After the Bomb

Section 2   www.AtomicBombMuseum.org/4_ruins.shtml

LIFE IN THE RUINS

Hiroshima’s population, down to roughly 83,000 soon after the bombing, swelled to 169,000 by February of 1946. But only some 6,500 lived in the city’s center, i.e., within Close space 1 kilometer of ground zero. For several years more, population growth was concentrated at the same remove from the city’s devastated center. The increase was largely due to the return of evacuated persons, civilians repatriated from overseas colonies, and demobilized military personnel.

The sudden population expansion, however, caused acute shortages of food and shelter. Many A-bomb survivors faced death from starvation and exposure unless something was done soon. As early as December of 1945, however, a council of “war victims’ associations” had been convened to regulate distribution of lumber, nails and glass panes, as well as charcoal and electrical heating devices. The council also dealt with immediate issues such as care of orphans, community bathhouses, and use of warehouses in neighboring towns for community housing.
When food scarcity became especially acute in the summer of 1946, the city imposed compulsory evacuation of 50,000 people to surrounding farm villages, and arranged for relief rice supplies to be provided.

In Nagasaki, reconstruction proceeded slowly. It was the latter half of 1946 before the first simple emergency dwellings were provided in various communities. Such fell far short, however, of meeting desperate housing needs. As late as 1950, applicants for corporate dwellings exceeded availability by ninety times.
Reconstruction Gets Under Way

Meantime, the national government in November 1945 adopted a “war disaster reconstruction plan” for rebuilding 119 war-devastated cities, including Hiroshima and Nagasaki. This enabled Hiroshima to plan for the restoration of its central area, covering 1.3 million square meters and accommodating an estimated 350,000 people. Nagasaki likewise projected a new city concept that would abandon its old war industries, focusing rather on revival of foreign trade, shipbuilding, and fishing industries.

These plans did not bear fruit, however, until the National Diet (parliament) in May 1949 passed the Hiroshima Peace Memorial City Reconstruction Law and the Nagasaki International Culture City Reconstruction Law. These laws went into effect on the two cities’ respective bombing anniversary dates, August 6 and August 9.

Long-term Medical Care and Relief

1. The first desperate years
   Wartime care for casualties and hospitalization were based on national laws of 1942 that provided only minimal help for two months. The majority of patients needing emergency care were housed temporarily in schools, but they had to be evacuated as children returned from outlying areas and needed to enroll.

   The acute stage of A-bomb injuries reached a peak by the end of December 1945, making the situation desperate. A few Japanese and U.S. army medical facilities were taken over for treatment of A-bomb victims.

2. The Atomic Bomb Casualty Commission
   Back in November 1944, the U.S. Strategic Bombing Survey had been formed to conduct an investigation of bombing effects in Germany; on August 15, 1945, President Truman expanded its mission to investigate effects at all bombing sites in Japan. Its staff included 350 officers, 500 noncommissioned officers, and 300 civilians.

   In November 1946, Truman ordered a more focused study of A-bomb injuries by a newly founded Atomic Bomb Casualty Commission (ABCC). It studied a wide range of injuries: cancer, leukemia, shortened life-span, loss of vigor, growth and developmental disorders, sterility, genetic alteration, abnormal pigmentation, hair loss, and epidemiological changes. The existing Japan National Institute of Health (JNIH) was ordered to assist ABCC.

   Located first in Hiroshima’s Ujina township, the ABCC moved in November 1950 to the top of Hiroshima’s highest hill, Hijiyama. In Nagasaki it was based in the Nagasaki Health Center.
While ABCC generated a wide range of scientific and medical studies, it offered no medical care to the A-bombed citizens of either city. Individuals were ordered to report to the ABCC facilities for examination, and often were picked up by U.S. army vehicles. This procedure did not elicit positive attitudes among the Japanese.

After the American Occupation ended in 1952, Japanese health officials recognized certain limitations of the ABCC program, and set up the A-bomb Aftereffects Research Council in JNIH, and it in turn sought the cooperation of the two cities’ Casualty Councils (see next).

3. A-bomb Casualty Councils, function and funding

Seven years after the bombings, independent citizens’ movements arose to form A-bomb Casualty Councils in Hiroshima in early 1953 and in Nagasaki about the same time. Funds were raised to provide free care for distressed patients and subsidies for others. The councils were chaired by the mayors of the two cities, and fundraising campaigns were assisted by Japan’s Central Community Chest and by the national broadcasting corporation (NHK). A ten-day nationwide campaign in August 1953 raised over five million yen for A-bomb patient care.

4. A-bomb Victims Medical Care Law

National concern escalated in 1954 when radioactive fallout from an American H-bomb test at Bikini Island in the Pacific fell on the Japanese fishing boat “Lucky Dragon No. 5.” [See next section]

Public protest aroused by this incident stimulated the national parliament (Diet) to allocate 12,442,000 yen in 1955 and 25,682,000 yen in 1956 to cover A-bomb victims’ medical expenses. This then led to passage of the national A-bomb Victims Medical Care Law in 1957, with an initial allocation of 267,493,000 yen (trimmed later to 174,589,000 yen). Passage of this law stimulated formal establishment of the A-bomb Casualty Councils in Hiroshima and Nagasaki. As the national economy recovered, various provisions for livelihood relief, welfare measures, and remedial surgery were made.
5. Advocacy of an A-bomb Victims Relief Law

Public awareness and concern peaked in 1966 with passage of the A-bomb Victims Special Measures Law, based on the consensus that A-bomb victims experienced unusually severe hardships and injuries. This law provided special allowances for such needs as medical care, nursing, health maintenance, burials, and severe livelihood difficulties.

A 1980 review by the Health and Welfare Ministry, however, reversed this stand, reasoning that “the general sacrifices of war were suffered by all the people,” and thus “there must be no pronounced inequality between policy for A-bomb victims and that for war victims in general.”

Of far less concern, unfortunately, were the many Koreans living in Hiroshima and Nagasaki at bombing times. Of some 50,000 living in Hiroshima, about 20,000 died in the bombing; and about 27,000 returned to Korea. Of the 12,000–14,000 Koreans in the bombed area of Nagasaki, 1,500 to 2,000 are believed to have died. Most of the rest returned to Korea. Then, in the Japan–Republic of Korea Normalization Treaty of 1965, Korea relinquished all claims against Japan, leaving Korean A-bomb victims still there without access to Japanese legal provisions for A-bomb victims.
*Korean A-bomb victims with Korea-born Eiichi Hashimoto (back, right), then principal of Hiroshima Jogakuin High School. (HIMAT)

The same difficulties applied even more to lesser numbers of Chinese and other Asians, as well as to Japanese-Americans (with U.S. citizenship) who were working or studying in Hiroshima and Nagasaki at bombing times.