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Photos from the authors’ visit to the disaster-affected area three weeks after 3/11

Opposite, damage after the earthquake and tsunami near the city of Sendai; above, an evacuation center in Fukushima; below left, four women who were widowed by the tsunami; below right, temporary housing in Sendai.
Foreword

AKIKO DOMOTO

The strengths and weaknesses of every society are laid bare when disaster strikes. Perhaps as consolation in times of tragedy, we tend to gather around hopeful narratives – stories of great heroism, sacrifice, compassion, generosity and endurance. But if we do not also acknowledge the failures that were made in the face of adversity, we will surely fail at the time of the next calamity.

Within minutes of the massive earthquake and subsequent tsunami that struck the northeast coast of Japan’s main island on March 11, 2011, dreadful images of the disaster flashed around the world. Horrified viewers everywhere responded with a wave of global generosity and compassion for which all Japanese remain deeply humbled and grateful.

In subsequent days, what television viewers saw was mostly Japan at its best (with the glaring exception of events at the Fukushima Dai-ichi nuclear power plant). Rescue and relief teams raced to the scene swiftly and efficiently. Faithful nations flew in aid. And the victims showed typi- cal Japanese grace – stoic endurance of the unbearable.

For those who know Japan, none of this was surprising. So when an American news anchorman asked his reporter cal Japanese – stoic endurance of the unbearable. And concern mounted among the nationwide network of accomplished women (from the professions, academia and business) to which I belong. Beyond the immediate concern for the survivors, we had long been alarmed by the lack of gender sensitivity in plans for disaster risk reduction and reconstruction. But it took the March 11 disaster to galvanize us into action.

This report is an account of what we have done in the two years since.

**Japan Women’s Network for Disaster Risk Reduction**

**Japan’s struggle for gender perspective in disaster response**

In the three weeks of the disaster, we had begun to form a network of activists with specialization in various fields, and to seek support from women’s groups and individuals nationwide.

In early April, our core group – the authors of this report – visited Fukushima and Miyagi, two of the three hardest-hit prefectures, to talk with evacuees, local physicians and political leaders.

Upon returning to Tokyo, we began immediately to lobby the government to include a gender perspective in disaster-related policy, and to reform both policy and systems to make them gender sensitive.

With information coming directly from women in the disaster-affected areas, and the participations by women from all parts of Japan, our momentum grew quickly. Thanks to support from women legislators, we were able to get our issues actively discussed in government. And – as you will read in my report – we were able to achieve signifi- cant results within a relatively short period.

**Fives perspectives on the struggle**

My report provides a narrative history of our networks activities, particularly our intensive effort to influence key disaster risk management policies, plans and decision-making processes, and to make them gender sensitive.

During “normal” times, women in Japan live in a soci- ety where patriarchal traditions and male-centered social systems predominate, and women discrimination is deeply rooted, though not always obvious. In times of disaster, however, such male-centric attitudes and discriminatory practices come glaringly to the surface.

Sure enough, within two days we began to hear stories from Tohoku about the harsh conditions in the evacua- tions centers faced by women, children, the elderly, the disabled and other vulnerable groups. Organized solely by men and operated on the basis of bureaucratic expediency, the tightly regimented shelters completely disregarded the women’s needs. For example, there was no privacy in which to change or nurse babies. And the organizers had not even thought to stock female sanitary supplies.

Although these issues were largely ignored by the media, reports began to filter through to women across Japan. And concern mounted among the nationwide network of accomplished women (from the professions, academia and business) to which I belong. Beyond the immediate concern for the survivors, we had long been alarmed by the lack of gender sensitivity in plans for disaster risk reduction and reconstruction. But it took the March 11 disaster to galvanize us into action.

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How we wrote gender perspective into Japan’s disaster legislation
AKIKO DOMOTO

Environmentalist, Feminist and Former Governor of Chiba Prefecture

Women’s needs seen from the top

Every year from 2001 through 2009, it was my responsibility as governor of Chiba Prefecture to lead a large-scale disaster response drill. It was a way to ensure the efficacy of the emergency services and government functions. My jurisdiction covered 6.2 million people inhabiting an area between Tokyo and the Pacific coast that is roughly twice the size of Luxembourg. Some of these drills even required me to be flown by helicopter to a designated command center from where I had to authorize tactical response measures.

Disaster planning and response being among the most crucial duties of a prefectural governor in Japan, I had the opportunity to observe in great detail how each function of local, prefectural and national government is expected to respond in the event of a major disaster.

When the devastating earthquake struck Japan’s north-east coast at 2:46 pm on March 11, 2011, followed by the massive tsunami, Chiba was at the southernmost end of a 700-kilo-meter stretch, and mercifully, suffered relatively little damage. Having completed my second term as governor two years earlier, I was not called on to put into practice what I had learned in the drills. As I watched the television news coverage of response efforts, though, I knew what was supposed to be happening. So I could see clearly what was going according to plan and where the authorities were overwhelmed by the scale of the disaster.

What is more, I was on the alert for evidence of what I knew to be a woeful gap in Japan’s emergency preparedness: an awareness of women’s needs. From my time as governor, I knew how, among all the teams and committees tasked with disaster response planning, women were almost entirely absent.

Lack of gender sensitivity adds to survivors’ misery

In the days and weeks after 3/11 I assembled a group of women specializing in gender issues – the authors of this report. We traveled to Fukushima, Chiba and Miyagi prefectures on a fact-finding mission and to initiate national expediency at the expense of social infrastructure and other social concerns. If these concerns are at the core of recovery plans – as they should be – gender equality must be an indispensable element. Women’s skills, experience and resilience must be recognized and utilized. While HFA clearly reflects all these concerns, the government’s Seven Principles completely ignored them.

As a former member of the Upper House of Japan’s Diet, I know my way around our nation’s legislature and how to get things done. So in response to these unfortunate developments, we decided to write to our female members to an emergency dialogue on May 19, which we called “Aftermath of the Disaster from a Gender Perspective – Thinking with Women Diet Members.” Thirteen women legislators showed up to meet with 50 members of our network.

The consensus that emerged was to demand that the government improve the situation, and all participants signed a “Diet Members’ Initiative to the Cabinet on Gender Equality in Response to the 3/11 Disaster.” This called for the administration to increase representation by women, the elderly and disabled persons in the Reconstruction Design Council, and to make their active participation a priority in the recovery plans.

Subsequently, we submitted 15 separate petitions, and negotiated with the National Diet, the Recovery Office, and other bodies in charge of the reconstruction.

Whether in response to our petitions or not, ten days later on May 29, the Reconstruction Design Council announced its finding that, “in regions to build back, it is important to aim for a true planned society, an active society and gender equality society, by having women, elderly, disabled, and various people participate in the consensus development process.”

To this end, it was decided to “region building,” having “women, elderly, disabled” and “gender equality written in was our first success with the petitions, and our first step.

Basic Act on Reconstruction and the 6/11 Symposium

As hundreds of participants from all over Japan gathered in Tokyo for our 6/11 Symposium, “The Basic Act on Reconstruction” was making its way through the Diet, passing into law on June 20. Right up front in a section entitled “Basic Philosophy,” it states that “opinions of the residents in the disaster-affected regions shall be actualized and utilized as a vast range of people including women, children and the disabled persons shall be taken into account.”

Although the content of this passage was somewhat unsatisfactory to us, our ability to influence the legislative process was unmistakable. So we took this small achievement as a useful stepping-stone as we moved from petitioning and raising awareness toward realizing concrete gender equality policies and the achievement of social justice.

In that respect, our 6/11 Symposium was perfectly timed. After a great deal of enthusiasm discussion, several proposals emerged that we believed would help to achieve our goals.

• To demand the proactive placement of women in decision-making bodies such as recovery and prevention councils, and the thorough inclusion of gender perspective in disaster prevention policies.

• To demand an increase in the number of members on the Reconstruction Design Council, and the inclusion of members with a gender equality perspective, especially women.

In the days and weeks after 3/11 I assembled a group of women specializing in gender issues – the authors of this report. We traveled to Fukushima, Chiba and Miyagi prefectures on a fact-finding mission and to initiate discussions after, our group reached two main conclusions:

• That women survivors faced manifold problems, indignities and absurd discrimination. That gender-related obstacles women experience in everyday life were being amplified by the hardship of disaster. That gender roles were being hardened in an environment where domestic violence and sexual harassment were intensifying.

• That women were not participants in decision-making processes.

• That there was a lack of consideration for the caregivers of the sick and disabled. Furthermore, even when individual pregnant or nursing mothers, disabled, or elderly would appeal to the shelter leaders, they would not listen, and the claimants were compelled to simply endure.

In response, we decided to call on our personal contacts among women’s organizations throughout the country in order to urgently push for change. This led to the formation of ‘Women and Disaster Network Japan’.

While numerous other NGOs were formed to directly support women in the disaster areas, our network focused on demanding systemic change from the national and local governments: proposing policies based on gender equality in disaster prevention and response.

To this end, we gathered support from a wide range of women’s organizations nationwide: Political action groups, like the International Women’s Year Liaison Group Japa and Accountability Caucus for the Beijing Conference; National unions, including the National Federation of Regional Women’s Organizations and the National Council of Women’s Centers; Academic groups, such as the Society of Japanese Women Scientists and the Japanese Association of University Women; Professional bodies, such as the Japan Medical Women’s Association and Japan Society of Disaster Nursing; Plus international, welfare and educational NPOs and NGOs in various fields. In all, more than 100 organizations rallied to our cause.

Three months after 3/11, on June 11 we held the 6/11 Symposium on Disaster, Reconstruction and Gender Equal- ity. As a result, we drafted a demand to the national govern- ment to include gender perspective as a fundamental aspect of disaster and recovery policy, and to allow women from the disaster areas to participate in the policy-making process. After the following summer we mobilized women’s groups nationwide to lobby senior government bureaucrats and legislators to implement our resolution. We beseeched them with personal visits and petitions.

But even as we worked to gather support, the fight began right away as reconstruction efforts got off on the wrong foot.
To demand that the Reconstruction Agency and similar organizations reflect the interests and opinions of women, children and disabled persons with a gender-equal perspective. More important than any specific resolution, though, was the fact that we came together as a national movement with great enthusiasm and common purpose. We generated momentum in striking down the requirement that women do not make the same mistake, we prepared a new petition on June 28, which asked for several specific changes in the wording of the guidelines for the Reconstruction Design Council. To the report statement regarding the “incorporation through broader incorporation of gender perspective” and “the participation of women,” add, “This is particularly important in key local authorities and autonomous organizations that are closely involved with people’s everyday lives.”

To the report statement regarding “increasing the number of members of the Reconstruction Design Council,” add, “appoint members with the perspective of gender equality; and particularly female members even to council organizations dealing with community reconstruction efforts in areas affected by the nuclear plant accident.”

Add “Establish a ‘Gender Equality Perspective’ post (tentative name) in the current Reconstruction Headquarters in Response to 3/11, as well as to local prefectural response offices, that will play a constant role in cross-sectional planning and coordination. This will be taken over by the Reconstruction Agency.”

In addition, we also stated our core demands for equalizing the roles of men and women in participating in disaster management and reconstruction: “While it is desirable for the perspective of equal participation of men and women to be included in the planning of building, this is still a narrow approach. This is not simply about women being able to participate in discussions and share their perspectives; we must take up the challenge of overcoming our fundamental social problem of gender inequality during normal (non-disaster) times.” Using disaster as an opportunity to correct the structural distortions in Japan’s socioeconomic structure is the essence of our requests. There we also pointed out the report’s narrow interpretation of DRR, which was translated as simply “disaster reduction.” In the petition, we defined the term as “an approach that seeks not to completely prevent or guard against a natural disaster, but rather focuses on minimizing the impact of such a disaster. Disaster reduction requires both structural [hard] measures (development of seawalls and coastal levees) and people-oriented [soft] measures.”

The international understanding of “soft measures” is quite different from that of Japan. “Disaster reduction” is translated as simply “disaster prevention” or “disaster management,” while “disaster reduction” in Japan means “disaster prevention” or “disaster management.” The international community is equally vital on an international level. When disaster struck Japan on 3/11 we were deeply humbled by the tremendous outpouring of goodwill and support from governments and individuals across the world. That spirit of shared humanity may just be the most hopeful force on our planet. We should strive to continue to foster such a spirit of shared humanity, not simply in Japan but around the world.

Conclusio
Japan is often called an “archipelago of disaster,” and our long history records many calamities that have profoundly shaped our culture and left us with an instinctive predilection to pull together when the worst happens. Fortunately, the six decades since 1945 have been a period of relative volcanic and seismic calm with fewer disasters than many other eras. But historical averages show that we are not safe from disasters. In fact, we have already experienced a magnitude 8.2 earthquake. While I cannot say we were completely successful – the inclusion of many of our demands into the Basic Policy for Reconstruction is a more small victory for our side. After the July 14 meeting, our working team put their heads together and expanded the content of the demands. After much further discussion over ten meetings, the demands that cannot last any longer. Finally, after a great deal of navigating the corridors of the Diet, we were happy to get the crux of the demands included. On July 28, the Basic Guidelines for Reconstruction were established, including the key elements of community building, this is still a narrow approach. This is not simply about women being able to participate in discussions and share their perspectives; we must take up the challenge of overcoming our fundamental social problem of gender inequality during normal (non-disaster) times.” Using disaster as an opportunity to correct the structural distortions in Japan’s socioeconomic structure is the essence of our requests. There we also pointed out the report’s narrow interpretation of DRR, which was translated as simply “disaster reduction.” In the petition, we defined the term as “an approach that seeks not to completely prevent or guard against a natural disaster, but rather focuses on minimizing the impact of such a disaster. Disaster reduction requires both structural [hard] measures (development of seawalls and coastal levees) and people-oriented [soft] measures.”

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Top, a minute's silence held by attendees to the Symposium. The authors of this report giving presentations;
Reiko Aoki (above), Miho Ohara (opposite top), Hiroko Hara (left) and Akiko Domoto.
This report considers gender issues in emergency disaster response and discusses appropriate emergency disaster response measures, based on findings from studies on the needs of both men and women after 3/11 and the actual response.

1. Considerations Regarding Gender in Emergency Disaster Response

Many issues regarding the differences between men and women’s needs were identified after the 1995 Kobe Earthquake. These can basically be divided into: 1) Women in need of care; 2) Women as caregivers to those in need; and 3) Women involved in society. Differences in the needs of men and women were also identified in the stricken areas after the 3/11 disaster, and have become the focus of the Gender Equality Bureau Cabinet Office and various NPOs. Most of the issues had already been identified after previous disasters but the livelihood of women in agricultural and fishing related industries arose as a new focus of the earthquake. This chapter will focus on disaster relief efforts and investigate why these efforts did not consider gender issues.

(1) The Lack of a Shared General Concept

Women wear many faces within the family structure, depending on their age and position. As shown in Figure 1 (p.13), women’s needs can be divided into those as a “care receiver” and as those of a “care giver.” Since these are usually vaguely discussed as “women needs,” a specific, shared notion of the serious issues faced by women in different situations does not come into the conversation. Also, discussions do not take into account the numbers and distribution of women playing different roles in different situations.

(2) A Lack of Quantitative Data on Target Group Needs

After a disaster, the necessary emergency supplies and emergency medical care change as utilities such as electricity and water are restored. The groups in need of priority consideration and support also change, as do the needs of men and women. Right after a disaster, the numbers and situations of those in need can be difficult to ascertain, making support and consideration that conform to people’s needs difficult to ascertain. It is important to study the necessary personnel and communications systems that can quickly identify target groups after a disaster prior to the occurrence of an event.

(3) Fragmented Bureaucratic Fiefdoms

In recent years, administrative services have been fragmented. While some local governments have disaster response offices, these generally remain the domain of fire, disaster prevention and crisis management bureaus. When a disaster occurs, these offices handle the response independently, so the issues illustrated in Figure 1 become the domain of different government departments. Pregnant women and infants, for example, are handled by the children and family support offices; the elderly are handled by nursing insurance offices; and the disabled by various welfare offices. It becomes necessary for these offices to quickly identify those in need and share information in real time with other offices because of the inherent inefficiency of the offices working independently. In many local governments, a gender equality office or division set up as a cross-sectional organization between various offices. The gender equality office should be central in overseeing the distribution of those who require attention and support during a disaster.


This section will examine the specific issues of disaster emergency measures that consider men and women’s needs using, as an example, the situation after the 3/11 disaster in Sendai City.

(1) Responding to the Needs of Shelters

The number of people who need emergency shelters changes dramatically depending on when utilities are restored, the distribution of goods, and whether people have somewhere safe to go. Figure 2 (p.13) shows the change in the number of refugees and the number of shelters after the disaster: The number of refugees reached a maximum of 10,947 people on March 12, the day after the earthquake; the number of shelters reached a maximum of 288 on March 14, 3 days after the earthquake; the last shelter closed on July 31. Since the disaster was larger than anything that had been covered in the March 2007 Regional Plan for Disaster Prevention, drastic changes were made. Permanent staff were placed in emergency shelters, and worked hard to get a grasp on the number of refugees actually in the shelters. However, they did not have the resources to determine the numbers of men, women, elderly, or those in need of medical attention. It is very important for the response to be based on people’s actual needs, but gathering and managing such information requires time and labor.

Under the Regional Plan for Disaster Prevention, several offices – such as the Health and Welfare Office – were in charge of the provision and distribution of food and daily necessities. However, these duties were quickly consolidated into the Finance Office after the disaster. Then, on March
15, the Ground Self-Defense Forces were put in charge of distribution. Each day, shelters would fill out a form listing the supplies they needed, and the Ground Self-Defense Forces would distribute supplies. The smooth distribution of supplies was possible due to the city’s focus on the distribution of goods and the cooperation of the Ground Self-Defense Force. A research group analyzed the contents of the delivery request forms and delivery manifests.

An analysis with the Management Cooperative for distributing emergency supplies of feminine hygiene products, adults and children’s diapers, and wet wipes had been concluded in April, 2010. Although 14,500 feminine hygiene products were delivered to the shelters, as arranged, the demand for feminine products reached a peak on March 25. Due to a shortage of emergency stores, the requested amount could not be delivered. After an appeal by the city through the donations came in from all over the country and the demand was met on March 28. Sendai’s emergency supply distribution arrangement was the first of its kind, and should be regarded highly. Although the actual number of refugees based on attributes such as sex and age could not be determined, their needs were determined and met through the delivery request forms. It became apparent at a later hearing, however, that it was often difficult for women to receive emergency supplies of feminine hygiene products and dividers for privacy, because the shelter leaders and permanent administrative staff who filled out the delivery request forms were largely male.

A examination of the type and amount of emergency supplies based on the lessons learned is sorely needed. According to a survey presented at the 2008 Conference of Prefectural Governors, the percentage of women on the disaster-risk reduction committees and among the consultants for emergency supplies was as low as 10.6 percent at the prefectural level, and 4.2 percent at the municipal level. According to the same survey, only 6.8 percent of the crisis management staff at the prefectural level are women; only 6.1 percent at the municipal level. Some have noted that many were saved because women volunteers were running the emergency supply distribution arrangement in Sendai. These participants added a women’s perspective to the issues of supply management, such as the size of underwear. It is important that women take part in the disaster response process.

The larger the disaster, the longer people will need to stay in shelters, and the harder it is to move supplies. It is important to guarantee the continuous distribution of emergency supplies within the stricken areas. It is also important to ensure local emergency aid does not run out before supplies can be brought to from outside of the disaster area. It is necessary to study the required emergency stores and distribution from this experience to prevent goods from running out after a future disaster.

(2) Needs and Response of Welfare Shelters

Sendai City created 40 welfare shelters that took in 288 people. Of these, 26 facilities that had prior agreements to take in people from intensive care elderly homes, elderly welfare centers, and centers for the disabled, actually took in such refugees. Agreements had been made with the 52 facilities affected by the earthquake, but many were either damaged during the earthquake or tsunami and no longer had enough staff to operate. There were 14 other facilities without previous agreements that were established for the care of seniors with cognitive impairments and those from rehabilitation facilities.

In Sendai City, even in areas where there was no damage from the tsunami, many people suffered from damaged utility facilities and gasoline shortages. Because food delivery was hampered, many at home and not in special care facilities found themselves having to go to shelters. When considering plans for welfare shelters, it is important to also consider those who will be forced to leave their homes when utilities are down.

The 14 facilities in Sendai City that were established without previous agreements were not entered into the Self Defense Force’s supply distribution system. The Health and Welfare Office’s Nursing Insurance Division and Disabled Person’s Support Division delivered food to these 14 facilities on their own. The Health and Welfare Office’s Preventive Care Division delivered food to the elderly in their homes through the Local Comprehensive Support Center. However, according to hearings, after the utilities were disabled, gathered for shelter at other places, such as vocational centers. These places were not considered welfare shelters, however, and material aid was not provided. There is controversy over how broad support should be, since even healthy people face serious obstacles to their livelihood during a disaster. Women often face this challenge as special caretakers of family members. Consideration must be given to support these women and keep this from becoming too immense a burden.

In most shelters, nurses making the rounds recommended that refugees be moved to welfare shelters as necessary. Doctors from the local medical association also made rounds, but information gathered this way was not acted on. Permanency of staff and nurses who travel to various shelters are able to compare shelters and make judgments based on this comparison. It would be prudent to put the opinions of those regularly monitored various shelters into practice. At hearings held by the city, the opinions of aid workers from other areas were said to be invaluable. A system that takes diverse viewpoints into account is necessary.

(3) Needs and Response Outside of Shelters

After the earthquake, 840,000 houses were left without power. Three wards that were not directly hit by the tsunami had their power restored one week later, on March 17. There were also 230,000 households without water for 19 days, until the supply was mostly restored on March 29. Gas was restored to 310,000 homes by April 16. Even households that didn’t suffer from the tsunami itself were put under great duress by the loss of these critical utilities.

Tokyo University’s Center for Integrated Disaster Information Research (CIDIR) conducted a web survey of 1,000 households in the disaster area not directly impacted by the tsunami. The survey was conducted from February 17 to 26, 2012, and 989 people between the ages of 20 and 69 participated. Of these 100 were elderly, and the rest were women in their 60s. According to the survey, 98.9 percent of respondents lost electricity, 76.9 percent lost water, and 80.2 percent lost gas. Chart 1 (p.14) shows the average number of days it took to restore various utilities and the percentage of respondents who lost those utilities. On average, electricity and mobile phone service was restored within one week, while gas took the longest to be restored. The average response for “whom life returned to normal” was 59 days, meaning that it took more than just the restoration of facilities for people to feel that life was back to normal.

Respondents were also asked about the difficulties they faced with: 1) their life and health, and 2) their health and wellbeing. The response was divided into a) the first three days, b) after the first three days until the end of the first week, and c) from the first week to the end of the first month after the earthquake.

The most common problem in the first category for the first three days was “inability to wash underwear,” at 51.8 percent. From day four to the end of the first week the most common problem was “the inability to wash underwear,” at 52.5 percent. From the end of the first week to the end of the first month the most common problem was “the inability to take a bath,” at 64.5 percent. During all three periods the second most common concern was “a lack of variety and balance in meals,” at around 45 percent. The number of respondents who said “the inability to take a bath” increased dramatically in the last period, and the time it took to restore gas had a large influence. The issues of “dealing with raw garbage,” “not being able to stay in lines for an extended period of time,” and “the closing of preschools and kindergartens” increased slowly over a period of time, and were not alleviated within the first month. While the total percentage of respondents who replied with “the closing of preschools and kindergartens” was small, it remained a long-term concern for 30-40 percent of 72 respondents with preschool or nursery school age children.

The number of respondents who put down “not being able to remain in line for extended periods of time” was large among those talking about the lack of children’s care. Comparing the responses of men and women, 10 percent more women responded with “lack of variety and balance in meals,” “the inability to bathe,” and “inability to wash underwear” than men. This has been confirmed by the chi-squared test as a statistically significant difference.

Since this difference in men and women’s responses dissipated as time passed, women’s awareness of pertinent issues can be thought to be higher than men’s. Statistically, there were no items with a larger response among men.

Of difficulties with people’s health and welfare, the most common problem for the first week was “an inability to sleep well,” at 34.8 percent for the first three days and 30.8 percent from the fourth day until the end of the first week. The most common issue from the end of the first week to the end of the first month was “inability to wash underwear,” at 38.1 percent, which increased rapidly as time went on. Responses including “difficulty of getting everyday medicine,” “the inability to visit a hospital or clinic,” “the lack of hygiene,” “the inability to take a bath,” “the inability to wash underwear,” and “fights with family” gradually increased over time; they were not alleviated even after one month. Comparing the responses of men and women, 10 percent more women responded with “an inability to sleep” and “depression” in all of the time periods. This has been confirmed by the chi-squared test as a statistically significant difference. In all the time periods, women reported “increased fights with family” more often than men, which shows women’s heightened awareness of this issue.

It is clear that life was difficult even for those not directly affected by the tsunami, and that their wellbeing was affected over a long period of time. Nurses did not visit people outside of the shelters because the population was dispersed. But those outside of the shelters also faced difficult situations. It is necessary to create a system to set up advisory services, and to make the location and utilization of these services common knowledge, so that those who need support and consideration are not left on their own.

3. Standardization of Disaster Response that Includes the Gender Perspective

One year after the disaster, the national government issued a report on a series of meetings that local governments reassessed their earthquake and tsunami damage simulations and disaster prevention plans. As mentioned in the previous section, it is necessary to gather quantitative data about disaster areas needs and recovery.
work in order to develop a shared concept about the necessary amount of support and consideration. Generally, the 6W1H shown below is necessary when forming a disaster response plan. Analyzing the quantitative data from previous disasters and preparing a standardized disaster response model according to 6W1H will lead to the creation of an effective and efficient disaster response plan. Multiple standardized disaster response models are required to meet the different needs that arise from a variety of disasters, such as earthquakes with or without tsunamis, or with or without large fires. These models can then be adapted to work with regional characteristics in making practical regional disaster prevention plans. This should raise the standard of disaster response and relief for the entire nation. Also, “who” does not stop with the government. It is also necessary to examine what kind of support is necessary amount of support and consideration. Generally, the 6W1H shown below is necessary when forming a disaster response plan. Analyzing the quantitative data from previous disasters and preparing a standardized disaster response model according to 6W1H will lead to the creation of an effective and efficient disaster response plan. Multiple standardized disaster response models are required to meet the different needs that arise from a variety of disasters, such as earthquakes with or without tsunamis, or with or without large fires. These models can then be adapted to work with regional characteristics in making practical regional disaster prevention plans. This should raise the standard of disaster response and relief for the entire nation. Also, “who” does not stop with the government. It is also necessary to examine what kind of support is

The Women’s Centers Network Fundraising Project for 3/11 Disaster Relief

The nonprofit National Council of Women’s Centers is a network organization of 89 women’s centers all over Japan. Women’s Centers in the 3/11 disaster areas began relief activities for affected people immediately after the earthquake occurred. Centers all over Japan continue to provide support to Fukushima residents evacuated due to the accident at the Fukushima Daiichi nuclear power plant. The National Council has also raised funds and implemented a number of projects to assist relief activities.

We are very grateful to all those who contributed to the fundraising project. This is a report on how the funds were spent on support to various groups.

The fundraising project
A total of ¥3,755,279 in donations was received. ¥2,276,452 from organizations and individuals in Japan; ¥478,787 from overseas through Japan Women’s Watch (JAWW). Among overseas contributors, Thanpuying Sumalee Chartikavanij and the members of Thai Women’s Watch donated $3,933, the NGO CSW/NY donated $1,348 and an additional $145 in November, and two women from the Philippines, Ms. Aurora Dios and Senator Leticia Shahani, donated $2,070.

How donated funds were spent on support
1) Emergency relief supplies
Two Women’s Centers in Iwate Prefecture made visits to women who had lost their homes because of the 3/11 disaster, and were living in evacuation centers. Essential supplies, such as underwear, cosmetics, baby baths, etc. were delivered to them. Funds spent: ¥600,000.
Participating centers:
• Iwate Prefectural Center for Gender Equality: Visit to disaster areas
• Morioka Women’s Center: Delivery of emergency funds

2) Consultation, a toll-free phone number system and workshop for consultancy staff
Women’s Centers in Fukushima and Aomori prefectures set up a toll-free phone number and established a booth for consultations with women. An exclusive space was also set up in an evacuation center for use in changing clothes and breastfeeding infants. Local women’s organizations supported these operations and also held workshops for the consultancy staff. Funds spent: ¥1,000,800 (part of this from overseas donations).
Participating centers:
• Fukushima Gender Equality Center: Staff workshop at the evacuation center’s space for women
• Association for Supporting Autonomous Women: Setting up of a toll-free phone number
• Aomori Prefectural Center for Gender Equality: Establishment of a “relaxation room”

3) Network and care, etc. for evacuees from Fukushima Prefecture
The Saitama Prefectural Center for the Promotion of Gender Equality created an information exchange network for people who had evacuated from Fukushima Prefecture because of the nuclear power plant accident. Funds spent: ¥469,000 (part of this from overseas donations).
Participating centers:
• Saitama Prefectural Center for Promotion of Gender Equality (With You Saitama), Disaster-Link Café Committee

4) Lecture meetings, symposia and workshops
Women’s organizations in Osaka, Miyagi and Tokyo held lecture meetings, symposia and workshops to discuss the disaster and disaster relief from the gender perspective. Funds spent: ¥921,000 (continuing).
Participating centers:
• Osaka City Gender Equality Center, Central Building: “Toward March 11, 2012 – The Role of the Gender Equality Center in Disaster Recovery”
• Public Interest Foundation, The Japan Association for Women’s Education (JAWE)
• Miyagi Women’s Culture Association: “Disaster and Recovery – Network Building Emphasizing the Participation and Viewpoint of Women”

5) Employment and entrepreneur support
The Tokyo and Aomori Women’s Centers supported women in finding employment in the disaster areas and also provided support for women setting up businesses dealing in local farm produce, etc. Funds spent: ¥129,180 (part of this from overseas donations).
Participating centers:
• Otanakamura Center for Gender Equality
• Aomori Prefectural Center for Gender Equality: Support for new business development in the disaster areas

The “Women’s Centers and the Disaster” website
Information about support provided by the Women’s Network for Disaster Risk Reduction.

Acknowledgment: Thanks to the Sendai City Economics Office and related offices for their cooperation in holding the hearings and gathering related data.

6WH1:

6W

1. When
2. Whom
3. What
4. Where
5. Who
6. Why

H1

1. How
Gender issues in disaster prevention, disaster relief and the reconstruction process in Japan

HIROKO HARA

Nihon Bosai Hyakunenshi (“A 100-year Record of Disaster Prevention in Japan”) was published in 1990. The publication included a chronological table covering the period from the first year of Meiji (1868) through to the end of the Showa period (1989), but in the entire book there is only one mention of special considerations for the elderly and none at all of gender issues.

1. The Kobe Earthquake, January 17, 1995

(1) Overcoming the difficulty of gaining access to statistics on earthquake-caused deaths by age and gender

Following the Kobe Earthquake of January 17, 1995, the national government and local governments began to release gender/age-disaggregated data on the number of dead, after saying it was extremely difficult to ascertain correct figures and a heavy load to calculate (Table 1).

Overall, the number of women who died was greater than the number of men; the number of deaths of elderly women was particularly high because there are more elderly women than elderly men.

There was more damage among the poor because they tend to live in seismically less stable areas where property values are lower. Ideally, a cross-tabulation showing socio-economic factors, such as whether the casualties were on social welfare or whether they were in a high tax bracket, should be made available (even though it might be technically quite difficult). The relationship between gender and class is another issue that needs to be investigated.

(2) Activities by women

The activities of the NGO “Women’s Net Kobe” helped bring more attention to the subject of “disaster prevention and gender issues.” Women’s Net Kobe was originally involved in efforts to increase the number of women members in the Kobe City Council and the Hyogo Prefectural legislature. They were active even prior to the Kobe Earthquake, and one of their early activities

<table>
<thead>
<tr>
<th>Age at the time of death</th>
<th>Men</th>
<th>Women</th>
<th>Total</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - 4</td>
<td>67</td>
<td>55</td>
<td>122</td>
<td>1.91</td>
</tr>
<tr>
<td>5 - 9</td>
<td>64</td>
<td>66</td>
<td>130</td>
<td>2.03</td>
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<tr>
<td>10 - 14</td>
<td>66</td>
<td>79</td>
<td>145</td>
<td>2.26</td>
</tr>
<tr>
<td>15 - 19</td>
<td>70</td>
<td>102</td>
<td>172</td>
<td>2.69</td>
</tr>
<tr>
<td>20 - 24</td>
<td>151</td>
<td>148</td>
<td>299</td>
<td>4.67</td>
</tr>
<tr>
<td>25 - 29</td>
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<td>173</td>
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<tr>
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<td>60</td>
<td>62</td>
<td>122</td>
<td>1.86</td>
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<tr>
<td>35 - 39</td>
<td>62</td>
<td>57</td>
<td>119</td>
<td>1.86</td>
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<tr>
<td>40 - 44</td>
<td>97</td>
<td>109</td>
<td>206</td>
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<tr>
<td>45 - 49</td>
<td>118</td>
<td>162</td>
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<td>4.37</td>
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<td>50 - 54</td>
<td>136</td>
<td>236</td>
<td>372</td>
<td>5.69</td>
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<td>249</td>
<td>461</td>
<td>7.20</td>
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<tr>
<td>60 - 64</td>
<td>261</td>
<td>299</td>
<td>560</td>
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<tr>
<td>65 - 69</td>
<td>272</td>
<td>385</td>
<td>657</td>
<td>10.26</td>
</tr>
<tr>
<td>70 - 74</td>
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<td>411</td>
<td>677</td>
<td>10.57</td>
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<td>75 - 79</td>
<td>222</td>
<td>369</td>
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<td>9.23</td>
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<td>413</td>
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<td>85 - 89</td>
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<td>242</td>
<td>397</td>
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<tr>
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<td>19</td>
<td>28</td>
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</tr>
<tr>
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<td>4</td>
<td>2</td>
<td>6</td>
<td>0.09</td>
</tr>
</tbody>
</table>

was setting up a “Women’s House” to function as an information exchange hub. Though the house was lost in the earthquake, the group was already set up and running, and were therefore able to provide extensive and systematic support to earthquake survivors. Their establishment of a support hotline for domestic violence survivors after the earthquake deserves special mention. Women’s Net Kobe compiled records and published a book (Women’s Net Kobe, Nakagawa, 1998) until nearly a decade after the earthquake that it became well-known domestically and internationally (Masa, Kuzunishi, and Kondo 1998). In line with the group’s original intentions, their representative, Reiko Masai, stood for the Kobe Council in 1995, but lost the election. Women’s Net Kobe’s original objective was partly reached when the Act Concerning Support for Reconstructing Livelihoods of Disaster Victims was finally enacted in 1997. Nakagawa, at the time a member of the lower house of the Diet, was also a member. This report had such an impact on committee members and government officials that disaster issues were included in the second and third Basic Plans on Gender Equality.

There was some progress in the government’s response to the Chubu Earthquake in October 2004 and the Indian Ocean Earthquake and Tsunami in December 2004. Partly because of the lasting influence of the ISOR of 2002, when the Chubu Earthquake occurred, a female officer from the Cabinet Office Gender Equality Bureau was dispatched to the support and countermeasure office of the affected area in order to make sure that women’s points of view were reflected. This was the first time that the government response included the gender issue. When the Indian Ocean Earthquake and Tsunami occurred in December 2004, Japan immediately made a donation of one million dollars through the United Nations agency UNIFEM. The Japanese government’s response to the Indian Ocean disasters is mentioned in the White Paper on Disaster Management FY2006 (2006, Vol. 1, Chapter 4-1, 1-3).

Following this, from 2004 through 2005, the Council for Gender Equality and the expert committee on the Basic Plan on Gender Equality began to debate disaster prevention policies from a gender perspective. The Second Basic Plan on Gender Equality introduced a new field, “Priority field 12: Promoting gender equality in fields requiring new initiatives.” This includes disaster prevention in addition to other fields, such as science and technology, community development, town planning, tourism, and the environment.

The Third Basic Plan on Gender Equality, which was approved by the Cabinet on December 17, 2010, includes the disaster prevention field from the point of view of gender equality as a part of Priority field 14. Specifically, in the contents of this plan, Priority field 14 is “Promoting gender equality in disaster prevention, development, disaster prevention, environment and others.” 3. Event at Japan Women’s Conference, Hiroshima (October 19-20, 2007)

In the private sector, Japan Women’s Conference is held every year in a different Japanese city. Many people are involved in organizing the conference, including city office employees as well as NPOs and NGOs. At the Women’s Conference held in Hiroshima in 2007, a session titled “Including women’s views into disaster prevention measures” was held (Organizing Committee of Japan Women’s Conference, 2007, Hiroshima (ed) 2007).

4. “Disaster and women’s empowerment” at the FY2005 International Forum on Women’s Learning, National Women’s Education Center

Women’s empowerment” was held at the 2005 International Forum on Women’s Learning at the National Women’s Education Center. A lively discussion from a wide range of perspectives took place, with speakers from abroad also contributing (NWWE 2005).

5. “Conference on disaster prevention for women” and the “Anamizu Declaration”

On March 25, 2008, at a conference on disaster prevention for women in Anamizu, Ishikawa Prefecture, the “Anamizu Declaration” was proclaimed. After an earthquake occurred there in 2007, members of an NGO set up by disaster survivors in the Kobe region to help recovery efforts came to support Anamizu residents, creating the momentum for the Conference. The support from Kobe meant a lot to the people of Anamizu; as one participant said, “The people from Kobe didn’t just come and give moral support, they provided great practical support.”

6. Special Committee on Gender Equality, National Governors’ Association, chaired by Akiko Domoto

Disaster and gender were recognized as important national issues by the Special Committee on Gender Equality under the National Governors’ Association (NGA), and a Gender Specific Plan of Action was adopted (Special Committee on Gender Equality, National Governors’ Association 2008). When Akiko Domoto became the governor of Chiba Prefecture in 2001, four female governors participating in the NGA were joined by several other governors in a special committee to develop the project. A survey titled “Disaster prevention measures from the point of view of women and local residents” was sent to all prefectures and municipalities in Japan. Responses were received from all the prefectures and 1,746 municipalities (96.6 percent). In response to recommendations from the prefectural governors, many prefectures built a framework for integrating the local government’s policies on women’s participation in disaster prevention into action at township and village levels.

7. Review of White Paper on Disaster Management

I reviewed White Papers on Disaster Management from 2001 through 2010 to analyze their descriptions on women and gender. Women have been participating in the voluntary recovery efforts in various capacities and organizations under the name of the “Women’s Fire Prevention Clubs.” Originally they were the fire corps’ “wives of officers” group, but they seem to have gradually become more involved in system building in the community.

In the 2006 issue of the white paper, there were a number of places that deserve attention. On December 26, 2005, the Indian Ocean earthquake occurred and in January 2006, a special AEDMEM leaders’ meeting was held in Jakarta.

8. Final Declaration of the Asia-Pacific NGO Forum on Beijing + 15

In 1995 the 4th World Conference on Women was convened by the UN in Beijing. Government leaders participating in the conference adopted the Beijing Platform for Action, identifying 12 comprehensive critical areas of concern to be addressed globally. Each year in the spring, the Commission on the Status of Women is held at the UN Headquarters in New York, mainly to discuss themes. The 2010 session marked 15 years since the Beijing Conference. To commemorate this, large-scale, inter-government meetings and NGO forums were held in each of the UN’s five regions. The Asia-Pacific regional NGO forum was held in October 2009 in Quezon City, a suburb of Manila. The forum’s declaration recognized that in disaster women face various gender-specific problems, such as sexual abuse. Cases where women are extremely disadvantaged when it comes to recovery efforts were also mentioned.

9. UN World Conference on Disaster Reduction (WCDR) and the Asian Conference on Disaster Reduction

As part of the International Decade for Natural Disaster Reduction, the World Disaster Reduction Conference was held in Yokohama in 1994, and the “Yokohama Strategy and Plan of Action for a Safer World” was adopted. This document had a specific section on gender and women. However, in the “Hyogo Framework for Action 2005-2015,” which was adopted at the UN Disaster Reduction Conference held in Kobe about ten years later, reference is made to a document from the 23rd Special Session of the UN General Assembly: Women 2000: gender equality, development and peace for the 21st Century. This framework mentions paying attention to gender-sensitive disaster countermeasures.

As part of the Asian Disaster Reduction Center (ADRC) was established in Kobe in 1998 and the Asian Disaster Reduction Conference has been held almost annually since 2002. It was held in Japan in 2003, 2009 and 2011, at Kobe. At the conference, Kishie Shigekawa, a member of the Human Security and Gender Committee of the Science and Technology Council of Japan, was also a member. This report had such an impact on committee members and government officials that disaster issues were included in the second and third Basic Plans on Gender Equality.

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For this to happen, prefectural governors and local mayors must be very conscious of the issues, including disaster prevention, immediate response, management of evacuation centers, temporary housing, and long-term care, by including issues related to vulnerable groups such as children, elderly people and persons with disabilities as well as gender perspectives (ADRC 2010). The 9th conference, held in Kobe, was Japan’s host country. Japan, with the progress of both domestic and international practice. Unfortunately, Japan’s Basic Act on Disaster Control, last revised on August 31, 2011, did not mention gender and women’s issues.

Conclusion

Disaster prevention and disaster response at the national, prefectural and municipal level in Japan must include women, the elderly and persons with disabilities from the planning stage.

For this to happen, prefectural governors and local mayors must be very conscious of the issues, including disaster prevention, immediate response, management of evacuation centers, temporary housing, and long-term care, by including issues related to vulnerable groups such as children, elderly people and persons with disabilities as well as gender perspectives (ADRC 2010). The 9th conference, held in Kobe, was Japan’s host country. Japan, with the progress of both domestic and international practice. Unfortunately, Japan’s Basic Act on Disaster Control, last revised on August 31, 2011, did not mention gender and women’s issues.

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An Examination of Medical Care and Healthcare Management in Clinics and Shelters after 3/11

DR. KEIKO AMANO
JAPAN ASSOCIATION FOR GENDER SPECIFIC MEDICINE

I. Survey Objective
The purpose of this survey is to clarify the emergency medical care issues as seen from the medical activities of the Prefectural Medical Association members who shouldered the burden of medical treatment and health care after the March 11 disaster. It also intends to serve as documentation for those looking at how to best structure disaster emergency medical care.

II. Survey Executing Agency
Senior Researcher: Dr. Keiko Amano (Japanese Association for Gender Specific Medicine)
Participating Organizations:
- Women and Health Network
- Gender-Specific Medicine Center, Fukushima Medical University
- Miyagi Medical Women’s Association
- Fukushima Medical Association

III. Survey Method
The survey was conducted by questionnaire with the cooperation of the Miyagi Medical Women’s Association and the Fukushima Medical Association.

Miyagi Prefecture: The survey was mailed to 96 members of the Miyagi Medical Women’s Association on June 6, with 30 as the deadline for response. A total of 50 members responded (51.9 percent).

Fukushima Prefecture: Copies of the survey were mailed to 325 doctors who visited the shelters, with 10 copies each sent to 164 hospitals on July 29, with a response deadline of August 15. There were 188 responses (58.8 percent).

The survey content: Questions 1 through 5 on demographic data; Questions 6 through 22 on the situation at a facility the respondent worked at during the disaster; Questions 23 through 33 on the situation in the shelters.

IV. Survey Results (Summary)
A. Clinics, Hospitals and Care Facilities (not including free responses)
Some 78 percent of the doctors were also victims of the disaster, but 43.9 percent of those did not close their offices. Within one week, 87.3 percent of the medical institutions had reopened. The continuation or resumption of medical services served as a source of relief for local residents.

A large number of respondents cited the lack of staff members as important compared to their previous status. Some 82 percent of respondents said a lack of gasoline and kerosene was the biggest obstacle once the facilities had been reopened. Other responses focused on infrastructure, medicine and staff. Lack of water was cited by 48 percent, 38 percent said a lack of medicine, 22 percent said staff shortages, and 22 percent said road and transportation disruption. Other responses pointed out the importance of information: 20 percent cited the lack of disaster information, and 16 percent cited the disruption in telecommunications.

Illnesses that increased over the period of time from the end of the first week to the end of the first month were insomnia, mental health ailments, and anxiety about radioactive contamination. However, the anxiety about radioactive contamination in Miyagi Prefecture only increased from 2 percent to 8 percent, while in Fukushima Prefecture it increased greatly from 12.8 percent to 29.3 percent.

Some 77 percent of the respondents said there was no difference between the illnesses of men and women at medical institutions; 11 percent said that there was a difference. After the disaster, women more commonly cited insomnia and mental health ailments. That trend continued to the end of the first month, with the number of women reporting sleep disorder and mental health ailments continuously increasing drastically. After the first week, a large number of men reported high blood pressure and insomnia. After the first month, the number who reported insomnia increased, and anxiety about radioactive leakage also appeared later. Generally, women react earlier on the mental side, while men first react physically, then the latter follow the same path as women.

Among the patients at medical institutions, 72 percent reported anxiety about aftershocks, 66 percent about radioactive contamination, 46 percent about the nuclear power plant, 34 percent about their lost homes, 34 percent about their lost jobs and companies, 33 percent about their and their family’s futures, 28 percent about the deaths of their family members or relatives, 24 percent about resettlement, 21 percent about the worsening of a chronic disease, and 21 percent about the lack of privacy in the shelters. The seriousness of post-traumatic stress is striking.

B. Shelters (not including free responses)
After the 3/11 disaster, the number of medical personnel placed in shelters in Miyagi and Fukushima prefectures went up by 82 percent. In Fukushima alone the number went up by 95 percent.

The day of the disaster, 6 percent of the respondents entered the shelters. As time passed, the percentage increased, with 41 percent entering on the second or third day after the disaster. Only 10 percent entered after the first month.

While 45 percent of the medical personnel said they experienced some kind of problem in the shelters, 51 percent said they did not. While 60 percent of the doctors from hospitals experienced trouble, only 39 percent of private practitioners reported problems. This is likely the result of private practitioners being used to primary care givers, and consulting on a wide range of illnesses.

The most common problem medical personnel experienced in the shelters was dealing with the elderly, which was reported by 76 percent of the respondents. Other common problems were dealing with infants, at 63 percent, dealing with women, at 52 percent, and dealing with the handicapped, at 44 percent. A lack of appropriate medicine for the aged was a common reason for the trouble (30-50 percent). However, in the case of the handicapped, the lack of someone to look after them was listed as the reason 46 percent of the time (36 percent gave the lack of medicine as the reason). When dealing with women, the most common reason was not having the space to examine women at 67 percent, with lack of medicine at 30 percent.

Some 89 percent of respondents said that consideration of the victim’s gender was necessary: 48 percent said “very important,” 40 percent said “somewhat important.” There was no real difference between the opinions of doctors working in hospitals and private practitioners. A total of 67 percent of the respondents also said that not having the space to examine women patients was a problem.

The respondents, 94 percent said that diverses were necessary to maintain privacy: 66 percent said “very important” and 27 percent said “somewhat important.”

C. Free Response Summary
Question 22: “After experiencing the earthquake, what are your thoughts on the medical care in shelters, clinics, hospitals, and care facilities after a disaster?”

The responses can be broadly categorized as follows:

1) Medical facilities must be protected from disasters.
2) A certain amount of gasoline, food and medicine needs to be stored.
3) Roles during emergency disaster situations must be decided in advance.
4) Habitual disaster drills must be organized.
5) Medical and health care consultation service in the shelters.

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The respondents, 94 percent said that diverses were necessary to maintain privacy: 66 percent said “very important” and 27 percent said “somewhat important.”

Illnesses reported by medical institutions 1 week and 1 month after the disaster

<table>
<thead>
<tr>
<th>Illnesses reported by medical institutions</th>
<th>1 week after</th>
<th>1 month after</th>
</tr>
</thead>
<tbody>
<tr>
<td>High blood pressure</td>
<td>35%</td>
<td>29%</td>
</tr>
<tr>
<td>Cold / Influenza</td>
<td>20%</td>
<td>29%</td>
</tr>
<tr>
<td>Insomnia</td>
<td>25%</td>
<td>35%</td>
</tr>
<tr>
<td>Gastroenteritis</td>
<td>20%</td>
<td>21%</td>
</tr>
<tr>
<td>Worry about radioactive contamination</td>
<td>13%</td>
<td>25%</td>
</tr>
<tr>
<td>Mental health ailments</td>
<td>-</td>
<td>23%</td>
</tr>
</tbody>
</table>

Utilities

1) Training beforehand, preparation for disasters: A) Medical facilities must be protected from disasters.
2) A certain amount of gasoline, food and medicine needs to be stored.
3) Roles during emergency disaster situations must be decided in advance.
4) Habitual disaster drills must be organized.
5) Digital medical records need to be backed up in the “cloud” or some other offline location.

Cooperation in Medical Care, Swift Resumption of Medical Care: A) For patients, the quick resumption of medical care is a priority. B) There should be cooperation and backup of functions and posts other than doctors.

Medical network with other areas, and a system for medical institutions to support each other should be created.

Utilities

1) Quick restoration of utilities is a priority. 2) Independent power generation should be available.

Ensuring sewage services through the use of rain and well-water system.

Information, Communication, Transportation: 1) A system for dispersing information on not just the reopening of public hospitals, but clinics as well is necessary. 2) Create a communications center.
Comments to the Medical Associations:

1) There were too many and too much coordination problems between local medical personnel and medical support staff from outside the prefecture.
2) There were coordination problems between local medical personnel and medical support staff from outside the prefecture.
3) A means of identifying refugees and other people is required.
4) A structure and personnel for coordinating medical support is necessary.
5) Rules for how the administration and volunteers back up medical teams are necessary.
6) Health Care Management and Medical Practice within the shelters is necessary.
7) There was too much bureaucratic organization and medical personnel, and medical support staff from outside the prefecture.

The Shelter Environment:
1) Bureaucratic coordination problems between local medical personnel and medical support staff from outside the prefecture.
2) There were coordination problems between local medical personnel and medical support staff from outside the prefecture.
3) Too many people in each shelter and too much distance between shelters for administration to control.
4) Privacy was not maintained. There were hygiene problems (water, toilet, ventilation, quarantine, disease, etc.).
5) Dietary problems. Facilities were shabby, cold and lacked noise reduction measures.
6) There was insufficient consideration for the needs of the elderly, handicapped, children, and women.
7) Transportation services are necessary for those in need of medical care.

The responses can be broadly categorized as follows:

The Shelter Environment: 1) There were too many people in each shelter and too much distance between shelters for administration to control. 2) Privacy was not maintained. There were hygiene problems (water, toilet, ventilation, quarantine, disease, etc.). 4) Dietary problems. Facilities were shabby, cold and lacked noise reduction measures. 6) There was insufficient consideration for the needs of the elderly, handicapped, children, and women.

The responses can be broadly categorized as follows:

Systematic coordination of shelters: 1) Systematic coordination of shelters is necessary.
2) Information and maps of various facilities around the shelters are necessary.
3) A means of identifying refugees and other people is required.
4) A structure and personnel for coordinating medical support is necessary.
5) Rules for how the administration and volunteers back up medical teams are necessary.

A. Representative reports from the disaster areas:

1) There were coordination problems between local medical personnel and medical support staff from outside the prefecture.
2) There were coordination problems between local medical personnel and medical support staff from outside the prefecture.
3) Too many people in each shelter and too much distance between shelters for administration to control.
4) Privacy was not maintained. There were hygiene problems (water, toilet, ventilation, quarantine, disease, etc.).
5) Dietary problems. Facilities were shabby, cold and lacked noise reduction measures.
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Small number of casualties quickly withdrew, leaving the site with a shortage of doctors.

From March 19 a DMAT team from Tohoku University stayed for one week and was extremely helpful.

From April 10 a DMAT team arrived.

From around April 10 infectious diseases began to spread, and the DMAT teams helped at the Koriyama Healthcare Center until it closed in August.

The manual that had been prepared was useless.

Iwaki City (President Mukota of the Iwaki City Medical Association):

that there were few injured among the survivors of the tsunami, and there wasn't much for airlift personnel to do.

On March 13 it was learned that Ishinomaki Municipal Hospital was flooded and isolated.

An emergency meeting was held at 1 am on March 14 to consider emergency countermeasures.

DMAT transported around 170 patients on the same day. Ishinomaki Red Cross Hospital received over 1,200 patients on March 13 alone.

With transportation systems destroyed, there were a great number of patients who could not get to a hospital right away.

In 2010 Ishinomaki City established a Network Conference for disaster medical workers consisting of the prefecture, cities, main hospitals, local medical associations, Japan Self-Defense Force, and the police. Dr. Iishi of the Ishinomaki Red Cross Hospital was appointed the Miyagi Prefecture Disaster Medical Coordinator by the prefecture one month before the March 11 disaster.

Dr. Iishi began an evaluation of the shelters 6 days after the disaster. An assessment of the medical treatment, hygiene environment, and utility restoration in over 300 shelters began immediately following the disaster.

A team of 10 to 20 Japanese Red Cross Society Logistical Support members was stationed in the disaster counter-measures office to register medical support teams, enter and manage assessment data and take the minutes at meetings.

Disaster Health Care Professionals were added to the disaster counter-measures office by the end of the week.

The situation changing constantly, the presence of professionals was reassuring.

The number of patients at the shelters and Ishinomaki Red Cross Hospital did not decrease after the clinic within the city reopened.

Dr. Iishi and the director of the Tohoku University Hospital, Dr. Satoshi, determined together that long-term medical support was necessary.

A new system was instituted, putting operations in designated areas under the top charge of medical support teams.

B. Disaster prevention activities of the national, prefectural and local medical associations

Dr. Iishi, the director of the Tohoku University Hospital, determined that long-term medical support was necessary.

A new system was instituted, putting operations in designated areas under the top charge of medical support teams.

B. Disaster prevention activities of the national, prefectural and local medical associations

During the disaster, the urgent necessity of involving the medical associations in disaster prevention and response planning became evident. Two points were identified regarding the role of medical association activities centered around DMAT during the March 11 disaster and their future roles.

It is important to strengthen the placement and role of medical treatment during disasters by involving medical associations in the planning of disaster prevention and
response at the city, prefecture, and national levels.

To restore local medical care, it is important for medical associations, which provide the most intimate medical care to local residents, to participate in reconstruction planning. In 2011, the Japan Medical Association and six other organizations formed the Survivors Health Support Liaison Council. Upon a request from the government’s Special Headquarters for Measures to Assist the Lives of Disasters-Afflicted Citizens, their recommendations were:

1) The dispatch of mid-term medical teams to respond to the medical needs of affected areas.

2) To determine the healthcare needs of the shelters and disaster areas while implementing the necessary initiatives to prevent the spread of infectious diseases and insure the health of survivors.

Dr. Kusumasa Hara was appointed president of the Japan Medical Association, which presently consists of 34 organizations. The designation of the Japan Medical Association as a designated public entity, and its participation in the Central Disaster Prevention Council are necessary to include JMAT in the national basic disaster prevention plan. Dr. Hara was appointed a member of the Central Disaster Prevention Council’s Disaster Planning Promotion Investigative Commission. This commission reevaluated the basic disaster prevention law and disaster prevention legislation, and recapplied the response to the March 11 disaster.

In the Basic Disaster Prevention Law and Disaster Prevention Investigation Commission. This commission reevaluated the basic disaster prevention law and disaster prevention legislation, and recapplied the response to the March 11 disaster.

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Those for whom further professional care is deemed necessary as a result of the survey and further screenings will be introduced to medical university facilities, where detailed surveys about mental health and lifestyle will be administered. Other detailed surveys will also be administered, such as the survey for expectant and nursing mothers.

This kind of survey is unprecedented, and will provide a valuable opportunity to gain scientific evidence regarding exposure to low-level radiation over long periods of time. Presently, what is wanted most is a way to reduce anxiety about radioactive contamination. For doctors, it is a necessity to share accurate knowledge and information about radiation with the citizens of the prefecture.

Other Special Characteristics
The ten most indispensable things for preventing the spread of infectious diseases after the disaster, Dr. Mitsuo of the Tohoku School of Medicine Infection Control and Diagnostics Laboratory had this to say about the situation in the shelters in a medical journal:

“Within the shelters, the disruption of the medical system and stoppage of utilities such as plumbing, electricity and gas, combined with cramped communal living over an extended period of time, drinking water shortages and insufficient hand washing due to water shortages, the deteriorating sanitation of toilets and garbage storage, and malnourishment from lack of food, were all major factors in the spread of infectious diseases.

Tohoku University had made support and cooperation between the medical associations and the administration its mission, forming the Tohoku Crisis Management Network for Infectious Diseases, and performing diagnosis and treatment of infectious diseases, as well as implementing infection control measures. However, in the early stages after the disaster, the combination of a breakdown of utilities and medical facilities along with low-level radiation exposure is extremely difficult.

There are a number of issues that need to be dealt with: ensuring communication and information sharing between hospitals, shelters, local governments, clinics and social welfare facilities when telephone and internet are disrupted; setting standards for infectious disease control when utilities and logistics are disrupted or stopped completely; setting up a system for examinations by dispatch medical personnel; training support for an infectious disease control headquarters; and information communications starting with the mass media. During large-scale disasters, it is extremely important that expert organizations such as medical associations, government administrations, universities, etc., are in regular communication before an event occurs.

After the 3/11 disaster, the most desired utility in the shelters from the viewpoint of healthcare providers was heating (40 percent). Losing body heat is very damaging to one’s health, and heating is a large factor in maintaining health and preventing the spread of infectious diseases.

Regarding problems reported by healthcare providers regarding examinations, “dealing with the elderly” at 76 percent, “dealing with infants” at 63 percent, and “dealing with women” at 52 percent, all had high numbers. A common cause for all three of the above was the “lack of medicine,” but for “dealing with the disabled” the largest reason was “there was no one to take care of them” at 46 percent, with “lack of medicine” at 36 percent. Women, the main complaint was “there is no space to examine women” at 67 percent, with “lack of medicine” at 30 percent. The unease about not having a space to examine women can also be seen in that 89 percent of doctors who responded that considering the sex of the patients in medical treatment was necessary, and the 94 percent of doctors who said dividers were necessary to maintain privacy for the patients.

Glossary
DMAT (Disaster Medical Assistance Team)
These national Disaster Medical Assistance Teams were developed in 2005 based on the lessons learned from the 1995 Kobe earthquake. The teams consist of doctors and registered nurses trained in emergency medical care and administrative staff who go to the locations of large accidents, outbreaks, or large scale disasters within 48 hours to provide medical treatment and support to hospitals.

EMIS (Emergency Medical Information System)
A system to share information on the actual situation of operations in medical facilities and disaster emergency medical care across prefectures in order for governments and medical institutions to rapidly deliver the appropriate medical care and relief aid.

JMAT (Japan Medical Association Team)
These disaster emergency medical teams were formed immediately after the Great East Japan Earthquake by the Japan Medical Association. The consist of one doctor, two registered nurses, and one administrative staff who are dispatched from three days to one week.
Author Profiles

AKIKO DOMOTO began her career in the 1960s as a television journalist and producer. Following her election to the Upper House of Japan’s Diet in 1989, during 12 years as a parliamentarian she played a pivotal role in the drafting of landmark social legislation and was an active participant in inter-parliamentary bodies, including GLOBE (Global Legislators for a Balanced Environment), for which she served as president in 1999. In 2001 she was elected Governor of Chiba Prefecture and served two terms in office thru 2009. Since 2009 she has been an active policy advocate on gender and social issues and biodiversity.

MIHO OHARA is an associate professor at the University of Tokyo’s Center for Integrated Information Research (CIDIR), Interfaculty Initiative in Information Studies. She graduated from the master course of the University of Tokyo’s Department of Civil Engineering in March 2001, and received a PhD degree in September, 2005. She worked as a Research Associate at the university’s International Center for Urban Safety Engineering (ICUS), Institute of Industrial Science from 2003 to 2008. Her research fields are disaster risk reduction planning, people’s capacity building against disaster and the effective use of disaster information.

AOKI REIKO is a research fellow at the National Women’s Education Center of Japan, an associate professor at Wako University and Ferris University and a permanent board member of the National Council of Women’s Centers. She was an information specialist at Tokyo Women’s Plaza until 2000, and the director of the Koshigaya Gender Equality Support Center from 2001 to 2006. She was also operations coordinator at the Saitama Prefectural Center for Promotion of Gender Equality from 2006 to 2009. Her specialty is gender issues.

HIROKO HARA has been the vice-representative of the Women and Health Network Japan (WHN) since 1994. She is also a professor at Josai International University’s Faculty of International Humanitarian Studies and professor emeritus of Ochanomizu University. She received her PhD in Anthropology at Bryn Mawr College in 1964. Hara was president of the Japanese Society of Ethnology from 1990 to 1992, and was awarded the Prime Minister’s Commendation for Efforts Toward the Formation of a Gender-equal Society in 2009. Her specialties are cultural anthropology and gender studies.

DR. KEIKO AMANO is a pioneer in gender-specific medicine in Japan and president of a Japan-based network of gender-sensitive medical experts. She has contributed greatly to the expansion of women’s clinics in Japan. Amano graduated from the University of Tokyo’s School of Medicine in 1967, where she began lecturing in 1988. In 1993, she became a professor at Tokyo University of Marine Science and Technology, and in 2002, she was appointed vice director of Chiba Prefectural Toin Medical and director of Chiba Prefectural Institute of Public Health. From 2009, she has been an advisor at Seifuso Hospital. Her specialty is cardiac medicine.