4. Programme implementation: key issues

4.1 Initial needs assessment

89. While there were other nuclear accidents before (e.g., Chelyabinsk/Kyshtym/USSR, 1957, 1967; Three Mile Island/USA, 1979), the Chernobyl disaster was totally new for all involved in terms of its nature, scale, and the immediate, mid-term and long-term consequences. Managing assistance, recovery and rehabilitation in the aftermath of such an emergency required highly sophisticated scientific and technical knowledge. Since the IFRC's secretariat at that time lacked sufficient information on previous nuclear accidents, and had no direct experience in dealing with such emergencies, it was decided to bring together *an interdisciplinary group of experts* to assess the situation.

90. The assessment team analysed in detail the radiological/ecological, socio-economic, informational, psychological and medical aspects of the situation. Its conclusions and recommendations laid the foundation for the key CHARP components: environmental, food and full body monitoring, distribution of information material and PSS. Subsequent needs assessments (November 1990, January–February 1991) and evaluations (1993, 1996, 1999) confirmed most of its findings.

91. A number of *factors* contributed to the success of the initial needs assessment. The team combined expertise in disaster management, radiological medicine, mental health and knowledge of the Red Cross, and provided a *good balance of technical and management expertise*, as well as both *Red Cross and non-Red Cross perspective*. The assessment covered not only the needs but also the *origins* of these needs: it explicitly stated that anxieties, stress and fear originated from the lack of information and misunderstanding the effects of radiation on human health. The measures proposed to address the needs were *realistic and adapted to the context and capacities* of the National Societies.

> "We defined extremely well what to do. We knew the needs. We had top-notch expertise, and we set the standards high."
>
> **IFRC top manager in the 1990s**

92. In addition to providing all the information needed to design a successful programme, the assessment was also *forward-looking*. Noting that "many large

scale disasters result in much stress related behaviour among victims … and that the Red Cross/Red Crescent Movement as a whole has paid little attention to these important aspects", the mission affirmed that "it is imperative that the League gives serious thought to the possibilities of incorporating meaningful responses in this sphere of activity to its disaster response plans".

93. The high quality and professional standards of the initial 1990 IFRC needs assessment *substantially contributed to the design of an appropriate and highly relevant International Red Cross and Red Crescent Movement response programme*. The international community, including UN agencies specializing in health and radiological issues (WHO, IAEA), promptly recognized the importance of its findings: the assessment's conclusions on health effects unrelated to radiation exposure, including improved screening and changed patterns of living and dietary habits, as well as the origins of psychological stress and anxiety, were quoted in, among others, the IAC report in 1991. *The assessment's conclusions and recommendations are still relevant and can be applied to the design of successful programmes in case of nuclear and radiological emergencies*.

The high quality and professional standards of the initial 1990 IFRC needs assessment substantially contributed to the design of an appropriate and highly relevant International Red Cross Red Crescent response programme. The assessment's conclusions and recommendations are still relevant, and can be applied to the design of successful programmes in case of nuclear and radiological emergencies.

4.2 Formulating programme objectives

94. The evolution of programme goals and objectives reflects different phases of CHARP implementation, as well as new trends in humanitarian assistance. In 1990–2001 the IFRC, like many other humanitarian agencies, was less structured in formulating programme objectives. During this period CHARP documents did not make clear distinctions between goals, objectives and activities, often referring to *activities* (e.g., "providing medical screening", "providing accurate and immediate information", "monitoring gamma radioactivity", "distributing milk powder, vitamins and micronutrients") as *objectives*.

95. With the increased international demand for accountability, from 2003 CHARP documents started explicitly formulating the programme *goal* ("The health of the population affected by the Chernobyl nuclear disaster is improved") and *objective* ("Effective medical, social and psychological assistance is provided to targeted individuals in the six regions affected by the Chernobyl nuclear disaster"). They also started mentioning *expected results* (e.g., "deaths from thyroid cancer prevented", "stress and anxiety is reduced", "immunity is improved"). Indicators, however, were identified only for medical screening as the annual target number of patients.

96. *The way CHARP objectives were formulated had direct implications for programme implementation*. At the early "learning" stage (1990–2000), focusing on activities allowed for a certain flexibility and quick response to the emerging needs without the constraint of a formal framework. However, at later stages (2001–2011), presenting activities as objectives *focused managers' thinking on implementing*

activities without always checking whether they still fitted into the "bigger picture", i.e., what that particular activity contributed to. Even when the goal and objective were explicitly formulated in 2003, the goal ("health is improved") was *generic* enough so that *any* health-related activity would contribute to it. The objective ("effective medical, social and psychological assistance is provided") was more a description of a "generalized" activity, thus reinforcing the "activity-centred" approach. *That eventually contributed to missing the change in priority needs after 2001–2003,* when governments and international organizations moved from *emergency* assistance to recovery and *rehabilitation*.

97. Since programme *activities* would almost always be implemented, presenting activities as objectives also created *a false sense of always "achieving the objectives"*. While large quantities of information brochures were distributed (i.e., the "false" objective of "distributing information materials" was achieved), programme managers were not encouraged to verify whether the information had any impact on changing behaviours, reducing anxieties or improving people's well-being (i.e., whether the "true" objective was achieved).

98. Finally the "activity-centred" approach led to focusing more on the *process* rather than the *result*. In the 1998 appeal "*continuation* of the PSS" itself was listed as the main (!) objective; the 1997 appeal included "*campaigning* for long-term sustainability" as one of the objectives. The objectives also reflected the PSS component becoming more "*inward-focused*": in 1999 five out of six PSS objectives in the annual IFRC appeal referred to Red Cross staff, rather than the affected population, as the main beneficiaries.

The way CHARP objectives were formulated had direct implications for programme implementation. Presenting "activities" as "objectives" focused managers' thinking on implementing activities without always checking whether they still fitted into the "bigger picture", i.e. what that particular activity contributed to. That eventually contributed to missing the change in priority needs after 2001–2003, when governments and international organizations moved from emergency assistance to recovery and rehabilitation.

4.3 CHARP "delivery" strategy

99. Choosing the strategy for delivering CHARP services was as much a learning process as any other aspects of the programme. The 1990 assessment identified the key *need* to reduce radiation-related fear, stress and anxiety among the affected populations. It outlined *four "categories" of assistance* to address the need: providing accurate information on radiation and protection from contamination, using counselling skills to help alleviate psychological problems, providing Geiger counters to Red Cross workers, and encouraging closer cooperation between scientists. The report effectively summarized this as follows: "A Red Cross worker armed with counselling skills, a Geiger counter and appropriate publicity material could do much to help the population affected by the Chernobyl disaster come to terms with their new situation."

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1990 IFRC Assessment Report

100. In 1991–1992, the concept of installing the measuring and medical equipment on a "*mobile platform*" to reach remote rural areas was adopted; that led to the start of the MDL service, which eventually became the backbone of the CHARP delivery mechanism. *Installing measuring and diagnostic equipment on MDL vehicles allowed remote rural areas to be reached that would otherwise have limited access (if any) to medical assistance and reliable information*. Choosing the MDL "model" for service delivery in CHARP therefore clearly filled in the gap, in particular at times of economic difficulties during 1991–2000.

101. At the same time, providing medical services via MDLs *had its limitations, mainly in terms of costs and sustainability*. The combined initial investment (each of the first MDL vehicles cost around 500,000 Swiss francs), costs of replacement and running costs (estimated at around 25,000 Swiss francs per year per vehicle) made the prospects of handing MDLs over to the ministries of health or Red Cross societies in Ukraine, Belarus and Russia problematic.

102. Though ministries of health in all three affected countries valued the work of the Red Cross MDLs and recognized it as one of the "models" for providing health services in remote areas, they continued to address health needs in rural areas by investing in the development of the system of *stationary* rural health centres (a number of such centres were renovated and/or rebuilt by the governments of Russia, Belarus and Ukraine during the massive Chernobyl resettlement programme in late the 1990s), showing little interest in supplementing them by creating and maintaining mobile health services.

Recommendation 6

R6.1 Wherever there is a need to provide timely and accurate information on the levels of radioactive contamination of the environment, food and people, as well as medical screening to the population in remote areas with otherwise limited access to health services, *choosing mobile clinics or MDLs as a "delivery model" might be considered as part of a short-term medical emergency response strategy*.

R6.2 It is imperative that any National Society examining this option following a nuclear or radiological accident *should assess its potential benefits against the costs and, most importantly, potential sustainability* of mobile medical services, taking into account the general strategy of the public health authorities for providing health services in remote areas.

During the CHARP implementation there was an attempt to replicate the CHARP MDL "model". In June 1993, at the initiative of the Russian Red Cross, one MDL was transported from Kursk to the Chelyabinsk region (Russia) to assess radiological and health consequences of the nuclear accidents at the Mayak Nuclear Reprocessing Facility (1957, 1967). The MDL conducted radiological monitoring and medical screening for one month, which helped identify various general health pathologies and reduce radiation-related stress and anxiety among the residents of the affected area. Since no major environmental anomalies were detected, the MDL was redeployed back to CHARP. This proved to be an expensive and logistically complicated exercise, and CHARP MDLs were not deployed outside the Chernobyl-affected areas again. However, Red Cross experience in running mobile medical services during CHARP has been recently recognized: in January 2015 the Ukrainian Red Cross, in cooperation with WHO and ECHO, started a Mobile Medical Clinics project, inspired by the CHARP MDL "model", to provide short-term medical assistance to internally displaced people (IDPs) from Eastern Ukraine.

4.4 "Centralized" versus "decentralized" management

103. Following the first CHARP appeal (June 1990), the first IFRC delegate was deployed in Kiev to assist the Alliance in environmental monitoring, further clarifying needs and programme planning. After the CHARP cooperation agreement was signed between the Alliance and the League secretariat (April 1991), the IFRC appointed a technical delegate to assist the National Societies in technical aspects of environmental and food monitoring, and in making the first MDL vehicles operational. Thus, *initially the IFRC was providing technical assistance to the Alliance in starting CHARP, rather than directly managing it.*

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104. In the early 1990s the IFRC secretariat directly managed most of its emergency response programmes, working through or in cooperation with the National Red Cross and Red Crescent Societies in the host countries. It followed a "vertical" operational management structure, whereby the overall programme management, including key decision-making, operational support, contacts with donors, fundraising, monitoring and reporting, was directly managed by the regional department in Geneva (Europe department for CHARP). The IFRC delegation in the field (Kiev and Minsk for CHARP) would implement programme decisions taken by the regional department and ensure operational management of the assistance programme in the field.

105. Following the collapse of the Soviet Union in 1991, the dissolution of the Alliance, the ensuing economic crisis and the creation of three independent National Societies with a substantially reduced programme implementation capacity, *it became important to ensure that the programme continued and to maintain its coherence as a single programme (rather than three separate ones).* In May 1992 the *International Chernobyl Coordination Committee* (ICCC), comprising the chairpersons of the Russian, Ukrainian and Belarus National Red Cross Societies, was formed to ensure that the three National Societies continued working "as a single entity". The ICCC, however, was more of a "coordination" rather than a "management" body, so in line with its practice of directly implementing emergency response programmes, *from 1992 the IFRC – through its delegation in the field – started directly managing CHARP implementation.*

106. For technical issues (e.g., medical, logistics, procurement, communications, training) regional departments would draw on the expertise of the relevant technical departments, all based in Geneva. In CHARP the Europe department worked very closely with the health department: both would bring in outside technical expertise if and when necessary. Since little was known at the time about the impact, consequences and appropriate actions in case of a nuclear disaster, *during its first decade CHARP relied heavily on external medical and radiological expertise. This approach largely determined the programme's success in correctly identifying needs and addressing them adequately.*

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107. Around 2001–2002 a major change in the IFRC strategic direction from *directly* implementing and managing programmes to *supporting* National Societies in programme implementation led to *a number of changes in the operational management structure, which had a direct impact on CHARP.* In 2001–2004 the role of regional departments in managing programmes, coordinating input from technical departments and providing management support to the IFRC delegations was gradually reduced; most programme decision-making was delegated to the field level. However, *the reduced support from the secretariat resulted in a certain loss of the overall strategic perspective and reduced attention to changing needs and priorities.*

108. Following decentralization of the secretariat, from 2007–2008 part of the operational support functions was transferred to the regional zone offices (Europe Zone Office for CHARP). However, despite the efforts of individuals, the new structure apparently had difficulty in providing the same level of overview, technical and operational guidance, and support as before. As one of those interviewed put it, "from 2005 we were completely disconnected from Geneva and its resources".

109. From the CHARP experience, it appears that *a* more *centralized management structure* with the active involvement of the IFRC secretariat in Geneva and its regional and technical departments in programme management and decision-making, applied during the first decade of the programme implementation, helped to better identify needs and respond to them, which allowed the response to be promptly adjusted as new needs arose. A more *decentralized* approach, applied from 2005, allowed for initiative and freedom of choice. However, it resulted in *reduced technical, operational and managerial support to CHARP* from the IFRC secretariat. This led to loss of strategic focus, missing newly emerging needs and overlooking threats to programme sustainability at a time when they could still have been addressed.

A more centralized management structure with the active involvement of the IFRC secretariat in Geneva and its regional and technical departments in programme management and decision-making, applied during the first decade of the CHARP implementation, helped to better identify needs and respond to them, which allowed the response to be adjusted promptly as new needs arose.

4.5 Interaction with the UN and scientific community

110. "Encouraging closer cooperation between scientists and other interested parties within and outside the Soviet Union" was one of the four categories of assistance proposed in the 1990 assessment report. CHARP interacted with the scientific community at local and international levels. Interactions with hospitals providing MDL staff and medical centres involved in treating radiation-related pathologies *at the local level* were mainly technical and operational: National Societies and medical institutions worked as partners, each supplying its inputs to the programme. CHARP contributed to scientific cooperation by participating in various medical and scientific conferences, supporting them financially and logistically, and by providing access to the data collected during radiation monitoring and medical screening.

111. At the *international* level during 1990–1999 CHARP established direct *personal* contacts with renowned international medical and radiological experts, seeking their technical advice on identifying and addressing the needs of the affected population. From 2001, contacts with individuals gave way to a more *organizational* interaction. During this period the IFRC and the National Societies maintained regular contacts with UN agencies (WHO, IAEA, UNDP, UNICEF) by participating in inter-agency meetings, conferences, workshops and seminars. *Most of these contacts, however, focused more on sharing information and avoiding duplication in the field, rather than aiming at creating synergies between CHARP and the programmes of the UN agencies.*

112. Interestingly, many IFRC and National Societies' managers interviewed seemed to underestimate the importance of the UN's analytical and scientific work, while overemphasizing the value of the "practical, direct and operational" action of the Red Cross in the field. As one of them put it, "the Red Cross in CHARP was not *talking*, it was *doing*". *CHARP, however, clearly demonstrated that insufficient attention to the scientific community and UN analysis, in particular in the case of technological disasters, could adversely affect programme implementation.*

113. Nearly all UN analytical reports on the consequences of the Chernobyl accident identified very accurately the changes in needs over time: the need to focus on *rehabilitation* of the affected areas, for instance, had been mentioned in various UN reports since 2002. All of them also clearly formulated priority areas for possible new interventions, many of which were within the capacity for the IFRC and the National Societies to implement. Some – e.g., dissemination of information on the consequences of the Chernobyl accident and practical advice on healthy and productive lifestyles – were similar to those CHARP was involved in in 1990–1997. Both the IFRC and the National Societies were aware of this information through their regular contacts with UN agencies. However, little was done to reassess and/or readjust CHARP activities on the basis of the findings and recommendations of UN reports.

114. In nuclear and technological disasters the IFRC and National Societies would generally focus on providing assistance, rather than producing technical, scientific and medical analysis of the consequences of such disasters. Therefore the IFRC should rely more on UN analytical and technical documents to inform its programming. *Combining Red Cross action-oriented strength with the UN and scientific community resources and capacities for reflection and analysis can create powerful synergies, allowing both to excel in assisting populations affected by the consequences of nuclear and radiological disasters.*

Combining Red Cross action-oriented strength with the UN and scientific community resources and capacities for reflection and analysis can create powerful synergies, allowing both to excel in assisting populations affected by the consequences of nuclear and radiological disasters.

115. CHARP experience also showed that the *gap between the objective scientific data and the subjective, often exaggerated perception of danger and needs by the population, local governments, politicians, NGOs and the media is likely to be common for all nuclear and radiological emergencies.* This was first identified in the 1990 assessment report: "It appears that people attribute all their complaints to radiation, clinging to this explanation which is in line with their worst expectations." The very first CHARP component – measuring the levels of radioactive contamination in the environment, food and humans – was effectively providing objective information to address these perceptions.

116. In fact, the *Red Cross and Red Crescent Movement is ideally positioned to "bridge the gap" between the scientific, objective and rational data on the existing levels of radioactive contamination and its health consequences and people's subjective emotional perceptions of such risks*. Working together with the scientific community and international organizations, the IFRC can *access* a wealth of scientific analysis and information. Working through National Societies' volunteers it can *translate* this information into emotionally acceptable explanations supported by concrete assistance, thus addressing people's concerns.

The gap between the objective scientific data on the existing levels of radioactive contamination and its health consequences and the subjective, often exaggerated, perception of danger and needs by the population, local governments, politicians, NGOs and the media is likely to be common for all nuclear and radiological emergencies. The Red Cross and Red Crescent Movement is ideally positioned to "bridge this gap".

Recommendation 7

R7.1 Taking into account the highly technical nature of assistance in the case of nuclear and radiological emergencies and the considerable resources and capacity of the UN specialized agencies to mobilize international technical expertise and produce high-quality analysis of the consequences of and needs resulting from such accidents, *the IFRC and National Societies must take into account the findings, conclusions and recommendations of UN analytical documents in designing their response programmes* and adjusting implementation strategies to address newly emerging needs in a timely way.

R7.2 In responding to nuclear and radiological emergencies the International *Red Cross and Red Crescent Movement should focus on "bridging the gap" between scientific, objective data and people's subjective, emotional perceptions of radiation-related risks and dangers*. As both a grass-roots and an international organization, the Red Cross Red Crescent is ideally positioned to provide the affected population with information that is based on scientific and objective data, and is presented in a way that addresses irrational fears and anxieties among the affected population.

R7.3 Since nuclear and radiological disasters and their consequences, being essentially man-made, are highly politically charged, to succeed in this role *the International Red Cross and Red Crescent Movement should avoid taking sides and must strictly adhere to its Fundamental Principles, in particular those of neutrality and impartiality.*

4.6 Interaction with public health authorities

117. During CHARP implementation the IFRC delegation and the Ukrainian, Belarus and Russian Red Cross Societies worked very closely with various medical institutions and public health authorities, mostly at the oblast level. The implementation of each programme component was closely coordinated with local departments of health: memoranda of understanding on CHARP were signed with the ministries of health in Ukraine and Belarus; in Russia, relations were formalized at the Bryansk oblast level.

118. Both parties worked in *true partnership*, each operating in its area of competence. In most CHARP components, with the exception of PSS, the health authorities focused on providing *software* (personnel, training, research) while the IFRC and National Societies took care of the programme *hardware* (vehicles, medical equipment, medicines, vitamins, consumables, fuel, maintenance, logistics, finance, administration).

In most CHARP components the health authorities focused on providing software (personnel, training, research) while the IFRC and National Societies took care of the programme hardware (vehicles, medical equipment, medicines, vitamins, consumables, fuel, maintenance, logistics, finance, administration).

119. The ministries of health in Ukraine, Belarus and the Russian Federation in the early 1990s received extremely limited funding from the state budget, had insufficient and ageing medical equipment, and badly lacked supplies of medicines and consumables (another Federation programme in the former Soviet Union, "Solidarity", focused on supplying basic medicines, such as *aspirin*, to children's hospitals in Russia). Since the ministries of health had no access to other international funding at the time, medical equipment and supplies for MDLs received through CHARP addressed important needs of the public health system. In this respect the Red Cross societies were truly operating as *auxiliaries* to their governments.

120. The Soviet Red Cross, one of the few non-governmental organizations in the Soviet Union, *had always worked very closely with the public health system*, delivering first-aid training, providing medical and social care for the elderly, and promoting blood donation. Nearly all chairpersons in oblasts, as well as the Soviet Red Cross leadership, either had a medical background or were former officials of the ministries of public health. It is therefore natural that they brought with them to the Red Cross their public health expertise and knowledge of the system, which both facilitated their contacts with the public health authorities and shaped their preferences and choices.

121. Supporting the ministries of health with equipment and supplies, filling the gaps not covered by the public health system and mobilizing resources for it through the IFRC was therefore "organic" for the three National Societies. In a way, even *before CHARP started, all three National Societies were well integrated into their respective public health systems, with all the advantages and inconveniences that this involved.*

Even before CHARP started, all three National Societies were well integrated into their respective public health systems, with all the advantages and inconveniences that this involved.

122. The external environment and the National Societies' auxiliary relationship with the authorities had a direct impact on the issue of transferring the responsibility for CHARP to the health authorities which was often raised during the last years of the programme's implementation. The latter welcomed the services provided by the Red Cross, but took them "for granted". *The Red Cross societies in the three affected countries were expected both to provide these services and to fund them from their own or International Red Cross resources.* Consequently the public health authorities showed *little interest* in funding Red Cross activities from the state budget, and the National Societies were *reluctant* to raise this issue with their ministries of health or to actively pursue it.

Public health authorities expected the Red Cross societies in the three affected countries both to provide various health-related services in the affected areas and to fund them from their own or International Red Cross resources.

4.7 Exit strategy

123. *CHARP never had a viable exit strategy. In fact, it was originally conceived as an emergency response programme expected to last for only a few years.* In 1990 the Soviet Union, despite its economic and social problems, had a functioning public health system, fully capable of absorbing additional technical inputs (equipment, vehicles, medicines, expertise) provided by CHARP. When in December 1991 the Soviet Union unexpectedly ceased to exist, and the public health capacity in the three affected countries was substantially reduced, the programme had to continue beyond its initially anticipated time span. As one of the interviewees said, "a few years later we were all trapped".

CHARP was originally conceived as an emergency response programme expected to last for only a few years.

124. From 2002, when the public health systems started functioning, the issue of a possible exit strategy was raised again. The 2002 CHARP evaluation called for "continuing discussions with authorities on increasing their financial contribution to CHARP". However, the first agreements with the regional health authorities, signed in 2004, simply formalized an already existing division of roles and responsibilities, without explicitly mentioning the possibility of handing over the programme to the ministries of health. It was only in 2008 that the local health authorities in *some* oblasts agreed to cover "reagents for MDLs and *some* running costs". After that and until the funding for CHARP stopped in 2012, the situation basically remained unchanged.

The reasons for the absence of an exit strategy in CHARP were both rational and emotional.

125. *The reasons for the absence of an exit strategy in CHARP were both rational and emotional.* Developing an exit strategy effectively meant *the end of CHARP* for all those involved in it. *Rationally* that meant the loss of funding, jobs and income for the CHARP and Red Cross staff involved. *Emotionally* it meant the end of something "excellent" that people "owned", identified themselves with and "invested into" over the years. As one of the CHARP managers put it, "National Society leadership and all involved in the programme were very proud of it. It was not about simply getting the funding and paying for their jobs; money was not that important. It was a profound event in their lives." Losing that would be painful indeed.

> "National Society leadership and all involved in the programme were very proud of it. It was not about simply getting the funding and paying for their jobs; money was not that important. It was a profound event in their lives."
>
> **CHARP manager in the 2000s**

126. It is not surprising therefore that many among the CHARP managers and National Society leadership developed a sort of "*denial*" of the fact that CHARP would end one day, in particular since for 22 years there was plenty of evidence to the contrary: the programme was indeed "saved" a few times by an unexpected donation (the Dutch lottery), good use of public relations opportunities (the 20th anniversary) or the efforts of committed individuals, among others. Developing a viable exit strategy under the circumstances was hardly possible.

Recommendation 8

R8.1 To allow all the people involved in CHARP to release the feelings of frustration, anger and "unfinished business" left by the abrupt way CHARP ended, to move on in their Red Cross work and to be able to address new challenges, it is *extremely important to give the programme a decent closure.*

R8.2 This closure could best be done by for example organizing an *informal "get-together"* of all IFRC, National Societies' and MOH staff and volunteers involved in the programme since 1990, as well as some programme beneficiaries. Ideally it could be organized in connection with the 30th anniversary of the Chernobyl tragedy in April 2016. *The meeting should be informal, centred on people sharing their personal experiences, memories and achievements from CHARP.* The meeting should in no way be combined with scientific or technical conferences, workshops or seminars organized by governments, the UN or other agencies. The proposed event in this format would be *unique* among any others planned for the 30th anniversary, and would *improve the promotion of the IFRC and National Societies' expertise in nuclear and radiological disasters and their unique people-centred role in assisting affected populations.*

R8.3 To achieve a higher impact it is strongly recommended that a *20–30 minute "BBC-style" documentary, based on interviews with people who were involved in the programme*, could be produced. The documentary could then be used as a "centrepiece" for the proposed meeting and the discussions.

R8.4 Should *any new programmes* aimed at assisting the populations still living in the affected areas be considered by the National Societies in Ukraine, Belarus and Russia, they *should be in line with the overall international focus on rehabilitation.* Any activities within such programmes should focus on restoring people's normal life, rebuilding their sense of self-confidence, self-reliance and "spirit of activism", and regaining control over their lives, *helping people live, not just survive.*


КРАСНОГО КРЕСТА
ВОРОНОВ
Александр Иванович
лаборант