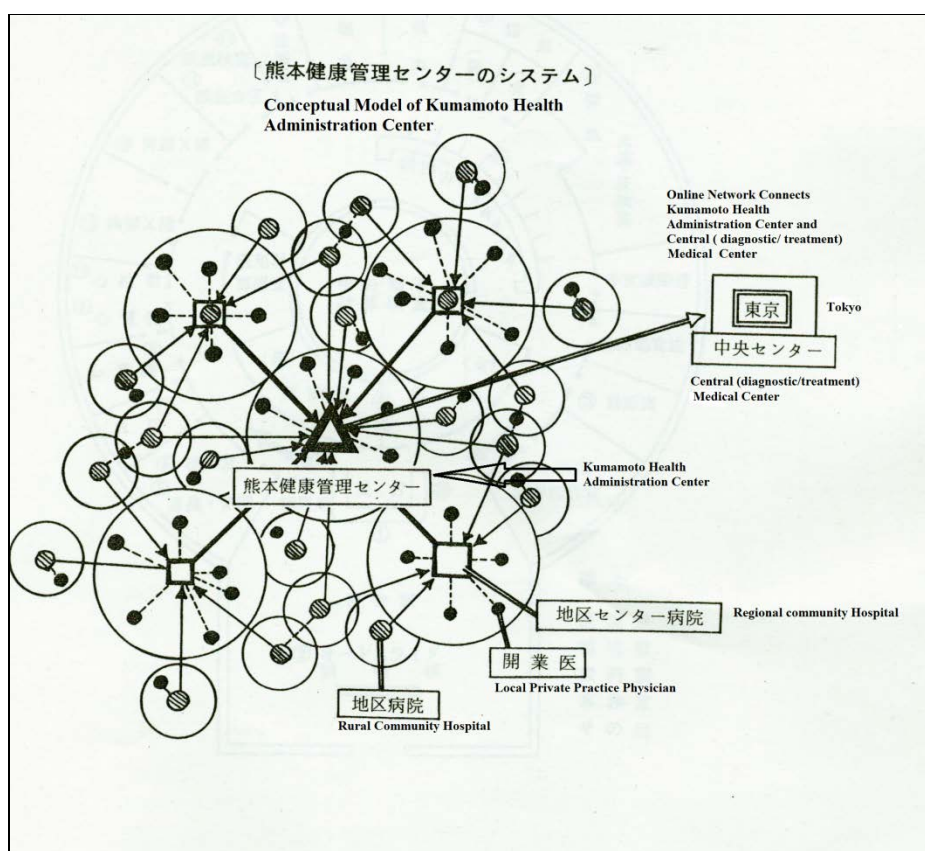


Figure 6. Conceptual Model of Kumamoto Health Administration Center. This diagram described the network and linkages that the Center would support. (Kumamoto Health Administration Center Task Force, 1970, p. 3)

The organization's conceptual model indicated that the Kumamoto Health Administration Center (KHAC) was not proposed as a simple health screening facility, but it was aimed to be a true Center that would connect local providers and facilities, municipalities, specialty care hospitals, a central diagnostic center in Tokyo, and the Kumamoto University Hospital and medical school. The Center had four departments: 1) Clinical Services, 2) Education and Training, 3) Research, and 4) Health Promotion and Disease Prevention. In the Department of Clinical Services, patients referred by local private physicians would see an interdisciplinary healthcare team to evaluate them from multiple

perspectives. This idea was forged from the experiences of rural physicians who lacked a proper referral network. The proposal considered provision of what is today called alternative medicine and traditional Oriental medicine to promote better outcomes (Kumamoto Health Administration Center Task Force, 1970, p. 8).

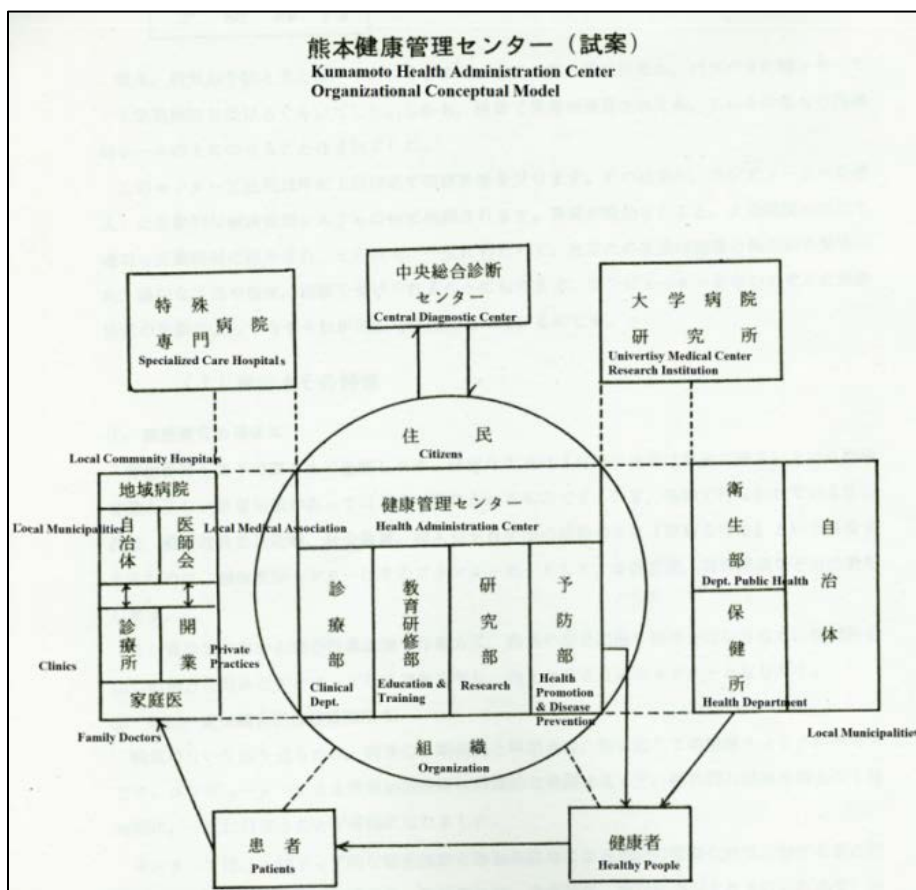


Figure 7. Conceptual Model for the organization of the Kumamoto Health Administration Center. (Reproduced from the Kumamoto Health Administration Center Task Force, 1970, p. 4.)

The Department of Education and Training were responsible to develop programs for continuing education for healthcare professionals. The department would fill the lack of continuing education so that professionals could update skills and learn current healthcare

trends, establish networks, and build an urgently needed interdisciplinary approach to the provision of care. Curriculum for this Department would be developed by staff physicians, public health nurses, community health specialists, and faculty members from the health science programs of Kumamoto University. The Department of Education and Training also focused on continuing education for private practice physicians in rural communities and retention of healthcare professionals, particularly young physicians who were assigned to serve in rural and regional community hospitals. Lack of professional development and educational opportunities were the major barriers to retaining good physicians in rural communities (Kumamoto Health Administration Center Task Force, 1970, pp. 8-9).

The Task Force included a Department of Research in the proposal because its vision included not only serving the community's needs, but also policy development, clinical practice and intervention, disease prevention and health promotion, and education. The proposal clearly stated that at KHAC, research would be conducted in response to real problems, voices of the community members, and concerns of local healthcare professionals. The research team would work together with basic scientists to link basic science and community-based health science research (Kumamoto Health Administration Center Task Force, 1970, p. 11). The proposal contained a concept of translational research, which was not an established research approach/concept in health science in 1970s. From this perspective, KHACTF did propose a breakthrough research concept in the field of health science.

Task Force, 1970, p. 7). Those targeted groups of people were out of the loop of benefits of employer-based health insurance. Such health insurance only covered annual health screenings for the primary insured, which usually was the head of the household employed by a large business; it was aimed as a part of the occupational health annual screening, thus it did not cover dependents (Kumamoto Health Administration Center Task Force, 1970, p. 7). One of the objectives of the KHAC was to protect lives of those 1,050,000 people who were left out of such health management programs. The proposal sought to pull funding from the health administration budgets of the local municipalities, potential reimbursement from health insurance policies, and a nominal contribution of 100 yen/ month (approximately equivalent to current \$3.00 US in market value in 1960s) from the citizens.

The proposal for the KHAC was drafted based on a philosophy of autonomy, self-reliance, and mutual aid. The goal of a health management center, which would be supported “by the citizens for the citizens,” called for community engagement. Individuals would need to opt for autonomy, expressed in the proposal’s phrase “I will protect my own health” (Kumamoto Health Administration Center Task Force, 1970, p. 2).

Regarding this KHAC proposal, on November 24, 1970, Nishinippon Newspaper, a daily newspaper widely distributed in Southwest part of Japan, published a comment by Dr. Toshikazu Wakatsuki, a leader of Japan Society of Rural Medicine:

The proposal suggested an ideal image for future community health – a comment from Dr. Toshikazu Wakatsuki. “This is a very unique proposal! I am praying for successful development of this ‘Kumamoto System’ to promote the health

of Kumamoto Citizens. I believe this proposal suggests the future of healthcare in Japan. Our healthcare should actively focus on identification of latent diseases, which are not yet diagnosed, but surely exist due to lack of access to healthcare, ignorance, or acceptance of conditions. We need to make more efforts to do community outreach. Early detection and treatment for various diseases are critical. Delivery of a community health screening program should be encouraged. Prevention is as important as treatment. Contributing to the program's success will be facilitation of health awareness, implementation of educational programs, and more community-based and epidemiological research to collect evidence about the conditions we are fighting. If we can integrate health management activities with life improvement programs in rural areas, it will be even more effective. For successful programs, we need to establish the Kumamoto Health Administration Center, equipped with advanced technologies and highly skilled and motivated professionals (Association of Creating New Health Care in Kumamoto Archive, 1970).

The efforts of KHACTF and its proposal for the KHAC became a driving force to create a current to revisit the health and healthcare of Kumamoto and a community-based movement that facilitated restructuring of the healthcare provision in Kumamoto. On July 21, 1970, Kumamoto Citizens' Forum for Better Health took place in Kumamoto City. This forum was epochal, shifting the Reverence for Life Movement (RLM) to the next stage.

Kumamoto Citizens' Forum for Better Health

Kumamoto Citizens' Forum for Better Health took place at the Kumamoto *Shimin* Concert Hall in Kumamoto City on July 21, 1970, hosted by ten organizations and a sub-sponsor:

1. Women's Group for Better Health (健康を守る婦人の会)
2. Kumamoto Medical Association (熊本県医師会)
3. Kumamoto Central Agricultural Cooperatives (熊本県農協中央会)
4. Japan Broadcasting Corporation (日本放送協会)
5. Kumamoto Society of Rural Medicine (熊本農村医学会)
6. Kumamoto Prefecture (熊本県)
7. Kumamoto City (熊本市)
8. Kumamoto Federation of Food Hygiene Associations (熊本衛生協会連合会)
9. Kumamoto Association of City Mayors (熊本市長会)
10. Kumamoto Association of Towns and Villages (熊本町村会)
11. Kumamoto Daily Newspaper (熊本日日新聞社)

(Kumamoto Citizens' Forum for Better Health flyer, Association of Creating New Health Care in Kumamoto Archive, 1970)

At the forum, with presence of the governor Kosaku Teramoto, five representatives presented current issues on healthcare in Kumamoto. Dr. Yoichi Miura, from Kumamoto

Medical Association (KMA) presented about health management from the KMA perspective. Dr. Yoshitaka Takekuma reported the healthcare issues in rural Kumamoto and findings from the epidemiological study by KSRM; and he made a tentative proposal for the KHAC. The Director of the Kumamoto Prefecture Department of Public Health, Mr. Hasuo Ito, made the case for a prefecture-wide health promotion program. Two community members, Mrs. Midori Kita, from the Women's Group for Better Health, and Mr. Kiraku Takamichi, president of the Federation of the Kumamoto Agricultural Cooperatives Men's Groups, presented serious concerns and frustrations at lacking an appropriate modality to guide citizens to better health. Mrs. Kita and Mr. Takamichi stressed the urgent need of intervention to save lives of women and farmers (Kumamoto Citizens' Forum for Better Health, 1970; Nagao, 1972). From the floor audience, private practice physicians addressed the realities and hardships of running clinics and hospitals in rural areas—providing health care in rural areas only drove clinics deeper into debt (Abe, 2000, pp, 50-51). The Kumamoto Citizens' Forum for Better Health was a significant event that moved the KSRM agenda forward; for the first time it brought together healthcare providers, local municipal and prefectural leaders, politicians, and community members to discuss the healthcare issues of Kumamoto and find common ground to address them (Nagao, 1972).

The Kumamoto Citizens' Forum for Better Health was a booster to raise citizens' awareness of the health and healthcare of Kumamoto. Media such as local newspapers, radios, and TV reported on the forum and the proposal for the KHAC by the KSRM was often featured by the media. The KHAC proposal was welcomed and received positive feedback from the citizens, but it also faced considerable opposition from local

municipalities, prefectural government, and the Kumamoto Medical Association (KMA). Funding issue was the major concern of the prefectural government, and KMA was concerned about further loss of business for its private practice physicians (Abe, 2000. pp. 51-52). Initially, the KSRM had hoped to advance the agenda of the KHAC with unanimous support from the local government, citizens, and healthcare providers. However, this hope did not materialize; instead, the proposal from the KSRM was ignored by KMA. Instead, KMA established a taskforce to work on community healthcare planning separately (Abe, 2000. pp. 51-52).

Kazuharu Nagao, MD. PhD, one of the leaders of the ACNHCK and a former executive director of Kumamoto City Hospital recollected:

We struggled with KMA. The tension between KMA and us young doctors [members of KSRM], was really something else. They [leaders of KMA] were probably thinking – “what are ‘these pups’ thinking about?” We were so serious and passionate about what we were working on. We were so driven, enthusiastic about seeking better healthcare and improving health of the people in Kumamoto. I remember, once we were asked to come to the office of the Medical Association in Kumamoto city - then we were severely scolded by the senior executives of that time [for what we were trying to do]. The threat did not scare us, but instead, it fueled us. We wanted to make a change – and we had both strong conviction and strong support from the community members. (Kazuharu Nagao Interview, 2010).

Yoshitake Takekuma, M.D., Ph.D., one of the leaders of the ACNHCK, described the situation this way:

It was related to politics in Kumamoto—who had the power and who controlled the organizations. It was not logic. It had nothing to do with idealism. But we were going against it; we were pushing our idealism and objectives really hard. You know, there is a proverb in Japan, “A nail that sticks out will be hammered down.” It was just like that. We were the nail. Personally, I did not care; I knew, if the nail sticks out too much, they would stop hammering it down because it would be too much work! So, what I aimed to do was – make ourselves into a nail that stays sticking out! When we considered all the things that were going on with the Medical Association and others, we had to move quickly. While people’s awareness and enthusiasm were up and alive, we had to shift the direction of the movement. We held strategic meetings with representatives from local municipalities, hospital administrators, doctors from rural private practices, ladies from community women’s groups, representatives from area agricultural cooperatives and other farmers’ groups, nurses, public health nurses, paramedical professionals, and journalists from local media. We did open discussions without any walls or hesitation. We discussed almost everything that we could possibly think of about healthcare. We talked a lot about issues such as how we could strengthen trust and how to fill the gap between doctors and patients, how to establish policies that would facilitate prevention of diseases... We were so interdisciplinary, open, and equal. Like Dr. Wakatsuki, we too were seeking a way to democratize healthcare. After the strategic meetings, it

came down to a conclusion that we needed to establish a community-based organization: the Association for Creating New Health Care in Kumamoto. We were very positive and hopeful that this organization would take our Reverence for Life Movement to the next stage. (Yoshitaka Takekuma Interview, 2010).

This chapter described brief socio-cultural context of the phenomenon of interest and the development of Reverence for Life Movement (RLM) through several stages. Contemplating period with Kumamoto Student Settlement Movement (KSSM) and inception period with Kumamoto Society of Rural Medicine (KSRM) and Kumamoto Health Administration Center Task Force (KHACTF) provided readers a trail of growth of the RLM. The oral histories of the leaders of the movement also revealed that the RLM encountered oppositions and obstacles during the course of the movement, which required them to be strategic leaders with diplomacy. The RLM did not have a concrete structure, but it was rather a philosophical concept, or an ideal that influenced over the people, who strongly believed in health and provision of better healthcare in the society, to pursue actions to materialize systems to provide better healthcare and achieve better health. Stories of the processes of development of the proposal for the Kumamoto Health Administration Center presented a future of healthcare services, which had been proven by time, by current utilization of online network, remote diagnostic services between rural areas and the center cities, and implementation of electronic medical records to share health related information without institutional boundaries. It is important to acknowledge that a group of young physicians, nurses and other healthcare professionals, members from agricultural cooperatives, and community members who supported the cause worked across disciplines

and developed the proposal, which in the future became a blueprint for a standard of preventive healthcare services in Japan. In the following chapter, further development of the RLM through the establishment of the Association of Creating New Healthcare in Kumamoto (ACNHCK), a community-based grassroots organization, which became a vehicle of the RLM, will be described.

Chapter 4

Mobilizing Communities

The 1970s saw the establishment of the Association for Creating New Health Care in Kumamoto (ACNHCK). It was a community-based grassroots organization that became a major vehicle for the Reverence for Life Movement (RLM). This chapter describes the history of the ACNHCK, its activities, and its organizational characteristics. The chapter ends with oral histories by ACNHCK members, who describe the group's leadership and its political diplomacy.

By 1970, the time was right. After the Kumamoto Citizens' Forum for Better Health, public media started campaigns to raise awareness of healthcare issues in Kumamoto. The Kumamoto Daily Newspaper specially featured columns titled "Struggling Healthcare" from mid-July to the beginning of November over 28 times. Nishinippon Newspaper delivered a series of 19 special reports on the RLM in Kumamoto starting on November 2, 1970. Japan Broadcasting Corporation (NHK), Kumamoto Central Office, delivered TV and radio campaigns, including "Dawn of New Healthcare" programs that featured RLM; and it reported on development of the community-based grassroots organization through TV and radio programs over five times (Nagao, 1972, p. 29). Those media campaigns were not focused on criticism or whistleblowing about the healthcare services of that time, but rather they invited Kumamoto citizens to think about the issues and challenges that their society was facing, and encouraged them to consider what they could do to make a change.

Farmers, too, stood up for themselves to promote their health. The Kumamoto Central Agricultural Cooperatives created a 16-mm movie based on "Dawn of New Healthcare," the

program by NHK Kumamoto Central Office—their feature on RLM. The movie was viewed at gatherings of the local Agricultural Cooperatives throughout the prefecture. At a gathering, usually a KSRM member reported the findings from the epidemiological study, showed the movie and led a discussion (Nagao, 1972, p. 29). These wide media campaigns and consecutive study groups and gatherings held throughout the prefecture steadily raised concerns and awareness about the unfavorable health status of Kumamoto citizens and its causes.

After the Kumamoto Citizens' Forum for Better Health, a group of concerned community members formed the Concerned Citizens for Better Healthcare. The primary purpose of the group was to take what they had learned from the epidemiological study, community-based study groups, and media campaigns, and shift knowledge into action. The participants in the Concerned Citizens came from various occupations and backgrounds. They were all eager to involve themselves actively in the movement rather than being passive learners (Nagao, 1972, p. 29). Starting in August 1970, the group met over 12 times. The meetings provided a place to discuss the potential to organize a community-based citizens' organization to create new healthcare in Kumamoto (Nagao, 1972, p. 29; Takekuma, 1983, pp. 146-158; Abe, 2000, p. 52; Yoshitaka Takekuma Interview, 2010). At the meetings of the Concerned Citizens for Better Healthcare, the discussions boiled down to three core issues:

1. There has been a great divide between doctors and patients; how can we reestablish trust and strengthen partnerships in healthcare?

2. How can we facilitate policies to offer health checkups to Kumamoto citizens, checkups that screen for diseases and potential health problems before they worsen?
3. In cases of emergency or serious diagnoses, how can we provide the most appropriate care and intervention in the most prompt and cost-effective manner? What we can do to systemize health care in Kumamoto? (Takekuma, 1983, pp. 146-158)

The Concerned Citizens for Better Healthcare concluded that there was a need to establish an organization that would embrace a wide membership, not only from Kumamoto City, but from the entire Kumamoto prefecture. The group meetings turned into strategic planning meetings to start a new organization: the Association for Creating New Health Care in Kumamoto (ACNHCK) . On November 29, 1970, ACNHCK held its first annual meeting with 120 participants, and the organization was officially established (Nagao, 1972, p. 29; Takekuma, 1983, p. 148). From that day, ACNHCK became a major vehicle of the RLM, which would implement the proposal for the Kumamoto Health Administration Center, and promote the rest of the agenda of Concerned Citizens for Better Healthcare.

Association for Creating New Health Care in Kumamoto

The passage below, from the opening report by a member of ACNHCK, clearly presented the nature of the organization:

Forging a community-based health care movement from within – this was what set RLM apart from other healthcare movements. Our movement came about

from strong criticism of our current healthcare system, and from the self-reflection and self-critique of our members. On this date, we held the inaugural meeting of the Association for Creating New Health Care in Kumamoto, with hope to materialize our passion for the community-based health care movement and our wish to create new health care in Kumamoto. (Takekuma, 1983, pp. 147-148)

ACNHCK attempted to break from the traditional worldview of medicine and healthcare and to create a new approach toward them. Its approach to health and healthcare was based on philosophy of reverence for life. This new philosophy was oriented to three principles, articulated by Takekuma and Koyama:

1. Healthcare from the perspective of health and wellness
2. Healthcare with citizens' participation
3. Healthcare with an interdisciplinary team approach that included the full range of health- and social-service professionals

“Our goal was to transform people’s mindset—not merely to raise a building [the Kumamoto Health Administration Center] and offer health check-ups. Through the RLM, we wanted to motivate citizens of Kumamoto to get actively involved in their healthcare and take ownership of their own health and well-being.” (Takekuma, & Koyama, 1978, pp. 1954-1955). At ACNHCK’s first annual meeting, citizens came together from various backgrounds. Documented participants included public health nurses from local municipalities, nurses, dieticians, pharmacists, lab technicians, acupuncturists, officers from local health departments, private practice physicians, young physicians from the university

hospitals, agricultural cooperatives' technical advisors, life-improvement advisors, politicians, mayors from local villages and townships, aldermen, journalists, academicians, teachers, business owners, farmers, homemakers, and physicians from clinics, the health department, and community hospitals. In the eleven month of ACNHCK, the membership boomed to 2,500 as of October 20, 1971 (Nagao, 1972). In 1975, ACNHCK held 4,700 members (ACNHCK Archive, 1976).

Members' Involvement

As a community-based grassroots organization, ACNHCK was able to carry out its objectives, many of which materialized from 1970 to 1980. ACNHCK primarily focused on healthcare; however, the members prioritized safe farming practices, concerns about pesticide usage, and regulations for food safety. They voluntarily established additional groups to discuss these issues, and naturally the member farmers organized a division within ACNHCK to develop ways to farm safely yet productively. Consumers, small business owners, women members—mainly homemakers—formed a group to discuss safe food and healthy eating. In conjunction with the farmers' group, they organized a network to obtain safer food and organic, locally grown produce from those member farmers who had begun practicing organic agriculture. Within a year of establishment, ACNHCK officially organized three divisions within the organization: 1) Healthcare, 2) Food, and 3) Farming. With three divisions and members' active involvement, the ACNHCK became a powerhouse during the 1970s. It pioneered in Japan's organic farming movement and its grassroots consumer movement. Over the 10 years of its life, ACNHCK's projects became cornerstones of the Reverence for Life Movement. Major accomplishments of ACNHCK include:

1. Submission of Official Request (five agendas) to the Governor of Kumamoto and Kumamoto Prefectural Congress (March 1971)
2. Petition for Kumamoto Health Maintenance Association presented to Governor of Kumamoto and Kumamoto Prefectural Congress (October 1971)
3. Establishment of Kumamoto Health Maintenance Association (December 1972)
4. Establishment of Kumamoto Society of Organic Farming (October 1974)
5. Revitalization and relocation of the Japanese Red Cross Society's Kumamoto Hospital (June 1975)
6. Reverence for Life and Earth Forum (March 1975)
7. Establishment of Kikuchi Yojo-en Public Clinic (April 1975)
8. Establishment of Kumamoto Organic Produce Distribution Center (June 1976)
9. Establishment of Kumamoto Reverence for Life and Food Association (July 1977)
10. Japan Organic Farming National Conference (November 1977)
11. Establishment of Kumamoto Red Cross Health Maintenance Center (April, 1978)

(ACNHCK Archive, 1976; Takekuma, 1983, pp. 146-170)

The strength of ACNHCK was rooted in its motivated members, their network, dedication of their time and funds, and passion to seek better health and energy to create a new current in the society that was in great need of change.

ACNHCK and Its Impact on Nursing

One of the first items on ACNHCK's healthcare agenda was to establish a school to educate Public Health Nurses (Nagao, 1972). When ACNHCK's membership reached 1,000 in March 1971, it officially submitted a petition that contained five agendas to the Governor of Kumamoto and Kumamoto Prefectural Congress.

1. We urgently request the establishment of a task force in the Kumamoto prefectural government to improve health services to meet the need of the citizens.
2. We value the critical roles of registered public health nurses and registered dietitians who work in the front line of community health administration to prevent disease and promote our citizens' health. We are very concerned that 23 local municipalities are unable to recruit and retain public health nurses due to a severe shortage. It is supremely critical that we relieve the shortage of public health nurses, in order to protect the health of citizens. We urge the prefecture of Kumamoto to establish an institution to educate public health nurses in Kumamoto. We also request a registered dietitian in each municipality.
3. Currently, the insurance system does not reimburse for any preventive health services. However, it is very important to consider reimbursement for such services, to maintain health and minimize the health care costs. Some municipalities already provide some assistance for preventive services. We value the role and effectiveness of alternative medicine and therapies such as acupuncture to maintain health and well-being of the citizens. We request that you

consider insurance reimbursement for preventive medicine as well as for the alternative medicine and therapies.

4. The local health departments and community clinics and hospitals are suffering from a shortage of physicians. As a result, some health departments cannot offer mandated services to the citizens. We recommend that the prefectural government facilitate partnerships between public health offices and community clinics and hospitals, in order to improve local healthcare services for citizens.
5. Currently there are disparate health information cards issued by community clinics and hospitals. In the near future, there should be a standardized health information card system that would standardize a health management program.

We request your consideration.

(ACNHCK Official Request to the Governor of Kumamoto and Kumamoto Prefectural Congress, 1971)

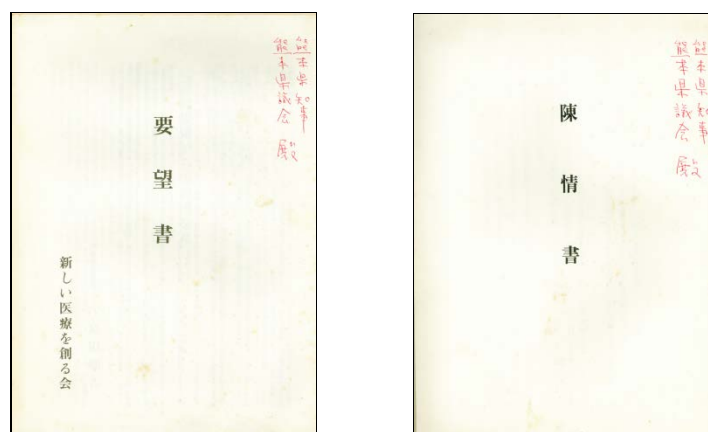


Figure 9. Left: Front page of the official request to the governor of Kumamoto and Kumamoto prefectural congress (March, 1971). Right : Front page of the Petition for Kumamoto Health Maintenance Association presented to Governor of Kumamoto and Kumamoto Prefectural Congress (October, 1971). (Yoshitaka Takekuma Private Archive, 2010)

The establishment of an institution to educate public health nurses was taken into consideration. There was no school to educate public health nurses in Kumamoto. Such a school had existed from 1943 to 1946, established by the Health Department Act. However, after Japan's loss of WWII, the school closed (Kumamoto School of Public Health Nursing, 2009). Kumamoto School of Public Health Nursing and Midwifery was reestablished in April 1972. By 1975, 258 public health nurses were registered in the prefecture. In 1984, that number had increased to 367. Between 1975 and 1995, the number of public health nurses in Kumamoto doubled; 521 public health nurses were practicing in local municipalities, local health departments, and community clinics in Kumamoto (Ministry of Health, Labor, and welfare of Japan, 2010).

In its 1971 petition, ACNHCK presented data that illustrated the poor health status of citizens of Kumamoto. In 1968, Kumamoto was ranked the fifth highest prefecture in Japan for infant mortality, the fourth highest in overall mortality, and the highest in prevalence of tuberculosis. By promoting public health nursing, ACHNCK confidently hoped to reverse those alarming statistics. Public health nurses were not only educated but employed in the community. ACNHCK's petition urged the Kumamoto government to prioritize health education in the community and the school system. ACNHCK recommended that the government promote immunization, health education, and health screening—and do so by ensuring placement of public health nurses in each local municipality (ACNHCK Official Petition to the Governor of Kumamoto and Kumamoto Prefectural Congress, 1971).

It is important to recognize that ACNHCK, a community-based, grassroots, primary health care organization contributed to the development of community health nursing in

Kumamoto. By the establishment of the Kumamoto School of Public Health Nursing and Midwifery in April 1972, the government solved the shortage of public health nurses and every municipality had at least one public health nurse. When nursing education transitioned from diploma to baccalaureate programs in the 1990s, the school closed its doors in March 2002. Until its closing, the Kumamoto School of Public Health Nursing (the midwifery program was closed in 1990) continued to offer advanced public health nursing program to registered nurses in Kumamoto (Kumamoto School of Public Health Nursing, 2002).

Leadership and Strategies

A key to ACNHCK's continuous progress, it is important to acknowledge that ACNHCK held a strong leadership team and carefully considered strategies. When ACNHCK was established in 1970, Tokichi Rokutanda, M.D., Ph.D., a former president of the Kumamoto University, was unanimously elected as the first chief executive and board chairman. Dr. Rokutanda was a supporter and the faculty advisor for the Kumamoto Student Settlement Movement, an inter-collegial student organization established in 1957, and he was quite familiar with the leadership of the ACNHCK, who had once been the student leaders of the movement. Dr. Rokutanda was led to support the organization by his personal relationships with ACNHCK leaders such as Wasaku Koyama, M.D., PhD and Yoshitaka Takekuma, M.D., Ph.D., and his continuous support for the RLM and all the research efforts of the Kumamoto Society of Rural Medicine. Dr. Rokutanda was unique in his background as an academician, physician, and his social status as a former president of the Kumamoto University (the only national university with prominent history and recognition in Kumamoto). His acknowledged leadership would put ACNHCK in a position to earn

credibility and to transcend partisan politics. As an organization, ACNHCK was not affiliated with any political group or religious belief. It remained solely an independent grassroots citizens' organization. The common interest of the members was Reverence for Life: and on that platform it welcomed anyone who valued life and health.

『新しい医療を創る会』入会のすすめ

あなたも是非ご参加ください

この会は、それぞれが知恵と労力とお金を出し合って、自分のいのちを守り、より健康な生活が営める社会を創り出そうと言う自主的なあつまりです。この会には、年額一口300円以上を納めれば、誰でも入会できます。ただし会の運営は、すべて会員の会費でまかなわれますので余裕のある方は、より活発な活動ができるようにと一口にこだわらず、3億円のお金を会費として納めて頂いても結構です。

会員になることは、「私も、新しい医療を求めているのだ」という名のりをあげることもあると思います。

新しい医療を創る会では、機関紙『新しい医療を創る』を発行したり、機会あるごとに医師をはじめ医療関係者と住民の話し合いや健康相談の場をつくってゆきます。日頃から、こうした機会をつくって、「病気への不安」「もし病気をしたらという不安」をとり除くと共に、「病気をした時にも気軽に相談できる」常設窓口や場所を作っておくことが大切だと思います。

事務局は、こうしたお世話をしたいと思います。また、事務局でも30人程度の話し合いができますので気軽に御利用下さい。

この会は、誰でも、何の遠慮もなく意見がいえようとしてありますのであなた自身で、あなたの『いのちを守る』ための夢を實現させて下さい。

新しい医療を創る会
代表運営委員 六反田 藤 吉
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入 会 申 込 書

新しい医療を創る会に参加を申し込みます 昭和 年 月 日

氏名 (姓・名) _____ 性別 男 女 年齢 才

職業 _____ (所属) _____

自宅 〒 _____ 番 町 番地 電話 局 番

勤務先 〒 _____ 番 町 番地 電話 局 番

機関紙『新しい医療を創る』等の発送名簿にしますので、郵便物が届くよう、住所・アパート名・部屋号数等も、もれなく書いて下さい。会費は、年額300円（一口）以上です。

Figure 10. Invitation to Association for Creating New Health Care in Kumamoto
The text reads: Invitation for Association for Creating New Health Care in Kumamoto – Text reads: Please join us! Association for Creating New Health Care in Kumamoto (ACNHCK) is an organization of self-motivated individuals with willingness to contribute wisdom, labor, and money to create a society where we can protect our life and improve our health. Anyone can join ACNHCK with a minimum annual fee of 300 yen. If you are wealthy and willing, you are welcome to contribute 3 billion yen for your membership fee! Becoming a member of ACNHCK means that you join us in proclaiming, “I want better healthcare and I am creating a new healthcare system!” ACNHCK publishes a newsletter, *Creating New Healthcare*, to

communicate with you. Also we will dialogue with healthcare providers and as many community members as we can. We will offer health-counseling services for members. It is very important for us to have a “go to” place when we need to discuss health issues. Our office has a meeting room for 30 people, and members may use it. At ACNHCK, we can express our opinion freely. It is a safe environment for discussion. Please join ACNHCK and make your wish “to protect your life” come true.

Association for Creating New Health Care in Kumamoto
Chief Executive Board Member: Tokichi Rokutanda

Yoshitaka Takekuma, M.D., Ph.D, one of the leaders of ACNHCK described about the strategies of ACNHCK:

To make ACNHCK well accepted to the wide range of citizens of Kumamoto, we were very firm about staying politically neutral. Kumamoto, by its rural nature, is a very conservative place. At that time, people were very sensitive about politics because politics was often connected with where you live, what you do, and whom you are associated with through blood (family) and work. It was not simple. Also, there was already some tension between the Kumamoto Medical Association (KMA) and us (Kumamoto Society of Rural Medicine) regarding what we were doing and our proposal for the Kumamoto Health Administration Center. The KMA was a very political organization, you know. In addition, there was a very strong family that was quite influential over both the KMA and Agricultural Cooperatives in Kumamoto. One of the family members was a congressman representing Kumamoto. The family was powerful and they were, of course, politically very savvy. Therefore, to successfully deal with this power, we had to act carefully and always consider politics in Kumamoto. What we were doing was something that was not beneficial for that family. At times, there were some rumors of unknown origin going around even in

the University Hospital where I worked. Someone told our professors that the ACNHCK member physicians in the department were putting so much time in the movement that they were not working hard on research. Or, there was a rumor such as “Professors! Soon or later, there will be a ‘red flag’ on top of the hospital!!” – Oh, they were terrible. Also at that time [the 1960s and 1970s] certain social movements had arisen. Therefore, I am sure it was hard to distinguish which was which, and what was what. But I sensed that people in Kumamoto were somewhat resistant to communist ideology. Therefore, we purposely did not use the term “social justice.” Of course, our concern was for justice in healthcare, but a term like “social justice” would not work in Kumamoto. It sounded similar to the slogan of the communist party. “Social justice” sounded too strong, too hard, and too left-wing. We really had to think of something that touched people’s emotions and positively motivated them – something that glued everyone together regardless of political affiliation or religious belief. The single common philosophy that united ACNHCK was Reverence for Life. No matter who you were and what you were, the importance of life was a universal and easily understood value; no one opposed it. Everyone agreed, “Yes! Life is important! Yes! We want better health and healthcare!” We all wanted better health and better healthcare. We stayed strictly politically neutral and rooted in Reverence for Life. I believe that this strategy was good and worked well in Kumamoto.

(Yoshitaka Takekuma Interview, 2010)

ACNHCK’s other strategy was education. Raising awareness about Reverence for Life and “Protecting your life and promoting better health” were top priorities of ACNHCK.

Young physician members organized telephone health counseling service every weekday evenings; lines were open not only to members but also to the general public. They took turns answering the phone calls. This phone counseling service was one of the efforts to fill the divide between patients and physicians. During the first year of service, ACNHCK conducted about 1,200 telephone counseling sessions (Abe, 2000, p.54). ACNHCK created a line to connect with physicians when patients and family members needed more time to discuss their health issues. The young member physicians also participated in outreach efforts and delivered educational programs and health checkups at Komin-kan, community gathering places, and temples in the communities. For these health checkups and other outreach programs, all preparations were managed by volunteers. In the first year of ACNHCK, 80 community outreach programs were delivered throughout Kumamoto and about 12,000 educational materials were distributed at the meetings (Figure 4-2; Abe, 2000, p. 55). To administer these outreach programs, the Kumamoto Prefecture Coalition of Women's Groups partnered with ACNHCK. Ms. Gaku Hatano, the President of the Coalition, was also President of the Concerned Women for Better Health which had been actively engaged in prevention of tuberculosis. Ms. Hatano joined ACNHCK and brought with her the prefecture-wide network of women's groups. From the Kumamoto Agricultural Cooperatives, Mrs. Tatsue Nishimura, president of the Kumamoto Agricultural Cooperatives Women's Group joined ACNHCK and facilitated rural outreach programs in farming communities. (Abe, 2000, pp.52-53, Yoshitaka Takekuma Interview, 2010).



Figure 11. Educational materials that were used for *Gakushu-kai* (community outreach program). Both were published by The Association for Creating New Health Care in Kumamoto in 1971. Left: Struggling Healthcare ; Right : Reverence for life. (Yoshitaka Takekuma Private Archive, 2010)

As an organization, ACNHCK had an executive board that oversaw seven units: 1) planning, 2) public relations and marketing, 3) fiscal, 4) legal affairs, 5) survey/research, 6) organization/internal affairs, and 7) administration. The initial board members were mainly former members of the Kumamoto Society of Rural Medicine and affiliated with Kumamoto University College of Medicine: Ryusuke Kawazu, M.D. Ph.D., Wasaku, Koyama, M.D., Ph.D., Hidenobu Matsukane, M.D., Kazuharu Nagao, M.D., Ph.D., Yukio Hashimoto, M.D., Ph.D., Yoshitaka Takekuma, M.D., Ph.D, Yukihiro Kusumoto, M.D., Ph.D., and Makoto Futatsuka, M.D., Ph.D. Some of the board members were classmates from medical school and former members of the Kumamoto Students Settlement Movement. (Yoshitaka Takekuma Interview, 2010; Kazuharu Nagao Interview, 2010; Wasaku Koyama Interview, 2010).

ACNHCK had no paid staff; all the work was shared by member volunteers. Every member participated in ACNHCK as a contributing member. There was no difference in status or privilege regardless of social status, occupation, amount of contribution, or gender. Members with a specific skill set, knowledge, or network volunteered to lead a unit. Journalists from Japan Broadcasting Cooperation (NHK) and Kumamoto Daily Newspaper volunteered to publish newsletters and helped with public relations and media campaigns. The Legal Affairs Unit was led by a former member of Kumamoto Student Settlement Movement who was a graduate of Kumamoto University Law School. ACNHCK remained grassroots and egalitarian, in part because its leadership team members were closely connected by that philosophy, and by shared experiences, personal trust, and friendship (Abe, 2000, p. 54; Yoshitaka Takekuma Interview, 2010) .



Figure 12. A picture from a planning meeting in 1971 with some of the ACNHCK leadership team members. Second from left, Yoshitaka Takekuma; center, Yukio Hashimoto; third from right, Kosei Shioyama (Japan Broadcasting Cooperation [NHK]); and second from right, Wasaku Koyama. (Yoshitaka Takekuma Private Archive, 2010)

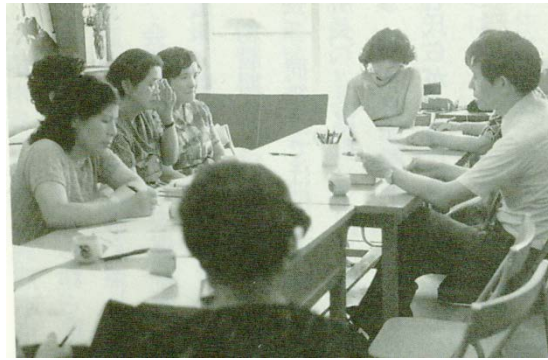


Figure 13. A snapshot from a meeting at ACNHCK office in Kumamoto city. Most of the participants were women volunteer members. (Yoshitaka Takekuma Private Archive, 2010)

Leadership and Political Diplomacy

To advance ACNHCK, leaders extensively utilized personal networks and connections to overcome the obstacles of politics. For example, they had to maneuver carefully to establish the Kumamoto Health Maintenance Association and revitalize the Japanese Red Cross Kumamoto Hospital. Those projects could have been derailed by the ongoing tension between the Kumamoto Medical Association and the leadership of ACNHCK.

Their strategy was to gain a wide range of support from community members and to move their agendas forward. As a stepping stone, in December 1972, ACNHCK members worked on a project to establish a foundation, the Kumamoto Health Maintenance Association. It was funded solely by donations and member contributions. The Kumamoto Health Maintenance Association delivered health checkups via health mobiles throughout Kumamoto (Abe, 2000, pp. 52-59). The outreach health check-ups/disease screening programs were a part of strategies to raise awareness about preventive health service

programs as well as to promote the activities of the Kumamoto Health Maintenance Association. Yoshitaka Takekuma reminisced about the political diplomacy of ACNHCK and how the organization dealt with oppositional power:

The ACNHCK leadership team held various opinions about how we should pursue our agendas. The pressure from the Medical Association was continuous, and it was getting quite difficult. I was personally feeling that if we did not get some help, the movement itself would disappear. On one occasion, I shared my concerns with Mrs. Gaku Hatano. She was the head of the Kumamoto Coalition of Women's Groups. She was also very active with the movement in preventing tuberculosis in Kumamoto. she was also connected with quite powerful individuals, too. She told me straightforwardly, "You need to meet with Mr. Torao Kawazu and ask him for his support. Probably no one else could help you in this situation. I will contact Tora-san [Torao Kawazu's nickname] and see if he will meet with you." Torao Kawazu was at that time a very special political figure not only in Kumamoto, but at the national level. He was the mayor of Oguni village in Aso [in the northeast of Kumamoto]; but he was also the president of the National Association of Towns and Villages. And he was the head of the Kumamoto Liberal Democratic Party of Japan. He was called a man with 100 titles, or some people called him Emperor Kawazu. In other words, he was like a godfather. Even the oppositional power from the Medical Association was not able to go against Mr. Kawazu, because, politically, Mr. Kawazu managed the Liberal Democratic Party in Kumamoto, which was a majority power in Kumamoto. Plus, being the president of National Association of Towns and Villages, even the

prime minister could not go against him. He was extraordinarily powerful.

Within the ACNHCK members, there were two members who were actually related to Mr. Kawazu. Dr. Ryusuke Kawazu was son-in-law to Mr. Torao Kawazu; and Dr. Masaaki Uchida was his nephew. I knew these two men very well from the University. Dr. Kawazu was OB/GYN and we were in the same faculty rank, and Dr. Uchida was junior to me in the same department. I shared Mrs. Hatano's recommendation with them, and asked them if they would help us to set up a meeting with Mr. Torao Kawazu. Of course, they did.

A couple of ACNHCK member physicians and I went to see Mr. Kawazu in Kumamoto City. He welcomed us and listened to what we were trying to accomplish through the Reverence for Life Movement and ACNHCK. I was very anxious, but I was able to connect with Mr. Kawazu and he responded to us in a very positive manner. He said, "Please pursue your plan as you wished. Let me work on the funding issues and we will manage it." Mr. Kawazu was also willing to accept the position of the chairman of the board of the Kumamoto Health Maintenance Association. I think in this way, he protected the movement for us: as chairman of the board, he knew no one would destroy the movement. Of course, he also became a member of ACNHCK as the mayor of Oguni village.

From Mr. Kawazu's perspective, there was a strong reason for him to support our movement. He shared with us that it had been challenging for him to recruit doctors to his rural village. Securing adequate healthcare for a rural village like Oguni [in a mountainous region] was always a headache. He told me, "I had to go to

the University's Medical School to beg professors to consider assigning a young doctor to the community hospital in my village. In return, usually, we were informed what they wanted – such as equipment for research or for the department. So we bought those and donated them to the department. They were not cheap, but it was almost like buying a toy for doctors. Still the frustration remained: young doctors did not stay in rural villages. In a year or two, they were gone. And the toys [equipment] were not fully utilized. Now, that is wrong.” Even for Mr. Kawazu, when it came to recruiting doctors and retaining them in a rural village—it was not an easy thing to do. Therefore, when he understood what we were trying to do—systemizing healthcare to provide prompt healthcare services in rural areas and promote health for communities in Kumamoto—he was fully supportive. I think Mr. Kawazu felt our passion and knew we were very serious about the health of rural people and determined to revitalize rural community health services. (Yoshitaka Takekuma Interview, 2010).



Figure 14. The front page of the first newsletter of the Kumamoto Health Maintenance Association: “Yes, I am Healthy!” published in December, 1974. Center picture: A photo from the gathering to celebrate the second anniversary of the Kumamoto Health Maintenance Association, which was held on October 19, 1974. Lower left picture: Mr. Torao Kawazu. (Yoshitaka Takekuma Private Archive, 2010)



Figure 15. The third page of the first newsletter of the Kumamoto Health Maintenance Association, “Yes, I am Healthy!” published in December 1974. Upper half: report of activities. From 1973 to 1974, with its health-mobile service, the Kumamoto Health Maintenance Association performed health screening programs in 116 communities, over a total of 160 days, and provided preventive health services to 14,124 individuals. Health education programs were offered in 114 communities and 14,900 individuals participated. Lower half: health and occupational health screening programs: A) Semi-annual health screening course; B) Comprehensive annual health screening course; C) Cardiovascular disease and screening program; D) Hematology and Anemia course; and E) Occupational physicals and occupation-related disease prevention and screening programs: 1) Greenhouse syndrome screening; 2) Pesticide poisoning screening; 3) Agriculture-related respiratory disease screening; and 4) Occupational physical exam. (Yoshitaka Takekuma Private Archive, 2010)

When ACNHCK proposed a plan of revitalization and relocation of the Japanese Red Cross Society Kumamoto Hospital, the leadership of ACNHCK used personal networks to encourage the prefecture to make a critical political decision. Yoshitaka Takekuma continued to describe the strategy of ACNHCK:

At that time [1970], there was an election coming up for Governor of Kumamoto. Running for that office was Mr. Issei Sawada, a Congressman from Kumamoto who had also been Lieutenant Governor of the prefecture. My dear classmate Dr. Kazuharu Nagao, who was an enthusiastic ACNHCK leader and a surgeon working for the department of surgery at Kumamoto University College of Medicine, was brother-in-law to Mr. Issei Sawada. His elder sister was married to Mr. Sawada. In February 1971, Mr. Sawada was elected Governor of Kumamoto. One day, I asked Dr. Nagao, “So, do you know what your brother [Mr. Sawada] would like to do as Governor of Kumamoto? Mr. Teramoto [previous Governor] built a new Kumamoto Airport.” Dr. Nagao said, “I don’t know. I have no clue.” In my mind, I wanted him [Dr. Nagao] to sense our plan for revitalization and relocation of the Red Cross Hospital and inform Mr. Sawada about the idea. Then, the old Red Cross hospital was located near Shirakawa River by Taiko Bridge, a central location in Kumamoto. It was located in a prime spot, but the hospital had become so old that it was just not functioning well as a hospital. We [ACNHCK physician members] all knew it. Then, the old airport location in Nagamine, in the eastern part of Kumamoto City, was flat and empty, because the previous Governor had built a brand new airport outside of the city. The old airport was called Mitsubishi Kengun Airport. We

wondered, if we would be able to rebuild the Red Cross Hospital in this new location in Nagamine. Building a hospital with a 24-hour emergency department was one of our dreams because there was almost no coverage of medical emergencies in the northern part of Kumamoto. Building a hospital in Nagamine would boost the quality of healthcare in Kumamoto tremendously, because the hospital would serve Aso, Yamaga, Kikuchi, Kikuyou regions [northern rural regions], and of course, Kumamoto City as well. To secure that land, we really needed help from the Kumamoto prefecture and the governor.

One day, I don't remember exact date but probably in late 1971 or 1972, Dr. Nagao and I went to see Mr. Torao Kawazu at his office. Oh, I will not forget what happened that day! We proposed our vision for the revitalization and relocation of the Red Cross Hospital and explained why we needed to build a hospital in Nagamine, and why it had to be the Red Cross Hospital. Mr. Kawazu was sharp, and he immediately got it. What happened in the meeting was that he picked up the phone on his desk and called Mr. Sawada's office, the Governor's office. The conversation was like this. "Hello, this is Mr. Torao Kawazu. Governor, I would like to inquire if there is any specific plan already made to utilize the land where the old airport was?" Then Mr. Sawada said, "No, there is no plan at this moment." Mr. Kawazu asked Mr. Sawada, "Well, then, is it possible to use the land to relocate the Red Cross Hospital from the center city to the old airport site?" And Mr. Sawada said, "Yes, please go ahead and use it." That was it. The deal was done. We were sitting close to Mr. Kawazu, so we heard the conversation between the two. I thought, "Wow, this is

politics!” A political decision like this actually happens behind the official stage.

And we actually witnessed it.

Also, at that time, Mr. Kawazu was Board Chairman of the prefectural Red Cross Society, appointed by Mr. Sawada. Mr. Kawazu told us ACNHCK leaders that “The most important part of any organization is its human resources. I really want to have excellent dedicated doctors and staff for this hospital. Therefore, I want you to be in charge of selecting good doctors for the Red Cross Hospital.” By gaining strong support from Mr. Torao Kawazu, we were able to move our agenda forward quickly. Selected ACNHCK members were appointed to the planning committee for the new Japan Red Cross Society Kumamoto Hospital. In May 1975, the hospital was opened as a teaching hospital with 300 beds and a 24-hour emergency department. Now the hospital has become one of the top teaching hospitals in Japan with more than 450 beds. It is also Japan’s foremost hospital for the dispatch of domestic and international disaster relief teams. I feel really good when I think of what we have done through the movement and ACNHCK: we really worked hard to rebuild the Red Cross Hospital! (Yoshitaka Takekuma Interview, 2010)

Kazuharu Nago, M.D., PhD recalled the political diplomacy of ACNHCK this way:

About the politics, I remember all the pressures coming from the Medical Association. I remember when the Kumamoto Medical Association boycotted vaccines produced by Kaketsu-ken (The Chemo-Sero-Therapeutic Research Institute), where Dr. Tokichi Rokutanda was the President. Dr. Rokutanda was the Chairman of the Board of ACNHCK. Boycotts of vaccines of Kaketsu-Ken brand by

private practice physicians caused tremendous negative impact to Kaketsu-Ken and put so many burdens on Dr. Rokutanda. These boycotts were actually the physicians' challenge against ACNHCK but not against Dr. Rokutanda personally. To deal with the situation, Dr. Chiro Shinomiya took over the Chairmanship and Dr. Rokutanda resigned. And the boycotts were resolved. Dr. Shinomiya was a professor emeritus from the Kumamoto University School of Economics. Because he was a non-medical academician, there was not much the Medical Association could do.

Concerning Mr. Torao Kawazu, he truly supported ACNHCK and what we were trying to do. I was selected to tour Europe, including visiting the U.S. and WHO in Geneva visiting various institutions and facilities to learn more about healthcare and healthcare systems; Mr. Kawazu contributed 700,000 Japanese yen to support that trip right out of his pocket! Another person who contributed just as much was the President of the Taiyo Department Store. It was a tremendous support. I think he also wanted to see a change in healthcare. (Kazuharu Nagao Interview, 2010).

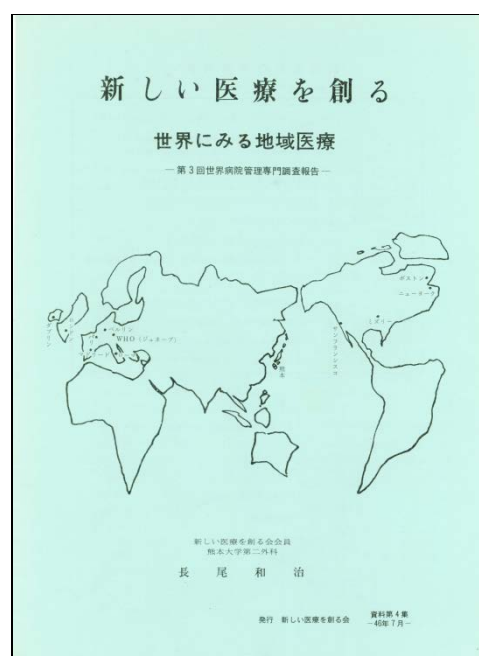


Figure 16. Front page of Creating New Health Care: Community Health Care in the World. Report published by ACNHCK in July 1972. Dr. Kazuharu Nagao, M.D., PhD reported on various community healthcare practices after he spent one month visiting Europe and the United States from June to July 1972. In the U.S. as a part of Japan Hospital Management Institute, Dr. Nagao visited San Francisco, St. Louis, New York, Chicago, and Boston. In Europe, he visited Dublin, London, Madrid, Berlin, Paris, Geneva, Rome, and Dusseldorf. In Geneva, Dr. Nagao submitted a report on activities of ACNHCK to the Japanese delegate to World Health Organization. Dr. Nagao made a special remark about Harvard Community Health Program, which was a community-based health insurance and health service program, whose trial service started in a very small apartment office in Boston. He felt a kinship with the “homemade” community health services that a community-based organization in Boston was attempting then. By sending a delegate from ACNHCK to the world healthcare tour, ACNHCK was learning the best community healthcare services from various parts of the U. S. and Europe (Yoshitaka Takekuma Private Archive, 2010)

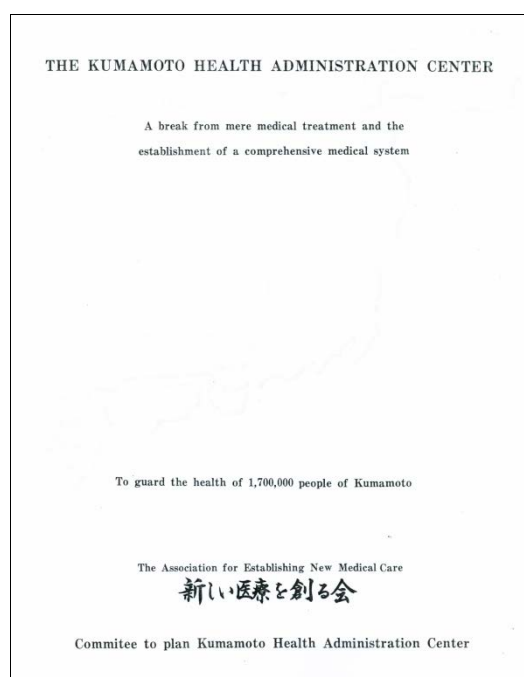


Figure 17. Front page of the report: The Kumamoto Health Administration Center (ACNHCK, 1971). Published in May 1971, this report, written in English, was submitted to the Japanese delegate to the World Health Organization in June 1971 by Dr. Kazuharu Nagao. The report included a mission statement, a report on Kumamoto's current healthcare system and its issues, and planning for the Kumamoto Health Administration Center. (ACHNCK Archive, 1971)

This chapter presents the establishment of Association for Creating New Health Care in Kumamoto (ACNHCK) and its activities. ACNHCK continued to move its agenda forward through not only through its healthcare division, but also in the divisions of Food and Farming. The stories of the two divisions will be described in the later chapters. As a community-based grassroots organization, ACNHCK focused on action – they utilized extensive educational programs, continued to offer health screening programs by the volunteer member healthcare professionals. While they were actively involved in such community-based health programs, ACNHCK continued to gain a wide range of support

from ordinary citizens as well as from politically influential individuals. ACNHCK strictly maintained political neutrality never affiliating with any political organizations; however, its activities and diplomacy became quite political as they pushed ACNHCK's agendas of establishing the Kumamoto Health Maintenance Association and the revitalization and the relocation of the Japanese Red Cross Society Kumamoto Hospital. ACNHCK worked closely with politically influential individuals and elected officials wherever they found mutual understanding and benefits. Over the ten years of ACNHCK's organizational life, from 1970 to 1980, its leadership team strategized carefully to realize their agendas.

Chapter 5

Women

In the Reverence for Life Movement (RLM), women played significant roles. Women helped initiate the movement, move the agendas forward, and make the RLM thrive. In the beginning of this chapter, health issues of women in Kumamoto are described through social, cultural, and historical perspectives. In the middle section, distinct women's leadership and contribution to RLM are introduced; and the end of the chapter describes a women's initiative forged from RLM to connect consumers and organic farmers, thus ensuring safe food and a cleaner environment for better health.

Women's Health

For a long time, women in rural Kumamoto suffered from multiple burdens: poverty, hard farming labor, social norms and gender roles imposed by the conservative patriarchy, multiple pregnancies, malnutrition, and lack of freedom and privacy in the multi-generation family structure. All those years, rural women had endured and survived. Even after WWII ended, the situation for rural women did not bode well. During the late 1950s through 1970s, Japan grew rapidly and reconstructed its infrastructure. Larger cities such as Tokyo, Sendai, Nagoya, Osaka, and Fukuoka attracted more and more workers from rural communities for constructions, factories, and other business markets. Thus rural communities suffered from the out-migration of men. Women were put in the position of managing not only the households but the family business—farming.

Women comprised more than 50% of Japan's farming population. From 1946 to 2004, women were the major work force in the farming industry (Ministry of Agriculture,

Forestry and Fisheries, 2010). Between 1960 and 1974, women carried out the majority of family-operated farming (Ministry of Agriculture, Forestry and Fisheries, 2010). Women not only ran the farms, they were expected to take care of older family members such as grandparents-in-law, parents-in-laws, and their children, and at times they took care of siblings-in-law. In Japanese cultural tradition, a woman married to a son who was the heir of her husband's family was assigned a servant's role. The wife was literally "*given in marriage*" to her husband's family. In Japanese society, with its influence of Confucianism, the cultural and social expectation for women was often described this way: "When you are young, follow your father; when you marry, follow your husband; and when you become old, follow your son." When the husbands were working in the cities, wives were expected to follow their parent-in-law's orders. Usually no financial freedom or days off were allowed; adult women in the farming villages were often physically overloaded with hard labor, family responsibilities, and they were under heavy stressors. During 1960s and 1970s, despite rapid economic and societal development, the cultural and social expectations for rural women's roles remained. And those roles threatened women's health.

In early 1960s, media reported a concerning phenomenon among women in rural Kumamoto: "Moms in farming villages are light blooded." A campaign for blood donation by the Japanese Red Cross Society revealed that over 40% of the adult women donors were not qualified to donate blood due to low hemoglobin level below $< 12\text{g Hb/dl}$. In the rural area over 50% of adult women donors were rejected to donate blood due to low hemoglobin level (Nishinippon Newspaper, 1972, pp. 168-169). According to the World Health Organization, iron deficiency anemia is the most common malnutrition-related illness among

women of all ages in developing countries (World Health Organization, 2010). This severe problem afflicted women in Kumamoto during the 1960s and 1970s. The contributing factors included lack of iron-rich food and protein in diet, parasites, gastric ulcers, hemorrhoids, and multiple pregnancies without long enough intervals to recover from the previous pregnancy and nursing (Kumamoto Society of Rural Health, 1972). In Kumamoto, prevalence of iron deficiency anemia among the population 65-years and older was 24%; however, among the adult women in rural farming villages between ages 20 and 59, it was 42% (Nishinippon Newspaper, 1972, p.170).

Mrs. Katsuko Ueda, a dietitian from the Kumamoto Central Agricultural Cooperatives (JA Kumamoto), was one of the strongest advocates for rural women's health issues in Kumamoto. As a life improvement consultant from JA Kumamoto, Mrs. Ueda was very familiar with rural farming communities, sociocultural issues, and rural family structure in relation to women's health. When she joined KSRM, she had served more than 15 years for JA Kumamoto, visiting every rural village to offer cooking classes through JA women's groups to improve diet and lives among the farmers. She literally knew every one of the villages because she had observed daily lives of people in the rural farming communities in post WWII Kumamoto (Yoshitaka Takekuma Interview, 2010). Mrs. Ueda described her struggles in the interview with Nishinippon Newspaper:

Farming moms are so busy, they have literally no time to stand at the kitchen counter; therefore, they tend to cook very easy, quick meals such as dumpling miso soup, miso soup, and potato soup, but nothing much beyond that. Because of the hard life, busy work, and frugality of farmer's nature, farming women had little exposure

to other foods except on very special occasions. Their children now criticize their mothers' cooking as "out of date." When I ask questions such as "What kind of programs would you want JA women's group to offer for you?" there is usually one typical answer: "cooking classes." Therefore, I usually offer cooking classes in villages. I choose nutritionally well-balanced dishes. When I teach a new item at the cooking class, the general reaction of farming moms is something like, "Oh my, how tasty it is! It looks beautiful and stylish!"

You know, I want them to use the recipes I teach, but it just doesn't happen. They keep the recipes for special events, like a village festival, and their daily meals stay the same! If I ask them, "Why you don't change your daily diet? If you don't get decent nutrition, you feel tired and lack energy, don't you?" Then, they would tell me, "Whether I eat good food or not, how I look won't change." Or "If I feel tired or uncomfortable, it's a proof I'm alive." When I hear those answers, there's nothing I can do.

I often wondered why my strategy to improve farmers' diet did not work well with farming moms. You know, I think the problem originated in the culture of farming families. Farmers sacrifice themselves. They are so frugal they feel investing in themselves is indulging themselves. Also, a farmhouse kitchen is pre-modern and not functional. And most of all, there's a destined relationship between the young wife and mother-in-law! I know many young wives who attempted to vary their cooking, but they were blamed by the in-laws and being told "Such a waste and you eat too much!" Usually, the mother-in-law is in charge of the kitchen; even when a

young wife proposes a new dish, the in-law replies, “Humans can live on the three precious grains: rice, wheat, and millet,” and turns down the daughter-in-law’s proposal. You know, there are mother-in-laws that hide sugar in the closet to keep sugar away from daughter-in-laws because they were afraid that the young wives would waste it! Farming moms’ lives are so tight and full of endurance; and it is hurting their health.” (Nishinippon Newspaper, 1972, pp. 165-167)

The migration of men from Kumamoto villages concerned Mrs. Ueda because it deepened the stresses on farming women. She responded in 1964, when Prime Minister Hayato Ikeda was pursuing a “high economic development and income-doubling plan;” she made an appeal at a constituents’ meeting at which cabinet members attended. She voiced her concerns from a seat in the audience:

Men in the farming villages are now gone to the cities to develop the economy, making buildings and roads. As a result, all the hard labors of farming are now heavily pressing the shoulders of women in the villages. There is no one to look after their children. When children get washed away in the river and die, when small children get trapped in an outhouse and drop into the pit and die, farming women must keep cultivating rice patties and cutting grass in the fields without knowing where their children are. They have no clue what is happening to their children.

Demands of farming and heavy responsibilities stretch women in farming villages so thin. These burdens are eroding the health of women in the farming villages. We must do something about this! (Nishinippon Newspaper, 1972, p.167).

When the RLM was initiated in 1960s, adult women in rural farming villages in

Kumamoto were severely disadvantaged and vulnerable. However, through the RLM, the efforts of an individual like Mrs. Ueda, and rural farming women's participation, the long-ignored women's health issues were brought to the frontline of critical healthcare issues in Kumamoto. Women's health issues and gender inequality are still one of the target areas that the World Health Organization has emphasized in its campaign for PHC (World Health Organization, 2011). It is noteworthy that, decades ago, women in Kumamoto, too, suffered from gender-related health issues just as many do today in other parts of the world. In the case of Kumamoto, the health status of women in rural communities has improved dramatically because Kumamoto has annual health screening programs, community health services by municipal public health nurses, a population that is aware and participates in health improvement, and sociocultural changes over the three decades since 1970s.

Women's Leadership

During the 1960s and 1970s, Kumamoto benefited from distinguished women leaders. In the RLM, those women leaders helped to pave the way to success. When the Kumamoto Society of Rural Medicine (KSRM) was established and began its epidemiological study, women members volunteered to organize the fieldwork and helped communicate with each village. When the Association of Creating New Health Care in Kumamoto (ACNHCK) was formed, women members outnumbered men. Women put their voices together to express their concerns and hope for better health for themselves and their families. Women participated actively to move ACNHCK forward. And finally, by actively participating in ACNHCK, some women members became leaders of Japan's movements for consumers' rights, environmental health, and organic farming; they contributed to advancing

healthy communities and a healthy society. It is critically important to illustrate those women's contributions because without their leadership, RLM would have failed to mobilize the community.

Ms. Gaku Hatano, an educator, became the first women principal in the Kumamoto Public Schools; an activist, she joined RLM in 1970. She became an ACNHCK member and supported ACNHCK efforts to establish the Kumamoto Health Maintenance Association. When Kumamoto Health Maintenance Association was officially founded, she joined the board as a vice chair. Ms. Hatano was recognized as a distinguished individual who contributed to the betterment of humanity and culture in Kumamoto in 1976 (Kumamoto Prefectural Board of Education, 2010).

Gaku Hatano had been born in 1904 in Aso, the northeast region of Kumamoto, a land of forests and mountains (Kumamoto Prefectural Board of Education, 2010). Growing up in a rural village, she knew very well the lives of people in rural farming villages. When she joined ACNHCK, she was the President of the Coalition of Women's Groups in Kumamoto, an organization that connected women's groups from each city, township, and village in Kumamoto. The objectives of the women's groups were to educate women, to improve women's family and social lives, and to contribute betterment of society. With her background as an educator and her status as the first woman principal in the Kumamoto Public Schools, she influenced the women's groups in Kumamoto. Gaku Hatano was also the President of the Concerned Women for Better Health, an organization to raise awareness of tuberculosis and its prevention. It was founded in 1965 because Kumamoto had the highest prevalence and mortality of tuberculosis and the lowest screening rate in Japan (Kumamoto

Health Maintenance Association, 1974). Hatano described how she and the members of the Concerned Women for Better Health struggled:

In 1965, we formed Concerned Women for Better Health with hope of reversing our tuberculosis screening rate of 40%, the worst screening rate in the country. Our members created a tuberculosis screening record for each person. Our members visited each household in the community and collected baseline information. We offered educational programs and study groups to raise awareness about tuberculosis. I was speechless and deeply shocked to see the tuberculosis screening rate still remained in 40% even after 10 years of our women's dedication and tremendous efforts to improve the situation. I told to myself that if we could improve the screening rate, tuberculosis would be identified and treated early—a good thing—but in statistics, the increased screenings would show a higher prevalence, which we had to bear with. However, the screening rate was still low. What was wrong with the picture? Then I realized that not only were few people screened for tuberculosis screening, few were screened for anything. We needed to change the system. (Kumamoto Health Maintenance Association, 1974)

At the first annual meeting of ACHNCK, Gaku Hatano spoke:

There should be no one who opposes the establishment of the Health Administration Center that protects and promote health of 1,700,000 Kumamoto citizens. If there is any opponent, it must be the one of the few who would lose profits. We must advance this movement in a right and orderly manner. To move our agendas forward, we need to raise awareness for health among our citizens—this

movement is not a planned movement from the top (government), but it is indeed a voluntary movement based on our severe need, strong hope, and our demand for better health and healthcare! (Nishinippon Newspaper, 1972, p. 208)

Ms. Hatano also advised the young physicians based on her experience as a health promotion activist: “We need to explain the objectives and processes to accomplish what we plan. Until those issues are clear, we should not collect any membership fees. We need to make what we are trying to do crystal clear to everyone (Nishinippon Newspaper, 1972, p. 208). She recommended that the young member physicians go into the communities and rural villages to introduce themselves, host study groups, and share the visions and goals of the movement. The young ACHNCK physicians held over 80 study groups throughout Kumamoto and participated in discussions with concerned community members (Nishinippon Newspaper, 1972, p. 209).

Yoshitaka Takekuma, M.D. PhD. described Gaku Hatano:

Ms. Gaku Hatano was an educated and dedicated leader who led the women’s groups to work with us (ACHNCK). The Kumamoto prefecture was supporting women’s groups based in townships and villages—which meant that if we got support from Mrs. Hatano, we had the support of 200,000 Kumamoto women. She spearheaded prevention of tuberculosis when we were doing the study with KSRM, and we were able to collaborate for one purpose: “better health and better healthcare for the citizens of Kumamoto.” She had a depth of knowledge about politics in Kumamoto. She helped us to connect with Mr. Torao Kawazu, who later helped us tremendously to establish the Red Cross Hospital as well as the Health Maintenance

Center. From that perspective, without Ms. Hatano's help, the movement would not have been so successful. (Yoshitaka Takekuma Interview, 2010).

There were two other distinguished women leaders from the Kumamoto agricultural cooperatives. These were Mrs. Tatsue Nishimura, President of the Coalition of Agricultural Cooperatives Women's Groups (JAWG) and Mrs. Katsuko Ueda, a dietician and a life-improvement consultant from JA Kumamoto, who actively advocated for women in farming villages in Kumamoto. With the efforts of these two leaders, JAWG and its members were the most active but the least known actors in RLM during the 1960s and 1970s. From the inception of the Kumamoto Society of Rural Health, JAWG recruited rural women to participate the study, organized study groups at local agricultural cooperatives (JA) offices. In the conservative environment of rural farming communities, women worked patiently to raise awareness about their own health and contributed to the RLM to establish better healthcare. The JAWG members started a "one yen (one penny) for health" movement to contribute to the establishment of the Kumamoto Health Maintenance Association.

Yasuyuki Hongo, a former chief manager of the Kumamoto Health Maintenance Association, described the contribution of women:

When the Kumamoto Health Maintenance Association was founded, we were able to collect 7,000,000 yen of donations from members and local businesses. The biggest business donation was about 500,000 yen, from a corporation such as Higo Bank. But the largest contribution to the Health Maintenance Association came from women. Out of 7,000,000 yen, 3,000,000 yen were donated by women's groups. Not many people know about this fact, but each woman from JAWG and the community

women's groups donated 10 yen per member to this cause and collected 3,000,000 yen. JAWG was doing "one yen (one penny) for health" movement, but the members actually donated 10 yen per person out of their tight allowance. About 300,000 women contributed to this cause with their hope. I think, this is something that we need to remember. For me, 10 yen from each one of the member from the women's groups was more precious than a big donation from a company. Women were our strongest supporters, and our center was built on the prayers of those women (Yasuyuki Hongo Interview, 2010).

The history of RLM from 1970 to 1980 records a trail of women's growth and development. When ACNHCK was established, women members took the initiative to create a division of food and nutrition within ACNHCK. The majority of the women who participated in the initiative were homemakers, who addressed concerns for health issues in relation to pesticides in agriculture. The initiative was congruent with ACNHCK's agricultural initiative, seeking safer and sustainable farming practice without use of chemical fertilizers and pesticides. There was a synergy between the two initiatives. In July 1977, with 600 memberships, Mrs. Toshiko Ito and the ACNHCK women members established an organization, Reverence for Life and Food, a consumers' organization to raise awareness about healthy eating and safe organic food. Reverence for Life and Food supported organic farming in Kumamoto.

Mrs. Chieko Takekuma, who was among the initial members of the Reverence for Life and Food, recollected her experience as a woman member:

I joined ACNHCK because my husband was one of the leaders of ACNHCK. I volunteered at the ACNHCK office to help with whatever I could do; however, I felt that my presence was not recognized as Chieko, an individual, but as Mrs. Takekuma. Yet that situation changed 180 degrees by the time I participated in the initiative for Reverence for Life and Food. My eyes were opened by Dr. Yanase, who addressed the negative health impact on humans and environment of pesticides and chemical fertilizers. I had four children, and I was motivated to protect my children's lives from harmful foods and a polluted environment. Later in the movement, I became very active in the environmental health movement to protect underground water and aquifers. As a homemaker, I continued to work with other women to raise awareness about the dangers of synthesized chemical detergent in households. While I was active in this movement, we hosted a national conference on environmental health and water in Kikuchi, where I live. When I became the leader of the movement, I was no more Mrs. Takekuma, but Chieko, an activist. (Chieko Takekuma Interview, 2010).



Figure 18. A photo from the environment health and water conference in Kikuchi, Kumamoto (Photo donated by Chieko Takekuma).

For RLM, women were cornerstones of the movement. Women advocated for better health, better healthcare, safe food, and better environment for their loved ones. Women actively voiced their hope. Together, they created a critical mass for the movement.

Women's dedication and activism in the RLM contributed significantly to the development of the Kumamoto Health Maintenance Association and the new movement to promote safe food, good eating, a better environment, and organic farming in Kumamoto.

Chapter 6

Farmers

Farmers and farming played significant roles in the Reverence for Life Movement (RLM) and development of its theoretical framework: integration of healthcare, food, and farming/agriculture for health. Farmers' voices and actions to seek better health opened a door for the RLM to bring its agendas to the forefront in Kumamoto. The agenda called for a new healthcare system that would systemize the healthcare services in a cost effective manner. Farmers themselves addressed questions and fears about their farming practice, which emphasized modern technology, increased productivity, and more profits. They were using chemical fertilizers, pesticides, and modern industrial equipment such as vinyl greenhouses, which drastically changed not only their practices but the seasonal farming calendar. Farmers' lives had changed from subsistence farming to year-round production of more profitable produce. At the same time, farmers continued to suffer from occupational health problems such as pesticide poisoning, heat stroke from work inside greenhouses, and farmers' syndrome such as severe back pain, shoulder pain, and neuropathy of extremities. These disorders came with long hours of hard labor to meet the need of the market.

Thus, along with women, farmers strongly supported the Reverence for Life Movement. In this chapter, firstly, background is introduced: farmers' health, farming practice, and issues related agriculture during the 1960s to 1970s. Secondly, the chapter presents case histories by a physician who had identified harmful effects of pesticides and other chemicals on health, food, and farming. Later in the chapter, farmers' roles,

contributions, and leadership in the RLM are described, along with the development of organic farming in Kumamoto.

Modern Agriculture and Farmers' Health

During the 1960s and 1970s, farmers in Kumamoto and throughout Japan were facing multiple challenges. Men migrated out of farming villages to the urban cities as laborers; remaining farmers adopted new technologies and equipment, chemical fertilizers and pesticides replaced traditional farming methods, and agriculture was driven by market forces that brought borrowing and increased financial burdens. In the era of rapid economic development, the farming-labor workforce was described as “three-person farming”: grandpa, grandma, and mom. The head of household, “dad” was missing. It was a little-known fact that the majority of the Japanese farming workforce consisted of women (Ministry of Agriculture, Forestry and Fisheries, 2010). The vulnerable farmers—elderly people and women—were brought to the forefront in the drastic modernization of farming. It seemed as if farmers in Japan enjoyed the benefits of the new technologies; however, behind the changes, Japanese farmers' health severely declined.

Dr. Giryō Yanase, M.D. was in private practice in Gojo City (approximate 1960 population, 35,000), in Nara Prefecture. He was one of the pioneer physicians who addressed the effects of pesticides on health and environment. In 1961, he published a book titled *Harmful Effects of Pesticides* (Yanase, 1961). He warned that harmful effects of pesticides would be a major public health problem. It was about the same time that Rachel Carson, a scientist and ecologist in the United States, published her alarming work *Silent Spring*, which addressed the harmful effects of pesticides and synthesized chemicals on health and

environment (Carson, 1962). In 1958, Dr. Yanase observed a group of patients who presented with some combination of neurological symptoms, mental status change, increase of liver enzymes with hepatitis-like symptoms, gingivitis, ulcers on tongue and other oral membranes, and/or acute gastroenteritis. In the same period, the Gojo City officials observed that many birds died with neurological symptoms of unknown causes (Yanase, 1961, pp.1-2). Yanase investigated further and conducted fieldwork in Gojo City in summer of 1958; he traced the illness to vegetables produced in the city. Yanase reported that farmers were using Parathion (diethyl patathion, brand name: Folidol), an organophosphate compound, a potent insecticide and acaricide, not as a field pesticide, its original purpose, but instead to maintain freshness of produce. A day before shipment for the market, farmers washed vegetables in the Parathion solution (diluted in 1,500 -2,000 times) or sprayed it over the vegetables. This trick was widely practiced among the area farmers to keep vegetables fresh longer, which would increase their market value (Yanase, 1961, pp. 1-2). Yanase assessed and treated 72 individuals during this Parathion incident in 1958. Subsequently, Dr. Yanase continued his research and reported an increased prevalence of acute and chronic pesticide poisoning among farmers in Japan. As a physician, he recommended that farmers return to organic farming, which facilitated better health as well as environmental safety (Yanase, 1961, pp. 1-2). In 1961, Dr. Yanase initiated an organic farming movement with area farmers in Gojo City. He later connected with Dr. Yoshitake Takekuma, M.D., a leader of the RLM, and contributed to the RLM in facilitating organic farming movement with the ACNHCK member farmers.

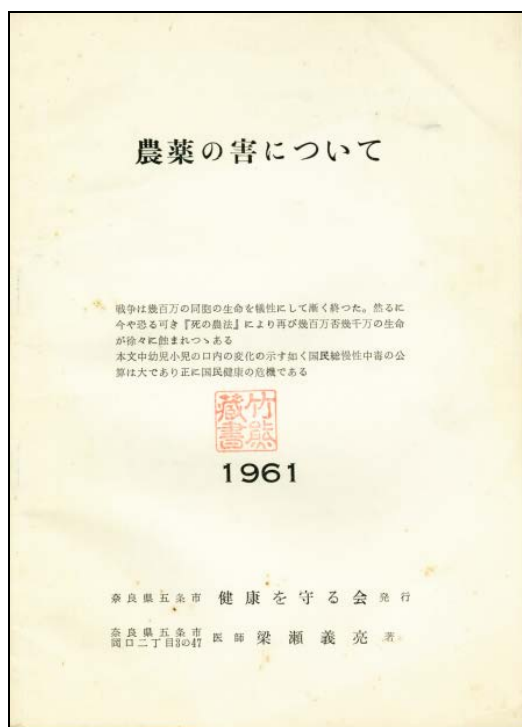


Figure 19. Front page of *Harmful Effects of Pesticides* by Giryo Yanase, M.D. (Yanase, 1961). (Yoshitaka Takekuma Archive, 2010)

Yoshitaka Takekuma, M.D., described his encounter with Dr. Yanase:

Dr. Yanase's evidence-based approach to the effects of pesticides, and his passion and dedication to organic farming were very inspirational and instrumental to me. I learned a great deal from Dr. Yanase. He had many patients who were suffering from acute and chronic pesticide poisoning. While he was seeing his patients, he educated them that their cure was only possible if they stopped using pesticides and ate only foods completely free of such chemicals. As physicians, we were able to connect deeply in our concerns for the health of farmers, the health of all citizens, and the health of our environment. Dr. Yanase shared with me how he had connected farming and medicine, and farming and food in relation to health, based on his

clinical practice as a physician. During the upsurge of Gojo City parathion poisoning in 1958, Dr. Yanase found out that there was something wrong with green cabbage, which was grown there. You know, in Kansai (west region of Japan), people love eating pancakes with lots of shredded green cabbage in them. He realized that the patients who presented those multiple symptoms with unknown cause, all loved to eat pancakes with green cabbage. He analyzed ingredients of the pancakes and pinpointed that the green cabbage was the cause. He found out that the cabbages which were used for the pancakes were coated with Parathion solution to keep their fresh, crisp texture and extend shelf life. That farming practice harmed both food and environment and caused severe health problems. As Dr. Yanase identified, farming, food, and health are not separate, but really, they are very closely connected—like a trinity. In the RLM, we were working with farmers who were really struggling for health. Therefore, integrating organic farming and producing safe food for the citizens of Kumamoto was so relevant. Dr. Yanase was a futurist. By collaborating with Dr. Yanase, we were able to develop a new conceptual framework that connected healthcare, food, and farming for health. (Yoshitaka Takekuma Interview, 2010).

Takekuma also shared his experience as a child farmer:

After the war (WWII), my mother and my siblings moved to my mother's hometown, Yamaga (northern Kumamoto). By the end of the war, my family had lost everything by fire after an airstrike in Kumamoto City. In Yamaga, my two brothers and I became child farmers and grew rice and vegetables. One hot summer day, when

I was a ninth grade, while my two brothers and I were participating in a neighborhood duty to spray pesticide in the area rice paddies, an accident happened. All such work was done in a group with the neighbor farmers, because it was an intense operation. Since we were the youngest farmers, we had to pull the spray hose and walk through the rice paddies, and it was hard labor. While we were spraying, suddenly we realized my younger brother was missing. My older brother, Koichi, and I searched for him around and we found him unconscious in the middle of the rice paddies. He was so pale! Koichi and I took turns and carried our younger brother on our back and run to a small hospital in the village. I also picked up an empty bottle of the pesticide from the edge of the sidewalk, and took it to the hospital with me. I showed the bottle to the doctor, but he did not pay much attention to it. It was Folidol (Parathion). My brother got pesticide poisoning. We were only wearing sleeveless shirts, short pants, and sandals. No mask, no gloves, and no protection at all. We were so poor and had no knowledge about pesticides. My brother was unconscious for several days, but he was saved. In fact, this experience determined me to become a doctor. I wanted to be a doctor to help farmers. I knew how hard the life of farmers was. With all the insects and weeds, with no young men in villages, farmers could not help using pesticides and chemical fertilizers to reduce hard farm labor; otherwise they could not catch up with the amount of work that needed to be done. But as a result of this “labor saving,” the farmers suffered from new burdens (Yoshitaka Takekuma Interview, 2010).

A woman farmer in Yamaga, Kumamoto, complained about their situation to an ACNHCK doctor during a health check-up:

I would like to get revenge on whoever invented vinyl. Vinyl greenhouses are killing us and changed our life for the worse. JA [agricultural cooperatives] recommended that we invest in a vinyl greenhouse, because they told us that we could sell our vegetables much earlier and keep selling until much later than the normal season; we could earn a lot more money. Our neighbors were going for it, so we did, too. We did not want to be left behind. We are growing watermelons and cantaloupes. Sometimes, we had to heat the greenhouse to keep the temperature consistent, so it cost a lot. During the summer, that vinyl house is just like a heated hell – it is so hot, and we need to spray (pesticides) inside of the vinyl houses. It makes you so sick. My asthma is not getting any better. It causes headache, dizziness, and backache. I am tired all year around, because there is no down season. Vinyl houses have become a burden for me, but I do not know how to stop using them (Nishinippon Newspaper, 1972, pp. 176 – 180).

The RLM and the Organic Farming Movement

During the course of the RLM, improving farmers' health was part of the main agenda. The farmer members were very concerned about the harmful effects of chemicals and pesticides in their daily farming practices. With influence of Dr. Yanase and his organic farming movement in Gojo City, a new initiative to facilitate organic farming in Kumamoto was forged from within the RLM (Abe, 2000, pp. 71-81). Organic farming was a new concept for farmers in Kumamoto. Officially, the use of the term “organic farming” was initiated when the Japan Organic Agriculture Association (JOAA) was established in 1971.

During 1970 and 1980, the ACNHCK was the major vehicle of the RLM, and ACNHCK farmer members established a division of farming within the organization to promote organic farming in Kumamoto; however, there were few organic farmers at that time in Kumamoto, so the member farmers had to learn methods of organic farming.

It is important to acknowledge that Kumamoto had been the birthplace of an enlightened philosophy of farming. Mr. Kiichi Matsuda had founded the Japan Farming Fellowship in 1918 in Kumamoto (Masuda, 1990, pp.186-188). He was later called “Saint of Farming” among the farmers in Japan. Matsuda dedicated his life to teaching farming methods and philosophy of farming. In Kumamoto, there was a network of students who were taught by Matsuda and became active members of the Japan Farming Fellowship. The network was like an aquifer; the members were connected silently and bonded closely under Matsuda’s teachings and philosophy.

In March 1974, ACNHCK farmer members and leaders of ACNHCK encountered with Mr. Mitsuyuki Takamaru, who was a leader of the National *Ainou-kai*, a Christian farmers’ group founded in Mie, Japan. Mr. Takamaru was running an egg farm in Mifune, Kumamoto. He had extensive knowledge and skills in raising chickens, and he produced quality eggs by using hens that ate organically home-grown feeds. Mr. Takamaru was experimenting with a home-developed organic chicken manure to fertilize other crops organically. Mr. Takamaru and the farmer members of ACNCK found a connection through the Japan Farming Fellowship. As a young man, Mr. Takamaru had apprenticed to Mr. Kiichi Matsuda. Thus the Japan Farming Fellowship brought together innovators and common farmers, and the organic farming movement thrived in Kumamoto. In October, 1974,

Kumamoto Organic Agriculture Association (KOAA) was established as an independent entity to facilitate organic farming in Kumamoto (Abe, 2000, pp. 72-74).

When RLM had mobilized a critical mass of public opinion on an issue, it shifted efforts to the next level by holding a conference. During the course of the RLM, from 1962 to 1980, it hosted three significant conferences: Kumamoto Citizens' Forum for Better Health in 1969, Reverence for Life and Soil Forum in 1975, and the Japan Organic Agriculture National Conference in 1978. The role of a conference for the RLM was to organize extended groups and individuals into the movement. The conferences provided opportunities to raise awareness about the topic matters, and empowered participants by creating a new network, and motivated them to take action for the next agenda.

In 1974, the KOAA was established, by ACNHCK members and other farmers who were interested in organic farming in Kumamoto. There was a severe need for a stable market and mechanism to distribute organic produce. Regular fresh produce was traded in the central market under certain sizes and grades; but organically grown vegetables were often irregular in sizes and shapes. Difficult to grade, they were difficult to market. And without a stable market farmers could not make organic farming pay. Establishing a system to distribute organically grown produce from the farmers to the consumers was a critical issue for the organic farming movement. About the same period, the food division of the ACNHCK, most of whose members were non-farming homemakers, was synergistically working with the ACNHCK farming division to support farmers who made the transition to organic farming; and the food division helped coordinate distribution of organically grown produce among ACNHCK members. However, other consumers demanded organic produce,

so there was a significant need to expand the movement's services to connect them with farmers who wanted to transition to organic farming and needed a stable market and support systems. Thus the ACNHCK and the KOAA jointly hosted the Reverence for Life and Soil Forum in March 1975. Invitations were sent to consumer cooperatives, women's groups, agricultural cooperatives, and local municipalities. On March 16, 1976, the conference became a great success, with the Kumamoto *Shimin* Concert Hall full of participants (Abe, 2000, pp.72-80; Yoshitaka Takekuma Interview, 2010). The forum provided an opportunity of farmers and consumers to meet and exchange their opinions and perspectives on healthcare, food, and farming for health. It was indeed the first conference in Kumamoto where rural farmers and the urban consumers joined together to learn about importance of safe food for better health, and the importance of protecting soil from chemicals and pesticides. The conference helped to create mutual trust and partnership between consumers and farmers.

The Reverence for Life and Soil Forum was a booster for the RLM as well as for the organic farming movement in Kumamoto. The consumers and the farmers continued to work together to create a market for organic food. In June 1976, the Kumamoto Organic Produce Distribution Center was opened as an independent entity. In July 1977, the Kumamoto Reverence for Life and Food Association was formed, with 400 initial members, a majority of whom were also members of ACHNCK.



Figure 20. A photo from the Reverence for Life and Soil Forum in 1975 (Yoshitaka Takekuma Private Archive, 2010)

Economic development during the 1960s and 1970s brought changes among Japanese farmers' lives. New technologies, agricultural method advancement, pesticide, and synthesized chemical fertilizers enhanced productivities and expanded marketability. Increase in revenue and lightened farming labor was expected in the course of development; however, economic development and modernization in agriculture brought mixed outcomes to the farmers. Occupational and environmental health problems made concerned farmers to re-evaluate their farming practices and made them to venture for organic farming. It is very important to acknowledge that in the RLM, with a new theoretical framework of healthcare, food, and farming for better health, the movement facilitated to develop a system that is relevant for consumers and farmers to support sustainable agriculture that would contribute to the health of citizens and the environment. The process was taken place in intersectoral manner with community participation, which was addressed as critical elements of PHC, defined by World Health Organization (PAHO/WHO, 2007, pp. 8-16).

Chapter 7

Contributors

This chapter describes notable contributors to the RLM. The RLM was initiated by a group of young physicians and others from the community who were concerned about the health of Japan's rural population. Over the course of the RLM, from 1962 to 1980, the movement thrived and gained a wide range of support from the community. But certain professions, groups, and key political figures played unique roles in the RLM.

Journalists

Journalists played critical roles in the RLM. During the course of the movement, journalists helped disseminate information about the health status of the rural population. They continued to report healthcare news, much of which exposed the challenges of healthcare in Kumamoto. The mass media helped to mobilize the community; it built a critical mass of opinion for creating a new healthcare system. Journalists informed citizens of Kumamoto about the progress of the RLM through newspapers, TV programs, radio programs, and co-hosting conferences with ACNHCK. In fact, the news about the prevalence of “light blood”—iron deficiency anemia—among women in rural Kumamoto triggered the Kumamoto Society of Rural Medicine (KSRM) to initiate the five-year study on the health status of farmers in Kumamoto.

In fall 1970, a team of journalists from Nishinippon Newspaper published a series of articles titled “Reverence for Life—whose healthcare is it?” In 1971, the series received the Japan Newspaper Publishers and Editors Association Award, the most respected awards in newspaper publication (Japan Newspaper Publishers and Editors Association, 2010). One of

that team of journalists, Mr. Takamichi Tamagawa, reported on the RLM from a member's perspective. Tamagawa joined both the RLM and ACNHCK and wrote the articles that reflected the farming communities' realities, and the efforts and challenges of ACNHCK members. He addressed issues of healthcare and the need for a system that would serve the whole community. Mr. Harutoshi Kanemoto, a chief editor of the Nishinippon Newspaper, acknowledged that the series "Reverence for Life—whose healthcare is it?" received severe criticism from some physicians, and there were pressure and financial threats—pharmaceutical companies withdrew advertisements. However, what kept the campaign going were the 2,000 letters of support from readers, sharing their concerns for healthcare (Nishinippon Newspaper, 1972, pp. 1-2). By reporting stories of struggling farmers and ACHNCK members' activities, the journalists themselves also became active change agents in the movement, with hope of emancipation from traditional healthcare. The journalists admitted that they had to break through a traditional way of reporting—staying objective and eliminating opinion—but they consciously chose to be a part of the movement. They challenged readers to raise awareness about healthcare issues, and they encouraged readers to think about gaining ownership of their health.

Other journalists participated in the RLM to achieve their wishes to reconstruct the traditional health system that was dominated by departmental networks based in the medical schools. Mr. Kosei Shioyama, a former producer of Japan Broadcasting Corporation (NHK), reflects below on his intentions when he participated in the RLM and created a series of TV and radio programs about the RLM in November 1970:

To be honest, my intention as a journalist to join the RLM was to destroy the

influential “ivory towers” in the medical schools and reconstruct a new healthcare system in our society. Healthcare in Japan, particularly hospitals, were controlled by departmental networks based in medical schools. These networks meted out physicians’ staffing and assignments. It was almost like a power game within a medical school, or between the medical schools. If a medical school refused to cooperate, small community hospitals and clinics were not able to receive physicians to provide healthcare in the community. Doctors were playing games, expanding their power outside of the school into the community. I wanted to make a change in this conservative system; however, the system is still alive today. My goal was shared by the ACNHK member doctors, who tried hard and changed the system somewhat by rebuilding a hospital free of influence from any medical school or medical association. But we could not completely replace the power of the “ivory tower” itself. Therefore, from my perspective, my personal objectives in the movement were, unfortunately, not accomplished.” (Kosei Shioyama Interview, 2010).

Researchers and Academia

Researchers and academia played important roles in the RLM. Researchers, staff, and retired academicians from the local colleges and universities joined the RLM and raised its credibility. The general public accepted scholars as authorities, and academicians held a high position in Japanese society. Researchers from Kumamoto University contributed most significantly to the RLM when they conducted a five-year epidemiological study on health of rural farmers, without which there would have been no clinical evidence to support the movement. Kumamoto University College of Medicine had departments of public health and

of internal medicine/hematology; these two departments jointly supported the activities of the Kumamoto Society of Rural Medicine (KSRM). Many of the founding members of the KSRM were also physicians and researchers from Kumamoto University.

Since the 1990s, such collaboration between researchers and communities has been acknowledged as community based participatory research (CBPR) or community based participatory action research (CBPAR). These are based in a theoretical orientation drawn from critical social theory that reflected Jurgen Habermas' ideas of knowledge production (Wallerstein & Duran, 2003, pp. 35-37). Within a Primary Health Care (PHC) framework for nursing, Beverly J. McElmurry implemented a model of collaboration of community, health professionals, and an academic institution in Chicago communities (McElmurry, 1999, pp. 2-13). CBPR, CBPAR, and PHC collaboration models contain emancipatory characteristics that address health disparities and promote health of individuals and communities by mutual and active participations of community members, community partners (health systems, organizations, and other entities), researchers, and academic institutions.

The RLM's philosophy was rooted in Wakatsuki's principles of rural medicine practice and the values and mission of the Japan Society of Rural Medicine (JSRM), which advocated that research be based on sound evidence, applicability, action, and emancipation (Wakatsuki, 1971, pp.109-111). That JSRM mission had been presented in July 1952 —long before CBPR, CBPAR, or PHC. The philosophy of Wakatsuki and influence of his practice were gradually recognized internationally. Rural medicine and JSRM's new mission and values for academic activities had been integrated in the International Association of Rural Health and Medicine (formerly International Association of Agricultural Medicine and Rural

Health), established in France in 1961 (Japanese Society of Rural Medicine, 2010). The researchers who joined the RLM did not proclaim themselves as critical theorists or emancipatory researchers; however, their values and resulting research activities empowered the movement with evidence. That powerful evidence facilitated peoples' awareness and motivation toward creating a new healthcare system in Kumamoto.

Nurses

Nurses brought critical mass to RLM. During the course of the RLM, nurses addressed their central roles in protecting citizens from illness, preventing harmful environmental effects, and promoting community health. Nurses' concerns were strongly reflected in the official request to the prefectural congress and the governor, submitted by the ACNHCK in March 1971. ACNHCK acknowledged that there was a severe shortage of public health nurses in Kumamoto and urged the government to establish an institution to educate public health nurses. By April 1972, Kumamoto School of Public Health Nursing and Midwifery started its instruction to enhance the workforce in public health nursing.

An ACHNCK membership directory issued in September 1971 indicated that 58 registered public health nurses participated in ACHNCK as active members. According to the registration record in 1975, 258 public health nurses were registered in the prefecture (Ministry of Health, Labor and Welfare of Japan, 2010). Based on the record, about 22.4% of the registered public health nurses of Kumamoto had become early members of ACNHCK. Nurse midwives (including private-practice registered midwives) participated in the movement with strong hope of improving the health status of women of childbearing age and better healthcare access in rural communities. By September, 1971, 37 registered nurse-

midwives and 192 nurses (registered nurses and licensed practical nurses combined) had joined the ACNHCK. Within a year of establishment of the ACHNCK, its rosters included 257 nurses. With 208 physician members, together, nurses and physicians formed the core of the healthcare division in the ACNHCK and joined forces to advocate for a better healthcare system in Kumamoto.

Physicians

The RLM was initiated by young physicians and a few community members who supported improving healthcare for everyone in Kumamoto. The physician founders and their colleagues who joined later on all wanted to improve the healthcare system. Most RLM member physicians were either working for community hospitals, health departments, or the university hospital. Those physicians who affiliated with the community hospitals and health departments were struggling with lack of resources, shortage of physicians and staff, and lack of continuing education. The physicians with the university hospitals were struggling with conservative, departmental network-dominated medical schools. Physicians' appointments and assignments were often ordered by professors who headed departments. Decisions by the professors were final and there was no input from the young physicians. This power structure, centered in the medical schools, created frustration and a sense that the healthcare system needed to change (Yoshitaka Takekuma Interview, 2010). There were 25 medical students listed in the ACHNCK directory issued in September 1971 (ACNHCK, 1971). Thus it seems the RLM attracted a younger generation of future physicians, and that they welcomed an opportunity to build an interdisciplinary community-based organization to facilitate better healthcare in Kumamoto.

RLM physician members fulfilled several important roles. Their input revitalized the community hospitals and clinics and systemized health provision in the community by serving those entities as healthcare providers. Some of the ACNHCK member physicians took positions at Kumamoto City Hospital, Oguni Municipal Hospital, Kikusui City Hospital, Kikuchi Yojo-en Clinic, the Japanese Red Cross Kumamoto Hospital, and the Kumamoto Health Maintenance Association (ACNHCK Archive, 1979). In accepting these appointments, without any influence from the medical school itself, these RLM physicians were defying the traditional healthcare system.

Another notable contribution by the physicians was that they made efforts to reduce the distance between patients and physicians, as well as between the physicians and other healthcare professionals. The member physicians offered free telephone health counseling to the public every weekday evening (ACNHCK, 1976). They were responding to a common criticism from non-wealthy citizens: “three hours wait and three minutes visit.” Patients often waited at the hospital waiting room for three hours but were seen by a doctor for only three minutes. Thus the young RLM physicians were working to reconnect with the public and regain their trust as well as to provide information about health and help people to make informed decisions (Yoshitaka Takekuma interview, 2010).

Katsuyo Hama, a registered public health nurse and an ACNHCK member, described her satisfaction in working with ACNHCK member physicians in a horizontal, collegial relationship.

I joined the ACNHCK to participate in the health counseling program as a public health nurse. If I did not join the ACNHCK, I could probably not have

discussed issues freely with physicians without concern for “class” or “rank” in the health professions. We were all equal members and each member was valued. We nurses were able to participate in the ACNHCK and were fully appreciated. When I needed to consult on some health issues, I could freely call our member physicians for their opinions. (Suehiro, 1976)

The physicians who participated in the RLM through ACNHCK challenged their own profession by correcting its shortcomings. By breaking with the traditional practices, the physicians helped bridge the divides between the health professions and healthcare consumers; they regained public trust and created better partnerships.

Politicians

Behind of the success of the RLM were certain politicians who involved themselves. These were men in the Kumamoto prefectural administration who approved the expansion of Kumamoto’s healthcare infrastructure: the Japanese Red Cross Kumamoto Hospital, Kumamoto School of Public Health Nursing and Midwifery, and Japanese Red Cross Kumamoto Health Maintenance Center. If physicians and nurses made healthcare “softer” and more accessible, then politicians contributed the “hardware.” Without involvement of politicians, the RLM would have failed to develop facilities and thus to provide services.

During the 1960s and 1970s, Kumamoto was home to a nationally influential political figure, Torao Kawazu, mayor of Oguni village, chairman of National Association of Towns and Villages (NATV), and chairman of the Federation of Kumamoto Prefecture Liberal Democratic Party Branches. He was also an owner of TKU Television Kumamoto, one of two private broadcasting networks in the prefecture. Thus he had established his position as a

politician and a successful business owner. Kawazu's involvement in the RLM has been described in the previous chapters. The RLM and its leaders used connection and support from Kawazu to establish a new infrastructure of healthcare facilities. Kawazu's connection with Issei Sawada, a Governor of Kumamoto Prefecture and a former Congressman from Kumamoto led to the rebuilding of Japanese Red Cross Kumamoto Hospital. Dai Sakata, a journalist who wrote a biography of Torao Kawazu, described how the Japanese Red Cross Kumamoto Hospital was rebuilt and how Kawazu worked with Sawada on that project (Sakata, 1981, pp. 212 -216). Issei Sawada, Governor of Kumamoto from 1971 to 1981, made high-level political decisions to develop new healthcare infrastructure in Kumamoto. He made rebuilding the Japanese Red Cross Kumamoto Hospital one of his highest priorities, as the hospital was very old and needed updated equipment (Sakata, 1981, pp. 212-213). Customarily, the Governor was *ex officio* the Chair of the prefectural Red Cross Society. However, to accomplish the rebuilding project, Sawada delegated the position of the chairperson to Torao Kawazu, so that Kawazu was able to work with Sawada on behalf of Red Cross Society (Sakata, 1981, pp. 212-215). Kawazu's biography described the two politicians closely working together in relocating the hospital and, after it was rebuilt, expanding its blood center and health maintenance center (Sakata, 1981, pp. 212-215). Both politicians had strongly desired to establish a hospital that served the highest quality of care with 24-hour emergency services for the citizens of Kumamoto. The 24-hour service was one of the most needed healthcare services in Kumamoto as no hospital or clinic was offering such services. Especially during the evening hours, the city of Kumamoto lived in a medical blackout. This was partially because healthcare was heavily dependent on private practice

physicians, who did not offer office hours or home visits in the evening. Those small private practices were not prepared to handle emergency trauma cases (Hidenobu Matsukane Interview, 2010).

Governor Issei Sawada described his involvement in the reestablishment of the Japanese Red Cross Kumamoto hospital in his autobiography. When he became a Governor of Kumamoto, he did a massive buyout of the land in Kumamoto City like “a real estate developer.” One of the sites was the former Mitsubishi Kengun Airport in Nagamine, which later became the site of the Red Cross Hospital (Sawada, 2006, pp. 97-98). Sawada’s visionary plans included a district administration that would centralize medical, rehabilitation, social welfare, and human services. He also planned to relocate prefecture-funded colleges into the district. He hoped that a central district administration would better serve each entity. One of Sawada’s priorities as Governor was to enhance the educational infrastructure and to improve educational opportunities for the citizens of Kumamoto (Sawada, 2006, pp. 84-85; Issei Sawada Interview, 2010). Once the Red Cross Kumamoto Hospital was rebuilt in Nagamine, Kumamoto Prefectural University (formerly Kumamoto Women’s College) and Kumamoto College of Early Childhood Education moved to their new campuses to Nagamine. Kumamoto Center for the Disabled and Rehabilitation Center was also established by the Red Cross Hospital.

In the oral history interview with Issei Sawada, he revealed the model that he wanted to follow to elevate the health status of Kumamoto citizens: “the Nagano model.” It was based on the Yachiyo Village Total Health Management program implemented by Toshikazu Wakatsuki and his team in Saku, Nagano. That model had been adopted by the Nagano

prefecture and made Nagano the healthiest state in Japan. As an administrator of Kumamoto Prefecture, Sawada had noted the successful outcomes in Nagano Prefecture, and he wanted to adopt their system (Issei Sawada Interview, 2011).

In the oral history interview, Sawada recollected his ambitions for healthcare and described his political relationship with Torao Kawazu.

Mr. Kawazu and I were very close. To be honest, I adored him as my father in my political life. My life as a politician was guided by Mr. Kawazu and I just followed his wishes and recommendations. As for the healthcare issues of Kumamoto at that time, I was very much aware of the success of Nagano Prefecture and it made a strong impression on my mind. When I became a Governor, I wished to implement the Nagano model in Kumamoto. Luckily, Kumamoto Health Maintenance Association and the movement of ACHNCK helped to improve healthcare services in Kumamoto.

The Red Cross Hospital was one of my top priorities of the “to-do list.” The old hospital was standing in the center of the city—the best location, but the building was miserably old and it was not performing well. The plan of relocation and reestablishment of the hospital was done based on the discussions with Mr. Kawazu. We worked closely together, and I asked Mr. Kawazu to act as the Chairman of the Japan Red Cross Society of Kumamoto. For the first several years, the Kumamoto prefecture leased the land in Nagamine to the Red Cross Society for free. We sold the land of the old hospital in the center of the city, and with the funds, the Red Cross Society bought the land from the Kumamoto prefecture. I believed that it was a good

decision to rebuild the Red Cross Hospital. We were able to later add the blood center; then we established the Japan Red Cross Health Maintenance Center by merging the Red Cross facility with the Kumamoto Health Maintenance Association. As a result, this hospital stimulated other hospitals in Kumamoto, and healthy competition among the large hospitals led to higher quality healthcare services in Kumamoto.

I have a great attachment with the Red Cross Hospital. My mother was taken care of by Dr. Kusumoto, one of the founding physicians of the new Red Cross Hospital. Mr. Kawazu, too, was cared for by the doctors and nurses at the Red Cross Hospital. He died at the Red Cross hospital. In that year, on New Years' day, my wife and I went to visit him in a private room there. We brought homemade New Year dishes that my wife had cooked. He enjoyed the dishes, we had a good relaxed visit with him, and it became the very last occasion when we spent quality time together. Mr. Kawazu worked passionately to reestablish the Red Cross Kumamoto Hospital and dedicated himself to improving healthcare for the citizens of Kumamoto. (Issei Sawada Interview, 2010)



Figure 21. Issei Sawada, former governor of Kumamoto at his home office at the oral history interview in November 2010.

The presence of the two politicians who were committed to improvement of healthcare in Kumamoto became a great advantage for the RLM. At the same time, from the politicians' perspectives, the RLM also served to accomplish their aims. In the socio-political context of 1960s through 1970s in Kumamoto, healthcare improvements served the need of society, benefited from available resources, were timed appropriately, and found dedicated leaders. All of these elements contributed to the development of healthcare infrastructures in Kumamoto. However, these infrastructure improvements would never have happened without the political leadership, decision making, and commitment of the two politicians, Kawazu and Sawada. In memory of Torao Kawazu, the Kumamoto Health Maintenance Association established the Torao Kawazu Award, which annually honors a dedicated public health nurse who has contributed to nursing and health of the citizens of Kumamoto.

This chapter presented professions and key individuals who served the RLM. Each profession played a different role in the RLM; however, they agreed on main agendas and

reasons for involvement: creating a new healthcare system and better services for the citizens of Kumamoto. Journalists, nurses, physicians, and politicians communicated, served, envisioned and enabled a truly community-based healthcare system.

Chapter 8

Reverence for Life Movement and Primary Health Care

Previous chapters have outlined the history of the RLM from 1962 to 1980. In chapters three and four, we saw how the movement developed historically through the activities of the Kumamoto Society of Rural Medicine (KSRM) and the Association for Creating New Health Care in Kumamoto (ACNHCK), which became major vehicles of the RLM. Chapters five, six, and seven focused on the stories of the actors and their roles in the RLM movement. Here we will proceed to balance the achievement, outcomes, and shortcomings of the movement—in particular, what the RLM accomplished.

In 1980, the ACHNCK voluntarily terminated its activities, and the RLM evolved and branched out to further develop in arenas as such as healthcare, consumer empowerment, environmental health, and promotion of organic farming and distribution. Every termination calls for a retrospective evaluation; thus this section puts the RLM in perspective, describing its accomplishments by 1980 and challenges it faced subsequently. Next we will update the trends in the movement as of 2010. Finally, this chapter analyzes the RLM from the perspectives of a community-based social movement and contemplates its meaning for Comprehensive Primary Health Care around the globe.

Accomplishments of the RLM from 1962 to 1980

Since its inception, the leaders of the RLM and its members have engaged in carefully planned actions that propelled its agendas to improve healthcare in Kumamoto. In this section, the accomplishments that RLM influenced from 1962 to 1980 are listed and

briefly described. During this time, the RLM acted through two major organizations: KSRM and ACHNCK. For better understanding of their activities, the list is divided into two phases: 1) phase 1 (1962 -1970) as cultivation period, and 2) phase 2 (1970 -1980) as building period. In the phase 2, focused activities and objectives of the RLM expanded widely as the RLM articulated its objectives in a triple framework: healthcare, healthy food and eating practices, and farming. At a glance, food and farming might seem unconnected with “creating a new healthcare”; however, all activities by the ACHNCK were congruent with the movement’s original purpose—“Reverence for Life”—which the ACHNCK then applied strategically to real needs of the community.

Phase 1 (KSRM from 1962 – 1970): Cultivation Period—Laying the Foundation

1. Established Kumamoto Society of Rural Medicine (KSRM), mentored by Toshikazu Wakatsuki, M.D., from Saku, Nagano.
2. Built evidence – KSRM conducted a five-year epidemiological study of health status of rural farmers in Kumamoto, in partnership with Kumamoto University School of Medicine, Departments of Public Health and Hematology/Internal Medicine, and Kumamoto Agricultural Cooperatives.
3. Identified health needs of the population and mobilized the communities by intersectoral collaborations with agricultural cooperatives and local women’s groups.
4. Continually offered outreach health education programs to raise awareness about health status and campaign for both a new healthcare system and individual responsibility for health promotion and health care.

5. Collaborated with mass media and journalists to raise awareness about health issues and the imperative to systematize health care in Kumamoto.
6. A taskforce within the KSRM developed a blueprint for the Kumamoto Health Administration Center (KHAC) with new concepts such as a centralized diagnostic system using computer networks, electronic medical records, and an interdisciplinary healthcare approach.
7. In July 1970, KSRM cohosted the Kumamoto Citizens' Forum for Better Health and presented its proposal for the Kumamoto Health Administration Center (KHAC).
8. Established a taskforce, Concerned Citizens for Better Healthcare, to form a community-based citizens' organization, Association for Creating New Health Care in Kumamoto (ACNHCK) to promote the establishment of the KHAC and systematize health care in Kumamoto.

Phase 2 (ACNHCK 1970 - 1980): Building Period—Development of Infrastructure

9. In November 1970, KSRM established the ACNHCK— a community-based citizens' organization.
10. By the end of 1975, ACNHCK had gained 4,700 interdisciplinary members from the community.
11. From the organization's inception, ACNHCK physicians and nurses volunteered free telephone health counseling to the public every weekday evening.
12. ACNHCK presented a new concept of healthcare, moving from a disease/treatment-centered model to a health-and-wellness-centered model. It

facilitated citizens' engagement in health management, health promotion, and gaining ownership of one's own health.

13. ACNHCK developed a new conceptual framework for health that contained three elements: healthcare, food, and agriculture. Based on the new conceptual framework, ACNHCK established three divisions, devoted to 1) improving healthcare, 2) building a consumer movement for better nutrition and eating practices, safe food and its distribution, and environmental health concerns, and 3) protecting the health of farmers and the environment and facilitating organic and sustainable agriculture.
14. ACNHCK continued to engage in media campaigns in Kumamoto in collaboration with Japan Broadcasting Cooperation (NHK), TKU Television Kumamoto, Nishi Nihon Newspaper, and the Kumamoto Daily Newspaper, to facilitate the RLM and advance its agendas.
15. ACNHCK presented an official request with five agendas to the prefectural congress and the Governor of Kumamoto in March 1971. One agenda included establishing a school of public health nursing. The Kumamoto prefecture established Kumamoto School of Public Health Nursing and Midwifery, which opened its doors in April 1972.
16. ACNHCK petitioned to establish the Kumamoto Health Maintenance Association (KHMA) in October 1971.
17. In December 1972, ACNHCK established the Kumamoto Health Maintenance Association (KHMA) as an independent foundation based on donations from the

members of women's groups, individual donors, and local major businesses.

KHMA delivered annual health screening programs via health mobiles throughout Kumamoto prefecture. ACNHCK member nurses, physicians, and allied health professionals served as healthcare providers.

18. In October 1974, ACNICK member farmers established the Kumamoto Organic Agriculture Association (KOAA), an independent organization to facilitate organic farming in Kumamoto.
19. In June 1975, ACNHCK facilitated relocation and reestablishment of the Japan Red Cross Kumamoto Hospital to Nagamine, Kumamoto. A 300-bed teaching hospital with 24-hour emergency medical services became available to the citizens of Kumamoto. The ACNHCK member physicians served as members of the leadership team as well as healthcare providers.
20. ACNHCK member physicians staffed community hospitals such as Kumamoto City Hospital, Oguni Municipal Hospital, and Kikusui City Hospital to enhance provision of healthcare in the community.
21. In March 1975, ACNHCK hosted a Reverence for Life and Earth Forum to help farmers adopt organic practices, promote consumer support of organic farming and marketing, facilitate provision of safe food to consumers, and promote healthy eating practices.
22. In April 1975, Yoshitaka Takekuma, M.D., an ACNHCK member physician, assumed directorship of Kikuchi Yojo-en Public Clinic in Kikuchi, Kumamoto. He proposed to the board that the clinic integrate the new conceptual framework of

healthcare, food, and farming. The Kikuchi Yojo-en Public Clinic delivered healthcare services focused on disease prevention, health promotion, and extensive education programs so that individuals could take ownership of their own health. In this small rural clinic, Takekuma worked to integrate the RLM principles into clinical practice.

23. In June 1976, ACHNCK's food and farming divisions together established Kumamoto Organic Produce Distribution Center, a cooperation to support sustainable distribution of organic produce and safe food.
24. In July 1977, ACHNCK's food division established the Kumamoto Reverence for Life and Food Association, an independent organization to partner with KOAA to facilitate better eating practices at home and schools, sustainable agriculture, and environmental conservation.
25. In November 1977, ACHNCK co-hosted, with KOAA, the third annual Japan Organic Farming National Conference. As a pioneer project to facilitate organic farming and consumer-supported organic produce distribution, the conference promoted partnership between consumers and organic farmers. It became one of the early successful models for environmentally friendly and sustainable agriculture in Japan.
26. In April 1978, ACHNCK facilitated the establishment of the Japanese Red Cross Society Kumamoto Health Maintenance Center, which merged the Kumamoto Health Maintenance Association, and thereby added a new building to offer annual

health screenings, health promotion, and health education programs year-round.

The annual health screening services by health mobiles were also continued.

27. In December 1980, ACNHCK closed as an organization by hosting a theater production—"A Samurai from Edo"—a story of a man who saved people from famine. The event brought together the members of ACHNCK and supporters of the RLM and reflected the mission of the RLM. The revenue from the event was used to pay off the organization's deficit. The ACNHCK had fulfilled its task, but the members continued to participate as the RLM evolved.

The RLM grew steadily in the 1960s and gained more support from community members and key stakeholders in Kumamoto in 1970s. The RLM documented and met the emerging need for a better healthcare system in Kumamoto, and it built infrastructure to provide systematized healthcare services for all. The RLM's greatest strength was that its interests were solely rooted in the betterment of health for the whole community. The RLM stayed free from financial gain; it was funded only by members' contributions. The democratic and interdisciplinary approach of the RLM allowed participants to voice their ideas freely without concern for social status, gender, or class differences. RLM members felt they owned the movement, and took responsibility for their roles in it.

During the 1970s, the ACHNCK, too, served as a place of emancipation for its members. Each member participated in the movement based on their interests, talents, and availability. It provided ordinary citizens, such as farmers and homemakers, a chance to exercise their leadership skills and creativity, to pioneer in support of their families' health, including safe, sustainable farming. Because the movement directly involved their own

health, participants were motivated to engage and excel. The members of the ACHNCK often described their common values and missions as “the ACNHCK spirit,” which unified members from every occupation and lifestyle. With the ACNHCK spirit, members grasped opportunities to connect with other members and participated in making a social mechanism that would support healthy and happy life (ACNHCK Archive 1980).

The closure of the ACHNCK in 1980 was a conscious decision by the ACHNCK leadership team. By 1980, the organization had achieved most of its original objectives. Activities of each of the three divisions had successfully evolved into other organizations. The ACHNCK leaders were also heavily involved in the management of the hospitals and clinics where they served. The RLM was facing a time for change.

Yoshiyuki Suehiro, the editor of the ACNHCK newsletter and a journalist of the Kumamoto Daily News, wrote an editorial in the final issue of the ACNHCK newsletter. Suehiro, as member of ACHNCK, addressed remaining challenges of the ACHNCK and expectations for the future.

Over the ten years of community-based activism, the ACNHCK has produced significant outcomes in the areas of healthcare, food, and farming. Seeds have been sown in the field and we are still waiting to see the growth and harvest of our work. The ACNHCK’s major objectives—such as to create a new healthcare system for all the citizens of Kumamoto, to facilitate citizens’ engagement in healthcare, full implementation of a total health management program, and reverse the shortage of rural healthcare providers—are still critical agendas in progress. We need to prepare for the next leap to achieve these goals. When the time comes, we will bring our

ACNHCK spirit together again... (Suehiro, 1980)

Public acceptance for preventive healthcare, health promotion, and lifestyle changes did not occur quickly; it was rather a very slow process. The concept of preventive healthcare was only gradually accepted. During the 1980s, Japan was moving toward an aging society, and costs of health care were increasing. Thus, economics also contributed to the acceptance of preventive healthcare.

Looking back on the RLM, Dr. Yoshitaka Takekuma, one of its leaders reflected:

A social movement transforms itself, just as our lives take turns over the years. The needs of society change, and the social climate and politics also change. Therefore, we need to be flexible and open to change, but stay focused on what we are trying to accomplish through the movement. The focus of the RLM has always been on “life” and thus it has aimed to protect life and promote health; it is totally acceptable to expand the movement or to create a new approach.” (Yoshitaka Takekuma interview, 2010)

The closure of the ACNHCK was not the end of the RLM, but it was the end of a phase of the RLM as a movement. By that time, the RLM had progressed to the next phase, which would bring more board participation from the arenas of healthcare, consumer movements, education, and agriculture.

The Trends of the RLM in 2010

Health Care.

From 1962 to 1980, one of the RLM's major goals was to improve the health status of the prefecture's people and establish annual health screenings, where participation was voluntary and citizens paid a fee. But during this time, the Japanese government acknowledged the need for preventive healthcare throughout the adult population. Thus, in 1983, it established the Elderly Health Maintenance Act. It implemented an annual health screening program for adults 40 years and older. It mandated that insurers offer to all insured an annual health checkup, including health education, use of a health maintenance diary, an annual physical, chest X ray, labs, cancer screenings, and EKGs. The new insurance coverage for preventive healthcare services motivated local hospitals and clinics to invest in preventive healthcare services. The law rapidly convinced Japanese people to accept preventive healthcare as important.

From 1980s to 2000s, due to economic growth and lifestyle changes, Japan faced new threats to public health. Iron deficiency anemia was no longer a main health issue; instead, new issues were cancer, cardiovascular disease, diabetes, and obesity. In April 2008, annual health screening programs were enhanced to target increasingly the so-called life-style diseases, and extensive health education and counseling by public health nurses became available to all Japanese citizens (Ministry of Health, Labor, and Welfare, 2008). From the perspectives of preventive health services, health management, and health promotion, the RLM had paved the way for a flexible healthcare system, responsive to the people and open to all of them.

As of 2010, Kumamoto can look back on a well-developed healthcare infrastructure, including the Japanese Red Cross Kumamoto Health Maintenance Center, the Japanese Red Cross Kumamoto Hospital, and the Kikuchi Yojo-en Clinic and Health Maintenance Center (formally Kikuchi Yojo-en Clinic). Each entity has been managed independently, has developed under its own organizational mission, and plays a unique role for the communities of Kumamoto. However, they all contribute to protect life and maintain health.

The Japanese Red Cross Kumamoto Health Maintenance Center.

Since its inception, the Japanese Red Cross Kumamoto Health Maintenance Center has been the pioneer facility in Kumamoto to offer such comprehensive programs as adult annual health screening, including screening for cancer, cerebrovascular disease, dental health, cardiovascular disease, women's health issues. It offers programs for metabolic syndrome and vascular health, digestive health, and wellness and fitness (The Japanese Red Cross Kumamoto Health Maintenance Center, 2010). Wasaku Koyama, M.D., one of the RLM's leader physicians, directed the center and developed it into one of the nation's leading health maintenance centers. It still delivers workplace-based screening via health mobiles for businesses that have limited access to health care facilities. The RLM's original objectives were to promote health, prevent disease, and protect life and appreciate wellness; these objectives are still integral to the services of the Japanese Red Cross Kumamoto Health Maintenance Center (Figure 22).



Figure 22. The Japanese Red Cross Kumamoto Health Maintenance Center (November, 2010)



Figure 23. Wasaku Koyama, M.D. Ph.D. at the Japanese Red Cross Kumamoto Health Maintenance Center at the oral history interview in June, 2010.

The Japanese Red Cross Kumamoto Hospital.

The Japanese Red Cross Kumamoto Hospital has developed into a 480-bed hospital with 21 clinical departments and five specialties: 1) area trauma center and emergency department; 2) community healthcare support hospital; 3) area central operation center for disaster relief; 4) area central pediatric emergency health services; and 5) residency and teaching hospital. Since 1980, the Japanese Red Cross Kumamoto Hospital has been serving

as the nation's top international disaster-relief healthcare organization, which dispatches healthcare teams overseas (The Japanese Red Cross Kumamoto Hospital, 2010) . Hidenobu Matsukane, M.D., one of the RLM leader physicians, served as a CEO (1975 – 2004) of the Japanese Red Cross Kumamoto Hospital and led its development. Matsukane currently serves as an executive board member of the Japanese Red Cross Society and provides his leadership in national and international arenas. Matsukane has prioritized the development of emergency medical services, because Kumamoto lacked them until the mid-1970s (Hidenobu Matsukane Interview, 2010). Daisuke Higashi, M.D., PhD, an ACHNCK physician, led the hospital to its position as a leading teaching hospital; he implemented the intern-residency system of the Okinawa Central Hospital, a nationally recognized teaching hospital since the mid-1960s (Daisuke Higashi Interview, 2010). The continuous efforts of the RLM leader physicians further advanced healthcare and medical education in Kumamoto.



Figure 24. The Japanese Red Cross Kumamoto Hospital, Kumamoto, Japan, 2010.



Figure 25. Hidenobu Matsukane, MD, and Daisuke Higashi, MD, PhD, both RLM leader physicians (Photo taken at the Japanese Red Cross Kumamoto Hospital, June 2010)

The Kikuchi Yojo-en Public Clinic.

The Kikuichi Yojo-en Public Clinic was established in April, 1975 in rural farming community in Kikuchi, Kumamoto. The word “*yojo*” represents the concept of self-care, and nurturing one’s own well-being. The former clinic had been closed due to a shortage of physicians. To fulfill the ACHNCK goal of community health care in Kumamoto, Yoshitaka Takekuma, M.D., PhD, took a position as a director of the new clinic to revitalize health services in the rural community. The uniqueness of the Yojo-en Public Clinic lay in its conceptual framework for health, which reflected the philosophy of the RLM. The three components of the framework—health care, food/healthy eating, and farming/agriculture—have always been integrated into the clinic’s practice. The Yojo-en Clinic has focused on outpatient clinic, clinical services which included oriental medicine and alternative medicine approaches, annual health screening programs for citizens, extensive health education for all

ages, education about safe food and good eating practices, facilitating organic farming and farm support, the local agricultural cooperatives. It partners with the Yojo Educational Organic Farm, which was established for community education. Over the 35 years, the Yojo-en Clinic has continually engaged the community. Once a year, the clinic celebrates health and a healthy lifestyle by hosting a festival whose theme is “Reverence for Life.” The festival hosts community artistic performances and other educational activities (Kikuchi Yojo-en Public Clinic and Health Promotion Center Archive, 2010).

Takekuma has continually been lecturing on Reverence for Life, which encompasses health, healthy life style based on good eating practice, safe sustainable agriculture, education that nurtures healthy children, environmental issues, and peace. In particular, Takekuma has focused on health education for the younger generation, with the hope that a healthy person and healthy society can be built on conscious, life-affirming education from early childhood (Yoshitaka Takekuma Interview, 2010). In 2009, the Kumamoto Board of Education honored Takekuma for his contributions to Kumamoto’s culture and betterment of humanity through his lifework with the RLM. The care delivered at Kikuchi Yojo-en Clinic and Takekuma’s devotion to education have been among the driving forces to expand the RLM in society.



Figure 26. Yoshitaka Takekuma, M.D., PhD, a RLM leader physician giving a health talk to the residents who came for annual health screening at the Kikuchi Yojo-en Clinic (around 1975) (Yoshitaka Takekuma Archive, 2010)



Figure 27. Kikuchi Yojo-en annual festival (1988). Community members participated in a performing art to appeal importance of farming and agriculture. (Yoshitaka Takekuma Archive, 2010)



Figures 28. Yojo-en annual festival in 1996. Community members gathered to listen to the keynote “Reverence for Life” by Rokusuke Ei (Yoshitaka Takekuma Archive, 2010)

Food and Consumer Movement.

In the areas of food and consumer activism, the movement logged more than 20 years of steady efforts; it reached a pinnacle of achievement in 2005. In June of that year, the Japanese government passed the *Shokuiku* (Food and Nutrition Education) Basic Act and implemented it in 2006. This Act responded to the tremendous changes in Japanese dietary practices, which had begun to promote chronic illnesses. The Japanese government became aware of increasingly poor eating habits, irregular and unbalanced diets, obesity, life-style related diseases, anorexia, bulimia among young females, food safety issues, overdependence on imported food, and the loss of traditional food culture in the context of globalization (Cabinet Office, Government of Japan, 2010). The government acknowledged that basic education must include dietary education that could equip Japanese people with knowledge of nutrition and skill sets to make better food choices. Nutritional education has been accepted on a par with intellectual, moral, and physical education (Cabinet Office,

Government of Japan, 2010). Now nutrition education is recognized not only by the national government, but also local municipalities, schools, healthcare organizations, food industries, teachers, farmers, fishers, dietitians, healthcare professionals, and parents. In 2009, more than 330,000 Japanese citizens volunteered for these educational activities (Cabinet Office, Government of Japan, 2010).

Kumamoto Reverence for Life and Food Association has been active since its establishment in July 1977. In 1985, the organization became a consumer cooperative, and it continues to distribute organically grown produce and safe food items to its members weekly. The organization has maintained its objectives: 1) to cultivate trust and friendship between producer and consumers; 2) to protect the environment by supporting environmentally friendly, sustainable agriculture; and 3) to promote children's health and continue to educate them about the importance of safe food and sustainable agriculture. The Kumamoto Reverence for Life and Food Association has 1,002 members in 240 groups throughout Kumamoto (Kumamoto Reverence for Life and Food Association, 2010). The philosophy of RLM is alive and well. With the *Shokuiku* Basic Act in effect, the role of the Kumamoto Reverence for Life and Food Association has continued to be a significant resource for Kumamoto.

Farming and Agriculture.

In line with the *Shokuiku* Basic Act, the Japanese public has grown in awareness of environmentally friendly, sustainable agriculture. By 2005, organic farming was a familiar concept throughout Japan. With increased interest in safer food and better diet, and increased awareness of environmental health, the organic farming and agriculture movement welcomed

a significant turning point in the movement. On December 8, 2006, the Japanese government passed the Organic Agriculture Facilitation Act (Marutei, 2010). This law acknowledged that organic farming enhances the natural cycle and reduces the environmental impact of modern farming. By facilitating organic farming, the law will contribute to the market for safer food. The law facilitates three aspects of organic farming and agricultural practice: 1) agricultural production, 2) distribution of produce, and 3) consumption of produce (Rural Culture Association Japan, 2010). These are the same aspects that the RLM had publicized when pioneer farmers initiated organic farming practice in Kumamoto. The establishment of the Organic Agriculture Facilitation Act has made organic food more accessible to the general public as well as aiding potential organic farmers who need support during the transition.

The organic farming movement has been active in Kumamoto, which continues to model the facilitation of organic farming. Today, the Kumamoto Organic Agriculture Association (KOAA) acknowledges its origin in the RLM and ACNHCK (The Kumamoto Organic Agriculture Association, 2010). In 2000, KOAA was designated a not-for-profit organization, authorized to certify organic farms and organically grown produce under the Organic Japanese Agricultural Standards (The Kumamoto Organic Agriculture Association, 2010).

The RLM is still progressing as of 2010. Since 1980, the movement has developed in all three areas of its theoretical framework for health. The movement has grown beyond Kumamoto, and joined the national movement toward policy development, its highest level of social impact. Establishment of national health policies marked a significant epoch for the RLM, which continues to facilitate better health and promote Reverence for Life. Its ethos

has remained rooted in the shared value of “life” and individual ownership of one’s health, inextricably bound up with the health of the community.

The RLM and Comprehensive Primary Health Care

In this section, the researcher analyzes the RLM as a community-based social movement and contemplates its meaning for Comprehensive Primary Health Care as defined by the World Health Organization. The analysis includes the core values, principles, and elements in a Primary Health Care Based Health System as defined by the Pan American Health Organization (PAHO)/World Health Organization (WHO) (PAHO/WHO, 2007).

When the RLM began in 1962, there was no defined concept of Primary Health Care (PHC); therefore, the RLM movement itself was not identified as a PHC movement.

However, the RLM has successfully addressed and reflected the core values, principles, and elements of a PHC-based health system through its community-based social movement.

PAHO/WHO defines a health system as that which “comprises all organizations, institutions, and resources that produce actions whose primary purpose is to improve health” (WHO, 2000). This definition does not limit a health system to a single organization. A PHC system emphasizes a health care system’s comprehensive strategy for organizing within society to promote health (PAHO/WHO, 2007). If the comprehensive PHC is defined as a strategy for organizing healthcare systems and society to promote health, the community-based social movement such as the RLM, which attempted to systemize healthcare to optimize health of the citizens of Kumamoto in culturally relevant manner, could certainly be a case of community-based and comprehensive PHC.

Values

PAHO/WHO posits that values are essential for setting priorities, and that they provide a moral anchor for policies and programs (PAHO/WHO, 2007, pp. 8-10). The core values of a PHC based Health System are:

1. The right to the highest attainable level of health, which implies legally-defined rights and responsibilities of citizens and other actors, and creates accountability in the health system.
2. Equity. Equity in health addresses unfair differences in health status, access to healthcare and to a health enhancing environment, and treatment within the health and social services system. An equity-enhancing health system is not simply focused on efficiency or cost effectiveness, but rather equity should be viewed as a moral imperative and a legal and social obligation.
3. Solidarity. Solidarity is defined as the extent to which people in a society work together to define and achieve the common good. Social solidarity could be interpreted as choosing those collective actions that can overcome shared problems.

(PAHO/WHO, 2007, pp. 8-10)

The three core values are clearly addressed in the RLM, most strongly in the early phase of the movement from 1962 to 1980. After 1980, while the right to the highest attainable level of health continued to be central, equity and solidarity were emphasized to overcome urgent health care issues such as poor health status of women and farmers. By forming organizations such as KSRM and ACNHCK, the RLM created venues for individual

community members to act collectively and to appeal for better health care and a safer environment. By being a part of the RLM, the participants grasped opportunities to act in their areas of interest or expertise, and they worked in solidarity to achieve the objectives of the movement. As a quintessential community-based health care movement, the RLM integrated the three PHC core values at its foundation.

Principles

The following seven principles are the foundation of PHC-based health systems. The principles provide the basis for health policies, legislation, evaluative criteria, resource generation and allocation, and operation of the health system. The principles bridge broader social values and the structural and functional elements of the health system (PAHO/WHO, 2007, pp. 10-11).

1. Responsiveness to peoples' health needs. Health systems are centered on people and try to meet their needs in the most comprehensive way possible.
2. Quality-oriented services. Quality-oriented services respond to peoples' needs and treat all people with dignity and respect, avoiding any harm and assuring the best possible interventions for their health problems.
3. Government accountability. Government accountability assures that social rights are realized and enforced, and citizens are protected from harm.
4. Social Justice. Social justice in healthcare is assurance of the welfare of all citizens, particularly the most vulnerable.

5. Sustainability. Sustainability of the health system requires strategic planning and long-term commitments. Investment in the population's health needs must be sufficient for today and include plans to meet future health challenges.
6. Participation. Participation makes people active partners in making decisions about resources, defining priorities, and ensuring accountability. There are two levels of participation: the individual and the societal. At the individual level, people must be able to make free and fully informed decisions regarding their own health in a spirit of self-determination and self-reliance. At the societal level, participation in health assures that health system reflects social values, and it provides means of social control and accountability.
7. Intersectorality. Intersectorality in health means that the health sector must work together with other sectors and actors in order to assure that public policies and programs are aligned to maximize their contribution to health and human development. The principle of intersectorality requires that the health sector collaborate with sectors such as employment and labor; education; housing; agriculture, food production, and distribution; environment, water, and sanitation; and social services and urban planning.

(PAHO/WHO, 2007, pp. 10-11)

The seven principles of a PHC-based health system are represented in the RLM philosophical principles and actions. Most of all, the RLM was initiated in response to the health needs of vulnerable populations in Kumamoto. The RLM did not use the term “social

justice”; however, one of the principles of the RLM was to bring justice to healthcare access. To create better access to healthcare in the rural population, RLM participants worked in areas of shortage, e.g., to create and staff health care institutions and to train public health nurses. Using an evidence-based approach, the RLM carefully tailored its proposals to the prefectural government, to facilitate governmental support in establishing a comprehensive health care system that would provide quality services to the citizens of Kumamoto. The Kumamoto prefecture and the Governor also contributed to development of the infrastructure of healthcare, social services, and education.

The RLM did not hesitate to expand its objectives beyond the health sector. The RLM leaders strategically linked with entities such as agricultural cooperatives, the Red Cross Society, women’s groups, educational institutions, and local businesses. The RLM was supported by community members from all regions of Kumamoto and by a wide range of occupations and industries. As a result, the strategies of the RLM reflected diversity of the participants and intersectoral nature of the movement. The RLM has well demonstrated its sustainability since 1962. One of the key factors that contributed to its sustainability was flexibility to meet changes over 40 years, and remain focused on its fundamental shared values.

Elements of a Primary Health Care–Based Health System

There are 13 elements that comprise a PHC-based health system, structurally and functionally. These elements are interconnected and are present in all levels of the health system (PAHO/WHO, 2007, pp. 12-14).

1. Universal coverage and access. Universal coverage and access form the foundation of an equitable health system.
2. First Contact. In a PHC-based health system, primary care should serve as the main entry point to the health system. The majority of the health problems are to be resolved in this level.
3. Comprehensive, integrated, and continuing care. The range of services available must be sufficient to provide for the health needs of the population. This element includes providing health promotion; prevention; early diagnosis; curative, rehabilitative, and palliative care; and support for self-management.
4. Family and community-based. This element encompasses a population-focused approach because providers use community and family information to assess risks and prioritize interventions.
5. An emphasis on promotion and prevention. Health promotion and prevention are cost-effective, ethical, and can empower communities and individuals to gain ownership of their own health.
6. Appropriate care. Appropriate care implies that a health system is person-centered and is not centered simply in the disease or the organ. Health services should be tailored to the culture, the needs of the community, and the full course of human life.
7. Active participation mechanism. A PHC-based health system should be an integral part of national and local socio-economic development strategies, based on shared

- values, and it should involve ways for individuals to participate actively. In the promotion of healthy lifestyles and a healthy environment, PHC includes both individuals and groups that incorporate actors in the public, private, and civil sectors.
8. Sound policy, legal, and institutional framework. Such a framework enables a PHC system to perform its specified functions.
 9. Pro-equity policies and programs. Development of pro-equity policies and programs ameliorate the negative effects of social inequalities on health.
 10. Optimal organization and management. PHC-based health systems require optimal organization and management practices that allow innovation to constantly improve organization and delivery of care.
 11. Appropriate human resources. Appropriate human resources are critical to deliver quality health care services to the population. Ensuring appropriate human resources requires strategic planning and long-term investments in training, employment, retention, and continuing education. Interdisciplinary teams with the right skill mix are essential. Equitable geographic distribution of human resources is critical.
 12. Adequate and sustainable resources. A PHC-based health system must be based on planning that provides adequate and sustainable resources that are appropriate to the health needs.
 13. Intersectoral action. PHC-based health care systems have a scope and impact beyond mere provision of healthcare services. Intersectoral actions and community

approaches are significant to promote health and human development. Mechanisms to facilitate health require creating synergistic links with other sectors and actors, such as schools, workplaces, economic development, agricultural development, and environmental health.

The foregoing analysis on the RLM from the perspectives of a PHC-based health system shows that some of the elements of a PHC-based health system were enabled by the Constitution of Japan. The Constitution states, in article 25, that “All people shall have the right to maintain the minimum standards of wholesome and cultural living. In all spheres of life the state shall use its endeavors for the promotion and extension of social welfare and social security and public health” (The Constitution of Japan, 1946). The Constitution mandates the state’s responsibility for promoting social security, welfare, and public health; and it guarantees the right to life—all of which provide a firm foundation on which to build a PHC-based health system. The RLM addressed elements such as universal coverage and access, pro-equity policies and programs, emphasis on promotion and prevention, appropriate human resources, adequate and sustainable resources, and a sound policy, legal, and institutional framework. All of these were assured by the government of Japan, or addressed jointly with governmental involvement. Therefore, in the case of the RLM, although parts of its agenda remained unfulfilled, its “seed fell on fertile ground”: a societal foundation of respect for life and a readiness to tackle healthcare issues.

The uniqueness of the RLM was that it contained the elements of a PHC-based health system during the 1960s and 1970s, well before the concept of PHC had been formalized. The RLM itself directly included active participation mechanisms, appropriate care, a family

and community based approach; comprehensive, integrated and continuing care; first contact/primary care; emphasis on promotion and prevention, and intersectoral activity. The RLM developed partnerships to build infrastructure, which provided multi-leveled health services, from preventive health and health education to 24-hour emergency medical services—all of which were elements of a PHC-based health care system.

The leaders of the RLM implemented strategies by responding to the health needs of the people. The original conceptual framework for health, which was developed in the movement, provided the RLM a structure, a direction, and foundation for intersectorality and cultural relevance. The RLM was a sustainable community-based PHC movement, characterized by strong leadership, a democratic management process that preserved transparency, engagement of motivated participants, action-oriented strategies to produce outcomes, a strong shared value on health and life, and an acceptance of changes that fostered flexibility and sustainability.

Conclusion

Now more than ever, achieving better health for all is a critical global health issue as well as a critical community health issue. In 1978 the World Health Organization (WHO) declared PHC as a philosophical framework to deliver comprehensive health services everywhere (World Health Organization, 1978). PHC is a strategy for organizing healthcare systems and society to promote health. It is important to recognize that, for PHC, both the country and the community participate in developing an accessible and equitable health care system that meets the health needs of the population. To build an acceptable health care system, health care services need to be congruent with the cultural, geographic, historical,

and economic contexts of the community, as well as local health profiles.

In this study, the researcher has described the RLM, the community-based social movement that improved health in Kumamoto, Japan, from 1962 to 1980. Health care in Japan owes a great debt to the nation's philosophical leader in rural medicine, Dr. Toshikazu Wakatsuki, and the movement he influenced, starting with the Japan Society of Rural Medicine. Inspired by Wakatsuki and that Society, the RLM responded to the health care needs of the population in Kumamoto. Since its inception in 1962, the RLM has both addressed current health needs of the community and adapted strategically to make the community a healthier and safer place for future generations. Its name was its generative principle: "Reverence for Life" identified the movement's passion for health and powered both its notable achievements and its sustainability. That passion has been traced through the course of the present study, in oral history accounts by the participants and in historical records of the RLM. The participants found worth in their shared experiences, their joy in reaching goals, and their increase of self-esteem and sense of emancipation through growth and self-development. The exercise of political empowerment revealed unanticipated skills, which in turn served the goals of the movement. In the case of the RLM, both social and individual accomplishments helped the movement both sustain it and evolve.

In 2007, PAHO/WHO initiated efforts to renew PHC, 30 years after the original concept of PHC was introduced (PAHO/WHO, 2007). Over those 30 years, PAHO/WHO had struggled to implement programs based on a comprehensive PHC framework, and it identified that community engagement and intersectoral actions were the most difficult elements to address. In the renewed comprehensive PHC model, community engagement and

intersectoral actions were clearly addressed as the foundation of comprehensive PHC; however, PAHO/WHO did not offer much-needed strategies to strengthen these two principles. The lack of effective strategies in these two areas was perceived as a serious challenge to realizing a PHC-based health system with the strong community engagement that it required.

Dr. Toshikazu Wakatsuki, the leader of rural health in Japan, believed that development of rural health practice deeply involved “time,” “place,” and “people”: the historical context of the society and its health system, the poverty stricken farming community, and the people who lived and worked in the community (Wakatsuki, 1994, p.362). Among those three, Wakatsuki emphasized “people.” Human relationships, compassion, leadership, participation, and cooperation of the people made it possible to build a successful health care system in the Saku region of Nagano, Japan. Its success inspired imitation. In the case of the RLM, the most notable characteristics of the movement were the passion and engagement of the motivated participants and intersectoral cooperation to promote health. There is a need to invest more efforts to emphasize motivating participants in the comprehensive PHC. Its theoretical framework provides direction for strategic planning; however, theoretical framework alone does not ensure success. When motivated individuals and communities join together and share their values, it is possible to build a successful PHC-based healthcare system. The key to success is passion for health and reverence for life: the shared value and motivation that forge progress from within.

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APENDICIES

APPENDIX A

List of Core Questions to the Individual Interviewees

1. Would you please tell me your name?
2. Would you please tell me about your current occupation/role?
3. Would you please share with me about your role (what have you done) when you participated in the Reverence of Life Movement?
4. Why did you engage in this role?
5. Individually tailored questions
6. What does the Reverence for Life Movement mean to you?
7. Is there anything that you would like to share with me?

APPENDIX B

ORAL HISTORY AGREEMENT FORM (English)

ORAL HISTORY AGREEMENT FORM (Japanese - researcher copy)

ORAL HISTORY AGREEMENT FORM (Japanese - interviewee copy)

APPENDIX B (continued)**ORAL HISTORY AGREEMENT FORM**

Project name: Reverence for Life Movement – A Primary Health Care movement in Kumamoto, Japan

Date: _____

Interviewer: Asako Takekuma Katsumata

Interview file number: _____

Name of person(s) interviewed: _____

Address: _____

Telephone number: _____

Date of birth: _____

By signing the form below, I, _____, a participant in an oral history interview, give my permission for any audio files, transcripts, and photographs made during the project to be used by Asako T. Katsumata for educational purposes including publications, exhibitions, World Wide Web, and presentations. I hereby give and deliver to Asako T. Katsumata all the incidents of ownership in that interview, any audio files, transcripts, and photographs including copyright, from this time forward.

Name (please print): _____

Signature: _____

Date: _____

Researcher's signature: _____

Asako Takekuma Katsumata

Date: _____

APPENDIX B (continued)

オーラルヒストリー（口述歴史）プロジェクトに関する合意書

プロジェクト名: いのちを守る運動－熊本におけるプライマリー
ヘルスケア運動の歴史

日付: ____月 ____日 ____年 ____

研究者（聞き手）: 勝又 T. 麻子

インタビューファイルナンバー: _____

口述者ご氏名: _____

住所: _____

電話: _____

生年月日: _____

私こと、_____は、オーラルヒストリー（口述歴史）インタビューに参加することを承諾します。このオーラルヒストリー（口述歴史）のプロジェクトにおいて記録された音声のファイル、口述記録、そして写真等を学術および教育の目的において、出版、展示、ウェブサイトを通しての情報の提供、また学術、教育、また一般を対象とした発表に勝又T.麻子氏が使用されることを承諾します。私は、このオーラルヒストリーのプロジェクトにおいて記録された音声のファイル、口述記録、そして写真などの所有権及び著作権を勝又T.麻子氏に譲渡することに合意します。

ご氏名（およびふりがな）: _____

ご署名: _____

署名日付: ____月 ____日 ____年

研究者署名: _____

かつまた T. あさこ

署名日付: ____月 ____日 ____年

(研究者控)

APPENDIX B (continued)

オーラルヒストリープロジェクトに関する合意書（日本語訳）

プロジェクト名: いのちを守る運動－熊本におけるプライマリー
ヘルスケア運動の歴史

日付: ____月 ____日 ____年

研究者（聞き手）: 勝又 T. 麻子

インタビューファイルナンバー: _____

口述者ご氏名: _____

住所: _____

電話: _____

生年月日: _____

私こと、_____は、オーラルヒストリー（口述歴史）インタビューに参加することを承諾します。このオーラルヒストリー（口述歴史）のプロジェクトにおいて記録された音声のファイル、口述記録、そして写真等を学術および教育の目的において、出版、展示、ウェブサイトを通しての情報の提供、また学術、教育、また一般を対象とした発表に勝又T.麻子氏が使用されることを承諾します。私は、このオーラルヒストリーのプロジェクトにおいて記録された音声のファイル、口述記録、そして写真などの所有権及び著作権を勝又T.麻子氏に譲渡することに合意します。

ご氏名（およびふりがな）: _____

ご署名: _____

署名日付: ____月 ____日 ____年

研究者署名: _____

かつまた T. あさこ

署名日付: ____月 ____日 ____年

（口述者控）

APPENDIX C

LIST OF ORAL HISTORY INTERVIEWS

<u>Interviewee</u>	<u>Role and Oral History File ID Number</u>
1. Hongo, Yasuyuki	Former Business Manager, Kumamoto Health Administration Association (File ID: hongo062410)
2. Higashi, Daisuke	Former physician member of Association for Creating New Health Care in Kumamoto President of Japan Red Cross Kumamoto Hospital (File ID: d-higashi060910)
3. Koyama, Wasaku	Former physician member of Association for Creating New Health Care in Kumamoto Former Director of Japan Red Cross Kumamoto Health Maintenance Center (File ID: koyama062110)
4. Nagao, Kazuharu	Former physician member of Association for Creating New Health Care in Kumamoto Former President of Kumamoto City Hospital (File ID: nagao042011)
5. Matsukane, Hidenobu	Former physician member of Association for Creating New Health Care in Kumamoto Japan Red Cross Society Executive Board Member (File ID: matsukane06091020)
6. Sawada, Issei	Former Governor of Kumamoto Prefecture, Japan (File ID: Sawada111311)
7. Shioyama, Kousei	Journalist, former member of Association for Creating New Health Care in Kumamoto Former Producer, Japan Broad Casting Cooperation (File ID: shioyama061210)
8. Takekuma, Chieko	Former member of Association for Creating New Health Care in Kumamoto, Consumer Movement leader and environmental health activist (File ID: chieko_t062510)

APPENDIX C (continued)

LIST OF ORAL HISTORY INTERVIEWS (continued)

<u>Interviewee</u>	<u>Role and Oral History File ID Number</u>
9. Takekuma, Yoshitaka	Former physician member of Association for Creating New Health Care in Kumamoto Leader of Reverence for Life Movement Director emeritus, Kikuchi Yojo-en Clinic, Kumamoto, Japan (File ID: y_takekuma062810)

APPENDIX D

Table 1

Results from Kumamoto Farmers' Health Assessments (%)

Result	1967	1968	1969	1970	1970	1971	1971
	Female	Female	Female	Male	Female	Male	Female
I Normal/Healthy	15.2	9.2	6.8	23.5	12.1	18.3	10
II Slightly Abnormal (Able to perform daily life without any problem)	4.5	5.4	2.2	8.2	5.8	5.7	3.7
III Abnormal (Careful attention required)	36.9	21.2	20.5	17.5	24.4	27	29.4
IV Abnormal (Further investigation needed)	23	31.9	37.6	29.8	29.4	31.3	33.1
V Abnormal (Treatment required)	20.4	32.4	33	21	28.3	17.7	23.9
Total	n=1,311	n=1,201	n=1,100	n=636	n=761	n=492	n=599

Note. Figures are percentages of samples tested.
 This table was translated from the report of the Association for Creating New
 Health Care in Kumamoto Archive, 1971;
 Nagao, 1972; Kumamoto Agricultural Cooperatives Men's Group, 1970

APPENDIX E

LIST OF HISTORICAL ARCHIVES AND PERSONAL COLLECTIONS

Chieko Takekuma Private Collection

Location: 3182 Yoshitomi, Shisui-machi, Kukuchi-Shi, Kumamoto, 861-1201 Japan

Creating New Health Care in Kumamoto (ACNHCK) Archive (1970-1980)

Collection includes documents, newsletters, photographs, manuscripts, conference materials.

Location: *Yojo Densho Kan* Community Center. Yoshitomi, Shisui-machi, Kikuchi-shi, Kumamoto, 861-1201 Japan

Reverence for Life Oral History Archive (2010)

This archive includes oral history interviews of 18 individuals who had engaged in the Reverence for Life Movement in Kumamoto Japan during 1955 – 2010. The archive also includes portraits of the interviewees.

Location: c/o Asako T. Katsumata 2590 Westbrook Dr. Rockford, IL 61107 USA

Saku Central Hospital Agricultural Medicine and Rural Health Archive (1945-2010)

Collection includes historical photographs, documents, manuscripts, and exhibitions in relation to Dr. Toshikazu Wakatsuki, and agricultural and rural health practice at Saku Central Hospital.

Location: Saku Central Hospital 197 Usuda, Saku-shi, Nagano, 384-0301 Japan

Yoshitaka Takekuma Private Archive (1955-2010)

This private collection includes pictures, original manuscripts, magazine articles, newspaper articles, personal communications/ letters, videos, audio recordings, posters, conference materials, and personal items in relation to the Kumamoto Student Settlement Movement and Reverence for Life Movement.

Location: Yojo Institute 3182 Yoshitomi, Shisui-machi, Kukuchi-Shi, Kumamoto, 861-1201 Japan

VITA

NAME: Asako Takekuma Katsumata

EDUCATION: Study Abroad Program
Mary Baldwin College, Staunton, Virginia, 1988-1989

Bachelor of Arts, English Literature
Doshisha Women's College of Liberal Arts, Kyoto, Japan,
1990

Teaching Certificate Program
Doshisha Women's College of Liberal Arts, Kyoto, Japan,
1991

Diploma, Nursing
Japan Baptist School of Nursing, Kyoto, Japan, 1994

Master of Economics, Business Management
Saga University, Saga, Japan, 2000

Completion of bridge courses
St. Anthony College of Nursing, Rockford, Illinois, 2002-2003

Ph.D., Nursing Sciences, University of Illinois at Chicago,
Chicago, Illinois, 2011

**PROFESSIONAL
EXPERIENCE:** Provena Life Connections (Previously: Provena Senior
Services) Provena Cor Mariae Center, Rockford, Illinois,
Geriatric Nurse, 2007 – present

P.A. Peterson Center for Health, Lutheran Social Service of
Illinois; Geriatric Nurse, 2009-2010

College of Nursing, University of Illinois at Chicago, Rockford
Regional Program; Assistant to Director, Rockford Regional
Program, 2002 -2010

College of Nursing, University of Illinois at Chicago, Global
Health Leadership Office; Research Assistant, 2006 -2009

VITA (continued)

**PROFESSIONAL
EXPERIENCE:**

College of Nursing, University of Illinois at Chicago, College of Nursing and Illinois Department of Human Services, Office of Mental Health, Nursing Development Project: Grant Manager, 2002-2005

College of Nursing, Saga University, (Previously: School of Nursing, Saga Medical School); Research Associate, Instructor, Saga, Japan, 1995-2000

HONORS:

W E Van Doren Scholarship Fund, 2010
International Research Training Award in Memory of Beverly J. McElmurry, 2010
UIC Dean Joan L. Shaver Scholarship, 2010
Web Fellow, the Nurse Competence in Aging Initiative Asian American and Pacific Islander Nurses Association and American Nurses Association, 2006-2007
Phi Kappa Phi Honor Society, 2006
Web service award, Asian American and Pacific Islander Nurses Association, 2006
Doctoral Student Scholarship, Illinois Nurses Association District 3, 2006
AETNA/NCEMNA Scholar, National Coalition of Ethnic Minority Nurse Associations (NCEMNA), 2005-2007
Mentee Award, National Coalition of Ethnic Minority Nurse Associations (NCEMNA), 2005
Sigma Theta Tau, Alpha Lambda Chapter, 2004

**PROFESSIONAL
MEMBERSHIP:**

American Association for the History of Nursing
Asian American Pacific Islanders Nurses Association
American Society of Aging
Midwest Nursing Research Society
National Coalition of Ethnic Minority Nurse Associations
National Gerontological Nursing Association
Oral History Association
Sigma Theta Tau International Nursing Honor Society
Phi Kappa Phi Honor Society

PUBLICATIONS:

Takekuma-Katsumata, A. (2007). Interdisciplinary internship program for rural health. *The Japanese Journal of Nursing Education* 48 (10), 932-933

VITA (continued)

PUBLICATIONS:

Takekuma, A. (2000). Health care and long term care of the older adults: an analysis through phenomenon of “prolonged hospital stay with non-medical cause. (Master’s thesis, Saga University).

Hamano, K., **Takekuma, A.**, & Inoue, E. (2000). An analysis of student nurses self-identification from the perspectives of the student cohort admitted by recommendation. *Kango Kyoiku (Nursing Education)*, 41, 124-131.

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