REPUBLIC OF KENYA

MINISTRY OF HEALTH

A NATIONAL HANDBOOK GUIDE

FOR INTEGRATION OF MENTAL HEALTH SERVICES INTO MATERNAL AND CHILD HEALTH SERVICES FOR PREGNANT ADOLESCENTS

Division of Reproductive, Maternal, Newborn, Child and Adolescent Health
Every Life Counts

2025

Suggested citation:
Ministry of Health, a national handbook guide for integration of mental health services into maternal and child health services for pregnant adolescents.
Nairobi, January 2025.

Published by:
Division of Reproductive, Maternal, Newborn, Child and Adolescent Health. Ministry of Health
PO BOX 43319-00100 Nairobi, Kenya.

TABLE OF CONTENTS

Foreword

The development of this National Handbook Guide for Integration of Mental Health Services into Maternal and Child Health services for Pregnant Adolescents (2025) embodies the Ministry of Health commitment to improve maternal mental health. It also marks a significant advancement in the Ministry's efforts to improved maternal and newborn health outcomes through the implementation of High Impact Interventions.

The 2022 Kenya Demographic and Health Survey (KDHS) findings showed that the national prevalence of teenage pregnancy was 15%, posing a significant public health concern. Pregnant adolescents are faced with complex challenges that impact their mental health and overall quality of life. Some of the mental health conditions such as depression, anxiety, low self-esteem, alcohol and substance use and trauma are common among pregnant adolescents, but often go undiagnosed or untreated due to stigma, limited awareness, low health care provider capacities and inadequate access to care.

Perinatal mental health services for women and pregnant adolescents have been incorporated into the National MNH Continuum of Care (COC) package (2025) which is designed to ensure a holistic approach to maternal and newborn health from preconception, antenatal care, labour and birthing and postnatal period by optimizing health outcomes for both the mother and the newborn, promoting healthy pregnancies, and supporting the overall well-being of families. The integration of mental health services into MCH services will ensure pregnant adolescents receive comprehensive mental health support, enhance emotional resilience and empower them to lead healthier lives and in turn contribute to improved maternal and newborn health outcomes.

This Handbook is aligned with the World Health Organization (WHO) Guide for integration of perinatal mental health in maternal and child health services 2022 and it integrates the latest evidence for promotion of maternal mental health, prevention and screening/early detection of the common mental health disorders. It also emphasizes on the holistic and integrated approach to address the intersectionality of adolescent pregnancy and mental health challenges to improve the health outcomes of pregnant adolescents and the wellbeing of their children.

This Handbook is a critical resource for healthcare providers, policymakers, programmers and stakeholders involved in maternal, newborn, child and adolescent health. It provides clear guidelines for integrating adolescent-friendly mental health care and services into antenatal, labour & birthing, postnatal care services including community support. This handbook aims to strengthen the capacity of health system to deliver adolescent-responsive mental health services.

It is my sincere hope that all stakeholders including healthcare institutions and practitioners will utilize this handbook as a guiding tool for strengthening mental health services within maternal, child and adolescent healthcare service delivery points. Through collaborative efforts, we can create a supportive environment where no pregnant adolescent is left behind in accessing the care they deserve.

Dr. Patrick Amoth, EBS

Director General of Health

Acknowledgements

The development of the National Handbook Guide for Integration of Perinatal Mental Health Services into Maternal Child Health services for Pregnant Adolescents (2025) was as a result of the concerted efforts of several individuals and organizations. It was developed through a highly consultative process involving a wide range of stakeholders, including National and County Government, donor representatives, implementing partners, and technical experts from different organizations. The process involved key informant interviews, analysis of various national policies and guidelines, researches conducted on perinatal maternal health to identify key strategies, approaches, best practices, challenges and possible mitigation measures which formed the basis of this handbook.

The Ministry of Health would like to acknowledge the leadership and guidance of Dr. Serem Edward, Ag. Head, Division of Reproductive, Maternal, Newborn, Child and Adolescent Health for conceptualizing and spear heading the process. The Ministry would specifically like to thank Dr. Jeanne Patrick, Head-RMNH Section for leading the development process. Special thanks to Dr. Albert Ndwiga, Dr. Juliet Omwoha, Head-NCH Section, Dr. Christine Wambugu, Head-AH Section, Dr. Catherine Waweru, Dr. Janet Muia, Jane Koech, Karen Aura, Hellen Mutsi, Janet Mogire, Scolastica Wabwire, Dr. Laura Oyiengo and Naomi Ida Onyango for their valuable inputs and support to the development process. Our appreciation goes to the lead consultant Dr. Albino Luciani who led this process to its successful completion.

My sincere gratitude is extended to the RMNH TWG, Mental Health TWG members, County Health Managements Team (CHMT) representatives and Health Care Providers from Kilifi, West Pokot, Kisumu and Nairobi for their valuable input in the development process.

I also acknowledge UNICEF, White Ribbon Alliance (WRA), CHAK, KUTTRH, Tabasamu Cafe Pangani Clinic, African Gender & Media Initiative Trust (GEM TRUST), A360: PS Kenya, Breakthrough Action, TIKO Africa and NIGEE for providing technical support that made the development of this handbook possible.

A special mention goes to the editorial team that comprised of Dr. Jeanne Patrick, Dr Albino Luciani and Angelo Mwicuiri.

Lastly, I wish to thank UNICEF for the technical and financial support in the development of this National Handbook Guide for Integration of Mental Health Services into Maternal Child Health services for Pregnant Adolescents (2025).

Dr. Issak Bashir

Ag. Director, Directorate of Family Health

Acronyms

ADHD	Attention Deficit Hyperactivity Disorder
ANC	Antenatal Care
ART	Antiretroviral Therapy
ASRHR	Adolescent Sexual Reproductive Health Rights
AYFS	Adolescent and Youth Friendly Services
AYSRH	Adolescent and Youth Sexual and Reproductive Health
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CHPs	Community Health Promoters
CME	Continuous Medical Education
FGM	Female Genital Mutilation
GAD	Generalized Anxiety Disorder
GBV	Gender Based Violence
HCPs	Health Care Providers
HCW	Health Care Worker
HIV	Human Immunodeficiency Virus
IEC	Information Education and Communication
IFAS	Iron and Folic Acid Supplements
IPC	Infection Prevention and Control
IPV	Intimate Partner Violence
KDHS	Kenya Demographic and Health Survey
KHIS	Kenya Health Information Systems
KMC	Kangaroo Mother Care
KPIs	Key Performance Indicators
LLITN	Long-Lasting Insecticide-Treated Nets
LMICs	Low and Middle Income Countries
MCH	Maternal and Child Health
MHPSS	Mental Health and Psychosocial Support
MOE	Ministry of Education
MOH	Ministry of Health
NCDs	Noncommunicable Diseases
NHIF	National Health Insurance Fund
OJT	On-Job Training
OVC	Orphan Vulnerable Children
PHQ	Patient Health Questionnaire
PID	Pelvic Inflammatory Disease
PMTCT	Prevention of Mother-To-Child Transmission
PNC	Postnatal Care
POCU	Point of Care Ultrasound
PTA	Parents Teacher Association
PTSD	Post Traumatic Stress Disorder
SGBV	Sexual and Gender Based Violence
SHIF	Social Health Insurance Fund
SRHR	Sexual Reproductive Health Rights
STIs	Sexually Transmitted Infections
UTI	Urinary Tract Infection
VCAT	Value Clarification and Attitude Transformation
WASH	Water Sanitation and Hygiene
WHO	World Health Organization
YFS	Youth Friendly Services

Definition of Terms

Mental health	A state of emotional, psychological, and social well-being affecting how individuals think, feel, and behave.
Psychosocial support	Interventions that address emotional and social needs to promote mental well-being.
Emotional well-being	The ability to manage emotions, cope with stress, and maintain a positive outlook.
Adolescent pregnancy	Pregnancy occurring in individuals aged 10-19 years, often associated with health and social risks.
Maternal health	The well-being of a mother before, during, and after childbirth.
Reproductive health	A state of physical, mental, and social well-being in all matters related to the reproductive system.
Antenatal care (ANC)	Health services provided during pregnancy to ensure the well-being of the mother and baby.
Postnatal care (PNC)	Healthcare provided to the mother and newborn after childbirth.
Continuum of care	A coordinated process ensuring continuous and comprehensive healthcare services.
Sexual and reproductive health (SRH)	Services related to contraception, pregnancy, and sexually transmitted infections (STIs).
Gender-based violence (GBV)	Harmful acts directed at individuals based on their gender, affecting mental and physical health.
Teenage motherhood	The experience of being a mother during adolescence, often requiring tailored health interventions.
Self-care	Practices that promote mental and physical well-being, including rest, nutrition, and seeking support.
Integrated healthcare	A coordinated approach that combines mental health services with maternal and adolescent health care.
Referral pathways	Systems that ensure pregnant adolescents receive specialized mental health services when needed.
Multi-sectoral approach	Collaboration between different sectors (health, education, social services) to improve mental health care.
Key performance indicators (KPIs)	Measurable values used to evaluate the success of mental health integration efforts.

1. Introduction

1.1 Background to the Guide

Adolescent pregnancy is a significant public health concern in Kenya, with a national prevalence of 15% according to the 2022 Kenya Demographic and Health Survey (KDHS). These young mothers face a multitude of challenges, including social stigma, lack of emotional support, and limited access to healthcare. Research highlights a strong link between adolescent pregnancy and mental health issues. This increased vulnerability can be attributed to various factors, including stress of pregnancy and parenthood where young mothers may experience anxieties about their ability to care for a child, financial burdens, and changes to their bodies and education, social stigma, and isolation as well as history if trauma and abuse (Fortin-Langelier & Daigneault, 2022).

Early pregnancy increases the risk of negative mental health issues, such as depression, substance abuse, and post-traumatic stress disorder (Jia *et al., 2022;* Howard & Khalifeh, 2020). Additionally, adolescent pregnancy and motherhood are linked to stigma, discrimination, gender inequities, and the derailment of educational aspirations (Osok *et al.*, 2018; Tele *et al.,* 2022; Kumar *et al.,* 2018). Adolescents who are pregnant or recently gave birth are more prone to experiencing depression than their non-pregnant peers. The prevalence of depression in pregnant adolescents varies with a higher prevalence reported in low- and middle-income countries as compared to high-income countries (Mitchell *et al.,* 2023; Wang *et al.,* 2021; Mutahi *et al.,* 2022, Kumar et al, 2020). The rate of depression among pregnant adolescents may be higher because many are not screened for symptoms of depression or are unaware of perinatal depression.

1.2 Outline of the Guide

Chapter 1 of the guide provides an introduction, outlining the background, purpose, and intended users of the guide. Chapter 2 delves into the adolescent pregnancy and mental health context, covering sexual and reproductive health rights, prevalence, risk factors, common adolescent mental health issues, and cross-cutting concerns. Chapter 3 examines existing services available for pregnant adolescents, including mental health services, and outlines the continuum of adolescent health services. Chapter 4 discusses response and implementation strategies, while Chapter 5 focuses on monitoring, evaluation, and learning.

1.3 Purpose and use of the Guide

The guide is intended to be used to develop and sustain high quality mental health services by improving Service Delivery and Access. The guide provides a standardized approach to identifying, screening, and addressing mental health needs of pregnant adolescents across all antenatal care (ANC), Maternal and child health (MCH) and postnatal care (PNC) facilities within the MOH system. This ensures all healthcare providers have the knowledge and tools to offer effective mental health support. Further, by integrating mental health into existing programs, the handbook raises awareness among healthcare providers about the vulnerability of pregnant adolescents to mental health issues. This can lead to earlier identification and intervention.

The handbook can guide healthcare providers on available resources for pregnant adolescents, including referrals to community-based mental health services and support groups. Moreover, the handbook aims to enhance the quality of care for pregnant adolescents through the provision of holistic Care. Integrating mental health into the MOH continuum of care acknowledges the complex needs of pregnant adolescents. It ensures their physical and mental wellbeing are addressed simultaneously, leading to better overall health outcomes for both mother and baby. Also, the handbook can equip healthcare providers with communication strategies

to create a safe and supportive environment for pregnant adolescents to discuss their mental health concerns. This can empower them to seek help and improve their coping mechanisms. By normalizing mental health screenings and support within ANC, MCH, and PNC services, the handbook can help reduce the stigma surrounding mental health issues. This encourages more pregnant adolescents to seek the help they need. In essence, the national handbook serves as a roadmap for integrating mental health into existing programs, ultimately leading to improved service delivery, increased access to care, and better health outcomes for pregnant adolescents in Kenya.

1.4 Users of the Guide

This guide is intended primarily for healthcare providers delivering services to adolescents. These include medical doctors, nurses, clinical officers, counselors, psychologists, pharmacists, nutritionists, and medico-legal experts.

2. Adolescent pregnancy and mental health in context

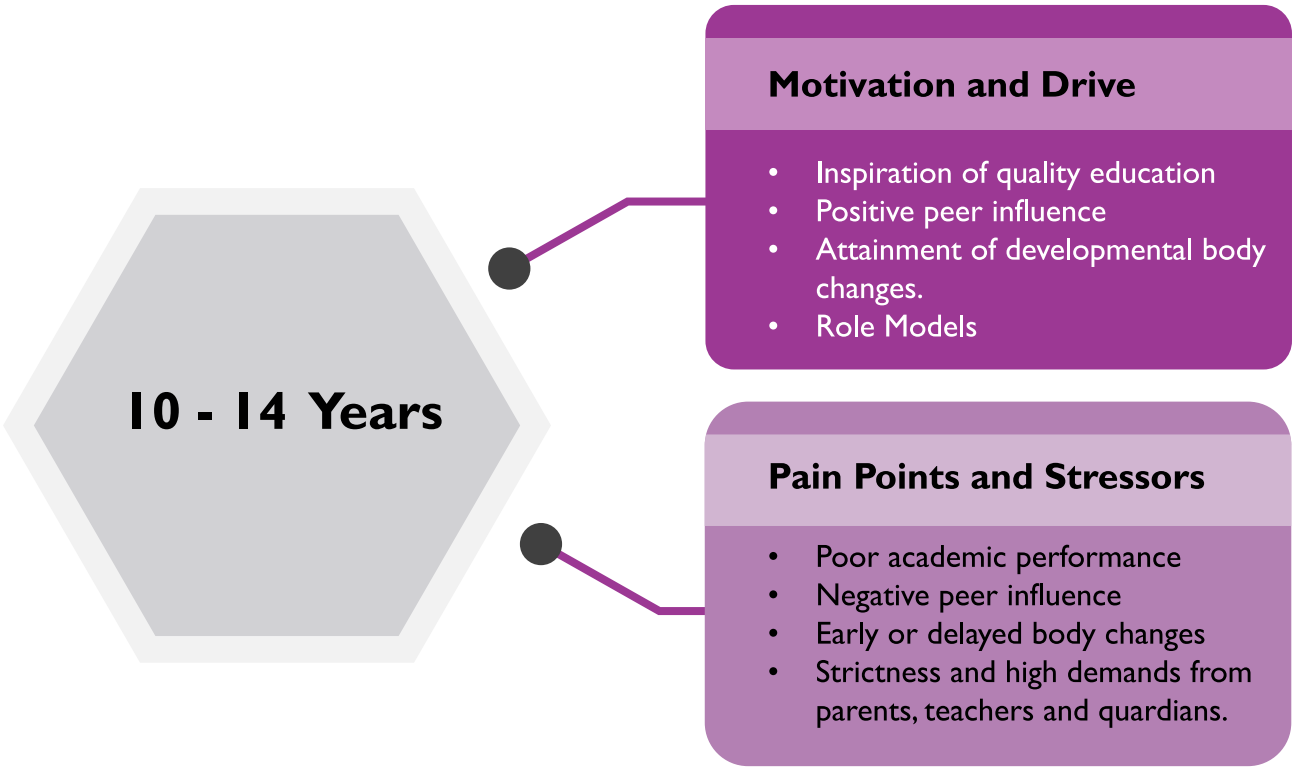
2.1 Adolescent persona

Adolescence is the transitional period between childhood and adulthood ranging from 10-19 years characterized by distinct developmental milestones and challenges (WHO, 2022). It is broadly categorized into early adolescence ranging from 10-14 years; mid adolescence from 15-17 years and; late adolescence between 18-19 years (Kenya APOC Guidelines 2015, Guide for integration of perinatal mental health in maternal and child health services, WHO, 2022). In Kenya, the legal adult age is 18 years (Constitution of Kenya, 2010). For the purposes of this guide, the Kenya APOC age classification has been adopted.

Adolescents experience the onset of puberty when hormonal fluctuations leading to physical cognitive and psychosocial growth are experienced. This affects how they feel ,think, make decisions and interact with the world around them (Guide for integration of perinatal mental health in maternal and child health services, WHO, 2022).

The Should be: Motivation, drives, pain points and stressors for adolescent ages 10-14 year old both boys and girls are summarized below;

Figure 1: Adolescents ages 10-14 years (Girls & Boys)



Addressing the needs of pregnant adolescents aged 10-14 through the lens of Maslow's hierarchy highlights the importance of a supportive and nurturing environment that goes beyond basic physiological needs. Each level of the pyramid builds upon the previous, suggesting that holistic support is essential for the well-being and development of both the adolescent mother and her child.

Figure 2: Maslow's hierarchy addressing the aspiration and needs for pregnant girls(10-17 years)

Pain points and challenges for pregnant adolescents

Pregnant adolescents encounter many challenges that influence their mental health and well-being as highlighted in the figure below.

Figure 3; Pain and challenges for pregnant adolescent 10-14 years

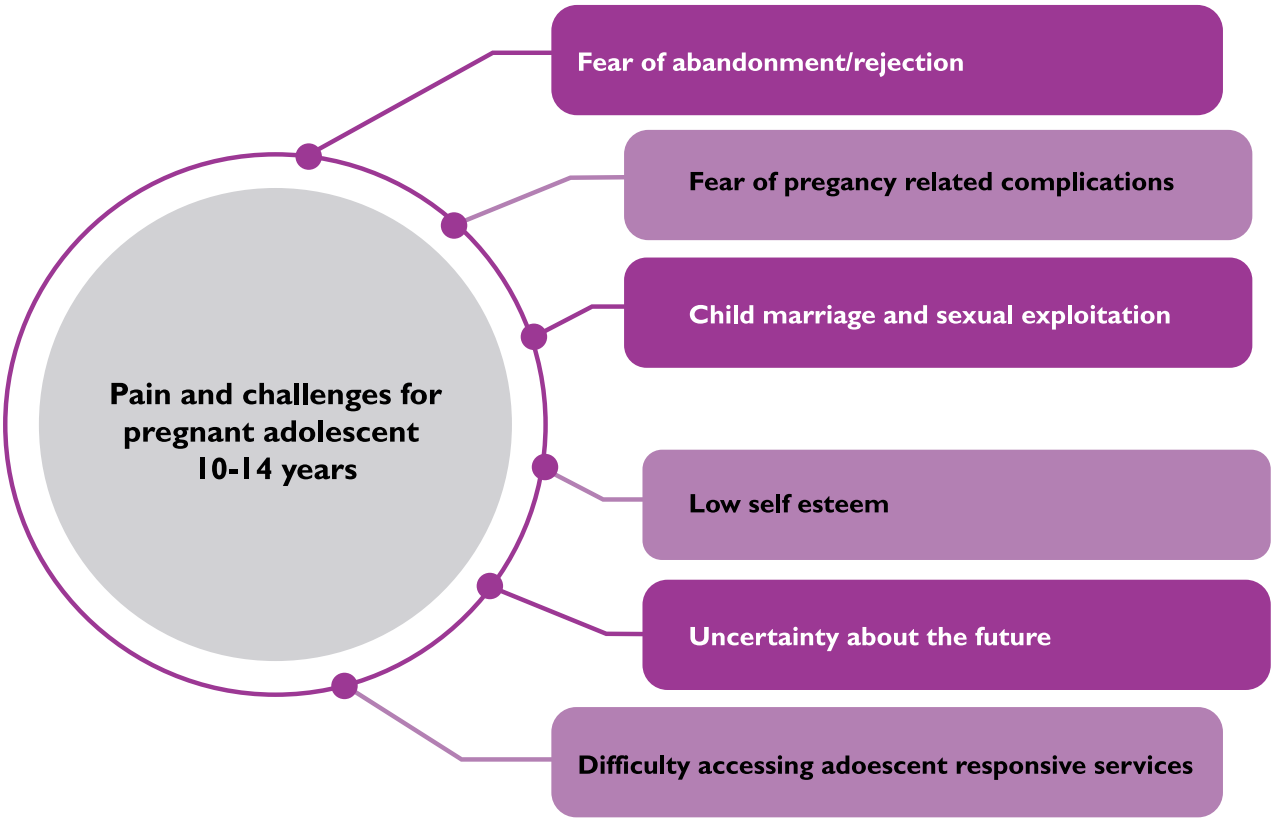
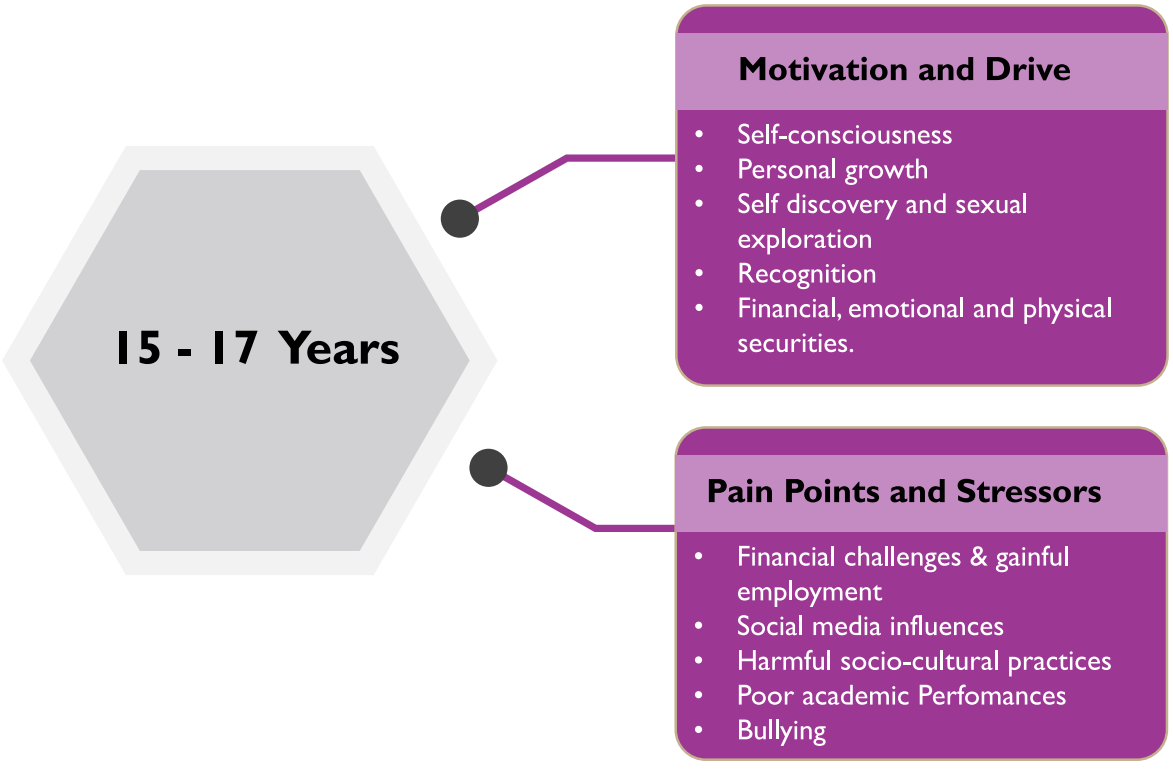


Figure 4: Motivation, drive pain and stressors for 15-17 years adolescents :



Aspiration and needs for pregnant girls

For pregnant girls their aspirations include;

- Expectation of a positive outcome for them and their babies,
- Support system,
- Proving the society wrong
- Parental care for their babies.

The young fathers aspire;

- Have a healthy baby and mother
- Having a support system
- Giving the best parental care to the baby.
- Prove the society wrong and continuity of their family lineage

b. Stressors & challenges for adolescents

Stressors and Challenges pregnant adolescent girls	Young fathers are worried about:
• Body changes as a result of the pregnancy, • Stigma and discrimination, • Social status change, • Interruption of schooling and its impact on their life trajectory. • They also worry about achieving their goals • How to handle the added responsibility • Negative naming of their children.	• Change in social status, • Added responsibilities • Stigma and discrimination. • Possible legal consequences of impregnating a minor, • Forced marriages and adoption as a result of the pregnancy • Physical and mental abuse.

Adolescents ages 18-19 years

Adolescents in this category, while still experiencing pubertal developmental changes, are legally adults and are capable of making independent decisions.

b. Figure 5: Below highlights the motivation, drives, pains and stressors adolescents ages 18-19 years go through

Aspiration and needs for pregnant girls

For pregnant adolescents aged 18-19, Maslow's hierarchy underscores the importance of a holistic approach that not only addresses basic physiological and safety needs but also fosters emotional support, self-esteem, personal growth, and fulfillment.This helps ensure that they can transition into motherhood and adulthood with confidence and adequate support.

Figure 6:

Young fathers aspirations

They aspire;

- To pursue their career aspirations
- Completion of their education,
- Freedom and self autonomy
- Financial freedom
- Meaningful relationships and friendships
- Curiosity and need to experiment
- Create identity and sense belonging
- Involved in their child's life and be a support system for the mother and the baby.

Pregnant adolescents 18 -19 year in this age bracket aspire;

- To complete their education and pursue their career aspirations,
- Find love and meaningful friendships
- Financial independence.
- Sense of belonging and identity
- Support and acceptance
- Baby shower and baby bump shoots

Figure 7: **Challenges for pregnant adolescents**

Physiological body change
Financial Challenges
Relationship challenges with baby daddy's
Delivery, birth process & postnatal stress
Abandonment
Dropping out of school
GBV
Abandonment by religious organizations.

Financial Challenges
Legal Issues
Lack of adequate information
Burden of added responsiblities
Self Stigma

2.1 Adolescent Pregnancy: prevalence and risk factors

Prevalence of Adolescent Pregnancy

Adolescent pregnancy is a significant public health concern in the country with notable prevalence rates and several risk factors contributing to this issue. Globally the adolescent birth rate for girls 10–14 years in 2022 was estimated at 1.5 per 1000 women with higher rates in sub-Saharan Africa (4.6) and Latin America and the Caribbean (2.4) (WHO, 2022). As of 2019 adolescents aged 15–19 years in low- and middle-income countries (LMICs) had an estimated 21 million pregnancies each year, of which approximately 50% were unintended and which resulted in an estimated 12 million births (Sully, *et al*, 2019, Darroch *et al*,2016). Africa has a higher proportion of adolescents and young people compared to any other continent; and adolescent pregnancy rates are therefore likely to increase further in countries in Sub-Saharan Africa (Maharaj, 2022).

According to KDHS 2022, there was a decline in teenage pregnancy from 18% in 2014 to 15% in 2022 which translates to roughly 1 in every 7 girls.. Adolescent pregnancies are also more likely to occur among poor communities, as 21% of women aged 15-19 in the lowest wealth quantile reported to have been pregnant, as compared to 8% in the highest wealth quantile. The prevalence varies across counties, with some areas having significantly higher rates.(Mutea et al, 2022). The highest rates of teen pregnancy were recorded in the counties of Samburu (50%)West Pokot (36%) Marsabit (29%), and Narok (28%) Nyeri and Nyandarua counties reported the lowest rates at 5% each.

Risk Factors for Adolescent Pregnancy

Adolescent pregnancy in Kenya is influenced by several key factors, including:

Limited access to Education

Limited access to education is a well-established risk factor for adolescent pregnancy. Studies consistently show a negative correlation between educational attainment and adolescent pregnancy rates (Kumar *et al*, 2018, Mang'atu & Kisimbii, 2019). This means that girls with lower levels of education are more likely to become pregnant as adolescents compared to those with higher levels of education. Education equips young women with knowledge about sexual health and reproduction , life skills, and creates economic opportunities that empower young women to navigate potentially risky situations and delay childbearing until they are prepared. Comprehensive sexual and reproductive health education provides adolescents with the information and skills to make informed choices about their bodies and sexuality. Early Poverty and socioeconomic disadvantage are key factors that contribute to adolescent pregnancy Poverty can limit access to education, healthcare, and family planning services. It can lead to stressors such as crowded living conditions, lack of privacy, family dysfunction and pressure to contribute financially which lead to risky behaviors such as early sexual activity, transactional sex and early marriage, (Maharaj, 2022, Mang'atu & Kisimbii, 2019).

Harmful socio-cultural practices

Certain cultural practices, such as child marriage and female genital mutilation (FGM), can increase a girl's vulnerability to sexual activity and pregnancy at a young age. In communities that promote these harmful practices there is normalization of child marriages which increases the risk of adolescent pregnancy. Child marriages often limit a girl's control over their bodies and reproductive choices which is further exacerbated by the cultural expectations of childbearing within marriages creating pressure for the young women to get pregnant.

Gender-based violence (GBV)

Gender inequality and gender-based violence (GBV) are deeply entrenched issues that significantly contribute to teenage pregnancy rates. Social norms that emphasize girls' roles as mothers and caregivers can perpetuate early childbearing. The financial dependence on men and families can make it difficult for young girls to resist unwanted sexual advances or negotiate safer sex practices creates a vicious cycle that increases the vulnerability of adolescent pregnancies and GBV .

Early sexual debut

Early sexual debut contributes to negative outcomes among adolescents including unwanted pregnancies. Young people who initiate sexual activity early may not have received comprehensive sex education thus have a limited understanding of their ovulation cycles and fertile windows and lack awareness of safe sex practices essential for protecting one's health and preventing pregnancy. This, coupled with limited access to contraception, increases the risk of unintended pregnancy.

Research suggests a link between adolescent pregnancy and mental health challenges (Sánchez-SanSegundo, *et al*, 2022, Karle *et al*, 2023). The relationship between mental health and adolescent pregnancy is complex and multifaceted. While mental health challenges can increase the risk of pregnancy, pregnancy itself can also negatively impact mental well-being. Adolescents struggling with depression or anxiety may be more likely to engage in risky sexual behaviors, including unprotected sex, to cope with negative emotions. Moreover, low self-esteem can make young people more susceptible to peer pressure or manipulation, leading to unwanted sexual activity and increased risk of pregnancy. By working on these factors, Kenya can create a more supportive environment for adolescent girls, enabling them to make informed choices about their sexual health and reproductive future.

2.3 Adolescents' sexual reproductive health rights including mental health.

Adolescents' sexual reproductive health rights (SRHR), including mental health, are fundamental human rights that are recognized internationally and enshrined in various legal and policy frameworks. Globally, the Universal Declaration of Human Rights under article 3 right to life and article 16 right to family, and article 25 right to health forms the foundation of Adolescents sexual reproductive health (United Nations General Assembly. The Universal Declaration of Human Rights (UDHR). New York: United Nations General Assembly, 1948) The United Nation Convention on the Rights of the Child describes adolescence as "a unique defining stage of human development characterized by rapid brain development and physical growth, enhanced cognitive ability, the onset of puberty and sexual awareness and newly emerging abilities, strengths and skills. It addresses the right of the child to the highest attainable standard of health, including sexual and reproductive health rights in Article 24. (Committee on the Rights of the Child, General comment No. 20 (2016) on the implementation of the rights of the child during adolescence.)

Mental Health being a growing public health concern and priority, WHO developed a Mental health, human rights, and legislation: guidance and practice to guide countries in adopting and implementing legislation related to mental health, which support the provision of high-quality care and support for all, in line with the international human rights standards.

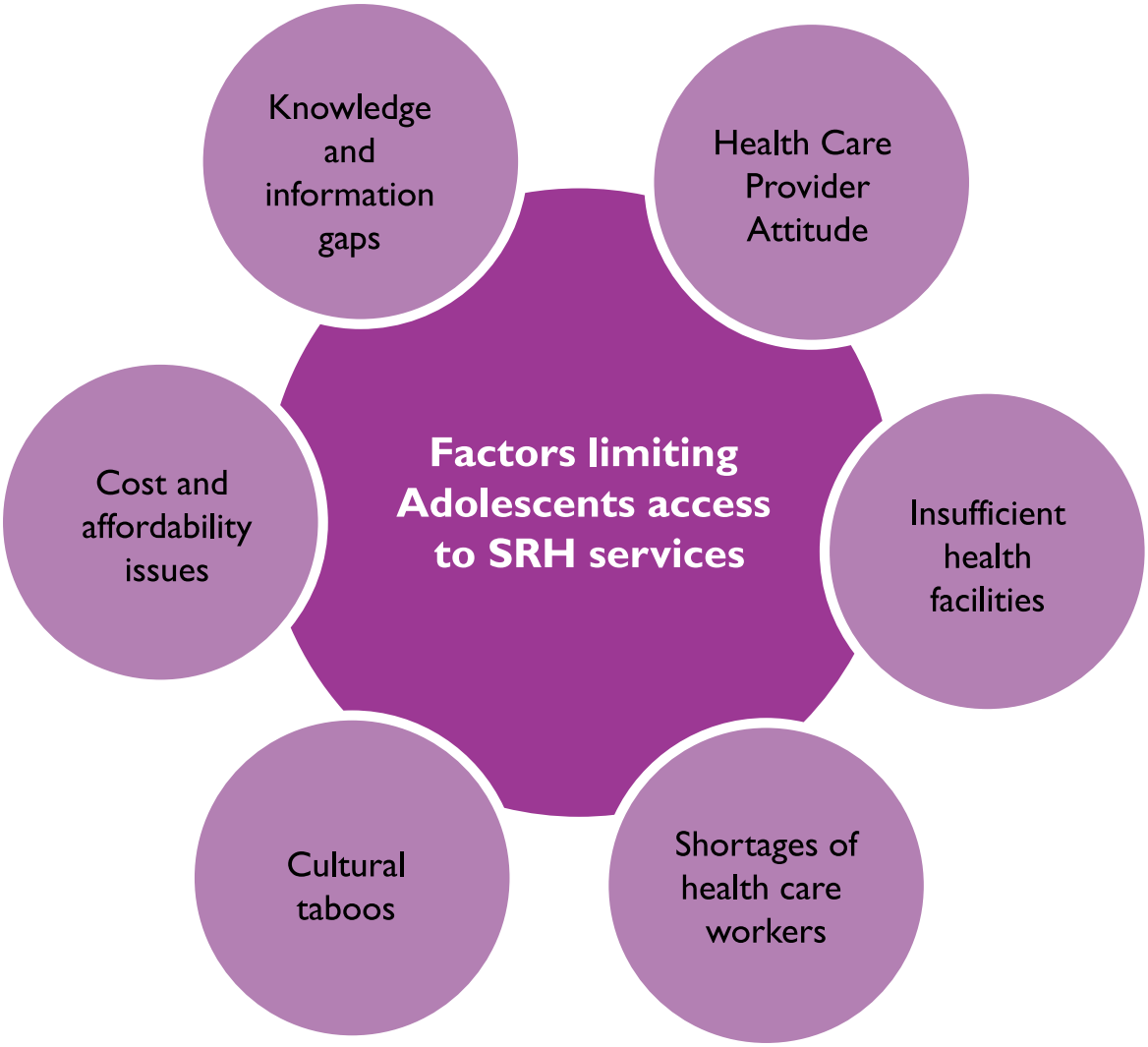
WHO also developed the Comprehensive Mental Health Action Plan 2013–2030, with revised indicators, options for implementation and updated global targets. The action plan objectives include more effective leadership and governance for mental health; support provision of comprehensive, integrated mental health and social care services in community-based settings; implementation of strategies for promotion and prevention; and strengthened information systems, evidence, and research.

Kenya has relatively made efforts to create a conducive legal and policy environment for the provision of adolescent sexual reproductive health rights. The Constitution of Kenya 2010 provides an overarching legal framework under Article 43(1) the bill of rights guarantees the right to the highest attainable standard of health including reproductive health. Further, the Kenya Health Policy, 2012 – 2030 provides direction on provision of highest possible standards of health, in a manner responsive to the needs of the population. Further, the National Adolescent Sexual and Reproductive Health Policy (2015) provides a framework for ensuring adolescents' access to confidential, youth friendly ASRH services that meets their SRH needs. The National Reproductive Health Policy 2022 – 2032 was developed to consolidate the gains achieved during the previous policy period and address the emerging challenges in reproductive health of the six RH operational life course cohorts including adolescence (10 to< 18 years).

Due to the increasing prevalence of teenage pregnancies the National Council for Population and Development in 2021, developed the Action Plan for Addressing Adolescent Health and Teenage Pregnancy in Kenya to provide a plan with processes and investments required in addressing adolescent health and teenage pregnancy prevention. To ensure mental health is integrated within health, the Kenya Mental Health Policy 2015-2030 was developed to support the attainment of highest standard of mental health and the Kenya Mental Health Action Plan 2021-2025 was rolled out to improve and streamline mental health outcomes in the country

Despite the relatively progressive legal framework to address issues of ASRHR, Kenya faces significant challenges ensuring adolescents have access to quality ASRH and mental health services. Access to services among adolescents is hindered by geographical barriers such as long distances and lack of transportation.

Figure 8: Factors Limiting Adolescent Access to SRHR



Adolescents in rural areas often have limited access to Youth Friendly health facilities as well as insufficient health facilities with trained HCWs to address adolescent-specific needs. Knowledge and information gaps exacerbated by limited comprehensive sexual education continue to hinder access as lack proper information to make informed decisions. Moreover, cultural taboos surrounding sexual education make it difficult for adolescents to openly discuss their sexual health concerns further inhibiting access and utilization of SRHR services. Cost and affordability are also challenges faced by adolescents in accessing SRHR services especially adolescents from low-income households cannot afford the direct services and indirect costs such as transport cost associated with seeking these services. While the existing legal frameworks have improved access to SRHR services, availability of services such as contraception and abortion still remains a challenge. The Constitution and the Penal Code,in Article 26(IV) and Sections 158-160 respectively prohibit abortion except where the mother's life is endangered. This has forced adolescents to resort to perilous abortions, a major primary cause of maternal mortality currently among this population group in the country. Further, the legal requirement of parental consent in some instances creates barriers for adolescents to seek SRH services.

This creates a need for the government to work on the challenges through creating a supportive environment for adolescents to access quality ASRH services. Enhanced access and utilization of ASRH services will lead to improved sexual and reproductive health outcomes for young people, contributing to a healthier and more empowered future generation.

2.4 Common adolescent problems relating to mental health.

Adolescence is a period of significant change, both physically and emotionally, which can lead to a variety of mental health challenges for young people. According to WHO (2021), one in seven 10–19-year-olds experience a mental health disorder which accounts for 13% of the global mental health disorder burden in this age. Among the common mental health disorders that affect adolescents are; Depression, anxiety, behavioral disorders, substance use disorders, eating disorders as well as self harm and suicide. The consequences of failing to address adolescent mental health conditions extend to adulthood, impairing both physical and mental health and limiting opportunities to lead fulfilling lives as adults.

Risk factors to mental health disorders adolescents

Biological Factors	Psychological Factors	Social Factors Bullying
• Family history of mental illness • Early puberty • Physical illness • Early pregnancy	• Alcohol and substance abuse. • Low self-esteem. • Emotional abuse. • Childhood trauma • SGBV. • Neglect	• Parental mental conflict • Family conflict • Social difficulties • Academic pressure/stressors • Discrimination • Poverty

Depression

Adolescence represents a vulnerable period for the onset of depression. Multiple biopsychosocial risk factors determine the onset, progression and outcome of depression. Family history of mental illness, childhood trauma, low self esteem, neglect, SGBV, bullying, poverty, academic pressure and family conflict are some of the common risk factors. Early identification, intervention and psychosocial support in a supportive environment are key protective factors that determine disease outcome.

Anxiety disorders

It is estimated that 3.6% of 10–14-year-olds and 4.6% of 15–19-year-olds experience an anxiety disorder. There are many different types of anxiety disorders thus not all adolescents will have the same symptoms). Symptoms often include physical manifestations like stomach aches or headaches, excessive worry, fear, and avoidance behaviors. Anxiety can profoundly affect school attendance and schoolwork.

Behavioral disorders is an umbrella term that includes specific disorders such as attention deficit hyperactivity disorder (ADHD) and conduct disorders. The symptoms have varying levels of severity . Only children and adolescents with a moderate to severe degree of psychological, social, educational or occupational impairment in multiple settings should be diagnosed as having behavioral disorders According to Meinzer, *et al* (2020), attention deficit hyperactivity disorder (ADHD) is associated with risky sexual behavior and early pregnancy. ADHD is associated with difficulties in impulse control and planning, and therefore adolescents with ADHD act on impulse without considering the consequences of their actions. This can lead to engaging in risky sexual behavior, such as having unprotected sex or having sex with multiple partners increasing their risk of pregnancy.

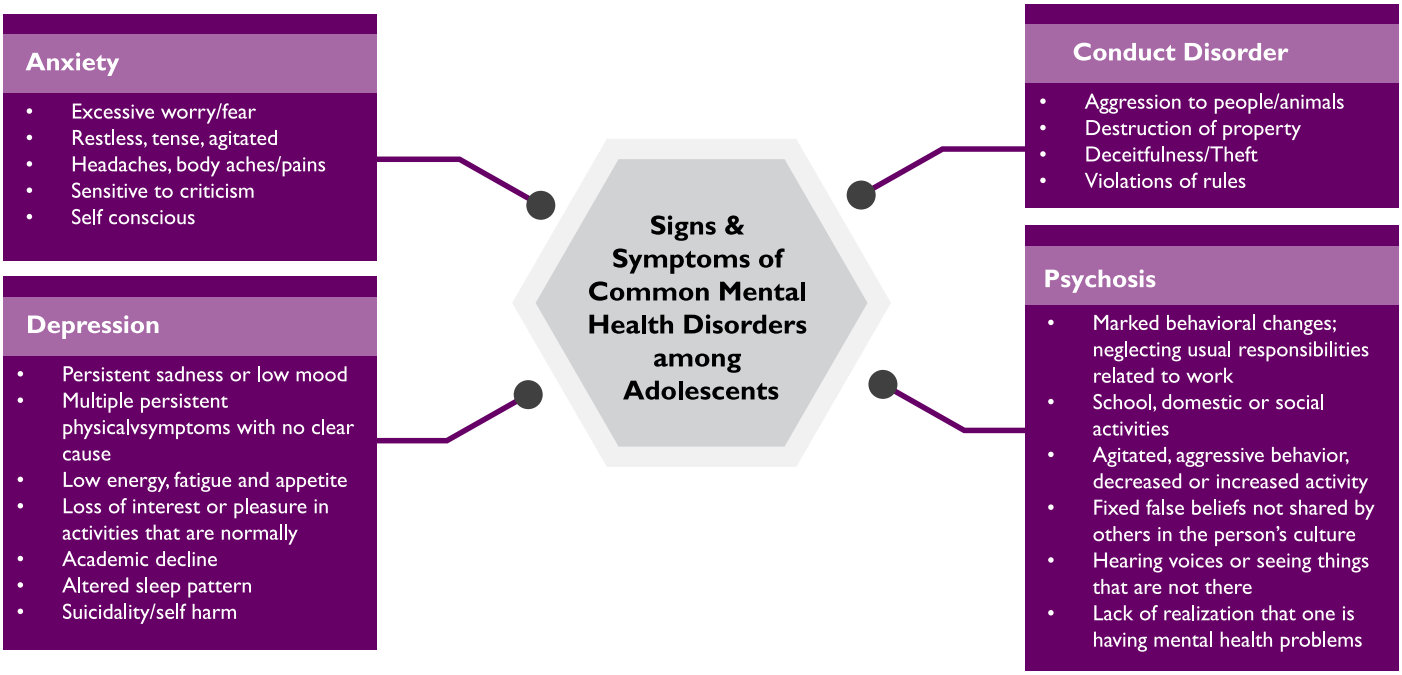
Suicide and self-harm are common among the adolescence. According to WHO suicide is the fourth leading cause of death in older adolescents (15–19 years). Adolescents may experience thoughts of suicide, either as a result of underlying mental health issues or due to significant stressors in their lives. Adolescents may engage in self-harming behaviors as a way to cope with emotional pain or stress. Cutting, burning, hitting oneself or other forms of self-injury provide temporary relief but can lead to further emotional distress and complications.

Eating disorders such as anorexia nervosa, bulimia nervosa, and binge eating disorder are characterized by distorted body image, preoccupation with food, and unhealthy eating behaviors. Often these conditions are rooted in anxieties about body image and control.If left untreated,eating disorders can have serious physical(nutritional deficiencies,hormonal problems,menstrual periods) and psychological consequences.

Alcohol and drug Abuse

National Survey on Alcohol and Drug Abuse among Secondary School Students in Kenya (NACADA, 2016) showed secondary schools are not drug free environments. Among this age group, alcohol had highest prevalence at 3.8%, prescription drugs recording 3.6%, miraa 2.6%, tobacco 2.5%, cannabis 1.8% and heroin and cocaine having the lowest prevalence at 0.2%.

Figure 9:



2.5 Cross cutting issues

Sexually Transmitted Infections (STIs)

Sexually Transmitted Infections (STIs) are critical cross-cutting issues that significantly impact adolescent pregnancy. Untreated STIs during pregnancy can lead to adverse outcomes such as preterm birth, low birth weight, neonatal infections, and congenital anomalies as well as cause pelvic inflammatory disease (PID), leading to blocked fallopian tubes and infertility (Tsevat, *et al*, 2017). This can cause fertility problems in future as well as lead to increased risk of ectopic pregnancy (implantation outside the uterus) if they do conceive.

Pregnant adolescents living with HIV face increased risks of maternal and infant morbidity and mortality if not provided with appropriate antiretroviral therapy (ART) and prevention of mother-to-child transmission (PMTCT) services. They are also at a higher risk of transmitting the virus to their babies during pregnancy, childbirth, or breastfeeding without proper interventions. This can trigger or worsen existing mental health problems negatively impacting their well-being and ability to make informed choices about their sexual health. The social stigma associated with HIV/AIDS can further lead to social isolation, rejection, discrimination, and difficulty in accessing healthcare services.

Water Sanitation and Hygiene (WASH)

Poor water, sanitation, and hygiene (WASH) conditions pose significant risks to the health of pregnant adolescents and their developing babies. Limited access to clean water and sanitation facilities increases the risk of exposure to harmful bacteria, viruses, and parasites. These can lead to infections like urinary tract infections (UTIs) or diarrheal diseases, which can complicate pregnancy and harm the fetus. Moreover, the frequent diarrheal diseases caused by contaminated water can lead to dehydration and hinder nutrient absorption which leads to malnutrition in pregnant adolescents, impacting fetal growth and development leading to preterm and low birth weight. Unsafe birthing environments and poor hygiene practices can increase the risk of newborn infections, such as conjunctivitis (pink eye) or umbilical cord infections which can increase the probability of complications and increased maternal mortality.

Equity

Equity in healthcare is crucial yet remains a significant challenge for pregnant adolescents, a group for which socioeconomic disparities, geographic location, and access to information and services substantially influence pregnancy outcomes ((Janaki &Prabakar, 2024, Lauga & Okolie, 2021, Kgopotso, *et al*, 2021)). Adolescents from lower socioeconomic backgrounds or residing in rural areas often encounter barriers like inadequate transportation and financial constraints, which hinder their access to necessary maternal and child health services. Discrimination further exacerbates these challenges, limiting effective care provision. Moreover, many healthcare facilities are not youth-friendly, and there is a scarcity of healthcare providers trained to deal with adolescent-specific needs, which discourages these young mothers from seeking necessary care. Additionally, adolescents with unsupportive family environments may experience increased social isolation and mental health struggles, complicating their access to essential resources. The cumulative effect of these factors not only increases the risk of pregnancy-related complications but also elevates maternal mortality rates among adolescent mothers, highlighting the critical need for more equitable healthcare solutions.

Referrals

In order to ensure access to comprehensive and specialized mental health care for pregnant adolescents, referral mechanisms from primary facilities should be functional.

Some of the key challenges faced by pregnant adolescents during referrals include anxiety, depression, or trauma, stigma, non-functional referral pathways, lack of trained staff, and limited access to specialized mental health services. Effective referral systems can create early detection which support continuity of care resulting in holistic support for pregnant adolescents. Multidisciplinary approaches with MCH providers, mental health professionals, social workers, obstetric care providers and other stakeholders is vital in ensuring pregnant adolescents receive holistic mental health care.

3. Pregnant Adolescent and Mental Health Services

3.1 Existing pregnant adolescent and mental health services

Various services are available to support pregnant adolescents and address their mental health needs, including counseling, self-awareness and self-care programs, antenatal, intrapartum, and postnatal care, community services, adolescent-responsive health services, both offline and online support, and peer support groups.

i. Counseling.

Counseling services for pregnant adolescents offered in health facilities vary depending on the stage of pregnancy. Counselling seeks to promote healthy behaviors like adopting self-care routines, mental health and reproductive health rights awareness. Counselled on risky behaviour like alcohol and substance use. Adolescents with existing psychosocial stressors receive support. They receive nutrition counseling that focuses on healthy eating habits including the early initiation of Iron and Folic Acid Supplements (IFAS). During the postpartum period, counseling focuses on menstruation, contraception and pregnancy prevention and HIV and sexually transmitted infections (STIs) prevention.

ii. Antenatal Care (ANC)

ANC services include antenatal routine checkups, adolescent G-ANC, obstetric point of care ultrasound at least twice during the pregnancy and diagnostic ultrasound done at 18 and 24 weeks, screening for obstetric complications, mental health screening and HIV testing and counseling. Refer to National Guidelines for Quality Obstetric and Perinatal Care. It is important to discuss the Mother and Child handbook to empower the adolescent.

iii. Intrapartum Care

Intrapartum services for adolescents should include: respectful maternal and newborn care, birthing positions options, emotional and psychosocial support during childbirth, pain management, contextualized and responsive communication considering their understanding of the processes, regular monitoring and documentation during childbirth and immediate care of the newborn. A birth companion of their choice should be included.

iv. Postnatal Care

The adolescent services to be provided include routine postnatal checkups to rule out postpartum complications like fistula, breast care and breastfeeding support, mental health screening for mental health disorders like postpartum psychosis, postpartum depression to ensure appropriate timely linkage to care. Emphasis on the need for mental health psychoeducation and self-care is key. Discuss postpartum contraception (PPFP) options, care of the perineum, postpartum nutrition to include weaning and essential immunization services. Adolescent mothers also receive parenting education and support to help them care for their newborns effectively which include guidance on infant feeding, hygiene practices, and recognition of danger signs for the mother and baby and developmental delays. Emphasis on postnatal visits as scheduled should be done. Initiate the adolescent to a Group PNC for peer support.

v. Community services

Pregnant adolescents should be linked to Community Health Promoters for follow up during and after birth. The CHPs should be supported to identify danger signs throughout pregnancy and after birth for both the mother and newborn baby and promptly refer to the link health facilities and other community support mechanisms. Embrace Community acceptance and reintegration of pregnant adolescents. Refer to Community Health Services MNH Training module 10.

vi. Hotlines and Online Support

Healthcare providers should refer to the available hotline and online support and link the adolescents to the said services. The available hotlines are 112 and 116

vii. Peer Support Groups

Peer support groups bring together pregnant adolescents and young mothers and fathers to share experiences, provide emotional support, and learn coping strategies. Health care providers should identify, form and facilitate psychosocial support groups for pregnant adolescents, guide them on activities and provide conducive spaces for their group meetings.(G-ANC and G-PNCs).

3.2 Gaps and Challenges in Mental Health integration

Pregnant adolescents seek services at different stages of their pregnancy- antenatal care (ANC), intrapartum care (IPC), and postnatal care (PNC). At each stage, they face different challenges. Further, there are gaps in service delivery that impact on access and utilization of health services at ANC, Intrapartum period and PNC.

Pregnant adolescents seek services at different stages of pregnancy, labor, birthing, and post pregnancy. They face challenges during this period that may affect their mental health. Gaps in service delivery can influence access and utilization of health services during the ANC, Intrapartum and PNC period.

3.2.1 Antenatal Care (ANC)

Issues identified as potential barriers to pregnant adolescents accessing quality care can be grouped into three broad themes namely: individual and family (parental/guardian), community/contextual factors, health facility (health care worker and health institution). All these factors can influence the mental health status of adolescents.

These challenges are:

i. Individual and Family challenges

- **Fear of disclosure**

  Adolescent could delay early initiation of ANC due to the fear of parental disapproval, anger/violence and child marriage, concerns on stigmatization and financial burden. The circumstances under which the adolescent conceived, past experiences of sexual harassment, assault, or abuse coupled with fear of judgment or disbelief. This in turn causes stress and anxiety , they may also contemplate abortion as well as other mental issues.

- **Self-stigmatization**

Self-stigmatization may propagate fear, isolation, shame, self-blame and pity, denial, neglect, lack of trust in the healthcare system and social isolation. This is exacerbated by inadequate knowledge, self-awareness and individual self-efficacy.

- **Inadequate family support**

A supportive family provides the essential psychosocial, physical and financial support which is critical during ANC. Inadequate support impacts their physical and mental well-being during this critical time.

ii. Community challenges

- **Lack of community support**

Stigma, lack of support, child marriage, cultural and religious beliefs and practices, physical assault and isolation from school and community trivializes the symptoms that pregnant adolescents face. This may stem from lack of community awareness, lack of sensitivity to adolescent mental health, myths and misconceptions about adolescent pregnancy and lack of awareness of existing policies.

iii. Health Facility level

The state of services in healthcare facilities can impede care seeking in adolescents with reproductive health problems/ concerns.

- **Inaccessible health services**

Pregnant Adolescents may face challenges in accessing quality health services which include long distance to the health facility, poor road networks, terrain, security issues, humanitarian situations, adverse weather conditions. Within the health facilities they may encounter challenges with long waiting hours, inflexible clinic hours, and financial constraints.

- **Inadequate pregnant adolescent responsive services**

These challenges can lead adolescents to disengage from ANC, missing out on crucial ANC and mental health support. The health care facilities should have innovative ways of providing responsive services such as cohorting the adolescents, scheduling specific days or hours for adolescents to receive services.

- **Health care provider related challenges**

Inadequate knowledge in adolescent and mental health, health care providers attitude and values inadequate staffing and overburdened HCP may lead to the pregnant adolescents losing trust with the services offered in the health facilities.

3.2.2 Labour and Birthing

Birthing is a demanding process that requires family support. Lack of this support may be overwhelming leading to negative impact on their mental health. All these may impact their mental well-being and potentially affect their bond with their newborn. Staff shortage, stressful working conditions, high workload and HCP negative attitudes during labor and birthing can compromise the quality of care offered to the adolescent. The suboptimal care accorded to the adolescent may predispose them to psychological trauma. Respectful care promotes good mental health for these adolescents.

- **Lack of companion during Labour and Birthing**

The birthing process can be challenging for both the pregnant adolescent and the teenage father(s). It is a demanding process that requires, among others, a trusted companion to offer comfort and encouragement or simply holding the hands of pregnant adolescents through the pregnancy journey. Lack of this support may be overwhelming leading to negative impact on their mental health. A supportive birthing companion can help the adolescent stay calm and focused without them feeling helpless and alone as well as advocate for their needs and preferences. Some of the challenges pregnant adolescents face include:

- **Traumatic experience during labour and birth**

Labour pain, pain from vaginal examinations, tears, surgical (e.g., C-section), delayed healing times or complications due to their age and developing bodies may have significant physical and emotional consequences for pregnant adolescents. All these may impact their mental well-being and potentially affect their bond with their newborn.

In severe cases, adolescents might develop PTSD due to the pain and trauma associated with childbirth, whereby they experience flashbacks of the birthing process they underwent, nightmares, and become hyper vigilant. Unprocessed trauma and emotional distress from childbirth, self-stigma and isolation can exacerbate existing mental health problems or lead to the development of new ones, such as postpartum depression or anxiety.

In addition, negative birthing experiences from peers and others may create fear among the pregnant adolescents. Abandonment, rejection, or family conflict can deter the pregnant adolescent(s) from seeking mental health services, potentially worsening mental health issues during labor and birth.

Teenage fathers are not an exception to experiencing challenges associated with the labor and birthing process. They are still developing emotionally and may not have the experience to handle the intensity of childbirth leading to feelings of isolation, helplessness, anxiety, and being judged by their family and community.

- **Lack of financial resources**

The financial strain of raising a child as a teen also increases anxiety and stress as they lack a job or financial resources to support a baby. lack of medical insurance cover for adolescent which may result to detention or long stay in health facility as they await other forms of financial support

- **Inadequate human resource**

Staff shortage or high workload, poor working conditions and turnover of healthcare workers can result in limited time and contact between the healthcare providers and the pregnant adolescent, affecting the health providers attitude leading to physical ,verbal abuse and unconscious biases, all this can create significant challenges for pregnant adolescents seeking mental health services during labour and delivery leading to suboptimal psycho-social support physical abuse by a health provider during childbirth, is a traumatic experience that leads to fear, distrust and strong aversion to seeking further medical help despite being in need.

- **Inadequate supplies and commodities in health facilities**

Reproductive health supplies and commodities if not procured to be available at the point of use e.g inadequate gloves ,warm clothing for the newborn baby, sanitary towels leads to stress and anxiety. Most of the adolescent rely on parents to support in provision of these supplies.

- **Inadequate knowledge on reproductive health rights**

Inadequate knowledge and understanding of their reproductive health rights as enshrined in the constitution 2010, to enable them demand for the service when they visit health facilities and providing

feedback on the mechanism of improvement of services, this may result to low self-esteem and insecurity about their abilities , leading to feelings of inadequacy, and emotional stress

3.2.3 Postnatal Care (PNC)

Postnatal period is very critical for pregnant adolescent since this is the time the young adolescent require both financial and psychosocial support for the mental wellbeing for herself and baby

The postnatal period challenges can be divided into three; immediate, intermediate and long term over 6 months). The challenges may include:

- **Inadequate information and knowledge**

Knowledge gap on self-care, essential care for the newborn, postpartum contraceptive, nutrition, breast care and breastfeeding including weaning and mental health among adolescents results in self-doubt, low self-esteem and insecurity about their abilities as young mothers, leading to feelings of inadequacy, and emotional stress.

- **Inadequate economic and psychosocial support**

Inadequate economic and psychosocial support is one of the factors that could lead to adolescent mental health challenges during postpartum. As a result, the adolescent is prone to rejection, social stigma and discrimination, burnout and exhaustion, isolation and ostracization. Additionally, the adolescent may lack essential needs for herself and the baby including funds to support routine clinic visits.

- **Inadequate Nutrition support**

A mother's diet directly affects the baby's development and health. Nutritional deficiencies can impact the baby's growth, immune system, and cognitive function. Financial constraints and lack of understanding of nutrition may result in unhealthy feeding. Poor nutrition can lead to fatigue, difficulty concentrating, and increased vulnerability to depression and anxiety among the adolescent mothers.

- **Inadequate adolescent responsive services in health facilities**

Adolescent mothers need to access responsive services during the postnatal period. These services include exclusive breastfeeding counseling,care of the newborn baby,immunizations, life skills counseling, link adolescent mothers psychosocial support groups, link to other non-health services for social economic support, contraceptive services . Privacy and confidentiality should be upheld. Generally, these services are currently suboptimal thus having a negative impact on the mental health of these adolescents.

- **Complications of labour and child birth**

The adolescent reproductive system is often not fully developed, leading to complications during labor and childbirth due to changes that occur as the body adapts to support a growing fetus. One significant challenge is an inadequate pelvis, which can cause obstructed labor . This complication can result in the development of obstetric fistula, further isolating and stigmatizing the adolescent mother, and preventing her from participating in social and economic activities. These complications can lead to adverse maternal and newborn outcomes, taking a significant toll on the adolescent's mental health.

3.2.4 Enabling environment

Pregnant adolescents require a lot of support to access the appropriate services for mental health issues they may be facing which require an enabling environment at the family, community, health facility, school and policy levels.

Some of the challenges faced by adolescents at the environmental level include;

i. Family

The adolescent mother may not get support from the siblings , parents to take care of the baby and herself to have adequate rest and conducive environment and this may lead to anxiety and post pregnancy depression, inadequate health care, judgment and stigma

ii. Community level

Social stigma where communities may stereotype or judge adolescent parents, leading to feelings of shame, isolation, and exclusion.

iii. Health facility level

- **Inadequate integration of mental health services;**

Mental Health services are not integrated in the routine perinatal care for pregnant adolescents in most healthcare facilities. Lack of routine mental health screening hinders early and timely identification and intervention for those requiring MH services. In addition, health facilities may lack private safe spaces to provide these services.

- **Inadequate human resource for health**

In all the levels of care, there is inadequate capacity among HCPs to adequately identify and appropriately support and link pregnant adolescents requiring mental health services. Shortage of HCPs and increased workload may compromise provision of psychosocial support. In addition, healthcare providers may hold biases towards adolescent pregnancy, leading to judgmental attitudes and inadequate support as well as struggle to communicate effectively with adolescents, creating an uncomfortable or dismissive environment.

iv. School Environment

- **Inadequate number of trained teachers and counselors in learning institutions**

Despite the existence of school health programs, there are inadequate officers and teachers who are trained to provide MH services in both public and private schools.

- **Lack of Standard Operating Procedures on how to deal with a pregnant adolescent in schools**

Lack of SOPs to guide teaching and non-teaching staff including Board of Management and parents on how to identify and respond to MH issues within the schools settings may lead to mis-handling of pregnant adolescents. This may lead to anxiety, stress, frustration, duress, depression and suicidal thoughts.

- **Rigid /punitive school culture**

In some instances, school policies are not fully adhered to and some schools may still practice corporal punishment for errant pupils instead of using positive disciplining methods.As such, adolescents presenting with mental health issues may be mistaken for being delinquents and are then punished. This may exacerbate MH challenges. Consequently, this leads to isolation and shame among pregnant adolescents,

making them less likely to seek help within the school system.

- **Unsupportive environment for returning to school**

Additionally some schools may not adhere to school re-entry policy, which requires that all adolescents who get pregnant are supported and reintegrated back into schools once they give birth. Some school environments may perpetuate stigma and discrimination, lack facilities for effective baby care (e.g breastfeeding rooms). This can result in MH issues among adolescents.

- **Inadequate Psychosocial support within the school system**

Adolescents spend most of their yearly time in school. The school environment is critical in enhancing good mental health among all adolescents. However, a toxic environment within schools can be caused by unruly learners, unfriendly teachers and lack of basic amenities such as clean toilets, inadequate co-curricular activities such as sports and recreation, food and other environmental issues may exacerbate MH in schools.

- **Weak referral and linkage networks**

Even though most schools are co-located within proximity of health facilities, linkage between the two institutions remains wanting. Adolescents presenting with mental health still find it difficult to get their issues addressed beyond the confines of the school's environment. Ineffective referral mechanisms prevent access to MH services.

iii. Policy level

- **Inadequate dissemination of existing policies and guideline on adolescent mental health**

The Ministry of health and its stakeholders develop policies and guidelines which take a number of years to be finalized and disseminated. These normally take long to be disseminated and to reach the intended audience. This could be as a result of inadequate resources or non-prioritization of those policies leading to suboptimal use of the policies to provide timely and comprehensive care to adolescents mental health.

- **Inadequate monitoring and evaluation on mental health policy implementation**

Monitoring and evaluation of implementation of mental health policy has been a major gap. This may be because of inadequate prioritization of this area due to low demand by leadership and stakeholders. In order to address this challenge,stakeholders and partners of good can be invited to develop, review, adopt and standardize tools that can be used to monitor and track progress for adolescent mental health issues and concerns in all sectors. By doing so, data will be available to support decision making at all levels of the system.

iv. Challenges related to financing

- **Inadequate funding for mental health programing**

Insufficient funding by the state and non-state actors hinder optimal provision and sustainability of adolescent mental health services

- **Uninsured caregivers or parents**

The higher level public (Level 4s, 5s and 6 facilities) charge for some services offered during pregnancy.The pregnant adolescents are expected to use the social health insurance fund where the employed parents need to pay 2.75% of their gross salary to benefit from the package and for those parents who work in the informal sector, they are expected to contribute Ksh. 500 monthly to benefit from the package. Pregnant adolescent girls may face challenges in accessing care if their parents or guardians cannot afford their monthly contribution.

V. Data monitoring ,evaluation and research

- **Limited research conducted on mental health**

Knowledge generation and innovation is critical in supporting mental health for pregnant adolescents. However due to limited research on the mental health of pregnant adolescent girls it's hard to generate evidence based interventions.The limited research have led to inadequate advocacy for adolescent mental health at the policy level leading to a lack of prioritization.

- **Lack of Monitoring and evaluation on mental health service implementation in all levels of care**

The HIS does not capture indicators providing information on pregnant adolescents' mental health

vi. Multisectoral/multidisciplinary collaboration and coordination

- **Inadequate multisectoral collaboration and coordination**

The interconnected nature of pregnant adolescents' mental health needs requires comprehensive care and support, reduction of barriers to access and optimization of resources. Lack of collaboration and coordination among the relevant agencies hinder the adoption of a holistic approach to addressing their mental health needs.Additionally, it may lead to lack of prioritization of mental health issues, lack of shared understanding of roles and responsibilities and disjointed interventions among key players.

4. Response/Implementation Strategies

In order to provide responsive maternal and child health services to adolescents, interventions have been grouped according to service provision.

4.1 Interventions during antenatal care

During ANC, pregnant adolescents require different interventions as individuals, through their families During antenatal care (ANC), pregnant adolescents require tailored interventions at multiple levels, including individual, family, community, school, and healthcare facility settings.

4.1.1 Individual level

i. Provide financial and psychosocial support

Engagement of Parents and caregivers to provide financial, emotional and psychosocial support will help the pregnant adolescent navigate the period of uncertainty , mental stability and prepared for the new responsibilities. *Referral and linkage to organizations and health facilities* supporting young mothers and fathers on social economic empowerment will further ease the financial burden.

ii. Life skills

Life skills training and mentorship program for the pregnant adolescent on aspects such as decision making, goal setting, self-esteem, self-awareness, problem solving skills, creative arts and sports will help them deal with shame, self-blame and denial.

Personal and social skills education such as effective communication, conflict resolution, leadership, Interpersonal communication, social emotional skills, & teamwork are also key in enhancing reintegration and individual future growth.

iii. Provide relevant and accurate information/knowledge

To bridge the knowledge gap and empower the pregnant adolescent to navigate through the season, *sensitization of pregnant adolescents on mental health and available services* is key. Further, *Digitization of mental health* by initiating digital health platforms on mental health and adolescent health which make information accessible from the comfort of their homes will significantly empower pregnant adolescents in their decision making (*Shillah Mwavua et al.2023).*

iv. Self-Care

Self care to the pregnant adolescent which includes interventions such as regular exercise, focusing on positivity , staying connected by reaching out to friends and family members who can provide emotional support will enhance their mental health and wellbeing.

Adolescents should be helped to know when to seek care including when they experience:

- Thoughts of self harm or harm to the baby
- Difficulty performing activities of daily living
- Feelings of detachment from the baby
- Alcohol and substance use disorder
- Gender based violence

Self-awareness-The adolescent should be empowered by the health professional to identify variations in emotional and mental state that occur during pregnancy or during **postpartum** period and seek care,

Self-diagnosis-The adolescent to watch out for mental health warning signs(anxiety symptoms, mood changes assess bonding and attachment of mother and fetus))Self screen using PHQ2 and PHQ9 and seek timely support

Self-management-The adolescent should develop a routine of self-care habits (physical activity, mindfulness, sleep hygiene, relaxation technique, social connectivity)

4.1.2 Health facility level

i. Accessible health facilities

Conduct integrated community outreach programs targeting adolescents in remote or underserved areas, incorporating mental health and adolescent-friendly health education sessions.
Use of technology to improve intervention reach (telepsychiatry) in facilities without mental health professionals.

ii. Provision of comprehensive adolescent responsive Maternal Mental Health Services

Create private spaces within clinics for confidential consultations and counselling with pregnant adolescents/ adolescent mothers such as teen mothers clinics. Train health care providers on adolescent mental health and adolescent responsive services. Flexibility in adolescent health service provision hours to cater to school-going pregnant adolescents. Referral linkage and adolescent specific group ANCs. Avail referral directories at facility levels and feedback mechanism to strengthen and enhance referral from low level to high level facilities.

iii. Enhance user friendly services for the special adolescent population.

Ante-natal Clinics to embrace social and disability inclusion like accessibility and availability (ramps), disability friendly examination coaches, digital accessible resources , signage, braille, sign language interpreters and disability inclusive IEC materials.

iv. Provision of Standardized Mental Health screening tools

Screening for mental health is important during antenatal care for early identification of mental health condition and timely referral, Currently most mental health tools are not standardized hence there is need to have tools that can be used to screen mental health at client level and service points at health facility. E.g Incorporate the psychometric screening tools into the MOH 216 (Mother child handbook)-to aid in screening for mental health challenges .

v. Positive approaches to address health care providers wellness

Implementing the national guidelines on workplace mental wellness to address HCP burnout and mental wellbeing i.e Care for the carer. Health facilities to have a department where health care workers can go for debriefing. Institutions to also adopt innovative approaches for wellness of their staff and families.

4.1.3 Community level

Enhance communities perception and knowledge on mental health issues

Sensitization of community on available Reproductive and mental health services through outreaches,in-reaches,community dialogues and community awareness campaigns should reduce stigma surrounding mental health and encourage positive health-seeking behavior. Community sensitization on holistic adolescent health including mental health issues. Community sensitization on adolescent and mental health issues *(ref: community handbook for engaging adolescents, parents and community leaders -2020*)to foster an adolescent friendly and responsive environment (*ref: understanding adolescents parents and caregivers guide*).

Other key stakeholders such as religious and cultural leaders ought to be sensitized on adolescent health and mental health.

4.2 Interventions during labour and birthing

4.2.1 Provide adequate information

Enhance the birthing experience by ensuring informed consent is obtained. Health care providers should prioritize the provision of comprehensive information and resources. Display of current Information, Education and Communication (IEC) materials and charts detailing various birth positions, pain reduction activities such as breathing exercises, mindfulness and relaxation techniques to empower adolescents to explore options that best suit their needs and preferences and ensures a more comfortable birthing process. Pregnant adolescents should also be informed of their reproductive rights.

4.2.2 Promote Positive birth experiences

Sensitize health care providers to approach adolescent care with sensitivity and empathy recognizing the unique needs and challenges faced by pregnant adolescents and encourage birth companions to offer emotional support. Provide information on the delivery and birth process, reassure and allay any fears the adolescents may have.Encourage use of techniques like soothing music and relaxation techniques which are useful in controlling anxiety.

4.2.3 Promote Respectful maternity care approaches for adolescents.

Advocate for adolescent friendly environments through partitioning of the labor and birthing rooms to provide privacy and a sense of security, provision of services that address the needs of persons livingisabilities like ramps. HCWs use language that is respectful, non-judgemental and non-derogatory to uphold the dignity and rights of adolescents as they seek care.

4.2.4 Enhance effective communication during the labor and birthing process for adolescents

Health care workers should avoid using medical jargon and instead use easy to understand language when talking to adolescents. They should create good rapport and a supportive environment to help minimize the physical pain and emotional distress of labor and birth. Should uphold respect, courtesy and culturally sensitivity, as they promote childbirth companionship and sensitivity when breaking news of loss of either baby or mother to the adolescent and family. Provide comprehensive information on care options, procedures, and any medical interventions.

4.2.5 Financial support

Liaise with medical social workers to source for items that adolescent mothers may need during labor and birth process. Link the adolescent mothers to institutions that offer scholaships / who can offer financial support and social empowerment Ensures access to affordable prenatal and postnatal care through medical

aid/insurance schemes.Provide flexible school schedules, child care, and support services to help adolescents continue their education.

4.3 Interventions during postnatal care

4.3.1 Provide relevant and accurate information among adolescent mothers

Provide information on self-care, essential care for the newborn(cord care) postpartum contraceptive, immunization, adequate maternal nutrition, personal hygiene, perineal care, hand washing breast care and breastfeeding including weaning, Counsel on positions of infant during breast feeding, empower on warning signs for mental health (self-harm/ depression) and obstetric complications(like fistula) in the postpartum period Counsel on postpartum danger signs for mother and baby. Emphasis on adolescents' father involvement (involvement of family members if adolescent is not married) and empowerment.

4.3.2 Provide economic and psychosocial support

- Counsel and capacity build on social skills, self-awareness, self-esteem and self-worth, self-discovery and counsel on risk for repeat adolescent pregnancy
- Encourage them to join postnatal peer support group at the facility and community level
- Counsel adolescent mothers on coping and life skills training to empower them economically.
- Counsel on the adverse effects of alcohol and substance use on both mother and newborn.
- Develop referral and link them to a peer mentor /champion/CHPs at the facility for support and education
- Special groups (street adolescents, child sex work, adolescents living with HIV to be linked to the respective social networks and linkages
- Specialized school based programs to provide a means of multidisciplinary services to the parenting adolescents while keeping them in school
- mHealth and social media can be used to promote participation in post natal care i.e reminders for clinic visits ,sharing clinic visits and family planning.This can be incorporated in G-PNC

4.3.3 Provide adequate nutrition support

- Nutritional assessment counseling and support on maternal nutrition and newborn feeding (NACS)
- Adolescents should be advised to avoid dietary restrictions.
- They should have nutritional assessment and referred for nutritional support
- Emphasis on adequate rest,more fluid intake and take one extra meal to the daily meals
- Consider the need for variety of food ,at least 5 from the 10 food groups

4.3.4 Avail adolescent responsive services in health facilities

- Train health care providers on adolescent responsive services and respectful maternity care
- Psycho-educate the adolescent on the appropriate services and where they can access them.
- Link them to Adolescent responsible Services if not available within the facility

4.4 Enabling environment

4.4.1 Community Level

- Conduct community sensitization campaigns on adolescent pregnancy and mental health.
- Encourage family support systems for pregnant adolescents.
- Promote adolescent father involvement, particularly for those in marital unions.
- Establish safe spaces for vulnerable adolescent populations.
- Strengthen Community Health Promoter (CHP) networks to facilitate early identification and support for pregnant adolescents.

4.4.2 School environment

- Schools should create a supportive environment that allows adolescent mothers to balance parenting and education. Key interventions include:

  - Establishing lactation rooms and changing facilities.
  - Providing appropriate and comfortable seating arrangements.
  - Implementing flexible schedules to accommodate breastfeeding and bonding time.
  - Assigning designated caregivers or babysitters during classes and exams.
  - Ensuring a quiet and conducive rest area for adolescent mothers.
  - The school to provide nutritious diet with plenty of fluids
  - Sanitation amenities to be in place for hand hygiene
  - Waste disposal mechanism to dispose diapers
  - Encourage Peer to peer support
  - Systems to demystify stigma,myths and misconception to the school community to empower them should be in place to support the pregnant adolescent

4.4.3 Health facility level

- Mainstreaming of mental health services in all service delivery points to ensure access to comprehensive and high quality mental health services at all levels for adolescents. Operationalization of adolescent friendly spaces in all health facilities to ensure provision of adolescent responsive services.
- Continuous on job training for health care providers through bi-annual refresher courses in available accredited MH platforms. E.g. using WHO Mental Health Gap Action Programme guidelines (MhGap) App.
- Lobby for recruitment, training and deployment of mental health professionals to bridge in human resources per population ratio.
- Prioritizing the Mental health and well-being of HCPs through self care to equip them to offer psychosocial support. 'Care for the carer.'

4.4.4 Policies and Legal Frameworks

- Dissemination and implementation of the relevant mental Health Policies and legal aid frameworks (Mental health action plan 2021-2025, Basic Education Act 2013, Children's Act 2022, Constitution of Kenya 2010)
- Advocate for user friendly amenities to support pregnant and lactating adolescents
- Standardization of training packages for health care providers
- Operationalisation safe spaces for adolescent girls as outline in the children Act
- Advocacy to all stakeholders to prioritize and champion for adolescent reproductive health.

3. Financing

- Advocate for budget allocation and ring fencing of funds towards mental health integration for pregnant adolescents at national and county levels to enhance service delivery of Mental Health Support
- Advocate for social protection support for vulnerable pregnant adolescents (health insurance, adolescents' mothers, for education support, alternative pathways for education)

5. Multi-sectoral partnerships, collaboration and, coordination

- Incorporation of adolescent mental health agenda in strategic meetings such as Reproductive Health Technical Working Groups (RH TWGs) at the national and county levels
- Ensure representation from various agencies in strategic forums including relevant government agencies (MOH, MOE, Directorate of children services, judiciary, Ministry of gender), private sector, FBOs, CBOs and NGOs.
- Strengthening referrals and linkages to enhance multisectoral collaboration for holistic support for pregnant adolescent girls (MoH, MoE, Directorate of Children Services, Judiciary, Ministry of Gender, private sector, NGOs, CBOs, FBOs etc)

5. Monitoring, Evaluation, Research and Learning

Effective mental health support for pregnant adolescents requires a robust Monitoring, Evaluation, Research, and Learning (MERL) framework to ensure quality care, measure impact, and drive continuous improvement. MERL provides a structured approach to track progress, assess service effectiveness, generate evidence-based insights, and adapt interventions.

5.1 Key performance indicators

To assess effective integration of mental health services into the MOH continuum of care for pregnant adolescents the key performance indicators are required to assess the quality of care, health outcomes, access, and utilization as well as capacity building for healthcare workers (HCWs).

Access and Utilization

i. Number of health facilities offering integrated mental health services for pregnant adolescents within the ANC, MCH, and PNC programs.
ii. Percentage of pregnant adolescents aware of mental health services available at the facility
iii. Percentage of pregnant adolescents attending ANC, MCH, and PNC screened for mental health concerns.
iv. Percentage of pregnant adolescents and adolescent mothers identified with mental health concerns
v. Number of pregnant adolescents/adolescent mothers receiving individual or group mental health interventions within the continuum of care.
vi. Percentage of pregnant adolescents/adolescent mothers referred for mental health services.
vii. Wait times for mental health services after referral from ANC, MCH, or PNC providers.

Quality of Care

i. Percentage of mental health screenings for pregnant adolescents conducted using validated tools.
ii. Percentage of mental health professionals providing services to pregnant adolescents who have received training on adolescent mental health and perinatal mental health.
iii. Percentage of pregnant adolescents referred for specialized mental health care
iv. Percentage of successful follow-ups on referred cases
v. Percent of clients reporting satisfaction with the quality of mental health services

Health Outcomes

i. Rates of depression, anxiety, and other mental health disorders among pregnant adolescents/adolescent mothers identified through screening.
ii. Reduction in mental health symptoms among pregnant adolescents/adolescent mothers receiving mental health interventions.
iii. Rates of prenatal care attendance, adherence to treatment plans, and positive birth outcomes (e.g., healthy birth weight, reduced preterm birth) among pregnant adolescents receiving integrated mental health services.

Capacity Building

i. Number of healthcare providers (doctors, nurses, clinical officers, nutritionists, Pharmacists) trained on integrating mental health screening and basic interventions into ANC, MCH, and PNC services for pregnant adolescents.
ii. Number of mental health professionals trained on providing services tailored to the needs of pregnant adolescents.

5.2 Tracking progress

To effectively integrate mental health services into the existing Ministry of Health (MOH) continuum of care for pregnant adolescents a robust tracking system will be required. The system will support systematic data collection, Analysis of results and data driven decision making to ensure the successful integration of mental health services and improve the well-being of pregnant adolescent.

Data Collection methods and tools will include:
Kenya Health Information Systems (KHIS): the HCWs will utilize the existing KHIS system to capture data on service availability, utilization rates, and basic client demographics.

Standardized Screening Tools: Standardized mental health screening tools will be developed and utilized in ANC, MCH, and PNC programs to ensure consistent data collection on identified mental health concerns.

Client Satisfaction Surveys: The HCWs will conduct surveys using client exit interviews to gauge client satisfaction with the integrated services, including wait times, provider communication, and overall experience.

Data collected will be analyzed to establish trends on the KPIs and will be used to produce monthly reports on mental health among pregnant adolescents/Adolescent mothers. The reports produced will be disseminated to relevant stakeholders, including National and County MOH, Facility in charges, healthcare providers, and mental health professionals to foster accountability and program improvement.

5.3 Knowledge management

To bridge the gap in integrating mental health services into existing healthcare systems, particularly for vulnerable populations like pregnant adolescents, a robust knowledge management system is required. The knowledge management system will include content creation that includes:

- Development of mental health training modules for MOH staff (doctors, nurses, nutritionist, clinical officers, mental health providers
- Development of Information Education and Communication (IEC) materials such as pamphlets, videos, flyers) on mental health during pregnancy and adolescence.
- Translation of the IEC materials to different local languages

This will also entail the creation of a knowledge sharing platform which can be integrated with existing MOH information systems and is accessible to the MOH staff to access training modules and patient education materials.

Workshops and conferences on adolescent mental health and integration strategies will be organized to share best practices and case studies.

5.4 Review of the Guide

The Guide is subject to review after 5 years of implementation to ensure the emerging mental health needs of pregnant adolescents are addressed; incorporate any new learnings from implementation.

6 References

1. Ahinkorah, B.O., Seidu, A., Appiah, F., Oduro, J.K et al. (2020). Effect of sexual violence on planned, mistimed and unwanted pregnancies among women of reproductive age in sub-Saharan Africa: A multi-country analysis of Demographic and Health Surveys. SSM-Population Health, 11.
2. Aluga, D., & Okolie, E.A. (2021). Socioeconomic determinants of teenage pregnancy and early motherhood in the United Kingdom: A perspective. *Health promotion perspectives*, *11*(4), 426–429.
3. Darroch, J., Woog, V., Bankole, A., & Ashford, L.S. (2016) *Adding it up: Costs and benefits of meeting the contraceptive needs of adolescents*. New York: Guttmacher Institute.
4. Fortin-Langelier, E. & Daigneault, I. (2022). Childhood sexual abuse, teenager pregnancy and the mediating role of psychiatric comorbidity. *Children and Youth Services Review*, 138.
5. Ho, L. L. K., Li, W. H. C., Cheung, A. T., Luo, Y., Xia, W., & Chung, J. O. K. (2022). Impact of Poverty on Parent-Child Relationships, Parental Stress, and Parenting Practices. *Frontiers in public health,* 10, 849408.
6. Howard L. M, Khalifeh H. (2020). Perinatal mental health: a review of progress and challenges. *World Psychiatry.* 2020. 19(3)
7. Jia L, Li W, Liu Y and Wang L, (2023). Psychologic Sequelae in Early Pregnancy Complications. *International Journal of Women's Health*. 2023:15 51–57
8. Karle, A., Agardh, A., Larsson, M. et al. (2023) Risky sexual behavior and self-rated mental health among young adults in Skåne, Sweden – a cross-sectional study. *BMC Public Health* 23, 9
9. Kenya Health Policy 2012-2030.
10. Kenya Mental Health Policy 2015-20230 https://publications.universalhealth2030.org/uploads/Kenya-Mental-Health-Policy.pdf
11. KNBS (2022). Kenya Demographic and Health Survey (KDHS) 2022
12. Kpodotsi, A., Baku, E.A., Adams, J.H. *et al*. (2021) Socioeconomic inequalities in access and use of skilled birth attendants during childbirth in Ghana: a decomposition analysis. *BMC Pregnancy Childbirth* 21, 850 (2021).
13. Kumar M, Huang KY, Othieno C, Wamalwa D, Madeghe B, Osok J, Kahonge SN, Nato J, McKay MM. (2018). Adolescent Pregnancy and Challenges in Kenyan Context: Perspectives from Multiple Community Stakeholders. *Global Social Welfare*, ;5(1):11-27.
14. Kumar, M., Huang, KY., Othieno, C. *et al*. (2020). Implementing combined WHO mhGAP and adapted group interpersonal psychotherapy to address depression and mental health needs of pregnant adolescents in Kenyan primary healthcare settings (INSPIRE): a study protocol for pilot feasibility trial of the integrated intervention in LMIC settings. *Pilot and Feasibility Studies*, 6 (136).
15. Maharaj, N.R (2022). Adolescent pregnancy in sub-Saharan Africa – a cause for concern. *Frontiers Reproductive Health,* 4.
16. Mang'atu, M., B. & Kisimbii, J. (2019). Factors Influencing Teenage Pregnancies in Kenyan Public Primary Schools: A Case of Kitui County Kenya. *Journal of Entrepreneurship & Project Management*, 3(4), 11-26
17. Meinzer. M.C., LeMoine, K.A., Howard, L.A., Stehil, A., *et al* (2020). Childhood ADHD and Involvement in Early Pregnancy: Mechanisms of Risk. *Journal of attention disorders*, 24(14).
18. Moulton, J. E., Corona, M. I. V., Vaughan, C., & Bohren, M. A. (2021). Women's perceptions and experiences of reproductive coercion and abuse: a qualitative evidence synthesis. *PloS one*, *16*(12), e0261551.

19. Mutahi, J.A., Anna L, B., Pim, C.C., Stefan, S., Peterson, D. *et al*. (2022). Mental health problems and service gaps experienced by pregnant adolescents and young women in Sub-Saharan Africa: A systematic review. *Lancet*, 44.
20. Mughal S, Azhar Y, Siddiqui W. Postpartum Depression. [Updated 2022 Oct 7]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2024 Jan-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK519070/
21. Mutea L, Were V, Ontiri S, Michielsen K, Gichangi P. (2022). Trends and determinants of adolescent pregnancy: Results from Kenya demographic health surveys 2003-2014. *BMC Women's Health*, 22(1):416.
22. National Adolescent Sexual and Reproductive Health Policy (2015). https://tciurbanhealth.org/wp-content/uploads/2018/03/Ministry-of-Health-ASRH-POLICY-2015.pdf
23. National Council for Population and Development (2021). Draft Action Plan for Addressing Adolescent Health and Teenage Pregnancy in Kenya. https://ncpd.go.ke/wp-content/uploads/2021/10/Draft-Action-Plan-for-Addressing-Adolescent-Health-and-Teenage-Pregnancy-in-Kenya.pdf
24. Osok, J., Kigamwa, P., Huang, KY. *et al.* (2018). Adversities and mental health needs of pregnant adolescents in Kenya: identifying interpersonal, practical, and cultural barriers to care. *BMC Women's Health* **18**, 96. https://doi.org/10.1186/s12905-018-0581-5
25. Roddy Mitchell A, Gordon H, Lindquist A. (2023). Prevalence of Perinatal Depression in Low- and Middle-Income Countries: A Systematic Review and Meta-analysis. *JAMA Psychiatry,* 80(5):425–431.
26. Sánchez-SanSegundo, M., Alarcó-Rosales, R., Zaragoza-Martí, A., Quesada-Rico, J. A., Gabaldón-Bravo, E., & Hurtado-Sánchez, J. A. (2022). The Associations of Mental Health Disturbances, Self-Esteem, and Partner Violence Victimization with Condom Use in Spanish Adolescents. *Journal of clinical medicine*, *11*(9), 2467.
27. Sully, E.A., Biddlecom, A, Daroch, J., Riley., Ashford, L., Lince-Deroche, N *et al*. (2020). *Adding It Up: Investing in Sexual and Reproductive Health 2019*. New York: Guttmacher Institute.
28. Tele A, Kathono J, Mwaniga S, Nyongesa V, Yator O, Gachuno O, Wamalwa D, Amugune B, Cuijpers P, Saxena S, McKay M, Carvajal L, Lai J, Huang KY, Merali Z, Kumar M. (2022). Prevalence and risk factors associated with depression in pregnant adolescents in Nairobi, Kenya. *Journal of Affective Disorders Reports*, 10:100424.
29. The National Reproductive Health Policy 2022 – 2032. http://guidelines.health.go.ke:8000/media/The_National_Reproductive_Health_Policy_2022_-_2032.pdf
30. Tsevat, D. G., Wiesenfeld, H. C., Parks, C., & Peipert, J. F. (2017). Sexually transmitted diseases and infertility. *American journal of obstetrics and gynecology*, 216(1), 1–9.
31. WHO & OHCHR. (2023). Mental Health Human Rights Legislation: Guidance and Legislation. https://iris.who.int/bitstream/handle/10665/373126/9789240080737-eng.pdf?sequence=1
32. WHO (2021) Mental Health Action Plan 2013-2030. https://iris.who.int/bitstream/handle/10665/345301/9789240031029-eng.pdf?sequence=1
33. WHO. (2021). Mental Health of Adolescents. https://www.who.int/news-room/fact-sheets/detail/adolescent-mental-health
34. WHO. (2023). Adolescent Pregnancy. https://www.who.int/news-room/fact-sheets/detail/adolescent-mental-health
35. Ziyi Wang, Jiaye Liu, Huan Shuai, Zhongxiang Cai, Xia Fu, Yang Liu, Xiong Xiao, Wenhao Zhang, Elise Krabbendam, Shuo Liu, Zhongchun Liu, Zhihui Li & Bing Xiang Yang. (2021). Mapping global prevalence of depression among postpartum women. *Translational Psychiatry,* 11(543).
36. https://www.aku.edu/bmi/Documents/kenya_mental_health_action_plan__2021-2025_.pdf
37. https://www.who.int/publications-detail-redirect/9789240084278
38. http://guidelines.health.go.ke:8000/media/Workplace_Mental_Wellness_Guideline-2023-308-With_Sign.pdf

7 Annex

7.1 Indicator list

Service Point	Mental Health service	Indicators
Antenatal Care	Mental health screening during ANC	Percentage of pregnant adolescents screened for MH at each ANC contact Percentage of pregnant adolescents diagnosed with a mental health condition (anxiety, depression, rejection, discrimination, alcohol and substance use, guilt or shame, suicidal or self-harm etc.) Percentage of pregnant adolescents referred for mental health care
	Counselling on psychosocial support	Percentage of pregnant adolescents who were provided with psychosocial support (partner, family, friends, teachers, mental health professionals, group ANC etc.) Percentage of pregnant adolescents who were sensitized on mental health issues
	Referral and linkages	Percentage of pregnant adolescents who were referred and received mental health care
	High risk screening	Percentage of pregnant adolescents screened for high risk/special needs at ANC contact (SGBV, HIV, chronic illness, disability, child sex workers, orphans, homeless, IDPs/refugees, etc.) Percentage of high risk pregnant adolescents referred for specialized care (comprehensive care clinic, SGBV centers, social workers, Child Services etc.)
	Social financial support	Percentage of pregnant adolescents who have access to social welfare cover
Intrapartum care	Respectful maternity care	Percentage of pregnant adolescent who have received sensitization on their sexual, reproductive and health rights during labour and birthing (right to be free from harm and ill treatment, right to informed consent and refusal of a procedure, respect for choices and preferences, right to privacy and confidentiality, right to be treated with dignity and respect, right to equality and freedom from discrimination and equitable care, right to liberty, autonomy, self-determination and freedom from coercion)
	Psychosocial support	Percentage of pregnant adolescents who had a birthing companion during labour and birthing
Post natal care	Mental health screening during PNC	Percentage of adolescent mothers screened for MH at each PNC visit. Percentage of adolescent mothers accompanied by their child's father for PNC visits. Percentage of adolescent mothers diagnosed with a mental health condition (post-partum psychosis, blues, depression, suicidal or self-harm, infanticide, rejection, discrimination, alcohol and substance use, guilt or shame etc.) Percentage of adolescent mothers at PNC referred for mental health care

	Counselling and psychosocial support	Percentage of adolescent mothers who were provided with psychosocial support (partner, family, friends, teachers, professionals, group PNC etc.) Percentage of adolescent mothers who were sensitized on mental health during PNC (self-care, social skills, life skills etc.)
	Referral and linkages	Percentage of adolescent mothers who were referred and received mental health care
	Social financial support	Percentage of adolescent mothers who have access to social welfare cover

7.2 Mental Health Screening Tools

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

ID #: _____ DATE: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(use "√" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
add columns		+	+	
TOTAL:				

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).

10. If you checked off *any* problems, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all _____ Somewhat difficult _____ Very difficult _____ Extremely difficult _____

PHQ-9 Patient Depression Questionnaire

For initial diagnosis:

1. Patient completes PHQ-9 Quick Depression Assessment.
2. If there are at least 4 ✓'s in the shaded section (including Questions #1 and #2), consider a depressive disorder. Add score to determine severity.

Consider Major Depressive Disorder

- if there are at least 5 ✓'s in the shaded section (one of which corresponds to Question #1 or #2)

Consider Other Depressive Disorder

– if there are 2-4 ✓'s in the shaded section (one of which corresponds to Question #1 or #2)

Note: Since the questionnaire relies on patient self-report, all responses should be verified by the clinician, and a definitive diagnosis is made on clinical grounds taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient.
Diagnoses of Major Depressive Disorder or Other Depressive Disorder also require impairment of social, occupational, or other important areas of functioning (Question #10) and ruling out normal bereavement, a history of a Manic Episode (Bipolar Disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms.

To monitor severity over time for newly diagnosed patients or patients in current treatment for depression:

1. Patients may complete questionnaires at baseline and at regular intervals (eg., every 2 weeks) at home and bring them in at their next appointment for scoring or they may complete the questionnaire during each scheduled appointment.
2. Add up ✓'s by column. For every ✓: Several days = 1 More than half the days = 2 Nearly every day = 3
3. Add together column scores to get a TOTAL score.
4. Refer to the accompanying PHQ-9 Scoring Box to interpret the TOTAL score.
5. Results may be included in patient files to assist you in setting up a treatment goal, determining degree of response, as well as guiding treatment intervention.

Scoring: add up all checked boxes on PHQ-9

For every ✓ Not at all = 0; Several days = 1;
More than half the days = 2; Nearly every day = 3

Interpretation of Total Score

Total Score	Depression Severity
1-4	Minimal depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

A26828B 10-04-2005

Patient Health Questionnaire-2 (PHQ-2)

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3

For office coding: _____0_____+_____+_____+_____

= Total Score _____

The PHQ-2 consists of the first 2 questions of the PHQ-9. Scores range from 0 to 6. The recommended cut point is a score of 3 or greater. Recommended actions for persons scoring 3 or higher are one of the following:

- Administer the full PHQ-9
- Conduct a clinical interview to assess for Major Depressive Disorder

1. Kroenke K, Spitzer RL, Williams JB. The Patient Health Questionnaire-2: Validity of a Two-Item Depression Screener. *Med Care*. 2003, Nov;41(11):1284-92.
2. Kroenke K(1), Spitzer RL, Williams JB, Löwe B. The Patient Health Questionnaire Somatic, Anxiety, and Depressive Symptom Scales: a systematic review. *Gen Hosp Psychiatry*. 2010 Jul-Aug;32(4):345-59.

Adapted from the patient health questionnaire (PHQ) screeners (www.phqscreeners.com). Accessed October 6, 2016. See website for additional information and translations.

CLIENT EXIT SURVEY TOOL

Pregnant adolescents' experience with integrated mental health services at maternal child health service delivery points

Date _____/_____/_____

Services Sought (tick all that apply):

☐ Antenatal Care (ANC) ☐ Intrapartum Care (IPC) ☐ Postnatal Care (PNC)
☐ Mental Health Services ☐ Others: _____

SECTION A: RESPONDENT PROFILE (OPTIONAL & ANONYMOUS)

Question	Response Options
Age	☐ 10–14 ☐ 15–17 ☐ 18–19 ☐ 20 and above
Is this your first pregnancy?	☐ Yes ☐ No
If No, state the number of pregnancy	☐ 2nd ☐ 3rd ☐ 4th ☐ 5th ☐ 6th ☐ 7th
Have you visited this facility before?	☐ Yes ☐ No

SECTION B: SERVICE EXPERIENCE

Question	Response Options
1. How were you received at the facility?	☐ Excellent ☐ Good ☐ Fair ☐ Poor
2. How long did it take you to receive services?	☐ Less than 1 hour ☐ 1–2 hours ☐ 2–4 hours ☐ Over 4 hours
3a. Were you informed about the length of time the services you sought would take?	☐ Yes ☐ No
4a. Were you treated with respect by the healthcare provider?	☐ Yes ☐ No
4b. If No in 4a, what form of disrespect did you experience?	Physical abuse ☐ Yes ☐ No Verbal/emotional abuse ☐ Yes ☐ No Non-confidential care ☐ Yes ☐ No Non-dignified care ☐ Yes ☐ No Denial of care ☐ Yes ☐ No Neglect/abandonment ☐ Yes ☐ No Detention ☐ Yes ☐ No Demand for bribe ☐ Yes ☐ No Other (specify)_____

5. Did the healthcare provider describe the services you would receive in a way you understood?	☐ Yes ☐ No
6a. Were you given an opportunity to ask questions?	☐ Yes ☐ No
6b. Were you satisfied with the responses provided?	☐ Yes ☐ No
7. How would you rate the cleanliness of the facility?	☐ Excellent ☐ Good ☐ Fair ☐ Poor
8a. How did you pay for the services?	☐ Cash ☐ Social Health Authority (SHA) ☐ Not Applicable ☐ Waived ☐ Any other? Specify (for other medical covers/insurance firms) _____
8b. Did you receive all the services that you needed during this visit?	☐ Yes ☐ No
If No to 8b, which services were not provided? (please list all)	
9a. How comfortable are you with the facility's operating hours?	☐ Comfortable ☐ Not Comfortable
9b. If you are not comfortable, what time would you be comfortable with?	☐ Early morning ☐ Lunch time ☐ Late evening ☐ Weekend ☐ Public holidays

SECTION C: PRIVACY AND CONFIDENTIALITY

Question	Response Options
10 a. Were the services provided in a private manner? (e.g. separate room, bed screens etc.)	☐ Yes ☐ No
10 b. Did the service provider assure you that the information you provided would be treated with confidentiality?	☐ Yes ☐ No
10c. If No (in either 10a or 10b), what would have been done differently to make you more comfortable?	
10d. Were you accompanied (by a friend, guardian, caregiver, parent etc.) during this visit?	☐ Yes ☐ No
10e. If Yes in 10d, did the service provider obtain your consent to allow the presence of the person accompanying you during service delivery?	☐ Yes ☐ No
10f. If No in 10e, would you have wanted your consent to be sought?	☐ Yes ☐ No

SECTION D: INFORMATION RECEIVED

Question	Response Options
11. What health education/ information did you receive during this visit?	
12. How was the information provided? (Tick all that apply)	☐ One-on-One Session ☐ Group Session ☐ Posters ☐ Visual Aids ☐ Other: _____
13. Is there any other topic/ information you feel could have also been discussed?	1. 2. 3.

SECTION E: PSYCHOSOCIAL SUPPORT

Question	Response Options
14a. Did you feel supported, cared for and listened to during your visit?	☐ Yes ☐ No
14b. If no, what would have been done differently to make you feel supported?	

SECTION F: REFERRALS AND LINKAGES

Question	Response Options
15a. Were you referred to this health facility?	☐ Yes ☐ No ☐ Self-referral
15b. If yes, where were you referred from?	☐ Community ☐ Health Facility ☐ Other: _____
15.c. If you were referred, how was it?	☐ Verbal ☐ Written (referral note)
16. What was the reason for referral?	Reason: _____ _____ _____
17a. Did you receive all the services you required today?	☐ Yes ☐ No
17b. If No, were you referred to another facility for those services?	☐ Yes ☐ No

SECTION G: OVERALL FEEDBACK

Question	Response Options
Would you return or come back for services in this facility?	☐ Yes ☐ No
Would you recommend/refer someone to this facility?	☐ Yes ☐ No
Overall, how satisfied were you with the services received today?	☐ Very satisfied ☐ Satisfied ☐ Not satisfied ☐ No response

SECTION H: RECOMMENDATIONS

How would you want services improved in the areas below?

Area	Your Suggestions for Improvement
Service Delivery	
Infrastructure	
Referral Systems	
Other Suggestions	

FACILITY BASELINE ASSESSMENT TOOL
MENTAL HEALTH INTEGRATION FOR PREGNANT ADOLESCENTS

Introduction

Good morning / Good afternoon. My name is _____, and I am supporting the Ministry of Health (MoH) in the piloting of a new handbook designed to integrate mental health support for pregnant adolescent girls into routine maternal and child health (MCH) services, including antenatal care (ANC), labour and birth, and postnatal care (PNC). The Unit of Reproductive and Maternal Health (DRMH) is spearheading this initiative to bolster Kenya's dedication to providing inclusive, high-quality, and adolescent-responsive care. According to the 2022 Kenya Demographic and Health Survey (KDHS), the teenage pregnancy rate in Kenya stands at 15%. Many of these young mothers experience emotional distress and mental health challenges that are often overlooked in routine care. To address this gap, the ministry has developed a comprehensive handbook that provides practical strategies for integrating mental health services into the continuum of care. Before national rollout, we are conducting a pilot in select counties and facilities that offer maternal and mental health services to adolescent girls and young women.

This survey will help us:

- Understand the current state of readiness in health facilities to offer mental health services for pregnant adolescents.
- Identify strengths and gaps in training, service delivery, referral systems, and tools.
- Inform adjustments to the handbook and implementation plan to better align with realities on the ground.
- Generate evidence for advocacy and policy formulation

We look forward to your honest feedback and experiences in delivering services to adolescent clients and a clear picture of what is working and what may need support so that we can strengthen adolescent care moving forward.

All responses will remain confidential and will only be used for programme improvement.

Estimated time: **30–40 minutes**

Consent to proceed? Yes _____ No_____ **Date _____/_____/_____**

SECTION 1: FACILITY PROFILE

1. Name of Facility	
2. Kenya Master Health Facility (KMHF) List Code	
3. Facility Level	☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6
4. County	
5. Sub-county	
6. Designation of the respondent	
7. Contact Information (Phone/ Email)	Phone number: ---------- Email: ----------

SECTION 2: SERVICE DELIVERY POINT

8. Service Delivery point (Tick all that apply.)	☐ Antenatal Care (ANC) ☐ Intrapartum Care (IPC) ☐ Postnatal Care (PNC)

SECTION 3: STAFF CAPACITY

Question	Response
9. What is the number of healthcare providers currently working in this service delivery point?	
10. What is the number of HCP trained in adolescent responsive services?	
11. What is the number of healthcare providers trained in mental health?	
12. Are healthcare providers trained to offer adolescent-responsive mental health services?	☐ Yes ☐ No ☐ In progress
13. Are healthcare providers able to identify mental health concerns in pregnant adolescents during service delivery?	☐ Yes ☐ No ☐ Somewhat
14. Are healthcare providers able to respond to mental health concerns in pregnant adolescents during service delivery?	☐ Yes ☐ No ☐ Somewhat
15. Do you have a designated mental health focal person?	☐ Yes ☐ No
16. Are there stress management mechanisms for healthcare providers?	☐ Yes ☐ No

SECTION 4: SERVICE DELIVERY PRACTICES

Question	Response
17. Does the facility provide mental health services to pregnant adolescents?	☐ Yes ☐ No
18. Is there a structured schedule for adolescent ANC/PNC services?	☐ Yes ☐ No
19. a. Are non-clinical staff involved in adolescent care?	☐ Yes ☐ No
b. If yes, how are they involved?	
c. If no, are there plans to involve them?	
20. What additional support would improve adolescent mental health integration? (Training, infrastructure, job aids, mentorship, staffing and others)	

SECTION 5: MENTAL HEALTH SCREENING PRACTICES

Question	Response
21. Are pregnant adolescents screened for mental health conditions?	☐ Yes ☐ No
22. At which service points is screening done?	☐ ANC ☐ Labour and Birthing ☐ PNC ☐ Other (specify) _____
23. What mental health conditions are screened for?	☐ Depression ☐ Anxiety ☐ Substance Use ☐ Suicidal Thoughts ☐Other_____
24. What tool(s) are used?	☐PHQ-2 ☐PHQ-9 ☐Other (specify)_____
25. Who conducts the screening?	☐ Nurse ☐ Clinical Officer ☐ CHP ☐ Other _____ _____
26. What challenges exist in mental health screening?	

SECTION 6: FACILITY ENVIRONMENT

Question	Response
27. Are adolescent-friendly IEC materials or signage visible at this service delivery point?	☐ Yes ☐ No
28. Is there a dedicated private space/room for pregnant adolescent consultations?	☐ Yes ☐ No
29. Are pregnant adolescents involved in service feedback (e.g., suggestion boxes, Community Health Promoters' reports)?	☐ Yes ☐ No

30. Are pregnant adolescents charged for mental health services?	☐ Yes ☐ No
31. What features make this service delivery point friendly to pregnant adolescents/new adolescent mothers?	
32. What features make this service delivery point accessible to pregnant adolescents with disabilities/new adolescent mothers with disabilities?	
33. Are pregnant adolescents/new adolescent mothers given the option for a support person during service?	☐ Yes ☐ No

SECTION 7: REFERRALS & LINKAGES

Question	Response Format
34. Does the facility refer adolescents for mental health or psychosocial services?	☐ Yes ☐ No
35. What types of referrals are made?	Facility-based 1. 2. Community-based 1. 2.
36. Are referral and linkage pathways documented (directory, talking wall, listing)?	☐ Yes ☐ No
37. a. Does the facility have standardised referral forms?	☐ Yes ☐ No
b. If yes, do staff use standardised referral forms?	☐ Yes ☐ No
c. What forms or tools are used for referral?	☐ MoH Form 100 ☐ Partner Tools (specify) _____ _____ _____ ☐ Other (specify) _____ _____ _____
38. a. Is feedback from referred/linked services tracked?	☐ Yes ☐ No
b. If yes, how?	
39. What challenges are encountered in the referral and linkage process?	

SECTION 8: DATA AND DOCUMENTATION

Question	Response
40. Does the facility record mental health data separately?	☐ Yes ☐ No ☐ Partially
41. Which tools capture mental health-related service data?	
42. Is adolescent mental health data included in monthly reports?	☐ Yes ☐ No ☐ Not sure
43. Who is responsible for mental health data compilation and submission?	

SECTION 9: CHALLENGES AND RECOMMENDATIONS

Question	Response
44. What are the main challenges to delivering adolescent ANC, labour and birth, PNC, and mental health services?	
45. What are your recommendations to improve adolescent mental health integration?	

Thank you. Your inputs are critical to improving services for pregnant adolescents across Kenya

LIST OF CONTRIBUTORS

No	Name	Job Title	Organization	County
1	Dr. Edward Serem	Head, DRMNCAH	MOH-DRMNCAH	Nairobi
2	Dr. Jeanne Patrick	Head	MOH-RMNH Section	Nairobi
3	Dr. Juliet Omwoha	Head	MoH-NCH Section	Nairobi
4	Dr. Christine Wambugu	Head	MOH-AH Section	Nairobi
5	Dr. Albert Ndwiga	PM	MOH-DRMH	Nairobi
6	Hellen Mutsi	PO	MOH-DRMH	Nairobi
7	Scolastica Wabwire	PO	MOH-DRMH	Nairobi
8	Karen Aura	PO	MOH - DRMH	Nairobi
9	Florence Ireri	PO	MoH-DRMH	Nairobi
10	Catherine Waweru	Psychiatrist	MoH-DMH	Nairobi
11	Kolum Cosmas	PO	MOH-DRMH	Nairobi
12	Jacqueline Kisia	PM ASRH	MOH-DRMH	Nairobi
13	Janet Nyaboke Mogire	PO	MOH-DRMH	Nairobi
14	Jane Koech	SPO	MOH-DRMH	Nairobi
15	Naomi Ida Anyango	PO	MOH-NASCOP	Nairobi
16	Mary Gathitu	PO	MOH-DRMH	Nairobi
17	Martin Mburu	SPO	MOH-DRMH	Nairobi
18	Susan Kariuki	Adolescent Dev. Specialist	UNICEF	Nairobi
19	Albino Luciani	Consultant	UNICEF/MOH	Nairobi
20	Jane Kishoyian	Prog. Coordinator - RMNCAH	CHAK	Nairobi
21	Dr. Janet Muia	Psychiatrist	KUTRRH	Nairobi
22	Stephen Muthama	CCO [RH Specialist]	Mama Lucy Kibaki Hospital	Nairobi
23	Janet Bonareri Machogu	AYSRH/GBV Coordinator	Mbita Sub-County	Homabay
24	Shillah Mwavua	Clinical Psychologist	Nairobi City County	Nairobi
25	Mary Magubo	PO	MOH-DRMH	Nairobi
26	Dr. Laura Oyiengo	MNH Specialist	UNICEF	Nairobi
27	Jonah K. Rotich	ED SPECIALIST	UNICEF	Nairobi
28	Dr. Saul K. Naibei	MO	CDH	Bungoma
29	Fidelis Wanjiku	A Young Mother	Tabasamu Cafe Pangani Clinic	Nairobi
30	Kevin Kiarie	A Young Father	Tabasamu Cafe Pangani Clinic	Nairobi
31	Winnie Mwanzia	F. O	GEM TRUST	Kajiado
32	Wanjiku Gathoni Kingori	Prog. Coordinator	A360: PS Kenya	Nairobi
33	Divina James	Country Rep.	REPSSI	Nairobi
34	Jane Owuor	CRHC	CDH	Kisumu
35	Consolata Siree	CRHC	CDH	West Pokot
36	Robina Anene	CRHC	CDH	Nairobi
37	Doris Mwanzui	CRH-FP	CDH	Kilifi
38	Alfayo Wamburi	SBC Advisor	Breakthrough Action	Nairobi
39	Morine Sang	CPO	UNICEF	Nairobi
40	Kevin Esanjilo	Champion	White Ribbon Alliance [WRA]	Nairobi

41	Stellah Rekenoi	Adolescent Parent	White Ribbon Alliance	Kajiado
42	Mupalia Antony	PO	White Ribbon Alliance (WRA)	Nairobi
43	Serah Musengya	Educator in Emergencies	UNICEF	Nairobi
44	Jennifer M. Joseph	Clinician - RH	CDH	Machakos
45	Eunice Moraa	Asst Director	MoH-DCS	Nairobi
46	Beth Moraa	Project's Assistant	NIGEE	Kisumu
47	Angelo Mwicuiri	PO	MOH	Nairobi
48	Grace Wanjiku	Mental Health O	TIKO Africa	Nairobi
49	Florence Musalia	DDE	Ministry of Education	Nairobi
50	Charity Murugu	Admin	DRMNCAH	Nairobi

PRETESTING TEAMS

KILIFI COUNTY	
Kilifi County Referral Hospital	
Name	**Designation**
Said Ndoro	Nutiritonist
Leonard Nasoro	Mental Nurse
Holice Maekaran	Medical Social Work
Halima Hassan Mwabundu	Registered Nurse
Mamam Salem	Nurse
Nyadzua M. Pandao	Nurse
Josephine Kazungu	Nurse
Mary Mwakughu	Nurse
Raymond Katana	Medical Social Worker
Malindi Sub County Referal Hospital	
Samuel Chiro	Medical Social Worker
John Ngira	Nurse
Janet Mnyazi Safari	Nurse
Maimuna Riungu	Nurse
Neema Johnson Kombe	Nurse
Beatrice Njeru	Mental Health Nurse
Dorice Welimo	SNO
Doris Mwanzui	CRHC
NAIROBI COUNTY	
Pangani Health Centre	
Jeniffer Kisilu	C.O Clerk
Beatrice Macharia	Counsellor
Peter Kibuchi	CHA

Lilian Moraa	Nursing Officer
Julius Miruka	Adherence Consultant
Lavina N. Abajila	Nutritionist
Stephen Omondi	Facility In charge
Modesty Chelagat Wekesa	Nursing Officer
Mama Lucy Kibaki Hospital	
Evans Nchoki Ayieng'a	Chief Pharmacist
Brenda Ochieng	Nutrition Officer
Ann Maru	Nurse Maternity
Stella Gacheri	Rco Mental Health
Carolyne Omasaja	Nurse Postnatal
Josephine Odhiambo	Nutrition Officer
Stella Mbaka	Psychologist
Julius B. Muya	Medical Social Worker
Lawrence Kamau Waithara	Nurse RH
Isabel Owiyo	Senior Nurse
WEST POKOT COUNTY	
Kacheliba Sub County Hospital	
Consolata Siree	CRHC
Philomena C. Akudian	Social Worker
Jacob Lumbasi	Psychologist
Ptormos Georgina	Nutritionist
Winnie Chepkorir Bomet	Nurse
Lokapel Lotuw Mark	No Incharge
Apurot Chepkemoi Monica	Nurse
Agnes C. Ngolekou	Sub County R.H
Lyndah Saina	Nurse
Filex M. Lorema	PHO
Kapenguria County Referral Hospital	
Monicah Maswai	Counsellor
Anna Epaalat	Nursing Officer
Sophia Chelimo	Social Worker
Fidelis Dola Otieno	Clinical Psychologist
Lonah Katul Arengenyang	Nutrition Officer
Agnes S. Khisa	CNO
Gladys Cheyech	Nursing Officer
Consolata Siree	CRHC
Justus Kosen	CHEW
Jane J. Kirop	NO In charge
Alice Waweru	Nursing Officer

KISUMU COUNTY	
Kisumu County Referral Hospital	
Jeniffer Apiyo Otieno	SCRH
Dorine Ciarah Salamba	Nurse
Lavine Akinyi Oluoch	Nutritionist
Basil Okumu Okoth	Nurse
Victor Alindi	Social Worker
Lucy Olang	CHA
Dr. Ogolla	DMS
Dr. Tom Nyanwara	Med. Sup
Maurice Ojowi	CNO
Jaramogi Oginga Odinga Teaching and Referral Hospital	
Cosmas Ngisa	NO
Doris Onyach	Nutritionist
Dorothy Ochieng	Medical Social Worker
Colleta Odero	Nurse
Kevin Juma Ndede	CHA
Camilla Mbogo	NO
Agnes Dawa	D/CRHC
Nahum Ochieng Owino	NO
Nyakinda C. Anyango	CRNO
Betty Onyango	Nurse
Janet Ooko	Nurse

REPUBLIC OF KENYA

MINISTRY OF HEALTH

Division of Reproductive, Maternal, Newborn, Child and Adolescent Health. Ministry of Health

PO BOX 43319-00100 Nairobi, Kenya.