

# FRIENDSHIP BENCH

## PROGRAMME AT THE GLANCE

The Friendship Bench (FB) is a multi-component intervention designed to address common mental health problems (including depression, anxiety, and trauma-related symptoms). People experiencing poor mental health are referred for one-on-one problem-solving therapy (PST) with a lay health worker on specially designated benches outside community health clinics. PST assumes that poor mental health is caused or complicated by everyday problems and uses a simple, guided approach to identify solvable problems, brainstorm solutions, and develop action plans. After receiving one-on-one PST, people are connected with peer groups for social support and income-generating activities (IGAs).



The programme is recognised for its meticulous formative work, attention to local culture and indigenous mental health concepts, and rigorous evaluations of feasibility, acceptability, and effectiveness. It has successfully reduced symptoms of poor mental health, particularly in urban Zimbabwe. While not designed or evaluated as a violence prevention programme, poor mental health is an important risk factor for both the experience and perpetration of intimate partner violence (IPV). Effective mental health interventions thus have the potential to prevent or reduce violence by improving mental health outcomes.

## BACKGROUND

Poor mental health is a leading contributor to the global disease burden. It is particularly common in contexts or populations such as conflict-affected countries, people living with HIV, and those exposed to high levels of violence. Poor mental health is linked to poor physical health, self-harm, and unhealthy coping mechanisms, including substance use. Additionally, it is a key driver of both experiencing and perpetrating violence, with negative implications for individuals, families, and communities. Therefore, efforts to improve mental health not only address individual well-being but

also can prevent other conditions, including HIV, substance use and IPV. (See our [evidence review](#) of pathways between poor mental health and IPV.)

In low-middle-income countries, an estimated 80 percent of those with common mental health problems are not treated. Mental health care is rarely prioritised in national healthcare packages, and there is a persistent shortage of trained personnel to deliver care. For example, despite high rates of common mental health problems in the region, only 1.6 mental healthcare professionals serve every 100,000 people in sub-Saharan Africa.<sup>1</sup>

Dr. Dixon Chibanda, a mental health physician in Zimbabwe, developed the Friendship Bench in response to calls for more accessible, evidence-based, and cost-effective treatment models. This programme aims to improve symptoms of common mental health problems, increase care capacity, and reduce stigma around poor mental health by bringing mental healthcare into communities.

## CONTEXT

In Zimbabwe, a lower-middle-income country in sub-Saharan Africa, an estimated 40 percent of the population live in extreme poverty.<sup>2</sup> About a third of the population live in urban centres, and a quarter in slums. About 13 percent of Zimbabweans are estimated to experience a mental health problem, with over 20 percent affected over their lifetime. The suicide rate is nearly two percent – twice the regional average.<sup>3</sup> Additionally, about 12 percent of the population live with HIV, 60 percent of them are women.<sup>4</sup> In this setting, poor mental health is more common among women, those in poverty or other negative life situations, and those with chronic illnesses such as HIV.<sup>5</sup>



The Friendship Bench was first developed in Harare, Zimbabwe, at primary care clinics, and implemented with adult attendees. People attending the primary care clinics faced significant challenges, including high HIV prevalence, violence in the home, poverty, unemployment, and displacement. These challenges were exacerbated by concurrent socio-economic and political uncertainties, severe drought threatening food security, and a government “slum clearance” operation.<sup>6</sup> The programme has since been adapted and implemented in many countries and contexts **(See adaptations below)**.

## MENTAL HEALTH AND INTIMATE PARTNER VIOLENCE IN CONTEXT

**The association between mental health and IPV is bidirectional: the experience of violence increases the risk of mental health problems, and mental health problems increase vulnerability to experiencing or perpetrating violence. According to the 2015 Demographic and Health Survey (DHS), about 40 percent of Zimbabwean women report ever experiencing physical or sexual violence, primarily by an intimate partner.<sup>7</sup> The Domestic Violence Act criminalised IPV in 2007. However, economic disparities, cultural practices such as bride price, high levels of social acceptance of IPV, and legal provisions such as those mandating married women to obey their husbands continue to support it. For instance, over a third of both men and women in the 2015 DHS justified a man beating his wife for arguing with him, refusing sex, burning food, going out without telling him, and/or neglecting the children.**

## PROGRAMME DESCRIPTION AND ACTIVITIES

The Friendship Bench starts with screening visitors at community care centres using locally developed and validated questionnaires. Some visitors receive referrals from other community organisations or members, while others come for reasons unrelated to their mental health. Those with mild to moderate symptoms of poor mental health are referred to speak with lay health workers (LHWs) at designated benches. Those with severe symptoms are referred to a higher level of care, although some may attend sessions on the bench simultaneously.







LHWs who meet literacy and skill requirements (such as the ability to use mobile technology) are trained in PST basics, symptoms of common mental health problems, and screening tools. Training is conducted through live sessions and following a detailed script manual over a period from about a week to a month. The programme establishes a tiered support structure with on-site meetings among LHWs, access to an on-site trained supervisor, and access to an off-site mental health professional.

The Friendship Bench have involved LHWs of various ages and characteristics, but older women already working as health promoters in their communities, or “community grandmothers,” are seen as key to the programme’s success. As trusted community members, they share social and economic problems with those visiting the bench. Their role builds on culturally meaningful associations (for example, grandmothers are seen as caring listeners and custodians of wisdom) to facilitate the therapeutic relationship. LHWs do not need to be professional psychologists or psychiatrists, echoing an aspect of global mental health strategies to ensure accessibility of mental health care, especially in the Global South.<sup>8</sup>

The programme comprises four to six one-on-one sessions, individualised text messages, and group sessions. In individual sessions, LHWs offer information, education, and support about common mental health problems. Ideally, LHWs use local concepts and words such as *kufungisisia* or “thinking too much” and *mwoyo unorwadza* or “heavy heart” instead of anxiety or depression. Participants are guided through a structured process to identify problems contributing to their poor mental health, choose one priority problem, brainstorm solutions, and implement a meaningful action plan. Throughout the process, LHWs send supportive text messages to participants to reinforce lessons learned and encourage continued progress.

After they establish individual care, LHWs refer participants to local peer-led support groups with current or former Friendship Bench attendees. These groups offer various activities based on members’ needs, typically including social and emotional support, IGAs, and mutual aid activities. Because most priority problems relate to limited access to resources, participants view IGAs and mutual aid as particularly relevant to their mental health.

**Table 1: Session Content**

	<p><b>Session 1</b>  <b>Time:</b> One hour</p>		<p><b>Content:</b></p> <ul style="list-style-type: none"> <li>▶ Opening the mind (<i>kuvhura pfungwa</i>; introductions, rapport-building, reflective listening, including about what life was like prior to current challenges).</li> <li>▶ Uplifting (<i>kusimudzira</i>; problem listing and non-directive identification of a single priority problem).</li> <li>▶ Strengthening (<i>kusimbisa</i>; brainstorming solutions and developing a SMART action plan).</li> <li>▶ Psychoeducation (providing information, advice, and support about common mental health problems).</li> </ul>
	<p><b>Session 2-6</b>  <b>Time:</b> 30-45 min</p>		<p><b>Content:</b></p> <ul style="list-style-type: none"> <li>▶ Strengthening (<i>kusimbisa</i>; summarising information from previous sessions and encouraging continued focus on the priority problem).</li> <li>▶ Strengthening further (<i>kusimbisisa</i>; reinforcing achievements).</li> <li>▶ Weekly text messages.</li> </ul>
	<p><b>Session 1-6 or more</b>  <b>Time:</b> Varies</p>		<p><b>Content:</b></p> <ul style="list-style-type: none"> <li>▶ Circle Kubatana Tose (CKT; “holding hands together”).</li> <li>▶ Social and emotional support activities, such as sharing problems and brainstorming solutions, prayer, and music.</li> <li>▶ Income-generating activities, such as crocheting bags.</li> <li>▶ Mutual aid, such as cooperative solutions/ventures, microlending or group vegetable gardens.</li> </ul>

## FORMATIVE WORK

The implementation and evaluation of the programme were first funded by the Zimbabwe Health Trust, Zimbabwe Health Training Support (ZHTS), and Grand Challenges Canada. This collaborative effort was coordinated by the Medical Research Council of Zimbabwe and the London School of Hygiene & Tropical Medicine (LSHTM) in partnership with the Harare City Health Department.

Before the seminal cluster-randomised clinical trial (RCT), the team conducted extensive formative work. This included:

- ▶ Foundational research to establish the prevalence of common mental health problems in the relevant communities.
- ▶ A systematic review to identify common features of effective psychological interventions in similar socioeconomic contexts.
- ▶ Translation and validation of screening tools for common mental health problems for local use.
- ▶ Needs assessment and capacity evaluation of Harare City Health Department clinics and their LHWs.
- ▶ Adaptation and pilot testing of PST for delivery by LHWs.
- ▶ Incorporation of indigenous mental health concepts.

[\(See the programme example page on our website for links to these resources.\)](#)

The most commonly evaluated version of this programme includes effective features for addressing poor mental health, such as positive coping strategies, supportive peer network activities to alleviate poverty, and efforts to normalise mental health problems at the community level.

**Table 2: Features of the Programme Evaluated in Seminal RCT<sup>9</sup>**

### Type of Intervention

Individual PST + group-based social support with IGAs.

### Participants



- ▶ Adults (n=563) screening positive for common mental health problems at 24 randomised community care clinics in Harare, Zimbabwe.

### Facilitators



- ▶ Community "grandmothers", or older women serving as LHWs who had received two weeks of training on common mental health problems, counselling skills, PST, and self-care.
- ▶ Tiered supervision system including weekly case reviews, ongoing in-clinic support from supervisors, and text/phone access to trained mental health professionals.

## Number of sessions



- ▶ LHWs deliver six individual PST sessions on a bench outside of clinics over four to six weeks.
- ▶ LHWs send personalised reinforcing text messages weekly.
- ▶ Participants are referred to six weekly group sessions after completing four individual sessions.

## Content



- ▶ Problem-solving module:
  - ▶ Opening the mind to sharing about issues;
  - ▶ Identifying and listing problems;
  - ▶ Selecting a solvable high-priority problem;
  - ▶ Developing an action plan with a clearly defined goal;
  - ▶ Receiving support during implementation and;
  - ▶ Evaluating the process.
- ▶ Group support sessions: sharing and peer support while crocheting shopping bags from recycled materials for later sale.

## ADAPTATIONS



Over the last two decades, programme implementers have continually refined FB in response to community and stakeholder feedback. It has also been adapted for use outside of urban Zimbabwe and for different populations. FB is in use in over 70 urban community care clinics in Harare, Chitungwiza, and Gweru and has been adapted for use in the Masvingo rural district in Zimbabwe. Evaluations are available for its implementation in Botswana, Kenya, Malawi, Vietnam, and Puerto Rico, with mentions in popular press of additional implementations in Canada, Qatar, the United States, and Tanzania.

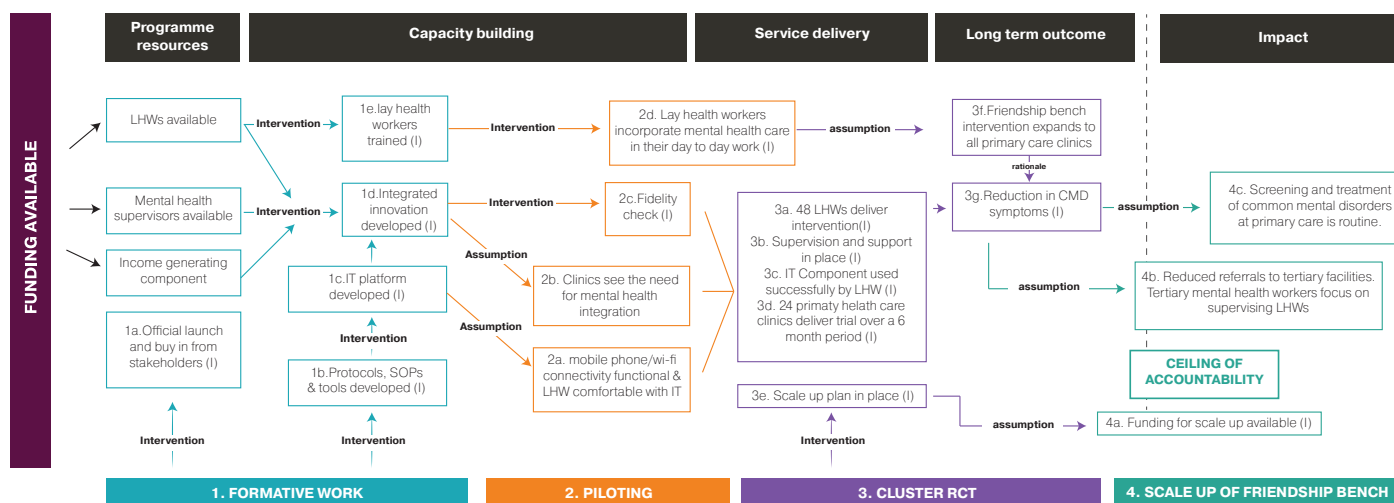
The programme has been further adapted to include home and virtual visits, additional curricular elements such as modules for HIV medication adherence, and to accommodate special populations such as youth. Different versions of the programme feature unique combinations of programme elements, numbers of sessions, and types of LHWs. The [Friendship Bench team](#) developed a comprehensive toolkit called *Friendship Bench in a Box* to facilitate future adaptations and quality implementation, available from the team.

## THEORY OF CHANGE

The programme is thought to improve individual mental health by helping people accurately assess their problems, develop the self-awareness necessary to identify factors within their control, and prioritise solvable problems. This practice enhances feelings of agency and destigmatises mental health problems. Peer group sessions further normalise mental health problems and offer social and structural support. Potential long-term benefits of the programme include healthier relationships, improved physical health, and better economic conditions.

From a programmatic perspective, the original developers emphasise stakeholder engagement to ensure the scale-up and sustainability of the programme in limited resource settings. They conducted eight theory of change workshops over a six-month period to define causal pathways and desired impacts and to discuss and evaluate interventions, indicators, assumptions, and rationales.<sup>10</sup> While not all versions of the programme have been preceded by this type of work, the original developers have cited the use of a theory of change map [see example below] as a critical facilitator of programme success.

**Figure 1: Theory of change map for the Friendship Bench project<sup>10</sup>**



## MONITORING AND EVALUATION

Several monitoring and evaluation efforts occurred during the formative stage of programme development and implementation. The most rigorous evidence comes from a cluster-randomised trial in Harare, Zimbabwe that compared FB to enhanced usual care, including a nurse-led assessment, psychoeducation, antidepressant medication, and/or referrals, plus two to three text messages.

- ▶ FB recipients were less likely to have depression, anxiety, or disability after six months and reported greater quality of life.<sup>11</sup>

- ▶ Those with suicidal ideation<sup>12</sup> and those experiencing both depression and anxiety<sup>13</sup> saw similar benefits as those without these mental health symptoms.
- ▶ Those with more severe symptoms of poor mental health saw greater improvement than those with fewer or less severe symptoms.<sup>14</sup>
- ▶ **FB was particularly effective for those reporting IPV.**<sup>15</sup>

These findings show that even those with more severe or complex mental health problems can benefit from the programme, which is particularly valuable in areas where accessing specialised treatment is difficult. An economic analysis showed that the programme was cost-effective at 2020 levels of treatment coverage, even if the programme was 80 percent less effective than observed in trials.<sup>16</sup>

The programme has been adapted, monitored, and evaluated for other settings and populations.

- ▶ Four out of five evaluations among **people living with HIV** showed improved mental health outcomes compared to an enhanced standard of care.<sup>17</sup> Another study found equivalent mental health outcomes and a lower HIV viral load than those receiving care from mental health professionals.<sup>18</sup> The study that found no positive mental or physical health impacts for those with HIV cited implementation challenges such as poor infrastructure and resistance from clinic staff.<sup>19</sup>
- ▶ Both impact evaluations for **maternal depression** showed positive results, even when compared to those treated with anti-depressants.<sup>20</sup>
- ▶ Evaluations of **a digital adaptation of the Friendship Bench** in Kenya and Zimbabwe (the Inuka Coaching Programme, consisting of four weekly one-on-one problem-solving chat sessions delivered by trained LHWs through a web or mobile application) found similar positive results.<sup>21</sup>

## PROGRAMMING LESSONS

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- ▶ Evaluations have found impacts with individual sessions only, group sessions only, both in combination, and with different types of lay providers. Future research is needed to clarify which elements are necessary, sufficient, and/or context dependent.
- ▶ Stakeholder engagement, community outreach, and proper infrastructure for ongoing training and supervision of LHWs have been cited as key to programme success and sustainability. This includes on-site supervisors, mobile connectivity at care sites, and integration with higher-level services for more complex mental health cases.
- ▶ The programme has a strong focus on indigenous concepts of mental health and local coping strategies. Developers, LHWs, and recipients widely cite this focus as key to de-stigmatise mental health care and establish trust between LHWs and recipients. Future adaptations are likely to be most successful in similar settings or after conducting context-specific formative work.



- ▶ Evidence shows that this programme benefits the LHWs. They report applying PST to their own problems, feeling engaged in important work, and experiencing fewer mental health problems. However, teen and young adult counsellors reported more burnout and vicarious trauma than older LHWs.
- ▶ Standard FB PST may not work well for children or young adolescents, given their limited agency to solve problems independently. Future adaptations might focus on problem discussion, setting achievable goals rather than priority problems, and better incorporation of caregivers into the PST process. Similar issues may arise for other populations with low agency, such as women in highly gender-inequitable settings.
- ▶ Participants expressed high satisfaction with the digital FB, citing anonymity as a key benefit. This format may be a good fit for those concerned about privacy, such as marginalised populations, members of smaller communities, or those feeling stigmatised for help-seeking. Additionally, the digital platform was especially popular with men and youth.
- ▶ Applying a gendered lens could meaningfully improve future programme implementations. Women made up about 80 percent of the LHWs and 78 percent of participants across all available impact studies. Many of the peer groups bring women and men together, facilitating collective discussion on mental health issues affecting both genders, including IPV. However, efforts to increase acceptability among men have not been clearly documented, and no known study directly compared effectiveness for women and men. Additionally, limited information is available on gendered risk factors for poor mental health and programme effectiveness.
- ▶ An evaluation specific to the perpetration and experience of violence is needed. While the potential benefits of this programme are clear, more information is needed about how PST is applied when violence is reported, which aspects of the programme are most effective for the mental health of those reporting IPV, and whether improvements in mental health lead to reduced violence.

**Acknowledgements:** This programme summary was written by Neisha Opper and reviewed by Ruti Levto, Tania Ghosh and Erin Stern from the Prevention Collaborative, and Charmaine Chitiyo from Friendship Bench. We are grateful to colleagues at the Friendship Bench for sharing insights and experiences. It was edited and copyedited by Oluwatobiloba Ayodele and Annie Holmes and designed by Ana Lucia Nustes.

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