Evaluation of the Response by the International Red Cross and Red Crescent Movement to the India Earthquake

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An Introductory Note

During the discussions with the Director of Evaluation and Monitoring and the Director of Cooperation and Development and the Head of the Asia & Pacific, it was suggested that the Evaluation Team may focus on major and critical organizational issues as a part of this evaluation rather just focusing on relief and rehabilitation programmes and outcomes on which information is available through various reports and internal documents.

It was felt that India is of critical importance to the Federation and has tremendous potential for mutual benefit and as such strengthening of the Indian Red Cross Society is of great importance and the lessons learned from the Gujart relief and rehabilitation effort would be great importance to the Federation.

As such we have made an effort to make this as a central focus of our report. The report also addresses some of the comments made during the Partnership Meeting in Delhi on Jan. 23-24, 2003 and the debriefing meetings in Geneva on Feb. 24 and 25, 2003.

The evaluation report begins with a set of key recommendations. We humbly submit that there is nothing revolutionary in these recommendations. However, we urge that these recommendations may be read and interpreted in their proper context elaborated to some extent the section III Observations and Comments and the discussions we had with the senior staff in the secretariat.
Key Recommendations

• The Gujarat Earthquake relief and rehabilitation operations have met all the objectives stated in the appeals in spite of several operational difficulties and delays.

• The Emergency Response Units (ERU) were an important feature in the relief phase. It is recommended that the Federation may assist IRCS in incorporating ERUs as a part of the disaster preparedness capacity building.

• It is recommended that the Federation should pursue a judicious and mission sensitive policy in deployment of expatriate delegates to India.

• In order to facilitate interaction between the Federation and the IRCS, there is need for a country specific delegation in India within SARD after the IOC phases out. It is recommended that the Federation may consider this seriously.

• The IRCS needs a sustained and long term capacity building and OD support beyond what is being proposed presently. We recommend that the Federation should provide continuing senior level assistance to IRCS.

• During the rehabilitation phase, the programmes such as reconstruction of health facilities, pre-schools and health worker training appear to be substituting for government action and lack adequate sustainability framework and NGO involvement or local Red Cross capacity building. There is very little knowledge and information sharing between the projects managers of the IOC and PNSs and between IOC, IRCS and the state government. We recommend that the Secretariat should have appropriate oversight in programme planning and implementation.

The IRCS appears to have a rather minor role in the project management and implementation, we recommend a review to examine how such projects should be implemented and managed in future to build capacity within the national society.

• The relationship between the Federation/PNS and the National Society appears mainly as a donor and donee. There is evidence that the Indian government and non-government organizations have been able to mobilize local material, financial and manpower resources in case of disasters and emergencies. The IRCS can actively undertake local resource mobilization steps by issuing local appeals. The Federation needs to broaden its involvement in India beyond just relief appeals. We recommend that the Federation should engage in such a dialogue with the IRCS and its Board and if possible with the Government and other key actors.
I  Background

A powerful earthquake of the magnitude 7.9 on the Richter scale struck India’s western state of Gujarat in January 2001. The earthquake left about 20,000 people dead, injured 166,000 and affected a population of 15 million. As an emergency response to the disaster the Federation launched an appeal for CHF 25.6 million in cash, kind and service support for the Indian Red Cross Society (IRCS). The aim of the appeal was to provide 300,000 beneficiaries with essential shelter material, health and medical services, safe water, and urgently needed relief items for a period of four months. More than 50 Red Cross/Red Crescent Societies responded in support of the IRCS and emergency response units of National Societies were deployed such as emergency response referral hospital, emergency water and sanitation units, primary health care unit, logistics and distribution teams, and mobile medical teams. Support was also received from governments, private companies and individual donors. Good progress was made during the emergency phase in the areas of health, relief provision and water/sanitation. The operation met its target in term of relief distribution and exceeded the target of 300,000 beneficiaries. The response was quick and the first personnel reached the epicentre Bhuj in 48 hours. Emergency response units were mobilised rapidly; for example a 310 bed Red Cross hospital was operational in Bhuj in less than a week.

In July 2001 a preliminary appeal was launched on behalf of the IRCS seeking CHF. 60.9 million in cash kind and services to enable the Society to implement recovery and rehabilitation programmes from 2001 to 2004. The main programmes to be covered by this phase were:

a. Integrated health -- consisting of six interrelated projects such as community health, reconstruction of health facilities, water and sanitation, psychological support, and prosthetics.

b. Capacity building to address the need to modernise and upgrade the current administrative and organisational structure of the IRCS and its Gujarat state branch.

c. Reconstruction of shelter, water containment structures, private housing, and primary schools.

d. Programme management and co-ordination- setting up the Federation’s India Operation Centre to manage the operation and co-ordinate between the various donors, the Secretariat and the IRCS.

The Federation response to the challenges of the Gujarat Earthquake has been the subject of formal and informal reviews. An inception report was commissioned by the Federation in 2001 to collate and analyse available information. This inception report was to be a prelude to a larger exercise to evaluate the effectiveness of the immediate response, subsequent relief operation and the management systems and processes supporting this response. The inception report contains a collation and analysis of available data;
identification of gaps; and articulation of key operational, management and policy questions -- supported with draft terms of reference for a deeper and wider evaluation. (Source: TOR)

Scope of the Present Exercise

The initial terms of reference and evaluation objectives issued by the Monitoring and Evaluation Department were extensive based on a projected involvement of a team of five members working for 45 days to undertake the evaluation in the field in India and intensive discussions in Geneva. However, due to budgetary constraints, the exercise was limited to 25 days including briefing sessions in Geneva and field visits in India to be undertaken by a team of three members. In the end even the third member of the team who was to be nominated by the IRCS was unable to join the team and the work was carried out by just two members of the team.

In view of these constraints of time and the size of the team, the terms of reference were reviewed and discussed with the Secretariat staff in Geneva and modified to focus on the following key issues:

- The evaluation would focus on post-relief operations particularly the rehabilitation operations and review aspects of programme management and coordination through review of documents and reports and interviews with key staff.

- One of the major components of the rehabilitation programme is the integrated health component as outlined above which is being implemented by the Federation and PNSs in cooperation with IRCS and its branches in Kutch and adjoining areas. The evaluation will review these programmes and their relevance in the context of ongoing programmes undertaken by the State Government and NGOs and address sustainability issues.

- Review the effectiveness of the capacity building and organizational development of IRCS as an integral component of the response to the India Earthquake. This will also include Disaster Preparedness/Disaster Response initiative undertaken by IRCS with support from IOC.

- Assess the management process and systems supporting the response at the National Society, IOC/SARD and Secretariat levels.

- Document lessons learned and appropriate recommendation relevant to the above.
Methodology

The evaluation team included two members- Madeleine Pousette through Finnish Red Cross as a specialist on health and Bapu Deolalikar, an independent international development, management/OD and evaluation consultant based in the USA as the team leader. The team began its work with briefing sessions on November 14, 2002 with the Director and the Head of the Monitoring and Evaluation Division when the scope of the work was reviewed. In addition, briefing sessions were also held with key senior staff in the Secretariat on November 14 and 15, 2002. The complete list of all the contacts is given in the annex.

The team arrived in Delhi on November 17, 2002 and had series of briefing-cum-interview meetings with key senior staff in IOC, IRCS and SARD from November 18-21, 2002 and proceeded to field visits in Bhuj, Rajkot, Ahmedabad and Patan from November 22-27, 2002. The list of all the contacts is given in the annex. The team was in Delhi again from November 28 to December 4, 2002. Ms. Pousette left for Finland on December 4 but Mr. Deolalikar continued with meetings and discussions in SARD and IRCS. The team leader was also invited to present the evaluation findings to The Partnership Meeting in Delhi on Jan. 23-24, 2003. The final debriefing meetings were held in Geneva on February 24-25, 2003.

The team contacted NGOs in Bhuj, Rajkot and Ahmedabad who were involved in Gujarat Earthquake relief and rehabilitation work so as to relate their experience with IOC/IRCS activities. The team had also meetings with Government health department program managers in Bhuj and Rajkot and the head of the Gujarat State Disaster Management Authority in Gandhinagar as well as with the UNICEF staff in Bhuj and Gandhinagar.

The team had detailed discussions with the office bearers of the Gujarat State Branch of IRCS in Rajkot and Ahmedabad apart from discussions at the national head quarters. The team had a meeting with the HOD of the American Red Cross in Delhi and Ms. Pousette visited AmCross Patan project. She had also meetings with the British, Spanish, and Canadian Red Cross delegations in Delhi.

This evaluation report is based on interviews as well as draws heavily on the reports and documents supplied to us.

Acknowledgements

The team wishes to thank all the admin and support staff in IOC including the delegates with whom we met in Delhi as well as in the field for their cooperation and assistance. We are particularly grateful to Mr. Azmat Ulla, HOD/IOC for his help and guidance. As HOD/IOC, he has excellent rapport with the Secretary General and all the staff in IRCS. This facilitated our meetings with all the relevant staff who were available for discussions with us in spite of their busy schedule. We are also grateful to Mr. Robert McKerrow, HOD/SARD and Mr. Alan Bradbury. Mr. McKerrow represents institutional memory of relationship between the Federation and IRCS over the last several years and particularly
since the Kutch relief operations began. He provided us an overview of all the history and
dynamics of events and relationships.

Our two extensive meetings with the Secretary General of IRCS- Dr. Vimala Ramalingam
were open and frank during which she outlined her vision for the future of the IRCS and
its relationship with the IFRC for disaster preparedness and capacity building efforts. We
are thankful to the Secretary General and her senior staff members- Dr. Ganthimati,
Deputy Secretary, Mr. Rakesh Kumar, Director, Finance and others for their cooperation
and assistance.

The Indian Red Cross Society was founded in 1920. While it has a history of pioneering
work in several areas, it has remained rather isolated from the mainstream international
Red Cross movement. However, since Dr. Ramalingam assumed the office as the
Secretary General more than two years back, there are attempts to build closer contacts
between IRCS and IFRC. She is also providing strong leadership to bring about
constitutional and organizational changes and to build a strong Red Cross movement in
India. The future potential for IRCS is great and in spite of many political and
organizational hurdles, the Secretary General is striving to create a cohesive organization.
The role of IRCS during the Gujarat earthquake relief and rehabilitation operations has
been greatly appreciated in the government and public circles and has established its
credibility as an important agency in the disaster preparedness and response in the
country. Because of the political, governmental and bureaucratic complexities in the
system, it is not always easy for any international organization to work in India. The
Gujarat earthquake could be considered as a watershed event in the relationship between
IFRC and IRCS and the credit for forging these constructive relationships goes to the
Secretary General of IRCS and the HOD/IOC and HOD/SARD.

All the information and data reported in this report are drawn from various reports,
reviews and records of IFRC, IOC, IRCS, UNDP, Abhiyan, and other organizations.
II The Gujarat Earthquake: Response by the Federation

The Impact of the Earthquake

The earthquake which struck India’s eastern state of Gujarat on 26 January 2001, peaking at 7.9 on the Richter scale, lasted about 110 seconds. It was the most powerful earthquake to strike India during the last 180 years. The epicentre of the earthquake was approximately 20 km northeast of the town of Bhuj. The disaster had devastating impact seriously affecting all the area within a range of 100 km and the tremors were felt across several states as well as neighbouring Pakistan and Nepal. A series of aftershocks, over 400 with 19 measuring over 5 on the Richter scale, created havoc and panic among the population. The official death role was estimated to be over 20,000 with some 167,000 people injured. Overall, more than 15 million individuals were affected by the disaster. Some 800,000 people were rendered homeless, about 400,000 houses destroyed and one million houses damaged. The social infrastructure of schools and health both in rural and urban centres as well as three major hospitals, over 1200 primary and sub-primary health centres and over 11,600 schools were totally destroyed or damaged. The initial calculation of the Government of Gujarat estimated the total loss of direct and indirect losses of over USD 4.5 billion. The transport, road, rails and telecommunication infrastructure was severely affected. The earthquake came at a time when the region was already experiencing a severe three year drought thus creating serious water shortage and livelihood problems.

Districts affected by the 26 January 2001 Earthquake in Gujarat
IFRC/IRCS Relief Response

The SARD/IFRC in Delhi along with IRCS team visited Bhuj on January 27, 2001 and a preliminary appeal seeking CHF two million to assist 50,000 beneficiaries with immediate relief was launched on the very day of the disaster. Based on the first assessment by the coordination team (FACT) a revised appeal was launched on January 30, 2001 seeking CHF 25.6 million to assist 300,000 beneficiaries for four months. Around 50 Red Cross and Red Crescent Societies, governments, international organizations, the European Commission Humanitarian Office (ECHO) and private enterprises responded to the appeal in cash, kind and services. The emergency appeal was 149 percent covered. The value in cash was CHF 16 million and in kind CHF 22 million. The IRCS and SARD/IFRC were operating at the heart of the disaster zone within 24 hours to coordinate relief work with supply of 80 units of blood and the regional DP delegate was stationed in Ahmedabad. IRCS released 30,000 blankets and 150 tents which were airlifted to Bhuj while the Federation procured 22,000 tarpaulins. The final report states that the initial response from RC/RC Societies and their governments to the Federation’s preliminary appeal, and directly to the IRCS was spontaneous and overwhelming with cash pledges from China, the UK, the Netherlands, Spain, as well as with offers of goods and services from Switzerland, the US, Canada, Finland, Germany, Italy and Japan. Several hundreds of IRCS volunteers and medical teams from different parts of India and Gujarat converged on Kutch and spread out in different parts of Kutch and other areas and started spontaneous rescue and relief efforts.

In support of IRCS activities, Red Cross Red Crescent Societies responded with relief supplies and emergency response units including a 350-bed joint Norwegian/Finnish Red Cross emergency response unit (ERU) referral hospital which was operational as of February 1, 2001; and a German Red Cross water and sanitation unit, largely financed by the European Community Humanitarian Office (ECHO) via the Finnish and German Red Cross Societies. The capacity to provide emergency medical assistance to earthquake victims was further strengthened by the Japanese Red Cross mobile hospital clinic team, which operated in co-ordination with the emergency response hospital, and a Spanish Red Cross emergency response primary health care unit. ICRC began tracing services; The French Red Cross deputed water sanitation team with water treatment kits, the British Red Cross logistics emergency response team and the Austrian and Spanish Red Cross provided telecommunications emergency response teams.

IFRC was able to undertake this major relief effort and carry it out with speed and efficiency due to various factors including the role played by the IRCS as a point of contact with the Indian government authorities at all levels and the intensive and effective flow of information from India, both through Bhuj, Ahmedabad and Delhi offices as well as the agreement of different PNSs to coordinate their effort through the Federation. The Secretary General of IRCS took a bold step in responding to the initiatives by interested PNSs and the Federation for assisting in the relief work without waiting for the government clearances.
The IRCS priorities stated in January 2001 Appeal were for shelter (plastic sheeting, tarpaulins, blankets and cold-weather clothing); medical services and supplies (a 350-bed hospital and mobile clinic, cholera and health kits); water sanitation equipment (buckets, tanks and purification tablets); and other relief supplies (high protein biscuits and kitchen utensils). The Federation’s Appeal received additional support from governments, ECHO, private companies and individual donations. There was overwhelming response to the appeal and all the supplies and services requested were more than adequately met. (The Relief Programme details provided in the appendix I)

Rehabilitation Programme Planning

The Government of Gujarat decided to end the relief operations on Feb. 26, 2001 one month after the earthquake and requested all the agencies to focus on rehabilitation work. Accordingly, many agencies started planning for medium and long term rehabilitation. The Federation/IRCS response to the relief operations in Gujarat was quick, well targeted and managed. It provided critical needs of the affected vulnerable population by setting up the tented temporary hospital and outreach health services and distribution of the relief supplies. The IFRC/IRCS were one of the several Indian and international private and governmental agencies working during the relief operations, none the less, IFRC/IRCS played an important and crucial role during this phase which was recognized by the State and central Governments and other international organizations.

Following the partnership meeting in Delhi held at the end of March 2001, the Federation, in cooperation with the IRCS and sister societies initiated planning and assessments for rehabilitation programming in Gujarat. Immediately after the partnership meeting, Red Cross Red Crescent partners held sectoral meetings and provided further details on their concrete interests. Smaller, sector specific groups were formed, establishing further involvement of partners in the transition towards full-fledged recovery and rehabilitation operation in support of the IRCS.

A meeting on reconstruction, including public and private housing, was followed by deployment of two teams. The first team comprised of representatives from the IRCS, Federation, British Red Cross, and German Red Cross researched potential programmes for public buildings. The second team composed of members of the Austrian Red Cross, the Belgian Red Cross and the German Red Cross researched possibilities concerning private housing.

The disaster preparedness and disaster response meeting resulted in agreement of all interested Red Cross Red Crescent partners that the considerable local expertise should be mobilized to implement this programme. The draft proposal for disaster preparedness and response programme was finalized by a team composed of members of the IRCS, the Federation, and the British Red Cross. This programme focuses on building the capacity of the IRCS at national headquarters and in disaster prone states including Gujarat.

There was considerable delay in finalizing rehabilitation plans by the Federation. During this vacuum, the PNSs were anxious to undertake rehabilitation programmes on their own and began discussions with IRCS for bilateral programmes. The momentum gained
during the relief phase was thus lost and funding support declined. The appeal launched in July 2001 for CHF 60.6 million for three years for 1.5 million beneficiaries had to be scaled down to CHF 28.6 million in June 2002. Eventually, the rehabilitation effort in Gujarat was undertaken by the Federation and the PNSs with coordination support by the Federation in specific areas. While rehabilitation activities were within IRCS programme goals, the actual implementation was guided by the Gujarat Government priorities and framework. The rehabilitation programme phase envisaged IFRC and IRCS involvement in the following:

A  **Integrated health services development in Gujarat**  
(The Rehabilitation Programme details provided in the appendix II)

B  **Capacity Building Programme**

The capacity building and organizational development are not strictly a part of the earthquake rehabilitation effort in Gujarat but the need and the rationale for capacity building emerged as a major concern for IRCS institutional development following the earthquake for its role in the nation as a leading agency to address emergency relief. The earthquake relief experience provided both IRCS and IFRC opportunity to assess the IRCS inherent potential as well as its organizational and management weaknesses. The new Secretary General who assumed the office in 2000 had already initiated discussion stressing the need for such efforts. During the partnership meetings in March and December 2001, it was agreed to move from crisis driven events/disasters to long term strategy and investment to strengthen the management and organization at the IRCS national head quarters as well as to undertake branch development programmes. The specific objectives for capacity building relevant to the Gujarat experience and achievements so far are as follows:

**Organizational and Resource Development**

A mapping exercise of the national headquarters organizational structure, staffing, resources, programmes and steering tools was initiated. A consulting firm was engaged to conduct a national branch mapping exercise to build a knowledge base of all programmes undertaken at all levels of the society for future development initiatives. The OD project team has been assisting in computer systems planning and setting up IT infra structure.

**IRCS Branch Development:**

Two branch development officer positions- one at NHQ and the other at Gujarat State branch are being created with support from IOC. IRCS is also creating a new department of organization and resource development in NHQ. The regional branch development office in the Gujarat Branch may service two or three adjoining states and will be a model for branch and programme development. Red Cross induction courses were held in Kutch, Rajkot, Surendranagar and Ahmedabad in which 163 IRCS members, volunteers and medical personnel participated. A fundraising workshop was also organized with the aim to strengthen fundraising capacity at the state and district levels.
**Human Resources Development (HRD):**

Comprehensive HRD programme is essential in order to build IRCS management capacity, skills and systems to deal with governance and management issues. This is being done through regional workshops, developing gender and volunteering policies and staff development programmes. 12 new key positions are being created at the NHQ to meet the future staff demands. A human resources mapping exercise is underway. A decision is also made to amend staff rules which were established in 1950 and needed updating.

**Disaster Preparedness and Disaster Response (DP/DR):**

The goal of capacity building DP/DR project is to build IRCS as a key actor and partner with the Government and other agencies in the disaster management field in India. The IRCS involvement in the Kutch Earthquake response has established its claim and credibility. A disaster management coordinator is being appointed at the Gujarat State branch. Eight most disaster prone states have been prioritised for DP/DR assistance. The recruitment of the three new positions for the Disaster Management Department is under consideration. DP/DR cross training programme has been planned in Gujarat.

(Source: IOC Reports)

**Relief Response from Government, Business and Non-governmental Organizations**

The response from the Government of India, Gujarat State Government and other State Governments to the earthquake disaster was quick and massive. The Ministry of Agriculture set up and activated its emergency management system and initiated coordination with the Gujarat State Government. Traditionally, the Government did not seek foreign assistance in cases of such disasters but the scale of the disaster was such that the Government decided that international assistance would be welcomed and facilitated. The State Government took the responsibility for the leadership and direction of the emergence relief operations. The military is traditionally a primary resource in disaster response in India and all their facilities and resources were diverted to relief efforts with immediate effect. Military hospitals were set up performing a vast number of surgical interventions and heavy equipment for rescue work and transport for relief work was provided in the early days. More than 30,000 military and para-military personnel were deployed in the rescue and early relief operations. Governments in the neighbouring states dispatched medical teams and relief. Private organizations, NGOs, businesses, corporations, individuals and mostly local voluntary agencies played a very important role in relief and assistance. As many as 300 NGOs were involved in relief effort in Gujarat.

This information is provided as we believe that IRCS and its state branches need to form coalitions and partnerships with NGOs in the field with a view to coordinate relief and rehabilitation work in case of disasters.

*(A detailed note on the role and work by NGOs in Kutch Earthquake Relief: Appendix III)*
### III Observations and Comments

#### Management of Relief Operations

The relief operations in Bhuj met all the objectives stated in the appeals as stated in various Federation reports. The Federation response to Gujarat earthquake relief operations was amongst its largest operation in the recent past. The response to the Federation relief appeal was overwhelming and was more than 140% funded by various PNSs, governments and other donors.

The relief operations encountered several difficulties such as presence of large number of delegates, deployment of volunteers to assist the medical staff in the relief hospital and distribution of relief supplies as well as import of unwanted supplies. Inspite of these difficulties the Gujarat earthquake relief operation was a successful enterprise largely because of the coordinated efforts of the HOD/SARD and ICRS Secretary General and IRCS key staff. There was excellent coordination between SARD and IFRC in Geneva. SARD was short staffed which affected to some extent the management and coordination between Kutch field office and Delhi. The slow Secretariat response to the staffing needs seemed to be due to non-availability of experienced staff who could be assigned to the field. The HOD/SARD functioned as in charge field operations in Bhuj and IOC in addition to his regional role. The Secretariat decided to suspend the use of some of its normal management, financial and personnel procedures in order to allow the rapid response to proceed.

The Federation’s involvement in the Kutch Earthquake operations came at a time when the new organizational changes at the Secretariat were being initiated. There was agreement that the relief response validated the organizational changes highlighting the Federations’s dual role of providing services and leadership to the membership in order to support the implementation of Strategy 2010 and also for strengthening the role of the regional delegations.

The FACT team, limited in size, did not operate as per established procedures for assessment of relief needs as the immediate emphasis was on rescue operations and emergency medical assistance. In addition, the FACT team members were needed to monitor the arrival of the medical ERU equipment and assist with the unloading of planes with relief goods and to set up the Red Cross camp in Bhuj. However, based on information from the government and other NGOs, they acted quickly to assess the relief needs as accurately as possible. All the Emergency Response Units deployed in the operations functioned efficiently and in a coordinated fashion.

One of the important features of the Bhuj relief management was the coordination of all the Federation and PNSs activities by the regional delegation in Delhi and in Bhuj. There were four main levels of coordination within the Red Cross Red Crescent operation in Bhuj: general coordination with all the PNSs and the team leaders for each sector; sectional meetings for each programme; coordination with the authorities; and interagency coordination. The Red Cross Red Crescent Bhuj camp was also a host to the
weekly health interagency coordination meetings, with the WHO as the lead agency. The International Federation initiated a separate temporary shelter meeting, aimed at ensuring the coordination of village needs assessment and tent distribution in the Kutch district. The British Red Cross logistics ERU which came equipped with a full complement of VHF equipment (hand sets and base stations, with antenna), as well as satellite telephones and the Austrian Telecommunications established a general Red Cross/Crescent network, and installed a functioning base station at the logistics base, to allow communication with the airfield.

Due to the weak volunteer base, organization, and management on the part of IRCS and its Gujarat State Branch, the Federation delegates had to be brought in to manage relief distribution. During the relief operations, more than 150 delegates were involved in the relief operation which put considerable logistic pressure on the IOC. At present there are 13 expatriate delegates in the Indian Operations Centre besides those in SARD and various PNSs both in Delhi and in the field. There have been comments on this in some political and other circles. The HOD/IOC is conscious of this and has plans for hiring experienced local nationals to replace expatriate delegates. There are some concerns as regards the experience and relevance of the delegates and the tasks they are supposed to handle. There is a feeling that the delegates may be technically qualified but lack managerial, planning and organizational development experience to work with senior level management.

**Rehabilitation Planning and Implementation**

The period for relief operations was estimated to last for about 120 days. This was an overestimation. The State Government decided to stop all the relief operations on 26 February 2001, one month after the earthquake struck and decided to shift to rehabilitation mode. While the Federation Bhuj relief operations were a success, the planning of rehabilitation programmes and implementation was delayed highlighting the weak rehabilitation planning and management capability in the Secretariat. The Federation has strong capability in responding to emergency relief needs worldwide. A senior Director commented that over the last decade or so, the Federation has become a relief machine acting with swiftness and efficiency but rather slow in responding to rehabilitation and development work. The reasons for this are many. There is shortage of senior staff with experience in rehabilitation and development work both at the Secretariat and field levels. There are differing opinions on the role of the Federation in rehabilitation and development work as against responding to relief needs which traditionally receives high priority. It is felt that donors respond more easily to emergency relief rather than to rehabilitation and development. Relief operations involve large financial resources, are of short duration with more visibility to donors and deployment of large number of technical personnel and volunteers for shorter period of time. As against this, rehabilitation and development work may involve less financial resources; need staff with relevant experience for longer period of time and less visibility for the donors if the programmes are implemented through the Federation or by the national society. While the relief operations may need minimum involvement of the local national society and could be implemented and managed by the Federation directly without least
interference but the rehabilitation and development programmes do need active and direct participation and cooperation of the national society.

The rehabilitation programme was slow to start but picked up after the initial delay. Many of the PNSs started work on bilateral basis and some activities were handled directly by the IOC in Gujarat. The basic thrust for the rehabilitation work was on integrated health programmes and capacity building. The integrated health programme was designed to support and complement the governmental health activities such as training for health workers and reconstruction of health facilities. While the Federation involvement in the health related programme was relevant, it appeared to be implemented in isolation and with very little participation of local NGOs or the government health department who are could maintain the continuity and follow-up. The cost of running these programmes could have been less if the local NGOs were involved in implementation in partnership with the IRCS. There are number of well organized and reputed NGOs in Gujarat and in Kutch and this was an opportunity to form partnerships with them. The local branches of Indian Red Cross are supportive but their involvement appeared to be rather notional as they had no clear plans or organizational resources to take over the work after the Federation programme phases out.

The construction of Anganwadis, PHCs and other health facilities involved major financial investments by the Federation. It was reported that the overhead costs of construction projects were about 30 to 35 per cent (or maybe even higher if the cost of using local design, supervision contractor from Delhi is included) which appear to be rather high. The Federation may review future reconstruction policy as to whether such projects should be directly implemented or to use local organizations to save heavy overhead costs.

While the rehabilitation projects are providing useful service to the earthquake affected communities, the activities are government directed and responsibility of the government rather than reflecting any innovative programme planning by the Federation and IRCS.

**Capacity Building**

The rehabilitation projects being implemented by the IOC and PNSs are going on as per the plans and meeting targets but there is very little coordination and knowledge sharing among the IOC and PNSs and between them and IRCS and local government and NGOs. The contacts with the governmental agencies at the state and district levels are on ad hoc and need-to basis rather than involving them in policy and programme implementation and utilize this as an opportunity for capacity building. The IRCS, the Federation/IOC and the PNSs are working in Gujarat at the invitation of the State Government as the projects and the locations were approved and assigned by it. The IOC and PNS programme managers experienced several operational difficulties and delays in choice of sites, approvals, and various other matters. In spite of these operational problems, both the IOC and PNS field teams did a creditable job in completing the projects on schedule. However, it must be noted that there was very little direct involvement of the State Government either at the State, Department or District levels in project planning,
management and implementation. It is suggested that at the State level there could have been a Project Management Committee under the chairmanship of the Relief Commissioner, Department Secretaries, IRCS/State Branch senior officials, IOC and PNS representatives to review programmes, operational issues and plans. A similar District Level Project Implementation Committee under the District Collector, District Departmental heads, District RC, IOC and PNS representatives could review project implementation and other issues. These interventions may not still solve all issues but it puts the government, for whom the projects are implemented, in the picture as a key stake holder. The IOC and PNSs may seriously consider these suggestions as they are going to be in Gujarat for the next year or more.

The rehabilitation projects are being implemented and managed by the IOC and PNSs with expatriate delegates. The role of IRCS in implementation is marginal and notional. It is IRCS which should be managing the projects in the field with its own staff in partnership with NGOs, IOC and PNSs. There have been some comments as regards the presence of so many expatriate delegates such as nurses, engineers and other general admin types when so many qualified and better experienced candidates are available in India. The cost of hiring local staff/delegates will be much lower considering the overhead costs involved in deploying expatriate delegates. Both the IRCS and the Federation are loosing a valuable learning opportunity by not involving the national society in taking the responsibility for project management.

The important feature of the rehabilitation programme is the training of local volunteers and should have received more attention in terms of local capacity building. Volunteer development and management is one of the weakest part of IRCS work at branch level. We did not see any plans on the part of local Red Cross branches to be involved in a sustained manner in training, development, management and retention of volunteers for the Red Cross work. Trained volunteers could act as link between vulnerable population in communities and health, educational services providers and also provide community based first aid services during normal as well as in emergency situations. While the health services in India are extensive (though not adequately funded), the service utilization is low and volunteers can act as liaison and promoters for access to these services by vulnerable and needy populations. The professional volunteers from urban areas like doctors, medical social workers and paramedics could provide mobile services in distant areas. It has been reported that during the earthquake relief operations hundreds of Red Cross and other volunteers and groups came from all over Gujarat and India and offered their services. There is no record of this with IRCS or its branches, no follow-up or no coordination. It is only recently that the OD and DP delegates from IOC are getting involved with the Gujarat State Branch to address some of these issues.

The capacity building component focuses mainly on organization and human resources development and disaster preparedness and response capacity in IRCS. Two delegates from IOC are assisting the national society in these activities. Much of the work during the last year involved discussions, data gathering and similar activities. IRCS is as yet to take substantive and firm policy and implementation decisions on institutional organizational changes. We had some discussions on these issues with the Secretary
General. While she is concerned on these matters, she is constrained by various major organizational issues. Since she assumed office in 2000, she has been preoccupied with one disaster after another including the major Bhuj earthquake and now with the drought in Rajasthan, Gujarat and other states. She has taken over the organization which has history of over 80 years but a rather staid and inactive organization with low staff morale and lack of vision for the future. It was continuing its existence with traditional activities like blood banks, ambulance services and health programmes in the state of Uttaranchal and social services programmes at the state level by some branches. The Secretary General has started to bring in fresh and new blood by hiring some key staff members. These include the Director of Finance and Accounts and the Deputy Secretary in charge of Medical Services. The Director of Finance has reorganized the department and finalized annual accounts. The Deputy Secretary was in her new position for just a week when the earthquake struck and she was in Bhuj to assist the Federation team along with the Secretary General. She was also a key actor for relief work during the communal riots in Gujarat. The IRCS work was greatly appreciated by all including the state government. These are senior level positions but the organization will have to make strong effort to retain them in the organization. Beside these two new staff, there are few others who can be considered promising but they are rather junior. Even the senior new appointees who are technically quite competent and committed but lack organizational and policy level experience.

IRCS has over 500 employees at national headquarters. Around 150 of them are professionals. The senior Deputy Secretary in charge of administration, finance and other functions will be retiring shortly. The Secretary General can depend on just two new senior staff appointees and 3-4 junior staff for administrative and planning support to manage this large and complex organization. The HOD/IOC has been of great assistance to the Secretary General in planning and development work and liaison with PNSs. The Secretary General has a vision for the future of IRCS but is handicapped by inadequate support system. She needs time and support to undertake branch development, institute constitutional changes, and focus on resource mobilization and public relations. The Federation needs to provide this support with sensitivity and care. The human resources development is a major issue, the pay scales for staff are not commensurate with governmental or private sector and career growth opportunities are limited. The State branches are governed by their own rules and by and large managed by honorary office bearers. Bringing in professionalism at state levels is a major task by itself.

The present capacity building efforts are rather limited. The disaster preparedness programme to be instituted at the headquarters and state levels is still in the discussion and rhetoric stage. The leadership is still lacking and coalition and partnership building with central and state governments, NGOs and private business sector still non-existent. For example, the disaster preparedness effort in Gujarat could use the local resources available through the Disaster Mitigation Institute in Ahmedabad which has a state wide network and has been offering training programmes at local and state levels. The State Governments disaster mitigation agency would be another source for partnership and assistance.
The IRCS does not have systematic and organized mechanism to mobilise resources locally for disaster relief and rehabilitation through governments, businesses and general public. Several state level and local branches on their own mobilized resources and so also the private sector and NGOs for the earthquake relief and rehabilitation. It has been reported that the contributions through the central and state governments, businesses, non-resident Indians, NGOs and local private donors for relief and rehabilitation operations were much higher in comparison to the total foreign contributions of which the IFRC was just one part. Many more lives were saved by local volunteers and organizations and military than through the external relief efforts. This is not minimizing the importance and value of the external assistance but there is a lesson to be learnt here by the IFRC and IRCS. The IRCS could provide coordination and partnership in such efforts as this may increase its visibility and credibility.

The Secretary General expressed interest in getting technical assistance for resource mobilization and for developing public relations strategy for the Society. The publics for the Society include a diverse group of interests- politicians and legislators, government ministries and officials, corporations, chambers of commerce, medical professionals, NGOs and lay public. The Society needs to develop strategies to reach these groups using various media and approaches.

Disaster relief and response is an enterprise which the national society cannot handle by itself alone. It calls for partnerships and coalitions with other NGOs, professional groups, businesses, corporations and state and central governments to develop common strategies for resource mobilization and deployment. There is need for partnership development as a separate activity and department in the society.

The relief operations in Gujarat involved several innovations such as deployment of ERUs which were critical to the success of the Federation’s operations. The special ERUs critical to Indian needs are ERU hospital- at least 75-100 beds capacity- as a packaged unit; Water and Sanitation purification units to go with the hospital; and Telecommunications and Logistics ERUs. This may need the IRCS partnership with the central and state governments, businesses, military establishment and ministries of health, agriculture, communications, and professionals groups.

**The Future**

The need for creating Indian Operations Centre emerged during the earthquake relief operations. The initial appointments for the position of HOD/IOC resulted in some friction and misunderstandings which were eventually sorted out. The current HOD/IOC has established a good rapport with the Secretary General and staff of IRCS based on mutual understanding and trust. Some of the earlier misunderstanding appears to be based on lack of clarity of tasks and functions of HOD and reporting relationships with the IRCS, the Secretariat and HOD/SARD.

There is a need to consider the continuance of the IOC as Bhuj and other relief and rehabilitation operations in India are scaled down. India being a major disaster prone
country, the Federation may continue to have a significant presence in India for a long
time to come. The regional delegation does not seem to have country specific delegates.
This issue came up for brief discussion during meetings with the Secretary General,
HOD/SARD and HOD/IOC. We feel that due consideration may be given to this issue
and some policy decision may be taken.

For many in the Secretariat, India is a rather reluctant and distant partner in the
International Red Cross movement. There is a strong sentiment at the senior secretariat
level that India could play an important and useful role and contribute to Red Cross
movement in Asia and Africa with its technical and managerial personnel and skills
which may be accessed by IRCS from within its organization, if available, and/or from
outside sources which are rich and plentiful. However, this remains just a concern as
there is no meaningful dialogue to explore this in real terms. It appears that the
Federation response to Indian needs is based on immediate needs of disaster relief rather
than long term institutional development and building partnership. The contact and
dialogue between senior levels in the Secretariat and IRCS on such issues is rather
limited. There seems to be no direct interaction between the Secretariat specialist
departments like health, OD, resource mobilization, India desk and IOC/SARD and IRCS
in programme planning and strategy development.

India is both a developed country in some areas such as its skilled professional
manpower, industrial base, a large middle class (150 million) as well as a developing
country with more than 40 percent of its population (400 million) living below the
poverty line. The role of the Red Cross movement in India and the mission of the IRCS
should be viewed by the national society and the Federation in this context. While the
national society may have to seek external assistance and resources, there is potential to
access both financial and professional resources from within and the national society
must be encouraged to mobilise these resources locally. The Indian government has been
assisting some developing countries in Asia and Africa with foreign aid. The relationship
between the Federation/PNSs and the IRCS does not have to be merely as donor and
donee but should be built on sharing and mutuality.

There is an increasing interest on the part of some PNSs to develop bilateral programmes
with IRCS directly. While this is a policy matter to be explored between the Federation,
IRCS and the PNSs, we would like to indicate some concerns in this regard. The
organizational resources of the IRCS are rather limited and dealing with several PNSs
will increase the work load. More importantly, IRCS will have to deal with the
Governments at the centre and states for clearances and coordination in regard to PNS
activities and personnel. The government authorities in India are rather chary about
foreign organizations and nationals working in India and particularly with non-
governmental organizations like IRCS.

Objective 1: “to provide 300,000 beneficiaries (60,000 families) health and medical services.

Achievements

The Finnish, the Norwegian and the German Red Cross Societies jointly responded to the Federation’s appeal for a 350 bed hospital.

Within four days after the earthquake, the Red Cross Emergency Response hospital was operational in Bhuj. The hospital, made possible due to an important contribution from the European Community Humanitarian Office (ECHO), began as a combined Emergency Response Unit (ERU) consisting of Finnish Red Cross and Norwegian Red Cross personnel and equipment. The German Red Cross provided the hospital with purified water through their Water Sanitation ERU. The hospital, which was situated in the centre of the Red Cross compound, was comprised of 32 tents to cover hospital functions such as patient’s wards, laboratories, operating theatres, offices and examination facilities. Seventeen delegates from the German Red Cross, 57 from the Finnish Red Cross, and 39 from the Norwegian Red Cross were deployed to India to staff and run the hospital and the accompanying water purification unit.

On 29 January, the Japanese Red Cross deployed an equipped clinic as well as medical personnel. The team consisted of four doctors, four nurses, one pharmacist and two coordinators. The Japanese Red Cross team came from three main hospitals in Japan. Two local doctors and one local nurse also worked with the Japanese Red Cross team. The clinic functioned in the open air for the first two days following its opening. On 1 February, the clinic started operating in Sukhpar out of two tents. The Japanese Red Cross clinic treated over 5,500 patients with an average of 120 patients per day. The medical staff also visited Taper, once or twice a week, where they treated patients who were unable to come to the clinic.

A Spanish Red Cross medical team, composed of two doctors, two nurses and five technicians, arrived in Bhachau on 11 February. The Spanish ERU consisted of consultative and curative components, where approximately 130 persons per day were seen. Most of the patients required pediatric care, but the primary health unit also had the highest number of earthquake-related trauma cases. For more than a month following the earthquake the Spanish ERU treated patients with injuries related to this disaster. Many of the patients were unable to reach the medical facilities in Bhuj because of their extensive injuries. The Spanish Red Cross also had a mobile clinic which treated patients who were unable to go to Bhachau. The more serious cases were then transferred by a Spanish Red Cross ambulance to the Red Cross referral hospital in Bhuj.

One month after the launch of the Red Cross Red Crescent emergency operation, the ERUs operating from the Red Cross compound in the town of Bhuj, as well as in
Sukhpur and Bhachau, began to integrate with the Federation’s system and structures. Following the close of the operation’s emergency phase the Japanese Red Cross clinic closed on 24 March having treated 5,288 patients, and the Spanish Red Cross clinic on 28 March after treating 5,228 patients.

With all three main hospitals in the Kutch district severely damaged, senior local officials requested at a meeting with the International Federation and IRCS, an extension to the mandate of the Red Cross field hospital - to become the district’s main referral hospital. Based on this request a plan was designed by the IRCS, the Federation and local authorities to integrate the hospital into Kutch health infrastructure by gradually handing over hospital equipment, management and responsibilities for staffing to the district of Kutch.

On 15 April, government doctors took over the running of the hospital from expatriate staff, and 30 April marked the full integration of the former Norwegian/Finnish Red Cross emergency response referral hospital into the Bhuj district hospital. The Federation in cooperation with the Indian Red Cross Society continued to provide technical support to the facility throughout the reporting period and the hospital continued to make use of the ECHO funded hospital equipment through the end of May. Prior to the hospital’s integration in April, the facility treated some 15,735 patients.

The Federation is financing a pre-fabricated hospital on the site of the referral hospital which is expected to be ready by October 2001. The prefabricated hospital will house hospital activities, equipment and the patients until the construction of a new government teaching hospital in approximately two-three years. Construction of the prefabricated hospital has been carried over into the Federation’s rehabilitation programming.

Final figures for Red Cross Health facilities as of 30 April, after the management of the hospital was fully handed over to the government, are: 25,251 treated patients, 589 operations, and 352 deliveries. Since 3 February, 3,401 patients were x-rayed, 7,543 tests were conducted in the laboratory and there were 99 registered deaths. During the first three weeks of the emergency phase Red Cross Health facilities focused on treating earthquake related injuries and trauma. Patients’ needs however changed by the end of March, and there was an increasing number of patients seeking treatment for general maladies. With the exception of two instances of large numbers of people developing food poisoning there was no outbreaks of epidemics.

In February, an orthopaedic technician made an assessment of the Indian Red Cross artificial limb centre in Ahmedabad. This facility consists of a prosthesis workshop and a physiotherapy department. The building was severely damaged in the earthquake and work is presently carried out in the open. Before the disaster, the centre was producing around 30 prostheses per month. According to the assessment, an estimated 150 prostheses per month could be produced using present techniques.

The nutritional survey conducted by the Federation, the WFP, UNICEF, Save the Children and Oxfam resulted in Federation backed recommendations to support the
restoration and the activities of the integrated child development service (ICDS) of the department of health of the state of Gujarat through its Anganwadi centres. In addition there was an ongoing assessment conducted in cooperation with the local authorities and the WHO, identifying needs in the health sector.

A medical logistics system was introduced in February to serve the hospital and the outpatient units in Shukpur and Bhachau, in order to facilitate appropriate use of donated, locally-produced and imported medical supplies.

Distributions of remaining medical supplies to the local health care facilities were completed on 8 May. The region’s clinics are ordinarily provided with medicine and surgical supplies by the government; however, following the surge in need from the earthquake the government stocks were depleted. Primary health care centres (PHCs) were reduced to rubble in the earthquake thus destroying the facilities and trapping existing hospital stock in the building. Consequently, the remaining primary health care centres service an average of 23 villages and approximately 30,000 people. Among the items provided to the community health care centres (CHCs), PHCs and community physicians were new emergency health kits donated by the Red Cross Societies from Austria, Belgium, the Netherlands and the United States, as well as bandages, pain killers and antibiotics. One new emergency health kit (NEHK), containing approximately 24 cartons, contains provisions for 10,000 people for three months. The kit contains infusions and surgical equipment among other essential medical supplies.

**Distributions of medical supplies between 25 April and 8 May were as follows:**

<table>
<thead>
<tr>
<th>Date</th>
<th>Beneficiary</th>
<th>Items distributed</th>
</tr>
</thead>
<tbody>
<tr>
<td>25 April</td>
<td>Dhori PHC</td>
<td>1 NEHK, bandages and cotton wool</td>
</tr>
<tr>
<td>25 April</td>
<td>Khavda CHC</td>
<td>1 NEHK, antibiotics and painkillers in tablet and injection form</td>
</tr>
<tr>
<td>26 April</td>
<td>Anjar taluka; three PHCs servicing the taluka</td>
<td>2 NEHK, 5 Cholera kits, bandages</td>
</tr>
<tr>
<td>27 April</td>
<td>Gadhuli (community physician)</td>
<td>1 NEHK, bandages, antibiotics and painkillers in tablet and injection form</td>
</tr>
<tr>
<td>27 April</td>
<td>Dayapar PHC</td>
<td>1 NEHK, bandages and cotton wool</td>
</tr>
<tr>
<td>28 April</td>
<td>Ravapar dispensary</td>
<td>1 NEHK and 1 vacuum extractor kit</td>
</tr>
<tr>
<td>28 April</td>
<td>Mata na Madh PHC</td>
<td>1 NEHK, antibiotics and painkillers in tablet and injection form, and surgical items such as rubber gloves, stethoscopes etc.</td>
</tr>
<tr>
<td>30 April</td>
<td>Kothara PHC</td>
<td>1 NEHK</td>
</tr>
<tr>
<td>30 April</td>
<td>Mothada PHC</td>
<td>1 NEHK, antibiotics and painkillers in injection and tablet form.</td>
</tr>
<tr>
<td>7 May</td>
<td>Naliya CHC</td>
<td>3 NEHK, oral rehydration salts (ORS) antibiotics and painkillers in tablet and injection form.</td>
</tr>
<tr>
<td>8 May</td>
<td>Manfara (community physician)</td>
<td>1 NEHK</td>
</tr>
</tbody>
</table>
Objective 2: to provide the 300,000 beneficiaries (60,000 families) with safe water.

Achievements

During February 2001, the Federation worked together with the German and French Red Cross water sanitation teams, to set up water storage units in order to provide clean water to an estimated 200,000 people. More than 50 water tanks (storage tanks, collapsible bladder tanks, "onion” tanks) with capacity ranging from 2,000 litres to 95,000 litres were installed by the French and German Red Cross Societies’ water/sanitation teams in the area of Bhuj, Anjar and Bhachau, totalling 524,000 litres of water storage capacity. The German Red Cross water purification facility in the Red Cross compound in Bhuj produced approximately 70,000 litres of water per day for the Red Cross hospital and compound residents. The German Red Cross emergency response unit was largely funded by the European Community Humanitarian Office (ECHO). The facility was handed over to the Indian Red Cross Society in April. Part of the handover process involved several weeks of training for locally hired national staff to learn how to run the equipment. The German Red Cross team also assisted with construction jobs within the field hospital. In co-ordination with the local authorities and Oxfam, the French Red Cross water and sanitation team also worked on the installation of a water filtration unit in a new prefabricated hospital in Anjar and a water tank north of Anjar.

After the Spanish Red Cross set up a mobile clinic, the German and Spanish Red Cross water and sanitation units installed a water purification system, and a bladder tank provided by the French Red Cross that held 15,000 litres. The system provided water for the clinic and the Spanish Red Cross team of medical staff and volunteers. Although the focus of the Federation’s attention was on water storage and water distribution during the initial weeks of the emergency phase, a number of other projects were initiated including the repair of 100 dams, a health and hygiene awareness programme, sanitation programmes and the repair of damaged foundations of existing concrete storage tanks. The region’s dams are designed to catch and retain rainwater either from runoff or by rainfall. The average size of the dams that were rehabilitated had a wall length of approximately 400 metres and an approximate depth of 5-6 metres. The dams can be used to provide water for livestock, drinking and washing. In addition the stored water recharges the villages’ diminishing ground water supplies providing enough water for the region’s cash crops such as peanuts and alfalfa. The rapidly diminishing levels of groundwater are a high priority for the region’s health officials and organizations.

Following the emergency phase the Federation focused its programming around these dams. Using Bhuj as the operational centre, initially two mobile teams were deployed to two districts. Each team comprised three bulldozers, two excavators and a dump truck to move the machinery between sites. Two supervisors on a motorbike were assigned to manage each team. A four day intervention in each village was devised to have maximum impact in as many villages as possible before the onset of monsoonal rains.
A three women Red Cross health and hygiene awareness team was paired with these initial construction teams. Following the dam construction the women would visit and give a brief and entertaining presentation to encourage safe health and hygiene practices for village women and children. The children were encouraged to follow up on good hygiene practices by being given a neem tree sapling and a bucket. Children would wash from the buckets and then use the dirty water to nourish their tree. Forty one villages were visited, 1,550 women and 5,305 children were attended to, and 3,384 neem trees and buckets were distributed. Although the target group for the programme are women and children, the number of men attending the sessions steadily increased.

By the end of May, five mobile construction teams were across Kutch throughout Rapar, Anjar, Bhuj, Nakhtrana and Lakhpat. Each team operates in a separate district. Similarly, an additional health awareness team was added with one team responsible for all of the villages to the west of Bhuj and the other covering all villages in the eastern sector.

Ninety of the one hundred dams were finished by 31 May with: 15 in Anjar; 27 in Bhachau; 22 in Bhuj; 25 in Rapar and 1 in Lakhpat. Rainfall in Kutch is cyclical. Generally there are three years of sufficient amounts of rain, three years of insufficient rainfall, three years with very little to no rain and one year of very heavy rains. This year, 2001, has turned out to be the one year out of ten with very heavy rainfall consequently all the dams are currently full.

Sanitation: As in other parts of India, leftovers and garbage are traditionally left in the city’s back streets to be consumed by local cows, pigs and dogs. However, the traditional methods were inadequate to cope with the large amount of debris created by the earthquake and the city’s streets were papered with litter. While the dam construction and health awareness programme have been the core activities of the Federation watsan team, the Federation has also been active in Bhuj town constructing a total of 46 single latrines and 30 washing rooms of concrete block at temporary tent camps, schools and the government run hospital. A daily garbage disposal team consisting of a trailer and a tractor empty on a daily basis over 70 Red Cross garbage bins at 12 different sites throughout Bhuj.

Tank repair: Some 22 concrete storage tanks associated with the piped network were repaired by the watsan teams. Many of the concrete storage tanks associated with the piped network were constructed on an unconsolidated base of stone. Pressure from the earthquake damaged the tank’s bases or caused them to collapse leading to the tanks having very little support. These storage tanks form an integral part of the overall piped network acting as gravity tanks on the pipeline or, distribution storage tanks in each village. A mobile team moved from damaged tank to tank, replacing the existing rubble foundations with a reinforced concrete ring. An average of two tanks was repaired each week.

Similarly stone spillways and foundation walls constructed of rock in dams damaged by the earthquake were repaired by a mobile team tasked with this activity.
Objective 3: to provide the 300,000 beneficiaries (60,000 families) essential shelter and other urgently needed relief items.

Achievements

Relief distributions in the sub-districts (talukas) of Bhuj, Bhachau, Anjar, Rapar, Mandvi, Mundra, Abdasa, Rapar and Nakhatarana by teams comprising members from the Indian Red Cross, Federation, American Red Cross, Japanese Red Cross and the Italian Red Cross were completed during the first week of May.

The distribution of blankets exceeded the targeted number of 210,000 and the total distributed was 228,000. As for other relief items, 117,000 tarpaulins, 35,463 tents, 52,409 kitchen sets and 63,000 water containers were distributed since the operation commenced on 3 February 2001. In addition special distributions of eyeglasses were made by the IRCS and the American Red Cross and the Federation donated rice, beans and vegetable oil to the community kitchen programme in the Bhavanagar District. Emergency relief distributions were completed by 16 May. The final figures for distributions are as follows:

<table>
<thead>
<tr>
<th>Updated Summary Table</th>
<th>Appeal Target</th>
<th>Total Received</th>
<th>Distributed 2-16 May</th>
<th>Pipeline</th>
<th>Status Total Distributed</th>
<th>Stock Distributed in %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blankets</td>
<td>210,000</td>
<td>230,000</td>
<td>0</td>
<td>0</td>
<td>228,000</td>
<td>1,800*</td>
</tr>
<tr>
<td>Tarps</td>
<td>118,000</td>
<td>117,000</td>
<td>1,905</td>
<td>0</td>
<td>117,000</td>
<td>0</td>
</tr>
<tr>
<td>Tents</td>
<td>34,038</td>
<td>34,940</td>
<td>1,463</td>
<td>0</td>
<td>35,463</td>
<td>55</td>
</tr>
<tr>
<td>Kitchen Sets</td>
<td>60,000</td>
<td>60,000</td>
<td>7,563</td>
<td>0</td>
<td>52,409</td>
<td>7,426*</td>
</tr>
<tr>
<td>Water Containers</td>
<td>63,000</td>
<td>63,000</td>
<td>11,813</td>
<td>0</td>
<td>63,000</td>
<td>0</td>
</tr>
<tr>
<td>BP5</td>
<td>160 mt (307,000 rtns)</td>
<td>250,000</td>
<td>0</td>
<td>0</td>
<td>90,000</td>
<td>159,000*</td>
</tr>
</tbody>
</table>

1. The number of tarpaulins/plastic sheeting distributed includes 8,000 from IRCS DP stocks
2. Tent distribution includes 2,600 distributed by IRCS, from DP stocks
3. Water containers includes buckets and collapsible jerry cans from USAID & 1,000 distributed by IRCS, from DP stocks
4. BP5 distribution includes 73,000 rations distributed by IRCS, from DP stocks
5. Remaining stock marked with * has been earmarked for Indian Red Cross DP programme

During the first two weeks of the relief operation in early February, there was only one relief delegate in the field, thus limiting the Federation’s capacity to assess and monitor aid. Consequently distributions in areas such as Anjar had to be centralised in one of the areas’ villages.
In the weeks immediately following the earthquake, assessment teams comprised of representatives from the Indian Red Cross Society and Federation delegates were sent to villages throughout the Bhuj disaster zone to assess their vulnerability. Since many of these villages lack access to telephones, electricity or the media, the Sarpanch (village leader) became the key source for informing the beneficiaries about the date and substance of the distribution, and organising volunteers from the village to facilitate a smooth distribution.

The arrival in mid February of additional Federation relief delegates, expanding the team’s size to six, allowed for more comprehensive coverage of the earthquake affected area. Assessment criteria was formalised into standardised questionnaires which were used by each of the relief delegates. With the support of the Red Cross delegates, seven Indian Red Cross teams (49 volunteers) were strongly involved in assessments and distributions of relief items.

Distributions evolved in accordance with beneficiaries’ needs and the Federation’s capacity. The urgent need for shelter, during the first five weeks immediately following the earthquake (“emergency phase”), was the determining factor for the Federation’s initial choice to focus on the distribution of tarpaulins as opposed to tents which are logistically difficult to procure on short notice. Aid provided by the Red Cross and Red Crescent immediately following the earthquake primarily consisted of tarpaulins and blankets. The ration consisted of two tarpaulins and five blankets per assisted family. Families whose homes were completely destroyed were provided with kitchen sets and water containers as well.

In March, as the relief operation progressed and the needs in the townships became more apparent, the Federation shifted the focus of the distributions to tents. Shipments of tents from the Hong Kong, British, Netherlands and Belgian Red Cross Societies as well as ECHO funded tents via the Italian Red Cross were distributed starting the end of March. The first distributions of tents were made to specifically vulnerable urban areas while rural areas were provided with tarpaulins and blankets.

Disaster Preparedness Stock: IRCS has five warehouses situated in strategic locations around the country: Viramgam, Gujarat - 60 kilometres from Ahmedabad; Calcutta; New Delhi; Chennai and Bombay. India generally has several disasters each year and the capacity of the Indian Red Cross Society is being strengthened through the development of a focused disaster preparedness programme which will include warehousing and training components.

Discussions were held with Indian Red Cross, Federation and Participating National Societies (PNSs) regarding re-distribution of remaining quantities of relief items (mainly BP5 and kitchen sets). Kitchen Sets: Three thousand kitchen sets were donated to the Italian NGO, MOVIMONDO for distribution to earthquake affected families. MOVIMONDO pledged to distribute to individual families whose houses have collapsed or have been so seriously damaged as to be likely to collapse during the monsoon season.
In addition, they also distributed them to families sleeping outside in inadequate temporary shelter. Staff from the organisation has personally visited the selected families to verify the situation.

**Logistics**

Chartered cargo planes carrying relief goods started landing in Bhuj the day the appeal was launched, and a logistics base for the relief operation was set up in Ahmedabad at the onset of the operation. The army air base in Bhuj was used for incoming of supplies. A separate plane was chartered for delegates arriving from Delhi as no commercial carrier offered direct flights between the two cities. Although the distance between Ahmedabad and Bhuj is 475 km, it took eight to 11 hours to travel that distance by car. Therefore, most of the relief supplies and equipment were flown into Bhuj either via Delhi or Ahmedabad or directly from abroad.

A distinct feature of the operation was the first time deployment and use of the British Red Cross Logistics (BRC) ERU. The logistics ERU arrived by the end of the first week of February. The unit consisted of two vehicles, bicycles, computers, communications equipment, tents and delegates’ survival kits equipped with sufficient provisions (food, cooking equipment, raincoats etc.) to run independently for up to two months.

Two logisticians from the BRC were deployed in support of the Federation FACT team on 28 January (one subsequently assigned to Ahmedabad, and the second to attend to air operations in Bhuj). Instructions to mobilise a logistics ERU were issued by Geneva on 29 January, and the Team Leader with the BRC logistics ERU equipment left London on 31 January, arriving in Bhuj with a BRC chartered cargo-flight at 0430 (gmt) on 2 February. The full team was in place by 4 February.

The BRC logistics ERU comprised of two persons from BRC, and one person from the Danish Red Cross. With the arrival of a Federation commodity-tracking delegate on 5 February, the logistics team in Bhuj totaled five persons (3 x ERU team members, 2 x Federation logistics delegates). In addition, the action was supported by two logisticians in Ahmedabad (warehousing, procurement), and two in New Delhi (procurement, flight coordinator).

From the moment the ERU arrived adequate reporting and control of the arrival and warehousing of the relief goods fell into place. The ERU’s communications equipment allowed the logistics team to have access to pertinent information concerning flight schedules and obtain the necessary clearances for incoming goods. Logistics teams, in addition to the ERU, were also based in Delhi and Ahmedabad. The ERU was handed over to the International Federation on 11 April.
The table reflects the status of goods at close of Federation relief activities as of 15 May

<table>
<thead>
<tr>
<th>Updated summary table</th>
<th>Appeal target</th>
<th>Unit</th>
<th>Total received</th>
<th>Total Dispatched</th>
<th>Stock</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blankets</td>
<td>210,000</td>
<td>Pcs</td>
<td>230,278</td>
<td>228,724</td>
<td>1,554</td>
</tr>
<tr>
<td>Tarpaulins</td>
<td>118,000</td>
<td>Pcs</td>
<td>110,323</td>
<td>110,209</td>
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<tr>
<td>Cholera kits</td>
<td>Kit</td>
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Appendix II: Health Programme in Gujarat Earthquake Rehabilitation
Madeleine Pousette

One of the main programmes in the Rehabilitation Appeal is the Integrated Health Programme. The overall goal of this programme is to support the government authorities in reducing the degree of vulnerability of the people living in the earthquake affected areas. The programme comprises five inter-related projects:

- Community based health project
- Reconstruction of health facilities
- Water and sanitation
- Psychological support
- Prosthesis project

A national health component was later included into the earthquake rehabilitation operation as part of the Integrated Health Programme.

1. Community Based Health Project (CBHP)

The stated purpose of the Community Based Health Project is to support the Gujarat authorities in safeguarding the long-term health of around 500,000 people in approximately 400 villages in the districts of Kutch, Surendranagar, Rajkot and Jamnagar as well as in the town of Bhuj with a specific emphasis on the most vulnerable (mother and children) in order to reduce the Infant Mortality Rate (IMR) and Maternal Mortality Rate (MMR).

The Project is made up of four different training components:

1) Training of Red Cross field workers and volunteers
2) Training of Traditional Birth Attendants
3) Training of grass-root level (Anganwadi) workers
4) Child-to-child initiative

The Project is implemented by the Federation in cooperation with the IRCS. Bilateral Participating National Societies, such as the Spanish and the American Red Cross Societies have adopted the programme with small variations according to their capacities, the American Red Cross working with the IRCS branch in Patan to implement the activities in Patan, Banaskantha and Mehsana, the Spanish Red Cross working with the branches in Bhachau and Gandhidham.

Training of Red Cross field workers and volunteers

One of the components in the CBHP is to support the Gujarat health authorities in the training of community-based health workers (Red Cross field workers and volunteers).

The training of volunteer trainers (Red Cross Field workers – RCFWs) started in June 2001. Possible candidates were interviewed and 23 were selected from different parts of
Kutch district. The curriculum for the training, developed by representatives from the IRCS and the Federation, includes fundamental principles of the Red Cross Movement, community based first aid, basics in community health, community approach and community involvement. In addition, the field workers have later participated in training in disaster preparedness and psychosocial support as well as in HIV/AIDS awareness. Every field worker receives a certificate after completed training. When the evaluation team visited the project, more than a hundred field workers had been trained.

Due to shortness of time and long distances, the evaluation team did not have the possibility to visit any of the villages, to take part in training sessions or to get a feedback from the volunteers. However, to get a picture of the RCFWs perception of the training course they received and their field experience, the evaluation team interviewed 24 field workers from three different districts. The field workers stated that the training course was valuable and useful. None of them has any medical background. More or less everything in the training course was new and the knowledge of the field workers increased significantly.

After completed classroom training, each field worker is assigned 20 villages. They start their work by visiting the villages making contacts with significant persons (community leaders, anganwadi workers, teachers and primary health care staff). They collect data about health problems and health structure in the villages. Together with the community, they identify one volunteer in each village for training. All RCFWs experience that it took a long time to get the confidence in the community. In the beginning, neither the villagers nor the local health authorities had a clear picture of the role of the Red Cross. By now the field workers feel they are appreciated by both the communities and the health authorities.

The volunteer gets a three days training about the Red Cross Movement, community based first aid and basics in community health. Progress in the training of RCVs is well on truck. The intention was to train 1,500 volunteers over a three year period. To date more than 1,300 RCVs have been trained and it is most likely that the target will be reached in a near future, maybe already by the end of this year. Year 2003 will be reserved for supervision and follow-up on the volunteer work in the field. The RCVs will gradually take over the current responsibility of the field workers in the villages. The number of RCFWs has already been scaled down (around 38 today). Every volunteer gets a certificate and a first aid kit after completed training.

The RCVs are motivated to learn and enthusiastic. Pre-post tests show that their knowledge has increased. The trained volunteers, with regular support from the field workers, provide community based first aid and assist in raising the consciousness and awareness of the population of health-related problems. Cooperation at village level is good with health authorities, local NGOs and international agencies. The RCFWs and RCVs assist with activities such as dissemination of health related information, identifying cases of malnutrition, promotion of immunization campaigns and prevention of common diseases. They cooperate with the health authorities in spreading information about HIV/AIDS and sexually transmitted diseases. The RCFWs regularly participate in health coordination meetings in the PHCs in their respective taluka (sub-district).
Twenty RCFWs volunteered to help the IRCS in the relief camps in Ahmedabad under the communal unrest in Gujarat in February 2002. They were responsible for distributing relief items, conducting water/sanitation/health assessments in the camps, recruiting and training volunteers drawn from the camps, putting into good practice lessons learned from the earthquake rehabilitation operation. During the annual festival of Navratri, field workers along with volunteers set up five 24-hour first aid posts along the pilgrim route. At least 593 first aid treatments were registered by one post alone. The Red Cross involvement in this annual pilgrimage has been widely reported in the local newspapers. This has reinforced the motivation of both the field workers and the volunteers.

One concern, though, that was raised by the RCFWs is the area of coverage. The fieldworkers felt that the area of coverage was too large. One reason for this is the long travel distances. With fewer villages there should be more time for follow-up of the activities of the volunteers.

Following the Community Based Training Curriculum developed by the IRCS/IFRC, the American and Spanish Red Cross have duplicated the initiative in various talukas in Gujarat. The Spanish Red Cross started RCV training in May 2002, with the support of nine RCFWs previously trained by and working under the supervision of the IRCS/IFRC. The American Red Cross is operating the community based health programme in Patan and Banaskantha.

**Child-to-Child initiative**

The basic philosophy behind the Child-to-Child initiative is to increase the knowledge of health and hygiene issues in primary-school aged children, especially in rural and remote parts, encouraging them to promote health and hygiene practices in their homes and in the community.

Eleven trained RCFWs from Kutch were selected to participate in a pilot study of the child-to-child health initiative in 12 selected primary schools. They attended a workshop at the CHETNA training institute in Ahmedabad. Since January 2002, the field workers have made weekly visits to the schools activating some 700 students on health topics with role plays, drawings, songs, games, etc. Post-tests carried out in March showed an increase (from 43% to 64%) in health knowledge of the students. The pilot study completed in April and based on the success of the initiative, it was decided to integrate the initiative into the RCFW activities. Due to summer holiday, there was a break in the training and in November the programme had not yet restarted.

**Training of Traditional Birth Attendants**

Training of Traditional Birth Attendants (TBAs) has little direct relevance to the earthquake. Given the high infant and maternal mortality rates in Gujarat mostly related to misconceptions about deliveries and traditional practices of TBAs, there certainly is a need to upgrade the knowledge and skills of TBAs. Most of the deliveries in villages in Gujarat are conducted by TBAs. This tradition has been followed for many centuries. Except from conducting deliveries, TBAs also advise on reproductive health issues, breast-feeding, infant care and child rearing practices. The TBAs act as a link between the village women and the local health services. Many of the TBAs are illiterate with no
formal education, they learn midwifery by watching or assisting other TBAs. Some TBAs have received a few days training as part of the government Family Welfare Programme. However, there is no effective system for follow-up after the training, for refresher courses or for replenishing their kits periodically.

The IRCs/IFRC training project is intended to assist the Gujarat government in decreasing the infant and maternal mortality rates in the districts included in the project. The project is designed to take place in two steps. First the trainers (local Gujarati nurses) are selected and trained. After completed training the nurses approach the villages and strat the training of TBAs.

The training curriculum was developed in October 2001, by the IRCs/IFRC in cooperation with the Principal of the Nursing School in Bhuj. The curriculum covers a training period of three weeks including one week institutional classroom training, one week practical training in a delivery room and maternity ward of a hospital, and one week practical training in the nearest Primary Health Care Centre (PHC), Sub Centre, Anganwadi and the trainees own village. The curriculum was tested and developed at seven consecutive training courses in four different PHC catchment areas in Kutch during the period October 2001 to February 2002. The result from pre- and post tests were encouraging, the knowledge of the trainees increasing from 30% to 60%.

The training programme is proceeding well in terms of number of trained. The initial plan for 2002 was to conduct training for a targeted number of 225 TBAs in Kutch and 100 TBAs in Rajkot. In November 2002, this number had already been exceeded (338 trained). The target for year 2003 in the two districts is 450. For Jamnagar and Surendranagar the target is 300. The total target for the TBA programme is around 1,500 trained TBAs.

The evaluation team was not able to visit the villages but interviewed two TBA trainers in Bhuj. They expressed their satisfaction with the training course. After completed training, the trainers receive a written training curriculum to guide them in their work. The majority of the TBAs are elderly women, some of whom can neither read nor write. Consequently the nurses have to work closely with individuals to make sure that knowledge is conveyed. For the most, the TBAs have been very receptive to training. They learn about antenatal care, labour and delivery, care of the newborn, postnatal care and infant care. They learn how to advice about family welfare, sexually transmitted diseases and HIV/AIDS. Each TBA is provided with a TBA kit. After completed training, the work of the TBAs is closely followed up. Results to date have been positive (no specific figures about impact available). There has been a close cooperation with both government health staff and with other agencies.

The American Red Cross is in the process of identifying key local government and NGOs whose cooperation are needed to identify and train trainers of trainees to conduct the TBA training in Patan. The Spanish Red Cross is currently undertaking assessment and planning of the TBA initiative in Rapar taluka.
Training of grass-root level (Anganwadi) workers

The most basic level of the Indian Health Care System is the Anganwadi Centres, under the Department of Family Planning. These community-based centres are providing health services to children under the age of five years, pregnant women and lactating mothers. Theoretically, there is one Anganwadi Centre for a population of approximately 1,000 people. The centre is staffed by a worker who has received a limited basic training. In addition to day-care type activities, the Department of Women and Child Development utilizes these centres for the Integrated Child Development Services (ICDS) Program which provides a package of benefits to children comprising supplementary nutrition, immunization, health checkups and referral services as well as nutrition and health education for pregnant and lactating women.

Already prior to the earthquake, the Anganwadi Centres were not meeting their mandate. Attendance by mothers was poor. One reason for this was that supplementary food packages were provided only on a sporadic basis. Another reason was that the worker in charge for the facility was poorly trained. The poor attendance resulted in many children not being immunized. After the earthquake, the already fragile system changed for the worse.

In March 2001, a nutritional survey was conducted by the IFRC in cooperation with the World Food Programme, Save the Children and Oxfam. The results of the assessment generated recommendations aimed at supporting the ICDS. Following the recommendations, IRCs/IFRC in cooperation with the WFP, Save the Children and UNICEF made an agreement with the Government of Gujarat (GoG) to assist the authorities in planning and funding a training programme to Anganwadi workers run by the National Institute of Public Cooperation and Child Development. The project is designed to take place in two steps. First trainer of trainees (local medical officers, child development project officers, female health supervisors and Red Cross field workers) are trained in different sub-districts. After completed training, these are responsible for the training of Anganwadi workers.

After six months of planning, a needs assessment workshop was arranged in October 2001. Based on the findings from the workshop a curriculum was developed. The responsibility for the training was divided between the participating organizations. The IRCS/IFRC is responsible for training in five sub-districts. Since December 2001, four training of trainers’ workshops have been arranged for 30 Red Cross field workers. The initial plan was to train 400 Anganwadi Workers (AWWs), 400 Anganwadi Helpers (AWHs) and 200 Auxiliary Nurse Midwives (ANMs) during 2002. The training started after some delay in August 2002 and by October a total of 87 AWWs, 57 AWHs and 8 ANMs have been trained.

The evaluation team visited one Anganwadi Centre in Rajkot. However, due to an ongoing polio immunization campaign there were no activities going on in the centre. The team was told that this was the case in most of the centres during the campaign.

2. Construction of health facilities

After the earthquake, there was an urgent need for reconstruction of health facilities, as most of the health facilities in the affected area, including Anganwadis, Sub Centres,
PHC Centres, Dispensaries and Hospitals had been either destroyed or severely damaged. Many of the activities provided by these facilities had come to a stop. Already in an early stage of the relief phase, there was a strong interest from the Indian government side to ask for assistance in reconstruction of health facilities. After the Partnership Meeting in March 2001, there was also a pressure from donor Red Cross Red Crescent partners to be involved in reconstruction.

The stated objective for the IRCS/Federation Reconstruction Project was to assist the Gujarat authorities to reconstruct health care facilities in allocated areas covering some 400 locations, assisting some 500,000 people. In line with the objective and based on information from the GoG, the initial plan was to construct 600 Anganwadis, 121 Sub Centres, 23 PHC Centres, 11 Dispensaries and 100 Red Cross rooms in selected affected villages as well as a temporary prefabricated hospital on the same site as the tented Red Cross field hospital.

**Construction of the prefabricated hospital**

One of the key elements of the IRCS/Federation emergency relief operation in Gujarat was the tented ERU hospital in Bhuj. After the emergency phase, the hospital was gradually integrated into the local health system. The expatriate staff acted as facilitators, supporting but not actively intervening in the clinical and nursing activities. The formal handover of services (including equipment and consumables) to the government took place in April 2001. From this date, the GoG has had the operational responsibility and control concerning the daily hospital activities. As the construction of the government permanent hospital was not completed, an agreement was made that a temporary hospital was to be constructed by the IRCS/IFRC.

The plan for design and construction of the temporary prefabricated hospital was proposed in June 2001. The construction work started in September and was completed in March 2002. After the hospital services, equipment and consumables were transferred from the tented hospital to the prefabricated hospital, the prefabricated hospital was fully handed over to the health authorities in April 2002. The construction of the government hospital is scheduled to be completed in January 2003. The future of the prefabricated hospital after this is still open.

The evaluation team visited the prefabricated hospital in Bhuj. The facility included an outpatient department, an emergency department, an intensive care unit, three operation theatres, ultrasound and X-ray rooms, a blood bank, a laboratory, a pharmacy, obstetrics and neonatal facilities and wards as well as support services. There are 204 hospital beds. Statistics on outpatient and inpatient visits show that the hospital is in frequent use. The hospital service is free of charge. Being the only public hospital in the district, it is accessible to all people in the district including the most vulnerable. The catchments area is 1.5 million people. The set-up of the hospital follows the common Gujarat standards. One room in the hospital has been assigned to IRCS training and other activities.

After less than a year in use, the facilities already need some repair. Assistance has been asked from the IRCS and the Federation. However, according to the hand over
agreement, the responsibility for maintenance of the facilities was handed over to the health authorities in April 2002.

Construction of other health facilities

Following an assessment of structural damage of the health facilities in the targeted area, the number of facilities to be reconstructed changed from the initial plan. Only those that were completely destroyed or so badly damaged that they were unsafe to use were included in the project. It was decided that some 160 health facilities were to be reconstructed, most of which are Anganwadis – in Kutch, Rajkot and Surendranagar.

Right from the beginning there was a delay in selecting a civil engineering and project management firm due to a difference in opinion between the Federation and the IRCS. The Federation was considering using an international consultant but the IRCS preferred the use of a national firm. The Federation’s construction programme coordinator arrived in the country mid-August 2001 to identify and select a project management firm.

Finally, a Delhi based firm was contracted to oversee the project.

Obtaining government approvals turned out to be both complicated and time consuming. The Ministry of Health (MoH) requires a four phase approval process for health facilities constructed as part of the earthquake rehabilitation programmes. MoH guidelines require government approval to assure designs are earthquake and cyclone proof. Still in May 2002, the project management firm was working to obtain the required governmental approvals for the selected sites. The IRCS Honorary Secretary of the Gujarat State Branch has had the lead role in obtaining the government permissions.

The construction work in Kutch, Surendranagar and Rajkot started in May 2002. Contractors were selected to construct 26 Anganwadis in Kutch, 81 Anganwadis in Rajkot and 8 Sub-Health Centres in Surendranagar. However, shortly after starting the construction work, all programmes in Gujarat were suspended due to political tensions between India and Pakistan. Due to security reasons, the Federation evacuated construction and other delegates and temporarily closed the field office in Kutch. The office was reopened in July and the reconstruction coordination office was moved to Rajkot in August.

The initial complexity in obtaining government approvals, the six-month communal violence across Gujarat starting in February 2002 and the heightened cross border tension during June 2002, aggravated by contractual issues over a disqualified contractor for Kutch anganwadi sites and the monsoon rains all caused the reconstruction project a few months delay. After that, the project has gathered its momentum.

The construction work in Rajkot district is progressing well. Three contractors are working with 30 anganwadi sites out of which 13 have been completed. The next 14 are planned to be completed in December 2002. Another 30 sites will be started in November 2002. In Surendranagar district, the construction of 8 Sub-Health Centres are in progress, of which 5 are scheduled to be completed in December 2002 and the remaining 3 in January 2003. The plan is to further construct 10 to 15 Anganwadis as soon as funding is available from the German Red Cross Society. The land approvals have been obtained and the sites are ready for construction. In Kutch district, the construction of 26
Anganwadis started in May 2002, but due to bad performance of the contractor and bad quality of work, the contract was terminated in June. In August the dispute was settled. The construction of 3 Sub-Health Centres will start as soon as the land problem is resolved. The progress of the IRCS/IFRC construction work is presented in table below:

Table  Summary of construction progress to date (IRCS/Federation)

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<th>Type of Health Facilities</th>
<th>Rajkot</th>
<th>Surendranagar</th>
<th>Kutch</th>
<th>Total planned</th>
<th>Completed to date</th>
<th>In progress</th>
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<td>11</td>
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<tr>
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<td>13</td>
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<td>82</td>
<td>26</td>
<td>40</td>
<td>148</td>
<td>13</td>
<td>135</td>
</tr>
</tbody>
</table>

Source: Reconstruction of Health Facilities – Monthly Progress Report October 2002 (IRCS/IFRC)

The British Red Cross is working with the IRCS Gujarat state and Jamnagar district branch in the district of Jamnagar on building 60 Anganwadis and 2 PHC Centres. The construction of 3 Anganwadis has been completed, whereas 57 are under construction. One of the two PHC Centres is nearly completed. Anganwadi based community development activities have started in the community. The British Red Cross Desk officer visit the project in September seeking possible integration with the IRCS/Federation supported community based health activities in Jamnagar. The cooperation between the community development project and the IRCS/Federation field worker activities in the district has been good. The Spanish Red Cross/IRCS plan to construct 62 Anganwadis during 2002 in Bhachau, of which 40 are in progress.

3 Water and Sanitation

The earthquake struck in an area with long-term water problems. Gujarat State is particularly prone to prolonged drought which has had a negative impact on the agricultural production, on the overall livelihood of the population as well as on the public health in the local communities. Reliance in recent years by villages upon government provided bore wells and piped and tanked networks has led to the neglect of more traditional water collection and preservation in rural areas.

The earthquake damaged or destroyed water-sanitation systems exacerbating the already existing water problems and increasing the population’s vulnerability to waterborne diseases. Three of the top causes of morbidity in Gujarat, namely diarrhea, skin diseases and conjunctivitis, are all diseases that are related to failure in promoting safe water supply and healthy hygiene practices.
Initially the IRCS/Federation Water-Sanitation Project was intended to assist the government to restore, improve or rehabilitate the water and sanitation environment in 400 villages assisting 500,000 beneficiaries. Almost from the start of the Red Cross Red Crescent emergency relief operation, a key component was an extensive water-sanitation programme. Through 2001, some 300 dams were completed, 41 wells constructed, 75 tanks rehabilitated/built, 74 toilet cubicles and 34 washrooms constructed and over 150 garbage bins were being emptied.

Community awareness training has been undertaken, focusing on health/hygiene education at the grassroots level. The health and hygiene awareness teams initially formed during the second half of the relief phase were originally responsible for disseminating information about the importance of proper hygiene. For the majority of the villages, these were the first contact with the IRCS and the Federation. The presentations, which were targeted towards women and children, were also intended to create awareness at the community level about possible alternative resources for water.

By August 2001, the health and hygiene awareness team had visited 135 villages and distributed 13,200 neem trees and buckets, and 385,000 chlorine tablets. A total of 14,500 children and 7,000 women had benefited from the activities. The teams, building on relationships in the villages, were gradually given responsibility for overseeing village projects, such as the building of tanks, tap stands, shallow wells, latrines and hand pumps. Work began on organizing the installation of various types of water containment/sanitation facilities in the villages, many of which had benefited from the dam rehabilitation programme. The process for deciding upon appropriate facilities started with a meeting with the village leader. Using an assessment questionnaire developed by the Federation’s water and sanitation delegates, discussions were held with the leader about the general water situation in the village. The assessment took into consideration the extent of earthquake damage, population, incidence of disease, source of income and willingness and capacity to participate in the project. In addition to speaking with the leader of the village, village women were consulted. According to the members of the teams, information from women is much more detailed and specific as the women are responsible for collecting the water for the household, washing, cooking etc. Depending on the result of the assessment, a proposal was made for project implementation. Each project has been implemented using a community participation approach (local contractors and labour).

Towards the end of 2001, it became clear that the water and sanitation project had become overstretched financially and a temporary halt was called. At the Partnership meeting in early December, the Federation undertook to carry out an operational review of the water-sanitation component as the basis for planning for the future. Meanwhile, a request to PNSs in January 2002 for further indications of funding levels for water-sanitation drew a very limited response. A small crew of national staff assumed the responsibility for running the project in Kutch and Rajkot until April 2002, when the whole water-sanitation project was brought to a complete due to shortfall of funding. In the middle of April, the water-sanitation community awareness teams were integrated into the field health programme.
At the end of 2001, based on an assessment, the IRCS/IFRC started rehabilitating dams in Patan, Banaskantha and Mehsana. From January 2002, the American Red Cross (AmCross) was assumed total responsibility for the water-sanitation activities in these areas. The purpose of the AmCross 3 year water-sanitation project is to improve longer term water availability through community-based watershed management and water harvesting initiatives. Until date, 57 ponds have been rehabilitated in Banaskantha and Mehsana. The construction work is followed up with community awareness activities.

4. Psychological Support

Loss of lives and livelihood was not the only suffering by the earthquake. Stress-related mental health problems were also widespread. In the emergency phase, the American Red Cross (AmCross) provided psychosocial support to earthquake victims and relatives. In April 2001, Amcross sent an representative to work on a project proposal on recommendations prepared in the relief phase. The proposal was rejected by the Federation Secretariat as over ambitious. The programme was redesigned and included into the rehabilitation appeal.

The intention of the Psychological Support Project was to provide psychological support to the population affected by the earthquake to deal with the long-term mental health of the earthquake victims. A range of measures was to be taken in order to help those suffering from psychological problems to recover. A need to increase the capacity of the Indian Red Cross Society to offer psychological support to the survivors and to meet the occupational stress management needs of the its staff and volunteers was identified.

As late as October, two AmCross delegates arrived with the intention to develop programmes for Gujarat. In January 2002, it was desided that a new assessment was to be undertaken prior to any project implementation. Since then, limited progress has been done. The results of the project to date comprise of psychosocial orientation to Red Cross fieldworkers. In regard to the communal violence in Ahmedabad, a brief training on psychosocial first aid and self care was conducted. A number of trained workers volunteered to assist in the relief operation in Ahmedabad and support was given to them. Meetings were also held with workers from other agencies operating in Ahmadabad to share information about psychosocial worker orientation and worker self care. Following the departure of the psychosocial delegate in April 2002, the project is on hold until a new delegate arrives.

The IRCS/AmCross have been part of a “Gujarat Collaborative” comprised of all NGOs, government agencies and other organisations delivering supportive psychological services to the earthquake affected areas in Gujarat. The IRCS/AmCross have been acknowledged as the coordinating agency for psychosocial programming.

5. Prosthesis Project

Already prior to the earthquake, the IRCS Gujarat State Branch was running a rehabilitation centre in Ahmedabad, consisting of a prosthesis workshop producing thirty
prosthesis items per month and a physiotherapy department. Although in function, the machinery, tools and furniture of the workshop was old and outdated. The workshop was also in urgent need of production materials. As a result of the earthquake, the rehabilitation centre suffered severe damage. At the same time, the number of people in need of prosthesis increased considerably. The purpose of the Prosthesis Project is to rehabilitate and expand the Gujarat State Branch run orthopaedic workshop in Ahmedabad.

The evaluation team was not able to visit the project, thus the findings are based on situation reports. The German Red Cross bilateral project started in August 2001. Since then, the project has been proceeding well. In February 2002, around 40% of the construction work was completed. The German Red Cross has funded major structural repairs to the workshop together with equipment update and staff training. The renovation work and installation of equipment were completed in July 2002, a few weeks later than planned due to the communal unrest. The compound was handed over to the Gujarat State Branch. The company that delivered the equipment will provide free training to the entire staff. Another company has been contracted to perform an operational consultancy for the workshop for six months. A final project review is planned to be taken by German Red Cross in January 2003.

6. IRCS National Health Project

Originally envisioned as part of the capacity building programme, the main emphasis of the National Health Project is to improve the capacity of the IRCS in health (disaster preparedness) and to increase the IRCS ability to provide relief health (disaster response). The IRCS has defined the priorities for nation wide health activities as being: CBFA, emergency health and HIV prevention. The main components of the project include training of community health workers, emergency health training, establishing a health database and carrying out a health review. The national health component has been included into the earthquake rehabilitation operation as part of the Integrated Health Programme and the activities started in September 2001.

In Gujarat, CBFA and emergency health have been part of the CBHP. In addition, HIV/AIDS awareness has been included in the training of TBAs and RCVs. At the World Aids Day in December 2001, 25 RCFWs and a Federation health delegate participated in a public education rally about HIV/AIDS. Manuals developed in Gujarat for health related training initiatives, such as TBA training and CBFA training, are being translated and used for national training.

At national level, a workshop on public health in emergencies – a joint endeavour of the IRCS, the Federation and the PNSs was held in New Delhi in September 2002. The overall goal of the workshop was to improve health response in disaster prone states and to achieve a better outreach to vulnerable communities during disasters in India. The workshop was attended by doctors, nurses, pharmacists and community based health volunteers with previous experience of working with IRCS during disasters.
The Secretary General of IRCS has approved the position of a CBFA training coordinator in the IRCS NHQ. The position funded by the Federation will be responsible for supervising all the health training programmes across the country and, applying the Gujarat model, for developing and revising training materials accordingly. Following the participation in the CBFA training in Gujarat in August, IRCS Bihar State Branch has initiated preparation for CBFA training in districts in Bihar.

7. Rehabilitation/Shelter Programme

Following the earthquake, both private houses and schools suffered considerable damage. In March 2001, at the Partnership Meeting in New Delhi, it was decided that a consortium of Red Cross partners from Austria, Belgium and Germany (the Consortium) were to undertake a private housing project. A joint assessment was conducted and based on the findings; the consortium developed a detailed project proposal and implementation strategy. The main target groups are the villagers whose houses collapsed or suffered irreparable damage. The project is intended to provide each selected family with a basic earthquake resistant housing unit, through technical and material support for reconstruction of houses. The families and individuals selected to participate in the project are responsible for providing the labour to erect the houses. The project focuses on the Surendranagar district. The target for the private housing project is to reconstruct basic housing for 1,300 families. The project started in June 2001 and in the first phase 561 houses have been completed. The second phase of the project aims at supporting 350 families.

The Italian Red Cross has constructed three primary schools in Bhuj taluka in three villages. The schools were completed and handed over to the government in February 2002. The IRCS and the Federation supplemented the project by initiating child-to-child health care activities in the villages where the school children live and were the schools were built.

Relevance of the Integrated Health Programme

Immediately after the earthquake, an assessment was undertaken by the IRCS and the Federation identifying needs and priorities in the earthquake affected communities. The earthquake had not only an immediate negative impact on the public health of the population it also contributed to more long-term health problems. The Integrated Health Programme responds well to the basic problems and needs identified. The IRCS/IFRC activities are complementary to many efforts realised by the GoG as well as by other national and international agencies.

The programme is designed to reach the most vulnerable population groups in the earthquake affected communities. It mainly targets the population in rural areas, already neglected and marginalized before the earthquake. Priority is given to women and children. Special emphasis is given community based health programmes.

After the earthquake, the government structure was weak on community based health education and easily accessible first aid services. Three of the leading causes of morbidity in the villages, namely diarrhoea, skin diseases and conjunctivitis are all diseases that can
be prevented. One of the leading causes of death in India is related to accidents and injuries. The Community Based Health Project has been designed to help the communities develop village based resource persons who can provide community based first aid services and training and who can support both formal and informal care providers at the community level in health prevention and promotion. First aid is a proven cost-effective, safe and simple way to save lives in an emergency. It can be used as entry point for disaster preparedness and health education projects. First aid as well as hygiene and primary health care education are traditional Red Cross activities.

One of the major goals of the Department of Family Welfare within the MoH is to reduce the IMR and MMR in India. To reach this goal, various government programmes targeting Maternal and Child Health are underway, some of them supported by international agencies. Red Cross Red Crescent Societies has been supporting and implementing health initiatives related to reproductive health and mother and child care for over 20 years. Both the training of community based volunteers, the training of TBAs, the training of Anganwadi workers and the Child-to-Child initiative will substantially contribute to the effort of the GoG to improve the situation of mothers and children in the earthquake affected villages.

The Community Based Health Project integrates with the construction and water and sanitation initiatives. After the earthquake, the majority of health facilities in the affected districts were destroyed, thus threatening the provision of adequate long-term health care to the population. Water and sanitation systems were damaged or destroyed. The GoG launched a massive reconstruction and rehabilitation programme to improve the infrastructure in the areas of health, sanitation and water supply as well as housing. It welcomed and invited both national and international actors. Many organizations showed their interest to assist in rebuilding the infrastructure. Temporary facilities are under construction by, for instance, UNICEF and Save the Children Fund, but few organizations have been invested in a long-term permanent infrastructure. The IRCS/IFRC as well as the IRCS/British Red Cross Society construction projects contributes to the efforts of the government to rebuild a permanent infrastructure.

Many people in the earthquake affected areas have undergone psycho-social trauma as a result of loss of family members, relatives, friends, neighbours, and the destruction of homes and livelihood. Trauma counselling started already in the relief phase by AmCross. The planned rehabilitation project should have been a relevant initiative supporting the government mental health system as well as initiatives taken by local NGOs and international organisations. However, the project never really started and is still on hold due to lack of human resources.

According to Federation thinking, rehabilitation programming should be used as an opportunity to further develop the National Societies’ own skills and capacities to better be able to respond to disasters in the future. Both the CBHP and the national health initiative will eventually strengthen the capacity of the IRCS to meet the needs of the population in future emergencies.

The Government of India has become increasingly aware of the importance of better preparedness for and response to natural disasters. It has intensified contacts with a
number of relevant international and national organizations, including the IRCS, acknowledging the need for support. Disaster response and disaster preparedness are within the sectors where the Federation’s experience and know-how is well known and recognized world wide.

**Programme management and coordination**

When the health initiatives started in May 2001, the Federation health team in the field comprised of a health coordinator and 2 health delegates based in Kutch. They started the planning of the CBHP together with a health representative from the IRCS NHQ. The health coordinator was responsible for overall management of the project as well as for keeping contact with health authorities and other organisations. An IRCS counterpart from Delhi, a St. John Ambulance First Aid trainer, together with the two Federation health delegates were responsible for the planning and implementation of training activities, as well as for follow up and supervision of the activities in the field. No counterpart from Gujarat familiar with the districts, traditions and language was available. This caused delays in the initial phase of the project implementation.

The plans for the CBHP were quite ambitious with four different training components in four districts. The original plan included one health coordinator and 2 health delegates in Kutch and 2 health delegates to expand the project to the three other target districts. Due to resource constraints the project only had a third health delegate for a short time. Still the field team was expected to expand its activities. From February to June 2002, there was only one health delegate in the project. The shortness of health delegates in the beginning of the implementation phase has been criticized by the members of the field team.

Today, the different projects within the Integrated Health Programme are coordinated from the Federation IOC within the IRCS NHQ complex and through field offices in Bhuj and Rajkot. In addition, temporary IRCS/IFRC site offices are established at three other sites to ensure effective monitoring of reconstruction activities. IRCS projects implemented in partnership with American, British and Spanish Red Cross and the Consortium are being supported from PNS offices in the IOC and field offices in Patan, Ghandhidam, Surendranagar and Jamanagar.

The overall coordination of the health projects is managed by a health delegate (expatriate), assisted by a health assistant (local) based in the IOC in New Delhi. The health team in the field comprises of two health delegates (expatriates), two health assistants (local), four senior supervisors (local), two nurses – trainers of TBAs (local) and 38 field workers (local). The health team is supported by finance/administrative staff.

In the beginning of the project, there was some confusion about reporting lines. The health coordinator was instructed to report to the Head of Sub-Delegation (HoSD) in Ahmedabad. In November, the HoSD resigned and until March 2002 there were no instructions about reporting lines, until it was decided that the health coordinator reports to the health delegate in IOC. Since then, the reporting line has been clear. At weekly reporting and follow-up meetings, the field workers and trainers of TBAs report about the
progress of their activities in the villages to the field health delegates. The field health delegates report monthly to the health delegate in the IOC. No quarterly or annual reports are prepared that could function as monitoring tool for continuous assessment of the interventions with regard to planned objectives, results, activities and means.

There has been a good coordination between the Red Cross Red Crescent group and other international agencies. The health delegate in IOC attends Inter-Agency meetings in Delhi to inform about the IRCS/IFRC projects and to coordinate the activities with other organisations. Close contact is maintained with the IRCS Deputy Secretary (Medical) at the NHQ level. At field level, representatives from the IRCS/IFRC have participated in health sector coordination meetings, chaired by WHO. These meetings are attended by representatives from different organisations with ongoing health related activities in the earthquake affected area. Cooperation between the agencies in field activities, such as campaigns regarding malaria and waterborne diseases and development of a training manual for Anganwadi workers, has been good.

Regular contacts have been maintained between the health delegate in IOC and the field. In the field, the Federation health delegates cooperate with the PNSs’ health projects. The cooperation between the RCFWs and the community awareness teams of the Water and Sanitation Project has been good. The RCFWs has been involved in the Construction Project in assessing sites for construction of health facilities in the villages.

**Sustainability**

Development of local institutional capacity is one of the crucial key issues of sustainability. Neither the state branch nor the district branches in Gujarat have had the institutional capacity enabling them to actively be involved in design and planning of the health projects. There has not been any counterparts from the district branches in the projects, the counterparts involved have been from the NHQ level. Hence, the ownership, defined as a commitment or active interest in the achievement of the project objectives, may be strong at the IRCS national level, but definitely needs strengthening at the state and district level.

During the implementation phase efforts have been taken to more and more involve the district branches in the activities. Today, the Federation field team is working with the branches in Rajkot, Jamnagar and Surendranagar. Until recently, the district branch in Kutch has been almost non-existing. The PNSs are working with the IRCS branches in their respective districts.

The local branches, however, presently still lack effective management and administrative systems, but developing these systems is one of the key outputs of the Federation rehabilitation programme. Several projects are going on and are planned to be phased out after roughly one year – the programme for strengthening the institutional capacity of the branches is in an initial phase. The continuation of the community based initiatives heavily relies upon the improved capacity of the district branches. One of the
key concerns for the sustainability at this stage is how the organisational development project will develop and facilitate the absorption of the initiatives.

The Code of Conduct of the International Red Cross and Red Crescent Movement and NGOs in Disaster Response Programme, principle 7 states: “Effective relief and lasting rehabilitation can best be achieved where the intended beneficiaries are involved in the design, management and implementation of the assistance programme. We will strive to achieve full community participation in our relief and rehabilitation programme”.

The Integrated Health Programme activities are a complement to the activities of government authorities. In the planning and the implementation of the programme, the IRCS, the Federation and PNSs have taken into account policies, standards and rehabilitation activities planned and implemented by the authorities. At field level, there has been a good cooperation with local authorities and the community in the implementation of project activities. However, in the design and planning of the projects, more could have been done to consult and engage local stakeholders.

India has a long tradition of active NGOs. During the last few years, the nature and scope of, for instance, the Government Family Welfare Programme has changed by progressively involving NGOs. This has proved to be a positive step since through the NGOs the government has been able to reach out far more effectively to people who need the programme the most. There are many indigenous NGOs involved in health in the post-earthquake environment. The IRCS/IFRC and field delegates could have more actively coordinated with these groups when planning and designing the projects, benefiting from their experience and knowledge of local socio-cultural situation. A more effective local partnership could have been developed to maximize efforts.

**Conclusions and recommendations**

After the devastating earthquake, the local health system was insufficient to meet the needs of its population. The Integrated Health Programme well supports the local authorities’ efforts to improve the provision of health services to the most vulnerable people in the earthquake affected area. The Programme is in line with current national policies and decisions. The activities undertaken are complementary not only to the government efforts but also to efforts realised by other donors and actors, national and international.

The Programme is compatible with Federation principles. In line with the *Post-Emergency Policy*, the Federation response has been targeting the most vulnerable people in the community. Special emphasis has been given to assist the government authorities in rehabilitation of community health support systems and public health infrastructure, water and sanitation systems and houses. The Programme follows the principles of the *Strategy 2010 for Red Cross and Red Crescent action* by supporting and building the capacity of the IRCS in the areas of health and care in the community and disaster preparedness and response.
As far as gender issues are concerned, all individuals regardless of gender benefit from the Programme. Through the activities targeting reproductive health special emphasis has been given to the health of women. Village women have been encouraged to participate in discussions and decision-making regarding both their own health and the health of their families. Most of the field workers and volunteers, however, are male which indicate a gender imbalance. If the project could include more women in these training activities it could at the same time promote the status of a large number of women in rural areas.

The training of the volunteers as well as the training of TBAs is proceeding well. It is most likely that the targets will be achieved. Pre-post tests show that the knowledge and skills of both volunteers and TBAs have increased considerably as a result of the training. Now an intensive follow-up and supervision of the activities in the field is crucial. At this stage, it is recommended that the project concentrates more on the follow-up and supervision of the activities rather than on the quantity of trained.

Neither the number of trained Red Cross field workers, volunteers and TBAs nor the number of constructed health facilities or water and sanitation facilities actually give any information about the impact on the most vulnerable people in the community. To be able to assess the impact on the beneficiaries there is a need for reliable baseline data and long-term follow-up on health indicators. Due to lack of relevant background data and a short project timeframe, it will be quite impossible to objectively measure long-term impact of the project. A mixing factor is also that many governmental, NGO and other donor programmes have the same development objective and similar purposes. The data from the baseline survey done on knowledge, attitudes and practices of Anganwadi workers and users can give some information when assessing the effectiveness of the community health activities.

The training of TBAs was the responsibility of the health authorities before the project started and will be the responsibility of the health authorities after the project phases out. New schemes in the government Reproductive and Child Health Programme are training of TBAs and outreach services for mother and child health. With the experience gained and lessons learned from the planning and implementation of the TBA training, it is recommended that the project take an active part in assisting the local health authorities in planning how these new schemes could be organised in the districts in the future.

The Community Based Project is quite large and ambitious, with four different training components in several districts. As the health initiatives are planned to be expanded to other states, it is recommended that the project starts in a smaller scale and then gradually expands according to capacities. It is also recommended that discussions are held with each state about which components should be included in the programme. Community First Aid and community health education are traditional Red Cross Red Crescent activities, but it is questioned whether or not training of TBAs is an activity that should be undertaken by the Movement.

The question of whether, and under which conditions, the Red Cross and Red Crescent Movement should get involved in housing and reconstruction programmes has been
discussed for a number of years both at the International Federation’s Secretariat in Geneva and among National Societies, and this question has been extremely actualised in regard to the India Earthquake operation. In the transition phase, construction proved a thorny issue. Representatives both from the Federation and the IRCS had reservations about large scale construction programmes. Whether this is a result of bad experiences from previous operations or a lack of capacities both at the Federation Secretariat and the National Societies can be argued. However, in some cases construction might be motivated but it has to be beared in mind that construction projects require long-term commitment and substantial funding as well as maintaining the completed projects. In regard to the construction project in Gujarat, maintenance of the health facilities will be a critical issue for the sustainability as the government maintenance budget for health facilities is relatively small. As neither of the members of the evaluation team has any experience in the field of construction, it is definitely outside the competence of the members to take a clear stand in this question. However, a separate review of experiences and practices in Federation construction projects during the last years could give valuable answers.

Regarding the Psychological Support Project, it is recommended that a reorientation of the project is made with new objectives, expected results, planned activities, means and time frame. As the time has passed since the earthquake, the initial needs and priorities of the beneficiaries have changed.

The Project has not been planned or implemented within the existing IRCS state or district branch environment. Being involved in the CBHP however, presents new opportunities for establishing branch engagement within the sectors of community first aid and community health. It is recommended that the health team takes an active role in assisting and supporting the branches in further developing these activities. As the project is planned to phase out in roughly one year it is recommended that a phasing out strategy is done with each branch already at this stage. Local counterparts in health should be appointed.

The International Red Cross/Red Crescent Movement is an humanitarian movement based on voluntary service. This is one of its Seven Fundamental Principles. A worldwide network of volunteers keeps the Red Cross/Red Crescent spirit alive. Volunteers are the Red Cross/Red Crescent’s interface with the community. The CBHP invests in human resources and capacities of the IRCS. Red Cross field workers and volunteers have been recruited and successfully trained. They are motivated and are well accepted in the communities. Retention of these field workers and volunteers is an issue of particular importance for the IRCS, the Federation and the PNSs.

It is assumed that the Programme will have long-term implications on the current IRCS in-house system and will facilitate better functioning of the overall IRCS network resulting in efficient management of traditional Red Cross activities, stronger volunteer recruitment and fundraising drives.
Appendix III: NGO Response to the Gujarat Earthquake Relief and Rehabilitation

In response to the earthquake, NGO’s commenced a monumental relief operation in the affected areas - probably the greatest-ever trial of their physical, moral and emotional strength. Janpath Citizen’s Initiative (JCI) was born as an emotional response to the disaster and as a coordinating group it included more than 200 NGOs and other members of the society who immediately started contacting aid agencies and Government for relief effort. Relief work took place in close coordination with the district administration, donor agencies, the Delhi Relief Group in New Delhi with its secretariat at Nirantar and the Bangalore Support Group in Bangalore with its secretariat at Human and Institutional Development Forum (HIDF). For the first time a disaster had opened a space for the civil society to be involved. The Delhi Relief Group in support of the Earthquake victims of Gujarat grew from a spontaneous coming together of groups on the 29th of January, as the magnitude of the catastrophe became apparent. They took over the task of mobilizing cash and material donations. The Bangalore Support Group comprised of professionals and NGOs and was involved in mobilizing cash and material donations. They regularly sent out updates on the relief being carried out in Gujarat and helped coordinate HAM radio and medical support. The Indians for Collective Action, an organization of non-resident Indians (NRIs), acted as a hub for information and rooted support of organizations/individuals from the US to JCI.

Navsarjan and Janvikas have been initiators and members of the core committee of JCI. Responsibilities were allocated to different members of the group. It was agreed that the Janvikas/Navsarjan team would act as the secretariat and be responsible for overall coordination of activities in support of the Abhiyan network in Kutch, while the Janpath team would link with organizations in Non-Kutch areas. However, much later Janvikas/Navsarjan also got involved in the relief efforts in Saurashtra. A 24 hours control room was established at the Janvikas office in Ahmedabad and in short, supply collection and supply lines were in place. The Janvikas control room was managed by staff of Navsarjan, Janvikas, Drishti, Anandi, Ideal, Aga Khan Rural Support Program, Swiss Development Cooperation, professionals from different parts of the country, volunteers from National Cadet Corps and HAM operators from Bangalore and Hyderabad. A steering committee to oversee finances monitored the financial situation on a daily basis. Kutch Navnirman Abhiyan – translates as “Kutch Rebuilding Campaign” and referred to as Abhiyan – is a network of 22 Kutch-based NGOs that came together following the 1998 cyclone to coordinate relief and rehabilitation work. Afterwards they stayed together to forge people-centred and people driven development of the district. Member priorities span various “issues” as women’s empowerment, handicraft, sustainable ecology, livelihood, water conservation, industrialization, health and education. After the earthquake Abhiyan did a rapid needs-assessment, and contacted Janvikas for support. Janvikas is a training and support organization, equipping groups to emerge as independent organizations. Besides this it is involved in enhancing capacities of personnel in development organizations, strengthening organizational systems, interfacing between government and NGOs and supporting the creation and functioning of networks on different issues. It is also working in the field of social justice, legal education and human rights, operating its programs through grass root as well as professional staff in various parts of Gujarat, Rajasthan and Maharashtra.
Navsarjan is a mass and membership based grass root organization, working in over 2000 villages spread all over Gujarat state with its primary focus on Dalit rights. It has a well defined ‘development agenda’, infrastructure in place and a range of activities in the social, economical and educational spheres. Due to its involvement and first-hand experience at the grass root level Navsarjan could easily take action when the earthquake occurred, ensuring that the relief operations would reach the most needy.

The main challenge was to set up systems to manage the chaos, and enable quick and organized responses, as supplies and donations were pouring in from all over the country, and volunteer teams, media people and donors were converging on Ahmedabad.

**Kutch**

There were morning and evening co-ordination meetings at the Janvikas control room to help the team share information and assure synergies between the activities of different ‘departments’. These meetings were never regular – the nature and pace of the work was not amenable to such systematization! Members of JCI suspended “normal” activities and professionals from the developmental sector were mobilized overnight. Throughout the period of relief, one or more JCI activists or Janvikas staff was always in Kutch – actively involved in strategizing, assessing needs and suggesting solutions. Reliable systems of communication between Abhiyan and Janvikas control room were set up within 24 hours. Before telephone lines and e-mail connectivity were restored, these teams were the only direct source of information for NGO support networks in other parts of the country.

At the same time in Kutch, Abhiyan members along with volunteers, formed into teams and fanned out to select routes to carry out firsthand assessment. This survey generated first-hand information on local needs, the first such list to be made available to the outside world.

Within ten days of the earthquake a preliminary survey of 360 villages was completed. A NGO desk was set up at the district collectorate and Bhuj airport. Ham radio units were made operational at Ahmedabad, Samkhiale and Bhuj, along with cell phone connectivity. The HAM radio teams – who came from Hyderabad and Bangalore on their own expenses - played a key role in keeping communication lines open between Kutch and the rest of the world.

A decentralized network of 22 sub-centres was initiated all over Kutch, each managed by senior workers of Abhiyan and other local NGOs. At the peak of the relief phase, the number of sub-centres increased to 33 supplying relief to 350 villages. Sub-centres were mandated to set up representative committees at the village level whose main function was to canalize the distribution of relief materials in co-operation with these centres. The sub-centres were also recognized by the Government as the official channel to route all information and assistance.

Another step in setting up the systems was a meeting chaired by the District Magistrate at the Abhiyan campus in the first week of February. This meeting focused on the need for
effective information sharing and efficient coordination between different agencies. It also formalized the sub-centers as nodal points for distribution and agreed on the need to begin thinking about long-term rehabilitation strategies. It was felt that focused discussions and planning in smaller thematic groups was needed to review the situation in depth and formulate long-term strategies. It was therefore decided to convene regular meetings for the sectors of shelter, water, health, child protection and primary education.

Non-Kutch Areas
Apart from the relief effort in Kutch, which got the most publicity, members of JCI also played key roles in rescue operations in Ahmedabad city. At a meeting called by ‘Gantar’ on the 27th morning, the city was divided into zones and different organizations took on the responsibility of coordinating search and rescue in each zone. In fact, it was a small group from JCI who facilitated and accompanied the work of the Swiss rescue team.

From the rural Non–Kutch areas there were requests to the Janvikas control room to send relief material. Local NGOs had done a damage assessment village wise either by the members of the organizations personally visiting the affected areas, or using the local administrative machinery to do the same. This helped in determining the immediate relief material required location wise.

Volunteer Management
Members of the Janpath Citizens’ Initiative suspended “normal” activities and went into high gear. Professional networks – built up over years of work in the development sector were mobilized overnight. Personal friends – often people who had never heard of Abhiyan, and who had no previous contacts with NGOs – came in (or were pulled in) to help with specialized tasks.

Addressing basic needs: Shelter

As winter peaked in February there was a very heavy demand for blankets and tarpaulins. 79,000 blankets and cheddars were dispatched from Janvikas control room out of which over 56,000 were sent to Kutch and 23,000 to Non-Kutch areas. Other items of basic need like tents, clothing, mats etc. were dispatched in the affected areas. Infrastructure to set up Abhiyan campus, which handled on average 200 volunteers a day, was also sent.

Food and Water

By the 31st of January, JCI and Abhiyan were able to identify the needs of the affected people and a plan was drawn out for preparing ration kits to serve a family of 5 persons for 1 month. During this period Abhiyan worked with the government to convince aid agencies to stop distribution of food items and focus their attention on enabling people to get back to work and use the wages for purchasing food items. This, it was felt, was a necessary first step in the rehabilitation process to restart the local economy and for people to start taking control of their lives again and getting on with their daily routine.
Health

A health desk was set up at the Janvikas control room by to respond to the medical demands coming from Abhiyan. With the help of volunteers from medical colleges sorting of medicines and surgical items was done and medical kits were prepared for the sub-centres of Abhiyan.

The health desk sent out a team, which visited the affected areas like Surendranagar, Morbi, Anjar, Bhachau and Bhuj for the assessment of first aid services of the injured and key suggestions were communicated to the health commissioner. It also observed the field condition for hygiene and sanitation to assess the possibility of epidemic. With the help of volunteer health teams from Gujarat and other states, primary health care services were provided and the reconstruction of temporary infrastructure for primary health care services was done. Medicines and surgical items were procured from all over the country.
Income & Expenditure statement of Janvikas/Navsarjan for the period from 27th January to 24th May 2001 for the Relief & Rehabilitation Operations. (In Indian Rupees)

<table>
<thead>
<tr>
<th>Income: Donations and Grants</th>
<th>55,110,052.33</th>
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</thead>
</table>

**Expenditure**

a) Contribution for Temporary Shelter
   - Building Material: 2,229,564.00
   - Blankets Expenditure: 3,945,353.40
   - Contribution for Temporary Shelter: 10,517,638.14

b) Ration
   - Food & Water Expenses: 11,526,588.65
   - Food & Other Expenses (Volunteers): 554,150.35
   - Water Supply: 332,727.16

c) Orthopedic Implants & Other Surgical Expenditure
   - Medical Expenses: 8,407.00
   - Orthopedic Implants & Other Surgical Exps.: 421,225.39

d) Transportation (Trucks, Vehicles): 2,629,053.70

e) Administration Expenses: 825,834.52

f) Campus Infrastructure: 161,712.50


g) Office Equipments – Abhiyan: 1,004,839.30

h) Personnel for Center Coordination: 261,630.00

i) Documentation & Data Collection: 50,030.00

j) Water Dowsing & Drilling Exps.: 941,117.00

**Total Expenditure for Relief**

35,409,871.11

Allocated & Earmarked Amount to Navsarjan for Rehab

9,242,580.57

Allocated & Earmarked Amount to Abhiyan for Rehab

8,727,526.61

Earmarked for Schools

300,000.00

Earmarked for KMVS

384,861.00

Earmarked for Staff of KMVS & Sahjeevan

556,887.97

**Balance**

488,325.07

**Commodities Distributed**

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<th>Product</th>
<th>Number</th>
<th>Product</th>
<th>Number</th>
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<td>Shawls</td>
<td>1950</td>
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<tr>
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<td>24632</td>
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<td>Water Tanks</td>
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</table>
From relief to rehabilitation

By 26th of February 2001 almost all the key partners in Bhuj agreed that it was now important to move from immediate relief to medium and long term planning for rehabilitation and reconstruction. Therefore on the 26th of February 2001 the relief period formally came to a close.

Hence the focus is now on sustainable development and medium- and long-term rehabilitation. Needless to say that the NGOs, which have played an important role during the relief phase, are more worried about the rehabilitation. In absence of concrete action by the State the affected are frustrated. Therefore Janvikas is supporting Abhiyan’s rehabilitation projects in Kutch district and is working jointly with Navsarjan in the Non-Kutch areas.

But rehabilitation extends beyond the reconstruction of houses and school buildings and must have its focus on the extremely poor and the issue of human rights. Hence, the look at rehabilitation in a broader way, that can encompass the wishes of the majority affected by the earthquake. In the long term social power and self-confidence of the community itself should be increased.

Abhiyan’s greatest strength is in its approach to disaster relief. It is based on a fundamental belief in self-help, confidence-building and enabling local villagers and communities to meet, plan, organize and implement their own relief and rehabilitation processes with facilitation from the Abhiyan network.

The strategies for rehabilitation have been worked out in consultation with a host of NGOs in Gujarat, donor agencies, district government administration, and in partnership with village level committees. It is a large-scale program consisting of:
• Construction of 20000 semi-permanent houses and 1600 permanent houses pre-monsoon.
• Construction of 11000 permanent houses post-monsoon.
• Establishment of 26 Sub-centers (Setus).
• Construction of schools.
• Repair of over 200 small and medium sized dams.

In the Non-Kutch areas Navsarjan and Janvikas are undertaking reconstruction programs covering 5500 families in the districts of Surendranagar, Patan, Ahmedabad, Rajkot, Bhavnagar, Mehsana and Kheda by providing seismic proof permanent shelters to the most marginalized communities. Training to 600 masons has taken place to insure community-driven rebuilding of the houses with the option of future self-employment. It also thrives to boost community activities that can bring about an atmosphere of hope and social harmony in such devastated villages. Accordingly, both organizations have come out with an action-program to construct Community Centers cum Balwadis (kindergartens) and Primary Schools in some of the villages. The Community Centers shall be owned and controlled by the most marginalized communities in the villages, especially Dalits and fulfill the following functions:

• Provide a platform to larger section of society to come together, interact and increase communal harmony. This might be in form of a meeting place, training centre, cooperative shop etc.
• Promote and enhance the existing organizational and promotional activities undertaken by such communities, especially women who have been running women’s organization and serve as their office and meeting place.
• Serve as Balwadis in the morning hours to provide an opportunity to children belonging to the poor and marginalized section of society who are un-cared as their parents are unable to provide them care at the cost of their own survival needs.

Rehabilitation Update in Kutch till August 2002

Health: This sector has focussed on orthopaedic rehabilitative care where around 14,000 injured patients received or are receiving on site and institution care. Over 52 organizations are currently active in the health sector, out of which 8 are involved in the medical rehabilitative care, 12 have been focussing on reconstruction of health infrastructure. Other interventions include provision of field level services, paraplegic care, physiotherapy, psychosocial support and food and nutrition support. The coordination has also opened avenues for capacity building of the government health workers and strengthening of the public medical services where organizations like IFRC, UNICEF, Save the Children, FICCI Care and others are involved in training of ICDS workers, TBAs, teachers and psychosocial support for children.

Out of the 29 primary health centers damaged only one was completed; out of the 34 dispensaries damaged only four have been completed and out of the 124 sub-centers damaged 65 have been completed and 29 are under construction. As regards hospitals, the Anjar and Mundra referral hospitals built by JICA has been completed; 500 bedded
hospital at Bhuj is expected to be ready by January 2003, reconstruction of Gandhidham hospital is under construction; Bhachau and Rapar hospitals donated by Gems and Jewellery group are expected to completed by January 2003.

**Water:** The recurrent droughts and the need for evolving sustainable mitigation strategies for addressing them is a major concern in Kutch. Currently 34 NGOs are active in this sector. Their activities focus on repairing water harvesting structures in which all the damaged 185 minor/medium irrigation scheme dams have been repaired. Theses dams will be taken up for permanent strengthening with seismic safe features by the end of the year. Out of the 468 small water storage structures, 372 have been repaired/reconstructed in 168 villages.

disaster and as a coordinating group it included more than 200 NGOs and other members of the society who immediately started contacting aid agencies and Government for relief effort. Relief work took place in close coordination with the district administration, donor agencies, the Delhi Relief Group in New Delhi with its secretariat at Nirantar and the Bangalore Support Group in Bangalore with its secretariat at Human and Institutional Development Forum (HIDF). For the first time a disaster had opened a space for the civil society to be involved. The Delhi Relief Group in support of the Earthquake victims of Gujarat grew from a spontaneous coming together of groups on the 29th of January, as the magnitude of the catastrophe became apparent. They took over the task of mobilizing cash and material donations. The Bangalore Support Group comprised of professionals and NGOs and was involved in mobilizing cash and material donations. They regularly sent out updates on the relief being carried out in Gujarat and helped coordinate HAM radio and medical support. The Indians for Collective Action, an organization of non-resident Indians (NRIs), acted as a hub for information and rooted support of organizations/individuals from the US to JCI.

Navsarjan and Janvikas have been initiators and members of the core committee of JCI. Responsibilities were allocated to different members of the group. It was agreed that the Janvikas/Navsarjan team would act as the secretariat and be responsible for overall coordination of activities in support of the Abhiyan network in Kutch, while the Janpath team would link with organizations in Non-Kutch areas. However, much later Janvikas/Navsarjan also got involved in the relief efforts in Saurashtra. A 24 hours control room was established at the Janvikas office in Ahmedabad and in short, supply collection and supply lines were in place. The Janvikas control room was managed by staff of Navsarjan, Janvikas, Drishti, Anandi, Ideal, Aga Khan Rural Support Program, Swiss Development Cooperation, professionals from different parts of the country, volunteers from National Cadet Corps and HAM operators from Bangalore and Hyderabad. A steering committee to oversee finances monitored the financial situation on a daily basis. **Kutch Navnirman Abhiyan** – translates as “Kutch Rebuilding Campaign” and referred to as **Abhiyan** – is a network of 22 Kutch-based NGOs that came together following the 1998 cyclone to coordinate relief and rehabilitation work. Afterwards they stayed together to forge people-centred and people driven development of the district. Member priorities span various “issues” as women’s empowerment, handicraft, sustainable ecology, livelihood, water conservation, industrialization, health and education. After the earthquake **Abhiyan** did a rapid needs-assessment, and contacted **Janvikas** for support. **Janvikas** is a training and support organization, equipping groups
to emerge as independent organizations. Besides this it is involved in enhancing capacities of personnel in development organizations, strengthening organizational systems, interfacing between government and NGOs and supporting the creation and functioning of networks on different issues. It is also working in the field of social justice, legal education and human rights, operating its programs through grass root as well as professional staff in various parts of Gujarat, Rajasthan and Maharashtra. Navsarjan is a mass and membership based grass root organization, working in over 2000 villages spread all over Gujarat state with its primary focus on Dalit rights. It has a well defined ‘development agenda’, infrastructure in place and a range of activities in the social, economical and educational spheres. Due to its involvement and first-hand experience at the grass root level Navsarjan could easily take action when the earthquake occurred, ensuring that the relief operations would reach the most needy.

The main challenge was to set up systems to manage the chaos, and enable quick and organized responses, as supplies and donations were pouring in from all over the country, and volunteer teams, media people and donors were converging on Ahmedabad.

**Kutch**

There were morning and evening co-ordination meetings at the Janvikas control room to help the team share information and assure synergies between the activities of different ‘departments’. These meetings were never regular – the nature and pace of the work was not amenable to such systematization! Members of JCI suspended “normal” activities and professionals from the developmental sector were mobilized overnight. Throughout the period of relief, one or more JCI activists or Janvikas staff was always in Kutch – actively involved in strategizing, assessing needs and suggesting solutions. Reliable systems of communication between Abhiyan and Janvikas control room were set up within 24 hours. Before telephone lines and e-mail connectivity were restored, these teams were the only direct source of information for NGO support networks in other parts of the country.

At the same time in Kutch, Abhiyan members along with volunteers, formed into teams and fanned out to select routes to carry out firsthand assessment. This survey generated first-hand information on local needs, the first such list to be made available to the outside world.

Within ten days of the earthquake a preliminary survey of 360 villages was completed. A NGO desk was set up at the district collectorate and Bhuj airport. Ham radio units were made operational at Ahmedabad, Samkhiale and Bhuj, along with cell phone connectivity. The HAM radio teams – who came from Hyderabad and Bangalore on their own expenses - played a key role in keeping communication lines open between Kutch and the rest of the world.

A decentralized network of 22 sub-centres was initiated all over Kutch, each managed by senior workers of Abhiyan and other local NGOs. At the peak of the relief phase, the number of sub-centres increased to 33 supplying relief to 350 villages. Sub-centres were mandated to set up representative committees at the village level whose main function
was to canalize the distribution of relief materials in co-operation with these centres. The sub-centres were also recognized by the Government as the official channel to route all information and assistance.

Another step in setting up the systems was a meeting chaired by the District Magistrate at the Abhiyan campus in the first week of February. This meeting focused on the need for effective information sharing and efficient coordination between different agencies. It also formalized the sub-centers as nodal points for distribution and agreed on the need to begin thinking about long-term rehabilitation strategies. It was felt that focused discussions and planning in smaller thematic groups was needed to review the situation in depth and formulate long-term strategies. It was therefore decided to convene regular meetings for the sectors of shelter, water, health, child protection and primary education.

**Non-Kutch Areas**

Apart from the relief effort in Kutch, which got the most publicity, members of JCI also played key roles in rescue operations in Ahmedabad city. At a meeting called by ‘Gantar’ on the 27th morning, the city was divided into zones and different organizations took on the responsibility of coordinating search and rescue in each zone. In fact, it was a small group from JCI who facilitated and accompanied the work of the Swiss rescue team.

From the rural Non–Kutch areas there were requests to the Janvikas control room to send relief material. Local NGOs had done a damage assessment village wise either by the members of the organizations personally visiting the affected areas, or using the local administrative machinery to do the same. This helped in determining the immediate relief material required location wise.

**Volunteer Management**

Members of the Janpath Citizens’ Initiative suspended “normal” activities and went into high gear. Professional networks – built up over years of work in the development sector were mobilized overnight. Personal friends – often people who had never heard of Abhiyan, and who had no previous contacts with NGOs – came in (or were pulled in) to help with specialized tasks.

**Addressing basic needs: Shelter**

As winter peaked in February there was a very heavy demand for blankets and tarpaulins. 79,000 blankets and cheddars were dispatched from Janvikas control room out of which over 56,000 were sent to Kutch and 23,000 to Non-Kutch areas. Other items of basic need like tents, clothing, mats etc. were dispatched in the affected areas. Infrastructure to set up Abhiyan campus, which handled on average 200 volunteers a day, was also sent.

**Food and Water**

By the 31st of January, JCI and Abhiyan were able to identify the needs of the affected people and a plan was drawn out for preparing ration kits to serve a family of 5 persons for 1 month.
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Documents Referred

Policies, Strategy and Codes of Conduct
Code of Conduct for the International Red Cross and Red Crescent Movement and NGOs in Disaster Relief Health Policy – International Federation of Red Cross and Red Crescent Societies
Emergency Response Policy – International Federation of Red Cross and Red Crescent Societies
Post-emergency Rehabilitation Policy – International Federation of Red Cross and Red Crescent Societies
Strategy 2010 – International Federation of Red Cross and Red Crescent Societies

Appeals (International Federation of Red Cross and Red Crescent Societies)
Emergency Preliminary Appeal no 04/01 26.01.2001 for CHF 2 million
Emergency Appeal no 04/2001 30.01.2001 for CHF 25.6 million
Emergency Appeal 20/2001 – Earthquake Rehabilitation 09.07.2001 for CHF 60.6 million (preliminary)
India Appeal no 01.36/2001 – year 2001-2002
India: Gujarat Earthquake Recovery and Rehabilitation: Appeal 27 June 2002

Situation Reports and Operations Updates
Situation Reports Nr. 1 (27.01.2001) – Nr. 31 (30.07.2001)
Operations Update Nr. 1 (21.08.2001 – Nr. 11 (05.11.2002)

Project Proposals (International Federation of Red Cross and Red Crescent Societies)
Project Proposal for Integrated Health Programme
Project Proposal for Community Based Health Project
Project Proposal for Reconstruction Project of Health Facilities
Project Proposal for Water and Sanitation Project – Draft
Project Proposal for Psychological Support Project

End of Mission Reports (International Federation of Red Cross and Red Crescent Societies)
Folke Lampen – End of Mission Report (Health Coordinator, Community Based Health Programme in Gujarat, 27.06.2001-05.06.2002)

Monthly Reports (Internationaal Federation of Red Cross and Red Crescent Societies)
Community Based Health Programme in Gujarat - Monthly Report February 2002
Community Based Health Programme in Gujarat – Monthly Report June 2002
Community Based Health Programme in Gujarat – Monthly Report July 2002
Community Based Health Programme in Gujarat – Monthly Report October 2002-12-19
Reconstruction of Health Facilities in Gujarat – Monthly Progress Report October 2002-12-19

Other Reports
Relief Needs Assessment; Gujarat Earthquake, May 2001 – Project Proposal Team for Relief, Andrea Wissinger and Harun-al-Rashid
Report by the India Earthquake Recovery and Rehabilitation Mission – March 2001 by IRCs and Federation
ABBREVIATIONS

AmCross | American Red Cross Society
ANM    | Auxiliary Nurse Midwife
AWH    | Anganwadi Helpers
AWW    | Anganwadi Workers
CBHP   | Community Based Health Project
ERU    | Emergency Response Unit
GoG    | Government of Gujarat
HOD    | Head of the Delegation
HoSD   | Head of Sub Delegation
HRD    | Human Resources Development
ICDS   | Integrated Child Development Service
IMR    | Infant Mortality Rate
IOC    | India Operation Centre
IFRC   | International Federation of Red Cross Society
IRCS   | Indian Red Cross Society
MMR    | Maternal Mortality Rate
MoH    | Ministry of Health
NGO    | Non Governmental Organisation
PHC    | Primary Health Care
RCFW   | Red Cross Field Worker
RCV    | Red Cross Volunteer
SARD   | South Asia Regional Delegation
TBA    | Traditional Birth Attendant
UNICEF | United Nations Children Fund
WFP    | World Food Programme