

5. Review conclusions

5.1 Relevance

127. *Programme objectives, though naturally evolving over 22 years of programme implementation, generally remained valid throughout.* The implicit objective of addressing the radiation-related fears and anxieties (1990–2000) was *highly relevant* during the first decade of CHARP implementation. The explicit objective of improving people's health by providing medical, social and psychological assistance (2001–2012), though still *relevant* during the second decade, was mostly addressing *secondary needs* (compared to the social and economic ones) due to the improved capacity of public health systems in the affected countries.

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128. *Different programme components had varying degrees of relevance at different stages.* Monitoring of radiation levels was highly relevant for addressing people's anxieties at the early stages. Thyroid gland screening was highly relevant when it was introduced, but became less so, when social and economic concerns became a major source of people's anxieties. Distribution of medicines was highly relevant when patients with thyroid gland pathologies could not be treated due to lack of medicines. Vitamin and milk distribution was relevant throughout, as a way of addressing parents' concerns about their children's health. The PSS component was relevant for enhancing Red Cross workers' knowledge and counselling skills, but less so for providing direct PSS to individuals.

5.2 Effectiveness

129. *All programme objectives, as formulated at different stages of programme implementation, were achieved.* The programme directly contributed to "alleviating anxiety about poorly understood consequences of radiation exposure" (formulated in 1990). CHARP "supported health-related recovery" and "assisted the authorities and affected populations in alleviating the medium and long-term consequences of the disaster" (1993). Thyroid gland screening and treatment of thyroid gland pathologies has largely contributed to the "improving health of the population affected by the Chernobyl nuclear disaster" (2001–2012). All CHARP activities, in one way or another, "facilitated daily life in the disaster-affected zones" (1993) and contributed to "restoring the community's capacity to recover" (1997). By supporting scientific forums, CHARP contributed to "closer cooperation between scientists and other interested parties ... within

and outside the (former) Soviet Union” (1990). The IFRC participation in UN and inter-agency bodies and coordination mechanisms on Chernobyl “facilitated exchange of experience and information ... on coping with the consequences of nuclear and other technological disasters” (1990).

130. One of the programme objectives – “strengthening the operational capacity of the three National Societies” (1993) – was achieved *partially*, mainly as improved project management and PSS skills of National Societies’ staff and visiting nurses. However, many of these retired from the National Societies after the programme ended, leaving National Societies without their personal expertise and experience.

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131. *Programme activities and outputs were generally consistent with the programme goal and objectives throughout the programme. Nearly all of the programme activities planned during the CHARP life cycle were successfully implemented.* Because of the novelty of the PSS concept and approach, the intended individual psychosocial counselling to the affected populations was implemented on a smaller than anticipated scale (see 3.3.4 *Limitations of PSS implementation* for details).

5.3 Impact

5.3.1 Impact on programme beneficiaries

132. *CHARP activities had a substantial impact on the health and welfare of people living in the Chernobyl-affected areas.* Hundreds of thousands of beneficiaries received accurate *information* of the levels of radioactive contamination and practical advice on avoiding radiation exposure and decontaminating food. *Thyroid gland screening* resulted in a high level of detection of thyroid gland pathologies leading to early treatment, thus substantially improving the patients’ survival rate and reducing mortality from thyroid gland cancer. Since the thyroid gland directly affects the functioning of most other body systems, the patients treated for thyroid gland pathologies substantially improved their overall well-being and quality of life. The Chernobyl Forum explicitly mentioned detecting and treating hundreds of cases of thyroid cancer as one of the successes of the international response to the aftermath of the Chernobyl accident.

133. *CHARP took its services to the population, providing access to sophisticated health assistance to people living in remote areas.* Health examinations and laboratory services delivered by CHARP took into consideration the *accumulated* stress added by the deteriorating socio-economic situation, and its effects on diet, health and welfare. CHARP provided *instant medical feedback and referrals*, and was available to both adults and children. The distribution of multivitamins and milk contributed to improving the health and immunity of hundreds of thousands of children, and to relieving the stress and anxiety of their parents. Thousands of people benefited from direct and indirect psychological support provided by Red Cross staff, nurses and volunteers.

“Taking into account all the constraints and limitations in the way the programme was conceived and implemented, a lot was achieved and accomplished.”

CHARP manager in the 1990s

5.3.2 Impact on public health

134. CHARP’s most important impact on the public health systems in the three affected countries was supporting them during the years following the collapse of the Soviet Union and the ensuing economic and social crises. CHARP provided much-needed medical diagnostic equipment, disposable materials and medicines. By addressing important health needs (i.e., thyroid gland screening) it filled some of the gaps left by the public health system due to lack of funds and focusing on other, more urgent health priorities.

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135. CHARP indirectly contributed to building the capacity of the public health systems in the affected countries. Medical staff involved in CHARP accumulated substantial practical expertise in providing mobile health services in remote areas, detecting thyroid gland pathologies, using modern diagnostic equipment and screening techniques, performing fine needle biopsy in the field and providing basic psychological support to patients.

5.3.3 Impact on National Societies

136. CHARP played an important role in supporting the Red Cross societies in the three affected countries during the political and economic turmoil of the 1990s, when they lost their traditional affiliation with the state, as well as their main source of income (membership fees). CHARP funding not only gave the three National Societies an important programme to manage, it let them maintain essential structures at the headquarters level, revived some branches, supplied basic office equipment and allowed the visiting nurses programme to be preserved and later expanded.

137. Through CHARP the National Societies in the three affected countries acquired experience in managing a logistically sophisticated assistance programme, renewed and strengthened their cooperation with the ministries of health and local authorities, maintained contacts and cooperation among themselves, developed bilateral cooperation with a number of other National Societies (including the German, Danish, Irish, Finnish, Norwegian, Swiss and Japanese National Red Cross Societies). CHARP helped to build the National Societies’ experience of working with international organizations and obtaining international funds: all of them currently have programmes funded by various grants (on TB, HIV/AIDS, drug addiction, combating human trafficking), and most assist IDPs from Eastern Ukraine in cooperation with the ICRC and other agencies.

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138. CHARP introduced the National Societies to the concept of PSS; as one National Society leader said, “Our psychosocial support services grew out of CHARP.” CHARP also provided for increased *visibility*, a more positive *image*, greater *recognition* and extra *credibility* for the National Red Cross and Red Crescent Societies at the national and local levels. Internationally it highlighted the important role the International Red Cross and Red Crescent Movement could play in preparing for and responding to nuclear and technological disasters and mitigating their consequences.

139. *At the same time, some opportunities to build upon CHARP successes were missed.* The leading role of the IFRC in managing the programme (see 4.4 “Centralized” versus “decentralized” management) did not encourage National Societies to innovate and develop new activities. When asked about possible *new* Red Cross activities for the Chernobyl-affected areas, nearly all the National Society representatives insisted on simply resuming “mobile medical screening”. *Continuous IFRC funding of the programme led to excessive reliance on the International Red Cross and Red Crescent Movement for covering programme costs.* That in turn reinforced the perception of the National Societies as “providers” of international funding for public health services, thus undermining their attempts to obtain funding or financial support from their own governments (see 4.6 *Interaction with public health authorities* and 5.4 *Sustainability* for details).

5.3.4 Nuclear preparedness and response capacity

140. *CHARP experiences had a relatively limited impact on building National Societies’ nuclear preparedness and response capacity.* National Society leaders are aware of the need to have a defined role in nuclear and technological emergencies. There is an understanding that Red Cross staff and volunteers should not “get into the epicentre” and would, as they did after Chernobyl, assist the authorities in evacuation and resettlement; some leaders mentioned the need to train and equip disaster response teams for dealing with the consequences of a nuclear emergency. However, apart from being included in generic state disaster response plans, there are no arrangements with the governments of Ukraine, Belarus or Russia that define the National Societies’ role in nuclear and radiological emergencies.

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141. At the branch level most staff interviewed were aware of the need to prepare for nuclear emergencies, but few did something about it. The branches visited had no stock of information materials, no dosimetry equipment and no people trained in using it. Apart from personal contacts between individuals, there is currently little cooperation between Red Cross branches and the radiation medicine centres. Though some branches in potentially affected areas are active in disaster preparedness, they prepare for more frequent emergencies (floods, accidents, snow-storms etc.) The nuclear response preparedness for the general public is dealt with by the Ministry of Emergencies in the affected countries, mostly through people’s workplaces, much like in the former Soviet Union.

142. Since CHARP experience has not been properly documented at any of the National Societies, all relevant knowledge and expertise resides with *individuals*. Though some still work at the Red Cross or in the health system, most have retired; there is currently no system for passing on their knowledge and expertise. As one of the former CHARP managers said, “we missed an opportunity to use CHARP funding when it was available to rejuvenate National Societies by employing young and enthusiastic programme managers”.

5.3.5 Impact on Red Cross staff and volunteers

143. A somewhat unique impact of CHARP is a strong sense of ownership and emotional attachment to it developed by most National Societies' and IFRC staff and volunteers involved in the programme. Nearly all those interviewed referred to the programme as something "special", a moment of "creativity, initiative and freedom". Many recalled a sense of clarity, leadership and vision, a "spirit of working together for a common purpose" and "being the best", responding to needs and delivering results. Many affirmed that "the operation made a lot of sense", "the approach was right", "it was good all the way through" and "we were very proud of what we did", and claimed they "missed" CHARP or were "nostalgic" about it.

"CHARP was one of many assistance programmes I participated in, and they were all special, but I keep thinking about CHARP as a very special one!"

IFRC Secretariat staff in the 1990s

144. One of the possible explanations of this phenomenon could be related to external factors. The early 1990s was an emotionally charged period in Europe. With drastic political changes in Eastern Europe and the former Soviet Union, the world as people knew it was rapidly transforming. There was a general sense of hope and excitement. Many in Western Europe wanted to express solidarity with the countries of the former Soviet Union; in doing so, individuals and organizations experienced the sense of doing something important, contributing to changing history. It is not surprising therefore that CHARP for most involved was more than "just another" emergency response programme.

5.4 Sustainability

145. Though CHARP was effectively "sustained" for 22 years by external funding, it can hardly be termed a financially "sustainable" programme. The IFRC and donor National Societies covered the bulk of programme costs throughout the programme implementation. While the governments and National Red Cross Societies in the three affected countries participated in covering programme costs, their share was never significant: in 2003 together they contributed around 60,000 Swiss francs: 7 per cent of the total CHARP funding or 20 per cent of the core activities. As soon as donor funding was withdrawn in 2012, nearly all programme activities and their benefits stopped.

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146. The need to ensure CHARP sustainability was repeatedly raised at various levels. It had been mentioned in all programme evaluations since 1993. Ensuring financial sustainability was the focus of the 2003 CHARP strategy, which emphasized the need to shift the main programme responsibilities, including its funding, to the National Societies and ministries of health. Sustainability and programme funding were regularly discussed at ICCC meetings. The ICCC would generally call for the IFRC and donor National Societies to "intensify their efforts" in raising funds internationally, but would rarely suggest ways to increase local input: on two occasions (2008, 2010) it explicitly stated that the "National Societies could not risk handing over the programme to local governments yet".

147. It appears that one of the main reasons for failing to sustain CHARP financially was a certain lack of interest and commitment of the parties involved. Though in 2006–2007 the public health authorities had sufficient capacity to take over – in 2007 alone the Ukrainian MOH operated 3,114 mobile emergency teams and over 1,000 vehicles – the MOH showed little interest in developing mobile health services in rural areas (see 4.3 CHARP “delivery” strategy for details). Thyroid gland screening, though recognized as important and addressing vital needs, was no longer one of the public health priorities after 2006 (see also 2.5 The situation in 2015).

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148. While the National Societies did not have an objective capacity to sustain the programme themselves, for a number of reasons they seemed to be more interested in keeping the programme within the Red Cross (see also 4.7 Exit strategy) and were reluctant to actively pursue the handover issue with the ministries of public health. Regrettably, the IFRC did not succeed in realistically assessing the situation. So while the IFRC was advocating more financial involvement of the National Societies or the ministries of health, the National Societies favoured exactly the opposite – more and longer-term funding for the programme from the donor National Societies and the IFRC. As a result, most attempts to ensure financial sustainability were limited to looking for alternative sources of funding inside the International Red Cross and Red Crescent Movement (see also 4.6 Interaction with public health authorities).

5.5 The two decades of CHARP

149. Overall during its life cycle CHARP clearly went through two distinct periods: the decade of “growth and development” (1990–2000) and the decade of “business as usual” (2001–2012). Though the transition between the two lasted for a few years, the difference between them in the way the programme functioned was quite spectacular (see Table 5.1 below).

Table 5.1 The two decades of CHARP

“Growth and development” 1990–2000	“Business as usual” 2001–2012
Accurate needs assessment	Overlooking changing needs and priorities
Learning by doing, exploring alternatives	Doing “what we know”, ignoring alternatives
Flexibility, adjusting plans to new needs	A certain rigidity, focusing on the known
Actively using external expertise	Underestimating external expertise
Clear initial objectives	Objectives too general
Strategy viable for emergency response	Strategy unsustainable in the long run
Responding to priority needs	Responding to secondary needs
Focusing on results and achieving objectives	Focusing on the process and activities
Rapid operational decision-making	Avoiding decision-making in the field
Being realistic about National Society capacity	Underestimating National Society “auxiliary” role
Direct operational and technical involvement of the IFRC secretariat	Insufficient technical and operational support from the IFRC secretariat

5.5.1 Growth and development, 1990–2000

150. By the time CHARP started in 1990–1991, the *Chernobyl disaster had passed an acute emergency stage and entered a recovery phase*. Since in nuclear and radiological disasters the consequences are linked with radioactive contamination and generally last longer (for up to 10–15 years) than in most “non-technological” emergencies (except long-term refugee crises), the unmet health, psychological and social needs were still numerous. But *what was required from the international community was rather the technical expertise provided by a “neutral” international body that people in the affected areas would trust more than the local authorities*.

151. However, after the dissolution of the Soviet Union in December 1991, the situation changed dramatically. When the newly independent Ukraine, Belarus and Russian Federation suddenly faced a severe political, economic and social crisis, CHARP found itself in the situation of an acute emergency: *the sudden and unexpected collapse of a public health system unable to provide even the most basic health services to the affected populations, not to mention the health consequences of the Chernobyl accident*. CHARP effectively had to step in and support the public health system in providing assistance to populations living in Chernobyl-affected areas.

152. *This task indeed required an emergency response intervention and the IFRC was well positioned to provide it*. As mentioned in the *Review of Strategy 2010* (2009), in the early 1990s the IFRC “regarded itself mainly as a relief organization. Its Secretariat had a very prominent implementation role. Its structure, culture and systems were in line with the dominant relief-oriented way of working.” While it lacked internal technical expertise in dealing with nuclear and radiological emergencies, its knowledge and experience in managing health emergencies and emergency responses in general proved essential in dealing with the situation.

153. The period 1990–2000 was a time of challenges, intensive learning, rapid programme build-up, flexibility, and the production of creative solutions by mobilizing internal and external technical and scientific expertise. “CHARP was an improvisation. We had no idea what to do, we simply responded to the needs”; “We were ‘learning by doing’”; “CHARP was the moment of creativity for the IFRC. The Federation had the guts and courage to take it on”; “There was no specific expertise but the willingness to be realistic and committed: let’s try and do something feasible that can be funded! And this was done!!” This is how CHARP managers described their experiences in dealing with a new kind of emergency.

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IFRC CHARP manager in the 1990s

154. Overall during the first decade of CHARP implementation the IFRC and the National Societies were successful because they were *doing the right thing at the right time*. CHARP experience during the first decade also clearly demonstrated that *a professional emergency response organization such as the IFRC can successfully integrate new skills and apply its existing knowledge and expertise in responding to any kind of emergency, no matter how new, large, unexpected or technologically sophisticated it is*.

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5.5.2 “Business as usual”, 2001–2012

155. By around 2001–2002 the “emergency” CHARP was successfully responding to in 1990–2000 was effectively over. The situation in the affected areas started gradually getting back to normal. Owing to natural decay the levels of radioactivity got considerably lower, people got used to living with the consequences of low radioactive contamination, their worst expectations never manifested, pathologies initially attributed to the effects of radiation were also found in the non-contaminated zones. The state authorities generally regained control of the situation: health services and structures started functioning again.

156. The general improvement of the situation resulted in a reduced need for assistance and declining donor interest. *The funding problems experienced in 2001–2002 clearly indicated that CHARP as an emergency response programme had reached its logical conclusion: there was a real possibility of ending the programme at that point.* However, rather than critically reviewing the relevance of the ongoing activities and either stopping the programme or refocusing it on addressing new needs, CHARP continued functioning as an emergency response programme, still supporting the public health system, and gradually becoming more and more “out of sync” with the primarily social and economic development needs in the affected areas.

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157. The issue of programme relevance could be explained by, among other things, the fact that CHARP services (e.g., thyroid gland screening) were still objectively needed and were not sufficiently covered by the public health system, in particular in remote rural areas. They continued to be welcomed and appreciated by both the population and the health authorities, and could, in principle, be continued indefinitely, provided the funding was available. Also, during the first decade of CHARP implementation the three National Societies learned how to manage a large-scale, technically sophisticated emergency response programme and were naturally keen to continue applying what they learned over the years (“emergency response”) rather than plunging into the unknown (“social and economic rehabilitation and development”). Since neither the IFRC, nor the donors questioned continuing CHARP as it was, National Societies were not encouraged to reorient, refocus or redesign the programme.

158. Overall, the second decade of CHARP implementation clearly showed that *both the IFRC and the National Societies developed the expertise, knowledge and capacity to effectively respond to nuclear or radiological accidents at the emergency phase, or to the associated emergencies* (e.g., the collapse of the health system in the former Soviet Union). Both, however, lacked expertise and were much less comfortable in operating during a recovery and rehabilitation phase or assisting in the social and economic development of the Chernobyl-affected areas after 2003.

Recommendation 9

R9.1 Taking into account the traditional Red Cross Red Crescent expertise and competence in providing an emergency response, *in technological and nuclear disasters the IFRC and the National Societies should focus primarily on preparing for and providing assistance at the emergency phase.*

R9.2 In the *acute phase* immediately after the disaster the IFRC can support National Societies in evacuation, resettlement and providing basic relief assistance, avoiding the exposure of their staff and volunteers to the immediate effects of radiation. At the *post-event phase*, the IFRC and National Societies should primarily aim at alleviating radiation-related fear, anxiety and stress by providing accurate and timely information on the actual levels of radioactive contamination of people, food and the environment, possible health consequences of the exposure to radiation, minimum safety measures and a safe lifestyle in the contaminated areas.

R9.3 Though the immediate health effects for the exposed professionals at the nuclear power plant will become obvious shortly after the accident, *other health effects* of radioactive contamination after nuclear and radiological disasters may take five to eight years before they appear among the affected populations, and before the direct relationship between the fallouts and the pathology is confirmed. Therefore *any assistance programmes addressing the health effects of nuclear and radiological disasters should be planned from the beginning as long-term interventions (for up to 10 to 15 years).*

R9.4 *Long-term recovery and rehabilitation needs can be best addressed by traditional Red Cross community-based and social support activities (health education, assistance to the elderly etc.) adapted to address specific radiation-related concerns. They should be initiated before the end of the emergency response phase to ensure smooth transition.*

