FACTORS INFLUENCING THE IMPLEMENTATION OF MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT PROGRAM: A CASE OF KALOBYEYEI INTEGRATED SETTLEMENT-CHILD RESOURCE CENTER, TURKANA COUNTY, KENYA

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A RESEARCH PROJECT REPORT SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE AWARD OF THE DEGREE OF MASTER OF ARTS IN PROJECT PLANNING AND MANAGEMENT, THE UNIVERSITY OF NAIROBI

2018
DECLARATION
This research project report is my original work and has not been submitted to any other university or institution for examination.

Signature______________________ Date __________________________

Irene Masitsa Mulunda
L50/5697/2017

This research project report has been submitted for examination with my approval as the university supervisor.

Signature______________________ Date __________________________

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DEDICATION

This work is dedicated to my parents, Mr. and Mrs. Mulunda, the support you have given me has been immense. To my brother Edgar, my sisters: Maureen, Christine; Linda and Daisy, the support you provided me during my studies cannot be gainsaid.
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<td>WSCC</td>
<td>Whole School, Whole Community, Whole Child</td>
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<td>CRC</td>
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<td>UNHCR</td>
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ABSTRACT
Health as defined by World Health Organization is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. Inter-Agency standing committee (IASC) considers refugees and migrants in irregular situations (especially trafficked women and children without identification papers) among others as people at risk of mental health problems. Child Resource Centers have been established in Kakuma and Kalobeyei as an avenue where children are able to obtain psychosocial support through various activities offered by psychosocial facilitators. There is still need for more to be done. In Kakuma and Kalobeyei exists mostly intervention models such as specialized services thus the need to increase preventive intervention models. To do so feasibility of such a program was assessed. The study objectives were to determine how contextual factors, to establish how input factors, to examine how process factors and to determine how product factors influence the implementation of a Mental Health and Psychosocial Support (MHPSS) program in Kalobeyei integrated settlement, Turkana County, Kenya. The study was delimited to Kalobeyei integrated settlement, Turkana County, Kenya. Limitation included unwillingness to participate by respondents but careful explanation of importance and purpose of study helped to encourage their participation. This study was significant as it is expected to establish the relevance, effectiveness, efficiency, impact and sustainability of such a project through evaluation of specific factors that have been identified by WHO, IUHPE as indicators in a holistic manner. The research study design used was a descriptive survey study using mixed method data collection method. The study used a census sample. The unit of study was 1 Child resource center (CRC) in Kalobeyei integrated settlement. The target population was 1 psychosocial support (PSS) officer, 10 facilitators and 30 parents from the CRC committee a total of 41 participants. The research instruments used were questionnaires and written documents. Content validity was used to validate the questionnaires and split-half testing for reliability of the instruments. Data was sorted, coded and run through SPSS software using correlation and regression analysis. Data presentation was tabular. From the findings the study concluded that contextual factors by a composite mean of 3.475, input factors by 3.325, process factors by 3.15 and product factors by 3.05 respectively influence implementation of MHPSS program in Kalobeyei integrated settlement CRC. The study recommends that further studies to be done at other humanitarian settings providing MHPSS program to provide concerted efforts on how to minimize them.
CHAPTER ONE
INTRODUCTION

1.1 Background of the Study
Health, as defined by World Health Organization (WHO) is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (WHO, 2006). Health therefore is looked at in a holistic manner and should be a continuous process not just sought at through treatment but through prevention as well. That put into consideration, health financing in many nations is constrained and thus a huge focus is put on curative measures other than prevention in order to address budgetary pressures (WHO, 2009). Thus, more needs to be done to address health concerns and this led to the growth of health promoting schools (St Leger, 1999). The declaration of Alma Ata (WHO, 1978) provided a platform for Health for all, Ottawa Charter for Health promotion (WHO, 1986a) provided a conceptual framework for health promotion and Adelaide Recommendations on "Healthy Public Policy" (1988) outlined areas for action (Dhillon, 1991) all of which are major milestones in shaping the direction of health promoting schools (St Leger, 1999).

According to (WHO) health promoting school is one that constantly strengthens its capacity as a healthy setting for living, learning and working (WHO, 1996). St Leger, (1999) in his study suggests that school health services could be more effective if attention was given to working collaboratively on partnerships (Shilton, 1993; Brelochs, 1995; WHO, 1996; NHMRC, 1997 cited in St Leger, 1999) and where school health services are integrated with other components of a health promoting school (Cohen, 1995, p.27). Holistic approach includes healthy school policies, the school's physical environment, the school's social environment, individual health skills and action competencies, home and community links and health services (WHO, 1996). As a result of multiple discussions and review, the Whole School, Whole Community, Whole Child (WSCC) approach was developed which provides an effective coordination between education and health (Lewallen, et al., 2015).
For a school health education program to succeed, additional support from parents and government needs to be put forth. In a UK study of health promoting schools, a small financial investment by parents in schools was considered important for success despite insufficient information to focus on costs (Lister-Sharp, Chapman, Stewart-Brown, and Sowden, 1999).

For half of the 20th century, schools were expected to address diverse classroom topics such as oral health, nutrition, sexuality, drugs, traffic safety, physical activity, AIDS/HIV and mental health (St Leger, 2004). Findings from an Austrian multiple case study of 40 different health promotion activities, which most targeted students, while mostly focusing on physical activity and/or psychosocial health; planning, coordination and cooperation at the school level were found to be minimal (Adamowitsch, Gugglberger, and Dur, 2017).

Acceleration of health promotion programs in Africa as a means for increasing societal responsibility for health is increasing steadily as seen in countries such as South Africa, Mauritius, Uganda, Guinea and Niger who are adopting broad concepts of health that encourage the involvement of players from education, justice, industry and politics (Nyamwaya, 2003). A case study in South Africa identified the need of strengthening macro-level policy initiatives for child mental health programs through development and incorporation of a monitoring and evaluation questionnaire tool for obtaining opinions of children about health promoting schools (Struthers, et al., 2017).

Emphasis on academic performance i.e. the mean-score syndrome, shortage of teachers, lack of pre-service training and methods of discussing sensitive topics with students, minimal funds to improve infrastructure or implement components of policies, inherent conflict with cultural practices or taboos around topics such as sex, lack of parental responsibility on talking to kids about healthy topics, administrative attitudes on health topics are some of the key issues teachers perceive to be challenges with regard to implementation of health topics in schools in Kenya (Nairobi City Council, 2016). Relevant literature has demonstrated that most health education in Kenya has been integrated into traditional subjects such as sciences, agriculture, home science, physical education and pastoral studies and despite these changes in knowledge, attitude and
practices concerning health have not been adequately achieved (Waswa and Waudo, 2004).

Healthy development of the child is of basic importance; the ability to live harmoniously in a changing total environment is essential to such development (WHO, 2006). Evaluation which is the process of determining the worth or significance of an activity, policy or program, an assessment, as systematic and objective as possible, of a planned, on-going, or completed development intervention (Kahan, 2008) is needed to cut across all areas that need focus.

1.2 Statement of the problem
Children and adolescents constitute almost a third (2·2 billion individuals) of the world’s population and almost 90% live in low-income and middle-income countries (LMIC), where they form up to 50% of the population. (Kieling, et al., 2001). Worldwide 10-20% of children and adolescents experience mental disorders. Half of all mental illnesses begin by the age of 14 and three-quarters by mid-20s (World Health Organization). About half of all mental illnesses, including anxiety, depression, severe emotional disorder, and attention deficit and hyperactivity disorder, begin in childhood or adolescence (Kirby and Keon, 2004). World Health Organization (WHO) also states that suicide is the second leading cause of death among 15-29 year old’s. Furthermore, - 78 per cent of suicide-related deaths in 2015 occurred in low and middle-income countries (WHO, 2017). Among adolescents who develop major depressive disorder, as many as 7 percent may commit suicide in their young adult years (Scottye and Jeffrey, 2018). Young people in Kenya have an alarmingly high rate of attempted suicides. In the Center for the Study of Adolescents, (2003) survey, as many as 6.8 percent of males and 10 percent of females (in other words, one in ten young Kenyan women) reported having attempted suicide at least once (worldbank.org).

Despite their relevance as a leading cause of health-related disability in this age group and their long-lasting effects throughout life, the mental health needs of children and adolescents are neglected, especially in low-income and middle-income countries (Kieling, et al., 2001) many of which have no resources to tackle mental-health concerns (Lancet, 2007). A study by Peters, et al., (2011) found a median of US$6 annual per
capita as government expenditure on health in Africa and with US$3 per capita in the lowest income countries such as Ethiopia and Democratic Republic of Congo with Kenya together with Angola and Sudan being in low income category, and Botswana and South Africa being the middle-income (cited in Govender, 2005). The extent of untreated mental disorders in developing countries is unknown; however, screening with a standardized tool in early childhood has the potential to identify the majority of children who exhibit significant emotional/behavioral problems in early elementary school (Briggs-Gowann and Carter, 2008).

While treatment offers one approach to intervening, research indicates that most sufferers will not actually receive clinical intervention (Farrell and Barrett, 2007), in developed countries with well-organized health care systems, between 44% and 70% of patients with mental disorders do not receive treatment. In developing countries the figures are even more startling, with the treatment gap being close to 90% (WHO, 2003) and of the minority who do, many will terminate prematurely, fail to respond, or experience recurrent difficulties despite treatment. Prevention approaches offer an alternative and adjunct to treatment, and have become a priority for governments, offering a cost effective and efficient means of providing services to children and youth prior to the onset of psychopathology (Farrell and Barrett, 2007).

In Kenya, there are about 100 psychiatrists. Most of who are based within Nairobi, the capital city. Outside of Nairobi, there is one psychiatrist per million populations (Meyer and Ndetei, 2016). It has 500 psychiatric nurses, of whom only 250 work in mental health, deployed at the national, provincial and district levels, so that each district of around 150,000 will have only one or rarely two psychiatric nurses (Jenkins, et al, 2010). The government has since put a call to employ 100 psychiatric nurses in 2018. Lack of a roll of clinical psychologists has made it difficult to know the number of these specialists (Meyer and Ndetei, 2016). Kakuma Refugee Camp and Kalobeyei integrated settlement in Turkana North Western Kenya is home to 185,449 registered refugees. The refugees are prone to living with desperation and hopelessness especially the young people due to the trauma caused from experiences of armed conflict in their countries and migrating to new regions. The camp and town has two hospitals; International Rescue Committee
IRC) Hospital with 2-6 doctors and several nurses, one mental health nurse with close to 600 patients and Kakuma Mission Hospital which does not deal with mental health cases. The hospitals serve both the locals and the refugees. The region is thus a critical region for mental health intervention.

Mental health services embedded within school systems can create a continuum of integrative care that improves both mental health and educational attainment for children (Fazel, Hoagwood, Stephen, and Ford, 2014). In the Child Resource centers in Kakuma refugee camp and Kalobeyei integrated settlement, psychosocial support programs are offered but less focus on preventive interventions. Early interventions draw a great impact on the healthy formation of the brain. Implementation of a preventive mental health program will thus raise awareness and encourage early intervention. There is therefore need for such a study to influence the implementation of preventive Mental Health and Psychosocial Support program.

Most studies look into context evaluation than process evaluation implementation of health programs (Han and Weiss, 2005; Mukoma, et al 2009) educators need proper preparation. The person should have expertise coordinating programs relating to prevention, health, social competence promotion, and character, and integrating these areas with the academic mission of schools (Elias, Zins, Graczyk and Weissberg, 2003).

1.3 Purpose of the study
The purpose of the study was to investigate factors influencing implementation of Mental Health and Psychosocial Support program in Kalobeyei integrated settlement, Turkana County, Kenya.

1.4 Objectives of the study
The study was guided by the following objectives;

i) To determine how contextual factors influence implementation of Mental Health and Psychosocial Support program in Kalobeyei integrated settlement, Turkana County, Kenya.
ii) To establish how input factors influence implementation of Mental Health and Psychosocial Support program in Kalobeyei integrated settlement, Turkana County, Kenya.

iii) To examine how process factors influence the implementation of Mental Health and Psychosocial Support program in Kalobeyei integrated settlement, Turkana County, Kenya.

iv) To determine how product factors influence implementation of Mental Health and Psychosocial Support program in Kalobeyei integrated settlement, Turkana County, Kenya.

1.5 Research questions
The study was guided by the following research questions;

i) How do contextual factors influence implementation of Mental Health and Psychosocial Support program in Kalobeyei integrated settlement, Turkana County, Kenya?

ii) How do input factors influence implementation of Mental Health and Psychosocial Support program in Kalobeyei integrated settlement, Turkana County, Kenya?

iii) How do process factors influence the implementation of Mental Health and Psychosocial Support program in Kalobeyei integrated settlement, Turkana County, Kenya?

iv) How do product factors influence implementation of Mental Health and Psychosocial Support program in Kalobeyei integrated settlement, Turkana County, Kenya?

1.6 Significance of the study
Incorporation of a preventive approach on the psychosocial support program may increase the level of interventions in health care. This study is expected to establish the relevance, effectiveness, efficiency, impact and sustainability of such a project through evaluation of specific factors that have been identified by WHO, IUHPE as indicators such as the capacity of a school to deliver a health program, knowledge gap,
environmental factors, social factors and policies and others such as design and methodology and outcomes that are most studies have failed to consider.

Thus the study may enable the society to look at alternative ways of addressing mental health issues such as trauma, suicide, anxiety and depression through preventive measures at an early stage other than curative measures only.

The project planners through assessing the factors influencing implementation of a Mental Health and Psychosocial Support program may be able to look into a diverse range of factors such as designs, methodologies, and fidelity of implementation so as to make prior planning and designing of the project for successful implementation.

The government/donors may be able to formulate and justify budget costs from the feasibility study, make operational resource allocation decisions and trigger in depth examinations of what performance problems exist in implementation of a MHPSS program.

The curriculum planners and developers may be able to put into consideration facilitators and parents views on the child mental health curriculum so as to increase participation and thus sustainability of the project.

The study may provide detailed information about project implementation, process and results to donors so that they are able to support the initiative.

1.7 Delimitation of the study
The study was delimited to Child Resource Center (CRC) at Kalobeyei integrated settlement which offers psychosocial support programs for children 4-17 years. The study was also delimited to Psychosocial Support Officer (PSS), Psychosocial Support facilitators and CRC Committee members as they are the target of the study. The data collection was delimited to document review and questionnaires.

1.8 Limitations of the study
Some parents did not know how to read and write and there was language barrier as some refugees understand only Arabic and some only Swahili but the research assistants assisted in translation of the questionnaires into Arabic and Swahili and recorded their
responses. Careful sensitization was done to participants who were unwilling to provide information. Data collection was anonymous thus identity of participants was not disclosed.

1.9 Assumptions of the study
The assumption of the study was that the respondents will be true to the information, objective and cooperative.

1.10 Definitions of significant terms used in the study
Contextual factors - Its purpose is to provide information about the pros and cons of the system for proper planning of the project. It gives a view of the situation as it is now with the implementation of health projects. It gives a description of factors that promote and hinder teachers/facilitators from proper delivery of child health projects and areas of focus for successful delivery of child projects. It is the basis for developing proper goals, objectives and visions for the project in order to avoid failure. The methods for the context evaluation include system analyses, surveys, document reviews, secondary data analyses, hearings, interviews which should be kept up to date to by the administrative authority to prevent such activities from re-occurring and report provided annually.

Input factors - Its purpose is to provide information for determining how to utilize resources to meet project goals. This is accomplished by identifying and assessing relevant capabilities of the responsible agency, strategies for achieving project goals (policies) and designs for implementing a selected strategy. It looks at cost benefit analysis, staffing, time, resource allocation and consequences for not overcoming and possibilities of overcoming them. Methods used to execute an input evaluation include inventorying and analyzing available human and material resources, proposed budgets and schedules, and recommended solution strategies and procedural designs.

Process factors - Its purpose is to provide information that is needed for implementing plans and procedures of the program. It detects or predicts defects in the procedural designs, to provide information for project design and to structure the design accordingly for its success. The process to follow is to identify and monitor continuously the potential source of failure in a project such to note main features of the project design. Methods
include daily logs, observation, interviews, questionnaires, open-end reaction forms, focus group discussions and others.

**Product factors** - Its purpose is to relate outcomes to objectives that is provide information on whether the objectives have been achieved, this may include whether the skills and knowledge have been gained, beliefs, perceptions and attitudes regarding an issue like mental health has been changed. For a feasibility study this can be done by comparing the products achieved with a specified standard.

**Mental Health and Psychosocial Support program** – Mental Health and Psychosocial Support (MHPSS) is a composite term used in these guidelines to describe any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental disorder. Psycho refers to the psychological state of a person, while social refers to the social context of a person. Overall, a basic belief is psychosocial approach is that the psychological well-being of a person and his/her social context influence each other.

**Child Resource Centers** - are widely used in emergencies as a first response to children’s needs and an entry point for working with affected communities. Because Child Resource Centers (CRC’s) can be established quickly and respond to children’s rights to protection, psychosocial well-being, and non-formal education, CRC’s are typically used as temporary supports that contribute to the care and protection of children in emergencies. However, they are used also as transitional structures that serve as a bridge to early recovery and long-term supports for vulnerable children. CRCs are also commonly known as Child Friendly Spaces (CFS).

**Integrated settlement** – It is a region that was established to offer both refugees and host community with an opportunity to trade, and benefit economically and socially from opportunities that have been provided to them both by government and non-government organizations alike.

**1.11 Organization of the Study**
This section gives a proposal of the organization of the study from chapter one to five. Chapter one gives a background of the study, statement of the problem, purpose of the
study, objectives of the study, research questions, significance of the study, delimitations of the study, limitations of the study, assumptions of the study and definition of terms.

Chapter two reviews the literature related to the study. It examines the implementation of child mental health program, contextual factors, input factors, process factors and product factors and implementation of a child mental health program. It gives a theoretical framework and conceptual framework.

Chapter three discusses the research methodology. This included; introduction, research design, the study population, sample size and sample selection, data collection instruments, reliability and validity of instruments, data collection procedures, data analysis techniques and ethical considerations.

Chapter four presents data analysis, presentation, interpretation and discussions.

Chapter five contains summary of findings, conclusions, recommendations and areas of further research.
CHAPTER TWO
LITERATURE REVIEW

2.1 Introduction
This chapter reviews literature related to the study based on the following thematic areas: Implementation of Mental health and psychosocial support program, discusses the contextual factors, input factors, process factors and product factors and implementation of child mental health psychosocial support program. It also looks into the complexity theory that is the map of the study and provides a conceptual framework and a discussion of it, examines the research gaps and lastly a summary.

2.2 Implementation of Mental Health and Psychosocial Support programs
10–20% of children and adolescents have a mental health problem of some type. Manifestations such as attention deficits, cognitive disturbances, lack of motivation, and negative mood all adversely affect scholastic development (Schulte-Körne, 2016). MHPSS programs to enable children live a more fulfilling lives are implemented through the following interventions: Basic services and security this is done through re (establishment) of security, advocating for provision of food shelter and clothing in a way that promotes MHPSS; Community and family supports through family tracing and reunification, assisted mourning and communal healing ceremonies, mass communication on constructive coping methods, supportive parenting programmes, formal and non-formal educational activities, livelihood activities and the activation of social networks, such as through women’s groups and youth clubs; Focused non-specialized supports which includes psychological first aid (PFA) and basic mental health care by primary health care workers; Specialized services which includes psychological or psychiatric supports for people with severe mental disorders (IASC, 2007; Hendren, Weisen, and Orley, 1994).

ParentCorps, a school-based program that engages family and partners in its implementation and considers cultural diversity has been used in New York and is considered as a universal intervention for young children in Pre-Kindergarten or other early childhood education settings. The program looks into upbringing in low income urban areas and has been offered as an evidence-based enhancement for all children in
New York City to develop the social, emotional and behavioral regulation skills that are the foundation for learning (Department of Population Health). Keng-Yen Huang, New York University School of Medicine has been working in collaboration with other partners as a Principal Investigator on introducing ParentCorps program to Uganda and Nepal which are low-resource countries (Keng-Yen Huang, MPH, PhD, 2017).

In Northern Ireland around 45,000 of children and young people have mental health need at one time and more than 20% suffer significant mental health problems by the age of 18. A curriculum project, Hopeful Minds, founded by The International Foundation for Research and Education on depression, (iFred) focusing on children aged 6-12 years has been piloted in 7 schools. It aims to teach hope and through that curb adverse effects of depression as suicide is the leading cause of death among adolescents. Just in the year 2015, 45% of suicide reports were aged between 15 and 34 years in Northern Ireland. Through intervention of the hope curriculum, statistical evidence showed significant improvements (p<0.05) in their variables among which included gaining hope, learning new skills and sharing hope (Kirby, Goetzke, and Dunne, 2018. The program is also being piloted in Malaysia. The curriculum consists of 12 lessons and, each lesson contains objectives, critical thinking questions, discussion points, hands-on activities and stories to enhance student comprehension. Supplemental lessons, critical resources on depression and an online forum are available to all facilitators, as well as access to iFred staff if additional assistance is needed.

In New Zealand suicide is second leading cause of death to traffic fatalities among those aged 15 to 24 years. In response, they reviewed evidenced programs and adapted two main types of school based program in youth suicide prevention which include categorical programs aimed at surveillance and instructional methods and general programs more as a protective factor for building resilience. The specific programs included grade-level PATHS, Zippy’s Friends, PRP and the FRIENDS for Life curricula which according to their study showed promise of success. The study suggested grade-level PATHS as suitable for primary school-aged children and for successful implementation funding and online support from curriculum developers was required (Appelhoff, 2013).
Somalia was one of the first countries in East Africa to establish a school mental health program for children. The King’s College London and The Tropical Health and Educational Trust (THET), established a partnership known as King’s THET Somaliland Partnership (KTSP). This was to raise mental awareness in schools incorporating both teachers and students through the Amoud-THET mental health project in response to the high suicide rates attempts represented by high school students. Like many other African countries, mental illness has been greatly linked to evil spirits. Despite this, results showed 98% acceptance by teachers for a mental health intervention need in schools. The results also showed a high proportion of students were able to go back to school and continue with their studies thus a huge impact (Handuleh, Whitwell, and Fekadu, 2013).

In Kenya the objectives of implementation of a child mental health program has been documented in the Kenya mental health policy (Bukusi, 2015). The Kenya Integrated Intervention Model for Dialogue and Screening to Promote Children’s mental wellbeing (KIDS) addresses part of it. This program’s main focus is on promoting mental health, preventing illness and treating existing mental illness among children. Through its early intervention measure it thus reduces the adverse effects of mental illness such as suicide screened for mental health problems and through the WHO mental health gap action program (mhGAP), the KIDS program is culture sensitive (AMHF).

2.3 Contextual factors and Implementation of Mental Health and Psychosocial Support programs

Literature has shown that contextual factors both within and outside the school, such as absence of support from the principals, undisciplined teachers, the low status of sexual or mental health education and lack of resources, can impede implementation and render interventions ineffective in changing behavior (Mukoma, et al., 2009). Factors such as the length of the initiative, the staff’s collective work, the institutional support and actors’ support and training will improve the intended outcome (St Leger, 1999; Han and Weiss, 2005; Peters, et al., 2011) making it more sustainable as the burden will not only be left on trainers to perform but other factors as well will contribute to the improvement of their capacity to provide a feasible delivery of child health education.
Institutional support has not been largely discussed in research material. But it involves the supervisor’s responsibility towards the institute such as ensuring facilitators are working to their required capacity, obtain the proper training and are designated to roles they are most comfortable with. This includes regular review on provider effort or fidelity of facilitators which can only be ensured through support from supervisors. A World Bank report shows in public and private schools in Kenya, teachers are roughly equally likely to show up at school. The main difference is that public teachers may be at school, but are 50% less likely to be in class teaching (Martin and Pimhidzai, 2013). Just a third (35%) of public school teachers showed mastery of the curriculum they teach. Seniority and years of training among teachers did not correlate with better teacher competence (Martin and Pimhidzai, 2013), same applies to women, older persons, those having longer higher university education, primary school teachers (compared to secondary teachers) and language teachers (compared to biology teachers) (Jourdan, Pironom, Berger and Carvalho, 2012)

Table 2.1 Service Delivery Indicators at-a-Glance: Education

<table>
<thead>
<tr>
<th></th>
<th>All</th>
<th>Public</th>
<th>Private</th>
<th>Urban Public</th>
<th>Rural Public</th>
</tr>
</thead>
<tbody>
<tr>
<td>School absence rate</td>
<td>15.5%</td>
<td>16.4%</td>
<td>13.7%</td>
<td>13.7%</td>
<td>17.2%</td>
</tr>
<tr>
<td>Classroom absence rate</td>
<td>42.2%</td>
<td>47.3%</td>
<td>30.7%</td>
<td>42.6%</td>
<td>48.8%</td>
</tr>
<tr>
<td>Classroom teaching time (also known as Time on Task)</td>
<td>2h 40 min</td>
<td>2h 19 min</td>
<td>3h 28 min</td>
<td>2h 37 min</td>
<td>2h 13 min</td>
</tr>
<tr>
<td>Minimum knowledge among teachers</td>
<td>39.4%</td>
<td>35.2%</td>
<td>49.1%</td>
<td>32.9%</td>
<td>35.8%</td>
</tr>
<tr>
<td>Student-teacher-ratio</td>
<td>32.0</td>
<td>37.1</td>
<td>20.8</td>
<td>40.8</td>
<td>35.9</td>
</tr>
<tr>
<td>Students per textbooks</td>
<td>3.1</td>
<td>3.5</td>
<td>2.2</td>
<td>2.5</td>
<td>3.8</td>
</tr>
<tr>
<td>Text books per student</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Teaching Equipment availability</td>
<td>95.0%</td>
<td>93.6%</td>
<td>98.2%</td>
<td>93.7%</td>
<td>93.5%</td>
</tr>
<tr>
<td>Infrastructure availability</td>
<td>58.8%</td>
<td>58.5%</td>
<td>59.3%</td>
<td>93.7%</td>
<td>93.5%</td>
</tr>
</tbody>
</table>

(Martin and Pimhidzai, 2013)

Other studies have looked into contextual factors, such as the development of the organizational infrastructure necessary to support and sustain change over time (for example, capacity building, redeployment of resources, and integration of services) (Han and Weiss, 2005). A study in Nigeria on implementation of a child vaccine found organization infrastructure and equipment as a fundamental factor for successful project
completion. The state mobilization unit that was in charge of coordination of communication activities lacked necessary facilities such as office equipment and communication materials (Oku, et al., 2017). Such facilities are necessary for staff meetings, class presentation and storage of sensitive health information.

Schools’ objectives, mission and goals could impact positively on child health education. Same applies to their policies whether governed by the government or privately governed. Kenya comprehensive school health policy for instance covers various areas such as values and life skills; gender issues; child rights, protection and responsibilities; water, sanitation and hygiene; nutrition; disease prevention and control; special needs, disabilities and rehabilitation; school infrastructure and environmental safety (Nairobi City Council, 2016). Such policies allow channeling of resources into school child health programs, redefinition of curriculum priority areas enabling its successful implementation. There is still need for preventive intervention such as school mental health education to be integrated in the curriculum and life skills education that is covered comprehensively in the Kenya Mental Health Policy (Bukusi, 2015). Studies have shown that key recurrent combinations of contextual factors could contribute to the design of implementation patterns, which could provide guidelines and recommendation for grass-root program implementation (Darlington, Violin, and Jourdan, 2018).

2.4 Input factors and Implementation of Mental Health and Psychosocial Support program.
WHO, CDC and the IUHPE have the task of summarizing the evidence and developing guidelines and protocols task of determining an agreed set of indicators on which to shape school-based health interventions, and to evaluate them (St Leger, 2004). Factors such as budget, staff number both teaching and non-teaching counselors and special teachers, time allocation and resource allocation are some of the contributory factors to a successful school child mental health program.

According to Martin and Pimhidzai, (2013), table 2.1, classroom teaching time also known as time on task and student teacher ratio affect implementation of an educational program. According to UNHCR policies the pupil teacher ratio should be 40:1 and complies with the general standards in developing countries that are essential for proper
learning. For the case of an educational curriculum, subject teacher approach should be used which allows for larger classes and a maximum of 30 minutes per week (UNHCR, 2003).

A pilot study in Kilifi and Msambweni found weaknesses in coordination and networking between the government ministries, monitoring support, lack of reference materials, lack of appropriate supplies especially for water, sanitation and hygiene (WASH) and other thematic areas such as life skills have failed or are not given priority they deserve. The government does not provide enough resources for implementation of school health policies thus a big gap between policy formulation and implementation (Wasonga, et al., 2014). For a mental health program, supplies for engaging in active learning by students such as drawing materials stationery, music club instruments like guitars, footballs could be provided through support from community and organizations.

There is need for provision of materials such as teacher manual, training and ongoing support, stakeholder engagement (Brooker, et al., 2010; Mukoma, et al., 2009). There is also need to strengthen the curricula to effectively address health concerns. The Kenyan school curriculum for instance is highly invested in traditional subjects such as agriculture, home science and physical education, (Waswa and Waudo, 2004) and thus does not effectively cover health education. In the new curriculum in Kenya health education is covered in hygiene and nutrition studies but mental health education is still left behind. Stakeholders should be engaged in modification of existing child mental health curriculum taking into account culture sensitivity.

A study in Western Kenya factored in a cost analysis and program implementation of school based malaria program. Costs were differentiated between initial set-up and recurrent costs, and separated into the following categories: drug procurement; drug distribution; national supervision; local supervision; training; and drug administration. Office equipment, training of trainers and community sensitization were the main set-up costs. The need for annual refresher training of teachers was assumed given high rates of staff turnover in schools, and included as a recurrent cost. The results found a school based intervention more cost effective (Temperley, et al., 2008). Factoring out drug costs,
such ongoing school health programs could help in cost analysis of feasibility of a child health program.

2.5 Process factors and Implementation of Mental Health and Psychosocial Support program.
A study by Jourdan (2016) illustrates that teachers had a broad conceptualization of their role in health promotion. The study showed there was more success at classroom than at whole school level as despite most studies promoting a whole school approach (Rowe et al., 2010; Hunt et al., 2015; Rooney et al., 2015; Chiang et al 2015; Morse et al., 2015). Such a study provides insight on other possibilities not being restricted to whole school approach in areas where it may be challenging. The study also identified limited limitation in terms of teacher support in health (Jourdan et al., 2016) of which reluctance could be overcome also through teacher support and involvement (Mak-van der Vossen et al., 2014; Wasonga et al., 2014; Mukoma et al., 2009).

A 4 year pilot study in France (2003-2007) carried in 21 schools showed success through training at various levels that is regional to locally on how to deliver training, advice and support to school staff regarding the principles, values, resources and evaluation of the intervention. Training was as well done after implementation on issues occurring in the schools and post implementation training to share first results after evaluation. The initiative was voluntary for the schools with support from the national committee and supervision by scientific committee (Guevel, Pommier, & Jourdan, 2015). Thus a tier level training design at pre, during and post implementation of project could provide a successful training for teachers on MHPSS programs. For instance HIV/AIDS in Kenya is taught as a subject in schools. Some of the challenges facing HIV/AIDS education in Kenya are the preparedness of the teacher in pre-service training and the professional formation (Dahl, 2013).

Barry et al., (2013) in a Systematic review of 22 studies on the effectiveness of mental health promotion interventions for young people in Low and Middle Income Countries (LMIC) indicated 8 out of the 22 were implemented by teachers and improved psychosocial competence on children 6-11 years. The study also suggested that integration of mental health education in areas such as community empowerment,
poverty reduction, HIV/AIDS prevention, reproductive and sexual health is feasible and effective. This approach of integration has been supported by (Hendren, Weisen, and Orley, 1994). The intervention was implemented effectively in LMIC school and community settings, there was limited evidence of interventions for younger children and showed the need of strengthening mental health promotion in LMICs. In addition, the short-term follow-up periods of many of the studies point to the need for future research to evaluate long-term outcomes (Barry et al., 2013). Thus integration into other health curriculum than in extra curricula activities such as kids clubs might be more effective as all students will have participated.

Some studies have shown that training and participation of teachers in health promotion (HP) taking into account diverse views and experiences and targeting their attitudes, skills and self-efficacy to implement the intervention as well as in the review and implementation of the schools action plans, involving teachers in developing and piloting the lessons, ensured school level ownership and sustainability (Wasonga et al., 2014; Mukoma et al., 2009). Mukoma et al., (2009) did a process evaluation and part of the factors that hindered success of the project through participatory methodology was inexperience of teachers to utilize it thus a pre-training of the methodology and design is crucial for the target group for successful implementation.

According to Wasonga et al., (2014) bottom-top approach does not increase sustainability from the government sector. For instance in his study, the public health officers did not monitor and evaluate the projects thereafter. Lack of process evaluation before implementation of the pilot therefore resulted to lack of study of the inter-relationship with other key stakeholders to determine means of ensuring sustainability in the District, Division and Zonal levels.

Challenges faced both by researchers and practitioners regarding epistemological foundations, technical issues and regarding skills, time or resources, mixed methods as a methodological tool, may help in resolving some of these issues related to the evaluation of school health promotion initiatives, especially with regard to appraising a complex phenomenon and providing different points of view about it (Guevel, Pommier, and Jordan, 2015). Evidence drawn from other sector’s research in program design will
improve intended outcomes in the nature of health promotion practice (Rowling and Jeffreys, 2006).

2.6 Product factors and Implementation of Mental Health and Psychosocial Support program.
The judgement of the outcomes of most school health programs is based mainly on health indicators rather than educational measures (St. Leger, 1999). Health indicators could be prevalence, incidences, mortality indicators, health policy indicators among others instead of educational outcomes which include instructional behaviors, persistence in teaching situation, enthusiasm, commitment to teaching as well as student achievement (Han and Weiss, 2005).

Teachers are the primary implementers of social and emotional learning (SEL) programs. Their beliefs about SEL likely influence program delivery, evaluation, and outcomes. A study in New York found 3 scales of testing belief, that is comfort (sense of confidence in teaching SEL), commitment (desire to participate in SEL training and teaching), and culture (schoolwide support for SEL). Han and Weiss, (2005) in his study found that teachers’ confidence in their teaching ability affects their delivery. Those with high efficacy show greater effort on the task adapt better and persist despite hindrances. Those with low self-efficacy would give up easily. Learning academics than social emotional skills has been given more priority and is seen as a cultural effect (Brackett, et al., 2012). Thus giving high preference to arithmetic, sciences and languages than studying life skills shows cultural barrier towards delivery of child mental health education.

A study conducted to assess teachers’ attitudes toward the importance of mental health training as it relates to teaching success in the classroom highlighted the need for strengthening pre-service and in-service training for teachers in Kenya to increase teachers’ ability to identify and manage mental health issues in schools (Nyutu and Bertel, 2012). Another study on teacher trainees for P1 also concluded that a brief psychoeducation on mental illness and expectations about counseling for a mental illness significantly improves attitudes towards help seeking for a mental illness among young adults (Nyavanga, et al., 2016).
A growing body of research supports the notion that patterns of child and adolescent psychopathology are influenced by the culture in which youngsters grow up. Culturally mediated beliefs, values and traditions and associated child rearing and socialization practices may help shape both the kinds of problems youngsters show when distressed and the kinds of problems parents perceive or find distressing. A study in Embu suggested that parents demand strict adherence to social norms from their children that is a need to behave in a particular manner even for those children with under controlled behaviors thus a hindrance to their growth and development thus limited knowledge on children with social emotional problems affects child development (Weisz, et al., 1993).

In a study in rural Kenya-Kisumu community members, including CHWs, reported receiving no formal mental health education. This lack of education has contributed to the significant stigma surrounding mental illness, which has been further exacerbated by the belief of an association between mental illness and the supernatural (Walton, et al., 2016).

Such beliefs, lack of knowledge and poor attitude affects the outcome of a successful school child health education. Through an outcome evaluation proper planning in teacher training, parents’ involvement and awareness creation within the community could be properly carried out for successful program implementation in schools.

2.7 Theoretical framework
Theories attempt to explain and predict behavior based on observations and conclusions. They are based on the data that is systematically collected analyzed and interpreted. Theory is mostly used in evaluation literature but models are the terms used in evaluation of projects. Berk and Rossi (1999) put it, “So far… theory has not lived up to its promise in evaluation research” (p. 33). Six reasons were given: lack of conceptual consensus, relative recent emergence of the field, lack of financial support for theory development in evaluation, a focus on program theory, the field’s practical focus and a continuing concern with evaluation models and methods (Chrisite and Vo, 2015). Frye and Hemmer, (2012) identified some of the evaluation theories that are reductionism theory, system theory and complex theory that have influenced common evaluation models (Frye and Hemmer, 2012. This study will employ complexity theory.
2.7.1 Complexity Theory
Complexity theory was derived from works of biologists especially Stuart Kauffman (1993, 1995). As it names suggests it studies complex systems whose irreversible changes in terms of time, either large or small occur in a nonlinear/nonhierarchical manner and cause unpredictable outcomes. (Byrne, 1998). Complexity theory emphasizes that we can understand simple forms from its origin in the complex. Thus by use of CIPP model we can understand simple social indicators that affect the social system. Under the context-input-process and product we evaluate the whole system independent of each evaluation stage which represents the complex program. This theory has been used in education and health problems specifically mental health whose causes are complex to understand.
2.8 Conceptual framework
The figure 2.1 represents a conceptual framework that represents how the independent and the dependent variable relate.

Figure 2.1: Conceptual framework
Figure 2.1 represents a conceptual framework which acts as the map of the study. The independent variables which are the contextual factors, input factors, process factors and product factors influence the dependent variable which is the MHPSS program. Indicators include: institutional support, policies in support of a health program, organization’s objectives towards health promotion, organizational infrastructure such as capacity building mechanisms, time on task, budget allocation, teacher student ratio,
implementation designs used and teacher attitude affect the success or failure of the child mental health program.

Moderating variables act like the independent variable and has a significant effect on the relationship between the dependent and the independent variable. We therefore consider whether these independent factors will have an effect on implementation of a MHPSS program.

Intervening variables might affect the relationship between the contextual factors, input factors, process factor and product factors and implementation of a MHPSS but could be difficult to measure in our case it will include how much we can expect from donor support, parental support or government expenditure in support of MHPSS program we are not able to measure this at the formative phase.

### 2.9 Knowledge gaps

<table>
<thead>
<tr>
<th>Variables</th>
<th>Indicators</th>
<th>Author(Year)</th>
<th>Findings</th>
<th>Knowledge gap</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contextual factors</td>
<td>-Institutional support</td>
<td>Han &amp; Weiss, (2005).Mukoma, et al., (2009)</td>
<td>Studies have suggested the need of contextual factors in successful implementation of child health projects by teachers</td>
<td>Studies have failed to explain how recurrent of such factors could contribute to design of implementation patterns.</td>
</tr>
<tr>
<td></td>
<td>-Organizational infrastructure</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>-Policies, laws, regulations</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>-Objectives, missions, goals</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Input factors</td>
<td>-Time factor</td>
<td>Wasonga, et al., (2014)</td>
<td>The government does not provide enough resources for implementation of school health policies thus a big</td>
<td>Other stakeholders’ support has not been looked into for implementation such as parents,</td>
</tr>
<tr>
<td></td>
<td>-Cost benefit analysis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>-Staffing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>-Resource allocation</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
gap between policy formulation and implementation of child mental health programs

<table>
<thead>
<tr>
<th>Process factors</th>
<th>Participatory approach</th>
<th>Bottom-up approach</th>
<th>Tier level training</th>
<th>Integration in curriculum</th>
<th>Waswa &amp; Waudo, (2004)</th>
<th>There is need to strengthen curricula to effectively address mental health concerns.</th>
<th>Mental health education is still left behind</th>
</tr>
</thead>
<tbody>
<tr>
<td>Product factors</td>
<td>Instructional behaviors</td>
<td>Persistence in teaching</td>
<td>Enthusiasm</td>
<td>School staff commitment</td>
<td>Brackett, et al., (2012)</td>
<td>Learning academics play activities than social emotional skills has been given more priority and is seen as a cultural effect.</td>
<td>There is little research that has been done to measure such factors.</td>
</tr>
</tbody>
</table>

2.10 Summary of literature
From the overview of literature on MHPSS programs, Asia and Middle East have more information on clinical and home based interventions than school child health programs. South Africa represents more projects done in Africa but little literature is accessible for review. Nigeria has done more feasibility studies but less implementation of child mental health programs. Other parts of Africa do not provide literature on mental health and psychosocial support programs. Kenya has implemented a screening program but not an
educational support program. Despite these, studies suggest that data obtained from other child health programs that have been carried out such as malaria, nutrition, physical education, and HIV & AIDS are crucial for researchers as guidance on various literature associated with the current study.

More of the MHPSS programs are carried out in humanitarian settings. Little information is available on the activities that are carried out in those Child resource centers but non-formal education is provided that is supposed to supplement the formal education which is done in shifts as per UNHCR recommendations.

Stufflebeam through the context-input-process-product model has enabled easiness in evaluation of projects especially for educational programs in a holistic manner. The complexity theory that employs non-linearity and tends to expound on complex issues such as mental health is the most preferred for the study of school child health program. Most evaluation studies have failed to look into theories and focus more on models and others employ the models as theory. There is need for clear elaboration on this so that evaluators could employ theories in their evaluation literature and models in evaluation projects.

Literature has shown that a few research works have incorporated the CIPP model on feasibility studies. More so most of the studies have focused on contextual factors more than process, input or product evaluation on child health programs. There is need for more to be done in order to capture all aspects of evaluation of the project for successful implementation.
CHAPTER THREE
RESEARCH METHODOLOGY

3.1 Introduction
This section will look into the research design, target population, sampling population, validity and reliability of the research instruments, methods of data collection procedures, methods of data analysis and ethical issues.

3.2 Research design
A descriptive survey study design using a mixed method data collection (including qualitative and quantitative data collection) was applied for the purpose of getting more inclusive outcome of the research. A descriptive survey design depicts the participants in a more accurate way hence necessary for decision making. It allows examination of a large number of variables. The mixed method data collection method involved gathering data in both numerical on questionnaire instruments and in text form from written documents which will include: school objectives and goals, future decisions on mental health program implementation, funding opportunities, innovative efforts, meeting minutes, documents, proposed budgets and schedules, solution strategies and inventories (Stufflebeam, 1971).

3.3 Target population
The target population consisted of 1 child resource center in Kalobeyei integrated settlement, Kenya. The research is intended to target the supervisors, facilitators and CRC Committee members from the Child Resource Center.

Table 3.1 Target Population

<table>
<thead>
<tr>
<th>Category</th>
<th>Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supervisor</td>
<td>1</td>
</tr>
<tr>
<td>Facilitators</td>
<td>10</td>
</tr>
<tr>
<td>CRC Committee members</td>
<td>30</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>41</strong></td>
</tr>
</tbody>
</table>
3.4 Sampling Size and Procedure
Since the target population comprises of 41 respondents, the study adopted census sampling where all the 41 were used as key informants. This is according to Mugenda and Mugenda (2003) who states that when the target population is below 100 all the respondents may be used for the study.

3.5 Research Instruments
The data collection instruments used was written questionnaires which can be administered quickly to a large number of people and a lot of data can be collected in an organized manner. Questionnaires also produce reliable information and can be completed anonymous. Questionnaires may as well be costly thus pose as a challenge but careful administration is necessary by the researcher to get proper feedback and as well save on costs. Written documents were also used.

3.5.1 Pilot Testing
5 questionnaires were administered at a CRC in Kakuma which has been in existence for more than two years. The respondents were selected randomly, two weeks before the main study to enable proper adjustments to be made towards the questionnaire before administering them to the respondents.

The respondents were asked to respond to the questions as the researcher observes whether each question measures what it was supposed to be measure, how long it would take to measure, whether the responses would be accurate and whether tools were appropriate for the study. Where needed, adjustments were made to the tool.

3.5.2 Validity of the Research Instruments
According to Joppe (2002) validity determines whether the research truly measures that which it was intended to measure or how truthful the research results are. The instruments used were reviewed by the supervisor to determine whether they are acceptable as per the ethical standards. Content validity by use of expert review from the lecturer was used to ascertain whether the degree to which data is collected using the written documents and questionnaire represents contents of the factors to consider for implementation of a MHPSS program. Construct validity was used on how wordings are phrased and constructed through expert visit as well.
3.5.3 Reliability of the Research Instruments
Joppe (2002) defines reliability as the extent to which results are consistent over time and can be reproduced under similar methodology. Split-half testing was used to ensure reliability as the study can only be done in one session. The scores within the two sets of studies; pilot study and actual study were correlated to eliminate the chance of error.

The correlation was done using the spearman-brown prophesy formula i.e

$$\text{Reliability of scores on total test} = \frac{2 \times \text{reliability for } \frac{1}{2} \text{ test}}{1 + \text{reliability for } \frac{1}{2} \text{ tests}}$$

3.6 Collection procedures
Data was collected from the CRC. The supervisor was approached to seek consent to carry out research. The supervisor assisted in communication to the facilitators who assisted in reaching out to the parents. Questionnaires were provided respectively (Supervisor (n=1), facilitators (n=10) and CRC committee members (n=30) and take approximately 2 hours to complete. Written documents could be collected as they are completing the questionnaires.

3.7 Data analysis techniques
Qualitative data was analyzed using descriptive analysis as it happens or ex-post-facto sense which is used in behavioral sciences where variables; that is how an independent variable, present prior to the study in the participants, affects a dependent variable e.g. organization support that are impossible to manipulate affect implementation of a MHPSS program. For the quantitative data, Statistical Package for Social Sciences (SPSS) was used to analyze the data. The statistical method of Pearson Product of Correlation Coefficient was used to analyze relationship between various variables. Pearson Product Correlation Coefficient was used to determine the magnitude and direction of the relationship between the factors independent variables (contextual, input, process and product factors) and implementation of MHPSS program (dependent variable).
The regression analysis model is:

\[
Y = \beta_0 + \beta_1 X_1 + e \\
Y = \beta_0 + \beta_2 X_2 + e \\
Y = \beta_0 + \beta_3 X_3 + e \\
Y = \beta_0 + \beta_4 X_4 + e
\]

Where:

- \( Y \) = MHPSS program
- \( X_1 \) = Contextual factors,
- \( X_2 \) = Input factors,
- \( X_3 \) = Process factors
- \( X_4 \) = Product Factors,
- \( \beta_0, \beta_1, \beta_2, \beta_3, \beta_4 \) are the coefficient of the variables.
- \( e \) = is the error term

### 3.8 Ethical considerations

Ethical clearance was sought from the Ethics and Research Committee, University of Nairobi. Clearance from National Commission of Science Technology and Innovation NACOSTI was obtained. Finally voluntary informed consent was obtained from all the participants.

There was no risk to the subject as the data was collected only for the purpose of study. The study would benefit the community through provision of cultural sensitive details for implementation of MHPSS program and thus a ground breaking.
### 3.9 Operationalization of Variables

#### Table 3.2: Operational definition of variables

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Variables</th>
<th>Indicators</th>
<th>Measures</th>
<th>Measuring Scale</th>
<th>Analysis Technique</th>
<th>Data Analysis Tools</th>
</tr>
</thead>
</table>
| To determine how contextual factors affect implementation of MHPSS | Contextual factors | - Institutional support to the initiative.  
- Organization infrastructure  
- Objectives and goals of the organization  
- Institutional policies | - What is the % of participants accepting the initiative?  
- What are the facilities provided to support the initiative?  
- What is the level are the policies, objectives and goals in support of mental health program? | Nominal  
Ordinal | Descriptive | Correlation and regression analysis |
| To establish how input factors affect implementation of MHPSS | Input factors | - Amount of time allocated for child mental health program  
- Cost benefit analysis  
- No. of teaching and non-teaching staff | - How many hours per week are set to teach health promotion program?  
- What is the benefit of MHPSS program against cost?  
- What is the ratio of staff per child? | Nominal  
Ordinal | Descriptive | Correlation and regression analysis |
| To examine how process factors affect implementation of MHPSS | Process factors | - Participatory approach  
- Bottom-up approach  
- Tier level training  
- Integration in curriculum | Which processes have worked before for existing child health programs and which ones could work now?  
What epistemological factors need to be put into consideration? | Nominal  
Ordinal | Descriptive | Correlation and regression analysis |
| To determine how product factors affect implementation of MHPSS | Product factors | - Instructional behaviors  
- Level of persistence in teaching  
- Level of enthusiasm in health programs.  
- Level of commitment in | - What are the perceptions of teachers/parents towards delivery of a child mental health program?  
- Are the facilitators willing to deliver a child mental health program? | Nominal  
Ordinal | Descriptive | Correlation and regression analysis |
| Mental Health and Psychosocial Support program | teaching despite challenges -No of parents in support of the initiative | -How much time are the facilitators willing to commit in delivering a child mental health program? -What are the instructional behaviors used in delivery? | -Does basic services and security influence implementation of a child MHPSS program? -Does community and family support influence implementation of a MHPSS program? -Does focused non-specialized support influence implementation of a child MHPSS program? -Does specialized services influence implementation of a child MHPSS program? | Ordinal | Descriptive | Correlation and regression analysis |
CHAPTER FOUR

DATA ANALYSIS, PRESENTATION, INTERPRETATION AND DISCUSSIONS

4.1 Introduction
This chapter presents analysis of data, presentation, interpretation and discussion. On the following themes: contextual factors, input factors, process factors and product factors on implementation of Mental Health and Psychosocial Support program.

4.2 Response return rate
A total of 41 research instruments were administered. The response return rate was 100% since all the respondents filled the questionnaires. This response rate was within what Cooper and Schindler (2012) set as a significant response rate (above 50%) for statistical analysis.

4.3. Demographic information
To understand the background of the respondents participating in the study, the researcher required the respondents to indicate their job title, age, gender and educational qualifications.

4.3.1 Respondents designation
Respondents were asked to indicate their designation to enable categorization according to their responsibility in tasks in implementation of the project.

Table 4.1 Respondents designation

<table>
<thead>
<tr>
<th>Designation</th>
<th>Frequency</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychosocial support officer</td>
<td>1</td>
<td>2.44</td>
</tr>
<tr>
<td>Psychosocial support facilitators</td>
<td>10</td>
<td>24.39</td>
</tr>
<tr>
<td>CRC Committee members</td>
<td>30</td>
<td>73.17</td>
</tr>
</tbody>
</table>

Total 41 100

Findings in table 4.1 show that psychosocial support officer were 2.44%, psychosocial support facilitators were 24.39% and the CRC Committee members were 73.17% of the respondents. This means the respondents were in a position to respond to the questionnaire.
4.3.2 Age of the respondents

The study sought to indicate the age of the respondents to establish if they were of appropriate age to respond to the questions.

Table 4.2 Age of Respondents

<table>
<thead>
<tr>
<th>Age bracket</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-20</td>
<td>2</td>
<td>4.87</td>
</tr>
<tr>
<td>20-30</td>
<td>27</td>
<td>65.85</td>
</tr>
<tr>
<td>30-40</td>
<td>9</td>
<td>21.95</td>
</tr>
<tr>
<td>40 and above</td>
<td>3</td>
<td>7.32</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>41</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

The study indicates that 2 (4.87%) are between the ages of 18-20 while 27 (65.85%) are between the ages 20-30 years and 9 (21.95%) are between the ages 30-40 and 3 (7.32%) are 40 and above. This is in accordance with the UNHCR April (2018), Kalobeyei Settlement population statistics, which records ages 18-59 as the highest population of 3,873. The highest number being between ages 20-30 at 15 (65.22%) indicates that the working age group are young and vibrant and able to learn fast new knowledge and can handle working with children.

4.3.3 Gender of the respondents

The study sought to establish the gender of the respondents to show if it had any effect on implementation of MHPSS program
Table 4.3 Gender of Respondents

<table>
<thead>
<tr>
<th>Gender</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>10</td>
<td>24.39</td>
</tr>
<tr>
<td>Female</td>
<td>31</td>
<td>75.61</td>
</tr>
<tr>
<td>Total</td>
<td>41</td>
<td>100</td>
</tr>
</tbody>
</table>

The findings from table 4.3 established that 10 (24.39%) of the respondents are male while 31 (75.61%) are female. This indicates there is gender imbalance of parents representation within the CRC as per the gender balance policy of 2/3 representation. This could be that the number of men working is more and they are not able to find time to respond to the questionnaires.

4.3.4 Educational qualifications

The respondents were asked to state their level of education. This is to help in understanding if the respondents have adequate knowledge concerning the study.

Table 4.4 Education qualifications

<table>
<thead>
<tr>
<th>Highest level of education</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>More than a degree</td>
<td>1</td>
<td>2.44</td>
</tr>
<tr>
<td>Degree</td>
<td>1</td>
<td>2.44</td>
</tr>
<tr>
<td>Diploma</td>
<td>13</td>
<td>31.71</td>
</tr>
<tr>
<td>Certificate</td>
<td>21</td>
<td>51.22</td>
</tr>
<tr>
<td>Informal education</td>
<td>5</td>
<td>12.20</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>41</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

The table 4.4 indicates that 12.2% have informal education 51.22% of the facilitators have a certificate. 31.71% have a diploma 2.44% have a degree and 2.44% have more than a degree. The findings from the table establish that majority of the respondents have not attained higher level of education which could affect implementation of MHPSS. Studies done by Jourdan, Pironom, Berger and Carvalho, (2012) suggest that having longer or higher university education has no correlation with better teaching competence.
4.4 Implementation of Mental Health and Psychosocial Support program

There was need to establish the models used in implementation of the Mental Health and Psychosocial Support program at the in Kalobeyei Integrated Settlement.

Table 4.5 Implementation of Mental Health and Psychosocial Support Program

<table>
<thead>
<tr>
<th>Statement</th>
<th>n</th>
<th>Min</th>
<th>Max</th>
<th>Mean</th>
<th>Std Dev.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic services and security</td>
<td>41</td>
<td>2</td>
<td>5</td>
<td>3.9</td>
<td>0.889</td>
</tr>
<tr>
<td>Community and family support</td>
<td>41</td>
<td>2</td>
<td>5</td>
<td>3.46</td>
<td>1.002</td>
</tr>
<tr>
<td>Focused non-specialized services</td>
<td>41</td>
<td>1</td>
<td>5</td>
<td>3.66</td>
<td>1.063</td>
</tr>
<tr>
<td>Specialized services</td>
<td>41</td>
<td>2</td>
<td>5</td>
<td>3.90</td>
<td>0.889</td>
</tr>
</tbody>
</table>

**Composite mean**: 3.73

Findings on table 4.5 shows a composite mean of 3.73 which indicates that provision of basic services and security influences implementation of MHPSS by 3.9, community and family support does not influence implementation by a mean of 3.46, focused non-specialized services does not influence implementation of MHPSS by a mean of 3.66 and specialized services influences implementation by a mean of 3.9.

At the CRC in Kalobeyei, MHPSS services provided are focused non-specialized support through Psychological first aid, Stress management and emotional support through therapeutic activities, including, expressive art, music dance and drama; Community and family support through weekly group support meetings for PSS facilitators, supportive parenting programs through trainings on parenting skills, child protection, Gender Based Violence, Referral, Nutrition and Kitchen garden, child protection and leadership and team building among others, community awareness raising workshops, social networks such as CRC committee; Basic services and security through advocating for services such as water supply to be put in place and doing referrals on services that are not provided at the center.
Basic facilities used in support of the initiative according to UNHCR educational guidelines (2003) included cost-effective permanent roof and cemented floor designed for protection from heat that can accommodate 150 children, two quality latrines with walls separated for staff and children, mats for children to seat on, educational supplies such as drawing papers, crayons, pencils, flip charts, recreational sports and cultural activities such as playing cards, singing, dancing, playing football among others.

The challenges mentioned in implementing MHPSS program in Kalobeyei: The barriers, which hamper prevention of physical injuries, include lack of sufficient play space, lack of materials to provide for the large number of children attending the Centre and the harsh weather conditions experienced in the area, lack of water supply, few number of facilitators compared to the number of children, language barrier. According to the UNHCR educational guidelines (2003) initial rapid response includes games, storytelling, songs, dance and improvised sports, as well as simple number and language lessons, with minimal equipment and supplies which within 6 months there should be a formal program with an accepted curriculum. Culture plays a major role in hampering the implementation of MHPSS at the CRC, most parents in this neighborhood would prefer to visit a witchdoctor or a priest/imam instead of seeking for professional counseling services. It was also noted some issues at home they cannot refer here to the CRC such as issues of rape. Especially when it happens there in the community, they can sort from there. Sometimes it is worse they don’t even know the health status of that person who raped that person so they report at the center so that the appropriate procedures can be taken to go and check if that person is not sick or is sick and get first aid. Some issues like parents quarrelling they cannot bring to the center they resolve them at home.

4.5 Contextual factors influence on implementation of MHPSS

Contextual factors affect proper planning of a program. This is where needs assessment is done and the goals and objectives of the project are defined thus affects implementation of the program. Irregularities in this factors results to failure in implementation.

The respondents were asked to rate the statements about contextual factors.
Table 4.6 Contextual factors influence on implementation of MHPSS

<table>
<thead>
<tr>
<th>Statement</th>
<th>n</th>
<th>Min</th>
<th>Max</th>
<th>Mean</th>
<th>Std Dev.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Institutional support influence implementation of MHPSS program</td>
<td>41</td>
<td>2</td>
<td>5</td>
<td>2.9</td>
<td>1.053</td>
</tr>
<tr>
<td>Organizational infrastructure influence implementation of MHPSS program</td>
<td>41</td>
<td>1</td>
<td>5</td>
<td>3.5</td>
<td>0.978</td>
</tr>
<tr>
<td>Objectives, mission and goals influence implementation of MHPSS program</td>
<td>41</td>
<td>2</td>
<td>5</td>
<td>3.6</td>
<td>0.919</td>
</tr>
<tr>
<td>Policies, laws, regulations influence implementation of MHPSS program</td>
<td>41</td>
<td>1</td>
<td>5</td>
<td>3.9</td>
<td>1.053</td>
</tr>
</tbody>
</table>

Composite Mean: 3.475

Findings table 4.6 from the field reveal the composite mean to be 3.475. This therefore shows that institutional support does not influence implementation of MHPSS as shown with a mean of 2.9, organizational infrastructure influences implementation of MHPSS shown with a mean of 3.5, objectives mission and goals influence implementation of MHPSS expressed with a mean of 3.6 and policies, laws, regulations influences implementation of MHPSS shown by a mean of 3.9.

From the qualitative data collected through a review of monthly work plans, institutional support influences the implementation of MHPSS program there are usually weekly staff meetings and weekly group support programs conducted by the PSS Officer where the challenges and successes of the week are reviewed. Trainings are done to the PSS facilitators and CRC committee members on a regular basis to strengthen their capacity on MHPSS related issues. This is as per studies done by St Leger, (1999); Han and Weiss, (2005); Peters, et al., (2011). The study may disagree because sometimes the same challenges are discussed and it takes a while to resolve such challenges thus the discrepancies. Organization infrastructures such as storage facilities are necessary especially for storage of play equipment, daily reporting schedules, and referral forms among others that are confidential or needs more secure storage. The center has basic storage facilities though this has not hindered regular operations of the center since its
operations as opposed to studies done by Oku, et al., (2017). CRC’s mandate is in line with the objectives, missions and goals that influence implementation of MHPSS program. It is also in line with Kenya comprehensive school health policy (2016) and Kenya Mental Health policy (2015) which are in support of MHPSS program especially for children.

4.6 Input factors influence on implementation of MHPSS
The purpose was to establish whether input factors which are represented by the organizations capabilities influence its ability to meet program implementation goals. Statements on input factors were rated by the respondents focusing on their level of agreement on each of the following.

Table 4.7 Input factors influence on implementation of MHPSS

<table>
<thead>
<tr>
<th>Statement</th>
<th>n</th>
<th>Min</th>
<th>Max</th>
<th>Mean</th>
<th>Std Dev.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time allocation influence implementation of MHPSS program</td>
<td>41</td>
<td>2</td>
<td>5</td>
<td>3.7</td>
<td>1.063</td>
</tr>
<tr>
<td>Cost influence implementation of MHPSS program</td>
<td>41</td>
<td>1</td>
<td>5</td>
<td>3.2</td>
<td>1.249</td>
</tr>
<tr>
<td>No. of staff influence implementation of MHPSS program</td>
<td>41</td>
<td>2</td>
<td>5</td>
<td>3.2</td>
<td>1.054</td>
</tr>
<tr>
<td>Resource allocation influence implementation of MHPSS program</td>
<td>41</td>
<td>2</td>
<td>5</td>
<td>3.2</td>
<td>1.084</td>
</tr>
</tbody>
</table>

Composite mean 3.325

Findings shown in table 4.7 revealed a composite mean of 3.325 this indicates that time allocation per activity influences implementation of MHPSS program as shown with a mean of 3.7. Cost does not influences implementation by a mean of 3.2, Number of staff does not influence implementation by a mean of 3.2 and resource allocation does not influence implementation by a mean of 3.2.
Through the analysis of human and material resources, the ratio of staff per child is approximately 1:30 (one staff per 30 children) which is in line with UNHCR educational policy (2003) for developing countries thus agreeing with the study. Provision of materials is ongoing as per Brooker, et al., (2010); Mukoma, et al., (2009). This is not a constant measure thus might cause the difference between the quantitative and qualitative data. Recommended solutions, strategies and procedural designs as per their expert trainer include; Allocating time especially for children whose attention span is much less to 20-30 minutes per activity which PSS facilitators have been adopting. There is also having time for structured play and learning.

4.7 Process factors influence on implementation of MHPSS
The purpose of this objective was to establish whether process factors provide information that is needed for implementing plans and procedures of the program.

Statements on influence of process factors were rated by the respondents focusing on their level of agreement in each of the following tables.

Table 4.8 Process factors influence on implementation of MHPSS

<table>
<thead>
<tr>
<th>Statement</th>
<th>n</th>
<th>Min</th>
<th>Max</th>
<th>Mean</th>
<th>Std Dev.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participatory approach influence implementation of MHPSS program</td>
<td>41</td>
<td>2</td>
<td>5</td>
<td>3.9</td>
<td>0.889</td>
</tr>
<tr>
<td>Bottom-up approach influence implementation of MHPSS program</td>
<td>41</td>
<td>1</td>
<td>5</td>
<td>2.7</td>
<td>1.105</td>
</tr>
<tr>
<td>Tier level training influence implementation of MHPSS program</td>
<td>41</td>
<td>2</td>
<td>5</td>
<td>3.1</td>
<td>0.905</td>
</tr>
<tr>
<td>Integration of the program influence on MHPSS program</td>
<td>41</td>
<td>1</td>
<td>5</td>
<td>2.9</td>
<td>1.005</td>
</tr>
<tr>
<td><strong>Composite mean</strong></td>
<td></td>
<td></td>
<td></td>
<td><strong>3.15</strong></td>
<td></td>
</tr>
</tbody>
</table>

Findings shown in table 4.8 revealed a composite mean of 3.15. This indicate that participatory approach influences implementation of MHPSS by 3.9, bottom-up approach does not influences implementation by 2.7, Tier level training does not influence
implementation by 3.1 and integration of the program does not influence implementation of MHPSS by 2.9.

The study agrees with works of (Wasonga et al., 2014; Mukoma et al., 2009) that participatory approach influences implementation of MHPSS project. The staffs are involved in decision making such as preparations of psychosocial support time-table for children. The study has also agreed that bottom-up approach does not increase sustainability of the project. Level of education indicates that most do not have more than a certificate and as much as a lot of trainings are offered some decisions made require higher level of education. Guevel et al (2015) proposes a tier level of training which is being offered and has thus results to a better implementation of the MHPSS project. The study however suggests that tier level training has no correlation. The study also disagrees with Barry et al., (2013) that integration of MHPSS into other curriculum influences implementation. This could be due to the fact that the CRC incorporates other program into its curriculum but other programs have not fully incorporated MHPSS into its program.

4.8 Product factors influence on implementation of MHPSS

The purpose of this objective was to relate outcomes to objectives and to assess the overall worth of a procedure in terms of its effects.

Statements on influence of process factors were rated by the respondents focusing on their level of agreement in each of the following tables.
Table 4.9 Product factors influence on implementation of MHPSS

<table>
<thead>
<tr>
<th>Statement</th>
<th>n</th>
<th>Min</th>
<th>Max</th>
<th>Mean</th>
<th>Std Dev.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Instructional behavior influence on implementation of MHPSS program</td>
<td>41</td>
<td>2</td>
<td>5</td>
<td>3.2</td>
<td>0.892</td>
</tr>
<tr>
<td>Persistence in teaching influence on implementation of MHPSS program</td>
<td>41</td>
<td>2</td>
<td>5</td>
<td>3.5</td>
<td>1.002</td>
</tr>
<tr>
<td>Enthusiasm in health programs influence on implementation of MHPSS program</td>
<td>41</td>
<td>1</td>
<td>5</td>
<td>2.8</td>
<td>1.179</td>
</tr>
<tr>
<td>Staff commitment influence on implementation of MHPSS program</td>
<td>41</td>
<td>1</td>
<td>5</td>
<td>2.7</td>
<td>1.304</td>
</tr>
</tbody>
</table>

As per the opinions of the respondents shown in table 4.9, by a composite mean of 3.05, instructional behavior influences implementation of MHPSS program by 3.2, persistence in teaching influences implementation by 3.5, enthusiasm in health programs does not influence implementation by 2.8 and Staff commitment does not influence implementation of MHPSS program by 2.7.

The study agrees with the works of Han and Weiss, (2005) that instructional behavior that is how facilitators implement the MHPSS program has influenced success in the program. As per Brackett, et al., (2012) Socio Emotional learning has not been given more priority than academics thus showing need for persistence in providing MHPSS services which has resulted to a better outcome of the MHPSS program. Enthusiasm in health program and staff commitment also disagrees with the studies of Han and Weiss, (2005). This could be due to the fact that required scales are required to measure product factors for better results on their influence on implementation of MHPSS program.

4.9 Correlation analysis

The purpose of using correlation analysis was to determine the strength and direction of the relationship between the dependent variable and the independent variable. The assumption was that the data is normally distributed and also because the variables are continuous.
Table 4.10 Correlation analysis matrix

<table>
<thead>
<tr>
<th></th>
<th>Implementation of MHPSS program</th>
<th>Context factors</th>
<th>Input factors</th>
<th>Process factors</th>
<th>Product factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implementation of MHPSS program</td>
<td>Pearson Correlation</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sig. (2-tailed)</td>
<td>0.000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>41</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contextual factors</td>
<td>Pearson Correlation</td>
<td>0.362*</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sig. (2-tailed)</td>
<td>0.020</td>
<td>0.000</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>n</td>
<td>41</td>
<td>41</td>
<td>41</td>
<td></td>
</tr>
<tr>
<td>Input factors</td>
<td>Pearson Correlation</td>
<td>0.161</td>
<td>0.032</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sig. (2-tailed)</td>
<td>0.315</td>
<td>0.845</td>
<td>0.000</td>
<td></td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>41</td>
<td>41</td>
<td>41</td>
<td>41</td>
</tr>
<tr>
<td>Process factors</td>
<td>Pearson Correlation</td>
<td>0.147</td>
<td>0.556**</td>
<td>0.206</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Sig. (2-tailed)</td>
<td>0.358</td>
<td>0.000</td>
<td>0.197</td>
<td>0.000</td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>41</td>
<td>41</td>
<td>41</td>
<td>41</td>
</tr>
<tr>
<td>Product factors</td>
<td>Pearson Correlation</td>
<td>0.168</td>
<td>0.024</td>
<td>0.099</td>
<td>0.049</td>
</tr>
<tr>
<td></td>
<td>Sig. (2-tailed)</td>
<td>0.294</td>
<td>0.880</td>
<td>0.539</td>
<td>0.763</td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>41</td>
<td>41</td>
<td>41</td>
<td>41</td>
</tr>
</tbody>
</table>

*correlation is significant at the 0.05 level (2 tailed)

**correlation is significant at the 0.01 level (2-tailed)
From the table 4.10, context factors has a strong positive correlation with implementation of MHPSS program which is statistically significant at the 5% level of significance (r=0.362; p=0.02<.05). Input factors has a positive correlation with implementation of MHPSS program which is statistically significant at the 5% level of significance (r=0.161; p=0.315<.05). Process factors has a positive correlation with implementation of MHPSS program which is statistically significant at the 5% level of significance (r=0.147; p=0.358<.05). Product factors has a positive correlation with implementation of MHPSS program which is statistically significant at the 5% level of significance (r=0.168; p=0.294<.05).

From the findings all the variables were found to have a positive correlation with implementation of MHPSS program.
CHAPTER FIVE

SUMMARY OF FINDINGS, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction
This chapter deals with the summary of findings, discussion, conclusion and recommendations made on the factors influencing implementation of a Mental Health and Psychosocial Support program.

5.2 Summary of findings
To investigate the factors influencing implementation of Mental Health and Psychosocial Support program a census sample of 1 Psychosocial Support Officer, 10 Psychosocial Support facilitators and 30 Child Resource Center Committee members were used as respondents. Descriptive method of research was used and the research instruments were questionnaires and written documents. The study was conducted during the school year 2017-2018. The themes of the summary of findings have been formulated from the research objectives.

5.2.1 Contextual factors influence implementation of Mental Health and Psychosocial Support program
Of the 41 respondents, contextual factors influence implementation of MHPSS by a composite mean of 3.475. Institutional factors does not influence implementation of MHPSS by a mean of 2.9, organizational infrastructure influences by a mean of 3.5, objectives mission and goals influences by a mean of 3.6 and policies, laws, regulations influences by a mean of 3.9.

5.2.2 Input factors influence implementation of Mental Health and Psychosocial Support program
It was clear that input factors influence the implementation of MHPSS by a composite mean of 3.325. Time allocation per activity influences implementation of MHPSS program by a mean of 3.7, cost influences implementation does not influence by a mean of 3.2, Number of staff does not influence implementation by a mean of 3.2 and resource allocation does not influence implementation by a mean of 3.2
5.2.3 Process factors influence the implementation of Mental Health and Psychosocial Support program
Of the 41 respondents, process factors influence implementation of MHPSS by a composite mean of 3.15. That is participatory approach influences implementation of MHPSS by 3.9, bottom-up approach does not influence implementation by 2.7, Tier level training does not influence implementation by 3.1 and integration of the program does influence implementation of MHPSS by 2.9.

5.2.4 Product factors influence implementation of Mental Health and Psychosocial Support program.
Product factors influence the implementation of a MHPSS by a composite mean of 3.05. That is instructional behavior influences implementation of MHPSS program by 3.2, persistence in teaching influences implementation by 3.5, enthusiasm in health programs does not influence implementation by 2.8 and Staff commitment does not influence implementation of MHPSS program by 2.7.

5.3 Conclusion
Based on the findings and discussions, the following conclusions have been derived:

Low institutional support hinders implementation of MHPSS program whereas a high institutional support will strengthen its implementation. A strong organizational infrastructure has a positive effect on implementation of MHPSS program. Strong mission, visions and goals will promote implementation of MHPSS. Policies, laws and regulations highly affect implementation of MHPSS

Proper time allocation per activity will positively affect implementation of MHPSS program. Proper budgeting of fixed costs and recurrent costs will result to a successful MHPSS project. Enough staff will result to proper management of the project due to proper designation of tasks. Frequent and timely allocation of resources will result to successful implementation of MHPSS.

Use of participatory approach in implementation of MHPSS program will result to acceptance and sustainability of the program thus crucial factor. Bottom-up approach has a lower influence on implementation of MHPSS. Use of experts from international to local level for training will positively influence implementation of MHPSS program and
also integration of MHPSS program into other programs will positively influence its implementation.

Inconsistent or improper instructional behavior will inhibit proper implementation of MHPSS program. This also applies to lack of persistence, lack of enthusiasm and lack of commitment. It will result to poor implementation of MHPSS program.

5.4 Recommendations

1. It is recommended that similar researches should be conducted in other MHPSS intervention levels such as where counselling and specialized treatments are offered as this is limited to the intervention level of community and family support and focused non-specialized services.

2. Other non-humanitarian or emergency settings providing MHPSS program should also make inquiries on the status of their factors influencing its implementation so that in the case similar factors are experienced, concerted efforts should be made on how to minimize them.

3. Recommendations for language barrier in implementation of MHPSS in a refugee setting will be to offer non-formal educational activities like basic language lessons of the host country for ease in integration.

4. Age appropriate life skills learning should be integrated into the program after 6 months of operation for a better preventive approach to Mental Health and Psychosocial support.

5. Post implementation training should be done due to high levels of turnover staff probably due to repatriation or resettlement.

6. The study also recommends further research on Child Resource Centers that have been operational for more than 6 months on the same.
5.5 **Areas of further research**

1. The study was limited in researching on how Kalobeyei CRC has integrated other components into it MHPSS program, but has not looked into whether other areas have integrated MHPSS in their implementation thus an area for further research.

2. The study did not use recommended scales in measuring product factors due to limitations experienced thus use of scales may provide a more detailed analysis of product factors and influence of implementation of MHPSS program.
REFERENCES


Nyavanga, E. J., Barasa, M., Mmbone, I. C., & et al. (2016). Efficacy of Psychoedcation on Improving Attitudes Towards Professional Psychological Help Seeking for


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APPENDICES

Appendix 1: Questionnaire for Respondents

Section A: Demographic. Please answer the following questions

1. Job title

2. Age

3. Gender
   - [ ] Female; [ ] Male

4. Educational qualifications
   - [ ] Certificate ; [ ] Diploma
   - [ ] Degree;
   - [ ] More than Degree
   - [ ] No formal education

5. Number of years/months of experience in the CRC?
   - [ ] 0-6 months
   - [ ] more than 6 months

6. Number of years/months in the current position? _______ Years/months

Section B: Mental Health and Psychosocial Support

To what extent does availability of funding influence implementation of MHPSS in Turkana County?

- Very great extent [5]
- Neither small or great extent [3]
- Very small extent [1]


7. The following are statements that in relation to MHPSS services that are offered in Kalobeyei. Please tick where appropriate

<table>
<thead>
<tr>
<th>Statements</th>
<th>Very small extent</th>
<th>Small extent</th>
<th>Neither Small or great extent</th>
<th>Great extent</th>
<th>Very great extent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic services and security</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community and family support</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Focused non-specialized services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialized services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

8. What are the basic facilities provided to support the initiative?
9. What are the challenges in implementing MHPSS programs? (*list all you can*)

10. Who and what support is obtained from stakeholders on the MHPSS program? (*tick all that apply*)

<table>
<thead>
<tr>
<th>Actors</th>
<th>Financial</th>
<th>Materials</th>
<th>Training</th>
<th>Integration of services</th>
<th>Security</th>
<th>Other (Specify)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Government</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NGOs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parents</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health workers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private Companies</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Section C: Contextual factors**

11. The following are statements that in relation to contextual factors that influence the implementation of MHPSS program. Please tick where appropriate

<table>
<thead>
<tr>
<th>Statements</th>
<th>Very small extent</th>
<th>Small extent</th>
<th>Neither Small or great extent</th>
<th>Great extent</th>
<th>Very great extent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support from institutions influences implementation of MHPSS program</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Organizational infrastructure influences the implementation of MHPSS program</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Goals and objectives of the organization influences the implementation of MHPSS

Institutional policies influence implementation of program

12. In your own opinion how does contextual factors influence implementation of MHPSS program

**Section D: Input factors**

13. What learning activities do you have at the CRC?

14. How many hours per week are set for learning in MHPSS program?

15. What is the ratio of staff per child?

16. The following are statements in relation to input factors that influence implementation of MHPSS program. *(Please tick where appropriate)*

<table>
<thead>
<tr>
<th>Statements</th>
<th>Very small extent</th>
<th>Small extent</th>
<th>Neither Small or great extent</th>
<th>Great extent</th>
<th>Very great extent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost benefit analysis</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ratio of staff per child</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Class teaching time allocated</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resource allocation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

17. In your own opinion how does input factors influence implementation of MHPSS program?
Section E: Process factors

18. What type of training would you suggest for a MHPSS program and why?

<table>
<thead>
<tr>
<th>Statements</th>
<th>Very small extent</th>
<th>Small extent</th>
<th>Neither Small or great extent</th>
<th>Great extent</th>
<th>Very great extent</th>
</tr>
</thead>
<tbody>
<tr>
<td>International</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>National</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Local</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All levels</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

19. What would you consider as the suitable method of delivery of a MHPSS program?

<table>
<thead>
<tr>
<th>Method of delivery</th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>As a stand-alone program</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In health curriculum courses</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>As an extra curriculum course</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Integrated in other programs</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

20. Have the health programs been monitored and evaluated?

21. How are the programs evaluated?
   - (i) None (no evaluation)
   - (ii) Informal evaluation, based on feedback
   - (iii) Administering a survey to get feedback
   - (iv) Recording the number of participants
   - (v) Focus Group Discussion

22. The following are statements in relation to process factors that influence implementation of MHPSS program. Please tick where appropriate

<table>
<thead>
<tr>
<th>Statement</th>
<th>Very small extent</th>
<th>Small extent</th>
<th>Neither Small or great extent</th>
<th>Great extent</th>
<th>Very great extent</th>
</tr>
</thead>
</table>
There is evaluation and monitoring of the MHPSS program

There is a bottom top approach to the implementation process of MHPSS program

There is a participatory approach towards implementation of a MHPSS program

Mental health educational program is integrated in the psychosocial support implementation model

Section F: Product factors

23. The following are statements that in relation to product factors that influence MHPSS program. Please tick where appropriate

<table>
<thead>
<tr>
<th>Statement</th>
<th>Very small extent</th>
<th>Small extent</th>
<th>Neither Small or great extent</th>
<th>Great extent</th>
<th>Very great extent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Instructional behavior influence on implementation of MHPSS program</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Persistence in teaching influence on implementation of MHPSS program</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enthusiasm in health programs influence on implementation of MHPSS program</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff commitment influence on implementation of MHPSS program</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix 2: Consent/assent explanation and consent form

I, Irene Masitsa Mulunda, Masters student in Project Planning and Management from the University of Nairobi, wish to conduct a study on factors influencing the implementation of a Mental Health Psychosocial Support program.

This study aims to provide information on implementation of preventive MHPSS program. The research will be carried out under the supervision of Dr. Stephen Luketero, Senior lecturer from the Department of Mathematics in the University of Nairobi.

There will not be any payment to take part in the study but as participant you will enable the possibility of increased intervention levels to early, preventive measures of mental illness.

Thank you very much.

Yours sincerely,

Irene Mulunda
Masters of Arts Project Planning and Management
University of Nairobi
Tel. 0720526765
Appendix 3: Assent by study participants

I …………………………………………………………………having been explained the nature of the study by Irene Mulunda, P. O. Box 48949-00100, Nairobi, Tel. 0720526765, as detailed in the assent explanation, do hereby give assent to participate in the study. I understand I can withdraw from participation any time before the data collection is over without penalties or victimization.

Name:

Signature:

Date:
Appendix 4: Research permit from NACOSTI

THE SCIENCE, TECHNOLOGY AND INNOVATION ACT, 2013

The Grant of Research Licenses is guided by the Science, Technology and Innovation (Research Licensing) Regulations, 2014.

CONDITIONS
1. The License is valid for the proposed research, location and specified period.
2. The License and any rights thereunder are non-transferable.
3. The Licensee shall inform the County Governor before commencement of the research.
4. Excavation, filming and collection of specimens are subject to further necessary clearance from relevant Government Agencies.
5. The License does not give authority to transfer research materials.
6. NACOSTI may monitor and evaluate the licensed research project.
7. The Licensee shall submit one hard copy and upload a soft copy of their final report within one year of completion of the research.
8. NACOSTI reserves the right to modify the conditions of the License including cancellation without prior notice.

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Tel: 020 400 7800, 0713 705787, 0733 804245
Email: dg@nacosti.go.ke, registry@nacosti.go.ke
Website: www.nacosti.go.ke

RESEARCH LICENSE
Serial No. A 20727

CONDITIONS: see back page

THIS IS TO CERTIFY THAT:
MS. IRENE MASITSA MULUNDA
of UNIVERSITY OF NAIROBI, 300-100
Nairobi, has been permitted to conduct research in Turkana County
on the topic: FACTORS INFLUENCING IMPLEMENTATION OF A MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT PROGRAM. A CASE OF KALOBEYI INTEGRATED SETTLEMENT CHILD RESOURCE CENTER, TURKANA COUNTY, KENYA
for the period ending:
20th September, 2019

Applicant’s Signature

Permit No.: NACOSTI/P/18/93311/25211
Date of Issue: 21st September, 2018
Fee Received: Ksh 1000