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Mid-Term Evaluation
Bomb Blast Survivors Medical Assistance Program

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Winner 1999 Conrad N Hilton Humanitarian Prize

TABLE OF CONTENTS

Abbreviations

NGOs	-	Non Governmental Organisations
ADRA	-	Adventist Relief Agency
KSB	-	Kenya Society for the Blind
APDK	-	Association for the Physically Disabled of Kenya
KNAD	-	Kenya National Association for the Deaf
KSD	-	Kenya Society for the Deaf
MAP	-	Medical Assistance Programme
KNH	-	Kenyatta National Hospital
ENT	-	Ear, Nose and Throat
SDA	-	Seventh Day Adventist
UDPK	-	United Disabled Persons of Kenya

Executive Summary

Project Background

- AMREF has been running a two-year Medical Assistance Programme (MAP) funded by USAID from July 1999 to June 2001. The project goal is to ensure adequate physical, medical and surgical treatment and rehabilitation for the survivors of the August 7, 1998 bomb blast in Nairobi. The project has nine objectives, which can be classified into; provision of medical assistance, co-ordination; research, documentation and dissemination.

Internal Review

- The internal mid-term evaluation was conducted mainly to assess the project implementation process and make recommendations on areas that need improvement. The evaluation team involved various categories of stakeholders including clinicians and other service providers; survivors, collaborators; project staff and the donor. The methods used for gathering the information were one-to-one interviews, self-administered questionnaires; observation of the facilities; and general conversations.
- The evaluation team focused on three main components, namely medical assistance, co-ordination of the survivor assistance programmes and project management. The medical assistance component has been implemented through setting certain procedures in place. These include survivor identification and referral systems to enable smooth flow of patients and appropriate attention to their medical needs. Doctors have been identified to cater for the survivors' variant needs of care such as dentistry, gynaecological, orthopaedic surgery, neurological and ENT, among others. The facilities used by MAP range from private hospitals (e.g. Nairobi, Mater and Aga Khan), public hospitals (Kenyatta National Hospital) and others (laboratories, pharmacies and Physical Therapy).
- Collaboration with the other organisations serving the survivors has also been an important component of MAP. The other organisations are ADRA (which co-ordinates KSB, KNAD, APDK and UDPK), AMANI Counselling Centre and Ernest & Young. This collaboration has mainly been in terms of referrals and in attending joint meetings. Although AMREF has been vested with the co-ordination role this has not been very effective mainly due to the independence of the organisations in their implementation and also as a result of an unclear mandate from the donor.
- Project management has been well done. The project implementation has been timely with a clear exit strategy, which was in-built in the project document. The project manager has been submitting her quarterly reports to the donor on time. The staff members see themselves as a team and are highly appreciated by the survivors. The main problem encountered by the staff has been the workload, which has affected staff development.

  The staff needs capacity building in various areas including counselling, information technology, research and documentation.

Project Achievements

- The project has many achievements. There is a system in place for survivor identification and for referrals to the doctors and other facilities. Collaboration with the private and public sectors has been shown to be possible through this project. The fact that survivors and service providers can attest to improved health and well being is an indicator of achievement. AMREF is currently recognised as a credible institution capable of intervening in emergency and traumatic situations.

Project Constraints

- The project has, however, encountered several constraints including heavy workload on the staff. The range of medical ailments has surpassed the initial projections and the number of patients has more than doubled. The survivors' mentality of impatience and perceptions of themselves as the unfortunate victims is very demanding on the staff and service providers. Dishonesty of some survivors has resulted in financial losses that have necessitated a shift in strategies. The current Kenyan economy and the wave of retrenchment are a threat to the gains made through counselling.

Issues and Gaps

- Several issues and gaps have been identified in this review. The objectives as stated in the document lack clarity and are therefore not an effective monitoring and evaluation tool. An issue of concern for both the survivors and service providers is on information production and flow. In addition, documentation and dissemination of data and experiences has been very slow in taking off. Another area of concern is the AMREF co-ordination role, which is seen mainly as a facilitative one in terms of organising joint meetings. Sustainability, staff development and KCO management support are some of the other areas that require refining in the remaining project period and in the proposed phase II.

RECOMMENDATIONS:

1). Information

Information flow between the project, survivors and the collaborators has been inadequate and there is need for improvement. From discussions with the key stakeholders it is evident that there is need to do the following:

- Improve communication between and among the service providers in order to be more effective in meeting the needs of the survivors. This could be done through forums such as a newsletter or a brochure while the use of e-mail for such an activity would make it cheaper and more efficient;
- Improve communication with the survivors by providing relevant and timely information on the available services. This should be done in a manner that is appropriate and

sensitive to the survivors' abilities/disabilities e.g. notices in a language that can be understood by all using different communication channels; and

- Improve information and data collection processes. This could be done through building the staff capacities to collect and store the information.

2). Research

Research was identified as one of the key objectives of this project. Research is crucial in providing information for future disaster interventions. Unfortunately, this process has just been initiated. Considering the importance of research especially in such a unique situation, the project needs to focus on this urgently.

The evaluation team recommends that:

- All appropriate information and data be collected, analysed, documented and disseminated;
- A system of documenting the process and any other information needs to be developed urgently. This should also involve other players such as the doctors and collaborators;
- Publication of the research findings should be an important product of this project.

3). Survivors Discharge and Weaning Off

To ensure adequate rehabilitation of survivors there is need to:

- Discharge those whose medical treatment and rehabilitation is completed; and
- To wean the rest of the survivors off the programme. This process should be gradual with cost sharing being started initially at the pharmacy and later in the other areas.

4). Co-ordination

Co-ordination of the survivor assistance programmes is crucial if the service provision is to be streamlined and the information generated used for documentation for wider dissemination. Thus:

- There is need for the survivors to be given a single number which should be used by all the organisations for identification and follow-up purposes; and
- This co-ordination can only be achieved if the co-ordinating organisation has a mandate to do so. It is, therefore, recommended that USAID reviews the co-ordination objectives and provides a mandate to AMREF or any of the other organisations to co-ordinate the survivor assistance programmes.

5). Funding and Long- Term Follow-Up of Survivors

While most survivors' medical treatment and rehabilitation would have been completed at the end of the current phase of the project, 20 – 30% will require long-term treatment and follow-up. These are mainly those with respiratory problems, reproductive health problems, the deaf, those with prosthesis and the silent victims. Further medical assistance is required by the survivors who are still suffering and those who are presenting with new ailments that may be of research interest to the programme. AMREF has presented a

proposal to USAID for another funding year (2001 – 2002). It is, therefore, recommended that:

- Survivors with long-term problems should be identified by their doctors with a medical report being sent to AMREF;
- AMREF should form a medical board which will be responsible for reviewing the cases requiring long-term medical care;
- AMREF should work closely with USAID to come up with a feasible system of medical provision beyond the funding period; and
- AMREF should identify companies and other organisations to fund MAP activities beyond the USAID funding period. This would ensure a follow-up of the survivors, and specifically the silent victims for a much longer period.

1. Project Background Information

A terrorist bomb aimed at the United States of America embassy exploded on August 7, 1998. It resulted in an immense loss of lives (an estimated number of 260 dead and 5000 injured respectively) and property. The effects of the bomb blast led to immediate responses from individuals, companies, donors and agencies. AMREF intervened through setting up a Bomb Response Unit and used its friends and offices in Africa, Europe and North America to set up a special East African Emergency Appeal. AMREF received a total of US$ 1,258,323 to directly provide medical care to the bomb blast survivors.

AMREF worked in collaboration with USAID and Kenyatta National Hospital in the screening of 1,400 survivors and providing reconstructive surgery for 380 survivors. Upon realising the need for continued survivor assistance, USAID awarded Kenya funds for the survivors' rehabilitation and for businesses that were affected. This money was channelled through different organisations. AMREF was awarded US$ 1,619,331 to run a two-year Medical Assistance Programme (MAP) from July 1999 to June 2001. Other agencies contracted were Kenya Red Cross (KRC)* to provide mental health and school fees services and Adventist Development Relief Agency (ADRA) to cater for the physically disabled survivors.

At the end of the first year of the implementation of MAP, AMREF decided to conduct an internal mid-term evaluation to assess the implementation processes. Terms of reference were developed for the evaluation team (Annex 1) and the exercise took place in September 2000.

* Kenya Red Cross had major management problems, which led to the cancellation of their contract. Two organisations were awarded these contracts - AMANI Counselling Centre (Mental Health) and Ernest & Young (Education (School Fees) Programme).

2. Project Objectives

The project goal is to ensure adequate (physical) medical and surgical treatment and rehabilitation for survivors of the August 7, 1998 bomb blast. The objectives are to:

1. Ensure the start and/or completion of reconstructive, ophthalmology, orthopaedic and dental surgeries;
2. Ensure adequate rehabilitation, in form of physiotherapy, hydrotherapy and occupational therapy to survivors that require the service;
3. Identify, assess and assist special cases that need specialised medical treatment and rehabilitation outside the country where in-country care is not available;
4. Provide therapeutic devices as necessary – including dentures, bridges, eyeglasses, orthopaedic prosthesis, lumber corsets, hearing aids, and eye prosthesis;
5. Study the milestone development of babies born to mothers affected in the bomb blast;
6. Assist in co-ordination of efforts for agencies working on bomb blast survivors' projects;
7. Collect, synthesise and disseminate information to NGOs, patients and government bodies on bomb blast related matters;
8. Form communication network for implementing agencies through the development of a website on bomb blast survivor assistance, in view of verification of true survivors, avoid duplication of services provided and information on survivor assistance being offered; and
9. Research on overall medical responses to the bomb blast and national impact.

3. Evaluation Methodology

The evaluation team held a one-day planning meeting, which was also attended by the project team to identify the people to be involved in the review process. The evaluation tools were also developed. The participants in the evaluation process were categorised as:

- Clinicians;
- Survivors including parents of silent victims;
- Medical facilities;
- Project staff; and
- Collaborators.

MAP is currently working with 22 clinicians from a wide range of specialisation. It was decided that each of the specialities represented be involved in the discussion i.e.

- Ophthalmology;
- Physicians;
- Orthopaedic surgery;
- Dermatology;
- Reconstructive surgery;
- Ear, Nose and Throat;

- Neurology;
- Gynaecology;
- Urology;
- Paediatrics; and
- Dentistry.

In areas where only one doctor is involved, the name was automatically taken. However, in cases where there was more than one, random sampling was used for selection.

MAP has registered 1,200 survivors and the evaluation team considered it very crucial to hear their views about the programme. The project management team observed that the office receives around 20 patients daily. It was therefore agreed that 200 patients be given a questionnaire to fill and 20 be interviewed on a one-to-one basis by the evaluation team.

MAP utilises the services of hospitals (Mater, AgaKhan, KNH, Nairobi and SDA (Better Living Centre), Eros Pharmacy, Plaza X-Ray (Nginyo Towers and Re-insurance Plaza), laboratories (AMREF and Omicron) and physiotherapy (Physical Therapy and Nairobi Hospital). The evaluation team selected to visit KNH, Nairobi Hospital, SDA, AMREF Laboratory and Physical Therapy.

The other organisations providing services to the survivors were also included in the data collection design, i.e. ADRA, AMANI Counselling Centre, KSB, KNAD, APDK, UDPK, and Ernest & Young. The following, are therefore, the people, organisations and facilities involved:

- Clinicians 12
- Medical facilities 8
- Survivor interviews 27
- Survivor questionnaires 127
- Collaborating organisations 7
- Project staff 5

The data collection instruments used in this process are attached in annexes 2, 3, 4 and 5.

Out of the 127 people who filled in the questionnaire, more than 50 % were involved in low paying jobs and about 11% were unemployed as illustrated below:

Occupation	**%**
Clerks	25.5
Unemployed	16.5
Secretary	8.7
Teacher	5.5
Housewife	3.9
Manager	2.4
No answer	37.8

Although some patients did not respond to this question, it is clear that it would be difficult for most of the survivors to afford the medical services being provided outside the project period.

4. Project Components

This project has two main operational components: Medical Assistance and Co-ordination. The third component included in this evaluation is project management.

4.1 Medical Assistance

4.1.1 Survivor Identification

Survivors were identified using pre-determined criteria through a thorough scrutiny of medical records, letters from employers and appropriate medical history. The main challenge encountered by the project team was whether the medical problems presented were specifically bomb-related. Statements by the survivors that a particular problem developed after the bomb blast have been admissible. This problem may be as a result of the dearth of information on bomb related problems in medical literature. Consequently, the survivors tend to expect treatment of all their medical conditions under MAP. The project nurse and their doctors have however, specifically informed them that the programme covers only bomb-related conditions.

The survivors who do not meet the criteria set for registration, as bomb survivors have not been included in MAP. There have been around 2 cases of fake survivors who have cheated the system but when they were discovered they were dully thrown out.

4.1.2 Referrals

All referrals are channelled through the project nurse who directs the survivors to specific doctors who have been identified. The doctors mainly work in the public sector and all of them have appropriate speciality training and experience. They have all been head hunted and were recruited in good time, between July 1999 and November 1999. Referrals for rehabilitation have been done in collaboration with NGOs who have appropriate experience and ensure sustainability of care beyond project period. Such referrals are also provided through the project nurse. Most of the survivors (94.5% n=127) considered the doctors to be very good. For survivors who have had problems with their doctors, a change has been authorised by the nurse after consultations with the respective doctors.

4.1.3 Medical Care

The doctors observed that the survivors tend to be more demanding than other patients are, they have a sense of entitlement and generally expect all ailments to be covered by the project. One doctor expressed that AMREF has created ***"a class of people who want to be a priority, are demanding and do not want to wait"***. The main challenge is that many of the survivors are poor and would find treatment costs beyond their means if asked to pay.

Good quality treatment is administered by appropriately qualified medical staffs who are cognisant of the sustainability of care.

The facilities being utilised by MAP vary, but they are generally adequate for the care of survivors. Only a few of the survivors have required treatment overseas. Most of the patients (over 90%) appreciate the services rendered by MAP and attest to improvement in health. Thus, the treatment and rehabilitation of many of them can be terminated at the end of the funding period. However, there are some (approximately 20 - 30%) who may require long term follow-up such as patients with mental and reproductive health problems and those with prosthesis.

(i) Investigations

Laboratory tests are performed in good time. The main complaint by the survivors is that it is inconvenient because they make a specific trip to AMREF, which is geographically removed, from where all the doctors are located. AMREF laboratory gives reliable results for routine investigations. However, these are presented using the Imperial System of units while most doctors are now used to the International System. For more specialised tests, e.g. specialised chemistry, hormonal tests and histopathology, survivors are appropriately referred to Nairobi Hospital.
Good quality x-rays are obtained at Plaza X-Ray centre. These are taken expeditiously and are all reported by a radiologist, the facilities at this centre are excellent.

Facilities at KNH, specifically the ENT department are, however, inadequate. There are an insufficient number of audiometers and some are borrowed from KNAD and KSB, which means that survivors have to wait longer for appointments because of the numbers of audiometers available. Currently, there is no working audiometer belonging to KNH. There is a need to acquire such equipment to facilitate the follow-up of the survivors.
All the survivors have however had their tests done.

(ii) Treatment

Most of the surgical treatment has been completed which has been mainly reconstruction work, which has involved the removal of foreign bodies, tendon repairs, revision of scars and excision of keloids. Most of this was done under local anaesthesia at the SDA Better Living Centre and Nairobi Maxillofacial clinic while some has been done under general anaesthesia at Kenyatta National Hospital (KNH). Almost all these survivors have been discharged as their treatment has been completed. Orthopaedic patients who have had implant removal and repair of tendon injuries have also been discharged while those with backache and other musculoskeletal pain have been referred to physiotherapy. Those who have had amputations have been fitted with artificial limbs and surgical boots as appropriate, these patients require life long prosthetic management and should be considered during the exit plan.

Neurological patients mainly had head injuries while most of them are left with post head-injury syndrome, which manifests with non-specific symptoms of headaches, blurred

vision and nightmares. Such survivors will require long-term follow-up. Some survivors have had removal of slipped discs and have improved. One child had a brain tumour, which was removed unfortunately, the child died post-operatively. Facilities for such operations are, however, adequate.

More than 170 survivors had dental problems including missing teeth, fractures of the teeth, soft tissue injuries and gum disease. These have received gum therapy, extraction, crowns, bridges, dentures and fillings as necessary. Most have been discharged and only 20 - 30 may need follow-up beyond the present project phase. All the dental care was provided at SDA Better Living Centre, which has good facilities for dental work.

Urological patients have had mainly psychological concerns manifesting with genito-urinary problems including impotence and bed-wetting. These are being appropriately treated and referred for counselling. Investigations facilities at KNH are adequate.

Survivors with gynaecological problems have had problems manifesting in hormonal imbalances with premature menopause; pregnancy losses and cycle irregularity and a few have had inter-current problems like pelvic pain. Investigation facilities are adequate. Treatment is adequate for most of them except for a group who have premature menopause. Instead of receiving hormone replacement therapy, they are getting symptomatic treatment because of fear by the doctors of being unable to sustain the expensive treatment beyond the current phase of the project.

Most of the survivors referred to ENT department have had hearing loss (7 of the survivors are deaf). Some suffer dizziness and tinnitus (nagging sensation in ears). Out of 82 hearing aids required, only 46 have been obtained of which 32 have been fitted. These aids were sourced from Denmark and are adjustable. Thirty-six hearing aids are still required plus a small safety stock. These survivors will require life long follow-up. ENT department has tended to give counselling as part of the treatment process. This could explain the small number of patients referred to KNAD. Most patients with surgically correctable deafness have been operated, with improvement in hearing being realised. Only one survivor needs to go abroad for further treatment.

Survivors with opthalmological problems have either loss of sight (from perforating injuries or direct injury to the eye) or eye discomfort, pain, itch or redness. Treatment has included surgery for perforations, corrective lenses and topical medication. One of the survivors, a young girl who lost one eye was grateful to AMREF for enabling her to see again. She is still very aware of her situation and always wears braided hair, which covers the blind eye.

Medical patients have tended to have allergies leading to upper respiratory tract infections, bronchial asthma, eczema and conjunctivitis. Some have had anxiety, depression, hypertension and vague musculoskeletal symptoms. Majority have new symptoms and some have worsening of already existing conditions, these survivors tend to be frequent attendees at the different health care facilities. It is estimated that 20 - 30% will require long-term follow-up especially those with respiratory problems.

Skin conditions have been mainly allergic in nature. These are being treated with topical creams and have generally improved. It is estimated that up to half of these survivors will still require treatment after the current funding phase expires.

The pharmacy located at AMREF has worked well in terms of controlling over-prescription and fraud. All drugs are generally available but occasionally, however, patients need to collect drugs from the main pharmacy in town. Physical facilities are limited making storage difficult. Further, the pharmacy is only open during afternoon hours making it inconvenient for some of the survivors. There is, however, an arrangement where children can get medication out of hours at Nairobi Hospital. Some of the survivors noted that they have problems over the weekends because the pharmacy operates from Monday to Friday.

(iii) "Silent Victims"

Forty-seven (47) children are being followed up at Nairobi Hospital. These are mostly children born to mothers who were pregnant and were in the vicinity of the bomb blast. Five were born to mothers not expecting at the time of blast, while one was already 1 year old. Most of these children tend to be irritable but this has tended to settle by one year. In addition, they tend to have more respiratory problems (blocked nose, cough, wheeze) than other children as reported by the mothers and the paediatrician. They are being attended to at a Well-Baby clinic and will require long-term follow-up to find out if the problems will persist or others will arise. Further, these children may require ENT evaluation and psychological assessment before discharge.

(iv) Rehabilitation

Rehabilitation is mainly co-ordinated by ADRA who identified the collaborators. These are NGOs with experience in rehabilitating people with physical disabilities - APDK, KNAD, KSB and UDPK. ADRA has case managers who identify the survivors' needs. Facilities in each of the NGOs were variable, KSB for instance, is well organised with good facilities. It was involved in the initial screening of patients after the bomb blast and followed-up the survivors. Out of an initial caseload of 236 survivors, 70 were listed for follow-up, 62 regained sight after treatment and 38 were registered totally blind. To date, 19 are legally blind and have been fully rehabilitated. The project officer noted that the survivors are quickly rehabilitated compared to others who usually contact KSB much later.

The project officer observed that KSB's facilities were strained with the bomb blast and it had to get trainers from the provinces to come to Nairobi. Another trainer was obtained from USA through the Baptist Mission. With these personnel and its existing physical facilities in Nairobi and Machakos, the society has done well. In Nairobi, a computer-training programme for the blind has enabled some survivors to go back to work. KSB, however, continues to follow-up survivors who should have already been discharged from their care due to lack of confidence in ADRA case managers in the rehabilitation of blind people.

KNAD has done a good job considering its limited physical facilities. It offers counselling services and teaches sign language using a home-based program. It also offers sign language classes to KNH-ENT department staff, and offers interpretation services to the deaf. There, however, seems to be a low referral rate from KNH-ENT to KNAD department whereas this could help rehabilitate many of the affected survivors.

APDK has inadequate facilities, but it has personnel to offer a wide range of rehabilitation services including physiotherapy, occupational therapy and orthopaedic technology. ADRA has tried to improve its capacity but it still requires upgrading of its equipment to offer a satisfactory service, the current facilities are very strained. Cost sharing has reduced numbers from over 200 to 98 survivors. However, there needs to be clear goals of rehabilitation with patients who have not improved being sent back to the referring doctor for further assessment. Communication between APDK and referring doctors needs improvement for better rehabilitation of survivors. MAP has sent some of the survivors' to Physical Therapy Services. This facility is well equipped and should be commended for having clear goals of rehabilitation, good communication with AMREF and the referring doctors.

Support groups have been formed at TSC and TARDA (for mothers pregnant at time of bomb blast and those who have since delivered though not then pregnant). The TSC support group is now divided with some mothers being paid up members and others not. The paid up members seem to have changed the initial ideals of the group of providing support to one another to a financial group. The group leaders should be encouraged by ADRA to remain a support group pursuing their original goals. One of the mothers said; ***"we need support from AMREF to form another support group. The current one is focussed on making money but not sharing our children's milestones which was the initial objective".***

4.2 Co-ordination

In addition to implementing the medical assistance programme, AMREF's other role is to co-ordinate the key players in the USAID funded bomb relief assistance programme. The evaluation team sought to find out how the co-ordination is viewed by the collaborators and the beneficiaries.

(i) The Survivors

The survivors are happy with the project's co-ordination of the key medical care providers. However, they expressed unhappiness at the flow of information and services provided by the other organisations. The poor information flow made the survivors to feel that there was more assistance, which they were not aware of. Some survivors are suspicious that others may have more information on services available hence may be getting more assistance.

It was however, noted by the project manager and the donor representative that different media including radio, newsletters and face-to-face have been used for giving information but the survivors still pretend not to be aware of the services. AMREF is supposed to have produced a brochure to complement the other forms of communication but unfortunately this has not materialised.

(ii) Intra-Co-ordination

The collaboration between the different organisations was viewed by the members of staff as good and quite fruitful to them and the beneficiaries. Flow of information internally is good and this has enhanced the successful project implementation. The MAP project staff also stated that they felt they collaborated with the other agencies and the service providers well. However, due to the demands and needs of the survivors, the information flow is delayed or at times not available. Other departments at AMREF do not seem to be aware of the project's activities apart from knowing that bomb relief survivors visit the AMREF offices.

(iii) Inter-Co-ordination

The co-ordination between the key players in bomb survivors assistance program was loosely passed on to AMREF. The co-ordination mandate was "assumed" and is not clearly defined. This may explain the collaborators' view of AMREF mainly as a facilitator (calling) of meetings. AMREF was rated high by the collaborators in its ability to get the key actors together for meetings. However, it was noted that information flow and sharing of the same, especially from AMREF, was not up to the expected levels, e.g. the collaborators refer patients to AMREF and they expect to receive feedback on the patients but this does not happen. The collaborators also expected AMREF to provide a forum for sharing information and experiences on bomb relief and this has also not materialised. The collaborators' suggestion for a joint information magazine was not agreeable to AMREF who actually opted out of the venture. One of the collaborators stated that this was unfair as AMREF has been given money for this activity. The collaborators felt more could be done to improve information between the survivors' programmes as they all assist the same people.

4.3 Project Management

(i) Project Concept

The Project concept is a result of the experiences and problems encountered in the process of assisting the bomb blast survivors. AMREF's response was immediate after the catastrophe and efforts were made internally to mobilise appropriate resources to meet the needs. However, the internal funding was not adequate to meet the needs (medical, counselling and social-economic needs of the survivors). Based on this, AMREF sought funding from the USAID for two years (June, 1999 to June, 2001).

(ii) The Project Goal and Objectives

The Project goal stated as " to ensure adequate physical, medical and surgical treatment and rehabilitation for persons injured in the Nairobi bomb blast" is clear and gives a picture of what the project seeks to achieve, although it leaves out the mental health component. The project objectives are many and not clearly defined i.e. they are not specific, measurable, achievable, realistic and time bound (SMART). Given the extent and magnitude of the injuries and the scope of work/activities, full realisation of these objectives is an uphill task. The objectives should be reformulated and targets appended on each of them and where the objective requires long-term interventions, these needs to be stated to allow for the development of another proposal. The evaluation team noted that the project has made major achievements but measured against the objectives the achievements may not be "visible".

(iii) Project Strategies

The project strategies are broad and at times one is not able to separate the "how" i.e. strategies and the "what" i.e. activities, that need to be undertaken to achieve the set goal and objectives. Strategies also have not taken into consideration some of the objectives such as the research objective. This may explain why the budget does not reflect adequate resources for research and documentation.

(iv) Project Monitoring and Evaluation

Some mechanisms such as the quarterly reports to the donors are available and these give a general direction of where the project is, in as far as the activities are concerned. However, some crucial monitoring tools such as the logical framework are not in the document. For ease of clarity and in order to give a quick synopsis of the project, this tool is important and should be developed for the next funding period.

The document also identifies the collaborative management team (managers from other survivor assistance programmes) as part of the monitoring process. This role did not however, come out clearly during the discussions with the project manager and neither did there seem to have been the "every six weeks" meetings. Whereas the project document states that concise documentation on survivors' medical progress will be done and made available, the collaborators felt that this is an area that needs a lot of improvement because they do not get feedback on the survivors referred to AMREF for medical assistance.

(v) Phasing Out Exit Strategy

The phasing out strategy as stated in the document is noble and due consideration was taken in identifying the implementation of this exit without jeopardising the survivors' health/welfare. However, the nature of trauma and the injuries sustained during the bomb blast were beyond what one could have expected or imagined. Some effects of the bomb are delayed and are just being noticed now and some of these are long-term. Referral to the public hospitals is a noble idea considering the extent of the injuries and the time required to

heal and rehabilitate. However, some of the survivors may need specialised treatment for a long time and this may prove quite expensive considering the survivors' low social-economic status.

Cost sharing concept is a good exit strategy, but there is need to address the concept case by case considering that some of the survivors lost their ability to be productive. When the survivors were asked about their willingness to cost-share, the following responses were given:

- "It is okay if it will ensure that the medical assistance continues when the project ends".
- "I would like this programme to continue but if I have money I will pay".
- "This is a bad time economically".
- "AMREF should ask the Americans to provide more money".
- "If they introduce cost sharing, it means we will not get treatment because it is difficult even for me to get fare to come to AMREF".

(vi) Support Structures

The project document does not identify support structures that would be initiated during the funding period to address the needs of the survivors. This may explain some of the problems encountered in setting up the "silent victims" support group as lack of clean linkages between the different stakeholders. The survivors' attitude of grabbing any opportunity may explain why creating new support structures may not be feasible: they want tangible, preferably financial benefits.

(vii) Project Implementation

The project initiation started as scheduled and this was mainly due to the fact that AMREF had provided provisional funding. Most of the staff recruited for this project was inherited from the previous bomb unit. In October 1999 the project manager, the administrator, the secretary and the messenger were made regular AMREF employees by being awarded two-year contracts. The evaluation team noted that these were not interviewed for their posts because their association with the previous project begun on a voluntary basis except for the project manager who was issued with a short-term contract and made regular with this project. This, however, does not seem to have affected project implementation as the staff members are reported by the beneficiaries to be enthusiastic and quite helpful. Infact, 96% (n=127) of the respondents noted that the staff members are helpful and responsive to their needs. The counsellor and the project nurse were recruited much later and from the feedback received from the survivors, they too are doing a good job.

Mobilisation of the other project resources and materials was timely and this may be contributing to the project's success. The donor is happy with the staff and the donor representative noted that AMREF is doing a great job and reports reach her office on time.

(viii) Capacity Building

Staff development has been identified in the project including computer training and counselling. However, except for a brief effort to train the personnel on counselling the other areas have not been addressed. There is need to address this as a matter of urgency as the project is quite far-gone. The capacity building would also contribute immensely to the success of the project and staff motivation.

The staff members seem enthusiastic and happy to be working with the survivors. It was clear to the evaluation team that the workload at the bomb relief office is quite overwhelming and the staff have made tremendous effort to cope despite the numerous challenges. Initially there used to be regular staff meetings but these seem to have fizzled with time due to increased workload. The staff expressed the need to revive these meetings as they provide forums for discussion and sharing of experiences in working with the bomb survivors and other stakeholders.

(ix) KCO Management Support to the Project

The evaluation team noted that the project manager has done quite well in implementing the project sometimes with inadequate support from KCO management. For the successful internalisation/institutionalisation of this initiative, there is need for intensified management involvement in the project especially now as it draws to an end.

(x) Perceived Project Benefits

The survivors perceived the project as a major success and they wished that it could go on for sometime considering their numerous medical and social-economic needs. One survivor stated, ***" if it were not for this project, I would have been dead by now. I am praying to God to continue giving you that spirit to help"***. The provision of prosthesis such as the hearing aids has given the survivors a new lease of life.

During the evaluation exercise, a survivor narrated that:

I got several injuries during the bomb and I was so disillusioned with my predicament to the point of loosing hope. Infact, there were many times I envied the people who died during the bomb. Some of these depressing moments came when my children talked to me and I could not respond and they were stunned and confused by my new state. I used to write messages to my wife and she would in turn write and this was frustrating and quite depressing. I visited the bomb relief office and was referred to a doctor for the hearing aid. When I got the hearing aid, I was so excited and wanted to surprise my family. I put on a cap to hide the hearing aid and I went home. My wife wrote her message and as was normal when writing she would talk loudly. I answered her before she could hand over the message and she was just stunned. My greatest happiness was however, when my children came back from school and they talked not expecting me to hear. You cannot imagine their shock when I responded to them.

Out of the 127 survivors interviewed, 99.2% reported that the project has been very helpful to them. There is only one patient who did not see any change in his health status despite the medical attention he has received since 1999.

5. Achievements

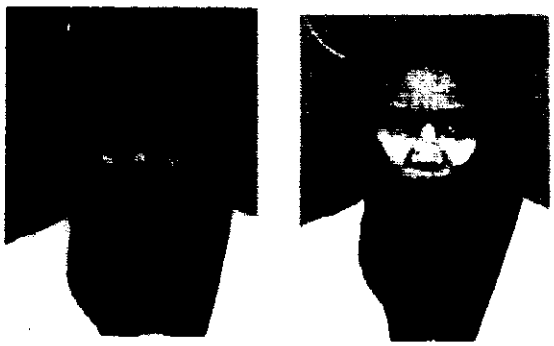
This is a complex project, which has realised many achievements.

5.1 Survivor Identification

MAP has been able to develop guidelines that are followed in checking the authenticity of the clients. Although as noted earlier few fake survivors have been given assistance, it has been possible for the management to identify them and promptly discontinue service provision. There have been success stories as summarised below.

Case Study I: Grace Kiuna

Grace Kiuna, a secretary at the Ministry of Trade lost her right eye sustained cuts on her face. After the first surgery at Kenyatta National Hospital, her right eye could blurry see and she had completely lost sight on the left eye. She had frequent headaches and her right eye was shrinking. "This affected my appearance and I lost my confidence, for example I had to run any time I crossed the road. I was frustrated because I could not even do some small house chores as pouring tea into a cup without spilling a lot. These are things I had always considered almost automatic but I realised they were difficult to do" explains Grace.



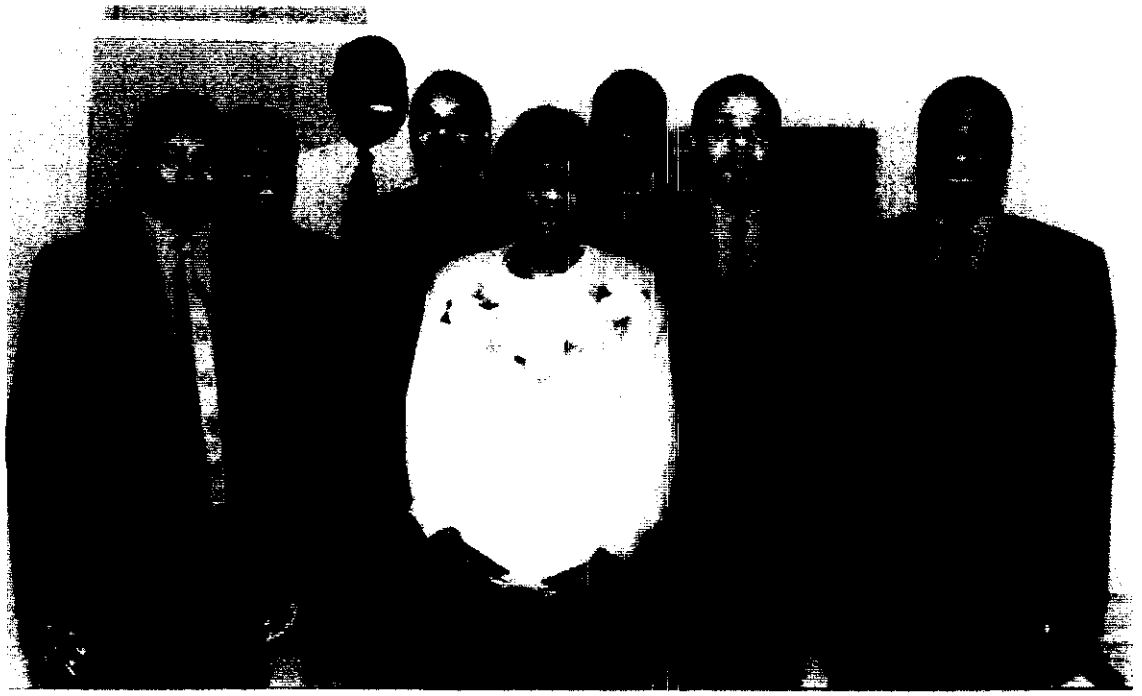
Before

Radiant Grace

Following various examinations, Germany doctors said the eye was inoperable and Grace has benefited from perfectly fitting eye prosthesis. She has gained her facial appearance and balance back. Her left hand, which was also seriously injured, was operated again in

Germany and is recovering well and she is now having physiotherapy. Grace has now resumed her secretarial duties at the Ministry of Trade.

MAP - putting a smile onto people's faces



This is a group of patients that went to Germany (November 1999) for opthalmological treatment.

Case Study II: Henry Jimmy Koweru

Jimmy is a 9-year-old boy, who was caught up in the bomb blast and sustained deep cuts on the forehead. He is the only son of a blind divorced lady. Both mother and son were at the ground floor of co-operative house during the blast, and since the mother did not know what was happening, and was not able to see the cuts on the boy's forehead, she immediately left for Kisumu where the boy received initial treatment.

He underwent first stage reconstructive surgery and underwent the second stage in July 1999. The young man has regained his appearance and confidence, seeing him at the AMREF offices renewed MAP's determination of continuing with the services to bomb blast survivors.

Before

After

5.2 Referral System

The project has put in place a system of evaluating the survivors and referring them to doctors and the other survivor assistance programmes as deemed necessary. Forms have been designed for the referrals to doctors and facilities, which the doctors fill and bring back to the pharmacy at AMREF. Although a few of the survivors find the referral process cumbersome, many found it a necessary evil given the bad experiences MAP has had in the past. However, the referral system still requires some improvement because a few of the referrals sent to the doctors are often vague, e.g. "physiotherapy" without any additional information by the referring person.

5.3 Collaboration with the Private and Public Sectors

MAP has successfully collaborated with the doctors and private hospitals/clinics and other health provision centres. Although this process has been rigorous involving several meetings and consultations, the health providers on board are providing services adequately and have made the survivor programme a priority. The doctors identified are committed to the programme and have a lot of empathy for the survivors.

The foundation has also played an important facilitative role for the survivor assistance programmes, which is recognised by the different partners. AMREF has also organised and facilitated two workshops on the Medical Assistance Programme in March and June 2000, which involved the collaborators and doctors attending to the survivors' needs. Presentations were made and the reports are available for reference and follow-up.

5.4 Management of Medical Ailments

This project is considered very helpful and successful as confirmed by all the survivors involved in this evaluation. Comments such as *"ningekuwa nimekufa" (I would be dead)* were made by many of the survivors. For the individual patients, their ability to walk, smile, hear and see are testimonies of the success of MAP. For the project management staff and the doctors, progressively witnessing improved well being of the survivors is an indication of success. For the donor, the successful implementation of MAP was also attested to.

5.5 Recognition

AMREF has gained recognition from the survivors, their families and the nation at large as an NGO, which is focused on alleviating the suffering resulting from the bomb blast. Due to this recognition, the project management team has been involved in the national planning meetings on disaster response. AMREF is also in the process of strengthening its disaster response unit under the flagship of MAP's manager.

6. Constraints/Challenges

The evaluation team identified 5 main constraints/challenges, namely, workload, wide range of medical ailments, survivors' mentality and dishonesty, retrenchment and low economic status of the survivors, and funding limitations.

6.1 Workload

This programme has been very involving for the staff and the workload has surpassed the initial expectations. The project targeted 600 survivors but this number has already doubled. If the current outreach activities by the other collaborators are successful this number may increase drastically. Although more members of staff have so far joined the team, the staff is still overwhelmed. For instance, the counsellor cannot accommodate all the clients seeking help and yet more are asking to be seen by her.

6.2 Wide Range of Medical Ailments

The programme is increasingly finding it difficult to divide the patients, who have diverse personalities and needs, into different parts. That is, in terms of what condition is bomb-related and what is not. There are also emerging health problems that were not foreseen initially. For instance, in one of the afternoon sessions during this evaluation four women complained of wetting their beds at night but they had never told anybody on the programme about this because of shame and also in fear of being told that this condition is not bomb-related. This is an issue that needs to be followed-up by the doctors attending to the survivors.

6.3 Survivors' Mentality and Dishonesty

The survivors have the tendency to be impatient. This may be a result of the initial special treatment they received immediately after the blast or due to the care and attention they have been accorded over time. They do not like waiting when they visit any of the health facilities, and for those survivors who were involved in the evaluation their main concern was "long waiting time". This puts pressure on the doctors and on the project staff who are trying to serve each of the patients as diligently and as quickly as possible.

Some of the survivors are hanging onto the programme in hope for better things to come. One survivor noted that: ***"I hope to get a medical cover for myself and the baby"***. This is a mentality that has created dependency and increase in number of people who are seeking medical care. This fact was captured clearly when the survivors were asked how they will sustain their health when the programme period ends. Many responded: ***" I will surely die", "you should go on for 5 years". "Ask the Americans to give you more money".***

Although many of the survivors are honest, a few dishonest individuals have managed to get money and services fraudulently from the project. This happened in 1999 when MAP lost thousands of Kenya Shillings in a pharmacy scam. More recently, the project manager has discovered that some patients do not provide their NHIF numbers when admitted in hospital but claim the money later. This has led to some shifts in operation, such as the running of the pharmacy in AMREF which some of the survivors find cumbersome and time consuming.

6.4 Retrenchment and Low Socio-Economic Status of the Survivors

The government is currently retrenching civil servants using criteria that are not clear to most people. What is, however, certain is that the government would be unwilling to maintain a sickly person and retrench a productive one. This is a major problem for the survivors who are often sick requiring many days off on sick leave or in search of treatment. There are fears that the gains made through counselling may soon be lost when the survivors loose their jobs. A female survivor noted: ***"it does not matter what you tell me during counselling. When I go home and my kids are out of school and I have nothing to eat, I simply go back where I started."***

Some of the survivors were affected by the bomb blast to such an extent that they could not go back to their employment. Some of them were self-employed and as such they can no longer continue with their businesses. The imminent withdrawal of MAP is worrying these survivors especially in view of the high costs of medical care in this country.

6.5 Funding Limitations

Although MAP was well funded by USAID, the funds are already exhausted due to the high demand and cost of medical care. Catering for over 1,200 clients instead of 600 and having to deal with new emergent health problems has stretched the budget. This has resulted in the suspension of some of the services, e.g. dental consultations and care. The

limited funding has also forced AMREF to be selective in the problems to be handled to the dismay of some of the survivors. One survivor said that: ***"you tell the nurse your problem and she responds that it is not bomb related. This is a problem I never had before the bomb"***. How does one tell the patient that may be she would have developed the problem even if s/he had not been involved in the bomb blast? Should the project cover all the problems? If it does so, where will the money come from? These are issues that the project management is currently grappling with.

7. Issues/Gaps

7.1 The Project Document

This project has 9 objectives most of which are not SMART which makes monitoring and evaluating complex. There are no clear goals and some of the objectives are phrased as activities or strategies. For instance: "assist in co-ordination of efforts for agencies working for bomb blast survivors projects" and "provide medical assistance for babies born to mothers who were pregnant and were within the vicinity of the blast" are not measurable objectives. For an evaluation exercise, it becomes difficult to assess the levels of achievements when objectives are phrased in this manner. The objectives have no indicators of achievement and yet this is an important project that can provide very useful experiences and opportunities for research and for future interventions.

7.2 Information Production and Dissemination

At the beginning of AMREF's intervention immediately after the bomb blast, there was a weekly newsletter that was circulated to all the collaborators. This newsletter contained information on the survivor programmes and it was found useful by both the survivors and the service providers. The newsletter died a slow death and it was supposed to be replaced by a brochure. The project manager indicated that the brochure should be ready in October 2000 but this will be too late because this funding phase ends in June 2001.

Information flow is a problem in terms of the feedback process. The doctors do not get feedback when they refer patients to other doctors or for rehabilitation. AMREF and the other collaborators do not give feedback to each other unless there is a problem. Most of the survivors interviewed claimed ignorance regarding the range of services available for them. This was, however, blamed on the mentality of the survivors who decide to forget everything when asked and yet they know. In addition, survivors have a tendency not to tell one another about the available services.

A problem identified by the evaluators is the mode of communication adopted and its relevance to the survivors. For instance, in the bomb relief office there is an announcement regarding "cost sharing". This announcement is in English and has been placed on the wall. The assumption here is that all the survivors can see and can read English. The use of diverse modes of communicating targeting the different survivor capabilities is necessary for this group.

7.3 Documentation

Although objective 7, 8 and 9 focus on the issue of documentation, very little of this has been done. It is understandable that the first year was used mainly for the provision of medical attention, however, this being a very important project this process should have received equal attention. This is an opportunity for AMREF to document a rare happening scientifically. There is an indication that the process has started (through recruiting a data entry clerk and initiating a doctors' discussion) but a lot more needs to be done to make sure that the information is collected, synthesised, documented and disseminated.

7.4 Co-ordination

AMREF has the dual responsibility of intervening directly on the survivors and co-ordinating the entire survivor assistance programmes. The latter requires constant communication with ADRA (KSB, KNAD, APDK and UDPK), AMANI counselling centre and Ernest and Young. This co-ordination has been mainly effected in having monthly joint meetings through which the various implementers share experiences and their plans. It has, however, not been easy for AMREF as the co-ordinator, to step in when things are clearly going wrong. There have also been differences in management between the organisations, which have been difficult to resolve. Survivors are managed differently and have in the past taken advantage of the different implementation processes. Sustainability is an issue of concern to AMREF management and this has been a point of contention with some of the organisations that have gone as far as picking patients from home and taking them back. How do we sustain this when the funding comes to an end? This is a crucial question that should be addressed.

The survivor assistance programmes have a wealth of information that can be used to inform the rest of the world regarding the impact, repercussions and implications of a bomb blast on the lives of individuals, communities and the nations at large. The organisations involved in these programmes have not produced information for wider dissemination. The co-ordinating organisation should facilitate this process if given the mandate to do so. The initial one-year has largely been used in intervening on the medical and socio-economic needs of the survivors. However, this second year should focus on consolidating the information and disseminating the same.

The doctors involved on MAP have agreed to form a committee in charge of documentation and they require support from all the survivors' assistance programmes. They also require constant follow-up due to their busy schedules.

7.5 Support Groups

MAP initiated the concept of support groups as a way of encouraging the survivors to accept their circumstances and go on with their lives. Mothers of the silent victims were

mobilised and facilitated to establish a support group. This group is, however, in shambles because, according to one mother ***"it's like an exclusive club for those who can afford to pay 1300 and are interested in loans"***[2]. From the questionnaire data, it became evident that many of the respondents belong to other groups such as Churches, self-help and social welfare. It may be better for MAP to encourage and enhance the capacity of such groups rather than facilitate the creation of very specific non-sustainable groups.

7.6 Survivors' Discharge and Weaning Off

The survivor programme is very expensive such that there is need for the programme implementers to establish a system of discharging people who have recovered without causing any psychological damage. In addition, for those who still require help, they should be weaned off in order to allow them to go on with their lives because the programme might be causing false hope by continuing with medical assistance. This is a problem for all the survivor assistance programmes. Do ADRA, KSB, APDK, UDPK and KNAD have systems for discharging and weaning off patients? For organisations such as KNAD, UDPK and KSB the survivors should be taken up in their regular services for the disabled.

7.7 Sustainability

The issue of sustainability has to be tackled by this project although it evokes bitter feelings from the survivors. Some feel that the US government owes them a lot because it caused the blast and consequently their suffering. MAP is fairly expensive and sustainability should, therefore, be viewed in terms of the survivors' health and the possibility of continuing with research activities.

AMREF has proposed the introduction of a cost-sharing system starting October 2000. It should, however, be noted that AMREF being a non-profit making organisation may not have a system of collecting and dispensing such money. More thought needs to be put in this area so that the system does not become too involving and complicated for the already strained staff.

Survivors who are ready for discharge are not a big problem. However, there are survivors (approximately 20 – 30%) who may require long-term follow-up and a system has to be put in place to ensure that their conditions do not deteriorate upon the withdrawal of the project. The proposal by the project manager to pay an insurance company a lump some of money for the care of these patients for a longer period should be considered and supported. The process of deciding who among the patients should receive such assistance has to be done in conjunction with the doctors and the collaborators.

[2] The four women that the evaluation team talked to at the Teachers Service Commission were not members of the support group because they claimed the group has lost direction. They also noted that the meeting times, every Wednesday at 5.30, are not favourable for women with young children.

7.8 Staff Development

Discussions held with the project staff identified areas where they need to be developed. Due to the fact the staff deals with a very special group, they need counselling skills. Although the counsellor had scheduled to give them these lessons, her tight schedule has not allowed her to do so. A system should be put in place for training the staff individually so as not to halt the provision of services to the survivors. Some of the staff members who are not computer literate need to be trained (they noted their main constraint of attending such a course to be time which should be created).

The staff dealing with programmatic issues requires training in research (data collection, analysis and writing). The staff members also need training in report production so that even when the project manager is busy they can take over that responsibility or they can assist her. The senior project nurse requires training in project management, an area where she has limited experience.

7.9 KCO Management Support

Although KCO management is expected to provide both technical and administrative support to staff, this has been minimal. There is an overall need for KCO to facilitate or co-ordinate documentation of information at the programme level. This would benefit MAP because the project manager would receive the necessary technical support and push to collate the information and publish/document it. KCO management should also be ready to support the staff in issues such as office space (which the project manager had to search for on her on) and other issues such as the fraud case that just fizzled out without anybody being taken to count.

8. Conclusion

This is a complex project whose implementation has been well planned and executed. The processes put in place for serving the survivors are sound including the identification of the doctors and facilities in ensuring that the survivors receive the best care available. The survivor identification process has been effective in limiting the number of people who would be tempted to cheat due to the project's benefits. Most of the survivors appreciate the project and are happy with the way the staff and the doctors address their needs.

The project has had to deal with new emergent health problems that were not foreseen and large numbers of survivors than initially budgeted for (1200 instead of 600). This has not only put pressure on the funds availed by USAID, it has also strained the staff members who often have limited time to engage in their own staff and career development. The project staff members have, however, performed well and are working within the agreed timeframe with the donor.

The co-ordination role that AMREF has been holding has not been well executed mainly due to the lack of a mandate and the concentration by the survivor assistance programmes in the first year on providing assistance. This collaboration should be utilised in

documenting and publishing/disseminating the information being generated by these programmes. The co-ordinating organisation should, therefore, be given the mandate to work with the implementers of the other programmes in coming up with research issues and processing the available and new data. This would enlighten the programme implementers and the world at large on bomb-related issues.

The issues and gaps identified by the evaluation team which include information low, research, documentation, sustainability and funding should be looked at as the project draws to an end and as the project team makes its future plans. The phase II proposal should also take on board some of the issues identified on the objectives in terms of clarity, speciality and measurability. There is need for the project team to come up with a logical framework that would spell out the milestones and indicators of achievement. This is a very important document and having these gaps addressed will ensure that the project is well documented and can be replicated in other situations and regions.

Annexes

Annex 1

Terms of Reference

The evaluation team will carry out an assessment of the following activities during the mid-term evaluation exercise:

1. Study the project proposal;
2. Study the grant document;
3. Design a methodology to obtain feedback from the survivors on services provided;
4. Assess the survivor registration methods in the office;
5. Assess the referral systems to consultants and other service providers;
6. Visit at least ten (10) consultants to assess project activities, progress, quality of services offered and constraints;
7. Visit at least four (4) service providers (hospitals, X-ray departments and laboratories) to assess quality of the services provided to the survivors;
8. Visit other implementing NGOs (Kenya Red Cross, AMANI Counseling Center and ADRA) and assess the efforts made by AMREF co-ordination and collaboration, and also obtain feedback on provision of services offered to the survivors by the project;
9. Assess the documentation, record keeping and reporting systems;
10. Gather information from survivors on services provided and improvement in health;
11. Assess the mental health component of the project and the impact it has on the physical and mental recovery of the survivors.

Annex 2

Clinician/Facility interview guidelines

1. Activities (No. of patients, medical problems and procedures)
2. Quality (Survivors, clinician, facilities and referral)
3. Constraints/gaps
4. View on MAP and suggestions for improvement/sustainability (sustenance of services)
5. Collaboration (MAP, Doctors etc)

Annex 3

Collaborators' Interview

1. Collaboration, networking and co-ordination

1.1.In what areas do you collaborate with AMREF?
1.2 How do you view this collaboration?
1.3 How can it be improved?
1.4 Who are your other collaborators?
1.5 In what areas do you collaborate?

2. Collection, synthesis and dissemination of information on the bomb blast related matters.

2.1 What kind of information have you been able to collect and disseminate in relation to the bomb blast?
2.2 Whom have you shared/disseminated the information to?
2.3 What modes of communication do you use in the information dissemination and networking?
2.4 How do you expect to use this information?

3. Research

3.1 Have you carried out any operational research on the overall medical responses to the bomb blast and the impact on the nation?
3.2 If yes, what are the key resulting issues?

4. Achievements

4.1 What are your achievements as per the planned activities?
4.2 Reasons for the achievements?
4.3 Are there any activities implemented which are not in your main operations?
4.4 If yes, which ones?
4.5 Have you failed to implement some planning activities?
4.6 If yes, what did you fail to achieve and for what reasons?

5. General comments

5.1 What lessons have your learnt during the implementation period?
5.2 What problems/constraints are you encountering and how have you tried to overcome these?
5.3 What recommendations do you have for the survivors and programmes (sustainability)?

Annex 4

Guidelines for Survivors In-depth Interviews

1. When the client joined the medical assistance programme

2. The type of assistance s/he has received to date

3. View on the services
   - AMREF
   - Doctors
   - Rehabilitation
   - Counseling

4. Process, procedures and referrals

5. View on AMREF's co-ordination

6. Impact of the project on their personal lives, family and others

7. How are you coping at home?

8. Suggestions for improvement and sustainability

Annex 5

Questionnaire for Survivors

This questionnaire is aimed at assisting us to evaluate AMREF medical assistance programme in order to be able to serve you better. Kindly answer all questions honestly.

1. Personal details

1.1 Age: 0 - 15
15 - 25
26 -35
36 - 45
46 - 55
55+

1.2 Sex: Male
Female

1.3 Occupation: Secretary
Teacher
Clerk
Manager
Housewife
Unemployed
Other (specify)

2. Bomb Blast experience

2.1 Where were you during the bomb blast? _____

2.2 How were you affected? _____

2.3 Did you receive immediate medical attention? Yes
No

2.4 If Yes, Where? _____

2.5 If no, why? _____

3. Medical assistance programme

3.1 When did you join the AMREF medical assistance programme?

_____

3.2 What assistance have you received? (tick where appropriate)

a) Doctors' examination and follow-up
b) Reconstructive surgery
c) Dental care
d) Eye glasses
e) Medication
f) Operation
g) Admissions
h) Counseling at Kenya Red Cross / Amani
i) Counseling at AMREF

3.3 Have you received any other assistance? Yes
No

3.3.1 If yes, what assistance?

3.3.2 If no, why?

3.4 Do you think this programme has been helpful to you? Yes
No

3.4.1 If yes, how? _____

_____

3.4.2 If no, why?

_____

_____

3.5 a) What is your view about AMREF staff in the medical assistance programme?

_____

b) What is your view about the doctors you are referred to by the medical assistance programme?

_____

c) What is your view about hospitals you are referred to by the medical assistance programme?

_____

d) What is your view about the Pharmacy services at AMREF?

_____

e) What is your view of the X-ray departments?

_____

3.7 Do you belong, to a support group? Yes
No

3.7.1 If yes, which one(s) _____

3.7.2 If no, why? _____

3.8 What services do you think need to be improved? _____

_____

3.9 How can this improvement be achieved? _____

_____

Any other comments? _____

_____