# Responsive primary health care systems for adolescents and mothers in West Africa

Policies, systems, and interventions to assure access, high quality and responsive adolescent mental, sexual and reproductive health: Adolescent, Maternal and Frontline health worker Mental health in West Africa.





**Dates:** 13 & 14 May 2024

**Location:** Abuja, Nigeria

# Acknowledgements

**Organizers:**

West African Health Organization (WAHO), in the context of the Assembly of Economic Community of West African States (ECOWAS) Health Ministers meeting held from 13 to 17 May at the ECOWAS Commission, Abuja. In collaboration with research partners: Ghana College of Physicians and Surgeons (GCPS) and Ghana Health Service, Research and Development Division, Dodowa Health Research Centre (DHRC); KNUST, ISSER, IASP Burkina Faso, LASDEL Niger, UdeM Canada, LSHTM & UoL UK, HUSPH Vietnam, UoM Australia (AdoWA and RESPONSE research teams).

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# Table of Contents

# Theme, Objectives and focus

## Theme

Improving Adolescent Mental, Sexual and Reproductive Health and Health Systems Responsiveness to Frontline Health Worker and Maternal (including adolescent Mothers) Mental Health Needs in West Africa

## Objectives

1. Share results from ongoing research and interventions on adolescent mental, sexual and reproductive health, and health systems responsiveness to maternal mental health in West Africa.
2. Engage with key stakeholders and reflect on implications for policy and program development, and implementation, for improving adolescent mental, sexual, and reproductive health and maternal mental health.
3. Collectively reflect with policy actors on needs and demands for future research.
4. Reflect on the strengths and limitations of coproduction approaches from the two consortia about establishing and sustaining research policy partnerships.

The focus of the meeting was presentations and discussions of research and interventions to strengthen and improve primary health policy, systems, and outcomes for adolescent mental, sexual, and reproductive health, as well as maternal (including adolescent mother) and frontline health worker mental health. This report summarizes the key highlights of activities from the two-day conference, the discussions and conclusions and the communique developed at the end of the meeting and presented to the West Africa Health Organization by the participants to contribute to inform health policies and programs in West Africa / the Economic Community of West African States (ECOWAS).

# Overview of Participants

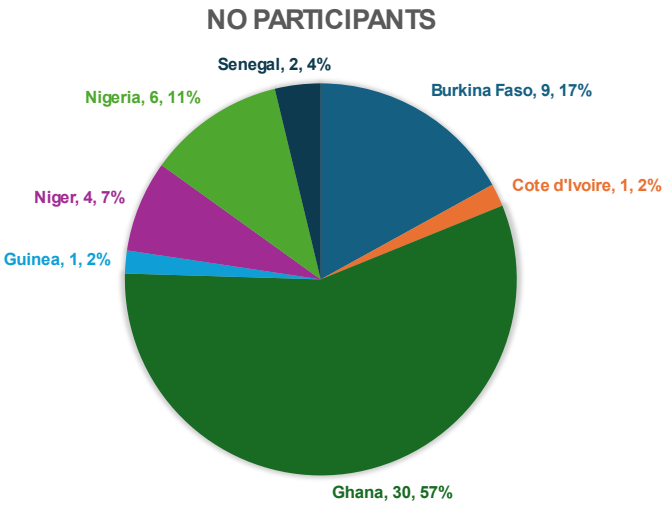
There were 53 participants from seven countries in West Africa namely: Ghana, Burkina Faso, Niger, Cote d'Ivoire, Nigeria, Senegal and Guinea. They were from national and sub-national levels representing decision makers, implementers, CSO, Journalists, frontline health workers, representatives of adolescents and researchers. The most participants were from Ghana because of the three research teams (AdoWA-REP, AdoWA-GTR, RESPONSE) as well as the national level decision makers, frontline health workers and manager involved in the pilot and formative evaluation of the joint RESPONSE & AdoWA-REP intervention in two districts in Ghana. The co-production and participatory action research approach taken to the piloting and formative evaluation of the intervention in Ghana, meant that most of the presentations of experiences and lessons was led by participants from the health system or done jointly by the research team and participants from the health system. The short timelines within which the meeting was organized (dates were finally confirmed only about 4 weeks to time) affected participation from several countries.

Three adolescents participated – two from Ghana and one from Burkina Faso. The two adolescents from Niger were unable to travel and the research team in Niger helped them to organize and send a video recording as their input into the meeting. In Ghana the adolescents were selected by an essay competition in the schools were the primary data collection was done. The essay competition was organized by the Alliance for reproductive health rights (ARHR). Because of the uncertainties generated

by the coups in Niger and Burkina Faso in 2023 ARHR was unable to travel there to support the research teams as originally planned.

Most participants were from ministries of health in their countries. There was one journalist from Senegal and Civil Society Organization participation from Ghana and Burkina Faso. Participants are summarized by country in figure 1. More detail can be found in appendix 3.

Figure 1: Participants by Country



# Communique

## Preamble

In the context of the technical meetings around the ECOWAS summit of health Ministers hosted by the Federal Ministry of Health Nigeria and the West Africa health organization (WAHO) and themed around quality of care in West Africa; multi-stakeholders in health from countries in West Africa participated in two days of presentations and discussion of research on health policy, systems and interventions for adolescent mental sexual and reproductive health and maternal and frontline health worker mental health on 13th and 14th May 2024 at the Continental Hotel, Abuja Nigeria.

## Observations

(1) Mental Health is important for everyone across the life course, but marginalized and neglected in health policy systems and implementation priorities.
(2) Much of maternal and adolescent health programing focuses on sexual and reproductive health and synergies between mental health and sexual and reproductive health are missed.
(3) Frontline health worker mental health is a neglected dimension of health system responsiveness across ECOWAS. Health worker mental health their ability to be responsive to clients and provide high quality of care. Health workers in situations of insecurity and conflict are particularly vulnerable.
(4) Adolescent health programming is dominated by sexual and reproductive health with a focus on girls and a relative neglect of the issues of adolescent boys such as increasing problems with substance abuse and other mental and social health and wellbeing issues.
(5) Households are the primary producers of health and family including male engagement is critical in adolescent as well as maternal mental health.
(6) There remains evidence to policy gap in health in the ECOWAS sub-region. Much of the research evidence generated remains within academics and researcher circles creating gaps between research, policy and practice.
(7) Drivers of adolescent and maternal health are intersectional cutting across multiple sectors. The tendency to ignore how to tackle some of the complex, difficult intersectional drivers and power issues, and focus on selective programs and low hanging fruit e.g. access to contraceptives yields sub-optimal results.
(8) Co-production (Co-design) of interventions with stakeholders drives development of innovative solutions that work in context.

## Recommendations

**(1) Quality PHC needs to be people centered and context relevant**

a. Design and implement programs around the whole person and the contexts in which they live rather than individual conditions.
b. Households are the primary producers of health and families need to be encouraged to support the health of adolescents and mothers.
c. Despite the complexity and difficulties, it is important to invest effort in development and implementation of interventions that address intersectionality and the social determinants of health.
d. Multi-sectoral approaches are important.

(2) **Integrate Mental health across the life cycle and for frontline health workers**

a. Mental health needs to be integrated into adolescent sexual and reproductive health and maternal health programing as part of PHC.
b. Interventions that provide rapid screening for mental health distress with follow up of those showing distress are implementable in context and can make a difference.
c. Frontline health worker mental health is an essential part of primary care. It should be supported using simple interventions such as periodic screening and provision of follow up support to those in need.
d. Development of simple mental health Indicators for use across health systems and programs in West Africa, and integrated into routine health management information systems and tracked as part of people centered rather than disease and program centered PHC is needed.
e. Mental health and SRH issues are still stigmatized and continued awareness raising, education and advocacy are needed.

(3) **Co-produce (Co-design) interventions with stakeholders**

a. Co-production of interventions with stakeholders ensures better design and implementation of interventions that are people centered, contextually relevant and effective.
b. As part of co-production, policy makers and funders should listen to and understand local stakeholders before choosing geographic locations, focus and shape of interventions.
c. Co-production helps to ensure that programs are designed to meet variations in need e.g. adolescents in school or out of school, younger or older adolescents.

(4) **Financing**

a. Resources allocation needs to be adequate to support integrated people centered approaches to primary health care.
b. To assure financial access, equity and universal health coverage it is important that services are free at point of service.
c. Where there is national health insurance adolescent health, maternal health and mental health must be part of the benefit package

(5) **Capacity Building and Innovation**

a. Capacity building is needed to help health workers at all levels to provide more integrated people centered care.
b. Capacity building needs to be sustained over time.
c. Cross country collaboration and learning across West Africa is important to support capacity building for innovation and development in the sub-region.
d. Build the capacities of journalists to be able to report health issues including adolescent and mental health.
e. Draw on and adapt existing and emerging technology, including the increasing use of smart phones for contextually relevant innovation.

# Appendices

## Appendix 1 – Time table

Day 1

Focus on findings and experiences in co-production of interventions related to adolescent mental, sexual and reproductive health in Burkina Faso, Ghana and Niger and relevance for wider ECOWAS community

Morning Session: 9.00am – 1.00pm

CHAIR: Ms. Vicky Okine, Executive Director, Alliance for Reproductive Health Rights

1) 9.00am – 10.00am Opening.
   a) Welcome & Self Introduction of participants - Chair
   b) Background to the AdoWA research presentation 10 mins – Irene Agyepong
   c) Brief Opening remarks by DG WAHO
   d) Group Photo with DG WAHO and team

2) 10.00am – 11.00 am. Country Presentations and discussion

Focus on: (i) Research findings related to Adolescent and stakeholder perspectives on adolescent mental, sexual and reproductive health, and the responsiveness of primary care to their needs and implications for implementation and de-implementation of interventions (ii) experiences with co-production of interventions for adolescent mental, sexual and reproductive health in Burkina Faso, Ghana and Niger. 25 min presentation from each country with 15 mins for clarification questions and discussions

   a) Start of morning presentations
      i) Burkina Faso: Dr. Maurice Yaogo (IASP Burkina Faso) (25 min presentation plus 15 mins discussion = 40 mins)

**11.00am – 11.30am Coffee break.**

3) 11.30am – 1.00pm. Country Presentations and discussion continued

   a) Continuation of morning presentations
      i) Ghana: Dr. Lauren Wallace & Ms. Natasha Darko (DHRC /GCPS Ghana) 40 mins
      ii) Niger: Mr. Saidou Oumarou (LASDEL Niger) 40 mins
   b) Documentaries on adolescent perspectives from Ghana, Burkina Faso and Niger
   c) Perspectives from Adolescents: Ghana (…..) Burkina Faso (……) (30 mins)

d) Comments from other stakeholders (Adolescent health focal persons, School health coordinators, policy makers, implementers, CSO in mental health and in adolescent health etc)
e) Moderated discussion with reflection and inputs from other countries in the sub-region: 60 mins
    i) commonalities, contrasts with experiences from other countries in the sub-region,
    ii) policy and program implications
    iii) Lessons for co-production

**1pm – 2.00pm. Lunch.**

Afternoon Session: 2.00pm – 5.00pm

CHAIR: Dr. Ama Fenny – Health Economist. UG-ISSER

4) 2.00pm – 5.00pm. Afternoon session – Efficiency of production of adolescent mental, sexual and reproductive primary care services.
    a) Presentations from 3 case study countries by
        i) Dr. Nassirou Ibrahim (LASDEL Niger),
        ii) Dr. Jacob Nonvignon (KNUST Ghana),
        iii) Mr. Ludovic Tapsoba (IASP Burkina Faso)
    b) Moderated discussion on:
        i) Commonalities, contrasts with experiences from other countries in the sub-region
        ii) Policy and program implications and way forward

Day 2

Improving health systems responsiveness to frontline health worker and maternal mental health (including pregnant and post-natal adolescents).

9.00am – 1.00pm Morning Session

Focus: Health systems responsiveness to Frontline health worker and Maternal Mental Health (including adolescent mothers)

CHAIR: ….TBD

1) Pre-Coffee break session (9.00am – 11.00am)
    a) Background to health system responsiveness & the RESPONSE intervention co-production process (Irene Agyepong & Linda Lucy Yevoo) 20 mins
    b) Clarification Questions and discussion (10 mins)
    c) Practical Exercise: Experiencing the frontline health worker intervention
        i) Introduction to the DASS21 questionnaires – Elizabeth Awini and Wonder Siegward (10 mins)
        ii) Self-administration of the DASS21 questionnaire by participants on their mobile phones to get first hand experience (10 mins)
        iii) Representatives of the intervention team will be available during the break to discuss results one on one for those would like to discuss
    d) Implementation of the Frontline health worker intervention - findings and experiences from first 3 months
        i) Presentation Dr. Adjei (Psychiatrist and Intervention lead Pantang Hospital) and Dr. Adjoa Kusi-Kyere (GHS HQ Mental health unit) [15 mins]
        ii) Discussion 15 mins

e) Implementation of the Maternal Health Client intervention
    i) Self-administration of the SRQ20 questionnaire by participants on the mobile phones to get first hand experience and understanding of the tool (15 mins) – Elizabeth Awini, Wonder Siegward & district implementation teams
    ii) Presentation – Maternal Health Client Intervention
        (1) Ningo Prampram district experience Dr. Nuertey DDHS Ningo Prampram, Madam Agnes Odum, Registered Community Mental Health Nurse Ningo Prampram (15 mins)
        (2) Shai-Osudoku district experience Rev. Ebenezer Asiamah DDHS Shai Osudoku & 15 mins)
        (3) Unique issues of Adolescent mothers – Ms. Abigail Miwornunyuie, Adolescent health coordinator Ningo Prampram and Ms. Sharifata Mohamed GHS HQ Adolescent health unit (10 mins)
    iii) Discussion will be after coffee break. Please write down all your questions and note your comments.

**Coffee Break 11.00am – 11.30am. Posters and policy briefs on display**

2) Post Coffee Break Session (11.30am – 1.00pm)
    a) Questions and discussions on the pre-coffee break session presentations (40 mins)
    b) Moderated discussion on improving responsiveness to frontline health worker and maternal mental health (includes adolescent maternal health clients) (40 mins)
        i) Commonalities, contrasts with experiences from other countries in the sub-region
        ii) Feasibility of the intervention in other contexts
        iii) Policy and program implications
        iv) Reflect on experiences of co-production of interventions from the perspective of research-policy partnerships

**1pm – 2.00pm. Lunch. Posters and policy briefs on display**

2.00pm – 5.00pm Afternoon session:

Focus on next steps and communique finalization

3) 2.00pm – 3.30pm
    a) What should we do next?
        i) Reflect on lessons for program implementation and de-implementation to support AMH, ASRH and MMH
        ii) Brainstorming on future research agenda from the perspective of the key stakeholders?
4) 3.30 – 4.30pm Synthesis of key policy and program implications, and finalization of communique
5) 4.30 pm Presentation of communique and close.

Note takers /Rapporteurs

Mr. David Owiredu, Ms. Bernice Gyawu, Ms. Maame Akua Asiamah and Dr. Paapa Yaw Asante

## Appendix 2 – Daily Rapporteur Summaries

**Day One (1) Overview:**

Day one (1) of the meeting focused on the context analysis research and findings from AdoWA-REP and AdoWA-GTR; including sharing findings and experiences in the ongoing process of stakeholder consultations for co-production of interventions including potentially gender transformative interventions for adolescent mental, sexual and reproductive health in Burkina Faso, Ghana, and Niger, and their relevance for the wider ECOWAS community.

The meeting included presentations, discussions, and excerpts from documentaries that highlighted the multifaceted challenges faced by adolescents in the various countries.

**Morning Session Highlights:**

The morning session of the meeting commenced at 9:45 a.m. with a warm welcome by Professor Agyepong. Professor Agyepong greeted attendees with an air of anticipation for the discussions ahead and introduced Madam Vicky Okine, Executive Director, ARHR as the chairperson for the morning session.

In welcoming attendees, Madam Vicky stressed the significance of the gathering in addressing the multi-dimensional health needs of adolescents across West Africa. Unpacking the efforts of the AdoWA project, she emphasized the importance of research, innovation, and partnership in advancing adolescent health outcomes.

**Presentations**

The day's round of presentations and discussions started with Prof Agyepong's presentation on the overview of the AdoWA project. Reflecting on the project's endeavours, Professor Agyepong highlighted the dedication of teams from Burkina Faso, Ghana, and Niger in unravelling the complexities surrounding adolescent health; specifically, adolescent mental, sexual and reproductive health.

She further expressed gratitude for the opportunity to share findings from the ongoing research and interventions, recognizing the invaluable insights they offer into the region's health landscape.

**Presentation from the Burkina Faso Team:**

Presentation from Burkina Faso focused on adolescent mental, sexual and reproductive health: a neglected dimension of primary health care for adolescents in West Africa.

Dr. Maurice Yaogo among other things, presented an overview of the research methods employed in Burkina Faso, providing insights into the adolescent health landscape and intervention co-production process. This included the analysis of existing reference documents and studies which provided a contextual understanding of adolescent health policies and programs; and interviews and focus group discussions with various stakeholders, including policymakers, health workers, teachers, and adolescents which yielded valuable data on challenges and opportunities in adolescent health.

**Key Results**

The study revealed that Burkina Faso has since the 1990s had an institutional framework to support adolescent health services. Despite these efforts, issues like unwanted pregnancies and STDs remain prevalent, highlighting service provision gaps. The study also found that mental health, particularly among adolescents, is significantly under-addressed due to societal taboos and negative attitudes from

healthcare providers and parents. Additionally, barriers to accessing care included restrictive social norms and centralized, resource-limited service delivery. However, initiatives such as welcoming healthcare environments and fee waivers have improved service utilization, leading to reductions in unwanted pregnancies. Participatory workshops from intervention co-production further emphasized the need for better education for parents and adolescents, improved mental health training for health workers, and more adolescent-friendly healthcare environments.

**Discussions/Questions/Comments and Responses**

- Addressing Insecurity Issues
    - Comment: Concerns were raised about addressing adolescent health needs amidst prevailing insecurity issues in Burkina Faso.
    - Response: The presenter acknowledged the impact of insecurity on research activities and highlighted the exclusion of certain sites due to security risks. Additionally, he noted the heightened vulnerability of adolescents to mental and reproductive health challenges in conflict-affected areas.
- Coverage of all Adolescent Age Groups
    - Comment: Questions were posed regarding the inclusion of all adolescent age groups in the research.
    - Response: The presenter affirmed the inclusion of adolescents across different age groups in the research methodology, ensuring a comprehensive understanding of the diverse needs and experiences.
- Data on Gender-Based Violence:
    - Comment: Participants requested more detailed data and statistics on gender-based violence (GBV) in Burkina Faso.
    - Response: The presenter acknowledged GBV as a prevalent issue but explained that the research primarily focused on exploratory findings. However, he noted that GBV has been prioritized for future actions, including data collection and intervention development.
- Reducing Undesired Pregnancies:
    - Comment: Participants commended Burkina Faso's success in reducing undesired pregnancies and sought insights into the contributing factors.
    - Response: The presenter and team attributed the success to initiatives such as free contraceptive care, safety centres for adolescents, and peer education. These interventions, coupled with recent policy support, have played a crucial role in mitigating the risk of undesired pregnancies.
- Impact of Illegal Sexual Activity:
    - Comment: Concerns were raised about the detrimental effects of illegal sexual activity on adolescent health. A participant noted that illegal sexual activity across Burkina Faso remains a significant impediment to adolescent girls' health, with profound implications for their mental, sexual, and reproductive health. She emphasized that older men continue to exploit young girls, especially those from poor households, and highlighted that girls lacking family support are at an increased risk of sexual abuse.
    - Response: Dr.Yaogo and team acknowledged the challenges posed by illegal sexual activity, especially for vulnerable adolescent girls. He highlighted the need for targeted interventions to address social determinants and protect adolescents from exploitation.

**Introduction of the Director-General of WAHO**

There was a momentary pause as the chair interrupted to introduce dignitaries. Dr. Issiaka took the floor and introduced Dr. Aissi Melchior Athanase Joel, the Director-General of WAHO. Dr. Aissi expressed his pleasure that the meeting's theme aligned with the broader conference theme on Maternal, Child, and Adolescent Health, emphasizing the importance of including fathers in health discussions alongside mothers and adolescent girls. A group photograph was taken afterwards with the delegation from WAHO. Various other dignitaries were also acknowledged during the session.

**Presentation from the Ghana team:**

Presentation focused on policy and stakeholder analysis, adolescent and community perspectives, and implications for Adolescent Mental Health (AMH) and Sexual and Reproductive Health Rights Policies, Programs and Interventions. Dr. Lauren Wallace and Ms. Natasha Darko presented a detailed analysis of adolescent mental, sexual, and reproductive health (SRH) issues in Ghana. They indicated that the study employed various methods such as focus group discussions, interviews, and observational to gather evidence. Findings highlighted several challenges that limit adolescents' use of services. This included stigma, issues of confidentiality and privacy, promptness of services, and insufficient resources. Again, the study highlighted that despite the presence of legislative instruments, policies, and a variety of services and programs, social norms and financial constraints significantly limit access to care.

To address these challenges, the team noted that proposed interventions focus on adolescent engagement, recognition of intersections between AMH and ASRH, and the restructuring of primary healthcare services to be more responsive and adolescent-friendly. Strategies highlighted included establishing frameworks for the co-production of policies and programs, recognizing sub-group diversity, and leveraging interactive methods to share educational messages with adolescents.

Specifically, the team proposed a participatory theatre-based mental and SRHR education workshops and the development and delivery of original theatre performance pieces by adolescent educators, supported by frontline providers in health, education, and social welfare. These performances, tailored to local contexts and prioritizing key mental and SRH topics identified during the situational analysis, aim to address SRH-related stigma, available health services, healthy relationships, gender-based violence, and the role of parents and other agents of change.

**Discussions/Questions/Comments**

- Comment 1: Madam Sheriffa from the Ghana Health Service (GHS) provided additional insights on the integration of services. She mentioned that an assessment by GHS revealed adolescents felt stigmatized when using designated adolescent corners. Hence, this informed GHS decision to integrate services to prevent adolescents from feeling singled out. She also noted that more health personnel are being trained to provide SRH services. Regarding mental health, she highlighted a widespread misconception that equates mental health issues with "madness." She stressed the urgent need for comprehensive education initiatives by all stakeholders to address these misconceptions, emphasizing that a proper understanding of mental health is crucial for effectively tackling the prevailing issues.
- Comment 2: The cost of care remains a significant barrier to accessing healthcare in many low- and middle-income countries, particularly for out-of-school adolescents. Participants inquired about the existence of subsidies for in-school adolescents in Ghana and financing modalities. In response, the team specified that there are no disparities in healthcare access between in-school and out-of-school

adolescents. They noted that while Ghana has a National Health Insurance Scheme (NHIS), the scheme does not cover all costs, such as scans and lab tests, which adolescents must pay out of pocket. This financial burden also extends to the cost of treating STIs. They further indicated that school clinics serve as entry points for reaching in-school adolescents, but due to a lack of resources, students often have to pay for medication, creating a barrier to accessing care. It was added that social determinants of health impact access to healthcare, with the cost of care and transportation posing significant challenges and barriers to obtaining healthcare services. However, the team indicated that the Ghana Health Service is currently piloting subsidy interventions in select districts to evaluate their impact on service uptake.

- Comment 4: Emphasizing the pivotal role of the media in improving sexual, reproductive, and mental health education, participants stressed that the media can serve as a crucial tool in educating adolescents, debunking myths, and bridging the gap between adolescents and available support services.
- Comment 5: Participants highlighted the crucial need of integrating mental health care into sexual and reproductive health services, noting the interconnectedness of these domains and their mutual influence on diverse dimensions of adolescent health.
- Comment 6: Concerns were raised regarding the operationalization of legislative instruments (LIs) and policies related to adolescent mental health and sexual and reproductive health and rights (SRHR) in Ghana. Participants highlighted the necessity of engaging adolescents in the co-production and implementation of interventions to ensure their accessibility and effectiveness. Additionally, leveraging media platforms to reach and educate adolescents, given their significant online presence, was deemed essential. Regarding desk reviews of existing LIs and policy documents in Ghana, it was confirmed that while provisions for adolescent SRHR were identified, provisions for adolescent mental health issues were lacking.
- Dr. Abdoulaye Diaw from Senegal discussed the necessity of integrating mental health and SRH interventions and strengthening the linkage between the two departments. He highlighted the ambiguous position of mental health within the health system and emphasized the importance of making mental health services accessible to adolescents, particularly those out-of-school.
- Participants inquired why the study focused on only three West African countries. Prof. Agyepong explained that the limitation was due to resource constraints.

The session concluded with a call for continued collaboration and efforts to address the identified challenges in adolescent health.

**Presentation by Seidu Oumarou from Niger**

The research in Niger focused on understanding policy priorities and the influence of social norms on adolescent health in Niamey and Maradi. It employed methods such as stakeholder mapping, examining political priorities, and assessing perceptions of SRH programs. The study analyzed the interests and roles of state actors, traditional and local leaders, transnational funding partners (TFPs), and local NGOs. It identified key players working to improve adolescent health, but also noted community concerns about Western demographic views undermining social values.

**Key results**

The research in Niger highlighted several key findings regarding adolescent health. The study found that mental health is a neglected area, often stigmatized and attributed to supernatural causes, with limited government programs and a reliance on traditional medicine indicating a need for external intervention.

Sustainability issues identified included lack of stakeholder ownership, inadequate preparation for program close ups, and underutilization of research and monitoring outcomes in redirecting and adapting interventions. The study also found that social norms, influenced by religious doctrines, make discussing sexuality taboo, leading to stigmatization and risky behaviours among adolescents.

Efforts to address adolescent health challenges involved workshops for feedback and co-production, wherein researchers and teenagers identified priority issues such as drug addiction, child marriage, and menstrual health, and proposed and co-designed interventions to address the problems.

**Discussions/Comments/Questions**

- It was noted that the taboo nature of discussing sexuality in Niger, influenced by religious doctrines, remains a significant barrier to achieving comprehensive adolescent SRH care.
- Additionally, it was highlighted that sustaining interventions in Niger has been challenging due to heavy reliance on external funding, with limited government support, despite previous efforts to address adolescent health issues.
- A participant raised a concern about the lack of existing structures for addressing health needs in Niger, suggesting that capacity building for school agents to handle issues like addiction could yield better results. In response, it was noted that while some healthcare provisions, such as school infirmaries supported by partners like UNFPA, exist in Niger, initiatives like health clubs often face religious opposition. This opposition poses challenges to promoting adolescent mental, sexual, and reproductive health within educational settings.
- Regarding statistics and sustainability, another participant inquired about the availability of data on undesired pregnancies and strategies for ensuring the feasibility and impact of the planned seven-month interventions, given the sustainability issues of previous projects. The response indicated that a fully qualitative approach was used, with no quantification of undesired pregnancies. It was also noted funding remains a challenge, necessitating adherence to funders' requirements—reiterating that interventions aim to inform and raise awareness about SRH activities and drug addiction.

**Adolescent voices**

The chairperson invited adolescents from Ghana and Burkina Faso, present at the meeting to share their contributions to the discussions.

A young female adolescent student from Burkina Faso highlighted the pervasive stigma surrounding mental health and sexual reproductive health (SRH) issues in her community. She emphasized that this stigma breeds misinformation and ignorance among adolescents, pushing them towards risky sexual behaviours. She also stressed the importance of involving adolescents in the development of interventions aimed at enhancing access to mental health and SRH care, advocating for their active participation in shaping solutions.

Similarly, a young male adolescent student from Ghana proposed leveraging digital platforms such as websites to enhance access to information, thereby addressing the issue of timidity often associated with seeking care and information among adolescents. He also emphasized the crucial role of the media in disseminating informative and educational content that promotes healthy living for African adolescents. Moreover, he emphasized the significance of instilling moral values and promoting sound decision-making among adolescents to foster a culture of health and well-being.

Echoing these sentiments, another young adolescent female student from Ghana reiterated the importance of improving the accessibility of information and resources related to mental health and SRH

for adolescents. She underscored the importance of ensuring that adolescents have easy access to knowledge that empowers them to make informed choices about their health and well-being.

**Closure of morning session by the Chairperson**

Closing the morning session, the Chairperson emphasized the significant investments and efforts directed towards sexual and reproductive health (SRH) initiatives, while acknowledging the under-representation of mental health. Stressing the importance of adopting an intersectional approach, the Chairperson highlighted the interconnectedness of mental health, sexual, and reproductive health and rights issues. It was emphasized that consolidating efforts and fostering collaboration among stakeholders is essential to develop a coordinated response action to effectively address the multifaceted challenges faced by adolescents. She asserted that integrating mental health considerations into broader SRH initiatives would lead to more comprehensive and holistic support for adolescent well-being.

**Afternoon Session**

**Focus:** How Technically Efficient Are Primary Health Care (PHC) in Facilities in West Africa in Providing Adolescent Mental, Sexual and Reproductive Health, and Well-Being Services? A Multiple Case Study of Burkina Faso, Ghana, and Niger

The session, chaired by Dr. Ama Fenny, delved into the examination of primary healthcare (PHC) facilities in Burkina Faso, Ghana and Niger to assess their technical efficiency in providing adolescent mental, sexual, and reproductive health (ASRH) services. It was noted that prior research in this domain has been limited, with a dearth of studies specifically focusing on the efficiency of PHC facilities in delivering ASRH care. The present study thus comprises pioneering efforts to evaluate the technical efficiency of health systems concerning ASRH and adolescent mental health (AMH) services.

Employing the Stochastic Frontier Analysis (SFA) approach, the research involved estimating a health production function for the selected health facilities, linking available inputs to outputs. Subsequently, the residual from this production function was disaggregated to gauge the level of inefficiency within the facilities. In the second stage of analysis, internal and external factors contributing to this inefficiency were identified. To facilitate cross-country comparison, a consistent research design was implemented across all countries, incorporating similar input and output variables for analysis.

**Ghana Case Study**

Dr. Fenny and Dr. Jacob Nonvignon presented a study conducted in Ghana, focusing on four districts within the Greater Accra Region, including both rural (Ningo Prampram and Shai Osudoku) and urban (Ga East and La Nkwantanang) populations. The study encompassed all primary healthcare (PHC) facilities within these districts, totaling 53 out of an initial 67 facilities. The analysis primarily concentrated on adolescent sexual and reproductive health (ASRH) services due to their higher prevalence, revealing significantly lower utilization of mental health care services among adolescents. Over 90% of the facilities lacked reserved rooms for adolescents, indicating a need for improved infrastructure to cater to adolescent-specific health needs.

The efficiency of PHC facilities in Ghana was found to be influenced by factors such as healthcare infrastructure, improved financial protection, enhanced economic well-being, and the availability of multiple services within the facilities. In light of these findings, recommendations were proposed to enhance the efficiency and effectiveness of PHC facilities. These recommendations included reallocating healthcare infrastructure to accommodate adolescent-specific needs, ensuring the availability of a diverse

service mix tailored to adolescent requirements, efforts to encourage service uptake among adolescents, and initiatives aimed at removing financial barriers hindering access to care.

**Niger Case Study**

Dr. Nassirou Ibrahim presented a study conducted in Niger, focusing on two regions and 160 health facilities to evaluate the availability and efficiency of adolescent mental health (AMH) services compared to adolescent sexual and reproductive health (ASRH) services. The study revealed a significant disparity, with only 9% of facilities offering AMH services to adolescents, while 89% provided ASRH services. In Maradi, 13% of facilities offered AMH services, compared to just 3% in Niamey. Additionally, very few facilities had adolescent mental health guidelines, indicating a lack of structured protocols for AMH care. Urban facilities were more efficient than rural ones, with a higher percentage having reserved rooms for adolescents.

The study identified several factors driving the efficiency of primary healthcare facilities in Niger, including the availability of adequate healthcare infrastructure, the size of the adolescent population in the catchment area, the presence of a trained health workforce, and the authority of facility management in implementing efficient service delivery. The recommendations emphasized the need to equip health facilities with specialists in adolescent mental health care, organize training workshops for providers on managing adolescents with mental health issues, ensure the availability of dedicated rooms for adolescents, and establish well-stocked, functional pharmacies for SRH and related services.

**Burkina Faso Case Study**

Mr. Ludovic Tapsoba presented a study conducted in Burkina Faso, focusing on ten districts in the West Central and Hauts Bassins regions to represent both rural and urban populations. The study aimed to evaluate primary healthcare facilities providing adolescent sexual and reproductive health (ASRH) services. The findings revealed that less than 42% of the surveyed facilities offered adolescent mental health (AMH) services, and only 15% had AMH guidelines. While all facilities provided ASRH services, only 5% had reserved rooms for adolescents. Urban facilities were found to be slightly more efficient than rural ones.

Several factors driving the efficiency of primary healthcare facilities were identified, including the adequacy of healthcare infrastructure, the duration of years spent as a facility manager, the presence of a trained health workforce, and the proximity of adolescents to healthcare facilities. The study's recommendations emphasized ensuring the provision of adolescent mental health services at the peripheral level, allocating resources for ongoing training programs for staff in adolescent mental health, and prioritizing funds to improve health infrastructure, particularly in rural areas.

**Summary of Key Findings from All Countries**

Across Burkina Faso, Ghana, and Niger, the study identified varying levels of inefficiency in the utilization of adolescent sexual and reproductive health (ASRH) resources within primary healthcare facilities. The degree of inefficiency differed based on the location and gender of the facility head, with inconsistencies observed across countries. However, the presence of basic healthcare amenities such as laboratories, pharmacies, and trained personnel appeared to mitigate some of the observed inefficiencies.

**Discussions/Comments/Questions:**

- Comment 1: A participant raised a concern about the seemingly lower efficiency of hospitals compared to health centres, despite hospitals typically having more resources. The response clarified that the efficiency metric considers the ratio of input (available and utilized resources) to

output (services delivered). However, the discrepancy in efficiency between hospitals and health centres may be influenced by the misidentification of certain private health facilities that function as health centres but label themselves as hospitals.

- Comment 2: Another participant inquired about the objective measurement of output variables in the study. The response indicated that output variables, such as ASRH outpatient department (OPD) cases, were objectively measured by extracting data from clinical records. Additionally, the average time spent by healthcare providers in attending to adolescent clients was recorded. Other metrics, including the proportion of laboratory tests conducted for ASRH clients, were obtained from laboratory logs to ensure comprehensive and accurate measurement of output variables.

**Constraints with Mobilization and Opportunities to Improve Access to Financial Resources - Presentation by Dr. Ama Fenny**

Dr. Ama Fenny shed light on the challenges and opportunities regarding the mobilization of financial resources for adolescent health services, particularly in the context of sexual and reproductive health (SRH) and mental health care. She stated that countries in the region are struggling to meet the targets set by the 2020 Abuja Declaration,

**Key Points:**

**In Ghana;**

Tracking resource flows is challenging due to the embedded nature of mental health and SRH service provision. Also, adolescents often have to pay out-of-pocket for SRH and mental health services not covered by the National Health Insurance Scheme (NHIS). Overall, investments in health fall short of optimal levels in Ghana.

**In Burkina Faso;**

The lack of a budget line in the state budget specifically designated for adolescent sexual and reproductive health (ASRH) leads to heavy reliance on funds from external partners.

Dr Fenny ended the brief presentations by posing three critical questions;

1. Why haven't funds been allocated specifically for adolescent health services, considering their importance?
2. Why isn't there the same level of advocacy and support for adolescent healthcare as there is for maternal and child healthcare from governments, NGOs, and individuals in Ghana, Niger, and Burkina Faso?
3. How can we establish a well-funded agenda to effectively address adolescent sexual reproductive health and adolescent mental health?

**Discussion/Comments/Questions**

Comment 1:

Participants emphasized the necessity for a clear conceptualization of mental health, emphasizing its importance in determining the scope of mental healthcare services. They stressed that establishing a solid foundation of understanding of these basic concepts is pivotal for garnering support and fostering collaborative efforts in addressing adolescent mental health issues.

In response, it was acknowledged that clarity on fundamental concepts like mental health is indeed crucial. This understanding forms the bedrock for rallying support and coordinating efforts across various sectors to tackle the challenges effectively. The importance of refining these definitions to guide comprehensive mental healthcare initiatives was underscored.

Comment 2:

Another participant raised concerns about the neglect of adolescent sexual and reproductive health (ASRH) and adolescent mental health (AMH) in government spending plans. It was highlighted that the over-reliance on external funding sources has resulted in a culture of low domestic investment in addressing these critical issues affecting youth.

In response, it was noted that the heavy dependence on external funding jeopardizes the sustainability of interventions targeting ASRH and AMH. Participants emphasized the need for policymakers and implementers to recognize the long-term implications of neglecting these areas and advocated for greater domestic investment in addressing the needs of young people. They stressed the importance of strategic engagement and research to raise awareness and drive policy change in prioritizing ASRH and AMH in public spending and policy agendas.

**Closing:** The meeting was closed at 5:19 pm by the Chairperson who thanked participants for their work, contributions and attention.

**Overview of Day Two (2)**

**Focus:** Improving health systems' responsiveness to frontline health workers and maternal mental health (including pregnant and post-natal adolescents)

**Morning session**

Chairpersons: Dr Maurice Yaogo and Dr Lauren Wallace

Professor Irene Agyepong and Dr. Yevoo led the introduction of the RESPONSE project in Ghana.

Dr. Yevoo presented an overview of health system responsiveness, emphasizing the importance of people-system interactions in addressing mental health needs. She introduced a conceptual framework for health system responsiveness and highlighted the engagement of diverse stakeholders, including maternal health clients, community leaders, healthcare workers, and policymakers, in the co-design and production process. Dr. Yevoo also explained the situational/problem analysis methods and the pivotal role of health worker change workshops.

Professor Agyepong outlined the co-produced intervention aimed at improving health system responsiveness, focusing on frontline health workers and maternal mental health clients. She discussed evaluation indicators such as financial and opportunity costs and workload. The intervention included capacity building, mental health promotion, early detection and response to mental health distress at the primary healthcare level, and appropriate referral and management. Professor Agyepong highlighted the comprehensive approach of the intervention to enhance overall health system responsiveness.

**Discussion/Comments/Questions**

Dr Tunde from the Federal Ministry of Health, Nigeria raised a question about engaging policymakers in the intervention process and whether it extended beyond those involved in delivering the intervention.

Prof Agyepong and Dr. Yevoo explained that policymakers, including the mental health department, were actively engaged in the co-production and design of the intervention. They also emphasized the participatory approach of the RESPONSE project.

**Introduction of the mental health screening tools used in the intervention**

Dr. Elizabeth Awini introduced the DASS21 questionnaire, the tool used in the frontline health worker aspect of the intervention. She explained its structure and administration, emphasizing its capacity to evaluate depression, stress, and anxiety levels. Additionally, Dr. Awini highlighted the questionnaire's accessibility and provided insights into the recommended cut-off scores for result interpretation.

Mr Wonder Siegward then led a demonstration of the DASS21 tool, projecting a QR code for participants to access the questionnaire on a secure webpage. Following completion, the questionnaire provided a total score and interpretation, with results sent to both the test taker and a secure database prompting the attention of the mental health specialists.

**Implementation of the Frontline health worker intervention, findings and Experiences from the first 3 months**

**Shai-Osudoku District Experience**

Presentation by Dr. Adjei and Dr. Adjoa Kusi-Kyere

Drs. Adjei and Adjoa Kusi-Kyere presented the findings and experiences from the first three months of implementing the frontline health worker intervention. They outlined the intervention team's role and provided an overview of the process.

Key findings from the intervention included data from 173 respondents, predominantly nurses and females, revealing varying degrees of stress, anxiety, and depression among frontline health workers. Work-related stress, personal stressors, financial issues, and traumatic life experiences were identified as common contributors to psychological distress. Protective factors such as financial remittances from work, support from family and friends, and engagement in religious activities were highlighted.

The support provided included text messages for those with mild distress or normal screening results, teleconsultations for those with moderate to severe distress, and referrals to mental health units for those with more severe distress.

Challenges encountered included low response rates, missing phone numbers, and difficulties in scheduling teleconsultations.

Moving forward, strategies such as awareness creation, establishing a dedicated phone line, collaborative support in the working environment, staff wellbeing clinics, and self-help apps were proposed to address these challenges and improve the intervention's effectiveness.

**Discussions/comments/questions**

Many voiced their surprise and concern upon seeing their DASS21 scores, prompting a deep reflection on the importance of prioritising mental well-being. Burkina Faso's representative highlighted the urgent need for intervention in their country, given the compounded stressors of security issues and family pressures. Representatives from Nigeria and Senegal expressed keen interest in adopting similar interventions, emphasising the importance of aligning innovative programs with local mental health care systems. Concerns about stigma affecting mental health sparked conversations about ensuring accessibility and understanding among all stakeholders. Questions about the success of teleconsultations and the gender implications of the intervention added depth to the dialogue, highlighting the importance of ongoing support and thoughtful planning. In the end, the session emphasised the need for a shared commitment to supporting frontline health workers' mental well-being, emphasising collaboration and resource mobilisation to address these critical needs across different contexts.

**Video presentation**

During the meeting, participants were moved by a video snippet showcasing the impact of the community intervention in Ghana. The video told the story of a young woman whose postnatal care visit revealed alarmingly high SRQ scores, shedding light on the significant burden of maternal mental health issues. Her journey emphasised the importance of early screening and intervention in addressing these challenges within communities.

**Presentation - Maternal Health Client Intervention**

Improving Health System Responsiveness to Maternal Mental Health and Wellbeing

**The Shai-Osudoku District Experience**

Reverend Asiamah, DDHS of Shai-Osudoku District, highlighted the healthcare challenges faced by this entirely rural district with scattered communities. He indicated that the intervention, aimed at maternal mental health, focused on capacity building and client screening, and training 67 healthcare providers in maternal mental health. Education and screening using the WHO SRQ-20 tool were also provided to

pregnant women during ANC visits, postnatal clients, and community members. Clients scoring 6 or more received psychoeducation and were referred to mental health officers and further to clinical psychologists or psychiatrists if needed.

The intervention assessed 293 clients, revealing that 34% exhibited mental health symptoms, and conducted 22 health education sessions on various mental health topics. Monitoring visits and follow-ups with 48 maternal clients were well-received. Results included increased awareness of maternal mental health and successful case management, including psychotherapy for clients with suicidal tendencies. Challenges faced included a short data collection timeframe, increased staff workload, lack of financial support for adolescents, absence of dedicated mental health units, and insufficient secured spaces for screening and counselling.

He concluded by indicating that the district plans to ensure sustainability by developing a structured reporting format, shift data collection to a monthly basis, support the "Adolescent Safety Net" initiative, ensure continuous support from mental health nurses, and improve privacy and confidentiality within the facilities.

**The Ningo Prampram District Experience**

Dr. Nuertey, DDHS of Ningo Prampram, detailed the district's intervention aimed at improving the health system's responsiveness to maternal mental health (MMH) needs, particularly among adolescents. Comprising a mix of peri-urban and rural areas, with the main occupations being informal sector activities Dr. Nuertey noted that the district lacked sufficient data and structures to address MMH issues, prompting the intervention.

The initiative involved training 256 health workers, including medical officers, nurses, and midwives, and piloting the program at Prampram Polyclinic, followed by two other primary healthcare facilities. Maternal clients were educated on MMH, and screenings were conducted using the SRQ-20 tool, with clients scoring above 5 referred to mental health teams for further management. Weekly follow-ups by community mental health officers ensured continued care.

The intervention screened 744 clients, referring 18 for further management and managing 199 within the facilities. The training improved case identification and management, raising awareness among maternal clients and improving the responsiveness to their needs. Despite the achievements, challenges included client uncooperativeness, privacy concerns, lack of financial and social support, and increased workload due to insufficient staff.

To ensure sustainability, he stated that the district plans to secure private screening spaces, provide ongoing training, maintain bi-monthly supportive visits, advocate for more resources, continue community education, and engage social workers and relatives to support client care within the community.

**Discussion/Comment/Questions**

During the discussion, participants raised several points and inquiries about the intervention.

- A participant inquired about the availability of a specific training module for maternal mental health, highlighting the importance of structured guidance.
- Another concern was whether postpartum women, particularly those who lost their babies, were returning for follow-up visits. It was noted that effective maternal mental health care could be

delivered by leveraging existing resources, despite challenges, and shorter screening tools could be considered to reduce administration time.

- There were requests to share the training guidelines and modules to facilitate adoption by other countries. In response, Rev. Asiamah clarified that the intervention includes postnatal care up to one year postpartum, emphasizing the project's early implementation phase.
- Dr. Nuertey added that 42% of screened clients were postnatal women and explained that the screening tool requires 10-15 minutes to administer due to literacy levels.
- Dr. Adwoah Kusi-Kyere detailed the adapted training guide, which comprises eight modules on various aspects of maternal mental health and peer support, underscoring the comprehensive approach of the intervention.

**Unique Issues of Adolescent Mothers**

Presented by: Ms Abigail Miwornunyuie and Ms Sharifata Mohamed

Presenters highlighted a range of unique issues significantly challenging adolescent mental health. These included survival difficulties such as school drop-out, poverty, malnutrition, and complications from pregnancy and childbirth, all contributing to an environment detrimental to mental well-being. They emphasized that strained interpersonal relationships exacerbate these challenges, with adolescents often facing severed social support, loss of friends and family, limited life choices and autonomy, and social stigmatization and isolation. Additionally, the rapid transition to adulthood forces many adolescents to prematurely assume adult responsibilities, leading to coping difficulties and heightened stress.

***Way Forward***

Presenters asserted that addressing these challenges requires several crucial measures, including empowering adolescents through targeted support services to significantly improve their mental health outcomes. They emphasized the importance of policies focused on reintegration into the educational system to provide adolescents with necessary opportunities for success. Additionally, changing the conversation around mental health to reduce stigma and promote understanding is vital. Concluding, presenters noted that protecting and empowering adolescent girls is essential to creating a supportive environment that fosters better mental health and overall well-being.

**Discussion/Comments/Questions**

Comment 1: Dr Camara reiterated that there is a need to define the notions, terms, and concepts of mental health clearly, as discussed yesterday. Also, he noted that there was an absence of interventions targeting men and boys. He stated that given the high incidence of gender-based violence, it's essential to include men and boys more, as they are often the perpetrators.

In response, Prof Irene stated that males are allowed to be screened and assisted when they accompany their partners to ANC and PNC visits. However, most males do not attend these appointments. Going forward, it is crucial to find workable approaches to reach males effectively.

Comment 2: Dr. Fenny asked "Given that the tool provides only binary "yes" and "no" answers, does it accommodate different levels of expression of mental health conditions?"

Prof Irene and Dr. Awini explained that the SRQ is a validated tool chosen for its simplicity and ease of administration, which is particularly important in contexts with low literacy levels. For frontline workers, the more complex DASS21 is used, as they are all highly literate. Prof Irene highlighted that the SRQ tool items are generally understood by the clients and are designed to quickly identify individuals with probable mental distress for further diagnosis and management.

Comment 3: Is there any relationship between socio-demographic characteristics and the outcomes being assessed?

In response, it was indicated that so far, only descriptive analysis has been completed on the data collected so far; and the team plans to conduct further inferential analysis in subsequent phases of the intervention.

Comment 4: Regarding the 7th item on the SRQ about 'feeling of poor digestion'.

In response, Dr Daniel Adjei clarified that the item refers to a general feeling of poor digestion, such as experiencing indigestion and bloating. Prof Irene emphasized that the tool's purpose is to rapidly distinguish individuals with probable mental distress for follow-up diagnosis and appropriate management or referral.

**Afternoon session**

The afternoon session commenced with a brief report of participants' screening results during the morning session. Presenting the results, Dr Adjei highlighted that while the majority of participants had DASS21 scores within the range of optimal mental health, a significant proportion of participants had scores indicative of probable stress, anxiety and depression.

**Key Messages to WAHO**

Key messages, later translated into a communiqué, were developed to inform health policies, particularly regarding mental health and sexual and reproductive health (SRH) in West Africa.

- Holistic Health Perspective
  - Avoid over-medicalizing health issues. Consider environmental factors, such as commuting stress, that affect the mental health of health workers, highlighting the interconnectedness of various health aspects.
- Integrate Mental Health into Existing Programs
  - Incorporate mental health issues such as anxiety, stress, and depression into existing sexual and reproductive health (SRH) programs for adolescents. Embed mental health programming within current health frameworks and institutions to ensure a comprehensive approach to health.
- Primary Health Care Integration
  - Integrate mental health services into primary health care (PHC). Train health workers to provide these services, emphasizing continuous capacity building and the use of ICT. Establish routine mental health screening as a standard part of adolescent SRH care.
- Strengthen School-Based Mental Care
  - Enhance mental health services in existing school care centres, like sick bays, to better serve adolescents.
- Comprehensive Mental Health Approach
  - Address the psychological aspects of mental health care early, rather than waiting until conditions become severe.
- Broaden Adolescent Age Group
  - Expand the focus to include children under 10 years old in adolescent mental health programs.
- Adolescent Inclusion in Solution Design

    - Use co-production approaches that actively involve adolescents in creating solutions to their mental health challenges.
- Address Gender-Based Violence
    - Maintain an ongoing dialogue about gender-based violence and its severe impact on female adolescents.
- Media Capacity Building
    - Equip media professionals with the skills to effectively communicate mental health information and educate the public, helping to reduce stigma.
- Advocacy and Reducing Stigma
    - Advocate for reducing mental health stigmatization and encourage family health and support as recommended by WHO. Emphasize evidence-based policy-making and advocate for free or heavily subsidized access to mental health care.
- Collaborative Efforts across Countries
    - Promote a collaborative approach to mental health care across West African countries, leveraging social media and other platforms for wider reach.
- Policy for Boys' Mental Health
    - Develop strategies to rope males in more when designing adolescent mental, and sexual reproductive health interventions

**CLOSING REMARKS AND VOTE OF THANKS**

- Prof Irene Agyepong gave the closing remarks and on behalf of all participants, Dr. Maurice Yaogo from Burkina Faso also gave the vote of thanks and appreciated all attendees for their active participation.

## Appendix 3 – Participants

| | Name | Country | Institution | Role |
|---|---|---|---|---|
| 1 | Mr. Jean Eliel Aye | Ghana | GCPS | Bilingual Research & Admin Assistant |
| 2 | Ms. Priscilla Prempeh | Ghana | GCPS | Research Assistant |
| 3 | Dr. Ama Fenny | Ghana | ISSER, UG | Health Economics Lead |
| 4 | Dr. Jacob Nonvignon | Ghana | KNUST | Health Economics, Senior Researcher |
| 5 | Dr. Adwoa Kusi-Kyere | Ghana | GHS-HQ Mental Health Unit | Psychiatrist/Training Focal Person |
| 6 | Dr. Daniel Adjei | Ghana | MHA, Pantang Hospital | Psychiatrist |
| 7 | Dr. Dominic Nuertey | Ghana | DHMT - Ningo Prampram | District Director of Health Services |
| 8 | Ms. Agnes Odum | Ghana | DHMT - Ningo Prampram | District Mental Health Focal Person |
| 9 | Ms. Abigail Miwornunyuie | Ghana | DHMT - Ningo-Prampram | Adolescent Health Focal Person |
| 10 | Rev. Ebenezer Asiamah | Ghana | DHMT - Shai Osudoku | District Director of Health Services |
| 11 | Ms. Fauzia Sulleyman | Ghana | DHMT - Shai Osudoku | District Mental Health Focal Person |
| 12 | Ms. Catherine Klutse | Ghana | DHMT - Shai Osudoku | Deputy Director for Nursing Services |
| 13 | Ms. Sharifata Mohammed | Gdhana | GHS-HQ Adolescent Health | Head of Adolescent Health |
| 14 | Dr. Elizabeth Awinin | Ghana | GHS-RDD DHRC | Biostatistician |
| 15 | Mr. Wonder Siegward | Ghana | Independent | IT Consultant |
| 16 | Dr. Linda Lucy Yevo | Ghana | GCPS | Medical Anthropologist |
| 17 | Mr. David Owiredu | Ghana | UG-SPH | Researcher, Systematic Reviews |

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|---|---|---|---|---|
| 18 | Mr. Samuel Ayisi | Ghana | DHRC | Bilingual Research & Admin Assistant |
| 19 | Prof. Irene Agyepong | Ghana | GCPS | Principal Investigator |
| 20 | Dr. Lauren Wallace | Ghana | DHRC | Ghana Co-Investigator |
| 21 | Ms. Natasha Darko | Ghana | DHRC | Pre-doctoral Reseacher |
| 22 | Dr. Paapa Yaw Asante | Ghana | UHAS | Post-doctoral Researcher |
| 23 | Ms. Maame Akua Asiamah | Ghana | DHRC | National Service Personnel |
| 24 | Ms. Vicky Okine | Ghana | ARHR | Research Uptake Lead |
| 25 | Mr. Isaac Nyampong | Ghana | ARHR | Research Uptake Officer |
| 26 | Ms. Bernice Gyawu | Ghana | ARHR | Research Uptake Officer |
| 27 | Ms. Nana Oye Gyimah | Ghana | ARHR | Communication Officer |
| 28 | David Otokunor Nii Ayi | Ghana | Presbyterian Boys' SHS | Adolescent (Student) |
| 29 | Elsie Abedi | Ghana | Prampram D/A Basic 'B' | Adolescent (Pupil) |
| 30 | Ms. Diana Asempasah | Ghana | GES | SHEP Coordinator |
| 31 | Dr. Maurice Yaogo | Burkina Faso | IASP | Burkina Faso Country PI |
| 32 | Ms. Assita Keita | Burkina Faso | IASP | Senior Research Assistant |
| 33 | Mr. Ludovic Deo Gracias Tapsoba | Burkina Faso | IASP | Doctoral Researcher |
| 34 | Dr. Yemboado Adolphe Namoano | Burkina Faso | Centre Medical Paul VI | Head of Paediatrics Department |
| 35 | Ms. Salimata Doussa | Burkina Faso | ABBEF | Resource Person (CSO) |
| 36 | Ms. Bintou Rachel Sara | Burkina Faso | Collège Médina Coura | Teacher/Facilitator of co-production activities |
| 37 | Achilia Marlyse Kone | Burkina Faso | Lycée Municipal de Koudougou | Adolescent (Pupil) |

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|---|---|---|---|---|
| 38 | Dr. Sandrine Konsimbo | Burkina Faso | Ministry of Health | Programme Coordinator, Reproductive Health |
| 39 | Dr. Paulin Somda | Burkina Faso | Ministry of Health | Resource Person |
| 40 | Mr. Nassirou Ibrahim | Niger | LASDEL | Doctoral Researcher |
| 41 | Mr. Saidou Oumarou | Niger | LASDEL | Doctoral Researcher |
| 42 | Mr. El-Moctar Oumarou Issaka | Niger | Lycée Issa Korombé | Teacher / Chaperone |
| 43 | Mr. Rashidatou Altine Samey | Niger | ANBEF | Resource Person (CSO) |
| 44 | Prof. Tiahou Gnomblesson Georges | Cote d'Ivoire | DFRS/MSHP-CMU | Deputy Director for Health Research |
| 45 | Dr. Samuel Olusegun Oyeniyi | Nigeria | Federal Ministry of Health | Director Safemotherhood |
| 46 | Dr. Adaeze Okunkwo | Nigeria | Federal Ministry of Health | Deputy Director Policy and Planning |
| 47 | Dr. Ojo Tunde Masseyfergusson | Nigeria | Federal Ministry of Health | National Mental Health Programme |
| 48 | Dr. Amina Mohid | Nigeria | Federal Ministry of Health | Resource Person |
| 49 | Mr. Theophilus Oyewale | Nigeria | Federal Ministry of Health | Resource Person |
| 50 | Mrs. Olufunmilola Janet Alaka | Nigeria | Federal Ministry of Health | UN Multilateral Cooperation |
| 51 | Mr. Mame Mbagnick Diouf | Senegal | Journalist | Specialist in Health Communication |
| 52 | Dr. Abdoulaye Diaw | Senegal | Ministry of Health | Director of Planning Division |
| 53 | Dr. Kankou Mamady Camara | Guinea | Ministry of Health | Director of Adolescent and Youth Division |

## Appendix 4 – Presentations