ABSTRACT

BACKGROUND: Cognitive interviewing is a well-recognised methodology to identify clinical and commensensical items of mental health questionnaire items by our research participants. Depression is amongst the most common condition impacting pregnant and parenting adolescents in sub-Saharan Africa (SSA). In Kenya, studies have reported depression prevalence estimates of 12-50% in peripartum adolescents. While young people prefer using English, there has not been enough data to point to how well they respond to Kiswahili translations of the commonly used tools.

METHOD: Thirty-two participants between ages 14-18 years were approached and through informed consent for them to participate. We used Edinburgh Postnatal Depression Scale (EPDS) and Patient Health Questionnaire-9 (PHQ-9) in English and Kiswahili versions to carry out the interviews and were coded along with 4 domains of comprehension, retrieval, judgement, and patient response. The interviews were discussed within the team and tables were shared between 3 raters for further consensus. The interview transcripts were analyzed manually using thematic analysis. We used the findings from the interviews to make modifications to the existing English versions of EPDS and PHQ-9 and to modify Kiswahili versions too.

DISCUSSION: We found that adolescents had challenges in fully understanding items in both sets of tools however, EPDS was better received than PHQ-9. Psychometrically, the EPDS English version and Kiswahili versions fared better than the PHQ-9 English and Kiswahili versions. PHQ-9 presented considerable issues with regards to semantic clarity however had simpler response options in comparison to EPDS which was more experientially appropriate, but response options were not simple. On our thematic analysis, we felt that the adolescents were significantly challenged by the new, unanticipated pregnancy or motherhood experience. Poverty, poor partner support, discord with parents and distress in the family, and traumatic end of supportive and helpful relationships were the notable problems. We believe the cultural and linguistic modifications made on these tools would make them more suitable to be validated with a sample of pregnant adolescents.

CONCLUSION: While sensitive cross-cultural translations for the commonly used open access depression tools is critical, it is also pertinent to understand whether these are developmentally appropriate. Our participants had multiple psychosocial and material challenges that necessitate measures sensitive to their age, social context, and health experiences. Additionally, we felt that both the tools may not be suitable for self-administration and may need the involvement of a case worker or community health worker.

KEYWORDS: Cognitive interviews, EPDS, PHQ-9, Kenya, adolescent girls, poverty, adversities

Background

Depression continues to be the second most critical psychiatric disorder contributing to disability in young women in Sub-Saharan Africa (SSA).1 As peripartum disorders and mental disorders intersect, the public health significance of appropriate timing and tools for assessing peripartum mental health disorders is critical for young girls.2 Prolonged depression or poor mental health has long term consequences for adolescents as it impacts maternal general health, child development, family functioning.3 Studies have shown that early diagnosis and screening at primary health care settings in Low-and-Middle Income Countries (LMICs) can offset significant later life perinatal mental health burden. Ensuring that whilst tools be psychometrically robust, clinically relevant, these also need to be well-understood by adolescents and be offered in
languages that offer them maximum flexibility in expressing themselves.4,5

Cultural and anthropological explanations of depression

Depression is a multilevel phenomenon and culture impinges not only to inform the biological and environmental factors such as heredity, poverty, marital stress but also embeds the larger social milieu in which depression is experienced by an individual.6 Mental health in itself is an extension of one’s cultural phenomena and neither culture nor mental life are static in any way. Similarly, the sociological aspects of depression are both influenced by and also influence the other biological and psychological aspects of people’s lives. Engel’s work in 1980 on biopsychosocial approach has widely been accepted today.7

Anthropologists have investigated discrimination related to mental health and other stigmatised disorders8 and ways in which individuals conceptualise their distress, express distress through idioms and colloquial terms and use culturally sanctioned and endorsed ways of resolving their problems. Depression is well known to be a condition that is expressed through somatic idioms and in many non-Western cultural contexts, it is represented by bodily aches, headaches, and such symptoms. Cross-cultural psychologists such as Marsella have questioned whether depression is a mood, a symptom, or a syndrome and if it has static features by which it can be identified.9 Cultural experiences can embed in psychophysiological manners impacting our cognition, emotions and interpersonal relationships.10 In the context of this study, pregnant adolescents bring with them certain sociocultural experiences – both good and bad, that impact their mood and mental health.

Cognitive interviewing and qualitatively understanding participants’ perspectives on depression including through the use of structured questionnaires assists in learning about the beliefs, individual stressors and ways in which depression comes to form in the illness narrative.10

Public Health Significance of Diagnosing Depression

The burden of mental disorders is by now well established in several published reports. Depressive disorders are prevalent, disabling, often chronic illnesses, which cause a high economic burden for society, related to both direct and indirect costs.11 Depression is acknowledged as a major public health problem by many national governments and international agencies.12 Adolescent pregnancies occur as a result of several factors and in most cases the adolescents are never prepared to become mothers. Some of these factors include peer pressure, unwanted sexual advances from adult males, relationships that are sexually coercive, poverty, lack of parental guidance and counseling, lack of comprehensive sexual education either at school, home, or health centers among other causes of pregnancy. Additional contributors are low education status, low self-esteem, inability to resist sexual temptation, curiosity, and inappropriate cell phone usage.13 The low socioeconomic status push most adolescents into relationships mostly with older or married partners who then abandon them once they conceive, their parents are less supportive thus the adolescent is almost left alone to take care of the new situation of either being pregnant or being a mother. These factors predisposes the adolescents to peripartum depression.14 There have been concerns that in the LMICs the diagnosis of depression despite refinements in symptom checklists continue to be assessed without reference to stress, cultural context, developmental stage, personality or coping. The World Health Organization’s Mental Health Gap Action Program–Intervention Guide (mhGAP-IG) provides modules on mental disorder diagnosis assessment, management and follow-up.15 These guidelines recommend that early screening as part of routine primary health care can enable timely detection and simple self-care and social support strengthening interventions that can address depression. Depression was until recently the leading cause of disability for both males and females, the burden of depression remains 50% higher for females than males.16 Currently, depression is the second leading cause of Disability-Adjusted Life Years (DALYS) following anxiety as the leading cause.1

Studies on local burden associated with adolescent peripartum depression

In a study conducted in Nairobi by Osok et al to screen for symptoms of depression among women attending antenatal clinics for a sample size of (n = 176); it was found out that 58% showed the likelihood of symptoms of depression using EPDS. This was then confirmed using PHQ-9 where 33% (n = 58) positively screened for clinical symptoms of depression.17 In Kenya, a study conducted by Ongeri et al found that the prevalence of symptoms of depression using EPDS was 18.7% (95% CI: 13.3-25.5).18 Another study conducted in Addis Ababa, Ethiopia by Biratu et al on antenatal depression in pregnant women using EPDS scale (n = 393), found the prevalence of symptoms of antenatal depression to be 24.94%(95% CI: 20.85-29.30%).19 In another Ethiopian study conducted by Dibaba et al pregnant women (n=627); the prevalence of depressive symptoms during pregnancy on EPDS scale was 19.9% (95% CI: 16.8-23.1%)20 and Govender et al.21 in South Africa found (n = 326) the prevalence of symptoms of depression among the pregnant participants was found to be 15.9% using EPDS.

Method

Participants, setting, and ethical clearance

The study was approved by Kenyatta National Hospital/University of Nairobi ethical review committee (approval no. P694/09/2018). Approval was also received from Nairobi County Health Directorate (approval no. CMO/NRB/OPR/
Cognitive interviewing as a method and theoretical approach

Cognitive interviewing of patients for whom the questionnaire is intended proved a valuable tool to increase its face and content validity. It is underpinned by the assumption that respondents are able to provide verbal reports of their thought processes. Cognitive Interviewing (CI) refers to a method used in research to help the researcher identify various sources of confusion in assessment items and to assess validity evidence on the basis of content and response processes. The process involves scrutinising the question-response to determine how well a question performs in capturing a particular concept when asked to respondents. The goal is for the EPDS 10 items and PHQ-9 items to capture the scientific intent of the question and, at the same time make sense to respondents.

Cognitive interview encourages an in-depth exploration of particular concepts, processes and patterns of interpretation. To achieve this, the process of cognitive testing analyses the question-response process in 4 stages:

(i) **Comprehension:** This is a stage where the respondent interprets the question. Difficulty at this stage may reflect unfamiliar or complex expressions or words or unclear concepts.

(ii) **Retrieval:** At this point respondent searches memory for answer. Recall difficulty can be a challenge at this stage.

(iii) **Judgment:** The respondent estimate response. Difficulty in estimating response may reflect bias or sensitive question.

(iv) **Response:** The respondent provides answer in the format requested. The answer provided may expose issues of incomplete response options.

The aim is to understand how each participant interprets the assessment items and selects responses.

Cognitive interviewing as a method explores how the researchers’ and participants’ understanding of the constructs intersect. It allows an opportunity to scan the participants’ perceptions, fund of knowledge, comprehension and at the same time gives unique information on the acceptability of the ideas tested in a tool. It allows cross-cultural, developmental (as we deal with adolescents) validation of depression constructs.

Tools, Their Translations and Psychometric Properties

This is a mixed method study to interpret data collected in 2 health care facilities, in Nairobi County- Kenya in 2019. Data collection was through use of semi-structured qualitative interviews that captured participants’ comprehension, retrieval and judgment of each item of Edinburgh Postpartum Depression Scale (EPDS) and Patient Health Questionnaire (PHQ-9) questionnaires pinned in cognitive interviewing theory. The tools used were Edinburgh Postpartum Depression Scale (EPDS) and Patient Health Questionnaire (PHQ-9) each with both English and Kiswahili Versions on 32 participants from July-November 2019 (5 months).

We have used the original English language versions of EPDS and PHQ-9. In addition to that, we have used the existing Kiswahili versions of PHQ-9 and EPDS for this mixed methods study. The purpose of this inquiry is to provide a clarity on further revisions needed for both English and Kiswahili versions of both tools based on cognitive interviews. We will at a later stage carry out a validation of these translations.

**The Edinburgh postpartum depression scale (EPDS)**

EPDS was developed by Cox, Holden, Sagovsky in the year 1987 by Scottish health centers in Edinburgh and Livingston. It was developed for screening postpartum women in outpatient, home visiting settings, or at the 6 to 8 weeks postpartum examination. The tool is comprised of 10 questions and can be completed within 5 (5) minutes using 1-week recall. Responses are scored 0, 1, 2, or 3 depending on the severity of the symptom. Items marked with an asterisk (*) are reverse scored (ie, 3, 2, 1, and 0), and total score is a summation of the 10 item responses. EPDS is structured into 4 severity ranges: (1) None or minimal depression (0-6), (2) Mild depression (7-13), (3) Moderate depression (14-19), (4) Severe depression (19-30) and a need to refer or follow up suicidal risk.

The EPDS has been validated in different cultures showing its importance in mitigating long lasting effects for mothers, their children and society at large. It has been widely tested globally including countries in Sub-Saharan Africa (SSA). Translations in Kiswahili developed in Kenya, where EPDS was translated into Kiswahili and it is the version that is being used here. Translations have been validated in different peripartum depression studies in Kenya and shown efficacy in diagnosing symptoms of depression.

**Patient health questionnaire-9 (PHQ-9)**

The patient Health Questionnaire-9 (PHQ-9) has 9 items and was developed by Spitzer, Williams, Kroenke, and colleagues in the year 2001. Scoring is by summation of the boxes on PHQ-9 questionnaire (For every Not at all = 0; Several days = 1; More than half the days = 2; Nearly every day = 3). Interpretation of Total Score: Depression Severity (1) Minimal depression (1-4), (2) Mild depression (5-9), (3) Moderate depression (10-14), (4) Moderately severe depression (15-19), (5) Severe depression (20-27). The diagnostic validity of the 9-item PHQ-9 was established in studies involving 8 primary care and 7 obstetrical clinics.
In South Africa, it was found to be reliable for criteria-based clinical depression disorders diagnosis, it is also good for severity check and perfect for clinical and research use. The study conducted a validation study of an interviewer-administered brief screening tool for depression, in a high HIV burden, low literacy PHC population in Johannesburg, South Africa. The results provide insight on how we can screen for and prioritise often overlooked and highly prevalent depressive symptoms in low-resource PHC settings in sub-Saharan Africa. Studies have been conducted using PHQ-9 to diagnose for depressive symptoms among different populations in Kenya. In a study conducted by Osborn et al., in 2019 about depression and anxiety symptoms, social support and demographic factors among Kenyan high school students showed high levels of depression symptoms (45.9% above clinical cutoff). In another study conducted in Kenya among HIV positive adolescents visiting Kenyatta National Hospital in 2019 showed that 1 in every 2 adolescents were showing depressive symptoms on PHQ-9 scale.

Data Collection and Analysis Procedure
This was a mixed methods study where participants were taken through a briefing on the objective of the interview and their written and oral consent taken to record their experiences at the health centers where the interviews were conducted. Participants were assured that they could withdraw when they felt like discontinuing and were assured of assistance if they experienced psychological distress or demonstrated high depressive symptoms. Referrals were made to the psychiatric nursing officer at the health facility and individual follow-up done by the clinical psychologist research assistant.

The protocol was developed by the first author and the 2 research assistants MK and VN interviewed and collated data on the tools. A structured worksheet was available for research assistants to transcribe the participants' response verbatim. These notes were translated by the interviewing research assistants. The study team reviewed cognitive interview transcripts, discussed and addressed items requiring revision.

We were not able to reliably use the same tools for all participants. Some participants preferred EPDS and PHQ-9 English version being administered by the researcher while they held the Kiswahili version of either tool. We did use existing translations to understand what kinds of refinements were needed in these tools to carry out further cultural adaptation.

The data was analyzed manually with an iterative process of 2 coders (MK and VN) carrying out cognitive interview rating and then the first author reviewed the coding. The qualitative analysis was again performed using thematic analysis after each of the coders read and assimilated the themes (MK, MK, VN). The preliminary thematic analysis was offered to the larger team to review for their feedback. Quantitative data for demographics was analyzed using SPSS software version 25.0. The cognitive interviewing was sequenced in a 4 domains assessment which was collated by the study team. Each participant was offered both tools but they could choose, English or Kiswahili version and for each item they were asked what the item (a) meant and how well they understood the question (b) what did they think it asked about and (c) what their own response was. This data was descriptively presented to reflect participants' understanding of the tool items. Finally, a thematic analysis informed qualitative synthesis of the core findings of these interviews was carried out to present gaps in our understanding of depression in young adolescent girls, their own life experiences and clinical signs and symptoms that depression and other mental health interventions need to target.

Results
The key findings are broken down into 3 sections. First, is the presentation of cognitive interviews along the 4 domains of comprehension, judgement, retrieval and experiential response to items described earlier. Although the purpose of these interviews is to scrutinise participant understanding of these items, specific words and response options, we did score the tool based on participant feedback just to ascertain how their experiences tallied with symptoms of depressive illness. Secondly, we offer an in-depth qualitative analyses of what depression meant for our sample and the kinds of associations to depression that young girls brought out in relation to the pregnancy or motherhood experience. We interviewed 32 female participants between ages 14 to 18 years. Half of the participants were pregnant and the other half were postpartum and 21 of these participants were living on their own or with parent (in the absence of a partner) and the remaining were married. See Table 1 for sociodemographic characteristics of the participants and Table 2 which has cognitive interview rating for various questionnaire items that were understood or not per participant.

Cognitive interviews summary
We had 8 participants interviewed using EPDS Kiswahili and another 9 using EPDS English version. Nine participants were interviewed using PHQ-9 English and 6 using PHQ-9 Kiswahili version. As described in the methods section, the participants were scored for their ability in comprehension, retrieval, judgement and response quality. We were also scoring these participants on the questionnaire using the formal scoring. See Supplementary Table 1 that looks at cognitive interview rating for PHQ-9 and EPDS English and Kiswahili versions.

PHQ-9 English interviews (n=9). On PHQ-9 English interviews (n=9) we found that our participants had a difficult time following the item 1, 'little interest or pleasure in doing things', with explanations such as, 'you could want to do something but you don't have the support needed, When I live in a mistreated environment'. On item 2, feeling down depressed and hopeless', one of our participants doesn't understand the item, she says 'doesn't
Table 1. Sample characteristics for full- and subsample.

| VARIABLE | CATEGORY | FULL SAMPLE | BY ASSESSMENT TOOL | BY CONDITION |
|----------|----------|-------------|---------------------|--------------|
|          |          | TOTAL SAMPLE | EPDS | PHQ-9 | PREGNANT | POSTPARTUM |
|          |          | N=32 (100%) | N=17 (53.1%) | N=15 (46.9%) | N=16 (50.0%) | N=16 (50.0%) |
|          |          | N (%) | N (%) | N (%) | N (%) | N (%) |
| Age      | 14       | 4 (12.5%) | 3 (17.6%) | 1 (6.7%) | 1 (6.3%) | 3 (18.8%) |
|          | 15       | 4 (12.5%) | 2 (11.8%) | 2 (13.3%) | 1 (6.3%) | 3 (18.8%) |
|          | 16       | 7 (21.9%) | 3 (17.6%) | 4 (26.7%) | 6 (37.5%) | 1 (6.3%) |
|          | 17       | 8 (25.0%) | 4 (23.5%) | 4 (26.7%) | 6 (37.5%) | 2 (12.5%) |
|          | 18       | 9 (28.1%) | 5 (29.4%) | 4 (26.7%) | 2 (12.5%) | 7 (43.8%) |
| Marital status | Single | 21 (65.6%) | 10 (58.8%) | 11 (73.3%) | 8 (50.0%) | 13 (81.3%) |
|          | Married  | 11 (34.4%) | 7 (41.2%) | 4 (26.7%) | 8 (50.0%) | 3 (18.8%) |
| Condition | Pregnant | 16 (50.0%) | 9 (52.9%) | 7 (46.7%) |                |                |
|          | Postpartum | 16 (50.0%) | 8 (47.1%) | 8 (53.3%) |                |                |

Table 2. Cognitive interview rating sheets for PHQ-9 English and Kiswahili, EPDS English and Kiswahili.

| PARTICIPANT | AGE (YEARS) | PHQ 1 | PHQ 2 | PHQ 3 | PHQ 4 | PHQ 5 | PHQ 6 | PHQ 7 | PHQ 8 | PHQ 9 |
|-------------|-------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| PHQ-9 ENGLISH |             |       |       |       |       |       |       |       |       |       |
| KII AD 01 KR | 16          | ✓     | x     | ✓     | ✓     | ✓     | ✓     | ×     |       |       |
| KII AD 04 KR | 18          | x     | ✓     | x     | ✓     | ✓     | ✓     | x     | ✓     | ✓     |
| COG AD 03 KG | 17          | x     | ✓     | ✓     | ✓     | ✓     | ✓     | ✓     | ✓     | ✓     |
| COG AD 06 KG | 16          | ✓     | ✓     | ✓     | ✓     | ✓     | ✓     | x     | x     | x     |
| COG AD 011 KG | 18        | x     | x     | ✓     | x     | ✓     | ✓     | ✓     | x     | x     |
| COG AD 013 KG | 16         | x     | x     | ✓     | ✓     | ✓     | ✓     | ✓     | x     |        |
| COG AD 014 KG | 18         | x     | ✓     | ✓     | ✓     | ✓     | ✓     | ×     |     | ✓     |
| COG AD 021 KG | 15         | x     | ✓     | ✓     | ✓     | ✓     | ✓     | ✓     | ✓     | ✓     |
| COG AD 018 KG | 15         | x     | x     | x     | ✓     | ✓     | x     | x     | ✓     | ✓     |
| PHQ 9 KISWAHILI |            |       |       |       |       |       |       |       |       |       |
| COG AD 07 KG | 16          | x     | ✓     | ✓     | ✓     | ✓     | ✓     | x     | x     | ✓     |
| COG AD 01 KG | 17          | ✓     | x     | ✓     | ✓     | ✓     | ✓     | x     |       | ✓     |
| COG AD 09 KG | 18          | x     | x     | ✓     | x     | ✓     | x     | x     | x     | x     |
| COG AD 012 KG | 17         | x     | x     | ✓     | x     | x     | x     | x     | x     | x     |
| COG AD 010 KG | 18         | ✓     | x     | ✓     | x     | ✓     | x     | x     |       | ✓     |
| COG AD 019 KG | 14         | x     | x     | ✓     | ✓     | ✓     | x     | x     |       | ✓     |
| EPDS ENGLISH |             |       |       |       |       |       |       |       |       |       |
| COG AD 04 KG | 18          | ✓     | x     | x     | ✓     | ✓     | ✓     | ✓     | ✓     | ✓     |
| COG AD 05 KG | 18          | x     | ✓     | ✓     | ✓     | ✓     | x     | x     | ✓     | ✓     |
| COG AD 017 KG | 16         | ✓     | ✓     | ✓     | ✓     | ✓     | ✓     | x     | x     | x     |

(Continued)
Table 2. (Continued)

| EPDS ENGLISH | EPDS 1 | EPDS 2 | EPDS 3 | EPDS 4 | EPDS 5 | EPDS 6 | EPDS 7 | EPDS 8 | EPDS 9 | EPDS 10 |
|--------------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|
| KII AD 02 KR | 17     | ✔      | X      | ✔      | ✔      | ✔      | ✔      | X      | ✔      | ✔      |
| COG AD 022 KG| 14     | ✔      | X      | ✔      | ✔      | ✔      | ✔      | X      | ✔      | ✔      |
| COG AD 023 KG| 16     | X      | X      | X      | X      | X      | X      | X      | X      | X      |
| COG AD 024 KG| 14     | X      | X      | ✔      | X      | X      | X      | X      | ✔      | ✔      |
| COG AD 025 KG| 15     | ✔      | X      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      |
| COG AD 026 KG| 14     | X      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      |

| EPDS KISWAHILI | EPDS 1 | EPDS 2 | EPDS 3 | EPDS 4 | EPDS 5 | EPDS 6 | EPDS 7 | EPDS 8 | EPDS 9 | EPDS 10 |
|---------------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|
| COG AD 016 KG | 16     | X      | ✔      | X      | X      | X      | X      | ✔      | ✔      | ✔      |
| COG AD 018 KG | 17     | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      |
| COG AD 024 KG | 17     | X      | ✔      | X      | X      | X      | X      | X      | ✔      | ✔      |
| COG AD 025 KG | 14     | X      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      |
| COG AD 026 KG | 14     | X      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      |

✔– Correctly understood, X– incorrectly understood.

Comprehend it all “feeling down” is hard’. On item 4 ‘feeling tired or having little energy’, most of the participants understood the item however there were odd 1 or 2 responses where there was some unclarity around comprehension. Responses such as ‘she feels lazy/feeling “maybe I am sick’ she forces self to go to work’ leave us wondering whether this 15 year old with 7-month pregnancy is able to grasp the item fully. Item 5 was well understood by all. On item 6 ‘feeling bad about yourself– or that you are a failure or have let yourself or your family down’ some responses like ‘blames oneself, feels she is a let-down’ does convey that there is an overwhelming sense of resonance with the theme that the item conveys. On item 7 around ‘trouble concentrating on things, such as reading the newspaper or watching television’, there were at least 2 participants who had issues with comprehending the question with responses such as ‘not being able to listen to news’ or another 15 years old saying that she didn’t get the question. On item 8, ‘moving or speaking so slowly that other people could have noticed. Or the opposite–being so fidgety or restless that you have been moving around a lot more than usual’ one of our 18 years old mother of 10-month old child responded ‘when unhappy her voice goes down’, another 6 months pregnant 16 years old said that ‘If you change hormones to walk or talk with say bit- terness, anger’. On item 9 about ‘thoughts that you would be better off dead, or of hurting yourself’, almost everyone had a good sense of what it meant.

PHQ-9 Kiswahili interviews (n = 6). On PHQ-9 Kiswahili cognitive interviews (n = 6), we found that 2 of our participants had a hard time following the question. With one 18 years old with a 10-month old baby saying, ‘I have not understood the question’ and another one having difficulties understanding the response items. On item 2, a 17 years old pregnant participant does not follow the item despite repeating and another participant 18 years old mother responds, ‘if you are going through a lot of trouble’. Item 3 was well-understood by all our participants. On item 4, one of our 18 years old young mother’s feedback was that ‘you feel tired after doing a lot of work’ and such responses can be perplexing as one may be offering one’s lived experience than the understanding of the question per sae. Another 17 years old 6-months pregnant participant felt that she didn’t understand the question and needed it to be explained. On item 5 one of our 17 years old participants shared her understanding that ‘maybe if you feel like eating’ which again did not capture the actual meaning of the item. One of our 17 years old 7-months pregnant participant had problems following the item 6. Another 17 years old 6 months and 18 years old young mother responded to the item as ‘maybe your parent asks you for something and you don’t have; you feel bad’, and ‘for example parents ask for money at the end of the month but you don’t have,’ another 14 years old 10-months pregnant adolescent said ‘means that you feel bad and not happy about your family and you think of bad things’. On item 7, one of our 16 years old 7-months pregnant adolescent responded that ‘paying attention while doing something or reading’ and the 18 years old adolescent mother said, ‘it’s like reading a magazine reduces stress’. A 17 years old participant wanted this item to be explained again. Another 18 years old with 1-year old baby made an interesting comment ‘I don’t have a TV and also don’t read newspapers.’ On item 9, one of our
16 years old 7-months pregnant participant’s interpretation was ‘people realizing that you have changed a lot. Looking as if you are absent-minded’. One of our 18 years old young mother didn’t understand the item while another 18 years old young mother said ‘I walk slowly because walking fast can make you get hit by a motorcycle’. On item 9, one 17 years old 6-months pregnant adolescent said that ‘I have understood but I don’t know how to explain’ and other than that all participants understood the meaning of the item well.

EPDS English interviews (n = 9). On EPDS English version (n = 9), on item 1, ‘I have been able to laugh and see the funny side of things’, one of our 18 years old with 2 months pregnancy, responded ‘I have been able to laugh and see the funny side of things’ though another 16 years old 5-months pregnant adolescent did not follow the item despite being reminded a number of times. One 14 years old 6-months pregnant adolescent responded “seeing the funny side of things” is difficult to understand and another 14 years old responded ‘I can laugh but sometimes I am angry’. On item 2 ‘I have looked forward with enjoyment to things’. Our 14 years and 6-months pregnant participant says, ‘if I can see and enjoy’ and the 16 years old 5-months pregnant participant does not understand the question. Another 14 years old 6-months pregnant says “waiting for the pregnancy with joy” and another 15 years old with 10-months old baby says, ‘due to baby responsibility she has to work hard and have hope’. On item 3, ‘I have blamed myself unnecessarily when things went wrong’, one of our participants says, ‘I hated myself’, another 16 years old 5-months pregnant participant does not understand the question even after multiple repetitions. On item 4, ‘I have been anxious or worried for no reason’, our 16 years old 5-months pregnant and another 14 years old 6-months pregnant participants did not understand the item. Another 14 years old 6-months pregnant says ‘waiting for the pregnancy with joy’ and another 15 years old with 10-months old baby says, ‘due to baby responsibility she has to work hard and have hope’. On item 5, ‘I have felt scared or panicky’, another 17 years old 3-months pregnant participant said, ‘that question is hard’, she didn’t understand the question and that it was hard. On item 6, one of our 16 years old 8-months pregnant participant said, ‘if you have laughed because you have seen things’, one 17 years 2-months pregnant participant did not understand. Another 15 years young mother of one also did not understand the item. On item 2, one of our 17 years old mother of 8-months old child also did not follow the question and another 17 years old 2-months pregnant participant also did not follow the question. Another 15 years old young mother said doesn’t understand the meaning of ‘I have looked forward’ and the 18 years old 8-months pregnant said, ‘it means if I have looked forward to things with enjoyment’. On item 3, one 16 years old 8-months pregnant interpreted it as, ‘if you were not used to blaming yourself’, another 17 years old 3-months pregnant participant did not follow the question and a 15 years old young mother said, ‘if you insult your parents’. On item 4, our 16 years old 8-months pregnant participant said, ‘if you never liked being worried’, another 17 years old 3-months pregnant participant did not understand. On item 5, our 16 years 8-months pregnant participant said, ‘In the past you were not scared or anxious’, however others did understand the item well. On item 6, one of our 16 years old 8-months pregnant participant said, ‘in the past you never used to face issues but now you are facing them’, and another 17 years old mother of 8-months old said, ‘it means failure to understand well’. Another 17 years old 3-months pregnant participant did not understand the item. On item 7, one participant a young 15 years old mother of 1-year old child said, ‘if your loved-one dies’. On item 10 our 15 years old mother of 1 did not follow the question.

Some of our participants had a hard time following the questions especially on the Kiswahili versions of the tools (which they preferred over English). Often times they would say that the question is hard to follow. For example, when asked if the participant experienced same levels of enjoyment in things she used to like doing before, one of our 17 years old 2-months pregnant participant said ‘that question is hard’, she repeated this for couple of other questions. Another 17 years old 3-months pregnant participant when asked if she blamed herself unnecessarily when things went wrong from EPDS said that she didn’t understand the question and that it was hard.
Thematic analysis of the participant interviews

The interviews were at another level very poignant and painful reminder of how deeply affected these adolescents were in some ways by the pregnancy and unintended/unplanned motherhood.

Manifestations of depression. Our participants shared through these interviews several feelings and experiences associated with being, down dejected and hopeless. Almost always there were adverse family experiences and lack of provision for their basic needs that contributed to feeling dejected.

"Yeah you cry and ask yourself why did it have to happen to- why is it only me that was supposed to be in this situation; so I ask myself several questions I even lose several things in life, education. Thoughts of harming myself have come to me several times." (18 years old with 2 months old baby)

"You can just be in deep thoughts thinking a lot of things, maybe you are stressed and you are unable to fall asleep..." (18 years old mother with 8 months old baby)

The second participant often contemplates suicide when her father is rough with her and the mother is pressing her to stay with the baby rather than take up a job and fend for herself and family.

"When you wake up feeling that way and the parents are around, they start quarrelling saying that you are a girl and you don’t want to work you have left all the house chores for other siblings. At times feel very tired and hungry – sometimes there is food sometimes there isn’t. I normally feel that I have let them down because they expected me to at least to raise their living standard in future but instead I got pregnant." (16 years old with a 4 months old baby)

"Depression is lacking peace. . . you feel bad about your body or it’s like you have let yourself or your family down. . . . I was in school when I got this child so my mother just wasted all her money taking me to school. I just feel bad because right now I am at home and all my sisters are at school continuing with their studies so I tell myself if I wouldn’t be in this situation I would be in school." (18 years old mother of 2 months old infant)

Similar sentiments around being disenfranchised were shared by another participant.

"That feeling you get when wronged, you don’t want to talk to anybody and just want to be left alone I do feel bad. At times I even contemplate suicide." (16 years old mother of 4 months old infant)

Absence of social support and loneliness was also alluded to by a participant.

"Because the child’s dad does not support me and I am suffering alone. I have contemplated suicide. I usually sit down and correct myself; I talk to myself and say that this is not the best thing to do. There are many challenges. . . .lacking a person to talk to sometimes." (17 years old mother)

These experiences of not finding support are also complex and also worthy of further exploration as they hinge on several challenging experiences of being left alone, not having anyone to talk to, going hungry, lacking provision of basic needs etc. The descriptions make it seem that the experience of unintended and unplanned pregnancy is a significant jolt for more or less every adolescent.

Acceptance of pregnancy. While accepting the pregnancy and receiving support from the parents to help deliver the baby, the adolescent feels that there will be significant trade-offs between returning to school, finding job and caring for the baby. Even though the pregnancy is accepted helplessly as a fact of life, the implications of long-term responsibility and support that an adolescent has to vouch for, is something that young girls seem to struggle with tremendously.

Support and stresses around adolescent’s caregivers especially mother

"It means the way I am and the way I was, the level of happiness before and now, if I am just happy just the way I used to be, I was very happy when I was pregnant and up to now it is not gone especially when I see my baby, it makes me feel happy because I know even though I am raising the baby alone I know one day she/he will help me." (17 years old with 10 months old infant)

"Yes. Because sometimes I just ask myself ‘now where is my life heading to?’, where I am today and where I will be, I sometimes try to give myself hope and then I feel that maybe I am giving myself hope yet I will not reach where I want to be... It is like when you over-think and feel like life has become difficult and you cannot take it anymore so you feel like the only solution is to take your life to avoid troubles, but again when you think about your baby you feel that ‘who will I leave him with?’ and you also don’t want to leave that burden to your mother, because you will also leave her with stress and she can even die." (17 years old 10 months old)

Problem of I mean many troubles whenever you are stressed it leads somebody to lose whatever – there is something you just lose; it is like you become insane. You lose a lot – cannot go to school... because you might find that even in school people are laughing at you, you regret so it makes you feel like you are stigmatized. My self-blame comes from due to peer pressure about others and my friends they led me into a wrong way then I fall out [Inaudible] I used to blame myself...now I have returned to school". (18 years old mother with 2 years child)

"It reached a point when my mother, you know my mother left us when we were still very young. When I was three years old when she died, so we were left with my grandmother, then my father was arrested, so we went through a lot, my grandmother’s leg broke, so our grandfather took the initiative of feeding us, clothing us. Taking us to school; either we go or we don’t because we have been sent away due to lack of fees and we are just at home. It reaches a point I could start to cry and say [Inaudible] ‘why has mum left us? Our father lived in prison about four years." (18 years old mother of 8 months baby)

Demanding multitasking and early adulterization

"Stress at home yeah; you may have gone to school then she tells you, you know she remains back; she doesn’t go to work then you tell her ‘mum since you are not going to work can you stay with the child for me for a
while,’ then she will refuse, even if it is Sunday. I may come back from school in the evening then you find that everything is waiting for you there so.” (18 years old with 2 years old baby, 16 on EPDS)

“Maybe you had something urgent that you wanted to do but you have not done it because maybe you have a lot of work to do, so you will be forced to be more faster to be able to handle other tasks, or maybe you have a lot of stress.”(16 years old with 4 months baby.)

Discussion

The paper has adopted a 2-pronged approach of introducing findings of cognitive interviews from the 2 sets of tools, briefly reviewing their psychometric properties using Kiswahili and English language versions and developing a thematic analysis of the experiences around various questionnaire items. We were hoping to summarise the life experiences of our participants as well as experience and process of conducting a cognitive interview exercise through this approach.

Psychometrically, we think that EPDS is a better tool than PHQ-9 for our adolescent sample for 2 reasons—one, the latter is more congruent with the peripartum context and second, the questions are organised more sensitively. The Kiswahili translation was significantly better than the PHQ-9 translation. On both tools we can see several items where the item reliability scores were poor and can see that PHQ-9 had many more items with poorer alphas. We think that the factor structure of the tools may be different for pregnant and parenting adolescents than the adult samples. This warrants further analysis that is currently outside the scope of this paper and we acknowledge that our sample is limited to make clear conclusions.

In Kenya, Cognitive testing of the PHQ-9 has been conducted for depression screening among pregnant and postpartum women. Results showed that most participants preferred to answer the PHQ-9 in Kiswahili (N=15; 52%). Overall, participants found the scale acceptable as an interviewer-administered tool. Participants reported few problems related to comprehension but had difficulty answering items not relevant to their lives (eg, ‘watching television’) and double-barreled items (eg, ‘poor appetite or overeating’). They were hesitant to endorse items related to ‘duties as a wife and mother’ and suicidal ideation. Most participants had difficulty distinguishing between response options of ‘several days’ and ‘more than half the days’.

Cognitive interview findings do make us feel that the distillation of actual experiences and the meaning of those states of mind and body reactions may not completely fit with each other. However, at the same time separating the 2 would be difficult. Both tools were better received for most parts when delivered in English as young people felt more comfortable in English. Very chaste Kiswahili may no more be used in urban informal settlements where ‘sheng’ a hybrid of Kiswahili, English, and colloquial dialects are used.

It is sometimes hard to be an objective witness of one’s distress while undergoing in that moment. This is something that trauma researchers know well in their work around testimonies of trauma. At times these cognitive interviews were akin to testimonies of pain and sadness of life circumstances and adverse choices 1 has made. In almost all statements that the participants offered their understanding and experience, we noted the overwhelming distress, helplessness, sadness and sense of isolation they went through. There was early adultification and end of school education, very painful reality of looking after a new being and not having time or resources to become a full time caregiver. The interview transcripts were a testament to how stoic adolescents were around particular questions of whether they have let others down, feeling hopeless and that their life is not worth living. Their pauses, delayed responses and at times asking for the question to the repeated again felt as though these questionnaire items were like frozen metaphors for their state of mind and existence.

We found interesting themes like participants wanting more attuned care and support from their mothers and at the same time knew how hard things were going to become for the adolescent’s mother. This duality was very striking. The interpersonal web of challenges around adolescent pregnancy and motherhood is quite significant. The missing supportive male caregiver and absence of a wiling and responsible partner/boyfriend cannot be underscored. The participants also appeared to become more aware of their state of mind as the questionaire items were presented. In a context where mental health is poorly understood, these questionnaires become an odd encounter of coming face to face with all cognitive processes and emotions that must underlie adolescent experience of encountering unplanned motherhood.

Limitations

We did not administer the 4 sets of tools on all participants. It would have been difficult from a design as well as measurement point of view repeating similar kinds of questions on participants raising even ethical issues of exposing them to further duress.

Conclusion

For pregnant and parenting adolescents in low resource settings or in LMICs it would be important to consider using the self-administered depression or mental health questionnaires carefully. It may be important to have group assessments facilitated by an experienced social worker, health worker with training in mental health or by a psychologist. We need to make response items of these public mental health tools more responsive to adolescent and less literate populations. Kenyan pregnant adolescents and adolescent mothers demonstrate significant mental distress and depressive symptoms however the precise assessment of the extent of their depressive symptoms cannot be reliably ascertained given the issues that have been presented in this paper.

Abbreviations
LMICs—Lower-and-Middle-Income Countries
PHQ-9—Patient Health Questionnaire— 9
EPDS—Edinburgh Postnatal Depression Inventory
CI-Cognitive Interviewing  
SSA-Sub-Saharan Africa

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Authors’ Contributions
MK developed the paper, MK and VN conducted the interviews along with MK; OY and BM helped us review the tools findings, all authors contributed to the draft and made edits and approved the MS. All authors have read and approved the manuscript. MK (Corresponding author) developed the paper, MK (4th co-author) and VN conducted the interviews along with MK; OY and BM helped in review of tools findings, all authors contributed to the draft and made edits and approved the manuscript. All authors have read and approved the manuscript.

Ethics Approval and Consent to Participate
the study which has been approved by Kenyatta National Hospital/University of Nairobi ethical review committee (approval no. P694/09/2018). The study received approval from Nairobi county health directorate (approval no. CMO/NRB/OPR/VOL1/2019/04) and approval from National Commission for Science, Technology and Innovation (NACOSTI/P/19/77705/28063). The written informed consent to participate was sought from all study participants.

Consent for Publication
all study participants would be asked for their written consent to publish the findings of this work. The key study participants and their family member data would be anonymised, and the personal information would be kept confidential.

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Availability of Data and Material
NIMH funded research requires the data to be made available in publicly available. The data from this study would be made available on repositories such as Clinicaltrials.gov, RDoCdb, FIC webpage. All the personal information would be de-identified, and the data put on excel sheets for research use. Some interview transcripts would be kept by the researcher and may be shared on reasonable request.

Supplemental Material
Supplemental material for this article is available online.

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