WHO Case Studies

Country: Kenya

University of Nairobi

The University of Nairobi is amongst the oldest universities in the East African region. Established as an independent university in 1970 in Kenya, the institution offers upwards of 300 programs to over 80,000 students. Through the university's partnership with the NIH/Fogarty Foundation, professors who received this grant work on providing services to the local population, including youth.

Were you delivering services to young people before the COVID-19 crisis?

We started our work prior to COVID-19 but made adaptations during this pandemic to address the needs of health care workers as well as the needs of vulnerable adolescent populations. Prior to COVID-19, we were offering psychological first aid, mental health literacy, and group psychotherapy using task-shifting, peer-delivered modalities[1]. We focused on adolescents living with HIV and peripartum adolescents. Furthermore, we conducted referrals to specialist and emergency services.

The ongoing NIH/Fogarty Foundation study aimed to look at the mental health needs of pregnant adolescents and make a case for integrated Mental Health Gap Action Programme (mhGAP) and the group therapy approach (specifically interpersonal psychotherapy). We used the WHO mhGAP community toolkit[2] for awareness building and for integrating screening of common mental health problems in primary care centers. Additionally, we offered group Isoniazid Preventive Therapy (IPT) for moderate to severely depressed pregnant adolescents.

What new approaches did you use to respond to the barriers created by the COVID-19 pandemic to reach young people?

We are using a number of strategies to reach young people, especially our target group of pregnant and parenting adolescents. Our strategies include talking to youth community-based organizations (CBOs) and youth leaders to disseminate messages of self-care, ways of preventing a rise in high-risk behaviors, sensitizing health-care workers (HCWs) to encourage

youth when they come to facilities and work with community health workers through phone messages, brief seminars, and talks. It was challenging in the beginning, but people were very keen to connect and enjoy the support we offered.

We have partnered with CBOs like Citiesrise, colleagues from universities, youth groups, the Kenya Psychiatric Association, the Ministry of Health, and other partners including UNICEF and UNFPA. Together, we focused on ways to prevent adolescent pregnancies, address gender-based violence (GBV), offer life skills, and support to those needing help during COVID-19. We also started developing Zoom and Skype groups to provide self-care, psychological first aid, and provide referrals to primary health care workers during COVID-19.

Along with Nairobi County, we developed a web-based psychotherapy service, a helpline as well as online assessments targeting youth living with HIV and youth LGBTQI+ groups to offer them a safe virtual space to talk. We received a supplement from Fogarty to develop an online training around mhGAP-based screening and group therapy addressing COVID-19-related distress, public health messaging and core mental health problems for primary health care workers to serve adolescent populations better.

Why did you decide to use these approaches?

We felt that one modality would not be enough. It has been helpful to give young people, health care workers, and community members options to test multiple modalities to engage. We decided to make the work broader and build on real linkages and referrals– from food banks, SRH support, and GBV prevention– so that young people and health care workers can be helped in real-time. Given the high amount of unrest and isolation during this pandemic, we thought such collaborations and cross-cutting work on mental health was important.

How are you working to find out if these approaches are having the desired impact?

We carry out process and impact evaluations to ensure that healthcare workers are using the appropriate tools and mhGAP procedures we put in place. In addition, we track the awareness of and interest in mental health at the University, tertiary hospital, primary care, and communities where we work.

1. Task shifting is an approach to improving mental health care delivery by shifting tasks from more highly trained providers to individuals with less training.

2. World Health Organization. (2019). Field test version: mhGAP community toolkit: Mental Health Gap Action Programme (mhGAP). World Health Organization. https://apps.who.int/iris/handle/10665/328742. License: CC BY-NC-SA 3.0 IGO

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