EVALUATION OF THE USAID BOMBING RESPONSE PROGRAM IN KENYA

Submitted to:

United States Agency for International Development
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ACRONYMS

ADRA	Adventist Development and Relief Agency
ALICO	American Life Insurance Company
AMREF	African Medical and Research Foundation
APDK	Association of the Physically Disabled of Kenya
ARO	Africa Regional Office, OFDA, USAID, Nairobi
BRU	Bomb Response Unit, USAID/Kenya
BTC	Blood Transfusion Center
BTS	Blood Transfusion Service
CDC	U.S. Centers for Disease Control
CERT	Community Emergency Response Team
CN	Congressional Notification
CTO	Contract or Cognizant Technical Officer
DA	Development Assistance
DART	Disaster Assessment Response Team, OFDA
DOD	U.S. Department of Defense
EMT	Emergency Medical Technician
ESF	Economic Support Funds
EY	Ernst & Young
FHI	Family Health International
FSN	Foreign Service National employee of the USG
FY	Fiscal Year (USG FY is October 1 to September 30)
GOK	Government of Kenya
HHS	U.S. Department of Health and Human Services
IDA	International Disaster Assistance
IFRC	International Federation of the Red Cross/Crescent
IMC	International Medical Corps
IQC	Indefinite Quantity Contract
IR	Intermediate Result
JICA	Japanese International Cooperation Agency
KMA	Kenya Medical Association
K-MAP	Kenya Management Assistance Program
KNAD	Kenya National Association of the Deaf
KNH	Kenyatta National Hospital
KPMG	Peat Marwick group in Kenya
KRCS	Kenya Red Cross Society
KSB	Kenya Society of the Blind
KShs	Kenya Shillings (currently about 78 KShs = US$1.00)
MAP	Medical Assistance Program
MOH	Ministry of Health
MSED	Micro & Small Enterprise Development Program, UDPK
NCC	Nairobi City Council
NOC	National (Disaster) Operations Center, Office of the President
NGO	Non-Governmental Organization
NPHLS	National Public Health Laboratory Services
OFDA	Office of Foreign Disaster Assistance, USAID

OMB	U.S. Office of Management and Budget
OR	Operation Recovery
PACD	Project Assistance Completion Date
PASA	Participating Agency Service Agreement
PTSD	Post traumatic stress disorder
RBTC	Regional Blood Transfusion Center
RCO	Regional Contract Office, USAID
RCK	Resuscitation Council of Kenya
REDSO	Regional Economic Development Services Office, USAID, Kenya
RFA/P	Request for Applications/Proposals
RHUDO	Regional Housing and Urban Development Office, USAID
RLA	Regional Legal Advisor, USAID
SO	Strategic Objective
SPO	Special Objective
UDPK	United Disabled Persons of Kenya
UNDP	United Nations Development Program
USAID	U.S. Agency for International Development
USG	United States Government
USPHS	U.S. Public Health Service

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I. EXECUTIVE SUMMARY

On August 7, 1998, terrorists exploded a massive bomb outside the U.S. Embassy in Nairobi, Kenya, killing 213 Americans and Kenyans and injuring about 5,000 more. A similar though smaller attack took place concurrently at the U.S. Embassy in Dar es Salaam, Tanzania. While the U.S., Kenya and Tanzania were all co-victims in this terrorist attack, the U.S. Government (USG) took the extraordinary step of appropriating $50 million in special funds to enable the U.S. Agency for International Development (USAID) to provide humanitarian assistance to Kenya and Tanzania to help with each nation's recovery from this disaster. This end-of-project evaluation is an assessment of the USAID bombing response program in Kenya, one that in its totality is perhaps unique in USAID's worldwide and historical portfolio.

The USAID/Kenya bombing response program has been composed of a comprehensive array of projects, including the immediate and follow-up medical care of the many Kenyans injured, trauma counseling for survivors, payments of school fees for the children of victims, aid to those disabled by the explosion, reconstruction and replacement of the more seriously damaged buildings, assistance to businesses hurt by the bomb blast and specific measures, such as blood safety programs, emergency medical training and disaster planning, to better prepare Kenya for future disasters. Over four years, USAID has provided Kenya a total of $42.3 million for these activities, consisting of $37 million from the special appropriation passed by the U.S. Congress and the balance from a combination of funds from USAID's Office of Foreign Disaster Assistance (OFDA) and other USG and USAID budgetary sources. USAID, especially its resident bilateral Mission, worked with a variety of U.S. and Kenyan contractors, non-governmental organizations (NGOs) and other partners to implement the many, diverse components of this bombing response program. This USAID assistance probably impacted some 50,000 Kenyan victims, survivors and their families in helping to rebuild their lives and to overcome the serious economic impact of this disaster.

USAID overall did an excellent job in managing this program. After a slow and difficult start, mostly due to funding problems in Washington and less than satisfactory performance by a few organizations in Nairobi, USAID/Kenya worked through a complex set of project, legal, managerial, compassionate and other concerns to design and implement activities that responded well to meet the legitimate needs of the Kenyan people impacted by this disaster. Having suffered through the immediate shock of the bombing, working in a highly charged political atmosphere, encountering new issues and precedents in USAID programming and challenged by the difficulties of some working conditions in Kenya, the staff from USAID's various offices in Kenya pulled together well as a team to implement an effective program to share with Kenyans the burdens of the effects of this terrorist attack. This evaluation team, consisting of American and Kenyan specialists in disaster preparedness, health and trauma, small business development and NGOs and USAID program management, found that the overwhelming majority of Kenyans interviewed individually and in focus groups were genuinely appreciative of this USG assistance. Despite some of the serious problems encountered, the evaluators applaud the efforts and successes of USAID in implementing this program and believe that Kenyans are emerging

reasonably well from their suffering and are now better able today to handle future disasters based on lessons learned in this tragedy.

As a result of this final evaluation, the team presents the following major recommendations and lessons learned:

- Because this 1998 terrorist bombing and the traumatic events of September 11, 2001 have sadly introduced a new era, USAID, like all USG agencies, needs to review urgently its management procedures about how best to respond to this type of disaster when it strikes again and to manage the ensuing recovery efforts. The experience in Kenya would be a very good case study to stimulate this discussion and hopefully to help update USAID and some other USG procedures.
- At the top of the list, there must be a change in the systemic problems that impede the provision of adequate funding expeditiously to Missions. An expansion of OFDA's mandate or some other "bridge" funding mechanism between the immediate disaster relief and the later recovery efforts needs to be arranged faster.
- USAID/Kenya, while fortunate to have adequate staff and regional resources to draw upon, would have benefited from more flexible delegations of authorities and temporary staff from Washington, particularly during the early stages, to design projects faster and avoid the ultimate delays and extensions in activities.
- Because of the uniqueness of the bombing response program, the establishment of a separate Bombing Response Unit (BRU) in the Mission, with technically qualified project management staff and procurement experts, is a practical model to be considered seriously in similar circumstances so as to carry out effectively these special activities without unduly hampering other Mission responsibilities.
- In implementing programs of this type, USAID Missions should still look to partner with U.S. and local contractors and other organizations as much as possible, but being careful to be sure of the management capabilities of these entities and their sub-partners to carry out the specific tasks required.
- It is important to involve and work with local government organizations to the extent of their capacities and interest in particular project activities, although this seems to have been difficult in this Kenya case.
- NGOs often rise to the occasion, having the right set of skills, motivation and funding, and are usually a valuable resource in such disasters and recovery efforts.
- When implementing partners collaborate and share information in their respective activities, they are much stronger and effective both individually and as a whole.
- USAID learned well a lesson from the Oklahoma City bombing that early and continuing mental health counseling is important in such traumatic situations.
- In the spirit of "public diplomacy", USAID and the U.S. Embassy in Nairobi should continue to provide appropriate information and publicity about the many positive results of this program in order to stifle lingering local criticism based on a lack of knowledge about what has actually been accomplished by the USG.
- Because there is some residual funding available from this program and since there are still worthy needs, USAID/Kenya should extend selected activities for one more year, like the payment of school fees, follow-up medical care and medications and improved facilities at the Nairobi morgue, to complete priority elements in this bombing response program.

- Other activities, like the blood safety project and counseling, should be continued under the Mission's bilateral health program especially as related to HIV/AIDS prevention, and the disaster preparedness assistance should be continued under the aegis of OFDA, especially working with the Kenyan National Disaster Operations Center and providing more training in emergency health care.

II. APPROACH AND METHODOLOGY

Following a competition under an Indefinite Quantity Contract (IQC), the Regional Contract Office (RCO) of the Regional Economic Development Services Office (REDSO) for East and Southern Africa of the U. S. Agency for International Development (USAID) and the USAID/Kenya Mission in Nairobi awarded a task order (No. AEP-I-816-00-00023) effective June 21, 2002 to Development Associates, Inc. of Arlington, Virginia. The purpose of this task order is to prepare an end-of-project evaluation of the USAID/Kenya Bombing Response Program. (A copy of the scope of work is attached to this report as Annex A). Development Associates mobilized a consultant team in the U.S. on June 21 composed of Dennis M. Chandler as team leader and Gus Konturas as medical advisor, both of whom have had extensive experience working on a variety of development and emergency programs in sub-Saharan Africa and elsewhere. Miriam Gachago, a Kenyan specialist in evaluation, gender issues and micro-enterprise, and Dr. Herman Kiriama, a Kenyan expert in disaster preparedness and management, joined the American team members upon their arrival in Nairobi on June 23, 2002.

The evaluation team's approach consisted of selected interviews in Washington in the brief time period allowed. The team conducted more extensive discussions and surveys in Nairobi with as many individuals as possible that were involved with the USAID bombing response program. These included representatives from USAID and the U.S. Department of State, other donors, the Government of Kenya (GOK), implementing partner organizations (contractors, sub-contractors, grantees and sub-grantees), private businesses affected by or assisting with the impact of the bombing, recipient firms and organizations, hospitals and schools that served victims and their families, beneficiaries and survivors of the bomb blast either individually or in focus groups. (See Annex B for a list of the persons contacted). Some of these interviews took place via long-distance telephone calls and email due to the fact that certain key individuals were no longer residing in Kenya. In addition, team members also visited various project sites throughout Nairobi and in Nakuru. At the same time, the evaluation team reviewed all available documents relating to the USAID/Kenya bombing response program. (Annex C contains a partial list of such documents).

Following this intensive review process, the evaluation team prepared a draft report, consisting of selected background information about the USAID bombing response program in Kenya plus the team's preliminary findings, conclusions, recommendations and lessons learned relating to this assignment. The team submitted this draft report in writing to the USAID/Kenya Mission on July 22 and then discussed it with USAID managers on July 25. On the following day, the team also reviewed in summary its report with the U.S. Ambassador in Nairobi, before the departure to the U.S. of Messrs. Konturas and Chandler that evening. The team then continued working on additional sections of and annexes for the report while awaiting the Mission's written comments on the draft. The Development Associates team carefully considered these USAID comments in the completion of the final evaluation of the USAID/Kenya bombing response program and submitted the final report to USAID/Kenya by the prescribed deadline.

The Development Associates evaluation team wishes to express its sincere appreciation to the staffs of USAID and the participating Kenyan and U.S. organizations for their assistance and cooperation in the preparation of this evaluation. The team also applauds the outstanding efforts of all of the U.S. and Kenyan staff of USAID and the many partners in assisting the victims and survivors of this bomb blast. Finally, the team extends its heartfelt sympathies to all Kenyans and Americans who were affected by this grave tragedy brought about by an act of terrorism.

III. INTRODUCTION

A. AUGUST 7, 1998 BOMBING

On Friday, August 7, 1998, at about 10:37 in the morning, a group of terrorists drove a truck onto the grounds of the U.S. Embassy Chancery building in downtown Nairobi and tried to enter the building's underground garage via an entrance behind the Embassy. Denied entrance by the Embassy's local security guards, the terrorists exploded a hand grenade, killing and injuring several Kenyan guards, and then detonated a massive amount of explosives in the truck. The bomb blast severely damaged the American Embassy, particularly the lower floors and rear sections, killing or injuring about three-quarters of the Kenyan and American employees in the Embassy. This bomb also destroyed the adjacent Ufundi Sacco building, with the loss of 45 lives, severely damaged the nearby Cooperative Bank building while killing 12 and injuring about 200 employees there and damaged about one hundred buildings in the downtown business district. In total, the terrorists murdered 213 American and Kenyan people, injured some 5,000 more and destroyed property worth millions of dollars.

Within minutes of the terrorist explosion outside the American Embassy in the Kenyan capital, a similar attack took place against the U.S. Embassy Chancery building in a residential area of Dar es Salaam, Tanzania where there was a substantial though lower loss of life and injury to Tanzanian employees of the Embassy and other citizens as well as significant damage to nearby buildings. Both terrorist attacks have been reliably traced to Usama bin Laden and his al Qaeda network.

B. INITIAL U.S. AND KENYAN RESPONSE

Surviving American and Kenyan employees of the Embassy and other Kenyans immediately swung into action to rescue co-workers and victims caught in the wreckage of the various buildings. USG employees located in other buildings, particularly Kenyan and American staff from USAID's Parkland building situated a short distance away, converged on the scene to help in trying to rescue colleagues and to assist with immediate emergency care. An operations center was set up at USAID where the Embassy relocated later that day and shared offices for about the next year. Numerous Kenyan and international NGOs sent health workers to the bomb blast scene to administer first aid and to transport the injured to hospitals. British soldiers and engineers in country on various assignments joined the relief effort, as did the Kenyan military. The Kenyan public also mounted a spontaneous humanitarian and massive response, taking the injured in taxis and any other available vehicles to numerous hospitals in the city, donating blood and providing food, medicine, and other supplies to the severely overworked hospitals.

Over the course of the next few days and weeks, Kenya received emergency assistance from the Israeli Defense Forces, the United Kingdom, France, Denmark, Japan, the United Nations and

numerous other countries and organizations. The U.S. responded with search and rescue assistance and medical supplies from the U.S. and military bases in the region, other USG departments, including USAID's OFDA, and state and local agencies from the U.S.

Kenya also set into motion its own major relief effort involving government and private resources, mental health counseling and a donation program to assist victims of this disastrous terrorist act. Of special note in describing how Kenyans garnered their resources to help one another was the Bomb Disaster Committee that was appointed by the President of Kenya on September 8, 1998 to receive the many donations made by the public and to pay those funds to the victims of this terrible disaster. Named the Njonjo Fund after its chairman, this group collected more than $4 million equivalent and distributed it to the victims and their families of the bomb blast. In total, some 3,000 victims and survivors were paid cash grants beginning at the end of September 1998 and most were paid within the first three months after the explosion. The committee established a formula by which victims would be paid specific amounts up to almost $8,000 equivalent according to the severity of their injury (totally disabled, partially disabled, serious injury, minor injury, etc., as confirmed by a doctor's certification). This was a generous and immediate grant to the victims and survivors and had specific implications for later assistance programs provided by USAID.

After the initial emergency phase had passed and other donor assistance dwindled, it soon became apparent that the disaster recovery was really to be the responsibility of the Kenyans and the United States to bear. The Government of Kenya (GOK) issued a formal appeal to donors on August 31 requesting the equivalent of about $150 million to be put into a trust fund to be managed by a local committee of government representatives, donors and NGOs. However, the donors viewed this amount as highly inflated and suggested that the GOK come up with a more realistic estimate. A later, lower request was also not acted upon, however, and the GOK and USAID/Kenya realized that they alone were expected to finance the relief and rehabilitation efforts. However, among the Kenyans, it was really the Kenyan people, NGOs and businesses, and not directly the GOK, that carried the burden of the recovery program, especially after the first weeks following the bomb blast as well as to this day.

IV. FINDINGS AND CONCLUSIONS: USAID ASSISTANCE TO KENYAN BOMBING VICTIMS

A. USAID ASSISTANCE

After the immediate chaos and initial efforts to rescue colleagues and other victims of this bomb blast, USAID mobilized to provide assistance to Kenyans impacted by this tragic event brought about by terrorist action. The USG, particularly working through USAID overseas, has a long and impressive history of helping those in need due to natural and man-made disasters. In this particular case, because USAID had both a bilateral USAID Mission as well as a regional USAID Mission resident in Nairobi, there were more American and Kenyan USAID employees available and qualified to provide support in various capacities than would normally be the case. Therefore, other responsibilities were put on hold as USAID staff worked hard to help recover from this tragedy. Medically trained staff from USAID's health program offices deployed to the bombsite quickly after the blast to assist with search and rescue efforts. Other USAID personnel manned the operations center, served as liaison with various GOK offices, provided logistical

support to the teams that started to arrive to render assistance and helped out in countless other ways as part of the overall USG team.

1. Office of Foreign Disaster Assistance (OFDA)

Of particular note was the role played by the Office of Foreign Disaster Assistance (OFDA), which is the arm of USAID that is specifically mandated to provide immediate assistance to people in foreign countries during times of emergencies and natural disasters. The first official USG assistance provided to Kenya in this circumstance was the early release to the USAID Mission of $25,000 in OFDA funding based on the U.S. Ambassador's issuance of a disaster declaration on August 9. On the same day, a three-person OFDA Disaster Assessment Response Team (DART) arrived to support the Mission and serve as liaison to the 70-member Fairfax County, Virginia Urban Search and Rescue team, whose work overseas OFDA funds under a standing agreement.

Working closely with the USAID Mission, OFDA continued in the next weeks to provide assistance to the Kenyans in this disaster, drawing on appropriated monies reserved in Washington for just such emergencies and using as appropriate the flexible implementation procedures allowed in the "notwithstanding" authorities for these OFDA funds. Therefore, OFDA was able to arrange an immediate shipment of 1,900 pounds of medical supplies and 500 body bags. In addition, OFDA provided through a $300,000 grant to the International Medical Corps (IMC), a U.S. NGO, medical equipment and first-responder training to Kenyan emergency medical technicians. Because of the key role being played by local and international NGOs in helping victims of this disaster, OFDA granted $40,000 in assistance to some of them to help implement and coordinate their efforts. Having learned from the experience of the Oklahoma City bombing, OFDA quickly recognized the mental trauma that would inevitably result from this momentous tragedy and therefore financed ($20,000) the early visit of a specialist from the U.S. to advise U.S. and Kenyan organizations about how best to deal with this post traumatic stress disorder (PTSD). Finally, OFDA also funded ($38,000) the rapid provision of technical advice in the form of structural engineers and experts to assess the damage to buildings near the U.S. Embassy. (See Annex D for a financial summary of this USG, including OFDA, assistance as part of the bomb response program).

Unfortunately, while there was strong sentiment within the USG to provide humanitarian assistance to Kenya in this disaster, the USG in August was at the end of its fiscal year (FY 1998) that ended on September 30, and the U.S. Congress was in recess until the first week of September. Therefore, financial resources were limited and the prospect for getting more quickly was not good. There were also serious legal and other concerns about the precedents that such additional assistance might provide and the need to avoid any appearance of providing compensation, which many Kenyans were clamoring for, when the United States was itself a victim of this terrorist attack. Finally, following the more immediate aftermath and its supply of emergency aid, OFDA/Washington then seemingly believed that it no longer had the mandate to continue assisting Kenya's recovery after the bomb blast even though the OFDA authorizing legislation cites "relief, rehabilitation and reconstruction" as the purposes of OFDA funding without any apparent restrictions on timing. Accordingly, OFDA decision makers, following their prevailing practices and perhaps reflecting understandings within the Administration and with the Congress about the timeframe and the role of OFDA in providing aid, ceased any further funding to Kenya after the first few weeks of emergency help in this unique situation.

2. Bilateral USAID Program

Aside from the OFDA resources, USAID/Kenya, like virtually all USAID Missions, did not really have any other flexible forms of funding that could be readily used in such emergencies and recovery. USAID/Washington specifically allocated the regular bilateral program money to the USAID Mission for particular purposes as stated in that USAID's approved Strategic Objectives (SOs). These Kenya SOs focused on and authorized spending only for approved activities in democracy and governance, economic growth, population and health and natural resource management. Then, such funds were provided to Kenya in the context of agreements negotiated with the GOK ministries responsible for those programs and technical sectors. Therefore, unless there was a legitimate overlap between the purposes for which bilateral funds had been previously authorized and the prevailing emergency and recovery needs, the Mission was not able to use bilateral program funds, other than the initial amounts from OFDA, during this emergency and in the early, critical stages of the following recovery period.

One of the few exceptions to the above-described rule was the pre-existing USAID/Kenya project to provide assistance to micro-enterprises in Kenya under the aegis of the economic growth SO. Therefore, because no other monies were readily available, USAID subsequently signed a cooperative agreement on December 14 to allocate $300,000 of those then currently available project funds to help the many micro-enterprises that lost stock and equipment in the bomb blast. The implementing partner in this activity was a local NGO, the Kenya Management Assistance Program (K-MAP), which had heretofore been providing management advice and training to small businesses while also working with local banking institutions that extended credit. The intent was to help those small and micro-businesses to recover from the damage to and losses of fixed assets brought about by the terrorist bombing. In addition, the Mission hired in November under an existing Indefinite Quantity Contract (IQC) a U.S. firm in Nairobi, KPMG, to assess 208 businesses affected by the bomb blast. Further details on these activities are discussed below in Section IV. B. of this report.

Otherwise, once the OFDA funds were stopped, the bilateral Mission had practically no financial resources to help the Kenyan victims and survivors of the bomb blast or to plan for any recovery activity. At the same time, there was constant and very strong Kenyan political and public pressure for the USG to take responsibility for the costs of helping those Kenyans impacted by this bomb attack. The USAID Mission was understandably very frustrated in seeing acute financial, medical, mental trauma, recovery and rehabilitation needs, but without the resources to even plan effectively for not to mention actually to provide the necessary help to the Kenyan victims and survivors.

The evaluation team notes that in more recent years USAID/Washington, with Congressional concurrence, allocated to USAID/Mozambique OFDA funding from the agency's International Disaster Assistance (IDA) account for a multi-year flood relief program to be implemented by the Mission, involving more flexibility in implementation and requiring fewer advance notifications but with regular reporting later.

3. Special Objective: To Meet the Critical Needs of the Kenyans Affected by the Nairobi Bombing and Build Capacity to Address Future Disasters

As a way out of the aforementioned bureaucratic dilemma and after much discussion and many exchanges of messages, USAID/Washington instructed USAID/Kenya in September 1998 to design a Special Objective (SPO) that would serve as the mechanism for providing further humanitarian assistance to Kenyans recovering from the effects of the bomb blast. This decision was also made in anticipation of there being a special appropriation by the Congress of funds to help Kenya and Tanzania recover from this disaster. Accordingly, the Kenya Mission prepared a new SPO, as entitled above.

As part of USAID's strategic planning matrix, this SPO was to include three Intermediate Results (IRs). The first IR was to reduce the economic impact of the bombing by assisting private businesses affected by the bombing, including rehabilitation and reconstruction of damaged infrastructure. The second IR was to meet health and socio-economic needs of bomb victims by making it possible for all persons injured in the bombing to receive adequate medical care by reimbursing Nairobi area hospitals for the treatment costs incurred but otherwise not recoverable, and coordinating and financing medical and mental health care follow-up. The third IR was to enhance future disaster preparedness in Kenya by strengthening blood transfusion services, emergency medical response capacity and disaster planning and preparedness.

This SPO was prepared rapidly by USAID/Kenya and sent to Washington later in September 1998. At about the same time, USAID/Washington sent to the Congress on September 14 the required Congressional notification (CN) that USAID planned to commit residual Economic Support Funds (ESF) from FY 1998 to the program in Kenya to assist with recovery efforts. Such CNs for ESF and Development Assistance (DA) funding involve a waiting period of 15 working days while Congress is in session in order to allow elected representatives or their staffs to express any concerns and seek clarifications about such planned uses of funding. This ESF, which is not as flexible in its application as OFDA funds, was unfortunately not made available by Washington to USAID/Kenya in the remaining days of FY 1998 and was carried over into FY1999 when it was finally provided to the Mission on October 27. The eventual amount was $850,000, most of which ($800,000) was used to reimburse Nairobi hospitals for the treatment of and medications for the many bomb blast victims, the overwhelming majority of whom had no medical insurance or other means to pay for their care. The remainder of $50,000 was granted to a local effort, Operation Recovery (OR), on November 7 to initiate mental health counseling for the many Kenyans traumatized by this disaster.

Administration officials and Congressional leaders finally decided to proceed with the special $50 million supplemental appropriation to help with recovery efforts in both Kenya and Tanzania. According to individuals that worked in Washington at that time, ESF was chosen as the type of funding because of the unique nature of the bombing response program and because the variety of projects to be financed were normally beyond the mandate of OFDA. When USAID/Washington had finally approved after three months the Kenya Mission's SPO on December 18, USAID was able to send to the Congress on that date the needed CN about the planned uses of the $37 million for humanitarian aid to Kenya. The CN waiting period expired on January 7, 1999, and the first tranche of $11 million in new ESF funds was transferred via other USG departments, including the Department of State that is responsible for ESF, to USAID and then finally sent to the Kenya Mission on January 14, more than five months after the bomb

blast. The balance of the $37 million was not fully allocated to the Kenya Mission until the very end of March, 1999, following further discussions with USAID/Washington and Congressional staff about some of the details of this planned aid, almost eight months from the date of the Kenya bombing. (See Annex E, USAID Timeline).

With the arrival in January 1999 of the first allotment of new ESF for recovery efforts, the Kenya Mission was finally able to shift into gear and start incurring costs in planning and implementing actual recovery activities. For example, the Mission officially formed a Bomb Response Unit (BRU) and started hiring Personal Services Contractors (PSCs) to plan and manage this humanitarian aid to Kenya (a Participating Agency Services Agreement (PASA) with the U.S. Army Corps of Engineers for a resident engineer project manager and contract officer was added later to complete this five-person unit). USAID/Kenya and the Cooperative Bank signed a memorandum of understanding on January 14 to plan the reconstruction of its building. The Mission reimbursed most hospitals that participated in the emergency relief efforts in January and February.

The remainder of the very busy bombing response program planning and implementation then followed over the course of the next two years. Despite its uniqueness, the Mission, consistent with USAID regulations, fit this special program into the agency's regular monitoring cycle with the design and tracking of performance indicators in the annual Results Review and Resource Request (R4s). This was not always an easy task for the Mission because of the local need to act reasonably fast to respond to urgent health care requirements, the Kenyan penchant to exaggerate or even deceive USAID and others about actual injuries and claims and the evolving data that often made it difficult to arrive at precise estimates, especially so late after the actual bombing. Also, while USAID has a clear management approach in relying on partners for implementation, sometimes the sub-contractors or grantees do not perform as well or as expected, causing problem, as described in several instances later in this evaluation report. However, in reviewing performance indicators in the R4s and project reports, and as mentioned in several sections of this report, it appears that virtually all targets were met or exceeded. Some were easier to determine than others (e.g., contribute to repairing a damaged building) while others were more subtle (e.g., the growing numbers of trauma counseling cases and ascertaining when a patient is well again).

Because of delays related to receiving funding to start planning as well as some performance issues with a few partners and sub-partners during implementation, the Mission eventually had to extend the Project Assistance Completion Date (PACD) to September 30, 2002. This was later followed by another PACD extension to September 30, 2004 to allow for selected activities to be completed and for an orderly closeout. Again, despite the Mission's oft-repeated statements to stakeholders that there was a definite limit to the life of these activities, some of the projects (e.g., school fees, medical care, counseling) could continue for several years to come.

As this bombing response program now comes to an end in almost all of its projects, the Mission is following a well laid-out phase-out plan to complete most activities on schedule and in an orderly manner, keeping stakeholders informed of progress and the status of the program. Numerous activities have been completed, mostly in the economic and infrastructure rehabilitation area, while others in the health and social sector are continuing until the funding runs out or if another source of financing is found.

Based on numerous discussions with Mission staff and implementing partners plus a review of files, it appears to this evaluation team that USAID/Kenya managed this bombing response program well. Project objectives were met, communications were very good with stakeholders and there seems to have been much "esprit de corps" among staff in the Mission that participated in helping out, many of whom spent long hours working on different aspects of this program. The walls of the Mission building are now decorated with numerous, well deserved awards given to the staff at large as well as to individuals for their outstanding efforts in managing the bombing response program.

Conclusions:

a) While USAID/Kenya did an excellent job in very trying circumstances, the task was made even more difficult by what are anomalies in USAID's operating procedures. The 1998 Kenya bombing, like the September 11, 2001 disasters in New York City and at the Pentagon, have arguably changed forever how some USG business is to be conducted. So it is with USAID's current operating procedures. For example, this new requirement of dealing with the aftermath of a terrorist attack or other causes of recovery programs has exposed a glaring gap between what USAID, through OFDA, typically does in natural disasters and other emergency relief activities and what USAID does with the rest of its ESF and DA-funded development programs. This "neither fish nor fowl" scenario involves recovery programs being situated somewhere between relief and development categories. This change requires that USAID, and probably other USG entities like the Department of State, OMB and the Congress, review existing procedures to devise more appropriate methods for dealing expeditiously with recovery programs that are likely to be needed again and for longer periods of time than is currently normal with OFDA activities. In view of this Kenya example and the more recent experience in Mozambique, perhaps USAID has begun to learn this lesson of needed flexibility for Missions in a changing world.

b) The delays in obtaining funding for USAID/Kenya's recovery efforts appear unacceptable given the earlier USG decision for humanitarian, political and economic reasons to help this key African nation. While no one is suggesting funding poorly planned activities, the requirement to create a special objective, conducting R-4 reviews when the money has been earmarked and already provided, withholding some funds or delegations of authority from a well qualified Mission, etc. when trying to address such obvious needs seems unreasonable and not the best management approach for USAID or the USG under these circumstances.

c) In addition, given the intensive efforts and trauma that all staff in Nairobi experienced during these difficult weeks and months in dealing with this emergency situation, one cannot help but wonder about USAID/Washington's management priorities and why more working staff support and implementation flexibilities were not provided quickly to the Mission to enable it to better carry out this most difficult set of tasks.

d) Once Washington finally provided the required funding, USAID/Kenya wisely set up a separate management section for the bombing response program. While almost every USAID employee in Nairobi had initially been drawn into the early emergency and recovery efforts, this was not sustainable and there were eventually other responsibilities

to get back to. Therefore, the Mission took a very pragmatic approach in establishing the Bombing Response Unit (BRU) to coordinate and manage all such recovery activities, calling on other staff as appropriate, and to be the point of contact in the Mission for the many inquiries to follow from Kenyan victims. This is a sensible model to be emulated in similar circumstances elsewhere.

e) While this evaluation was supposed to assess how the bombing response program promoted gender values, this was not possible because none of the projects were set up in a way to track gender data. There were no gender monitoring indicators in place and none of the partner organizations maintained gender disaggregated data or had any specific interventions on behalf of gender. The evaluation team made a special effort to extract such data wherever possible, but the information did not show particular trends that would have added value to the evaluation report. The team noted that both men and women participate in all components of the program.

f) While the evaluation team understands the USAID Mission's management approach in relying on prime contractors and grantees for assuring performance of their own sub-contractors and sub-grantees, it does not always work out as well in practice. Even though the primary partners are accountable and that management service is what USAID is paying for, the problems will ultimately end up as the Mission's responsibility. Because USAID's business is fraught with variable factors, these problems are almost bound to occur. It appears to this evaluation team that the Mission was burdened in a small but significant number of cases because of poor performance by a few implementing entities and/or their sub-partners. In each case, USAID/Kenya addressed the issue well, though a few cases are still pending.

g) Because some programs are almost as difficult to close-out as they are to initiate, USAID/Kenya has done a commendable job in completing a number of its projects according to a clearly laid out closeout plan under this bombing response program. In fact, the Mission has also drafted a worthwhile Mission Order for the eventual Closeout of all projects. Notably, the BRU has been doing a fine job of advising and informing the many beneficiaries and stakeholders in Kenya about the planned termination of these activities so that they can plan ahead as well as possible.

B. ECONOMIC IMPACT OF THE BOMBING REDUCED (SPO IR 1)

While there does not appear to be any definitive report on the subject, various donor estimates indicated that the effects of the bombing caused Kenya to lose 5-10 percent of its Gross Domestic Product, in addition to the grave personal losses. In 1998, Kenya was already suffering from a stagnating economy brought about by years of poor management, corruption, weak infrastructure, minimal investments and a severe drop in tourism and the bombing certainly aggravated this deteriorating situation. Unfortunately, these economic trends have continued, as confirmed by the recently released United Nations Human Development Report for 2002, which indicates that Kenya is one of the worst performing countries. Therefore, it was important for the USG to try to help alleviate this latest shock to the Kenyan economy generally and to help Kenyan victims, survivors and their families recover, get back to work and rebuild their lives.

1. Building Reconstruction and Repair

In the first week after the bombing, the USAID priority rightly went to the immediate medical care of the many Kenyans injured in the blast. However, USAID/Kenya soon realized that it would also have to start determining the extent of the damage to infrastructure and what role USAID would play in helping to address these needs. The USAID Mission wanted to help businesses resume operations, employ people and overcome the serious economic effects of the bombing.

Using OFDA funds, the Mission quickly obtained in mid-August 1998 the technical services of a specialist in bomb damage, who worked with a team from the United Kingdom and determined in a preliminary assessment that the Cooperative Bank building was structurally sound after the blast and could be repaired. Also using OFDA and regional funds, a USAID housing expert from a nearby post began to inventory damaged buildings and hired a local engineer to assist in surveying buildings and estimating the actual cost of repairs for later consideration by the Mission when funds were available.
Almost from the very beginning of the recovery effort, the cases of the replacement of the destroyed Ufundi Sacco building and the repair of the badly damaged Cooperative Bank buildings next to the Embassy were handled as separate projects because of their greater cost, size and complexity. These two projects eventually amounted to about $12.4 million, or about one-third of the portion of the special ESF appropriation from Congress earmarked for Kenya. After much discussion internally and with USAID/Washington, the Mission used distinct implementation approaches to these two projects.

As part of this process and in similar economic recovery activities, the Mission had decided that it would only contribute to the verified costs of repairing buildings and replacing fixed assets (computers, stock, etc.) and that it would not pay for the costs of revenue or profits lost due to the bomb blast. There was simply not enough USAID money to attempt to do this, it would have been a virtually impossible task, especially given the poor quality of record keeping and the strong tendency to inflate claims in Kenya, and it would have set a very difficult and expensive precedent for the USG when it itself was attacked. While there were legitimate concerns in this regard by Kenyan businesses, USAID consistently maintained that that was to be part of the Kenyan share of the burden. This was at times a contentious issue for the Mission as many local businesses complained about this USAID decision and the requirement for cost sharing. However, USAID "drew the line" at this point and persevered.

a) Insurance

Before proceeding any further in this area, however, there was a vexing issue that USAID had to resolve first. Early on, the Mission raised the question of whether the prospect of USG assistance to property owners might discourage Kenyan insurance companies from paying claims for damaged buildings, vehicles or other property. In fact, there was a "hold" placed by a Congressional staffer on the ESF funding due to this concern. A Mission review indicated that some building owners had no insurance or had policies that did not cover physical damage, others had policies with broad exclusionary language regarding terrorism and still others had specific exclusions regarding liability for terrorist attacks against the local government, the GOK. As a result, of the approximately fifteen insurance companies involved, only one, the American Life Insurance Company (ALICO), agreed to honor claims on the three buildings that

it insured, out of a total of some 100 damaged buildings. Eventually, and after much deliberation in Nairobi and with Washington, the Mission worked out a formula and process whereby owners that had coverage against acts of terrorism had to file suit against their non-paying insurance company and would receive from USAID 85 percent of verifiable damage costs (there was little expectation that such suits would be adjudicated in the Kenyan system). Building owners with policies that clearly excluded coverage against terrorism received 65 percent of verifiable costs. Finally, owners with no insurance would receive 50 percent of the confirmed repair costs. Legitimate claims up to $5,000 equivalent would be paid in full.

b) Payments to Building Owners

Once the added funding was finally made available to the Mission, USAID/Kenya contracted in 1999 for about $100,000 with Matrix Development Consultants, a local engineering and architectural firm with broad experience in southern Africa, to assess the damage to 107 buildings in the vicinity of the Nairobi bomb blast. After inspecting each building and estimating essential repairs, reviewing insurance possibilities, denying any amount for lost revenue and rejecting inflated or fraudulent claims, Matrix then submitted its recommendations to the Mission for payments to some 60 building owners. After clarifying facts in some cases, the Mission then issued checks to the owners for these recommended amounts as the USG contribution to the cost of repairs due to the bomb blast. These payments amounted to about $3.8 million.

Conclusion:

This system appears to have worked well between Matrix and USAID and the building owners benefited. The major negative concern is the fact that this activity started well after the bomb blast and after some of the damage had already been repaired. This delay was again due to the delays in the Mission's receiving the ESF funding and the protracted discussions, especially in Washington, about how best to make sure that any insurance claims were duly processed and paid. Many Kenyan businesses suffered as a result.

c) Ufundi Sacco Building

The Ufundi Sacco Savings and Credit Society, Ltd. is a cooperative savings and credit organization for Kenyan civil servants. Its seven-story building was adjacent to the American Embassy and collapsed with the force of the bomb blast, killing 45 employees and injuring scores of others. The building was a total loss and its insurance policy excluded coverage against terrorism. As a result of the Ufundi building's destruction, the coop organization lost significant revenue from lost rent, the added expenses of having to pay for new office space, the destruction of its records and the ensuing defaults, suits and claims against it by Kenyan coop members. There was an ensuing loss of business as members lost confidence in the organization and the retrenchment in the numbers of government employee members due to continuing budgetary cuts and economic issues.

USAID again decided that it was highly desirable to help defray the economic impact of the bombing by assisting Ufundi to resume more normal operations. Because the Ufundi building could not be repaired, the options were to rebuild it on the same site or to buy a replacement, each estimated to cost about $3 million, according to a U.S. engineering firm, Wilbur Smith

Associates, employed under an IQC with USAID. Since Ufundi staff did not want to work any longer at the site where they had lost so many co-workers, the decision was made to find a new building for Ufundi. However, USAID's funding delays again slowed down this process. There were also serious problems with Ufundi, which, after a major change in management due to charges of corruption, rejected as unsatisfactory any of the five prospective buildings identified for it by USAID and its technical advisors.

After protracted negotiations between USAID and Ufundi, an acceptable alternative building, Garden Plaza, was identified and purchased. However, given that it was a larger building (12 stories) which Ufundi wanted so as to generate more rental income, the building could have cost more than USAID wanted to pay and USAID thus insisted that Ufundi pay a share of the costs. This further issue was resolved because in the meantime real estate prices and the value of the Kenya shilling had dropped due to the stagnating economy. USAID's budgeted dollars would thereby go further in making this purchase in local currency. In addition, Ufundi made a significant contribution of its former plot of land, which was then in turn donated to become part of the memorial park on the former site of the U.S. Embassy building. The Mission and Ufundi sealed the deal on August 7, 2000, the second anniversary of the bomb blast.

Conclusion:

Based on a review of the information contained in project files, several interviews as well as a visit to the new Ufundi building and a meeting there with the current Board of Directors, the evaluation team believes that it is a very acceptable replacement for the building that was destroyed. The board also expressed to members of the team Ufundi's sincere appreciation to the USG and USAID in particular for their efforts in replacing Ufundi's building, which helped the coop organization to resume its operations, though still at a more modest level due to continuing economic difficulties in Kenya. Accordingly, the evaluation team believes that USAID is to be commended for persevering in working through what was surely another frustrating and complicated problem in this recovery effort and finding a reasonable and very tangible solution.

d) The Cooperative Bank Building

The single most expensive project in the USAID bombing response program was the repair and rehabilitation of the Cooperative Bank building. The 22-story Coop Bank
Building is located in the heart of the downtown business district and is the headquarters for a leading banking institution for Kenya's rural and urban poor throughout the country. In 1998, the Coop Bank was reportedly experiencing a very successful year in its business and in serving its many coop members. When the bomb exploded on August 7, 1998, the building was severely damaged, with all of the windows blown out on the side facing the blast. Twelve employees were killed and some 200 injured and maimed, and millions of dollars worth of equipment and revenue were lost.

USAID again made an early decision to assist with the repair of the Coop Bank building. On January 14, 1999, the Mission signed a memorandum of understanding with bank management to rehabilitate the building and made some preliminary engineering surveys of the damage. However, due to USAID's aforementioned funding delays, it was not until June 1999 that the USAID engineering firm, Wilbur Smith Associates, was contracted to assess the full damage and

estimate the total cost of repairs. The assessment confirmed that the building was still structurally sound despite the force of the blast and estimated repair costs at $12 million. Because USAID has virtually no engineers on its staff any longer since it hardly ever finances any construction projects (the large infrastructure projects in Egypt being the notable exception), the Mission entered into a Participating Agency Services Agreement (PASA) with the U. S. Army Corps of Engineers in May 1999 to finance the services of a resident civil engineer and a contract officer to manage this Coop Bank building reconstruction project. Later, several other bombing response construction activities in Kenya (e.g., blood safety centers) and in Tanzania were added to this scope of work.

Given the minimal interest expressed by U.S. firms in bidding on this construction contract as well as U.S. foreign policy goals, the Mission was able in March 1999 to waive the normal U.S. source and origin requirement for this work in favor of "free world" (code 935) procurement, which enabled local participation and more worldwide firms to compete for this contract. Following the bidding process, USAID then awarded on November 1, 1999 a $7.5 million design-and-build contract, to a well qualified Kenyan firm, Mugoya Construction and Engineering, Ltd. Work began shortly thereafter and the repairs are almost complete as of the time of this evaluation. In fact, the rehabilitated building is to be rededicated on August 7, 2002, by the President of Kenya, on the fourth anniversary of this bombing disaster.

Conclusion:

This major reconstruction project also appears to have progressed very well in restoring the headquarters and central operations of the Cooperative Bank headquarters to its former location so that it can more fully resume its work in assisting the nation's cooperatives. After walking through the bank building and inspecting the work underway, reviewing project files and talking to project staff, the team concluded that the building seems to have been well restored to its former condition, though with some reasonable improvements for safety and efficiency purposes (e.g., shatter resistant glass windows). It is now a very visible sign of Kenya's overcoming the effects of this disaster and the fulfillment of the USG's commitment to help with this recovery. The restoration of this building for the bank will also allow it to resume more normal operations at less cost and contribute more fully again to the nation's economic development. This more complete resumption of activities at lower cost by the Coop Bank should also have some positive impact on the abilities of the rural dweller engaged in agricultural work and helped by activities in the Mission's economic/agricultural growth and natural resources SOs.

The evaluation team believes that the Mission could not have accomplished this task as well as it did without the active, on-site management of the Army Corps of Engineers technicians to help supervise the work. As indicated above, USAID no longer has the in-house expertise to manage such projects. However, in the cases of the few construction projects still in USAID's portfolio, host country contracting has often offered a less management intensive approach to such projects. Therefore, host country contracting was not considered a viable alternative implementation mechanism in the Kenyan context. The Mission and the Army Corps of Engineers manages are to be commended for a big job well done.

When evaluation team members discussed this project with the Coop Bank's current managing director, he immediately indicated that the Cooperative Bank would not exist today if it were not for the excellent work by USAID and its project management staff, which he and his colleagues

very much applaud. The director also indicated that the bank had learned the hard lesson of having a disaster plan in place and the need for off-site data storage, which the bank management has now instituted.

2. Assistance to the Business Community

It was estimated that more than 250 small and medium size businesses were either destroyed by or suffered losses from the August 7, 1998 bombing of the nearby American Embassy in Nairobi. These businesses required relocating and restarting immediately to avoid substantial losses of income for the individuals and the economy at large. Most businesses had also lost equipment and stock that needed replacing before they could resume operating. A local committee consisting of representatives from the business community, GOK and NGOs had carried out a broad assessment and indicated that about $ 23 million would be required to assist these Kenyan small and medium businesses. The USAID Mission put in place several activities in order to help these Kenyan firms to overcome some of the economic effects of the bombing.

a) K-MAP Small Business Recovery Fund

K-MAP, a local organization that provides business-counseling services, was concerned about the small businesses that had been hurt by the blast. K-MAP had participated in the GOK/NGO committee that carried out the assessment and they wanted to participate in helping the small businesses that had less than 50 employees. Therefore, K-MAP developed a proposal whereby businesses would be assisted with local currency grants for replacement of lost equipment and a working capital revolving loan fund. This proposal was submitted to many organizations and attracted a total of US$325,000 equivalent, with USAID contributing $300,000 of that amount. This report will only concern itself with the usage of the USAID portion.

This USAID contribution came from a pre-existing bilateral project using regular DA funds and was made at a time when there was serious concern in USAID/Kenya about how best to help the small businesses that had been severely damaged or ruined by this disaster. The allocation of new funds from Washington was taking too long and the Mission wanted to help small businesses in some meaningful way. The K-MAP proposal, therefore, was opportune and enabled the Mission to decide in a more timely manner to channel some of the funds from the existing micro-enterprise project to assist these particular small businesses victimized by the bomb blast.

There were, however, some significant issues to consider in reviewing this decision. One was the wisdom of giving loans to individuals, who were in the very early stages of trying to recover from a disaster, requiring a judgment about their ability to restart their businesses and repay the loans. A related issue in this highly charged political atmosphere and emotional period was the ill feelings that would be directed against the USG if USAID insisted on such repayments.

An important second factor was an assessment of K-MAP's capability to manage credit programs. Though K-MAP had a lot of experience in business counseling and training, it had no expertise in credit management. The Mission had actually tried to interest one of the more established micro-finance institutions in Kenya to handle this credit activity, but it declined largely because it viewed the proposal as a risky business proposition. In spite of these concerns,

and in order to provide some assistance in the absence of better alternatives or other funds, USAID/Kenya eventually decided to take a chance and accede to K-MAP's proposal. However, the Mission also decided to limit its exposure by providing only $300,000 equivalent to K-MAP for a period of one year. A cooperative agreement for this purpose was signed in January 1999. This agreement was later extended to December 31, 2000 because it was not possible to implement the whole program within the first year.

The program disbursed approximately one-half of the funding in grants for the replacement of equipment and stock and an equal amount in working capital loans to 47 beneficiaries. The local currency loans were to be repaid within 12 months at an interest rate of 10 percent with a grace period of three months. This would have enabled the beneficiaries to continue borrowing from a revolving fund and become K-MAP clients on a longer term basis for business counseling and training.

The management of this project turned out to be extremely difficult. The Mission's earlier concerns about the capacity of K-MAP to run the program were confirmed.
K-MAP was very slow in reviewing the large number of applicants and took a long time to decide who were the genuine victims and the level of funding for each of them. The tendency to present inflated claims by the beneficiaries also cast a cloud of doubt over whether the money would be going to legitimate applicants. The internal management of K-MAP also had inherent weaknesses, taking five months before the first loans and grants were disbursed.

At this point, the larger businesses that had been hit by the same tragedy were also going through an assessment via another USAID/Kenya project and it was common knowledge that they were to receive grants from the Mission. Therefore, the rationale for the smaller businesses paying back the loans was defeated and they rejected the loan agreements that K-MAP wanted them to sign, further delaying implementation. When the money was finally disbursed, the beneficiaries did not start repaying the loans after the expiry of the grace periods. Because K-MAP wrote threatening letters to them, this caused an outcry, to which the Mission responded by urging K-MAP not to harass the clients. The sympathy shown by USAID to the beneficiaries, while understandable under the circumstances, made it difficult for K-MAP to manage the program according to the original plans. The beneficiaries' attitude also did not make it any easier for K-MAP as the companies considered it their right to be compensated by USAID for the loss of their businesses and that it was unjustifiable to be asked to repay such loans. Thus, it became clear that even though the small businesses accepted the funds that were stipulated as loans, they had no intention of paying them back. Through the two years of the project, only US$267 was repaid. Due to these problems experienced in this project, USAID decided not to disburse any more money to small businesses via K-MAP, but rather to have all the businesses assessed by KPMG and be provided with straight grants.

An audit carried out by Ernst & Young in March 2002 shows that funds were disbursed to small businesses according to plan, but there were internal weaknesses in
K-MAP's accounting systems that led to the project having disallowed costs of US$786.

Conclusion:

While this project did provide much assistance to micro-businesses at a critical time after the bomb blast, it did not achieve one of its main objectives of setting up a revolving loan fund to

continue assisting such small businesses. It must be noted that both the Mission and K-MAP contributed to this issue. Considering the situation of the beneficiaries, the decision to provide loans was not appropriate when there was another program funded by USAID that was giving grants via KPMG. The situation was not made any better by selecting an organization that did not have the required experience in the field of micro-finance. There was also a need for closer supervision of the project so that decisions could be made sufficiently in advance to prevent any embarrassing situations.

At the same time, the combination of loans and grants was not a good idea at that point in time. Considering that the clients were going through a personally and financially traumatic experience, they were bound to cry foul especially when a parallel program was providing strictly grants to larger businesses. While USAID's frustration with the lack of other funding and its strong desire to help were understandable, K-MAP and USAID/Kenya should have waited for the situation to normalize before introducing the idea of loans.

b) KPMG Assessment of Losses for Businesses

KPMG, a U.S. accounting and management consulting firm, was requested to carry out an assessment of all the businesses that had been affected by the bomb blast. By this time USAID had already provided the aforementioned assistance of $300,000 through
K-MAP to assist the small businesses with capital grants and working capital loans. The Mission signed a contract with KPMG to go up to January 31, 1999, but due to the complexity of the work, the agreement was extended to January 31, 2000. The job of KPMG was to assess and prioritize the businesses and their losses and USAID/Kenya would deal with the payments. The objectives of this activity were: 1) to obtain detailed estimates of the magnitude of the losses to individual private sector businesses resulting from the bomb blast; and 2) to provide recommendations to USAID concerning the level of contributions that should be provided to each of the affected businesses.

KPMG publicized this exercise to alert the business community to the program. This particular support would only cover physical assets. Loss of income was not included even though the businesses very much wanted it to be included. The challenge for KPMG was obtaining proof that the claims put in by the businesses were legitimate. Records were requested wherever possible and this was crosschecked with neighbors, dealers and others. KPMG put a team of ten experienced auditors on the job that started with establishing the criteria for the assessment. On the whole, the KPMG teams' judgments improved with experience and they were able to reach what they believed were very justifiable amounts. Over 346 businesses were assessed, but according to USAID records 260 of them received assistance for a total of $2 million.

The greatest challenge faced by KPMG was the delay, due to USAID's funding shortages, in being able to begin the assessments of the businesses immediately after the blast and fraudulent or inflated claims. Possible evidence had already been lost or tampered with and there was sufficient time for the potential beneficiaries to construct false records. While many business owners presented reasonable claims, the tendency to exaggerate the losses was very high and had to be brought down significantly. The deadline for submission of new applications was probably also too long. Some of the businesses that submitted their applications later were suspected of not being genuine bomb blast victims and their claims were rejected.

It also appears that KPMG and USAID worked well together in the performance of this activity. While KPMG says that it would also have been willing to issue the many checks involved, with USAID's consent on individual claims, USAID itself took on this very labor-intensive task. Most of the business owners were grateful for the assistance provided. There was, however, no organized follow-up by USAID to determine how many companies were actually able to restart their businesses or how they then fared.

Conclusion:

This USAID business assistance project worked well. In addition to aiding the affected businesses to resume operations, this activity helped to rebuild the image of the USG after it had received a lot of bashing from the Kenyan press immediately after the bombing. It most probably contributed to reducing the economic impact of the bombing by getting business up and running again and people back to work to produce goods and services. It also presumably created synergies with other Mission activities in its economic growth SO. The use of a professional accounting and management firm that was able to design objective criteria reduced appeals to a very low level. The project would have worked much better, however, had the assessment of the businesses been able to start sooner after the bombing in order to reduce attempts at fraud.

3. Vehicle Repairs

Because the U.S. Embassy was located at the intersection of two busy avenues and a major traffic circle in the downtown area of Nairobi, there were understandably numerous vehicles parked and being driven in the vicinity at the time of the explosion. Many of these personal and commercial vehicles were damaged or destroyed given the strength of the bomb blast. Consequently, as part of the USG effort to help reduce the economic impact of this disaster, USAID/Kenya signed a purchase order with KPMG offering to pay for the verifiable and reasonable costs of vehicle repairs or replacements.

Using the tried and proven method also applied in assisting affected businesses, USAID and KPMG advertised the USG's willingness to help those vehicle owners upon the presentation of sufficient proof of loss. KPMG again set up an orderly system to review pertinent documentation presented as part of these claims, including proof of vehicle ownership, any photographs of the damaged vehicles, police reports, evidence of insurance coverage and applications for and results of insurance payments, and actual costs of repairs or a bona fide mechanic's declaration that the vehicle was a total loss. KPMG staff reviewed these claims packages, made vehicle inspections, weeded out fraudulent claims, adjusted inflated amounts and submitted recommendations, with justifications, to USAID for payment. After USAID reviewed the KPMG claims package and accepted the recommendation (which it did in all cases, though sometimes after clarifications), the Mission then sent a letter to each vehicle owner explaining the payment, disclaiming any further USG liability and requiring the recipient to acknowledge the payment conditions by signing an appropriate form. When that signed form was received, USAID then proceeded to issue a check to each recipient for the prescribed amount. As of February 2001, when this activity expired, 42 vehicle owners were paid for the repair or replacement of their vehicles, at a total cost of approximately $165,000 equivalent.

Conclusion:

This activity also appears also to have worked well, based on a review of the project documentation and talking to USAID and KPMG representatives. When confronted with a requirement for what was basically an accounting/auditing function, USAID/Kenya again made the right decision in turning to a qualified financial management firm with whom it already had success in similar circumstances. KMPG did a fine job using an organized, common sense approach. Kenya vehicle owners who submitted legitimate, verifiable claims within the time period of this activity were served well. However, if it wished to alleviate some of its own management workload, USAID could have authorized KPMG, with USAID concurrence on individual awards, to issue the payment checks as well.

C. HEALTH AND SOCIO-ECONOMIC NEEDS OF BOMB VICTIMS MET (SPO IR 2)

While there were, of course, many losses due to the Nairobi bomb blast, the greatest concern was the toll that it took on people. Hundreds were killed, thousands were injured, countless others were traumatized and everyone's lives were changed in some way. Therefore, the greatest priority for the USAID bombing response program was to help address as many of these humanitarian concerns as possible.

1. Medical Payments

The manner in which the terrorists carried out the bombing was guaranteed to create the largest number of casualties possible. When the terrorists first detonated a hand grenade, the explosion drew people to the windows. Seconds later, a second and more devastating explosion created a hell-on-earth scenario. Secondary missiles from the blast in the form of glass shards and disintegrating solid structures sliced and smashed into the faces and bodies of the curious onlookers.

The August 7, 1998 bomb blast killed 213 people. While 600 people were immediately admitted as in-patients to 17 hospitals throughout Nairobi, about 5,000 people were arriving at hospital emergency rooms and being treated as outpatients. Of the original 600 victims hospitalized, by August 19, 131 in-patients remained hospitalized, and of those, 60 were the most serious and costly cases.

Due to the emergency, all public and private hospitals in Nairobi were compelled on humanitarian grounds to assist anyone needing medical treatment. However, because most victims were unable to pay for their medical care, it was unclear in the early stages of the crisis exactly how these costs would be financed. For the hospitals involved, the situation created major expenditure deficits, which they could ill afford. Many Kenyans also denied themselves medical treatment and follow-up because of the costs involved.

At USAID, there was a strong commitment to reimburse Nairobi-area hospitals for the resources they had expended throughout the initial emergency phase of the disaster. After receiving the first $850,000 of ESF resources, USAID contracted in December 1998 the accounting firm of Deloitte & Touche for the purpose of verifying hospital claims and to determine the average cost

per patient. The 17 Nairobi-area hospitals together with the Ministry of Health (MOH) worked out a formula that would establish the basis for such medical payments to hospitals.
Upon review of the reimbursement formula, Deloitte & Touche was satisfied that the calculations would provide cost estimates that were reasonable in paying for the actual costs of treating the victims. Deloitte & Touche arrived at three rates that would establish the basis for hospital reimbursement: a $135 rate for patients screened and sent home, a $1,750 rate for patients screened and operated on, and a $1,750 rate for patients needing repeat surgeries.

Conclusion:

By contracting Deloitte & Touche, USAID was able to obtain a clear and verifiable treatment cost per patient analysis for the purpose of reimbursing hospitals for the medical services they provided victims after the bombing and for which they badly needed payment. Working together with the MOH and 17 Nairobi-area hospitals, Deloitte & Touche was able to work out an equitable reimbursement plan that satisfied all the parties concerned. Utilizing ESF funds, USAID reimbursed 16 Nairobi-area hospitals (one private hospital, M.P. Shah, declined any payments) almost $800,000 for the medical costs they incurred providing emergency medical treatment to in-patient and out-patient victims during the emergency phase of the bombing response program.

2. Medical Care

The bombing caught the Kenyan medical care network by complete surprise. Though many assumed that the number of casualties as a result of the bombing would overwhelm the emergency health care system, Nairobi-area hospitals for the most part were able to cope, though just barely. The truth was that the entire health care system had been stretched to its limits and was unprepared to handle the inundation of injured victims. Specialized emergency skills were seriously lacking in even the better run private hospitals. Emergency blood supplies were inadequate to deal with the demand. Victims, who were extricated out of the wreckage of collapsed buildings by untrained rescuers, more often than not, suffered more physical trauma as a result.

Many of the injured victims, who might have been saved by the application of basic first aid, died as a result of a lack of trained rescue personnel. Rescue operation preparedness in the form of equipment, management and planning was completely lacking. The city mortuary was filled beyond capacity, which resulted in the need to identify cold storage trailers and facilities for the mounting number of dead. Ambulances from hospitals and private organizations were not equipped with life support systems. Medical emergency response capacities of police, fire and ambulance services were unable to handle the situation. Injured victims needing emergency medical care were driven to hospitals in taxis and other available vehicles. All in all, at the time of the bombing, there was no effective logistical and coordinated response to the emergency.

a) African Medical and Research Foundation (AMREF)

Twenty minutes after the bomb exploded in Nairobi on August 7, 1998, AMREF was present at the scene with its ambulances and staff resuscitating and transporting the injured to the nearest hospitals. Ten medical personnel from AMREF headquarters were distributed to different hospitals throughout the city. AMREF established an emergency blood donation center at its

own laboratory collecting and screening more than 600 pints of blood for transfusion. Within three weeks after the bombing, AMREF received a $40,000 grant from OFDA to establish a Bomb Relief Support Unit to help coordinate response activities. The office provided information for survivors and affected families as to where to receive counseling and medical services. By early October 1998, AMREF had set up an information hotline that fielded an average of 100 calls a day from bomb survivors and their families.

At the onset of the crisis, AMREF called upon its supporters and offices in Africa, Europe and North America to assist them in setting up a special East African Emergency Appeal. The appeal collected $1,258,323, of which US$350,000 was used quickly to purchase essential drugs and critical medical supplies for 17 Nairobi-area hospitals. The balance of the funds went to providing direct medical care and assistance to the victims.

During the first two weeks of November 1998, AMREF and Kenyatta National Hospital (KNH), the largest, government hospital in Nairobi, screened 1,482 bomb victims, out of which, 850 were identified as needing reconstructive surgery and further medical follow-up. In response to this need, USAID, AMREF, KNH, and other private institutions joined together and developed a plan for providing clinical services to the bomb victims. A repeat screening was done in February 1999 at KNH to assess to what extent healing had altered the initial surgical and medical assessments. Out of the original 850 victims identified for follow-up, only 680 presented themselves for a repeat evaluation. Of the 680 reevaluated victims, 400 were scheduled for reconstructive surgery. In March 1999, a major reconstructive surgery campaign for 312 survivors was organized jointly through AMREF, USAID and KNH.

An international primary surgical team arranged by AMREF consisted of surgeons, anesthesiologists, nurses and anesthetic technicians. A local surgical team included surgeons, anesthetic technicians, registrars, nurses and support services personnel. The composition of local and foreign medical personnel working side by side created a unique team that provided badly needed surgical care as well as an opportunity, through a professional exchange of knowledge, to learn and refine surgical techniques.

In March 1999, USAID provided KNH a grant for approximately $600,000 to help defray costs of 388 reconstructive surgeries and follow-up medical care. Combining the earlier ESF grant of almost $800,000 plus this grant of $600,000, USAID provided a total of $1.4 million for the medical treatment and reconstructive surgeries of the bomb victims.

During this period, AMREF had registered over 1,200 survivors of the bombing, 70 of whom received dental care, 11 were sent to Germany for eye surgery, and two were approved for other overseas surgery and treatment they could not receive in Kenya.

Medical Assistance Program (MAP)

Realizing the need for continued survivor assistance, USAID awarded AMREF $2.529,737 to implement a three-year Medical Assistance Program (MAP) from July 1999 to September 2002. MAP was designed to coordinate the timely provision of a comprehensive medical, psychological and physical rehabilitation service program for victims of the bombing.

Presently AMREF's caseload is currently at 1,412 consisting of 51 percent male and 49 percent female. The active client base in relation to the registered caseload has been reduced from about 75 percent to 14 percent. Outputs from the MAP program have included over 1,500 medical consultations for various conditions and complications, over 70 surgeries done, fitting and refitting of prostheses, over 140 admissions to hospitals, 900 medical assessments, over 5,000 medical prescriptions dispensed, and 48 children victims offered medical coverage.

MAP activities, throughout the project period have succeeded in providing registered bomb survivors direct ongoing medical care, prescriptions for medications, hospital referrals and admissions. MAP introduced a 10 percent cost-sharing scheme on drugs and $1.25 equivalent per medical consultation. It provided survivors a sense of awareness and education regarding their physical and emotional conditions. Most importantly, MAP provided ongoing psychological care in the form of individual, family and group outreach counseling. During a recent focus group session with AMREF patients, the evaluation team noted that all of them had directly benefited from AMREF's comprehensive medical approach and expressed a great deal of gratitude both to AMREF and USAID for the personalized medical and rehabilitation assistance they have received.

Conclusion:

Right from the onset of the bombing disaster, AMREF assumed the role of a major player in pulling together not only its own medical resources during a time of a medical emergency, but reaching out to other agencies who were also implementing survivor assistance programs. Realizing that specialized resources would be needed to address various medical, physical disability and psychological problems, a strong collaborative relationship was developed with other implementing partners. In working together, these NGOs and firms were able to cross-refer victims to where they, depending on specific needs, would be best served. Even when responding to medical prescription and victim identification card fraud, AMREF responded by taking immediate action to inform participating partners, who immediately implemented changes to prevent future fraud. To date, AMREF continues to provide excellent medical care to bomb victim survivors. As a spin-off from this USAID sponsored project, AMREF developed its own Disaster Management Plan (2nd Draft, June 2002) and as a result, AMREF is better "disaster prepared" now, than it was in August of 1998, to assist with emergencies in Kenya.

b) Special Surgical Cases

There were also special cases requiring multiple surgeries and extreme types of medical care. For example, USAID obligated $75,334 for reconstructive surgeries for a victim who, while on fire, had jumped out of the 5th floor of the Coop Bank building. The victim received emergency surgery at KNH, was medically evacuated for reconstructive surgery to Germany, followed by lower leg amputation and extensive facial and dental surgeries in the U.S. In addition, USAID funded $12,000 through AMREF to support a patient who had undergone surgery for a compressed spine. The American Women's Association and AMREF had originally sent the victim to South Africa, but were unable to pay for all her medical and surgical expenses. USAID stepped in and was able to use residual ESF funds to help defray the victim's surgical and medical follow-up costs.

Conclusion:

The only conclusion that the evaluation team could possibly reach was that USAID has done an outstanding job in providing financing and arranging for the medical care for all victims of the Kenya bomb blast. It has truly been a compassionate action on the part of the USG and should be heralded as such by all concerned. There are continuing needs, however, that financially challenge the individuals and organizations involved and that could continue to benefit effectively from any available USAID assistance.

3. Mental Health Counseling

a) Initial USAID Support

The immediate sense of loss combined with the physical and emotional trauma that the bomb victims experienced produced feelings of severe anxiety, grief and anger, feelings that can cause ongoing post-traumatic stress reactions, distress and impaired functioning. Individuals who experienced the bombing disaster second-hand were also dramatically affected by the death of fellow citizens, friends and loved ones, and by the carnage and human devastation to which they were exposed.

To its credit, USAID/Kenya realized from the onset of the bombing disaster, having learned from other experiences like that in Oklahoma City, that there would be, among other urgent emergency medical needs, a critical demand for mental health support services for the victims of the attack. The Mission responded immediately by providing both financial assistance and technical expertise using OFDA resources. Mental health experts from the U.S. Public Health Service (USPHS) and the Oklahoma University School of Medicine were requested by USAID's OFDA to come to Kenya and assist in a number of tasks related to the psychological sequel to the bombing event. One of the main objectives of their visit was to help the USAID Mission draft a scope of work for an eventual major mental health project.

In addition, the Kenyan Medical Association (KMA) requested assistance from the Mission to assist it in a number of tasks related to the psychological reaction to the bombing. USAID/Kenya responded by making available a mental health expert from the USPHS. Meetings and discussions were arranged with relevant mental health service providers, MOH and other professionals outside of the KMA to determine exactly what the mental health problems were. During Grand Rounds at the Nairobi Hospital, a presentation was made on the topic of mental health consequences to disasters and terrorist events. Upon completion of the needs assessment, a report with recommendations on the mental health needs for the victims of the bombing was provided to USAID and shared with the KMA and MOH.

Conclusion:

USAID responded quickly in realizing the need for immediate mental health intervention in the form of funding technical expertise. Providing support for locally active mental health service providers, it indicated USG concern for the emotional and psychological effects that the bombing had on the victims and the Kenyan people. The KMA and MOH benefited from the American technical expertise in providing information on the consequences of mental health trauma on a population experiencing a terrorist event.

b) Operation Recovery (OR)

Operation Recovery (OR) was a project initiated by the KMA to respond to the psychological and mental health needs of the bomb blast victims. The main objective of the project was to provide psychological support and mental health counseling to those Kenyans that were injured and to victims that were either directly or indirectly emotionally affected by the bombing. The KMA officially launched OR on August 13, 1998. During the emergency response phase of the bombing, OR immediately began providing emergency mental health services to victims, who were emotionally traumatized by the horror and extent of carnage caused by the bombing. During the initial phase of the emergency, OR initiated a series of radio and television emergency updates, providing listeners with a running commentary on the bombing, ongoing relief efforts and where to obtain medical assistance and counseling.

On November 7, USAID/Kenya awarded the KMA a grant of $50,000 to provide immediate funding for approximately three months in support of continued mental health counseling services through the OR project. Later, to continue OR activities for an additional six months, in April 1999, OR received a second USAID grant of $100,000. Through this project, OR provided counselor training, trauma counseling, outreach activities in communities where many of the victims had returned and an awareness of mental health needs for bomb victims. OR developed instruments for data collection to document the effects of the blast by noting the kinds of physical injuries suffered, deaths of loved ones, emotional effects and financial losses.

OR came into existence immediately after the bomb blast. Since there was little time to organize training and supervision for counselors, overall the organization worked on an ad hoc basis putting rules in place as it saw fit. During the crisis response phase of the disaster, OR grew too rapidly, moving forward with little technical capacity, inadequate funding and without a clear mission. Counselor morale suffered because counselors felt that documentation and the gathering of research data had a higher priority than providing mental health counseling to the bomb victims. By the time OR received its second USAID grant in May 1999, many of the OR staff had already left because of not being paid. More problems arose over complaints of OR's poor administrative practices and accounting mismanagement, which many felt was responsible for service providers' receiving delayed payments, partial payments or, in some cases, no payments at all. Overall confidence in OR as an organization ultimately took a down turn, which affected OR activities, causing them to shut down operationally.

A complete analysis of the of the data gathered by OR is unavailable, but a broad stroke review of available information indicates that out of 2,883 adult victims that responded to OR questionnaires, 1,038 had received some form of initial mental health counseling in the form of debriefing or crisis counseling at the time of being interviewed. 60 percent of those claimed that their symptoms improved after inter-acting with a mental health provider. However, this lack of information and reporting to USAID about actual performance, the aforementioned management problems and major communications problems led to serious relationship issues between OR and the USAID Mission.

In May of 1999, USAID/Kenya issued a Request for Applications (RFA) for a two-year, $1 million Cooperative Agreement in support of a mental health counseling program. Through a competitive evaluation application process, OR was unsuccessful in their bid. The primary

reason for OR not being awarded a new grant was its lack of institutional capacity to manage effectively a $1million grant.

Conclusion:

Though it was plagued with a lack of institutional capacity, management problems and minimal financial support, OR deserves credit for taking the initial lead among Kenyans and responding to the disaster by activating an extensive network of psychiatrists, psychologists, mental health professionals, religious leaders, NGOs, social workers and volunteers. OR's rapid intervention, alongside other mental health service agencies and providers, may have significantly reduced the levels of psychological trauma and post-traumatic stress in those directly and indirectly affected by the bombing disaster. However, OR's efforts were not sustainable and USAID rightly discontinued its funding.

c) International Federation of Red Cross and Red Crescent Societies (IFRC)

On July 6, 1999, the International Federation of Red Cross and Red Crescent Societies (IFRC) succeeded OR by entering into a $1.2 million cooperative agreement with the Mission. The purpose of the project was to provide a broad range of mental health counseling services, counselor training and outreach programs for adults and children.

IFRC, though not itself an operational organization, accepted the role of grantee on behalf of the Kenyan Red Cross Society (KRCS) that was the project's actual implementing agency. KRCS' implementation plan was to network with other Kenyan mental health service provider agencies that would provide direct counseling services to the bomb blast victims. The three counseling centers that were selected to assist in providing individual and group counseling services were the Amani Counseling Center, Neema Counseling and Training Center and the Oasis Counseling and Training Center.

The KRCS managed the Crisis Mental Health Program to assist victims directly affected by the bombing. During the project period, 3,992 people were contacted in Nairobi and in the rural areas through KRCS' outreach activities. Out of the 3,992 contacted, 905 adults and 281 children were evaluated and referred to counseling services. Out of a total of 1044 victims that were assessed by KRCS, 72 were terminated from the program. The clinical management and treatment of the remaining 972 adults and children were to be eventually taken over by Amani in the successor project.

Nine months after the IFRC signed the USAID cooperative agreement, KRCS had done little to meet the time considerations of the implementation plan of the mental health project. Nearly every aspect of the project was four to eight months behind schedule. KRCS began procuring essential equipment only in December 1999, nearly six months after the project had started. Computers were still not available for documenting outreach activities and for counseling needs as of February 2000. A serious lack of trained staff, office space and essential equipment were major factors in causing the counseling sessions to fall behind schedule for victims. By the end of January 2000, only 650 counseling cases, of a projected 4,000, had received any screening or counseling. By March 2000, only two of the 12 community outreach meetings planned for the first year of the project had been arranged. A major indicator of the KRCS' poor performance was also in their poor financial management of the project.

Conclusion:

KRCS' overall management problems and a lack of cooperation resulted in strained relations between IFRC and KRCS with USAID. On March 17, 2000, the Head of the Regional Delegation of IFRC in Kenya reached a management decision that the IFRC would not be able to meet the obligations of the agreement and would return to USAID the project's equipment and remaining unspent funds of $850,000. It thus requested that USAID identify another implementing agency for the Crisis Mental Health Program.

d) Amani

On June 26, 2000, USAID awarded a competitively procured contract to the Amani Counseling Center for the Crisis Mental Health Assistance Program. Amani had now become the third organization to manage this key project, although it had been involved as a sub-grantee with the two preceding implementing organizations providing counseling services and training from the moment of the disaster. Thus, Amani was well placed to take over and continue providing ongoing counseling services. As the new project began, USAID recommended that Amani retain the premises previously used by KRCS, most of the qualified staff and implementing partners, many of whom had started with OR, in order to maintain a continuity of services. Learning from the mistakes of the two previous organizations, Amani strengthened its technical capacity by hiring a consultant psychiatrist and an experienced program manager.

Amani essentially continued the program from where KRCS had left off in September 2000. Amani was committed to continue its support of mental health activities and projects that were already in place. Amani applied the same data collecting instruments and retained most of the implementing partners that had worked with KRCS. Amani also entered into a memorandum of understanding with the University of Oklahoma School of Medicine's Department of Psychiatry to engage in a collaborative research study, providing research assessments on 400 adult and 200 child victims. The research team consisted of doctors from the U.S. and Europe. These outside specialists were considered experts in the disaster field and provided Amani with a technical resource on research, documentation and data gathering capabilities. Data collection methods and instruments that were used during the Oklahoma City bombing were now introduced into Kenya (See Annex F for more details on Amani's work and impact).

When Amani began this project, several local organizations were being identified as possible implementing partners. Following a thorough review process of the agencies involved, where some were found to have irregularities in record keeping, it was decided that Amani would be better served by partners whose agents and counselors had been credentialed through Amani. The approved implementing organizations were the Neema Counseling and Training Center, specializing in counseling services for children and adults; Lifesprings Counseling Center for adults; and the Oasis Counseling Center, providing counseling services for children.

Having established itself as the primary mental health counseling service provider and referral center, Amani developed a collaborative relationship with other organizations, including AMREF and the Adventist Development and Relief Agency (ADRA), which were also assisting bomb blast victims and survivors. Victims, who were physically disabled and receiving medical care and follow-up treatment, were frequently diagnosed as suffering from severe depression or stress related illnesses. Many victims were identified as suffering from post- traumatic stress

disorder (PTSD) and related symptoms. As agreed upon by all of the collaborating partners, individuals that were recognized as needing psychological assessments and psychiatric evaluations were referred to Amani for counseling and treatment.

Amani staff overcame several major challenges during their transition period from KRCS to Amani management. Although it was the third organization to manage the mental health program, it had learned from the mistakes of OR and the KRCS. Retaining the better, former KRCS coordinators and counselors, Amani was able to capitalize on their experience and technical expertise. Amani's ability to work well with other organizations proved to be a major strength. It was able to utilize these outside resources to provide training, child counseling and psychiatric treatment directly to the bomb victims. By doing so, it could also concentrate on strengthening its management capacity, outreach projects, research and information documentation activities.

Conclusion:

Amani proved to be technically competent and a financially responsible organization. Because of its excellent reputation as a certified training institution for counseling, Amani was able to lead in forming an association with other service providers. Those agencies engaged in physical rehabilitation, medical care and mental health counseling and, in a collaborative effort, were able to develop a referral plan for their patients through Amani's network. Upon review of the data from the Amani Crisis Mental Health Assistance Program, the team concluded that this project clearly exceeded in achieving many of its performance indicators. Many bombing victims, however, will still require mental health care after the presently planned termination of this USAID project.

The bombing response program has clearly given a major impetus to a better understanding of mental health care in Kenya, particularly in connection with traumatic experiences. Many experts also see many parallels with the stress related to the HIV/AIDS syndrome, where counseling of the victims and their families is very important and needed.

e) University of Oklahoma

There are major gaps in knowledge about the impact of large-scale terrorist incidents, the course of recovery following these events and the effectiveness of treatment. Much of the current literature focuses on PTSD symptoms without regard for their effects on distress and functioning, both crucial in estimating the impact of trauma especially in settings where cultural beliefs and attributions about trauma and its effects may influence the outcome.

In August 2001, The University of Oklahoma Health Science Center, Department of Psychiatry and Behavioral Sciences research project was awarded a USAID grant of $126,633, to assess the victims of the August 7, 1998 bombing in Kenya utilizing measures employed in previous disaster studies. Using the initial adult victim sample assessed in 1999 as part of another federal grant, the research project studied the course of post-bombing symptoms. The project obtained information about bomb related distress and functional impairment and the duration of symptoms, which is helpful in estimating the cost of post-event assistance in future incidents. This information will ultimately provide a useful starting point when allocating limited resources and personnel in the face of an increasing number and intensity of possible future terrorist

attacks. The study provides knowledge about culture-specific and cross-cultural responses to large-scale terrorist events, which will improve the theoretical understanding of trauma reactions and systemic responses to such disasters.

A sample of 129 individuals who had been evaluated six to ten months after the Kenya bombing were reevaluated two to three years later. The adult victim follow-up sample included 48 males, 68 females and 13 who did not report their gender. Most of the participants retrospectively reported strong responsive reactions, such as nervousness or fear, tachycardia, and trembling or shaking. Most were injured and needed medical care and many had yet not fully recovered. Most lost time from work because of the bombing, with an average of 55 work-days lost. Participants reported ongoing post-traumatic stress reactions, distress and impaired functioning. Numerous participants had experienced other traumatic events.

The majority of the participants indicated that mental health services were available and most had received counseling after the bombing. Many received two or more forms of counseling and felt that the counseling was helpful or very helpful at most. Reasons for not obtaining services included concerns about the personal financial costs of treatment, inability to get an appointment, lack of time, concerns about confidentiality, worries about stigma, embarrassment, and the feeling that the problem resolved itself.

Conclusion:

Upon review of this Oklahoma University report, it confirms the fact that a strong mental health intervention, focusing on debriefing and counseling primary and secondary victims immediately following a major catastrophic event, can substantially decrease post-traumatic stress reactions. USAID/Kenya was thereby correct in its project actions.

4. Medical, Social and Economic Rehabilitation

The August 7, 1998 bombing of the U.S. Embassy in Nairobi left about 5,000 injured. Although immediate medical assistance was provided, many of the survivors required specialized care. Some became blind, deaf or even physically disabled. Their lifestyles changed permanently and it was necessary that they be reoriented to their new conditions. The work of rehabilitating the survivors physically, mentally, socially and economically was entrusted to the Adventist Relief and Development Agency.

Adventist Development Relief Agency (ADRA)

From the moment of the bombing, ADRA was involved in assisting survivors of the disaster. Responding immediately by mobilizing personnel and local resources, ADRA began transporting victims from the blast site to hospitals and providing volunteers to assist victims in the hospitals. ADRA went on to recruit donors for blood donations and provided food and other needed items for the victims. In the weeks following the bombing, ADRA, in collaboration with AMREF, was instrumental in coordinating information on the activities of NGOs providing support to the victims.

Prior to receiving USAID funding, ADRA, through its own network, mobilized resources in and outside of Kenya, receiving $70,000 from various ADRA donors. AMREF, through its own

fund raising activities, provided ADRA with $100,000 to further ADRA's efforts in providing needed services. These funds allowed ADRA to assist over 500 victims with medical and economic assistance.

a) Nairobi Bomb Survivors Follow-Up Services Program

In May 1999, USAID provided the first grant to ADRA for follow-up services to the survivors. The grant has gone through two modifications, with the second modification intended to provide small enterprise development services for the survivors. A total of more than $2 million was granted for various rehabilitation services. ADRA has implemented all of the project activities in collaboration with various organizations that address persons with disabilities. These are the Association for the Physically Disabled of Kenya (APDK), Kenya National Association for the Deaf (KNAD), Kenya Society for the Blind (KSB) and the United Disabled Persons of Kenya (UDPK).

The Nairobi Bomb Survivors Follow-Up Services Program grew out of a need to rehabilitate disabled victims who had survived the bombing disaster. Of the 5,000 victims injured, 332 of these cases were severely disabled as a result of the bomb blast. There are 23 victims who are totally blind, 75 with severely impaired vision; 15 totally deaf, 49 with severe hearing impairment; 3 with total paralysis from the waist down; 165 with severe bone and muscle injuries; and all 332 of the bomb victims being psychologically traumatized and severely depressed.

The objective of the project was to target over 400 severely disabled victims, who had suffered directly from the terrorist attack. ADRA and its sub-grantees provided outreach services in the form of home visits by case managers to primary and secondary bomb victims. These visits facilitated effective management of the physical and emotional needs of the disabled victims. It provided rehabilitation services in the form of supportive care through occupational and physiotherapists. The end result was to facilitate the victims' physical and emotional rehabilitation and the eventual reintegration back into their respective communities as functioning participants.

Due to the complexity of the caseload, and the inherent overlap among service providers, ADRA adopted a centralized record keeping system on the disabled victims' information concerning their specific disabilities. This patient profile and record keeping system allowed ADRA to implement a case management approach, ensuring the efficient and effective management of patients, coordination of rehabilitation services with other organizations and accountability to donors.

Upon review of project documents and during discussions with each of the implementing partners, evaluation team members noted that the project had exceeded the project's objectives. It not only provided successful rehabilitative services to disabled bomb victims, but through a strong management supportive role, it upgraded and strengthened the financial and management capacities of all the partners involved in the project. Collaborating under ADRA's "umbrella," all of the partners stated that during the project period, a closer personal and professional relationship had developed among all the agencies, and a realization of the need to work together rather than in competition with each other. It was noted that time and limited resources were

saved due to a sharing of information on the victims, which in the end avoided duplications of efforts.

As the primary NGO coordinator, ADRA provided its partners with computers and a standardized financial management system. It provided training for accountants and built up their capacities in financial reporting, instilling a sense of financial discipline. Collaborating NGOs that earlier used manual accounting systems greatly benefited by incorporating these accounting systems into their own financial management practices.

Rehabilitation was divided into two phases. The first phase addressed the survivors' physical, medical and psychological needs. The second phase focused on their overall economic needs. Implementing partners and collaborating agencies alike stated that they were extremely satisfied with the medical, physical and mental health rehabilitation services the survivors received and benefited from.

Survivors' views were also an indication of the success of the project. During a focus group meeting with participating survivors, they informed the evaluation team of their satisfaction with the referral system and expressed their gratitude for the rehabilitative approach, which enabled them to move from one stage of the rehabilitative process to the next. The participants also expressed their sincere appreciation for USAID's assistance to their rehabilitation.

Conclusion:

The evaluation showed that the rehabilitation of the survivors was successfully, professionally done and that a comprehensive approach contributed to the overall medical, psychological and general well being of the survivors. Many of the blind and physically disabled, for example, went on to become active members of their respective organizations (i.e., KSB, APDK), even with the ending of USAID's financial support.
During the project period, ADRA was able to prove that the close collaboration between itself and its implementing partners contributed to the overall success of the project.
Overall, the project had a sizable impact on all the implementing organizations involved as well as the individual victims and their families. Capacities were built up and strengthened within all the participating NGOs. Partnering during the implementation of the project led to a savings of limited resources, provided bigger impact and created opportunities to learn from each other. Most importantly, ADRA's holistic rehabilitative method provided the more than 400 survivors with a deep sense of appreciation for the personalized treatment and care they had received throughout the life of the project as they continue to resume more normal lives.

b) Economic Assistance to Survivors

UDPK has played a key role in providing economic rehabilitation for the survivors. A sub-grant from ADRA enabled UDPK to implement three activities, namely small and micro-enterprise development, vocational skills training and job placement.

1) Micro and Small Enterprise Development (MSED)

The objective of the MSED activity is to provide business training and loans to empower the survivors to be economically self-sufficient. The project has trained 568 survivors in business

skills and disbursed 332 small loans. The loan portfolio has grown six-fold over three years, with the clients starting small and graduating to bigger loans after repaying the previous one. Interest has been very low (5 percent), but will increase somewhat when the USAID support ends in order to cover operating costs. Business counseling is given prominence because most beneficiaries are in business for the first time. Loan recovery has averaged at above 95 percent. Loans are rescheduled if the beneficiaries have problems and lag behind in repayments for the best interest of the business as well as the recovery of the beneficiary.

The following are the targets achieved by MSED during its three years of activity as of the time of this report:

MSED Training and Loans Provided:

Year	Business Training		No. Of Loans	
	Target	Actual	Target	Actual
1999/2000	50	98	48	98
2000/01	200	220	165	84
2001/02	250	250	160	150
Total	**500**	**568**	**373**	**332**

The statistics testify to the good performance in business training as well as loan disbursement and repayment. As the beneficiaries go through the healing process, their interest in the MSED fund has increased. The participants are gaining confidence economically and many of them testify that the MSED fund has made a great difference in their lives. The effects are, however, dampened by the unfavorable economic situation still prevailing in Kenya.

UDPK has operated this project very well and will continue it after discontinuation of USAID's funding. The participants have already started to discuss the formation of a micro-finance group under their own management. UDPK itself has gained a lot of experience in micro-finance and has started exploring possibilities for bridging funds.

Conclusion:

The MSED activity has operated very well and should continue to run under the guidance of UDPK until the beneficiaries establish their own savings and credit organization. The beneficiaries are requesting that interest rates be kept low for the time being, but this cannot be realized if the management costs will come from the interest paid. UDPK has proven itself to be a reliable and credit-worthy partner in micro-enterprise activities.

2) Vocational Training

Some of the bomb blast survivors have lost their jobs due to poor health or because they no longer qualify for such jobs. For example, there are those that lost sight or hearing and need retraining to go back to the labor market or become self-employed. Opportunities have been provided for the survivors to acquire vocational skill as follows:

UDPK Vocational Training:

Period	No. Targeted	Accomplishment
1999/2001	50	50
2001/02	98	115
2002/03	263	184
Total	**411**	**349**

Among those that have received vocational training, many have been able to start their own businesses. Some have benefited from the MSED activity to start new businesses and are doing well. There are others who have jobs with new employers. While the search for employment has been hampered by Kenya's poor economic conditions, the beneficiaries are grateful for their new skills and acknowledge that they are now better prepared to resume a more normal life after the tragedy of the bomb blast.

Conclusion:

UDPK's vocational training has been very successful. The skills provided are marketable in the present job market or in starting one's own business.

3) Job Placement

UDPK's job placement was expected to serve those survivors that had lost their jobs due to injury and had recovered sufficiently both physically and psychologically to go back to work. It has also assisted those that had gained new vocational skills to obtain new jobs altogether. This activity has placed 42 survivors either with their previous or new employers. Because UPDK is well aware of the negative attitude towards the disabled in the workplace, it has continued as an advocate for the survivors with employers.

UDPK Job Placements:

Period	No. Targeted	Accomplishment
1999/2000	26	17
2000/01	25	4
2001/02	58	21
Total	**109**	**42**

As the statistics show, this has been one of the most difficult activities to implement because the current economic situation is forcing employers to retrench their existing employees. Those that are placed have to display exceptional skills in their area of work

5. Educational Support Program (ESP)

The Educational Support Program (ESP) has been one of the most important projects under the USAID bombing response program given the high value placed by Kenyan parents on the education of their children. The project's objective has been to provide for the schooling of 1) all children who lost in the blast their mother, father or breadwinner; and 2) all children whose parents were severely injured during the blast and cannot now provide any or the same income as

before. This project has been handled by two implementers to-date: IFRC through its local chapter, the KRCS, and the local offices of Ernst and Young (EY), a U.S. accounting firm.

a) IFRC/KRCS

IFRC and KRCS had helped in the bombing emergency from the first day and had received substantial assistance from foreign embassies in Nairobi. Because they had worked with the victims and their families (providing food and counseling), they were already familiar with the situation of the affected families. They were also implementing a school fees program for 49 children of blast victims using funds from other sources.

In February 1999, IFRC presented to USAID a proposal to pay school fees for children of those who died in the August 1998 explosion or those who were permanently injured. IFRC was awarded the grant through a competitive process and was deemed to have the experience required for the job. USAID signed a $1.4 million cooperative agreement with IFRC in May 1999 and it was estimated that $ 2.5 million would be required for the total program, then scheduled to last for two years. IFRC had a good record handling USG funds and experience in helping with the bombing emergency. Thus, it was expected to produce results immediately by ensuring the prompt payment of school fees for the third (final) term of the school year. IFRC's proposal indicated that KRCS would handle the actual implementation of the project.

KRCS publicized the project and started the difficult task of screening eligible children, using their earlier experience with these families. KRCS, however, had internal management problems that slowed down the decision making process, especially in setting firm criteria, leading to abuses in the selection process and thus tainting the project. Also, due to poor staff capacity, payments of school fees lagged behind and complaints from parents and guardians started flowing in, many of them directly to USAID/Kenya. Interviews with parents reveal painful moments while they were still in the hospital being treated for injuries and they were receiving reports that their children had been sent away from school due to non-payment of fees, even though the USG had promised to pay such fees.

Some of the other indications that the project was not going well were: a) it took seven months to hire needed project staff; b) fees did not get to schools at the opening of the term and the children were sent away from school; c) there were many returned checks because they went to the wrong schools, had wrong amounts or wrong names; d) files were lost, although some beneficiaries claim to have sent documents many times before their cases were assessed, while some were not assessed at all; e) due to lack of firm criteria some people that were not genuine victims tried to take advantage of the program; and f) project reports did not get to the IFRC and USAID as expected.

During the period, 687 children received school fees support while 800 had been projected. These children could be classified as follows:

Category	No. of Beneficiaries	No. of Children
Deceased	107	241
Injured	215	446
Total	**322**	**687**

USAID/Kenya expressed its serious concern on the low performance of the project to IFRC and IFRC promised that it would assist KRCS to deliver as agreed in the contract. While IFRCS had noted the declining capacity within its local chapter, it could not implement the project from the regional office. However, with stricter IFRC supervision, measures were put in place to ensure accountability in funds and results. Still, KRCS' performance did not improve significantly and IFRC reached the difficult management decision to request USAID in March 2000 to terminate the IFRC/KRCS role in the ESP project. IFRC then returned all but $350,000 that had been spent on the project.

Conclusion:

While KRCS was unable to manage the ESP, it should be noted that most of the staff that worked there moved with the program to Ernst & Young (EY) and have been there to-date doing a very good job. This indicates that the main problem was in the senior management of KRCS as well as in a lack of workable systems. When the staff went to EY and had proper supervision and management systems, they were able to deliver.

b) Ernst & Young (EY)

Ernst & Young (EY), a U.S. accounting firm, presented a proposal to USAID/Kenya through a competitive process and was awarded the ESP contract in May 2000. They were initially expected to deal with the backlog of fees from the IFRC/KRCS period, and specifically ensure that the third term school fees were paid on time, which it did. This was essential for the credibility of the project. After that, E&Y would set firm criteria for the identification of beneficiaries, define what should be included in "school fees" and set up management systems.

EY took over 687 children from IFRC and, in order to ensure a smooth transition, engaged all the KRCS program staff on three-month contracts based on their previous work. One-year contracts would later be signed with staff that were needed and proved capable of managing this key project efficiently.

During the second quarter of operation, EY worked out firm eligibility criteria, which were published in the local press. The beneficiaries were categorized as: a) school- going dependents of victims that died, if the victim was the family's breadwinner; b) bomb blast survivors, who had to be the family's breadwinner, must have received KSh.60,000 or more in compensation from the National Disaster Committee due to the extent of injuries and the applicant's name had to be on that committee's list; and c) the degree of permanent physical disability caused by the bomb blast must be 20 percent or greater and had to be confirmed medically.

The clear criteria attracted new applicants plus those that had applied to KRCS and had not received any response. By the end of the year 2000, the number of beneficiaries rose to 455 with 894 children. There was a steady increase of children and by September 2001, the optimum figure of 1,432 was reached for children around the country. This improved performance was facilitated by EY's decision making and management systems that included: a) employment of a senior manager with the authority to make decisions on the implementation of the program; b) development of a filing system to facilitate client follow up; c) hiring a reliable courier firm to deliver the checks to all the schools in the country; d) housing the project in a more workable and larger office space to facilitate consultation with clients and proper storage of documents; e)

involvement of text book and uniform suppliers in order to standardize purchases and avoid refunds; and f) the development of a data base for the project. (See Annex G for the numbers of children benefited and the geographic distribution of the ESP).

The direct and secondary stakeholders indicate that EY has managed the program well. The schools have received their checks within a week of opening and none of the schools interviewed by this evaluation team have had cause to return checks due to error. Having to send children out of school is a painful experience for the schools and they are happy that they have not had to do so over the last two years. The parents and guardians are extremely pleased with the reception they have received at EY whenever they have required any clarifications on issues. They indicate that they have not received any complaints from the schools since EY came into the project. USAID/Kenya has received reports regularly and EY has made it easy for the Mission to monitor the project.

At its optimum in January 2001, the population of children rose to 1432 and $ 297,279 equivalent was paid as first term school fees. This represents a growth of 108 percent in enrollment in the project between July 2000 and September 2001. The new criteria have broadened the base of applicants and EY has been able to pay fees on time.

Interviewed individually and in a focus group, the beneficiaries have expressed to this evaluation team their deep appreciation for the ESP and the USG's support thereof. Even with all the problems that arose under KRCS, many still believe that the relief from having to think about their children's school fees played a great part in helping them to recover both psychologically and physically. This is because education is highly valued in Kenya and parents are bound to feel inadequate if they cannot provide for their children's schooling. The guardians of the children of the deceased extol the ESP as best for the children. Considering the economic situation in the country, most could never afford to provide a good education for their own children and at the same time assist the orphaned children. When asked to prioritize the projects that have been assisting the bomb blast survivors, ESP has consistently been named as a top priority all the time.

Conclusion:

In short, EY has done a very fine job in managing the ESP. It is now a well operating priority project. Part of this success is due to the fact that the requirements involved are really accounting and management functions, which play to EY's strength. USAID/Kenya made a wise decision in eventually viewing the project in this light and changing implementing partners.

The current ESP is currently expected to close on September 30, 2002. While the beneficiaries have been informed all along that the project was to end, most of them have kept hoping that funds would be available to extend it until all of the children graduate from high school. However, discussions with the beneficiaries reveal that they are at different levels in terms of recovery from the bomb blast effects and becoming economically empowered. For example, there are those that have recovered reasonably well from the injuries, have a secure source of income and would be able to pay for their children's school fees. There are others that lost their spouses in the tragedy, but they also have a secure income and will be able to pay for their children through school.

While all beneficiaries would like to receive ESP assistance if it continues, many are sympathetic to the more vulnerable groups, which include children of a) single parents who died in the tragedy or thereafter due to bomb related complications; b) parents who were the sole breadwinners, but were permanently injured physically or psychologically and have not recovered sufficiently to obtain a job; and c) parents who died in the tragedy and the surviving parent has no means of earning an income. It has been stated many times over by survivors and others that if the ESP is discontinued, many of these children will stop going to school immediately. Therefore, given the importance of the ESP, USAID needs to consider seriously applying some of the residual funding from the overall bomb response program to extend the ESP for an appropriate period of time, informing all stakeholders accordingly of this continued USG assistance.

6. The Memorial Park

The Memorial Park is located on the former site of the U.S. Embassy and the Ufundi building. The idea of having the park came up when the USG decided to build a new embassy at a new location. A group of interested people came together and formed the August 7th Memorial Trust and started raising funds for the construction of the memorial park. USAID contributed US$175,000 towards that fund. The trust will be responsible for the management of the park and continue to make improvements. The park, however, belongs to the people of Kenya as a memorial to those who lost their lives there.

The U.S. Embassy site was opened to the contractor in June 2000 when construction work started. The park was completed in October 2000 and the names of all who died in the blast are permanently inscribed on a granite wall. In the same month, a decision was made to give the Ufundi site also to be used as part of the memorial. The trust is in the process of obtaining funds to complete the park with the building of a small museum where reading materials on the bombing can be kept so that the facts will be preserved.

Conclusion:

The memorial park is a very good idea because it acts as a reminder of the events that took place on August 7, 1998 and the fact that terrorism is a reality. It has also become a place of solace and reflection for those who lost their loved ones. Since most of the deceased are buried in their ancestral homes, members of the family who live in Nairobi can always go to the park to remember. The park is also open to members of the public, who would like to reflect on the events of August 7 or just sit quietly. The entrance fee is only about 25 cents equivalent, which is used for the maintenance of the park.

D. PREPAREDNESS FOR FUTURE DISASTERS ENHANCED (SPO IR 3)

Kenya's ability to handle to respond effectively to the August 7, 1998 bombing was clearly stretched to capacity and in many ways the GOK could not cope with needs, relying very much on the goodwill of individuals, hospitals, donors, NGOs and other service providers. In short, at the time of the blast, the GOK had no formal disaster preparedness plan and there were insufficiently equipped and trained rescue services, inadequate mortuary facilities and questionable blood safety.

It is within this background that USAID launched its SPO to meet critical needs of Kenyans affected by the Nairobi bombing, with IR 3 designed to enhance preparedness for future disasters. Thus, the USAID bombing response program planned to strengthen Kenya's blood transfusion services, emergency medical response capabilities and disaster management and coordination.

1. Strengthening Blood Safety

For some time now, the demand for blood products in Kenya has grown tremendously. Most blood transfusions are used primarily in young children for the treatment of malaria-associated anemia, among child-bearing women for pregnancy related anemia and for trauma and surgery. For instance, MOH figures indicate that in Nyanza Province, a highly malaria endemic area, up to 20 percent of hospitalized children are transfused. With the increase of HIV/AIDS and other blood borne diseases such as Hepatitis B and C and syphilis, the MOH is trying to improve its screening, thereby providing transfused patients with safe blood. Currently, reagents for Hepatitis C are unavailable, but identifying Hepatitis C is a future goal of the MOH.

In 1994, the MOH conducted a workshop on strengthening and reorganizing blood transfusion services in Kenya. In 1998, UNAIDS funded an assessment of the blood transfusion services in the country and strongly recommended that Kenya's blood services be reorganized.

The Blood Transfusion Services (BTS) in Kenya are managed and coordinated by the MOH's National Public Health Laboratory Services (NPHLS). In this role, the NPHLS delegates the collection, storage and distribution of blood to individual hospitals. The blood transfusion services are thus hospital based with each hospital collecting its own blood. The MOH wants to make the BTS at least a semi-autonomous entity that has its own line item in the budget, but that eventually can source its own funds and conduct its own business.

Currently, there are 190 facilities that provide the BTS throughout the country. Tables 1 and 2 give a detailed breakdown of these BTS facilities.

TABLE 1
Regional Distribution of BTS Facilities

Province	Number of BTS	% of total
Nairobi	16	8.4
Central	25	13.2
Eastern	26	13.8
North Eastern	3	1.6
Coast	16	8.4
Rift Valley	43	22.3
Nyanza	38	20.1
Western	23	12.2
Total	**190**	**190**

TABLE 2
Distribution of BTS Facilities by Provider

Provider	No. of BTS	% of total
Government	91	47.6
Private	58	30.7
Church run hospitals	41	21.7
Total	**190**	**190**

This fragmented collection of blood makes it impossible for the MOH to guarantee the safety as well as the quality of blood available in these centers. During the disaster, the MOH had not yet developed a comprehensive national blood policy. Only piecemeal guidelines were issued from time to time giving direction on blood transfusion standards.

Kenya obtains its blood from several sources, which include relatives or friends of the sick, students and a small number of registered donors, auto-transfusion and paid donors. The drawback of this system is its non-predictability in the availability of blood products and the suitability of donors. Also, the responsibility for mobilizing donors is borne by the individual hospitals and the patient or family.

A study carried out by the Japanese International Cooperation Agency (JICA) in 2001 revealed that 82 percent of government run hospitals had inadequate facilities to collect and screen blood. This study showed that only 65 percent of the GOK hospitals had physical facilities that could provide effective and reliable BTS all the time and of these, only 44.6 percent had working equipment. The same JICA report found that registers are poorly kept and are not up to date in most of these facilities. Monthly reports are not being done and most records are manually kept. Despite the many such studies, the GOK never took any steps to strengthen the blood transfusion services in the country. The 1998 bomb disaster, therefore, found the BTS unable to supply safe blood to the victims.

Against the above background, in 1999, USAID/Kenya signed a cooperative agreement of $2.062,331 with Family Health International (FHI) to establish a program whose core activity was the development of a comprehensive blood transfusion service with a centralized blood donor mobilization and education system, blood collection, testing, distribution, quality assurance and staff training. The initial cooperative agreement aimed at establishing a National Blood Transfusion Center in Nairobi, and one regional center in Kisumu. After an assessment conducted by USAID, MOH and FHI in April 2000, however, it was decided that additional regional sites needed to be constructed at Nakuru, Mombasa and Embu and three satellite centers along the Trans-African Highway where numerous road accidents occur. Consequently, the cooperative agreement between FHI and the Mission was modified in September 2000 to cover these additional costs.

In November 1999, USAID/Kenya excluded the refurbishment and construction of centers from FHI's scope of work. Instead, through its PASA with the U.S. Army Corps of Engineers, the Mission directly undertook the construction of the centers. The revised FHI scope of work includes provision of equipment and furnishings to the centers, staff training and the development and implementation of a quality assurance program. Working through a sub-agreement with the KRCS as a sub-grantee, FHI would assist with the recruitment and retention

of low risk blood donors and support the development and dissemination of a national blood policy. FHI also agreed to work with the MOH to conduct blood donor outreaches.

USAID/Kenya's PASA engineer has supervised the construction of five Regional Blood Transfusion Centers (RBTCs) at Nairobi, Mombasa, Kisumu, Nakuru and Embu. The Lion's Club will construct a sixth center at Eldoret, and FHI will provide the equipment. The design of all of the centers is standard, including the reception (sorting), testing (serology), component production, storing and the distribution of blood donations, administrative offices, rest rooms and work areas.

The Nairobi RBTC is also the National Blood Transfusion Center (NBTC) and provides blood to hospitals in the Nairobi region and its environs. It also oversees all RBTCs and satellite BTCs. Kisumu, Nakuru, Embu and Mombasa (and Eldoret) serve hospitals in their own catchment areas. When fully operational, each of these centers will collect 40,000 units of blood annually (MOH figures for October 2000 to September 2001 indicate that the country collected 200,000 units during this period).

Three Satellite Blood Transfusion Centers (SBTC) have been set up at Naivasha, Voi and Kericho. These SBTCs are along the Trans-African Highway and respond to the increasing number of traffic accidents there. These centers have minimal equipment for blood storage that they receive from the RBTCs. They do not collect any blood.

Teams of 16 people comprising four per center, including a doctor, two technologist and one donor recruiter, have been trained. Another team of four to serve the Embu center has been sent to Uganda for training.

The MOH has now developed and published policy guidelines on blood transfusion. This policy sets the standard operating procedures on blood collection, processing, preservation, distribution and supply.

The FHI signed a sub-agreement with the KRCS to mobilize a community of blood donors. As part of its efforts, the KRCS provides education, recruits the volunteer donors and provides pre-donation counseling and screening. Following problems experienced at KRCS with other USAID-funded bomb response projects, FHI signed the sub-agreement after it assessed the technical skills, personnel needs and capacity of KRCS to handle scopes of work and after KRCS changed its management. KRCS also agreed to adhere to an implementation framework developed by FHI. In addition, FHI developed a monitoring tool to assure better implementation of KRCS' field activities.

The BTS is now setting up a quality assurance laboratory at the Nairobi BTC and establishing national standards for blood collection and distribution that it will reinforce through training of its staff. FHI and the BTS are also contracting AMREF to provide external quality assurance testing of blood for the national and regional centers

.

To make the program sustainable, the BTCs are now charging private hospitals $3 per unit of blood, but this is being revised upwards to probably $12 per unit. Public hospitals get their units for free because in return the GOK staffs and pays salaries of BTC staff.

With the assistance of the U.S. Centers for Disease Control (CDC), the BTS is recruiting a marketer who will develop a donor recruitment department. Using its own funds, CDC has offered fellowship training program for two Kenyan doctors managing the BTS.

FHI has been instrumental in starting diploma and certificate courses on blood transfusion services management based on a World Health Organization (WHO) module on safe blood and blood products at the Kenya Medical Training College. Already 21 students have been enrolled for the diploma course and three for the certificate course. A total of 60 people are eventually to be trained.

Since becoming operational in January and March 2001, respectively, the Nairobi and Kisumu centers have collected a total of 27,435 units of blood. The Nairobi center has collected 13,992 units while Kisumu has collected 13,433 units. In the same period, through its mobilization program, KRCS reached 54,464 people (see Annex H). There are still problems with donor recruitment mostly because of cultural beliefs about blood donation and the inadequacy of BTC staff on mobilization techniques. Because of GOK budgetary constraints, at least on one occasion, a delay has occurred in reagent sourcing.

A visit by the evaluation team to the Nairobi and Nakuru centers found that no pediatric blood units were collected. This occasions major blood wastage because when a pediatric patient requires transfusion, either a small unit is selected or part of a larger unit is used. The remainder of the blood is discarded if it is not used within 24 hours. The team learned, however, that the CDC, using its own funds, is in the process of procuring pediatric bags to enable the BTS to minimize its wastage.

Nakuru Center

Originally, it was agreed that the hospitals where the BTCs are established would provide the screening equipment while the GOK would supply the reagents. Apart from Kenyatta National Hospital in Nairobi and New Nyanza Provincial Hospital in Kisumu, the other hospitals declined to do so. Therefore, apart from the Nairobi and Kisumu centers, the other centers are not fully operational, as they do not have blood-screening equipment. Through a modification of the

cooperative agreement with FHI, however, USAID has provided from its bilateral health program a further $125,000 to purchase this equipment.

In all of the centers, it is the technologists and technicians, who have little training in blood donor motivational techniques and donor screening, that are responsible for donor recruitment, screening and blood collection. Though FHI has funded KRCS to participate in blood donor mobilization, a visit by these evaluators to the Nairobi and Nakuru centers found that the role of KRCS in this exercise is not well understood to the technologists. In most cases, KRCS only played the role of notifying schools about the visit of BTC staff to the school. Also, subject to available funding, the end of this project may mean the end of the active involvement of KRCS in blood donor recruitment.

There is no networked reporting system in the BTCs. Only the Nairobi BTC is computerized.

Conclusion:

USAID/Kenya's efforts in strengthening the BTS have largely been successful. According to the Director of BTS, though the BTCs do not have a large pool of blood at the moment, they do have the capacity to handle a large number of donors and large quantities of blood if need arose. The centers are now in a better position to provide hospitals with safe quality blood and blood products, a situation that did not exist before and during the bomb disaster. For instance, the Nairobi, Nakuru and Kisumu centers are meeting the medical needs of the major public and private hospitals in their respective areas. Finally, the Mission is to be commended for providing increasing assistance to Kenya's blood safety program as part of the Mission's focus on the HIV/AIDS problem.

2. Disaster Education and Community Preparedness

A review of the response by the GOK and public to the bomb disaster reveals that there were major deficiencies in disaster preparedness and management. The civil authorities exhibited a lack or limited knowledge of how to handle mass casualties while medical facilities had limited capacity to meet medical needs of such an emergency. The quality of care provided by the first responders was inappropriate and, in fact, one medical officer remarked that most deaths could have been prevented if the first responders had training in basic first aid, resuscitation, extrication and stabilization techniques. The disaster was further compounded by the fact that the GOK had no incident command system. None of the medical schools and colleges in Kenya offers formal training in resuscitation, trauma or basic first aid. Therefore, at the time of the disaster, Kenya lacked or had few professionally trained emergency medical personnel.

In order to help fill this gap, in October 1998, USAID provided to the International Medical Corps (IMC), a U.S. NGO, a grant of $300,000 from OFDA funds, to conduct an emergency medical services upgrade pilot project. In partnership with St. John's Ambulance (SJA), a local NGO registered in Kenya, IMC initiated a three-month emergency medical technician (EMT) pilot training in December 1998. The project targeted 40 pre-hospital medical care providers from SJA, Kenyatta National Hospital (KNH), the Kenya Police, Nairobi City Council (NCC) ambulance and fire brigade and the Forces Memorial Hospital. IMC also provided the Resuscitation Council of Kenya with training and technical advice on basic and advanced life saving.

After the success of this initial activity, in early 2000, IMC submitted an unsolicited proposal to USAID for further funding. Consequently, on July 28, 2000, IMC and USAID/Kenya signed a cooperative agreement of $2.5 million for the implementation of an 18-month disaster education and community preparedness project. The activity was to benefit over 3,500 people, including members of the general public, survivors of the bomb blast, EMTs, ambulance attendants, medical personnel in hospitals, school children and staff of NGOs. In addition, IMC was to provide equipment and ambulances to various organizations, among them AMREF, Nairobi Hospital, SJA, NCC, Coast General Hospital and Knight Support as well as carrying out a national inventory of resources.

According to the terms of its USAID agreement to mitigate the impact of disasters, IMC was to implement the following activities:

1. Strengthen response capacity through training of EMTs, Community Emergency Response Teams (CERTs), hospital response teams and first aid providers. IMC is to provide ambulances to AMREF, Nairobi Hospital and SJA; rescue equipment to Knight Support; mass casualty response kits to hospitals; and first aid kits to schools and hospitals. IMC is also to facilitate a national resource inventory.
2. Increase public awareness of disaster preparedness and mitigation through a public education/media campaign and a regional disaster preparedness conference.
3. Build capacity of local NGOs and public institutions' support through training-of-trainers for EMTs, CERTs and first aid providers; provide training supplies; and arrange management and administration courses for NGO personnel.

Strengthen Response Capacity

a) Training

Training has had three components: (1) pre-hospital training, (2) hospital-based training and 3) first aid training.

1. <u>Pre -Hospital Training</u> — Emergency Medical Technicians (EMTs) and Community Emergence Response Teams (CERTs)

The CERT curriculum was developed late and has not been used. Apparently the delay was occasioned by disagreements between IMC and SJA, which was supposed to implement the course, over training content. IMC now intends to supply the curriculum to institutions with the capacity of offering the training. A decision was, however, not been made as of this writing about which institution(s) will carry this out.

The first aid curriculum has not been completely developed as of the end of this project and has not been used in the training process. Instead, SJA used its own curriculum to offer first aid training. The delay was again due to the disagreement between SJA and IMC as to the appropriateness of the curriculum that IMC was supplying to SJA. The first aid curriculum has also not been given to SJA.

It is curious that disagreements arose between SJA and IMC after having worked together so well during the pilot phase of the project. After having discussions with both organizations, it appeared to the evaluation team that both SJA and IMC had serious managerial problems and neither institution was ready to listen to the other.

The EMT curriculum was developed based on the American system and was used in training the EMTs. Most of those trained were satisfied with the kind of training that they received. EMT nurses at KNH, Nairobi Hospital and SJA praised the training as having been useful and indicated that it equipped them with life saving skills.

As a result of this training, three institutions are now interested in establishing EMT/paramedic programs. These are: Kenya Medical Training College (KMTC)- interested in establishing a four-month certificate program for EMT and a one year diploma course for Paramedics; Kenya Ports Authority's Bandari College — wants to establish a four-month EMT certificate course and a six-week certificate course for first responders and the Kenya Police College at Kiganjo — interested in establishing a six-week certificate course for first responders within its police training curriculum.

TABLE 3
Results of EMT and CERT Training

Course	Institution	Number Trained	Target
EMT Refresher	St. John's, Nairobi City Fire Kenyatta Hospital, Military and Police	24	30
Instructors (in CERT, EMT and First Aid	St. John's, Kenyatta Hospital, Coast General Hospital and RCK	30	20
EMT Basic (Nairobi)	St. John's, Nairobi City Fire Kenyatta Hospital, Military and Police	42	15
EMT Basic (Mombasa)	St. John's, Mombasa City Fire, Police, Military, Kenya Ports Authority, Navy Airport Fire, Kenya Wildlife Service	61	15
CERT Course	Police, Military, Public transport, schools	None	300
CERT TOT	St. John's, NCC Fire, Kenya Safety Council	20	20
EMT/Private Sector	AAR, 911, Mediplus, Amref, Nairobi Hospital, Knight Support, Gertrude's Children Hospital	18	18

2. Hospital-Based Training — IMC partnered with the Resuscitation Council of Kenya (RCK) and the Institute for Emergency Medicine and Health of Harvard University in offering this service. The partner hospitals were KNH and the Coast Provincial General Hospital. Both KNH and Coast Provincial General Hospital have now 45 certified instructors for Basic Life Support (BLS)/Advanced Life Support (ALS)/Advanced Cardiology Life Support (ACLS) and Trauma. This has enabled the two hospitals to institute in-house training.

It was originally targeted that RCK was to offer ALS/ACLS/Trauma training to 80 professionals in Nairobi and Mombasa only. However, with increased funding - initially RCK had been given $64,280, but this was increased to $90,691 - RCK has trained over 770 professionals spread throughout the country (see Annex I).

Although by the end of the project, both KNH and Coast General Hospital were supposed to have fully functional and equipped in-house training programs for their staff, this has not happened because of IMC's delays in procuring equipment from suppliers in South Africa. It is not certain whether the equipment will arrive before the end of the project.

The Casualty Officer Induction courses, where rotating medical students are exposed to ALS/ACLS/Trauma care, has not been started. Neither IMC nor KNH could give reasons why this was not done and it appears that it is not going to occur in time.

3. First Aid Training — This training component was done with the partnership of SJA. The courses were conducted in the slum areas of Nairobi. There was, however, a delay in starting the program again because of disagreements between SJA and IMC over the curriculum to be followed. IMC wanted the American first aid curriculum while SJA was insisting on using the modified British curriculum that it has been using in its normal training sessions. This problem was not resolved and SJA utilized its old curriculum. This further problem meant that, by the end of the project, only 2,285 people had been trained against a projected target of 3,000 trainees. Those trained were as follows: 1,083 school children, 638 members of community groups, 145 bomb blast survivors and 419 street children.

TABLE 5
Overall Training Performance

Activity	Number trained	Target	Provider
EMTs	192	40	IMC
Hospital Training BLS/ALS/ACLS	770	80	IMC/RCK
FIRST AID	2285	3000	IMC/SJA
CERT	Nil	300	IMC/SJA

Conclusion:

Despite the disagreements with SJA, IMC conducted the training component well. For the first time, Kenya now has 192 fully trained and certified EMTs. In fact, some of these EMTs have now formed an NGO (Safety and Emergency Management Council-SEMAC) that has started to offer first aid and other safety and emergency training to schools, community groups and private companies. Also, the country has now an EMT registered organization (Kenya Association of EMTs- KAEMT). The misunderstandings, however, have meant that some elements of the training program, such as the CERT and printing of first aid kits, will not be achieved.

b) Provision of Equipment

According to the USAID/IMC agreement, IMC was to deliver seven ambulances as follows: two new ambulances each fitted with advanced life support equipment to AMREF and Nairobi

Hospital, two new four-wheel drive ambulances also fitted with advanced life support equipment to SJA, one similar new ambulance to Mombasa City Fire Department and two refurbished and fully equipped ambulances for Nairobi City Fire Department. In total, IMC was to supply five new ambulances and two refurbished ones. IMC was also to provide rescue equipment and two boats to Knight Support, communications equipment to SJA and the National Disaster Operations Center (NOC), hospital equipment to KNH and Coast General Hospitals and first aid kits to schools and other public institutions.

At the time of this writing, IMC had delivered one new ambulance each to AMREF, Nairobi Hospital and SJA and one refurbished ambulance to Nairobi City Fire Brigade. One more ambulance for Nairobi Fire has yet to be refurbished. This delay occurred because City Fire wanted to see how the first one was done before taking the second.

Ambulance

The second SJA ambulance has not been supplied because of disagreements between SJA and IMC on the type of ambulance to be supplied. SJA has been arguing that they want another four-wheel drive while IMC insisted that it wanted to supply a minibus. After protracted wrangles, the two parties agreed that IMC could supply a four-wheel drive minibus. After being unable to procure the four-wheel drive minibus, IMC, which is not registered as an NGO in Kenya, asked SJA, as a duly registered NGO, to solicit for suppliers. SJA found one dealer who indicated that he could import such a vehicle from Japan. IMC approved the vehicle and asked the dealer to order the vehicle. SJA claims that against their advice, IMC went ahead and made an up-front payment to the dealer even before the vehicles arrived. When eventually the vehicles arrived, IMC and SJA found that they were not the same as the ones in the quotation, but were pick-up vans. Both IMC and SJA have refused to take delivery of the vans. IMC is seeking full refund from the supplier and if it does not do so, IMC will seek legal redress. What is not clear is why IMC made full payment before delivery of the vehicle when USAID regulations and good business normally require COD payments or reimbursements.

Although IMC had indicated in its proposal that all the ambulances were to have advanced life support equipment, none of the ambulances that IMC has supplied have this equipment. Apart

from the AMREF and Nairobi Hospital ambulances whose equipment has been delayed by the South African suppliers, IMC could not satisfactorily explain why the other ambulances do not have this equipment. For instance, despite the fact that the SJA ambulance has been fitted with an extrication equipment box, this item has not been supplied. IMC claims that the equipment was not supplied because SJA does not have people trained in extrication techniques. The evaluators were, however, shown extrication training certificates issued to two SJA EMTs after being trained by IMC. Equally, Nairobi City Fire Brigade does not know why the promised advanced life saving equipment was not fitted in the vehicle that it received.

Office equipment in the form of computers, copiers and printers plus training materials appear to have been supplied satisfactorily to SJA and the RCK.

Knight Support (KS)

Knight Support (KS) is a private Kenyan security consultant firm that, in partnership with other private sector firms and NGOs, undertakes search and rescue activities during emergencies. IMC proposed to give KS search and rescue as well as communications equipment. For reasons that IMC could not explain, KS only received their equipment in May 2002. Furthermore, according to KS, the equipment it received is not even a quarter of what it had been promised. All that KS has received are boats and some communications equipment. Rescue equipment such as extrication tools have not been supplied (the team could not obtain a satisfactory explanation from IMC why this was so). KS estimates that IMC owes it equipment worth at least $20,000. KS is not satisfied with the whole project because of what it perceives as attempts by some IMC staff to defraud the project using Knight Support's name. For instance, they showed the team invoices sent to them by IMC indicating prices of items seemingly ten times their landed cost in Nairobi shops. KS categorically refused to participate in the apparent deception.

Medical equipment for KNH and Coast General Hospital has not been supplied and IMC claims that the suppliers in South Africa have caused the delay. IMC has supplied the first aid kits for schools and institutions to SJA, which is now compiling the list of schools and other institutions that will benefit from this assistance.

Conclusion:

Unlike the training component, the equipment component poses serious problems to IMC and USAID/Kenya and may not be accomplished by the end of the project. This is especially worrying taking into account that IMC has been given several no-cost extensions by the Mission, which made clear to IMC that no further extensions will be given after September 30, 2002. The claims by SJA that IMC went against its advice and paid in advance for the two ambulances needs to be looked into. Equally bothersome are the allegations of deception made by Knight Support. Some beneficiaries also claim that the equipment component was not handled professionally by IMC because some equipment might have been given to people who either did not have the capacity to utilize it properly or who were engaged in commercial enterprises and may thus not come to public rescue in case of a disaster. It would be prudent for USAID to carry out a complete review and/or audit of all the equipment that IMC bought using USAID funds. The Mission Controller's Office has already indicated that it will be following up on these commodity problems with USAID/Kenya's project management, procurement and auditing staff.

c) National Inventory of Resources

In late 1997 and early 1998, the El Nino rains destroyed infrastructure in most parts of Kenya. Consequently, the GOK established the National Disaster Operations Center (NOC) to coordinate the GOK's response to problems emerging from a disaster. These efforts were low key and were restricted largely to the distribution of food.

In 1999, USAID, in collaboration with the UNDP, assisted the Kenya Action Network for Disaster Management to survey all available facilities in the country. The outcome of this survey was the formulation of the Disaster Management Policy, which reportedly is soon to be released, but was not yet available at the time of this writing. This policy will lead to a bill in parliament that will establish the National Disaster Management Authority, which will be an autonomous body with a Trust Fund and budgetary allocations. The Authority will have the responsibility for coordinating responses to all disasters (man-made and natural) in the country. Consequently, it is envisaged that the Authority will have a central Incident Command Center and seven response units spread throughout the country. These units will be equipped with advanced communications, ambulances and fire fighting equipment.

IMC has assisted the NOC with the supply of two computers and in the preparation of a national inventory of equipment, supplies and skills. This inventory is available to all stakeholders in the field of disaster preparedness, mitigation and response. Provincial and District Disaster Management Committees have also been set up.

Increase Public Awareness of Disaster Preparedness and Mitigation

As part of its cooperative agreement with USAID, IMC was tasked to sensitize the public on disaster preparedness and mitigation through both the print and electronic media.

a) Media

Fourteen TV and radio programs about how to prevent and deal with fire, road accidents, floods and mass casualty incidents (plane crash/building collapse/explosion) were produced. The TV programs were aired once a week between mid 2001 and early 2002 on local television (KBC, KTN and Nation TV) while the radio programs were aired on local stations (Nation and KBC) in both English and Kiswahili. The Nation Media Group also carried 10 ½ page articles in the National Newspaper. Based on the projected audiences of these media groups, it is estimated that close to 10.2 million people were reached by this media campaign.

b) Road Safety Campaign

In partnership with KMA and the traffic police, IMC held a road safety campaign along the main highways from Nairobi to Eldoret and Nairobi to Mombasa during the December 2001 holidays. Brochures on road safety were given to over 15,000 drivers.

A total of 30,000 pieces of safe driving materials were distributed over a two-week period. The campaign was also widely carried in the print and electronic media. Traffic police reported reduced accidents during this period compared to previous years.

c) Regional Conference

A regional five-day conference on Emergency Management in Africa with 275 participants from 12 countries was held in Nairobi in November 2001. Participants had the opportunity to exchange views and information on disaster preparedness.

Conclusion:

Some participants in the conference and people in the safety and emergency sector felt that the conference was not well organized and did not achieve much other than being a public relations exercise. For instance, at the end of the conference no document in the form of either a final conference statement or working paper charting the way forward was produced.

Building Capacity of NGOs and Public Institutions

IMC assisted in establishing a standard framework for financial records and reporting structures with its implementing partners. It enhanced the capacity of SJA and RCK by training its staff and providing equipment. For instance, during the project period, SJA was assisted in the payment of salaries; this enabled SJA to have more resources for its other activities. SJA reported that its relationship with IMC enabled SJA to streamline its internal operations and that it can now work effectively with other international organizations. The equipment supplied to Knight Support enabled it to respond effectively to the flood emergency in Western Kenya in May 2002.

IMC had wanted to set up a National Emergency Communications Network covering the whole country and incorporating NOC, SJA and Knight Support. However, because NOC is still just a unit within the Office of the President, it may not be allocated the appropriate radio frequencies. Kenya Power and Lighting Company could have assisted by allowing NOC to use its National Trunking system, but refused because of the same reason. This has delayed the implementation of this component. Instead, IMC is going to upgrade the radio equipment of SJA to enable it to communicate effectively with area hospitals. To do this, SJA will be provided with eight mobile radios and two base radios.

Disaster Preparedness

a) Hospitals

1. *Nairobi Hospital — T*hough Nairobi Hospital had a disaster emergency plan before the 1998 bomb blast, it was found wanting during this emergency. Since then, this plan has been strengthened. With the assistance of IMC, the hospital has trained a four-member Disaster Response Team consisting of a doctor, two nurses and a driver. This team has instituted an in-house EMT training course in the Accident and Emergency Department. The hospital has also acquired a fully equipped life support ambulance from USAID/Kenya and IMC. The hospital staff believes that they are now well prepared to respond effectively to any future disaster in Kenya.

2. *Kenyatta National Hospital (KNH) —* Through IMC, KNH has trained 20 of their nurses and doctors in EMT/resuscitation. These in turn have instituted in-house training programs for other staff in the Casualty Department. Because of the lessons learned after

the bomb blast, KNH has now reserved the parking lot in front of the Casualty Department for emergencies only. The hospital is in the process of setting up an Emergency Response Team. A visit to KNH by the evaluation team, however, revealed that despite being the largest hospital in the country, KNH does not yet have the capacity to respond effectively to mass disasters. For instance, there are no dedicated wards for disasters and the wards that can be used in case of such eventuality do not have such basic equipment as oxygen, suction etc. Also, even though KNH receives the single largest number of emergency cases in Nairobi, its ambulances are not equipped with advanced life saving capabilities.

b) NGOs and the GOK

After realizing that it is necessary for people to have some skills in emergencies and rescue, AMREF and SJA have started offering basic first aid courses to companies and school children. AMREF has also developed a draft disaster policy for itself and is presenting it to policy makers and medical personnel in Kenya.

The other NGOs that worked on the rehabilitation of the disaster victims, such as ADRA, KSB, APDK and Amani Counseling Institute, have all put into place the means of responding to disasters. Amani, for instance, is in the process of putting together a consortium of organizations that will have a capacity to respond to disasters of any magnitude throughout the East African region. This is borne out of the lessons learned from this Kenya bombing tragedy, namely that once disaster strikes, rehabilitation of victims should be holistic, including treatment of both physical and mental health as well as taking care of economic and social needs. The Amani team will consist of counselors, medical personnel as well as physical, economic and social welfare experts.

Finally, the GOK also appears to be more aware now of the need for greater disaster preparedness. In a recent conference on disaster preparedness organized by the U.S. DOD's Central Command, Kenya's President noted the rise in the number of disasters in recent years in East Africa, including volcanic eruptions, train accidents, floods, mud slides as well as the 1998 bombing in Nairobi. For that reason, he indicated the necessity for establishing a regional disaster preparedness action unit, possibly under the auspices of the East African Community (EAC) or the Inter-Governmental Agency on Development (IGAD).

c. Nairobi City Mortuary

The Nairobi City Mortuary has a capacity of 145 bodies, but was severely overburdened in the aftermath of the 1998 bomb blast, creating unhealthy and chaotic conditions. Therefore, as part of the bombing response program, USAID/Kenya gave the mortuary a grant of $60,000 to purchase six more cooling units, and another grant of $30,000 for a standby generator and fuel tank to ensure a continuous power supply. The additional cooling units have improved the morgue's ability to handle these bodies in a more professional way.

At the time of this report, however, the mortuary held up to 600 bodies. The mortuary superintendent indicated that one-half of the deaths are now caused by HIV/AIDS and as such most families are unwilling to take the bodies for burial for fear of spreading this dreaded and

deadly infection. For that reason, and to relieve the overloading, the morgue must bury the unclaimed bodies every three months in mass graves.

Conclusion:

The Community Education and Disaster Preparedness project was well conceived and much worthwhile training has been accomplished. However, managerial and logistical weaknesses at IMC have affected relations with some of its sub-grantees and have caused some of the targets not to be achieved. For instance, the delay in obtaining a duty waiver on imported equipment could have been avoided if IMC management had established its local legal status (apparently IMC has not been registered as an NGO with the GOK and thus did not qualify for duty exemption). The problems with SJA could also have been avoided if both IMC and SJA listened to and respected the opinions of each other.

Delays in procuring equipment from South Africa were apparently because of the incapability of the South African firm to service the orders. The same applies to the supplier who delivered to IMC the wrong type of vehicles. IMC should have established from the start the capacity of these suppliers to service the orders. There is no indication as to whether IMC looked for another supplier before settling on the South African one. There is also no assurance about the after-sales service after the vehicles have been supplied or whether there are local dealers who will service these vehicles.

To the credit of IMC, however, these management weaknesses have been identified and the entire IMC staff has been replaced. This, however, has come too late in the project to assure that the remaining targets will be met.

While conditions are better at the Nairobi City Mortuary, the situation is still somewhat fragile and not satisfactorily hygienic or respectful because of the new burdens brought about by the rapid increase in deaths caused by HIV/AIDS. Another disaster in the Nairobi environs would again greatly overtax the facilities at the city morgue unless further steps are taken to address these evolving needs. Improved facilities, such as a crematorium, which appears to be more culturally acceptable, would greatly help the situation at the mortuary.

Final Conclusion:

Overall USAID should be commended for starting this disaster preparedness component within its SPO. The project has definitely created increased awareness, especially within the NGO sector, for the need to be better prepared for the inevitable disasters and to have personnel trained in emergency and recovery skills. The medical personnel are now sensitized and better informed about how to handle casualties, but lack of equipment, especially in the public hospitals, makes their work difficult.

E. TANZANIA — OBSERVATIONS

While this evaluation team has no mandate to evaluate the Tanzania bombing response program and does not know if there will be such a separate evaluation, the team did find it interesting to learn of some similar and other different aspects of the recovery effort there in Tanzania as compared with that in Kenya. To begin with, the casualties and damage, while serious, were

much less in number. While there were no Americans killed, there were 12 Tanzanian fatalities, two of whom were employees of the U.S. Embassy in Dar es Salaam, with another five killed from the security guard company at the Embassy. There were also 83 Tanzanians injured, who required payments for medical attention and other assistance. In addition, USAID made payments for building damages to 12 private owners (100 percent of damage) and 13 parastatals (50 percent). Finally, USAID is restoring two houses as well as the rented office building used by the U.S. Embassy that were severely damaged or destroyed.

Despite the drastically smaller numbers of killed and injured and less damage, USAID/Tanzania was allocated $9.231 million, out of the special Congressional appropriation of $50 million. This ESF money has been used for a bomb response program under a Special Objective, like the one in Kenya, to reduce the suffering of Tanzania bomb victims and to enhance local disaster responsiveness. Its two Intermediate Results are 1) to reduce the psycho-social, economic and health impact of the bomb blast by providing direct assistance to bomb victims and rehabilitating infrastructure; and 2) to enhance the preparedness for future disasters.

The USAID/Tanzania Mission works with similar implementing partners, including the U.S. Department of Health and Human Services and John Hopkins University, in the field of disaster preparedness in order to assist the Disaster Management Department in the Prime Minister's Office, the MOH and the Tanzania Red Cross Society. USAID's OFDA, DOD and the UNDP also provided limited disaster preparedness training and technical assistance. In addition, Plan International and AMREF have provided immediate and medium-term assistance to individual victims, and there is a PASA arrangement with the U.S. Army Corps of Engineers based in Kenya to supervise the reconstruction of buildings, in this case being carried out by a U.S. contractor. Finally, the USAID Mission, working with the Regional Legal Advisors in REDSO/Nairobi, has been able to arrange for the eighteen children of victims to continue receiving school fees through high school by means of an innovative fund swap with local NGOs and through contribution to a pre-existing Social Action Trust Fund that will also provide the necessary administration.

V. RECOMMENDATIONS AND LESSONS LEARNED

This evaluation team submits the following recommendations and lessons learned to USAID regarding the Kenya bombing response program:

A. USAID MANAGEMENT

1. Recommendations:

a. USAID/Washington, working with other appropriate USG agencies, should establish a special disaster committee at a very high level to coordinate activities in the case of terrorist attacks or other special circumstances to facilitate the appropriate and rapid provision of assistance, funding and support to the field missions involved. Ideally, this committee, with the concurrence of the USAID Administrator or his designee, would authorize the quick allocation of OFDA-like financial resources from whatever account is available or reserved for this purpose. This could involve an expanded timeframe and mandate for IDA or OFDA monies, a special reserve of ESF but with "notwithstanding" authorities, or

other "bridge" funding between the currently available OFDA assistance and the more regular ESF or DA financing.

b. In a disaster like that experienced by Kenya, USAID/Washington should quickly send to the relevant field mission a "SWAT" or another DART-like team consisting of duly authorized and technically qualified working staff of different skills to work under the direction of the Mission Director in rapidly assessing needs, planning recovery activities, preparing implementation, facilitating procurements and providing other support services.

c. USAID/Washington should authorize in such circumstances flexible authorities to qualified missions, especially one like that in Nairobi. Such delegations should include expedited procurements, either by suspending normal competitive bidding for contracts in the early stages (e.g., the first six months) up to specific dollar limits (e.g., $5 million), shortening drastically and as realistically as possible the prescribed bidding periods or taking other steps consistent with good business practices to expedite the planning and implementation process for such humanitarian assistance and recovery activities.

d. Given the startling frequency of disasters and the new reality of the possibility or even likelihood of further terrorist acts, USAID, including OFDA and the geographic bureaus, should provide training and crisis management seminars to at least its senior field managers about how best to handle such emergencies and recovery programs. The Kenya example would be a worthwhile case study and its experience should be shared and publicized.

e. USAID/Kenya should vigorously enforce periodic management and financial reviews, including possible audits, of the performance of primary contractors and grantees, taking into serious account the capacities and work of sub-contractors and sub-grantees, so as to minimize implementation problems of the type that have affected a few of the projects under the bombing response program.

f. USAID Missions and OFDA should work more closely together to maintain an up-to-date assessment of the resources and capacities of individual host country governments, like the GOK, to handle natural and man-made disasters and to manage recovery efforts.

g. USAID/Kenya should allocate the estimated $1.2 million in residual funding in the bombing response program to be used to continue for one more year, to September 30, 2003, the Education School Program ($515,000), the follow-up medical care including medications and possible counseling ($450,000), improved mortuary facilities, including a possible crematorium, in Nairobi ($100,000) and appropriate closeout costs ($135,000), including maintaining needed project management staff to monitor and complete effectively this busy program.

h. Other activities in the overall program should be ended as scheduled and/or become part of the Mission's bilateral portfolio, especially in related health and HIV/AIDS fields, where there are already synergies and cost sharing, and in

cooperation with OFDA in its mandate to help prepare for disasters as well as to deal with them when they occur.

i. In the interest of public diplomacy, USAID/Kenya should announce as soon as possible its decision to extend selected activities under the bombing response and bilateral programs so as to blunt Kenyan criticism of the USG in this regard.

2. Lessons Learned:

a. Traumatic disasters like the Kenya bombing are understandably overwhelming for a Mission, requiring active Washington support.

b. Flexible funding needs to provided early and in sufficient amounts in order to deal effectively with the situation.

c. Good communications and publicity are needed in order to deal with local constituencies both during the planning stages and the later phases of the recovery program.

B. ECONOMIC IMPACT OF THE BOMBING REDUCED

1. Recommendations:

a. USAID should seriously consider labor-saving approaches, like host country contracting and having contractors issue payment checks, subject to USAID approvals and consistent with local conditions, in the implementation of appropriate project activities.

b. USAID/Kenya should also include the UDPK/MSED micro-business activity in the Mission's bilateral portfolio of assistance for at least one more year as an NGO with a proven track record of good performance. Since UDPK's capital fund is intact, only funds to cover administrative expenses would be required. The Mission could raise such assistance from either this incorporation into one of the Mission's existing bilateral micro-business projects, or by a PL 480, Title II monetization project managed.

2. Lessons Learned:

a. Contracting with reputable in-country accounting firms can save both time and frustration and improve project performance in financial management areas. These firms generally understand the accounting practices of the country and are better able to interact on behalf of their clients to verify specific financial needs and requests. The Kenya case is a good example of how this worked well.

C. HEALTH AND SOCIO-ECONOMIC NEEDS OF BOMB VICTIMS MET

1. Recommendations:

a. USAID/Kenya should use about $450,000 of the residual funding (est. $1.2 million total) in the bomb response program to extend for one year its grant to AMREF to pay for the costs of medical care and medications for survivors.

b. USAID/Kenya should further allocate approximately $515,000 of the residual bomb response program money to the ESP to continue funding school fees for all eligible children covered by the project for one more year.

2. Lessons Learned:

a. Following a catastrophic event, be it natural or man-made, but especially in violent situations like acts of terrorism, providing early mental health intervention is a priority along with emergency medical services.

b. Organizations that spring up almost over night in response to an emergency, generally speaking, have a limited capacity and do not have a solid base of management and financial support. Prior planning, management and backup financial resources are crucial ingredients to the success of any organization and USAID's funding of such groups.

c. Never assume that a non-operational parent organization with a solid international reputation is aware of the management and financial problems of its implementing associates. They need to be checked out as well in their specific performance areas.

d. More can be achieved by implementing organizations that stress coordination and cooperation among those in related areas of work, especially if all are funded by USAID. During times of limited resources, interagency collaboration can combine capacity, eliminate duplication and share scarce resources to attain a common goal.

D. PREPAREDNESS FOR FUTURE DISASTERS ENHANCED

1. Recommendations:

a. The high demand for blood transfusion is mostly due to anemia brought about by malaria. Because of the high prevalence of HIV/AIDS and hepatitis, it thus becomes imperative that safe blood be provided to the hospitals. It is recommended that as part of its HIV/AIDS prevention strategy, USAID/Kenya and FHI should continue assisting in blood donor education and recruitment until a viable pool of low risk volunteer donors that can donate blood on a regular basis is established.

b. It is also recommended that the Mission, in collaboration with other donors, help extend the MOH's malaria eradication campaign from one "target district" to all malaria endemic districts of western Kenya that also happen to be districts with a high prevalence of HIV/AIDS. This will prevent the transmission of transfusion related infections and will reinforce the Mission's SO3.

c. In view of the fact that Kenyatta National Hospital (KNH) is the largest hospital in Kenya and is the hospital to which most casualties are rushed, as evidenced in the aftermath of the bombing, it is recommended that the ambulance that IMC has not yet delivered to St. Johns Ambulance should instead be donated to KNH in order to achieve even greater impact in preparing Kenyans for future disasters.

d. In view of the claims that some IMC staff tried to falsify invoices, it is recommended that USAID/Kenya arrange for a thorough review and audit of all the IMC project components. IMC should supply the list of the equipment they bought with project money, certified invoices and also the identities of beneficiaries of this equipment. The legal status of each of the beneficiaries has yet to be established.

e. Because it has been claimed that the vehicles in dispute between IMC and the supplier might not meet specifications and their cost is inflated, the evaluators recommend that USAID/Kenya take steps to verify this and correct the situation as appropriate.

f. USAID/Kenya should also supply basic resuscitation/casualty equipment to district hospitals in disaster prone areas and also help with the establishment of Major Incident Management Systems (MIMS) at provincial hospitals and those hospitals in such potential disaster areas (e.g., along major highways).

g. Using up to $100,000 in residual funds from the bombing response program, the Mission should assist the Nairobi city morgue to establish more hygienic, cost effective methods of disposing of unclaimed bodies, including possible cremation facilities, in order to prevent further contamination from HIV/AIDS and to assist in future disasters.

h. Within its regional disaster management framework, OFDA should assist the NOC and seriously consider working within the East Africa framework to build a Regional Response Team with specialized equipment that can deal with collapsed buildings and marine and lake search and rescue.

i. OFDA should also seriously consider working with one of the local universities in Kenya to establish a Disaster Management program within its curriculum. This could help train people from the entire East Africa region

2. Lessons Learned:

a. The bombing disaster has made Kenyans aware that there is a need for all members of the community, especially public transport operators, police and civil

servants, to have basic life support training, as they are the first responders in case of a disaster.

b. The NGOs undertaking rescue and relief work have also learned that it makes their work much easier and they give the victims a comprehensive rehabilitation when they all work together, sharing information and supporting one another.

c. The host government, like that in Kenya, is much slower to show evidence that it has fully learned the hard lessons of recent disasters.

d. There was a very unfortunate attitude that developed especially among Kenyans in the aftermath of the bombing disaster in Nairobi that the United States, actually a co-victim in every sense of the word, was somehow responsible for the losses and therefore owed Kenyans a great deal of compensation. To a very real extent, this has helped to spawn a dependency syndrome among many Kenyans, who really need to look instead to their own resources to overcome their suffering. Other Kenyans, when comparing this bombing experience with other disasters, have reported that the Kenyans have been "spoiled" by the Americans in this instance because so much help has been provided by USAID and other parts of the USG, with very little distinction among those Kenyans that were severely hurt and those only slightly injured.

ANNEXES

A. Scope of Work
B. List of Persons Contacted
C. Partial List of Documents
D. Summary Table of USG Assistance to Kenya Bombing Program
E. USAID Timeline
F. Amani and the Crisis Mental Health Program
G. Education Support Program (ESP)
H. Strengthening Blood Safety
I. Number of Hospital Based Staff Trained by Resuscitation Council of Kenya

A. SCOPE OF WORK

I. PURPOSE OF THE EVALUATION

USAID/Kenya is contemplating an award to a firm to undertake an end of program evaluation of the bombing response program. The purposes of this evaluation are to: a) assess the impact of the bombing response program, b) assess the effectiveness of the program in achieving its strategic objective and intermediate results, c) provide recommendations on disaster/emergency preparedness, and d) provide broad lessons learned on the bombing program. The information gathered and the analysis performed will be used by USAID to inform its strategic programming decisions and for the design of similar projects in the future.

II. BACKGROUND

The August 7, 1998 bomb attack outside the American Embassy in Nairobi resulted in the catastrophic loss of lives, injuries to thousands, and destruction of businesses, buildings, and infrastructure. The American Embassy was located in the densely populated central business district, and the attack—which came at peak business hours — had a particularly devastating effect on workers and commerce. The bombing of the U.S. Embassy killed 213 people. It caused physical injuries to some 5,000 people and mental trauma to countless bystanders, co-workers, and families of the deceased and injured. In addition, it physically disabled over 400 persons. Approximately 250 businesses suffered losses as a result of damages to fixed assets and inventory. Sixty buildings suffered damages, many of which required major repairs before they could reopen to their tenants. The Ufundi Cooperative House was totally destroyed, and the Co-Operative Bank Building rendered unfit for use without extensive rehabilitation. Both of these organizations have had to rent interim premises and forego the rental incomes that they previously received. The deaths and injuries of so many working people have resulted in the loss of incomes for hundreds of households. The impact on Kenya's already ailing economy was extensive.

Kenyans from all walks of life spontaneously rallied to assist in the emergency by helping to extricate victims trapped in the rubble, providing first aid, and transporting the injured to hospitals. Public and private hospitals in Nairobi contributed by treating victims as necessary without consideration of payment. The medical care network in Nairobi was, for the most part, able to handle the inundation caused by the August 7, 1998 emergency. The health care system was, nevertheless, over-stretched and unprepared in many respects. In particular, a clearly defined system of rescue operations was completely lacking. Extricating victims and ferrying them to hospitals was ad hoc. Blood supplies were inadequate. Specialized emergency medical skills were lacking even in the best-run hospitals. Mortuary services were chaotic.

USAID/Kenya responded with a $37,850,000 disaster assistance program. The special objective was approved on December 18, 1998 for a three year period ending on September 30, 2001. However, USAID requested and was granted a one-year extension, to September 2002, for completion of the Bomb Response Program. The rationale for the extension was: a) the mental health counseling grant was not signed until May 1999, leaving insufficient time to provide adequate counseling to traumatized bomb victims; b) the education program required an

additional year to provide a better opportunity for surviving parents to recover economically to a point where they can adequately finance their children's education; and c) business training and loan programs for those disabled by the bombing require an additional year to be productive. The program will end on September 30, 2002.

The bombing response program pursues five related tracks to meet the needs of the bombing victims:

(1) reducing the economic impact of the bombing by assisting private businesses affected by the bombing, including rehabilitation and reconstruction of damaged infrastructure;
(2) making it possible for all persons injured in the bombing to receive adequate medical attention by reimbursing Nairobi area hospitals for treatment cost incurred but not otherwise recoverable;
(3) financing medical follow-ups, including mental health counseling;
(4) paying the school fees for primary and secondary school children of deceased or disabled bomb victims; and
(5) strengthening disaster response and preparedness programs by providing funds and/or technical assistance to local organizations.

Beneficiaries are thousands of Kenyan victims requiring medical, rehabilitation, and trauma counseling services; the children of deceased or disabled bomb victims; businesses with damaged buildings, equipment, and infrastructure; and institutions that provide emergency response and blood transfusion services.

III. DESCRIPTION OF TASKS

The contractor will carry out a comprehensive review of the following major components of this program: social services component (includes reimbursement of Nairobi-area hospitals for specified treatment costs, mental health, education support, medical follow-up and rehabilitation); assistance to small and medium-sized businesses, rehabilitation and reconstruction of damaged infrastructure (Cooperative Bank building, Ufundi Cooperative building, and assistance to other building owners, including vehicle owners); and disaster preparedness (emergency/disaster training and establishment of blood safety centers). After review of each of these components, the evaluators with provide:

- Empirical findings based on either qualitative or quantitative data as relevant,
- Conclusions, and the analysis lending to them,
- Recommendations, and
- Broad lessons learned that can be used by USAID to guide future interventions in similar or complementary programs. Whenever possible, data should be gender disaggregated.

The evaluation team will accomplish the following tasks:

1. Review the strategic objective and intermediate results. Were planned results achieved? Why and why not? Assess the extent to which activity results contributed to the achievement of the strategic objective results.

2. Assess the performance of the program and achievement of performance targets. Identify gaps and issues facing the bombing program that could have hindered performance.

3. Assess the relevance of the implementation approaches and identification of customers.

4. Analyze the mental health and medical follow-up/rehabilitation programs. This analysis should focus on design, implementation and performance of this critical program. Assess extent to which implementing partners identified victims, victims recovered, appropriates of approaches used to address client needs, and their ability to deliver results and adjust based on realities on the ground.

5. Assess the education support program. Assess beneficiary needs and the prospects for future continuation and sustainability of the program and whether structures are in place for continuing the program after the lapse of the current funding.

6. Review the small business assistance program. Assess the impact of this assistance on small businesses in terms of whether or not the assisted businesses have remained in business, improved management and are efficient and profitable.

7. Assess the blood safety program. That focuses on strengthening national blood transfusion services in Kenya. Has the objective is of improving the capacity of the Kenya blood transfusion services to meet the country's ongoing needs for safe blood and preparing Kenya to respond to disasters and/or other major emergencies been met? Why and why not? The assessment will also determine whether the program's objective of improving blood safety in Kenya through training and provision of equipment is being realized.

8. Review and analyze activities implemented to strengthen disaster planning and coordination and to prepare the country to be able to handle effectively future disasters. Has the capacity of the country to manage disasters been enhanced? Why and why not? Are these activities appropriate? Any gaps? Do we have a disaster plan of action?

9. Analyze the relevance and suitability of quarterly reports prepared by grantees? Do these reports discuss major accomplishments during the reporting period, problems encountered and challenges anticipated in the future?

10. Assess how the program promotes the objectives and values such as gender and women participation.

11. Review and analyze cross-sectoral linkages and synergies between this program and other Mission SOs and provide suggestions on how to enhance synergies after the completion of the program.

12. Review the performance and effectiveness of partners and grantees implementing the program and their contribution towards achievement of program objectives. This review will focus on managing for results and collaboration and coordination among partners and with other key donors and stakeholders.

13. Assess the small business capacity building program and determine whether the activities implemented will be self-sustaining in the long run particularly disaster planning and coordination. What are the prospects for sustaining project activities and the institutions participating in the program? Potential for replicating the program elsewhere.

14. Assess Bombing Response Units closeout plan. What management structures are underway for managing some activities such as the school fees program that may extend beyond the PACD?

15. Lessons leaned. The review should focus on the lessons learned in terms of project design, implementation, monitoring and reporting and contribution to achievement of results. What steps have been taken to ensure lessons learned are widely disseminated?

16. Prepare a report summarizing key findings, recommendations and lessons learned.

IV. METHODS AND PROCEDURES

The evaluation team will use a combination of techniques including document reviews, key informant interviews, and a survey of assisted bombing victims who have received medical care. The evaluators will review documents prepared by USAID and implementing partners. The evaluators will collect information from USAID, collaborating partners, and a sample of beneficiaries.

A. Meet with USAID to review the Scope of Work and the proposed work plan.

B. Review documents maintained by the Bombing Response Unit and by implementing partners.

C. Conduct key interviews with USAID staff from the following offices:

1. Bombing Response Unit,
2. Program Development and Analysis Office,
3. Controller's Office,
4. Population and Health office, and
5. Regional Contracts Office.

D. Interview all partners implementing the bombing response program.

E. In order to assess the impact of USAID assistance on bombing victims, conduct a survey of few beneficiaries. Identify a representative sample using factors such as:

- Type of assistance (for example medical or educational),
- Women and men,
- A Mix of older and younger beneficiaries,
- Rural versus urban, etc.

This survey will collect qualitative and quantitative data to be used in answering a variety of questions in the SOW. A variety of methods might be used, including:

- individual interviews
- group discussions
- drawings, or other physical models
- rankings

V. TEAM COMPOSITION & QUALIFICATIONS

It is anticipated that the evaluation will be carried out by a four person team. The team leader will be an evaluation specialist. One team member will be a medical doctor specializing on emergency medical care and trauma counseling. The third member will have extensive experience in emergency/disaster preparedness. The fourth member will have experience on participatory evaluations, rapid appraisal methods and statistical analysis. Two of the evaluation teams must be locally hired. The contractor will be responsible for identifying and contracting the two locally hired team members and several research assistants.

TEAM LEADER

The team leader will have overall responsibility for fulfilling the scope of work. S/he will coordinate and supervise the evaluation.

Essential Qualifications:

- Masters degree or above in economics, evaluation, statistics or management.
- Ten years and above extensive experience in evaluation of emergency and disaster programs.
- Background in management and organizational development.
- Seven or above years experience evaluating U.S. Government programs.
- Long work experience in developing countries, especially in Africa is preferred.
- Knowledge of and experience with gender issues.

MEDICAL PSYCHOLOGIST

Essential Qualifications:

- Masters or PHD in medicine with specialization in tactical emergency medicine.
- Ten or above years of extensive clinical experience.
- Seven or above years experience in disaster management or mass trauma intervention.
- Experience in evaluating emergency medical programs.

DISASTER PREPAREDNESS EXPERT

Essential Qualifications:

- Masters degree in social sciences.
- Ten years experience managing emergency/disaster preparedness and planning.
- Experience designing and executing disaster preparedness training of emergency medical care.
- Field level experience with first aid and disaster coordination.

- Seven years experience in evaluations.

EVALUATION SPECIALIST

Essential Qualifications:

- Masters degree or above in economics, statistics, or sociology.
- Seven years experience with participatory evaluation methods or rapid rural appraisal techniques.
- Three years and above experience conducting household or firm-level research in Kenya.

REPORTING REQUIREMENTS

The contractor with report directly to Assistant Director or his designee. Mission Evaluation Officer and Bombing Response Unit (BRU) Coordinator will provide technical directions during the performance of this contract. The contractor will be supervised by and written report reviewed for acceptance by the Evaluation Officer and BRU Coordinator. The contractor will work collaboratively with the Mission staff and bombing response program implementing partners.

A. ***Briefings:*** The evaluation team will debrief USAID/Kenya on progress and discuss problems and issues on weekly basis. Additional debriefings will be convened as required by either party.

B. ***Work plan:*** The evaluation team will provide a detailed work plan to USAID before commencing the evaluation. The work plan will outline how the evaluation will be undertaken and the methods to be used. It will be approved by USAID before work is undertaken.

C. ***The methodology*** for collecting and analyzing the data will be approved by USAID.

D. ***The evaluators*** will make a presentation to USAID on the main findings of the evaluation.

E. ***Draft Report:*** Acceptance of the draft report by USAID/Kenya will be contingent upon the report adequately fulfilling the scope of work and addressing major important areas of inquiry outlined in the scope. The draft report will follow the required format for the evaluation as listed below:

i) Executive Summary
ii) Table of Contents
iii) Main body of the Report
iv) Annexes

F. ***Final Report:*** The evaluation will incorporate USAID comments in the final report. Five copies and a diskette will be submitted.

VI. PAYMENT PROVISIONS

Payment, in accordance with standard U.S. Government provisions, will be made on satisfactorily completion and acceptance of the final report by the Mission.

VII. DUTY STATION

The duty station is Nairobi, Kenya. A six-day work week is authorized under this contract without premium pay.

B. PERSONS CONTACTED

USAID

Nimo Ali, Acting Program Officer, USAID/Kenya
Joseph Brown, BRU Contract Officer, U.S. Army Corps of Engineers PASA, USAID/K
Roger Brown, BRU Engineer/Project Manager, U.S. Army Corps of Engineers PASA, USAID/Kenya
Gerald Cashion, Acting Mission Director, REDSO/Nairobi
Jonathan Conly, Deputy Assistant Administrator, Economic Growth and Agricultural Development Bureau, Washington, formerly Mission Director, USAID/Kenya
Mark Cull, Executive Officer, USAID/Kenya and REDSO/Nairobi
Tad Findeisen, Contracting Officer, REDSO/Nairobi
Rose Gathungu, BRU Acquisition Clerk, USAID/Kenya
Gregg Gottlieb, Deputy Assistant Administrator, Office of Transition Initiatives, Bureau for Humanitarian Response, Washington, formerly OFDA/Nairobi
Kathleen Hansen, Regional Legal Advisor (RLA), REDSO/Nairobi
Surinder Kapila, Legal Consultant, RLA, REDSO/Nairobi
Yves Kore', Contracting Officer, REDSO/Nairobi
Shannon Lovgren, Coordinator, BRU, USAID/Kenya
Kimberly Lucas, Kenya Desk Officer, Africa Bureau, Washington
Emma Mwamburi, Health Project Manager, USAID/Kenya
Steven Ndele, Program Evaluation Specialist, USAID/Kenya
Agnes Ndungu, BRU Project Management Assistant, USAID/Kenya
Thomas Okeefe, Deputy, Development Planning, Africa Bureau, Washington
Joseph Ondigi, Supervisor Financial Analyst, USAID/Kenya
Amin Rashi, Controller, USAID/Kenya
Zachary Ratemo, Enterprise Development Advisor, USAID/Kenya
Peter Riley, Senior Regional Advisor, Africa Regional Office (ARO)/OFDA, USAID, Nairobi
Jay Smith, Director, Development Planning, Africa Bureau, Washington
Kimberly Smith, Deputy Senior Regional Advisor, ARO/OFDA, Nairobi
Kiertisak (Kiert) Toh, Mission Director, USAID/Kenya
Michael Walsh, Regional Contract Officer, REDSO/Nairobi
Carol Wanjau, Coordinator, Oasis Counseling Center and Training Institute, Nairobi
Mary Ann Zimmerman, Training Consultant, ARO/OFDA, Nairobi

DEPARTMENT OF STATE

Ambassador Johnnie Carson, U.S. Embassy, Nairobi, Kenya
Brian Phipps, Kenya Desk Officer, Washington
Joseph Huggins, Executive Officer, Africa Bureau, Washington

USAID'S IMPLEMENTING PARTNERS/BENEFICIARIES

Dr. Grace Achiya, Chairperson, Resuscitation Council of Kenya, Nairobi
Charles Appleton, Partner, KPMG, Nairobi

J.S. Buluma, Head Teacher, St. George's Primary School, Nairobi
Basilla Ciakuthi, Program Officer, Ernst & Young (EY), Nairobi
Phil Dastur, Chief Executive Officer, M.P. Shah Hospital, Nairobi
Nancy Gichuki, Bursar, St. George's Seconday School, Nairobi
Jackson M. Githaiga, Program Manager, Amani Counseling Center, Nairobi
Anthony Gituri, Program Manager, Amani Counseling Center, Nairobi
Mahesh Gohil, Managing Director, K-MAP, Nairobi
Graham Jenkinson, Director, Matirx Development, London, UK, formerly Nairobi
Nelson Kaburu, Manager, Deloitte & Touche, Nairobi
Alex Kamau, Accountant, K-MAP, Nairobi
Rose M. Kasina, Counseling Coordinator, Amani Counseling Center, Nairobi
Nick Kiptanui, Director, Regional Blood Transfusion Center, Nakuru
Obed Kimani, Bursar, Hospital Hill Primary School, Nairobi
John T. Kiwara, MSED Program Manager, UDPK, Nairobi
Victoria Krop, Program Officer, EY, Nairobi
Isaac O. Litali, Director of Finance, The Nairobi Hospital
Judith Mango, Chairperson, Ufundi Sacco Savings and Credit Society, Nairobi
"Mary X" (not her real name), mental health patient due to the bombing, Nairobi
Samuel N. Mbugua, Administrator, EY, Nairobi
Peter O. McOdida, Program Officer, International Medical Corps (IMC), Nairobi
Dr. Margaret Meck, Project Consultant, Amani Counseling Center, Nairobi
Omari Ali Mohamed, Project Manager, Family Health International, Nairobi
Peter M. Muasya, Rehabilitation Manager, Kenya Society for the Blind (KSB), Nairobi
Josphine N. Muli, Project Coordinator, ADRA, Nairobi
Dr. Mutiso, Executive Director, Amani Counseling Center, Nairobi
Gideon Muriuki, Managing Director, The Cooperative Bank of Kenya, Nairobi
Eva Mwai, Chief Executive Officer, St. Johns Ambulance Kenya, Nairobi
Susan W. Mwangi, Manager, Disaster Response/Medical Program, AMREF, Nairobi
Duncan M. Ndegwa, Executive Officer, APDK, Nairobi
Dr. Frank Njenga, Chairman, Operation Recovery, Nairobi
Josephat Ngugi, Superintendent, Nairobi City Mortuary
Wilson G. Noreh, Executive Director, KSB, Nairobi
Dr. Jack Nyamongo, Director, Blood Transfusion Services, Nairobi
Dr. Omondi, Documentation Officer, Amani Counseling Center, Nairobi
Dr. Meshack Onguti, Director, Kenyatta National Hospital, Nairobi
Peter W. Opany, Project Officer, Kenya Society for the Deaf, Nairobi
H.H. Roba, Laboratory Manager, The Nairobi Hospital
Ross Samuels, Knight Support, Nairobi
Smita Sanghrajka, Senior Consultant, KPMG, Nairobi
John Sutton, Director, Knight Support, Nairobi
Ian Vale, Regional Director, IMC, Nairobi
Carol Wanjan, Coordinator, Oasis Counseling Center and Training Institute, Nairobi
Herbert C. Wasike, Manager, EY, Nairobi
Col (Rtd.) B.S. Wendo, Director, National Disaster Operations Center, GOK, Nairobi
Andrea Wojnar-Diagne, Deputy Head of the Regional Delegation, IFRC, Nairobi

Three focus groups of about twelve persons each that were receiving school fee benefits via Ernst & Young, medical care via AMREF and rehabilitation for disabilities via ADRA

OTHERS

James Anderson, former East Africa Director, Africa Bureau, USAID/Washington
Gwendolyn Driscoll, Journalist and author of "Up from the Ashes", Nairobi
Fred Fischer, Consultant, former Mission Director, REDSO/Nairobi
Rodney Johnson, Consultant, former Director of Procurement, USAID/Washington
Elly Oduol, Assistant Resident Representative, Crisis Prevention, UNDP, Nairobi

C. PARTIAL LIST OF DOCUMENTS

ADRA Quarterly and Annual Reports, 1998 - 2002.

AMREF Quarterly Reports, 1998-2002.

AMREF Disaster Management Policy. 2nd Draft. June 2002.

Bombing Response Unit Close-Out Plan, USAID/Kenya.

Gwendolyn Driscoll, Up from the Ashes, Lessons Learned from the Bombing of the United States Embassy, Nairobi, Kenya, USAID/Kenya, August 7, 2001.

Ernst & Young Education School Program Quarterly Reports, 1999 - 2002.

FHI Quarterly Reports, July 1999 - March 2002.

Brian Flynn, Ed.D., Director, Program Development, USPHS. Report on Mental Health Consequences Following the August 7, 1998 Bombing. Nairobi, Kenya.

IFRC/Kenya Project Reports, 1999 - 2002.

IMC Quarterly Reports, September 2000 - May 2002.

K-MAP Small Enterprise Project Reports, 1998 - 2001.

KPMG Business and Vehicle Assessment Reports, 1999 - 2001.

Matrix Development Building Assessment Reports, 1999 - 2001.

Betty Pfefferbaum, M.D. and Carol North, M.D., Report on Follow-up Study Of Adult Direct Victims of the 1998 U.S. Embassy Bombing in Nairobi, Kenya, University of Oklahoma, May 24, 2002.

Strengthening Blood Transfusion Service in Kenya. USAID, MOH and FHI, September 2001.

The Study on Blood Transfusion System in Kenya. JICA and MOH. January 2002.

Kenya National Blood Transfusion Service Policy Guidelines on Blood Transfusion in Kenya. Ministry of Health, July 2000.

UDPK Monthly Reports, 1999 - 2002.

USAID/Kenya Integrated Strategic Plan 2001 - 2005.

USAID/Kenya Controller's Comprehensive Pipeline Report for the Bombing Response Program (MACS-PO7B), June 30, 2002.

USAID/Kenya Contracts, Cooperative Agreements and Grants and Amendments with Implementing Partners for Bombing Response Program, 1998 - 2002.

Wilbur Smith & Associates, Assessment Reports on The Cooperative Bank and The Ufundi Sacco Buildings, Nairobi, Kenya, June 1999.

D. SUMMARY TABLE OF USG ASSISTANCE TO KENYA BOMBING PROGRAM ($000)

1) Original Emergency Assistance:

	Search and Rescue Operations
	$3,400
Medical Equipment/First Responder Training	654
Small Business Aid	300
Mental Health Assessment/Counseling	20
Engineering Advisors	38
NGO Coordination	40
Sub-total	**$4,452**

(Sources: OFDA, RHUDO, USAID bilateral, DOD, HHS, U.S. Public Health Service)

2) FY '98 Carry-Over Economic Support Funds (ESF):

Operation Recovery	50
Medical Payments to Hospitals	800
Subtotal	**$850**

3) Special Appropriations (ESF):

Medical, Educational and Social Recovery	14,070
Economic and Infrastructure Rehabilitation	19,030
Administrative Costs	3,900
Sub-total	**$37,000***

Grand Total: $42,302

* Estimates based on USAID/Kenya Controller's records as of June 30, 2002 and making certain assumptions about the final use of the approximate $1.2 million in residual USAID funding for the bombing response program.

E. USAID TIMELINE

August 7, 1998 — Terrorists explode a massive bomb at 10:37 AM local time in the rear parking area of the U.S. Embassy in Nairobi, Kenya, killing 213 Americans and Kenyans and injuring 5000 more. Within minutes a similar though smaller explosion occurs outside the U.S. Embassy in Dar es Salaam, Tanzania. USAID/Kenya and REDSO staff respond quickly from USAID's Parklands offices nearby and assist in rescuing American and Kenyan personnel and treating the injured. The Embassy relocates to the USAID building, sets up an operations center there and shares office space with USAID for the next year.

August 8 — U.S. military and Israeli Defense Force assistance arrives.

August 9 — U.S. Ambassador declares disaster to trigger use of $25,000 OFDA assistance. Three-person OFDA/DART team arrives to support the Mission and serve as liaison with OFDA-funded, 70-person Search and Rescue Team from Fairfax County, VA that arrives the same day. The bodies and families of 12 murdered Americans and the more seriously injured Americans begin to leave Nairobi.

August 13 — $25,000 OFDA money received from USAID/Washington.

August 16 — OFDA engineer arrives to start assessment of the many damaged buildings in the downtown vicinity of the Embassy. OFDA shipment of medical supplies and body bags arrive.

August 17 — Secretary of Commerce William Daly arrives with U.S. business delegation and pledges assistance to Kenya's business community.

August 18 — Secretary of State Madeline Albright arrives and promises $1 million of U.S. aid to help Kenyan and Tanzanian victims.

August 29 — USAID Regional Housing and Urban Development Officer (RHUDO) arrives from South Africa to assess buildings damaged.

August 31 — The GOK, which along with the Kenyan press and public has been critical of the minimal U.S. assistance provided to Kenyans thus far, issues an appeal for about $150 million for a wide range of humanitarian assistance.

September 1998 — On the advice of USAID/Washington, USAID/Kenya prepares and submits a Special Objective, initiating the process for obtaining bombing response funds from Washington.

September 6 — A Health and Human Services and Centers for Disease Control team arrives to prepare for the later visit by the U.S. Surgeon General.

September 8 — The GOK's Bomb Disaster Committee or Njonjo Fund starts distributing funds to victims and victims' families. The Kenyan Red Cross and AMREF set up facilities to assist Kenyan victims and survivors.

September 14 — A Congressional Notification (CN) is delivered to the U.S. Congressional committees to secure FY 1998 Economic Support Funds (ESF) amounting to $850,000. USAID's Assistant Administrator for Africa arrives in Nairobi for an official visit.

September 28 — U.S. Surgeon General David Satcher arrives with a 10-person team of technical experts.

October 27 — $850,000 ESF in residual FY 1998 funding is cabled to the Mission.

November — Using a pre-existing contract mechanism (IQC), USAID/Kenya hires KPMG to begin to assess 208 businesses hurt by the bomb blast. Using OFDA money, AMREF begins an initial screening of 1,482 bombing victims to assess the nature and extent of injuries.

November 7 — USAID/Kenya grants $50,000 (ESF) to Operation Recovery for mental health counseling for bomb victims and survivors.

December 14 — USAID/Kenya signs a cooperative agreement with K-MAP using $300,000 from existing bilateral funds to assist small and micro-businesses affected by the bomb blast.

December 18 — USAID's Africa Bureau approves the Kenya Mission's Special Objective. A CN is delivered to the U.S. Congress to notify the appropriate committees about the planned uses of $37 million in ESF for Kenya out of the total special appropriation of $50 million earmarked for Kenya and Tanzania.

January 7, 1999 — The CN for the special ESF is released.

January 14 — The first tranche of $11 million ESF is sent to the Mission. Now that USAID/Kenya can begin to commit funds, the Mission establishes it's Bombing Response Unit and hires the first PSC staff to plan and implement bombing response activities.

January/February 1999 — With the assistance of Deloitte & Touche, USAID/Kenya uses $800,000 of the initial $850,000 ESF to reimburse local Nairobi hospitals for the medical care of blast victims.

March 1999 — The final tranche of ESF moneys are released to the Kenya Mission on March 31. The Mission signs a Strategic Objective Agreement (SOAG) with the GOK on the same date regarding the use of these funds.

F. AMANI AND THE CRISIS MENTAL HEALTH PROGRAM

MENTAL HEALTH EFFECTS AMONG SURVIVORS OF THE U.S. EMBASSY BOMBING IN NAIROBI CITY IN 1998

OBJECTIVE: To measure the psychological sequelae of direct and indirect survivors of the Nairobi City Bombing and to examine the prevalence rates of specific disorders identified on die Hopkins symptoms check list (SCL90-R).

DESIGN: This was a cross sectional study conducted by the Amani Crisis Mental Health Assistance Program on clients seeking psychological assistance over a 17 months period post bomb blast.

METHODS: Participation in the study was limited to subjects at least 18 years old, who directly sought psychological support or came through other collaborating agencies. Clients were screened and subjected to a battery of psychometric instruments specifically designed to identify psychopathology. A socio- demographic questionnaire was self-administered and the results of the Hopkins symptoms check list analyzed. (SCL90-R)

CLIENTS: A total of 1,038 individuals completed the assessment as part of a bigger study on psychological responses and recovery. Only 1,023 responded fully on SCL90-R scale.

RESULTS: The study sample comprised of 50.1 % males and 49.9% females. Mean age was 37.87 years with range 18-75 years. 1.8% had no formal education while 33.1 % has Secondary education. 64.0% were married, 56.2% lived with their children and spouse, and the commonest and clinically significant psychological manifestations were somatization, obsessive-compulsive disorder, anxiety and depression accounting for 46.62%, 45.78%, 44.98% and 41.83% respectively.

CONCLUSION: Study dam suggest that, unlike studies conducted in a western setting where depression and anxiety are more common, somatization is more prevalent in the African population. In addition, co-morbidity and co-occurrence of symptom dimensions is a frequent presentation and that health providers, should be aware of this phenomenon. Focus should be directed towards developing reliable valid and relevant psychometric instruments able to screen and identify cases requiring immediate psychological interventions following a disaster.

SCREENING FOR PSYCHOLOGICAL RESPONSES AMONGST SURVIVORS FOLLOWING A BOMBING INCIDENT

OBJECTIVES: To screen for the core psychological responses and morbidity amongst the lCJJ8 Nairobi Bomb Blast survivors.

DESIGN: This was a cross-sectional study carried out from February 2000 to June 2001.

SETTING: The study was carried out in Nairobi (Kenya) at Amaro Crisis Mental Health Assistance Programme.

SUBJECTS: 1038 direct and indirect survivors who presented for psychologica1 assistance were assessed.

INTERVENTIONS: The survivors were assessed using a battery of psychometric instruments and structured interviews, which included Social Demographic Data Questionnaire, Self Reporting Questionnaire (S.R.Q), those who had positive scores on S.R.Q were further screened using Hopkins Symptoms Check List (HCL, 9O-R), Beck Depression Inventory (B.D. I.), Ndetei Otieno Kathuku Symptoms Oteck List (N.O.K). Munich Personality Test A and B (MPT-A, MPT-B) and Social- occupational Functioning questionnaire. All these instruments have been found valid and reliable in other studies. Counseling interventions were provided on those with positive scores on Self-Reporting Questionnaire.

RESULTS: Out of 1038 direct and indirect survivors 736 (70.9%) had positive Self Reporting Questionnaire scores (S.RQ) on the neurotic sub-scale, 875 (85%) had positive scores on the psychotic sub-scale, while 178 (17.3%) had positive scores on substance use sub-scale. 65.9% of the survivors had positive Self Reporting Questionnaire (S.R.Q) scores on both psychotic and neurotic sub-scales.

Gender, Age, Marital Status, Level of Education and Living Arrangements were significantly associated with Neurosis. Age was significantly associated with Psychosis, while significant statistical association resulted between Gender and Substance use.

CONCLUSION: Based on these results, the post bomb blast psychological morbidity was high. Promotion of intensive psychosocial and economic interventions is recommended to enable early recovery and delay in the development of Post-Traumatic Stress Disorder (P1SD) and other trauma related symptoms following traumatic experiences.

PROGRAM ACHIEVEMENTS, VARIANCES AND REASONS

Objective 1: To ensure that people affected by the bomb have access to mental health services				
Activity		**Achievement**	**Variance**	**Reasons**
1	To provide counselling treatment to 900 adults survivors (bereaved injured & rescue workers) through implementing partners in 2 years	1937	Exceeded the target by 1037	▪ The proposal did not take into account the extended families that were also affected, especially in upcountry. ▪ Upcountry counselling was not in the proposal initially ▪ The homestead whereby you find grand parents live in the same yard with all their sons and their families which cultural ▪ Effective outreach and training ▪ Undeserved counselling sessions ▪ Fraudulent claims, for example Islamic Development for Education and D'awar (IDEAD) that was seeing Muslim clients but was discontinued. ▪ Some were not bona fide bomb blast victims. These were people pretending to be the bomb blast survivors in order to benefit from the services.
2	To provide psychiatric treatment to 142 affected adult survivors with severe psychological disorders through implementing partners in 2 years	212	Exceeded the target by 70	▪ Many people delayed early intervention of counselling and ended up developing PTSD. This was because many people did not realize the importance of counselling and did not know what it was all about. ▪ Multiple traumas in some people. ▪ Many people ignored Counselling as it was a new concept in Kenya ▪ Pre-existing psychiatric problem ▪ Fraud by the clients – This was because some clients would get more than one drug prescription from different psychiatrists
3	To provide counselling treatment to 300 affected children survivors through implementing partners in 2 years	1687	Exceeded the target by 1387	▪ 70 schools were attending a music festival at KICC, which is about 100 meters from the bomb blast site, and some of the children were affected.

					▪ Due to extended families, children numbers increased ▪ A Muslim school bus was at the Haile Selassie Round about next to the American Embassy on the day of the bombing and 50 children were injured. ▪ Media coverage - many children were affected by watching it on TV at home alone while parents were at work. It was a school vacation. ▪ Effective outreach and training ▪ Fraudulent claims that is double billing/invoicing and undeserved counselling sessions ▪ Inaccurate estimate of the survivors in terms of individual affected ▪ Family size (assumption of family of 4) is not realistic in Kenya ▪ Some were not bona fide bomb blast victims
4	To provide psychiatric treatment to 100 affected children survivors with severe psychological problems through implementing partners in 2 years	4	Less by 96		▪ Due to lack of well trained child therapists and specialists on children psychosocial issues few children were referred to psychiatrists. ▪ Implementing partners were doing the outreach of children - this limited the programme since some of the agencies were not cooperative. ▪ Implementing partners were also not conversant with the children's assessment tools even after the training. ▪ Shortage of well trained child therapists in the country barred the programme from getting proper diagnosis – there are very few trained child therapists counsellors who may have missed the presentation of problems hence no referrals were made. ▪ Children seem to recover more quickly than adults ▪ Most parents do not want their children to have stigma in psychiatric treatment. ▪ Many schools did not co-operate. Some schools refused outreach workers to their schools

5	To provide 48 clinical supervision meeting to implementing partners in 2 years	36	Less by 12	• Initially counsellors had a negative attitude towards supervision since they thought they would be assessed on their competence and experience on the job, they were reluctant to attend. • A new concept - It was a new concept to most of the counsellors and caregivers in Kenya. • Ignorance of supervision • Some feared that their incompetence and lack of experience would be revealed
Objective 2: To provide knowledge, skills and attitude change regarding the psychological management of disaster trauma.				
Activity		**Achievement**	**Variance**	Reasons
1	To train360 counsellors from implementing agencies in areas of trauma mental health in 2 years	341	Less by 19	• Due to poor remuneration in the agencies, there were few counsellors to train and some of them left the agencies to other greener pastures. • Amani counsellors' criteria – this disqualified quite a number of counsellors from implementing patners. • There a few qualified and experienced counsellors in the country.
2	To train 560 teachers in areas of trauma mental health in 2 Years.	411	Less by 149	• Bureaucracy in planning the workshops by the Ministry of Education who selected the participants. • There were last minute cancellations by the teachers with no proper reasons • There were interruptions in training during the end of term examinations, National exams, schools music festivals and sports period etc. • Logistics especially in upcountry training. • Teachers expected to be paid or given an allowance for travelling to and from their schools to attend the workshops.

3	To train 90 mental health providers and key decision makers in areas of trauma mental health in 2 Years.	139	Exceeded the target by 49	▪ There was more demand for disaster awareness at this level than expected. ▪ Many key decision makers especially in the government found the training to be very useful to civil servants. This was because the government is planning to put in place disaster management teams all over the country. ▪ It also played as a platform for government ministries to emphasize the importance of disasters preparedness in each ministry ▪ Bomb blast disaster awareness created a lot of interest and concern nation wide ▪ Concentrated on main / key decision makers ▪ Workshops were less expensive - savings on trainings financed extra workshops
4	To train 180 community based mental health providers at district level in areas of trauma mental health and conduct a follow-up workshop in 2	299	Exceeded the target by 119	▪ Pilot projects saw the need to train para-professionals at community level to develop support systems. ▪ This was the first time the communities were being involved in the counselling and mental health services outside institutions. ▪ The demand for communities to be disaster prepared was very high. These would equip them with skills to take care of disaster survivors within the communities ▪ Some communities requested for training especially where there were other disaster like cattle rustling and tribal clashes e.g. Eldoret ▪ Savings from the workshops were used to organize more workshops than previously planned for yet stay within the budget
5	To hold 3 staff development workshops in 2 Years.	Done 3 but proposed for one more	None	Okey

Objective 3: To Reach Out to survivors and their families and create awareness and sensitivity about Crisis Mental Health Programme.

Activity		Achievement	Variance	Reasons
1	To outreach and assess 1500 affected children in 2 Years.	1349	Less by 151	▪ Families had to give consent for their children to be outreached, which was very difficult, as parents/guardians did not understand why counselling was necessary. ▪ Assessing children in the schools was also difficult because of getting consent from the school heads. ▪ Implementing partners had logistic problems especially transport to schools. ▪ Administrative problems within implementing partners. ▪ Logistics problem during upcountry outreach exercise ▪ Outreach for children was done at school ▪ Administrative problem within the programme especially when children outreach was stopped without the knowledge of the concerned coordinator ▪ The cost of outreach for children was high ▪ Inter agencies rivalry ▪ Division of schools to agencies was not very clear ▪ Assessment tools were bulky and tedious to children.
2	To reach out 1260 affected adult survivors living in Nairobi and the environs through 16 Volunteers in 2 Years.	1123	Less by 137	▪ Volunteers were using public means and it was difficult to monitor them. ▪ Volunteers' remuneration was not enough and they were also expected to use this money for their own transport during the outreach exercise.

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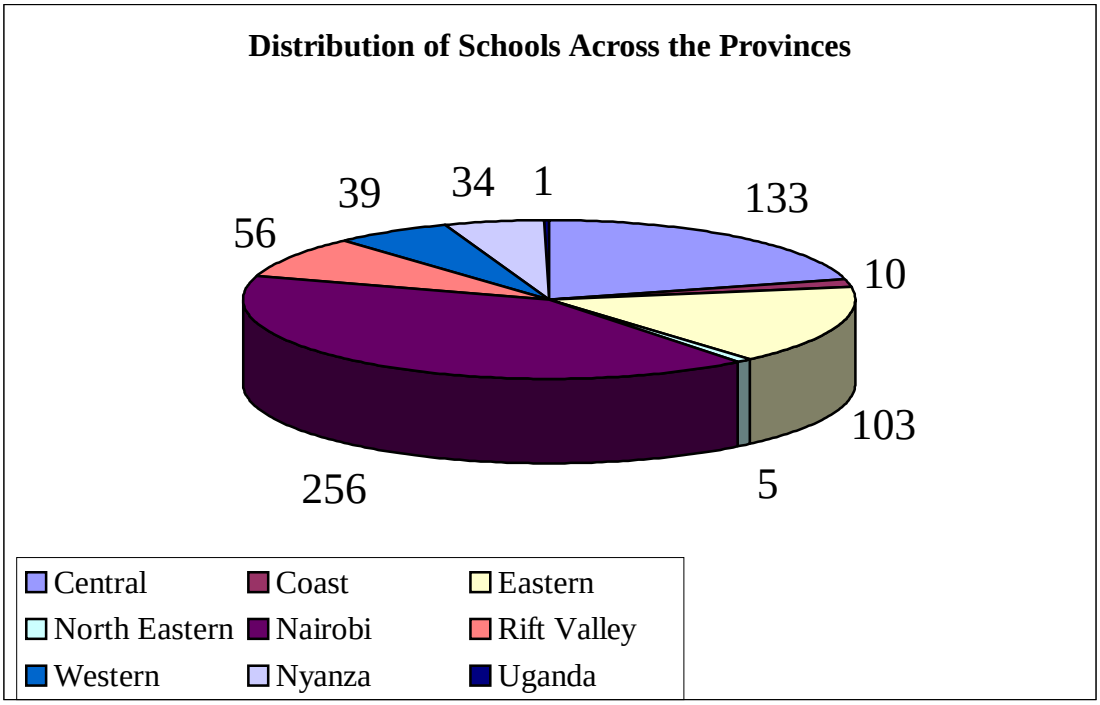
					▪ The assessment tools were too bulky and not culture sensitive.
3	To reach out 300 affected families living upcountry through 10 Volunteers in 2 Years.	529	Exceeded the target by 229	▪ The extended families set up gave an increase in numbers ▪ Many people moved upcountry due to loss of jobs after injury or death of breadwinners in the bombing. ▪ Found larger families than expected o Immediate extended family	
4	To outreach 300 permanently/seriously injured survivors through 6 peer counsellors in 2 Years.	209	Less by 91	▪ Some of the collaborating agencies were adamant in facilitating the trainings of peer counsellors in their institutions e.g. ADRA Kenya – they wanted to be given money to do the training ▪ The delay in buying vehicles for the programme interfered with some activities. ▪ In Kenya Society for the Blind, the training materials had to be written in Braille for the students. ▪ The programme did not have enough mental health facilitators who could communicate with the deaf peer counsellors ▪ Criteria for identifying the victims was problematic ▪ To determine the level of injury was also very difficult. ▪ Missed quite a number of survivors ▪ During outreach most of the seriously injured were still in hospitals multiple operations. ▪ Incomplete bomb blast survivors database – not identified immediately after the bomb blast ▪ Some of the seriously injured went upcountry and stayed away from Nairobi because of fear.	

5	To offer 8 children and family days/events in 2 Years.	8	Nil	As they were planned activities
6	To conduct 12 community meetings (Barazas") in 2 Years.	10	Less by 2	▪ Delay in procurement of vehicles in the early stage of the programme ▪ Bureaucracy in the provincial administration who were the key organisers of these meetings
7	To develop 70 media dissemination activities in 2 Years.	67	Less by 3	▪ Some media supplements are planned for the remaining two months and will be done before closure of the programme
OBJECTIVE 4: To Develop a comprehensive research and documentation programme for all internal and external documents with a statistical reporting				
Activity		**Achievement**	**Variance**	**Reasons**
1	To develop a comprehensive database system with timely information for the programme monitoring and evaluation in 2 Years.	1- Done	None	Okey
2	To process and analyze 1038 adult assessment and 936 children assessment data and consequently make 5 publications in 2 Years.	- 1038 adults' data analysed. - Four Publications are ready	Not Significant	▪ Change of personnel ▪ 3 months time delay before replacement of personnel ▪ Initially the documentation department lacked adequate computers ▪ 4 papers ready for publication • 2 have gone through 2nd peer review • 2 have gone through 1st peer review

G. EDUCATION SUPPORT PROGRAM (ESP)

A summary of school fees payments from commencement to date is as follows:

Description	No. of children	KShs	US$
3rd term 2000	1,041	4,002,241.55	51,310
1st term 2001	1,435	20,250,680.00	259,624
2nd term 2001	1,053	9,359,584.00	119,995
3rd term 2001	943	5,563,132.00	71,322
1st term 2002	1061	13,093,042.00	167,860
2nd term 2002	833	7,168,725.00	91,907
Refunds of fees for IFRC period	-	2,007,086.00	25,732
Shummy Abdalla	3	244,450.00	3,134
Total		**61,688,940.55**	**790,884**



Source: Ernst & Young, 8th Quarterly Report, ESP, April 1, 2002 to June 30, 2002

ANNEX H
STRENGTHENING BLOOD SAFETY

INSTITUTIONS RECEIVING BLOOD FROM THE KISUMU CENTER

Institution	Jan	Feb	March	Total
New Nyanza PGH	183	219	244	646
Kisumu District Hospital	69	81	134	284
Kisii District Hospital	60	61	90	211
Busia District Hospital	58	60	99	217
Vihiga District Hospital	7	20	57	84
Rachuonyo District Hospital	32	20	72	124
Kehancha District Hospital	11	30	0	41
Suba District Hospital	38	0	0	38
Siaya District Hospital	48	79	46	173
Kakamega PGH	0	100	90	190
Yala Sub-District Hospital	0	2	2	4
Butere-Mumias District Hospital	0	9	11	20
Bungoma District Hospital	0	40	18	58
Kuria District Hospital	0	0	38	38
Homabay District Hospital	0	0	27	27
St. Monica Hospital	3	9	14	26
Kendu Adventist Hospital	17	44	59	120
St. Joseph Hospital, Nyabondo	15	15	34	64
St. Joseph Hospital, Migori	0	0	30	30
Maseno Hospital	0	0	12	12
Lundu Maternity Nursing Home	3	0	1	4
Jalaram Maternity Nursing Home	14	11	6	31
Nightingale Medical Centre	4	1	12	17
Equator Hospital	12	12	18	42
Milimani Maternity Nursing Home	4	2	7	13
Star Children Hospital	0	6	4	10
Marie Stopes Maternity N. Home	0	1	5	6
Aga Khan Hospital	0	25	16	41
Kibos Road Hospital	0	0	5	5
Whitestone Hospital	0	0	2	2
Total	**578**	**847**	**1153**	**2578**

INSTITUTIONS RECEIVING BLOOD FROM THE NAIROBI NBTC

Institution	Units
Kenyatta National Hospital	1443
Forces Memorial Hospital	142
Pumwani Maternity Hospital	108
Mbagathi District Hospital	128
Machakos District Hospital	89
Thika District Hospital	70
Other Government Hospitals	237
Private Hospitals	32
Total	**2302**

ANNEX I
NUMBER OF HOSPITAL BASED STAFF TRAINED BY RESUSCITATION COUNCIL OF KENYA

Hospital	Course	Number Trained
Mbagathi District Hospital/Nairobi	ALS	24
	ACLS	22
Naivasha District Hospital/Naivasha	BLS/ALS	22
	TRAUMA	22
Kenyatta National Hospital/Nairobi	ATLS	25
	INSTRUCTORS ALS/ACLS/ Trauma	20
Nyanza Provincial Hospital/Kisumu	BLS/ALS	36
	ACLS/ATLS	32
Coast Provincial Hospital/Mombasa	BLS/ALS	52
	ACLS/ATLS	52
	INSTRUCTORS ALS/ACLS/ Trauma	25
Machakos District Hospital/Machakos	BLS/ALS	25
	TRAUMA	24
Kericho District Hospital	BLS/ALS	28
	TRAUMA	28
Moi University Hospital/Eldoret	BLS/ALS	35
	ACLS	35
	TRAUMA	34
Western Provincial Hospital/Kakamega	BLS/ALS	26
	TRAUMA	26
TOTAL PROVIDERS	**BLS/ALS**	**249**
	ACLS	**143**
	TRAUMA	**247**
TOTAL INSTRUCTORS	**BLS/ALS**	**45**
	ACLS	**43**
	TRAUMA	**43**
GRAND TOTAL TRAINED		**770**