How a wooden bench in Zimbabwe is starting a revolution in mental health

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Dixon Chibanda spent more time with Erica than most of his other

patients. It wasn't that her problems were more serious than others' – she was just one of thousands of women in their mid-20s with depression in Zimbabwe. It was because she had travelled over 160 miles to meet him.

Erica lived in a remote village nestled in the highlands of eastern Zimbabwe, next to the border with Mozambique. Her family's thatch-roofed hut was surrounded by mountains. They tended to staples such as maize and kept chickens, goats and cattle, selling surplus milk and eggs at the local market.

Erica had passed her exams at school but was unable to find a job. Her family, she thought, wanted her only to find a husband. To them, the role of a woman was to be a wife and a mother. She wondered what her bride price might be. A cow? A few goats? As it turned out, the man she hoped to marry chose another woman. Erica felt totally worthless.

She started thinking too much about her problems. Over and over, thoughts swirled through her head and began to cloud the world around her. She couldn't see any positivity in the future.

Given the importance that Erica would hold in Chibanda's future, it could be said that their meeting was fated. In truth, it was just the product of extremely high odds. At the time, in 2004, there were only two psychiatrists working in public healthcare in the whole of Zimbabwe, a country of over 12.5 million people. Both were based in Harare, the capital city.

Unlike his besuited colleagues at Harare Central Hospital, Chibanda dressed casually in a T-shirt, jeans and running trainers. After completing his psychiatric training at the University of Zimbabwe, he had found work as a travelling consultant for the World Health Organization. As he introduced new mental health legislation across sub-Saharan Africa, he dreamt about settling down in Harare and opening a

private practice – the goal, he says, for most Zimbabwean doctors when they specialise.

Erica and Chibanda met every month for a year or so, sitting opposite one another in a small office in the one-storey hospital building. He prescribed Erica an old-fashioned antidepressant called amitriptyline. Although it came with a suite of side-effects – dry mouth, constipation, dizziness – they would probably fade over time. After a month or so, Chibanda hoped, Erica might be better able to cope with the difficulties back home in the highlands.

You can overcome some life events, no matter how serious, when they come one at a time or in a small number. But when combined, they can snowball and become something altogether more dangerous.

For Erica, it was lethal. She took her own life in 2005.

Today, an estimated 322 million people around the world live with depression, the majority in non-Western nations. It's the leading cause of disability, judged by how many years are 'lost' to a disease, yet only a small percentage of people with the illness receive treatment that has been proven to help.

In low-income countries such as Zimbabwe, over 90 per cent of people don't have access to evidence-based talking therapies or modern antidepressants. Estimates vary, but even in high-income countries such as the UK, some research shows that around two-thirds of people with depression are not treated.

As Shekhar Saxena, the Director of the Department of Mental Health and Substance Abuse at the World Health Organization, once put it: "When it comes to mental health, we are all developing countries."

Over a decade later, Erica's life and death sits at the front of Chibanda's mind. "I've lost quite a number of patients through suicide – it's normal," he says. "But with Erica, I felt like I didn't do everything that I could."

Soon after her death, Chibanda's plans were flipped on their head. Instead of opening his own private practice – a role that would, to an extent, limit his services to the wealthy – he founded a project that aimed to provide mental health care to the most disadvantaged communities in Harare.

"There are millions of people like Erica," Chibanda says.

During her psychiatric training at the Maudsley Hospital in London in the late 1980s, Melanie Abas was faced with some of the most severe forms of depression known. "They were hardly eating, hardly moving, hardly speaking," Abas, now a senior lecturer in international mental health at King's College London, says of her patients. "[They] could see no point in life," she says. "Absolutely, completely flat and hopeless."

Any treatment that might lift this form of the disease would be lifesaving. By visiting their homes and their general practitioners, Abas made sure that such patients were taking their prescription of antidepressants for long enough for them to take effect.

Working with Raymond Levy, a specialist in late-life depression at the Maudsley Hospital, Abas found that even the most resistant cases could respond if people were given the right medication, at the correct dose, for a longer duration. When this tack failed, she had one last option: electroconvulsive therapy (ECT). Although much maligned, ECT is an incredibly effective option for a small number of critically ill patients.

"That gave me a lot of early confidence," says Abas. "Depression was something that could be treated as long as you persisted."

In 1990, Abas accepted a research position at the University of Zimbabwe's medical school and moved to Harare. Unlike today, the country had its own currency, the Zimbabwean dollar. The economy was stable. Hyperinflation, and the suitcases of cash that it necessitated, was over a decade away. Harare was nicknamed the Sunshine City.

Positivity seemed to be reflected in the minds of the people who lived there. A survey from the City of Harare reported that fewer than 1 in every 4,000 patients (0.001 per cent) that visited the Outpatients department had depression. "In rural clinics, the numbers diagnosed as depressed are smaller still," Abas wrote in 1994.

In comparison, around 9 per cent of women in Camberwell in London were depressed. Essentially, Abas had moved from a city where depression was prevalent to one in which – apparently – it was so rare it was barely even noticed.

This data fit snugly within the theoretical environment of the 20th century. Depression, it was said, was a Westernised disease, a product of civilisation. It wasn't found in, say, the highlands of Zimbabwe or by the shores of Lake Victoria.

In 1953, John Carothers, a colonial psychiatrist who had previously worked at Mathari Mental Hospital in Nairobi, Kenya, published a report for the World Health Organization claiming just this. He quoted several authors that compared African psychology to that of children, to immaturity. And in an earlier paper he compared the "African mind" to a European brain that had undergone a lobotomy.

Biologically, he thought, his patients were as undeveloped as the countries they inhabited. They were caricatures of primitive people at peace with nature, dwelling in a fascinating world of hallucinations and witchdoctors.

Thomas Adeoye Lambo, a leading psychiatrist and member of the Yoruba people of southern Nigeria, wrote that Carothers's studies were nothing but "glorified pseudo-scientific novels or anecdotes with a subtle racial bias". They contained so many gaps and inconsistencies, he added, "that they can no longer be seriously presented as valuable observations of scientific merit".

Even so, views like Carothers's had been echoed over decades of colonialism, becoming so commonplace that they were considered to be somewhat of a truism.

"The very notion that people in a developing black African nation could either be in need of, or would benefit from, Western-style psychiatry seriously unsettled most of my English colleagues," wrote one psychiatrist based in Botswana. "They kept saying, or implying, 'But surely they are not like us? It is the rush of modern life, the noise, the bustle, the chaos, the tension, the speed, the stress that drives us all crazy: without them life would be wonderful.'"

Even if depression was present in such populations, it was thought to be expressed through physical complaints, a phenomenon known as somatising. Just like crying is a physical expression of sadness, headaches and heart pain can arise from an underlying – 'masked' – depression.

A handy metaphor of modernity, depression became just another division between the colonisers and the colonised.

Abas, with her background in robust clinical trials, kept such anthropological viewpoints at arm's length. In Harare, she says, her open-mindedness allowed her to go about her work unclouded by the opinions of the past.

In 1991 and 1992, Abas, her husband and colleague Jeremy Broadhead, and a team of local nurses and social workers visited 200 households in Glen Norah, a low-income, high-density district in southern Harare. They contacted church leaders, housing officials, traditional healers and other local organisations, gaining their trust and their permission to interview a large number of residents.

Although there was no equivalent word for depression in Shona, the most common language in Zimbabwe, Abas found that there were local idioms that seemed to describe the same symptoms.

Through discussions with traditional healers and local health workers, her team found that kufungisisa, or 'thinking too much', was the most common descriptor for emotional distress. This is very similar to the English word 'rumination' that describes the negative thought patterns that often lie at the core of depression and anxiety. (Sometimes diagnosed together under the umbrella term 'common mental disorders', or CMDs, depression and anxiety are often experienced together.)

"Although all of the [socioeconomic] conditions were different," Abas says, "I was seeing what I recognised as pretty classical depression."

Using terms such as kufungisisa as screening tools, Abas and her team found that depression was nearly twice as common as in a similar community in Camberwell.

It wasn't just a case of headaches or pains, either – there was the lack of sleep and loss of appetite. A loss of interest in once enjoyable activities. And, a deep sadness (kusuwisisa) that is somehow separate from normal sadness (suwa).

In 1978, the sociologist George Brown published The Social Origins of Depression, a seminal book that showed that unemployment, chronic

disease in loved ones, abusive relationships and other examples of long-term social stress were often associated with depression in women.

Abas wondered whether the same was true half a world away in Harare, and adopted Brown's methods. Published in a study in 1998, a strong pattern emerged from her surveys. "[We found] that, actually, events of the same severity will produce the same rate of depression, whether you live in London or whether you live in Zimbabwe," Abas says. "It was just that, in Zimbabwe, there were a lot more of these events."

In the early 1990s, for example, nearly a quarter of adults in Zimbabwe were infected with HIV. Without medication, thousands of households lost caregivers, breadwinners or both.

For every 1,000 live births in Zimbabwe in 1994, around 87 children died before the age of five, a mortality rate 11 times higher than that of the UK. The death of a child left behind grief, trauma and, as Abas and her team found, a husband who might abuse his wife for her 'failure' as a mother. To exacerbate matters, what was described as the worst drought in living memory struck the country in 1992, drying up river beds, killing over a million cattle and leaving cupboards empty. All took their toll.

Adding to earlier reports from Ghana, Uganda and Nigeria, Abas's work was a classic study that helped demonstrate that depression wasn't a Westernised disease, as psychiatrists like Carothers had once thought.

It was a universal human experience.

Dixon Chibanda's roots are in Mbare, a low-income district of Harare that's a stone's throw – just across Simon Mazorodze Road – from Glen Norah. His grandmother lived here for many years.

Even though it is half an hour from the city centre by road, Mbare is

widely considered the heart of Harare. (As a waiter I met one evening put it: "If you come to Harare and don't visit Mbare, then you haven't been to Harare.")

At its centre is a market that people come to from all over the country to buy or sell groceries, electricals, and retro, often counterfeit, clothing. The line of wooden shacks is a lifeline for thousands, an opportunity in the face of inescapable adversity.

In May 2005, the ruling ZANU-PF party, led by Robert Mugabe, initiated Operation Murambatsvina, or 'Clear out the Rubbish'. It was a nationwide, military-enforced removal of those livelihoods deemed to be either illegal or informal. An estimated 700,000 people across the country, the majority already in disadvantaged situations, lost their jobs, their homes or both. Over 83,000 children under the age of four were directly affected.

Those places where resistance might have emerged, such as Mbare, were hit the hardest.

The destruction also took its toll on people's mental health. With unemployment, homelessness and hunger taking hold, depression found a place to germinate, like weeds among the rubble. And with fewer resources to deal with the consequences of the destruction, people were wrapped up in a vicious cycle of poverty and mental illness.

Chibanda was the among the first people to measure the psychological toll of Operation Murambatsvina. After surveying 12 health clinics in Harare, he found that over 40 per cent of people scored highly on psychological health questionnaires, a large majority of whom met the clinical threshold for depression.

Chibanda presented these findings at a meeting with people from the

Ministry of Health and Child Care and the University of Zimbabwe. "It was then decided that something needed to be done," Chibanda says. "And everyone sort of agreed. But no one knew what we could do."

There was no money for mental health services in Mbare. There was no option to bring therapists in from abroad. And the nurses already there were far too busy with dealing with infectious diseases, including cholera, TB and HIV. Whatever the solution – if one actually existed – it had to be founded on the scant resources the country already had.

Chibanda returned to the Mbare clinic. This time, it was to shake hands with his new colleagues: a group of 14 elderly women.

In their role as community health workers, grandmothers have been working for health clinics across Zimbabwe since the 1980s. Their work is as diverse as the thousands of families they visit, and includes supporting people with HIV and TB and offering community health education.

"They are the custodians of health," says Nigel James, the health promotion officer at the Mbare clinic. "These women are highly respected. So much so that if we try to do anything without them, it is bound to fail."

In 2006, they were asked to add depression to their list of responsibilities. Could they provide basic psychological therapies for the people of Mbare?

Chibanda was sceptical. "Initially, I thought: how could this possibly work, with these grandmothers?" he says. "They are not educated. I was thinking, in a very Western, biomedical kind of sense: you need psychologists, you need psychiatrists."

This view was, and still is, common. But Chibanda soon discovered what a resource the grandmothers were. Not only were they trusted members of the community, people who rarely left their townships, they could also translate medical terms into words that would resonate culturally.

With the buildings of the clinic already full of patients with infectious diseases, Chibanda and the grandmothers decided that a wooden bench placed under the shade of a tree would provide a suitable platform for their project.

At first, Chibanda called it the Mental Health Bench. The grandmothers thought that this sounded overly medical and were worried that no one would want to sit on such a bench. And they were right – no one did. Through their discussions, Chibanda and the grandmothers came up with another name: Chigaro Chekupanamazano, or, as it became known, the Friendship Bench.

Chibanda had read how Abas and her team had used a brief form of psychological therapy called problem-solving therapy in the early 1990s. Chibanda thought that it would be most pertinent to Mbare, a place where everyday issues are found in abundance. Problem-solving therapy aims to go straight to the potential triggers of distress: the social issues and stressors in life. Patients are guided towards their own solutions.

The same year that Abas published her work from Glen Norah, another piece of what would become the Friendship Bench was put in place. Vikram Patel, Pershing Square Professor of Global Health at Harvard Medical School and co-founder of the community-led Sangath project in Goa, India, had adopted Abas's research into the local idioms of distress to create a screening tool for depression and other common mental disorders. He called it the Shona Symptom Questionnaire, or SSQ-14.

It was a mixture of the local and the universal, of kufungisisa and

depression. And it was incredibly simple. With just a pen and paper, patients answer 14 questions and their health worker could determine if they were in need of psychological treatment.

In the last week, had they been thinking too much? Had they thought of killing themselves? If someone answered 'yes' to eight or more of the questions, they were considered to be in need of psychiatric help. Fewer than eight and they weren't.

Patel acknowledges that this is an arbitrary cut-off point. It makes the best of a bad situation. In a country with few health services, the SSQ-14 is a quick and cost-effective way to allocate scant treatments.

Although Chibanda had found studies showing that training community members or nurses in mental health interventions could reduce the burden of depression in rural Uganda and in Chile, he knew that success wasn't guaranteed.

Patel, for instance, after moving back to his home in India in the late 1990s, had found that psychological treatment was no better than giving patients a placebo. In fact, giving patients fluoxetine (Prozac) was the most cost-effective option.

Chibanda, thinking back to his days in Outpatients with Erica, knew that this wasn't an option. "There was no fluoxetine," he says. "Forget about that."

Late in 2009, Melanie Abas was working at King's College London when she received a call. "You don't know me," she remembers a man saying. He told her he'd been using her work in Mbare and how it seemed to be working. Chibanda told her about the Friendship Bench, the grandmothers, and their training in a 'seven-step' treatment for depression, the form of problem-solving therapy that Abas had used in

one of her first papers in 1994.

Notices about kufungisisa had been pinned up in health clinic waiting rooms and entrance halls in Mbare. In churches, police stations and inside the homes of their clients, grandmothers were discussing their work and explaining how 'thinking too much' can lead to ill health.

In 2007, Chibanda had trialled the Friendship Bench in three clinics in Mbare. Although the results were promising – in 320 patients, there was a significant reduction in depressive symptoms after three or more sessions on the bench – he was still apprehensive about telling Abas.

He thought his data wasn't good enough for publication. Each patient had only received six sessions on the bench and there was no follow-up. What if they just relapsed a month after the trial? And there was no control group, essential to rule out that a patient wasn't just benefitting from meeting with trusted health workers and spending time away from their problems.

Abas hadn't been in Zimbabwe since 1999, but still felt a deep connection to the country where she had lived and worked for two and a half years. She was thrilled to hear that her work had continued after she left Zimbabwe. Straight away, she decided to help.

Chibanda travelled to London to meet Abas in 2010. She introduced him to people working on the IAPT (Improving Access to Psychological Therapies) programme at the Maudsley Hospital, a nationwide project that had started a couple of years earlier. Abas, meanwhile, pored over the data he had sent her. Together with Ricardo Araya, a coauthor on a trial into using these types of psychological treatment in Santiago, Chile, she found it to be worthy of publication.

In October 2011, the first study from the Friendship Bench was

published. The next step was to fill in the gaps – adding a control and including a follow-up. Together with his colleagues from the University of Zimbabwe, Chibanda applied for funding to conduct a randomised controlled trial, one that would split patients across Harare into two groups. One would meet with the grandmothers and receive problem-solving therapy. The other would receive the usual form of care (regular check-ups but no psychological therapy).

At 24 health clinics in Harare, over 300 grandmothers were trained in an updated form of problem-solving therapy.

Since poverty or unemployment were often at the root of peoples' problems, the grandmothers helped their clients to start their own forms of income generation. Some asked relatives for a small kickstarter to buy and sell their chosen wares, while others crocheted handbags, known as Zee Bags, from colourful strips of recycled plastic (originally an idea of Chibanda's actual grandmother).

"They didn't have an intervention for depression before, so this was completely new in primary healthcare," says Tarisai Bere, a clinical psychologist who trained 150 grandmothers across ten clinics. "I didn't think they would understand it the way they did. They surprised me in so many ways… They are superstars."

In 2016, a decade after Operation Murambatsvina, Chibanda and his colleagues published the results from the clinics, incorporating 521 people from across Harare. Although starting at the same score on the SSQ-14, only the group from the Friendship Bench showed a significant decrease in depressive symptoms, falling well below the threshold of eight affirmative answers.

Of course, not everyone found the therapy helpful. Chibanda or another trained psychologist would visit the health clinics to treat those patients

with more severe forms of depression. And in the trial, 6 per cent of clients with mild to moderate depression were still above the threshold for a common mental disorder and were referred for further treatment and fluoxetine.

Although only based on what the clients were saying, domestic violence also seemed to decrease. Although there could be a number of reasons for this, Juliet Kusikwenyu, one of the original grandmothers, says that it is most likely a by-product of the income-generation schemes. As she says through an interpreter: "Clients normally come back and say, 'Ah! I actually have some capital now. I've even been able to pay school fees for my child. No longer are we fighting about money.'"

Although the Friendship Bench is more expensive than usual care, it still has the potential to save money. In 2017, for instance, Patel and his colleagues in Goa demonstrated that a similar intervention – called the Healthy Activity Program, or HAP – actually led to a net reduction in costs after 12 months.

This makes a lot of sense. Not only are people with depression less likely to keep returning to the health clinic if they receive adequate treatment, but there's also a growing pile of studies showing that people with depression are far more likely to die from other serious diseases, such as HIV, diabetes, cardiovascular disease and cancer. On average, long-term depression reduces your lifespan by around 7–11 years, similar to the effects of heavy smoking.

Treating mental health is also a matter of economic growth. The World Health Organization makes it very clear: for every US dollar invested in treating depression and anxiety there is a return of four dollars, a 300 per cent net profit.

This is because people receiving adequate treatment are likely to spend

more time at work and be more productive when they're there. Mental health interventions can also help people earn more money, equipping them to develop emotional and cognitive skills that further improve their economic circumstances.

The true test is whether projects like the Friendship Bench in Harare and HAP in Goa are sustainable at scale.

Getting there is a huge task. A few small projects dotted throughout a city need to become a national, government-led initiative that encompasses sprawling cities, isolated villages and cultures that are as diverse as different nationalities.

Then there's the very real issue of maintaining the quality of the therapy over time. Michelle Craske, a professor of clinical psychology at the University of California, Los Angeles, knows all too well that non-specialist workers often construct their own methods of therapy rather than sticking to the tried-and-tested interventions that they have been trained to provide.

After training nurses and social workers to deliver cognitive behavioural therapy (CBT) across 17 primary care clinics in four US cities, Craske found that even when the sessions were audiotaped they still intentionally went off track. She remembers one therapy session in which the lay health worker told her client, "I know they want me to do this with you, but I'm not going to do that."

To add some consistency to community-led therapies, Craske argues that the use of digital platforms – such as laptops, tablets and smartphones – is crucial. Not only do they encourage lay health workers to follow the same methods as a trained professional, they automatically keep track of what has taken place in each session.

"If we add in accountability through digital platforms, I think it's a brilliant way to go," she says. Without this, even a successful controlled trial can start to falter, or fail, in the future.

Even with accountability, there is only one route to sustainability, I have been told: merging mental health with primary care. At the moment, most community-led initiatives in low-income countries are supported by NGOs or the investigators' university grants. But they are short-term contracts. If such projects were a part of the public health system, receiving a regular slice of the budget, they could continue year on year.

"That's the only way to go," Patel said in June 2018 at a global mental health workshop held in Dubai. "Otherwise you're dead in the water."

One clear spring morning in East Harlem, I sat on an orange bench that looks like a giant Lego brick with Helen Skipper, a 52-year-old woman with short tan-coloured dreadlocks, half-rim glasses and a voice that seems to quaver with the ups and downs of her past.

"I've been involved in every system New York City has to offer," she says. "I have been incarcerated. I am in recovery from substance abuse. I'm in recovery from a mental illness. I've been in homeless shelters. I've slept on park benches, rooftops."

Since 2017, Skipper has been working as a peer supervisor for Friendship Benches, a project that has adapted Chibanda's work in Zimbabwe to fit within New York City's Department of Health and Mental Hygiene.

Although at the heart of a high-income country, the same life events that are seen in Harare are also found here: poverty, homelessness, and families that have been affected by substance abuse and HIV. In one study, some 10 per cent of women and 8 per cent of men in New York

City were found to have experienced symptoms of depression in the two weeks before being asked.

And even though there is an abundance of psychiatrists in the city, many people still don't – or can't – access their services. Have they been taught to keep their problems within the home? Are they insured? Do they own or rent a property and have a social security number? And can they afford their treatment?

"That cuts out a large portion of this city," says Skipper. "We're basically out here for them."

Since starting her role in 2017, Skipper and her peers have met with some 40,000 people across New York, from Manhattan to the Bronx, Brooklyn to East Harlem. They are currently planning to extend their reach into Queens and Staten Island.

In January 2018, Chibanda travelled from the summer of Harare into a freezing East Coast winter. He met with his new colleagues and the First Lady of New York City, Chirlane McCray. He was blown away by the support from New York's mayor, Bill de Blasio, the number of people the project had reached, and by Skipper and her team.

Chibanda seems to be in constant motion. As well as his work with the Friendship Bench, he teaches t'ai chi, helps children with learning disabilities acquire new skills, and works with adolescents who are HIV positive. When I met him in Harare, he often didn't even remove his satchel from his shoulder when he sat down.

Since the controlled trial in 2016, he has established benches on the island of Zanzibar off the eastern coast of Tanzania, in Malawi and in the Caribbean. He's introducing the messaging service WhatsApp to his teams. With a few clicks, community health workers can send Chibanda

and his colleague Ruth Verhey a text message when in doubt or if they are dealing with a particularly worrisome client. This 'red flag' system, they hope, can reduce suicides even further.

For Chibanda, the greatest challenge still lies within his own country. In 2017, he received a grant to pilot Friendship Benches in rural areas surrounding Masvingo, a town in south-eastern Zimbabwe. As is the case for Mbare, this region of rolling hills and wine-red msasa trees has a claim to be the true heart of Zimbabwe.

Between the 11th and 15th centuries, the ancestral Shona people built a huge city encircled by stone walls that are over 11 metres high in places. It became known as Great Zimbabwe. When the country gained independence from the UK in 1980, the name Zimbabwe – meaning 'large houses of stone' – was chosen in honour of this wonder of the world.

But it is precisely this history that makes it so hard for Chibanda's work to take hold here. As far as the people of Masvingo are concerned, he is an outsider, a Westernised resident of the capital city that is closer in its customs to the former colonies than to Great Zimbabwe.

Although Chibanda speaks Shona, it is a very different dialect.

As one of Chibanda's colleagues who is collaborating on the rural Friendship Bench project tells me, "It's easier to introduce this to New York than to Masvingo."

"This is the real test," Chibanda tells his colleagues as they sit around an oval-shaped table, each with their laptop open in front of them. "Can a rural programme be sustainable in this part of the world?"

It's too early to know. What's clear is that, as with his previous projects

and Abas's original work in the 1990s, the local community and its stakeholders are involved in every step. As of June 2018, the community health workers in Masvingo are being trained.

Although the process is becoming routine, this rural Friendship Bench project holds a special place for Chibanda. His patient Erica lived and died in the highlands just east of Masvingo, a place where such services may have saved her life. What if she didn't need to pay the bus fare to Harare? Did she have to rely solely on old-fashioned antidepressants? What if she could walk to a wooden bench under the shade of a tree and take a seat next to a trusted member of her community?

Such questions still plague Chibanda's mind, even as we speak over a decade after her death. He can't change the past. But with his growing team of grandmothers and peers, he is beginning to transform the futures of thousands of people living with depression around the world.

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