CHAPTER 7

PSYCHOSOCIAL RESPONSES TO THE BOMBING OF THE AMERICAN EMBASSY IN NAIROBI: CHALLENGES, LESSONS, AND OPPORTUNITIES

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Introduction

The Kenyan summer of 1998 was much like any other. The weather was hot and dry, the Moi government was firmly in control of the country, and refugees from the wars raging in nearby countries fled to the relative peace and stability of Kenya. Although internal strife flared up on occasion, the nation was at peace with its neighbors and had no known enemies. That doesn’t mean that Kenyans were living in a paradise or were unaware of the political battles being waged to the north in Israel and Palestine. Nor were they oblivious to the violent acts carried out by terrorists in many parts of the world. Still, it is fair to say that the bombing of the American embassy in Nairobi that August 7 came as an utterly shocking surprise.

Although the apparent targets were American, the vast majority of casualties were Kenyans occupying the immediate vicinity of the explosion. The scenes of carnage, broadcast on television and other news media, horrified the entire nation. As in any emergency, civil authorities and volunteers rushed to the aid of survivors and removed both dead and living victims from the rubble. The most severe physical injuries were treated in hospitals, while those that were not life-threatening were often treated at the scene. Families frantically searched to locate loved ones who may have been killed or injured, as public officials worked to identify the dead and notify next of kin.
As the immediate shock was wearing off and the human toll was being assessed, it became clear that not all of the wounds were of a physical nature that could be treated with medical resources. Those with some experience or expertise in working with victims of traumatic events warned that the profound emotional and psychological consequences of the terrorist attack were likely to require a mental health response comparable to that already being mobilized by the medical establishment.

The present chapter describes how local volunteers, mental health providers, international humanitarian agencies, and the American government competed, collaborated, and cooperated to provide mental health services to thousands of Kenyans who were psychosocially affected by the Bomb-Blast of 1998. The activities of those involved in these efforts are described, as well as the obstacles they encountered and the solutions they implemented. The effectiveness of these measures is critically evaluated, with examples given of both successes and failures that are instructive for those engaged in international projects designed to serve the psychosocial needs of disaster survivors. The authors conclude with a series of lessons learned from this experience and recommendations for how the parties involved in similar projects might operate more effectively.

**Awareness of Psychotrauma in Kenya prior to the Embassy Bombing**

Kenya has had its own share of disaster and psychotrauma, both natural and man-made even before the American Embassy Bomb-Blast. Disasters involving many people have been reported locally and internationally, both in the distant and recent past. These include a terrorist bombing of one of the leading hotels in Nairobi in the late 1970s, because of an alleged Kenyan bias in the Middle East political conflict. Scores of Kenyans, as well as foreigners, were killed, and property was damaged. Natural disasters involving the deaths of many people and the destruction of property have included floods, mudslides (particularly in 1997), and frequent famines.

Arson incidents in Kenya are man-made disasters that have involved many people, with much loss of lives and property at the same time. Among those that have been particularly conspicuous were a series of arson episodes in school dormitories in which tens of students were sleeping, causing sudden and unexpected death or injury to many students. Other mass disasters had political connotations. They included tribal clashes in several parts of Kenya in which thousands of people were violently displaced and hundreds killed, with extensive damage to property. In any given instance of a transportation disaster, tens of people have been killed by train wrecks, air crashes, ferry sinkings, and motor vehicle accidents on our roads.

On a smaller scale—at the individual level—incidents in Kenya of rape, domestic violence, armed robbery, personal violence, and the like have
always been reported in the Kenyan press, as well as in the international press. But until the America Embassy bombing, nothing happened beyond the initial condemnation, expressions of anger and helplessness, and the initial rescue operation. The country literally sat and waited for the next incident to happen. The American Embassy Bomb-Blast changed all that.

**The Nairobi Bomb-Blast**

On Friday, August 7, 1998, at around 10:37 A.M. Kenyan time, a truck driven by terrorists forced its way into the parking lot of the United States Embassy building in Nairobi, and detonated a grenade that was followed by a loud blast estimated to be the result of a two-ton bomb. The site of the Nairobi Bomb-Blast (NBB) was a busy cosmopolitan area with high-density human activity and rail and motor transport connecting all areas of Kenya. Thus, there were arrivals from and departures to various parts of the city and the country, including a nearby fresh-produce market, the biggest in the country. Buildings in the vicinity were multistory structures that were heavily populated. On that day, a National Schools Musical Festival was being held in a nearby conference center, and a large number of students and their teachers from all over the country were traveling to and from the festival. Friday mid-mornings are usually very congested in Nairobi’s central business district. In this setting, all of these factors presented the perfect conditions and timing for maximum destructive impact from a bomb.

The Bomb-Blast had an extensive destructive effect over a radius of a mile in the central district where the Embassy building was located. Also damaged were other significant business and government multistory buildings. One seven-story building adjacent to the American Embassy was reduced to rubble, trapping and killing most of the occupants in and around it. People were thrown from one corner of their workrooms to the other, and those on the streets were also tossed around. Others were struck by flying objects and broken glass as a result of the blast, and cars were damaged extensively. Fumes billowed from falling and burning buildings and other structures. Blood flowed freely from cuts and other open wounds as the injured fled in all directions, oblivious to their precarious state. Hence, the death toll rose to 213 on site, and about 5000 survivors sustained various types of injuries.

The subsequent governmental, nongovernmental, private, and general population reaction and response were spontaneous and overwhelming in addressing rescue operations and the medical and psychosocial needs of those affected. This response can be divided and discussed in several phases: (1) the initial rescue phase (including medical); (2) the immediate psychosocial response; (3) an intermediate phase of the psychosocial response; (4) and termination (or phase-out) of the psychosocial response. Some people will continue to need long-term response into the foreseeable future.
The Initial Rescue

The Local Effort

Almost immediately following the blast, the initial search for and rescue of the injured involved furious and desperate efforts. Everybody took care of anybody else who was worse off. The walking-injured assisted the immobile-injured. The general population pitched in and helped those bleeding or injured in any way. Any vehicle available was used to ferry the injured to a hospital. Kenyatta National Hospital (KNH) was the linchpin of the emergency response. However, a total of 22 hospitals and clinics were confirmed as having received the injured for treatment. Hospital staff were overwhelmed by emergency work. The survivors helped one another in any way possible to ease pressure on the staff, so that they could attend to the neediest victims. The Nairobi City Mortuary Services assumed custody of many of the dead, and private arrangements were also put in place, mainly by the American Embassy. The embassy also made arrangements for medical care for the majority of their staff.

This initial local rescue operation generated some conflicts between the locals and embassy security. Immediately after the blast, the general population moved to assist the injured at the disaster site. American Embassy security personnel also moved into battle mode to protect the embassy and its contents. An exchange between the swelling crowd and the embassy security personnel ensued, with the latter threatening to shoot the former. The media disseminated pictures of this fracas, and thereafter the American Embassy was depicted quite negatively as being insensitive to human suffering and preferring embassy property to human life. This perception was to last for quite some time, although the American ambassador did her best to correct it.

International Effort

The U.S. response was immediate, with initial daily rescue flights into the country starting the next day, with the first evacuation during the next two days. Apart from the United States, Israel, France, Egypt, Canada, Germany, and the United Kingdom responded by sending rescue personnel and equipment. Other supplies were sent by France, the UK, Saudi Arabia, Kuwait, and Iran. Humanitarian organizations included the World Food Programme (WFP) and the International Federation of Red Cross and Red Crescent Societies (IFRC), by way of the Kenya Red Cross (KRC).

The Initial Psychosocial Response

Given the extreme impact of the bombing, which resulted in so many deaths and even more people severely injured, the first priority was to save lives and treat the physical wounds of the survivors. It quickly became
apparent, however, that the psychosocial effects of the bombing, such as psychotrauma and intense grief, also deserved attention. This attention took several forms.

1. Counseling services were initiated at Kenyatta National Hospital (KNH) by hospital and volunteer staff. On the third day, they were joined by a medical combat stress control team from a U.S. base in Germany. Their services consisted mainly of explaining to those concerned what was happening and suggesting ways of handling the situation. These efforts involved hospital staff helping the survivors of the blast, the surviving relatives of those who were killed, and the general Nairobi population at large. Cooperatively, they trained 150 professionals and debriefed 360 people.

2. Training in psychotrauma was also put in place. Kenyatta National Hospital and the Department of Psychiatry at the University of Nairobi established a two-day structured crisis training program dealing with stress and trauma management, which went on to train 500 generic counselors. These counselors were intended to go into the general population and work with community-based organizations (CBOs) to address the effects of the Nairobi Bomb-Blast.

3. There was a significant religious response as well. Most religious organizations responded with counseling and prayers in order to mitigate the effects of the disaster. Most of this activity took place in institutions allied with houses of worship. Staff members were generally not trained in critical incident stress management, so most counseling was unstructured and consisted of methods that were not easy to quantify. However, this ad-hoc mode of counseling culminated in the formation of Operation Recovery.

4. The Operation Recovery (OpRec) project, created by the Kenya Medical Association, consisted of counselors and psychologists with little or no training in counseling psychology, plus a few Kenyan psychologists and psychiatrists. Their efforts focused on supporting the survivors and the bereaved. The service element of OpRec suffered greatly as a result of constraints on personnel and finances. The quality of the counselors was under scrutiny by service consumers, who often found the counselors to be too young to share intimate matters with. This situation arose from a cultural aspect of transgenerational relationships in Kenya, and it complicated the OpRec efforts.

As OpRec services progressed, it became evident that the economic well-being of the clients was the single most important concern for both the counselors and the counselees. Many questioned the benefit of the counseling services in light of the dire economic conditions they were facing. Most had no money for food, clothing, rent, school fees and other necessities, and OpRec lacked sufficient funds to address these pressing and stressful financial hardships. The counselors’ allowances became difficult to obtain, which
soon led to a high dropout rate among the volunteer counseling staff. The funding problem for OpRec had less to do with the unwillingness of donors to respond than with the actual operation of OpRec itself. OpRec operations ceased when the program was handed over to the Kenya Red Cross about one year after the bombing.

**Challenges and Opportunities**

Even at this stage of initial psychosocial response, difficult challenges began to emerge. They were mainly due to lack of previous experience in psychosocial response beyond that required for rescue operations. Hence, the organization of services was on ad-hoc basis, with an element of competition for limited resources instead of pooling resources together. Economic factors were another major challenge, creating the dilemma of how to provide counseling to economically deprived people who were more concerned with the basic needs required for physical survival than with processing their emotional reactions.

A third challenge was a cultural one. Kenya has more than 40 ethnic groupings with as many different cultural practices. In the face of atrocities and disasters, each group has specific and general responses, and expected interventions. In some ethnic groups of Kenya, bereavement is met with emotional displays of catastrophic proportions, whereas others are more reserved and discreet about showing emotions. This diversity posed a challenge for inexperienced counselors, and the need for a more organized and perceptive disaster response—with better professional skills developed through training—began to be recognized at this early stage.

**Transition from Initial to Intermediate Response**

The United States Agency for International Development (USAID) requested $37 million from the U.S. Congress for the Bomb-Blast response operations in Kenya. Subsequently, a USAID request for proposals to implement a $1 million mental health program was advertised in the local media in Kenya. This contract was won by the International Federation of Red Cross and Red Crescent Societies (IFRC), with the Kenya Red Cross (KRC) as the local implementer.

**Opportunities and Challenges for KRC**

The Kenya Red Cross was in an advantageous position because its volunteers had responded almost immediately after the explosion. This was accomplished by the volunteer service of three of its branches in and around Nairobi. It also had branches spread across Kenya, and therefore had the potential to achieve wide coverage across the entire country. When KRC won the USAID contract, these volunteers became the seed personnel for long-term service provision.
But KRC had some teething problems. OpRec was unable to transfer its operations to KRC because of sponsorship and administrative problems, so KRC had to start its program from scratch. Thus, the Crisis Mental Health Assistance Programme (CMHAP) was launched in June 1999, specifically for this project. It was based at the KRC’s Nairobi offices in the central business district, which is about 10 kilometers from their administrative headquarters. The new program had to completely renovate these offices, put in utilities, purchase equipment (e.g., transport vehicles, furniture, office supplies, and communication equipment), and hire adequate personnel before it could effectively deliver the services. These logistical problems—as well as the country’s unpreparedness for such an effort—caused delays in delivering much-needed services.

**Goals of the Kenya Red Cross**

The CMHAP program consisted of set goals in various activity areas, including:

- Outreach to serve as many survivors as possible
- Training for counselors and community opinion leaders on how to recognize trauma, and where and how to get help
- Providing both counseling and psychiatric services, and collaborating with other services

Outreach was performed by extension workers and the mass media. Training, counseling, and psychiatric services were provided by KRC in-house staff and were also contracted out to agencies. Documentation was the sole responsibility of KRC in-house staff. Collaborating with other services was handled administratively by the KRC program administration.

**The First and Last Evaluation of the Program by KRC**

One year after the operation was transferred to the Kenya Red Cross, an evaluation workshop was held at a retreat outside Nairobi in order to assess the effectiveness and efficiency of the Crisis Mental Health Assistance Programme in meeting the desired goals. The objectives of the evaluation workshop were to provide a forum for examining the extent to which the program’s activities were implemented on time, at what costs, and under what specifications, as well as to provide necessary recommendations to enhance future management of the program. It was an opportunity to re-examine the goals themselves, the challenges faced, the lessons learned, and strategies for future development.

**The Participants**

A total of 28 representatives from the Kenya Red Cross Society, the International Federation of Red Cross and Red Crescent Societies, USAID, and the various collaborating and implementing partners attended the
workshop. These partners included counselors, psychiatrists, social workers, and volunteers.

The Methodology

The deliberations began with a series of reports by KRC staff and by implementing agencies involved in delivering psychosocial services. There were also group brainstorming sessions on the future course and conduct of the Crisis Mental Health Assistance Program. The groups discussed the following issues concerning the program:

1. Structure and function
2. Implementation and constraints
3. Achievements versus set goals
4. The way forward

Finally, a plenary session deliberated the group reports and final conclusions, and recommendations were made.

Presentations by KRC

The keynote presentation was made by the CMHAP technical advisor, who was operationally the technical and administrative head of the program. He gave a brief background of CMHAP, highlighting the elements of the program, the structure under which it had been operating since December 1999, and how the program elements were interacting with each other and with the sociopolitical environment. He also gave an overview of the process, the instruments used to evaluate and do research on the beneficiaries’ information, and the flow charts for both adults and children. Other KRC staff made presentations on outreach and counseling activities. The KRC documentation section had been involved in the generation of the data presented. Data were being collected from all around the country and would be used to evaluate the performance of the program.

Challenges Raised by the KRC Presentation

Deliberations ensuing from the KRC presentations raised the following issues:

1. Persons not involved in the Bomb-Blast were taking advantage of the program.
2. The participants felt that the screening process used to recruit beneficiaries into the program should be reliable enough to disqualify clients unrelated to the Bomb-Blast.
3. It was observed that outreach activity, based on home visits, was the most effective way of reaching the beneficiaries. This activity was prone to logistical problems because of the vast distances and limited resources.
4. Adhering to pre-agreed quality assurance guidelines was important.
5. The need for professionalism was stressed.
6. Training was also classified as an outreach activity.
7. Documentation of all the data, for purposes of program evaluation and research, was emphasized and should be improved.

Presentations by Implementing Agencies: Challenges and Opportunities

Eleven implementing agencies made presentations based on their experiences and expectations. They emphasized the need to address various issues and problems related to or arising from the disaster, including medical, psychiatric, psychological, socioeconomic, and occupational needs. Counseling and support were necessary in helping people to progress from denial and bitterness to acceptance and forgiveness. In all of these areas, people were to be helped toward independence and carrying on with life as normally as possible.

Recommendations from the KRC Evaluation Workshop

The final plenary made the following recommendations:

1. The status quo of the operational structure and function of the Crisis Mental Health Assistance Program should be maintained
2. Additional administrative structure should be introduced in CMHAP
3. The policy structure of the program should be well understood
4. There should be less bureaucracy and red tape

Other recommendations for future activities emerged from the final plenary session:

1. Networking with other nongovernmental organizations (NGOs) and faith-based or religious organizations should be implemented in order to sensitize and educate the beneficiaries on the sustainability of the programs
2. Capacity-building for the beneficiaries should be put in place
3. Beneficiaries of the programs should occasionally be invited for a focus group discussion so that they can give their own suggestions on how best to address their program needs and the way forward.
4. Vehicles and other program facilitating tools should be put in place
5. There should be program review meetings among the program officers
6. Monitoring and evaluation procedures should be put in place

It is worth noting that this workshop was also intended to ease the transition occasioned by the IFRC. As administrator of the grant, IFRC chose to surrender the funding back to USAID because of various technical and administrative issues. This deprived the KRC of financial support as local administrator of the fund. Thus KRC, like OpRec before it, administered the program for only one year.
Administrative Transition from KRC to Amani

If the CMHPS were to continue following the withdrawal of the IFRC, a new administrative agency had to be designated. Amani Counselling Centre and Training Institute (ACCTI), one of several implementing partners for the CMHAP when it was under the KRC, was chosen by USAID to take over the administration of the program, while still functioning as one of the main service providers.

Opportunities and Challenges for Amani: The Amani Takeover Proposal

Amani had some clear advantages as a suitable host for the program, given its long history in the areas of providing direct counseling services and training counselors. Further, Amani was willing to take on the already-existing collaborating partners, with additional provision for a technical manager for the program. However, Amani had to take over the project as an ongoing program, with little if any room for modification. This meant that time was required to study and understand the program in its already structured format. The results of that study included a restatement of the program’s goals:

1. Continue a needs-driven counseling program informed by outreach activities. This would be coordinated through the assessment instruments that were used by the Kenya Red Cross.
2. People affected by the Bomb-Blast will continue to have access to mental health services during the transition. Coordination of existing outreach activities are to be improved, and services to specific populations added.
3. Increase public awareness of disaster preparedness. Amani would achieve this result through continued training, outreach, and information programs.
4. Counseled people will demonstrate increased positive coping mechanisms as a result of accessing quality professional counseling services. This result would be documented.
5. Mental health professionals will provide services that measure up to professional standards. That achievement will be assessed through a quality assurance program.
6. A mental health response strategy for future disasters (disaster preparedness) will be developed through the documentation program.

In their initial takeover proposal, Amani identified several critical indicators for monitoring the extent to which the results listed above were being achieved. These indicators took the form of projected outcomes to be achieved through outreach, educational, and service provision activities. These included reaching out to as many people as possible who were affected and needed services, provision of services, supplemental education in psychotrauma for mental health workers, and improved documentation.
A major flaw in both the goals and the indicators is that there were no specifications on how these outcomes would be measured.

The ACCTI steering committee took over the management of CMHAP from the Kenya Red Cross in September, 2000 after a successful bid to implement the program as an ongoing venture. However, CMHAP was to be managed as a parallel program to keep it separate from ACCTI's mainstream activities. It continued to be housed on the same premises as when it was under the KRC.

**The Program under Amani: Mid-Term Evaluation**

As Amani began to understand what was required in program implementation, it became necessary to revisit the proposal. The targets were adjusted so as to make them more realistic and achievable within the allotted timeframe for the program and with the financial resources that were available. One such revision was undertaken from April to June, 2001, and the figures proposed then have been used to assess the achievement of program objectives over the two years. Measurable objectives for each service department (i.e., Outreach, Counseling, Training, and Documentation) were developed, and detailed activities to be undertaken to achieve those objectives were identified. The four main objectives, and the detailed activities proposed for achieving each of them, are summarized in Table 7.1.

**OBJECTIVE 1**  
**To ensure that people affected by the bomb have access to mental health services.**

| Activity 1 | Provide counseling treatment, through implementing partners, to 900 adult survivors (bereaved, injured, and rescue workers) within two years |
| Activity 2 | Provide psychiatric treatment, through implementing partners, to 142 affected adult survivors with severe psychological disorders within two years |
| Activity 3 | Provide counseling treatment, through implementing partners, to 300 affected children survivors within two years |
| Activity 4 | Provide psychiatric treatment, through implementing partners, to 100 affected children with severe psychological disorders for two years |
| Activity 5 | Provide 48 clinical supervision meetings for implementing partners within two years |

Table 7.1 Amani Program Objectives and Activities (Continued on next Page)
OBJECTIVE 2
To provide knowledge, skills, and attitude change regarding the psychological management of disaster trauma.

Activity 1 Train 360 counselors from implementing agencies in areas of trauma mental health within two years
Activity 2 Train 560 teachers in areas of trauma mental health within two years
Activity 3 Train 90 mental health providers and key decision makers in areas of trauma mental health within two years
Activity 4 Train 180 community-based mental health providers at the district level in areas of trauma mental health, and conduct a follow-up workshop within two years

OBJECTIVE 3
To reach out to survivors and their families and create awareness and sensitivity about the Crisis Mental Health Assistance Program.

Activity 1 Reach out to and assess 1500 affected children within two years
Activity 2 Reach out to 1260 affected families living up-country, through 10 volunteers, within two years
Activity 3 Reach out to 300 affected families living up-country, through 10 volunteers, within two years
Activity 4 Reach out to 300 permanently or seriously injured survivors, through six peer counselors, within two years
Activity 5 Offer eight children and family days or events within two years
Activity 6 Conduct 12 community meetings (Barazas) within two years
Activity 7 Develop 70 media dissemination activities within two years

Table 7.2 Amani Program Objectives and Activities (Continued on next Page)
These objectives and activities result from a revision halfway through the program period, when it became evident that some aspects of the program, especially counseling, were generating a lot of sessions. If this trend had continued, then it would not have been possible to contain the program within the budget. These new targets have been used to measure the level of achievement or success of the program. Perhaps more importantly and positively, several recommendations in this mid-term evaluation demonstrated growing interest in trauma-related mental health activities beyond the response to the Bomb-Blast. These recommendations included:

1. Establish liaison with universities involved in trauma-related clinical services and research
2. Establish a directory of qualified mental health workers
3. A trauma response unit is needed to coordinate logistics, funds, and human resources so as to be ready when disaster strikes
4. Training of teachers in disaster management and crisis intervention should continue, with follow-up evaluations conducted to monitor progress
5. Continued private and public sector mental health activities are needed beyond the Bomb-Blast program to achieve capacity-building

Table 7.3 Amani Program Objectives and Activities

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<tr>
<th>OBJECTIVE 4</th>
<th>To develop a comprehensive research and documentation program for all internal and external documents with a statistical reporting.</th>
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<tr>
<td>Activity 1</td>
<td>Develop a comprehensive database system, with timely information for program monitoring and evaluation, within two years</td>
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<tr>
<td>Activity 2</td>
<td>Process and analyze data from 1038 adult assessments and 936 child assessments and publish the information five times within two years</td>
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The Program under Amani: Challenges and Opportunities

Challenges and Opportunities Related to Operations of the Program

Within the context of its operations, Amani was faced with some challenges that it had to address to ensure the program’s effectiveness and success.
1. Legal: Two organizations that were discontinued for fraudulent activity threatened Amani with legal action.

2. Political: The unstable political environment and the uncertainty occasioned by the rapidly approaching general elections were problematic.

3. Transition: Changing the administrator of the program from KRC to Amani created confusion and loss of clients. In the meantime the targets had been lowered and the budget reduced, which implied a reduction in the number of clients to be counseled.

4. Outreach to children: For Kenyans, support services made available through counseling was a new concept in disaster response. There was stigma to be broken in terms of the social acceptance of psychiatrists. Further, the timing of the Bomb-Blast coincided with a period when there were widespread incidences of child abductions, and this constrained outreach to children. Schools did not want school programs interrupted, and this was another constraining factor.

5. Funding: There were high expectations that the funding period for recovery programs would correspond to that of the Oklahoma City bombing (i.e., six years). These expectations persisted, despite the fact that targets and budgets had already been reduced.

6. Program timing: The timing of the project was also a big challenge, because it coincided with Amani (ACCTI) undergoing one of its worst administrative crises.

7. Turnover of counselors: High turnover of counselors threatened continuity and subsequent improvement in the mental health of survivors. The high turnover was attributed to low payments by the implementing partners. Amani addressed the problem in its role of an implementing partner by taking some counselors on to continue counseling survivors and others who were affected.

Challenges and Opportunities Related to the Program Design

The program design and implementation created further challenges to Amani:

1. Assumptions: One of the main assumptions was based on experience in Oklahoma. The process and structure of the program had to be adapted to the local context. A case in point was the use of complex and lengthy instruments for assessment and data gathering in a predominantly oral culture. This may have led to unreliable and invalid results. Counseling as a profession is very young in Kenya, yet there was an assumption that counseling organizations would be regulated and would operate professionally. The Kenya Association of Counselors’ set of professional regulations has not yet been enacted by an act of Parliament and cannot be effective in playing a regulatory role in regard to the counselors. Thus, there is need to develop local models for mental health intervention, rather than using Western models.
2. Financial inflexibility: The program design limited Amani’s use of financial resources. There was zero flexibility regarding payments, which were rigidly pegged to the numbers of counseling sessions provided. This created the temptation among some partners to provide unnecessary counseling sessions in order to log the numbers that generated money for their agencies. The program could have functioned better and with greater flexibility if, for instance, a fee was paid for counseling, along with other objectives built in by Amani.

3. Executive powers: Control was greatly decentralized, to the extent that the program administrator felt impotent to act in some challenging situations, including instances of unprofessional staff conduct.

4. Restrictions prohibiting Amani from providing counseling: The design did not allow Amani to provide counseling services and had to be revised to accommodate such services. This opportunity was critical in order for Amani to provide exposure and capacity building for its personnel, to help ensure the long-term sustainability of trauma counseling within the organization.

5. Regulatory role: There was a need to strengthen monitoring for greater program effectiveness by allowing Amani more regulatory control over the implementing partners.

Challenges and Opportunities Related to the Time Plan for the Program

The program duration of two years provided double-edged challenges. Two years was not adequate to comprehensively address the problems. On the other hand, serving Bomb-Blast survivors too long could create dependency and prolong suffering. To paraphrase the recommendation within in the executive summary of *Up from the Ashes* (Driscoll, 2001), it is important to make it clear to USAID/Washington and to Congress that infrastructure reconstruction and rehabilitation programs need approval for time enough to complete all activities. Some of the most important recovery programs—mental health counseling, scholarship, construction—are lengthy. Amani was on the program for two years, and just as they started to have a real feel of things, it was time to start phasing out. If Amani had been on board from the beginning, it would have given them additional years of core funding which would have made phase-out easier, as structures for sustainability would be better understood and established (pp. 30–33).

Challenges and Opportunities Related to Research

This is one area where opportunities with profound impact on science were, most unfortunately and most regrettably, lost! This loss was particularly bad for Kenya, as well as for the international community. This lost opportunity can partly be attributed to failing to involve the local universities and research institutions, right from the inception of the program. This contrasts sharply with events following the Oklahoma City bombing,
where the need for scientific examination was acknowledged and supported. Kenya’s universities were rich in human resources and experience with psychotrauma, even prior to the Bomb-Blast, but this went unrecognized and unutilized. Perhaps most importantly, involving local research institutions would have exposed students to these types of exploratory activities, thus enhancing the multiplier effect and resulting in superior capacity building.

Research was not adequately done, because there was no full-time professional charged with the responsibility. The KRCS technical coordinator had devised and implemented a research-based program operations process that was elaborate and self-checking. This process was continued, though reluctantly, during the Amani phase. Had it been fully implemented, it would have led to a comprehensive documentation of the whole process over time, and would have laid a firm baseline foundation for follow-up.

There were other difficulties. Implementing partners were not cooperative because they were not familiar with research methods. But even after training them there was high counselor turnover. There was also a lot of urban–rural migration, and consequently a high turnover of clients. Research assistants (post-graduate students in education psychology) were recruited from a nearby public university to assist. Those working in the Documentation Department established the database, and an expert from another nearby public university was brought in later (a year before phase-out, and as an afterthought) to do the analysis. These delaying factors decreased the usefulness of the research for the project because the feedback was belated.

Delay in keying in research data also affected the research process up to the time of the program evaluation. It was a case of missed opportunity. Publishing research on the program during its lifetime might have demonstrated change, thus enhancing Amani’s effort to obtain further funding for keeping the program going. Of course, the use of culturally relevant tools for assessment and research is necessary. There is a need to create local psychometric instruments relevant to Kenya. Better still, there is a need to validate for local use some of the many instruments that are well established and widely used in the West, for purposes of transcultural comparisons. This poses a challenge to the local universities to work in consultation with consumers and validate existing instruments, or else come up with new ones.

There is a need to consider more qualitative, rather than just quantitative, information from clients, with a smaller number of questions posed to each respondent. In the absence of such tools, the Western ones were adopted without going through a rigorous process of adoption and validation. Later, a locally derived psychiatric instrument, named the NOK after its authors [Ndeitei, Othieno, and Kathuku], was incorporated, although it was unpublished and still in development. Nevertheless, there is still potential for scientifically
reliable and valid data to be gathered and analyzed on the psychosocial impact of the Bomb-Blast.

**Challenges and Opportunities Related to Sustainability**

There were no adequate structures in existence to continue the program beyond the funding period. Most implementing partners will probably revert back to previous program activities from before the Bomb-Blast, with minimal or no attention to disaster response—largely because they lack the institutional capacity to do more. The counseling employment market in Kenya cannot adequately absorb the surplus numbers of individuals who were trained to work as counselors. Counseling is a relatively new field in Kenya, and counseling services are usually subsidized in this country.

The decentralization of executive powers and control for the purpose of strengthening collaboration and networking was not negotiated with the program administrator. It created insecurity in regard to ownership of the program when the funding partner is removed from the scene. This would also have implications for the roles played by other partners when the program was discontinued. Nevertheless, the role played by USAID (as the funding partner and “owner” of the program) in ensuring decentralization and strengthening collaboration cannot be underestimated.

**The Program under Amani: Facilitation, Management, and Implementation Strengths**

Despite all the difficulties, there were mechanisms mitigating the challenges, and there were strengths to fall back on:

1. There was effective and prompt conflict resolution among the implementers—by the USAID program director.
2. Bureaucracy and red tape in management were minimized.
3. A relatively well-established database provided useful and timely information for planning, implementation, monitoring, and reporting on the program.
4. The relative availability of funds and resources for adequately rising to the challenges as they arose greatly enhanced program implementation.
5. Weekly staff and coordinators’ meetings were very helpful in keeping everyone on board and in touch with what was going on in a new, challenging, and highly dynamic situation. Most of these personnel were inherited from the KRCS mental health program.
6. There was a lot of collaboration between highly reputable partners at the local level and government agencies, nongovernmental organizations, and religious bodies. The government agencies included the Ministry of Education; the office of the President, Ministry of Social Services; and the Ministry of Health. The NGOs were the Adventist Development and Relief Agency (ADRA), the Kenya Society for the
Blind, AMREF, Ernst and Young, and the United Disabled People of Kenya (UDPK).
7. There was international collaboration with the World Health Organization and various U.S. agencies and institutions such as the University of Oklahoma, as well as attendance at international and national conferences on trauma.

The Program under Amani:
Direct Opportunities from the Program

This program provided great opportunities for Amani in institutional capacity building.

The whole process of program management was a good learning experience for ACCTI, which had not handled such a project before. The very supportive working relationship with USAID enhanced the steering committee’s confidence to handle other projects in the future.

1. Empowerment at the individual level enhanced staff employment opportunities. This empowerment translated into the professional training of staff and enhanced awareness of disaster management among staff and other caregivers.
2. An exchange of survivors from the Nairobi and Oklahoma City bombings helped give Bomb-Blast victims and service providers a new perspective.
3. The program revealed that there was not just one agent, but several collaborators in multidisciplinary disaster response.
4. The design created a potential for capacity building in the long term. In other words, partners at both the organizational and personal level got enough exposure and can pursue a variety of socioeconomic activities related to disaster response at various levels: grassroots, national, and international.
5. The design has a multiplier effect that will serve the Kenyan population and beyond.
6. Short-term gains, such as client recovery and rehabilitation, were inspiring and provided tremendous impetus for partners, staff, and caregivers throughout the implementation process.
7. In addition to human resource development, the program provided Amani with vital financial and material resources that were invested in capacity building.

The Program under Amani: The Multiplier Effect

1. In addition to Amani, this program involved not just one agent, but several collaborators, in multidisciplinary disaster response.
2. This program brought together various disciplines for the first time, all working together for a common course.
3. The design created a potential for capacity building in the long term. In other words, partners at both the organizational and personal level got enough exposure and can pursue a variety of socioeconomic activities related to disaster response at various levels: grassroots, national, and international.

4. The design had a multiplier effect that will serve the Kenyan population and beyond.

**The Program under Amani: The End-Program Evaluation and Phaseout**

An end-program assessment was executed in August 2002, two years after Amani took over—unlike the one-year assessments for both OpRec and KRC. In the two years under Amani, the program had assorted impacts, some reaching or even exceeding their targets and others not achieving their targets. These effects were felt in three areas: counseling and psychiatric services, outreach, and training services.

Targets for the counseling of adults and children and also for the provision of psychiatric services to adult survivors were exceeded, for more or less the same reasons: effective outreach, but also the possibility that others who were not affected by the Bomb-Blast were also being included. However, there was underachievement in regard to the targets for providing psychiatric treatment to child survivors and for clinical supervision meetings. Reasons for underachievement in the area of psychiatric treatment for children included few referrals to the psychiatrists, a shortage of trained child therapists, and the stigma that parents associated with seeing a psychiatrist. The tools for assessment of the children were poorly understood, and the fact that clinical supervision is a new concept in Kenya could be an explanation for the underachievement.

On the outreach side, only the target on the upcountry families was achieved. This was because of the large, extended families in Kenya, and also because many people migrated from Nairobi after the Bomb-Blast. The rest of the outreach targets were underachieved: affected children, adults, families who were seriously injured, community meetings, and media presentations. The reasons for this underachievement varied from transport and communication problems to administrative constraints.

Similar patterns were noted in regard to the set targets for training services, with overachievement in the training of mental health providers and key decision makers, and also in the training of community-based mental health providers. The target for staff development was also achieved. The main reason for these achievements was the enthusiasm shown by the trainees. However, there was underachievement in the set target for training counselors from implementing partners and in the training of teachers in trauma mental health. The reasons for underachievement in these areas included a lack of qualified counselors to do the training, and administrative
constraints. The key goal of the program still remained: to provide mental health assistance to people affected by the bomb on August 7, 1998, that would enable them to cope with effects of the disaster. The purpose was to provide people with mental health services that would assist them in developing adaptive coping mechanisms.

The target population was classified into five groups:

1. Primary victims—those who were directly hit by the blast and needed psychiatric treatment, intensive counseling, and psychological and educational awareness.
2. The bereaved—those whose next of kin had died and who mostly were the breadwinners in their families. They needed direct material support and grief and loss counseling.
3. Rescue workers—those who rescued the injured and recovered bodies. They needed direct psychiatric treatment (for some), individual and group counseling, and psychoeducational awareness.
4. Community members—those who lived and worked in the vicinity of the Bomb-Blast. They needed basic psychoeducational awareness, group counseling and information on trauma management, and potential referral to mental health services.
5. Outside community—the larger public, which through their communities and involvement had been psychologically affected by the disaster. They needed information about symptoms of trauma-related stress and where resources were available for help.

**Beyond the Crisis Mental Health Support Programme**

The following have been direct results of the impact of the American Embassy bombing:

1. There is increased awareness in Kenya about the impact of terrorism and the need to contain it.
2. There is increased awareness of disasters and the need for disaster preparedness and management. Indeed, a disaster response unit has been put in place in the office of the President.
3. There is increased awareness of psychotrauma among the general public.
4. Some of the implementing partners and agencies associated with the response have continued to pursue trauma- and disaster-related activities in such areas as advocacy, service provision, research, and teaching.
5. Several research activities concerned with disaster and psychotrauma in Kenya have been undertaken, and others are in the process of being undertaken mainly by the United States International University (USIU), as well as by the University of Nairobi’s Department of Psychiatry and the Africa Mental Health Foundation. These have
been published as university Master’s degree dissertations, monographs, and articles in peer-referred journals.

6. The University of Nairobi’s Department of Psychiatry now has an operational postgraduate program on psychotrauma, with student enrolment from outside Kenya.

7. Psychological counseling and clinical psychology are being taught as professional degree programs in the local universities, with the University of Nairobi’s Departments of Psychiatry and Psychology playing the leading roles in the country and in the region.

8. Disaster preparedness is being taught as both separate units and full courses, with the University of Nairobi playing the leading role in the country and the region.

9. Many seminars on disaster and psychotrauma are being organized, both locally and regionally.

10. In summary, the achievements described in this chapter indicate that something good came out of the August 7, 1998, terrorist Bomb-Blast at the American Embassy building in Nairobi.

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Reference
