

A Practical Workplace Mental Health Intervention Model in the Manufacturing Sector: Preliminary Findings from Harare, Zimbabwe

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ABSTRACT

Addressing mental health challenges in the workplace requires a deliberate shift from theoretical frameworks to practical, scalable interventions. This paper presents a pragmatic evidence-informed approach to workplace mental health drawn from experiences within a manufacturing sector organization in Harare, Zimbabwe. The presentation outlines a comprehensive step by step model implemented to enhance mental health awareness, early identification of conditions, and utilization of support services among employees. The approach is grounded in a baseline assessment of employee mental health needs which informed the design and tailoring of targeted interventions. A key innovation within the model is the incorporation of digital mental health screening tools and tele therapy services to improve accessibility and facilitated early identification of employees requiring support. These tools complement traditional methods and enable early detection of mental health concerns in a non-intrusive and scalable manner. The model further incorporates provider initiated mental health screening, adapted from established HIV/AIDS care frameworks, to normalize routine mental health checks within occupational health services, Capacity building initiatives are implemented at all organizational levels, including structured training programs and the integration of employee mental health indicators into managerial key performance indicators (KPIs),thereby strengthening accountability and leadership enagement.In addition the approach emphasis sustained awareness campaigns to reduce stigma and improve mental health literacy. Employee experiences are also explored particularly in relation to accessing therapy services. Evidence point out that the employees are unlikely to forget the giver of the information. A clearly defined and widely disseminated referral pathway ensures continuity of care and appropriate escalation of cases. Preliminary observation suggest that this integrated and practical approach contributes to increased awareness, improved identification of mental health conditions and enhanced utilization of available support services. The provisional findings demonstrate the feasibility of embedding mental health interventions within existing organizational structures. This paper concludes by arguing that organizations can adapt and replicate this model to bridge the gap between policy and practice, ultimately improving employee wellbeing.

Keywords: Health, Mental Health, employee wellbeing, Interventions

INTRODUCTION

Workplace mental health has emerged as a critical component of employee wellbeing and organizational productivity.Globally,the World Health Organization (WHO) estimates that depression and anxiety cost the global economy USD1 trillion in productivity (WHO,2022).In Zimbabwe financial stress, commuting burden, substance misuse and gambling, sexual harassment, fatigue exacerbate mental health challenges (Zirima et-al 2026).Manufacturing industries, characterized by high pressure environments, repetitive task and occupational hazards are particularly vulnerable. The model explores a practical evidence informed model that is being implemented in Harare’s manufacturing sector, highlighting lessons that can adopted across industries. Research emphasize the importance of workplace interventions in reducing stigma and improving access to mental health services (LaMontagne et al 2014).AI supported tools and tele therapy have shown promise in early detection of psychological distress (Duffy & Ryan,2020). In Zimbabwe lessons from HIV/AIDS care frameworks demonstrate the value of provider-initiated screening in normalizing health checks (Nyatsanza &Chibanda,2019).

Aim of the Intervention Model

This study aimed to design, implement, and evaluate a comprehensive workplace mental health intervention model within a manufacturing sector organization in Harare, Zimbabwe. The intervention sought to strengthen mental health literacy, promote routine mental health screening, increase utilization of available support services, enhance leadership involvement in employee wellbeing, and establish sustainable referral pathways for mental health care.

Specific Objectives

1. To assess workplace mental health needs through a baseline survey.
2. To implement routine provider-initiated mental health screening within occupational health services.
3. To increase mental health awareness and reduce stigma through workplace education and awareness campaigns.
4. To strengthen organizational capacity through training of managers, health workers, and mental health champions.
5. To improve access to mental health support through tele-therapy and structured referral pathways.
6. To evaluate preliminary implementation outcomes and inform future workplace mental health programmes.

METHODOLOGY

Research Approach

The study adopted a convergent mixed methods design in which quantitative and qualitative data were collected and interpreted concurrently throughout the implementation of the intervention mode. Quantitative information contributed to understanding the extent of mental health needs, while qualitative evidence provided contextual understanding of employee experiences, service utilization, barriers to care and perception of workplace mental health initiatives. Findings from both approaches are being integrated during interpretation to provide a comprehensive assessment of the intervention model.

Research Design

The model is utilized an intervention research design that allows for the evaluation of changes in employee mental health outcome before and after the implementation of the workplace intervention. The pre-test phase included a comprehensive baseline survey that informed the intervention phase (the mental health model). A post test phase (follow up assessments) which will include pulse surveys every six months and a follow survey after 2 years to evaluate the effectiveness of the model. Post intervention quantitative outcome evaluation is ongoing, therefore the present paper focuses on implementation and preliminary observations.

Study Population

The study population comprised employees of a manufacturing company in Harare, Zimbabwe. The workplace mental health intervention was integrated within the organization's occupational health and wellness services and was available to all employees. Participants included employees from different occupational categories such as management, supervisory, administrative, and production staff.

Sampling Procedure

A convenience sampling approach was utilized for implementation of the intervention model. Employees who accessed the occupational health clinic during the intervention period were invited to participate in routine mental health screening and related mental health services. For trainings the Occupational Health Nurses working closely working with the Human Resource Office identify employees eligible for training. Participants were

therefore selected based on their availability and attendance at the clinic (for mental health screenings) rather than through random selection. The intervention was embedded within existing occupational health services to improve accessibility and facilitate early identification of mental health concerns. As part of the intervention model, a baseline needs assessment was conducted to identify workplace mental health priorities and inform the design of intervention activities.

Ethical Consideration

The workplace mental health intervention was implemented within an existing occupational health and wellness programme of a manufacturing company in Harare, Zimbabwe. Permission to conduct the intervention and collect programme-related data was obtained from organizational management prior to implementation. Participation in mental health screening, counselling, tele therapy, training activities, and feedback processes was voluntary. Employees were informed about the purpose of the intervention, the confidentiality of information provided, and their right to decline participation or withdraw without any adverse consequences.

To protect participant privacy, all screening results, counselling records, and programme data were handled confidentially and stored securely with access restricted to authorized health professionals involved in service delivery. No personally identifiable information was included in any reports, presentations, or publications arising from the intervention. Aggregate data were used for programme evaluation and reporting purposes.

Employees identified as experiencing psychological distress or mental health conditions through the screening process were provided with appropriate referrals and follow-up support through the established mental health referral pathway. The intervention was designed to promote employee wellbeing while minimizing any potential risk of harm. Ethical principles of respect for persons, beneficence, non-maleficence, and confidentiality guided the implementation of all intervention activities.

As the intervention was implemented as part of a routine workplace health and wellness programme and the present paper reports programme implementation experiences and preliminary observations, formal institutional ethical review was not sought. Nevertheless, all activities were conducted in accordance with professional ethical standards for mental health practice and occupational health services.

Intervention Components

Baseline assessment needs

The baseline survey was a critical first step in the intervention research design as it established the foundation for evidence based decision making. The comprehensive survey identified and quantified prevalence and severity of mental health issues in the workplace. Manufacturing industries present unique stressors (e.g. commuting burden) hence the baseline survey ensured interventions were context specific rather than imported wholesale from other industries or countries. The baseline survey established a benchmark for evaluation as pre-intervention data provided a reference point against which post intervention outcomes could be measured. Presenting the baseline findings to the managers and supervisors created buy in by showing the real impact of mental health challenges on productivity. This also justified integrating health indicators into managerial KPIs and capacity building programs. The baseline survey was not just a diagnostic exercise but rather a strategic anchor of the intervention, ensuring that subsequent actions were data driven, contextually relevant and measurable.

Tele-therapy-Online Therapy

Recognizing barriers such as limited access to in person services, transportation challenges and stigma, the intervention incorporated tele-therapy training for health professionals. This ensured digital mental health support to complement traditional face to face services. Cases that sought online therapy includes, relationship issues, gambling issues. More man are seeking online therapy as compared to women. Local pilot evidence indicates that digital mental health intervention are feasible and acceptable in Zimbabwe. The *Inuka* app pilot with adults in Harare found high completion rates with participants citing double anonymity and structured

support as key enablers, though data cost and connectivity were barriers to scale up (Mupedzi et al 2022). The youth friendship Bench showed more males utilizing online therapy compared to women. Regional evidence from Uganda similarly found that tele-therapy counselling services are mostly used by men due to preference for anonymity (Lara et al 2024). Tele-therapy can be the game changer in accessing men with mental health issues.

Provider initiated Mental Health Screening and Integration of service

Borrowing from HIV/AIDS care frameworks, provider initiated mental health screening was introduced. Employees attending occupational health clinics routinely screened for mental health conditions. This normalized mental health checks and reduced perception that only “problematic” employee seek help. The framework ensures early detection of mental health conditions as many employees do not self-identify or seek help until symptoms are severe. It ensures that all employees are screened not just those who feel confident to ask help. The framework also embeds mental health into occupational health services making it part of everyday workplace wellness.

How it works in Practice

1. Routine Check in-During occupational health visits employees are asked brief validated questions PHQ-2, GAD-2.
2. Screening tools are also placed in the waiting area (hard copies and QR codes) as part of the provider initiated mental health screening model.
3. Tiered screening: if the initial response suggest risk a longer tool (PHQ-9) (GAD-7) is administered.
4. Referral Pathway: Employees with moderate/severe scores are referred for tele-therapy or in person counselling.

Evidence from Research

1. HIV/AIDS analogy: Provider initiated testing increase uptake of HIV screening in Africa by normalizing it as routine care (Nyatsanza & Chibanda ,2019)
2. Mental Health adaptation: Studies show provider-initiated depression screening in workplace improves detection rate by up to 40% compared to voluntary screening (La Montagne et al 2014).

Capacity Building and Leadership Engagement

Capacity building was implemented at multiple levels as a means of enhancing mental health literacy. Executives and managers received a structured training program on mental health literacy. This culminated in the integration of mental health indicators into managerial KPI, ensuring accountability. Mental Health champions received a 3 day training on mental health. Leadership engagement proved crucial in modeling supportive behaviors. Health workers were trained on tele-therapy and mental health screening tools.

Awareness Campaigns and Stigma Reduction

Sustained awareness campaigns included posters and digital communication emphasizing mental health literacy. Testimonies from employees who accessed therapy services was utilized during mental health literacy training. Evidence suggested that employees were more likely to remember and trust the source of information, reinforcing the importance of consistent messaging. One employee who sought therapy for gambling had this to say:

“I came to you because of the short speech you gave on gambling, I trust that you are the only person who can help me”

Referral Pathways and Continuity of care

A clearly defined referral pathway was established from initial screening to specialized care. The purpose is to ensure employees identified with mental health concerns receive timely, appropriate and sustained support. It

also assist in avoiding gaps where employees are screened but not connected to care. Referral pathways embeds mental health into the existing occupational health system for sustainability.

Preliminary Outcomes

1) Training Outputs

Capacity building activities reached 230 employees with 49 managers trained in mental health literacy, 31 Executives, 16 tele- therapist and 134 Mental Health champions trained within 6 months.

2) Referral Pathway

Of the 12 cases referred to the resident psychologist, 58% were referred by trained mental health champions and 41% by trained supervisors.

During a one month period a total of 70 employees screened through provider initiated testing and counselling, 68% screened positive for mild to severe psychological distress and were referred for further management.

3) Tele-therapy Utilization

Of the 16 employees who sought tele therapy, 81% were males.

4) Awareness Activities

Five mental health videos were made talking to the recommendations of the baseline survey and are played during inductions, strategic televisions (in canteens and reception area) reaching out approximately 600 employees. Two employees with lived experiences of mental health conditions opened up and are currently volunteering to give testimonials during presentations.

5) Reduction in Mental Health Related Absences

Mental health related absenteeism decreased by 15% in the first quarter of the year compared to the previous quarter. However captured conditions increased by 80% which could be attributed to increased surveillance.

Limitations

- Conducted in a single manufacturing company hence limiting generalizability.
- Results are based on preliminary observations: long term impact requires further evaluation
- Tele-therapy may exclude employees without access to mobile devices.

RECOMMENDATIONS

The study proposes the following recommendations based on preliminary results:

- Organizations may integrate mental health into occupational health services by adopting provider initiated screening and embed mental health indicators into managerial KPIs to ensure accountability.
- Policy makers may invest digital health infrastructure to enable AI supported screening across sectors.
- For researchers: conduct longitudinal studies to access the long term impact of workplace interventions.

DISCUSSION

The purpose of this intervention was to integrate mental health services into existing occupational health structures through a combination of needs assessment, provider-initiated screening, tele-therapy, capacity building, awareness campaigns, and referral pathways. Preliminary observations suggest that the model is feasible and acceptable within a manufacturing workplace setting.

Increased awareness and the active involvement of mental health champions suggest that workplace-based education may improve mental health literacy and help-seeking behaviour. This observation is consistent with previous studies demonstrating that awareness programmes and mental health training can reduce stigma and improve employee recognition of mental health concerns (Joyce et al., 2016; Shann et al., 2014).

The integration of routine mental health screening into occupational health services reflects evidence suggesting that normalizing screening can improve early identification of psychological distress. Similar approaches have been successful in HIV/AIDS programmes where provider-initiated testing increased service uptake by making screening a routine component of care. The adaptation of this model to workplace mental health may contribute to reducing barriers associated with self-referral and stigma.

The observation that more men utilized tele-therapy services than women supports findings from studies conducted in Zimbabwe and other African settings, which indicate that digital mental health platforms may increase access among individuals who prefer anonymity. Tele-therapy may therefore offer an important strategy for engaging populations that traditionally underutilize face-to-face mental health services.

Leadership engagement and the inclusion of mental health indicators within managerial KPIs may have contributed to organisational support for the intervention. Previous research has shown that leadership commitment is a critical factor in the successful implementation of workplace mental health programmes because it encourages resource allocation, employee participation, and sustainability.

The establishment of clear referral pathways helped integrate mental health care into routine workplace health services. Similar integrated-care approaches have been associated with improved continuity of care and better navigation of support services for individuals experiencing psychological distress.

Although preliminary observations suggest positive trends in awareness, screening uptake, and service utilization, these findings should be interpreted cautiously as formal post-intervention assessments have not yet been completed, and therefore no conclusions can be drawn regarding the effectiveness of the intervention in improving mental health outcomes, reducing absenteeism, or increasing productivity.

Despite these limitations, the intervention demonstrates that workplace mental health programmes can be integrated into existing occupational health systems without creating entirely new structures. This may be particularly relevant for low-resource settings where organisations are seeking scalable and sustainable approaches to employee wellbeing.

Future research should utilize longitudinal designs and include post-intervention outcome data to evaluate the impact of provider-initiated screening, tele-therapy, leadership engagement, and AI-supported tools on mental health outcomes, service utilization, absenteeism, and productivity. Multi-site studies would also strengthen the generalisability of findings.

The intervention demonstrated feasibility and showed preliminary indications of improved awareness, screening uptake and service utilization; however, the effectiveness of the model will be determined through planned post-intervention evaluations.

Implication for Practice

The intervention model contributes to the growing body of knowledge on workplace mental health interventions in low- and middle-income countries. Unlike many workplace mental health programmes that operate as stand-alone initiatives, this model integrates mental health screening, capacity building, awareness campaigns, tele-therapy, and referral pathways within existing occupational health structures. This integration may enhance sustainability and accessibility while minimizing the need for substantial additional resources. The model also demonstrates how approaches successfully utilized in HIV/AIDS programming, such as provider-initiated screening, can be adapted to workplace mental health promotion. Although the effectiveness of the intervention has not yet been fully evaluated, the implementation experience provides useful insights for organizations seeking practical approaches to employee mental health support

CONCLUSION

This paper presented a practical workplace mental health intervention model implemented within a manufacturing company in Harare, Zimbabwe. The model integrates baseline needs assessment, provider-initiated mental health screening, tele-therapy, capacity building, awareness campaigns, leadership engagement, and structured referral pathways within existing occupational health systems. Preliminary observations suggest that the approach is feasible and acceptable within a workplace setting and may contribute to improved mental health awareness, early identification of mental health concerns, and increased access to support services. However, as post-intervention outcome evaluation is still ongoing, definitive conclusions regarding the effectiveness of the model cannot yet be drawn. Future longitudinal evaluations are required to assess the impact of the intervention on mental health outcomes, service utilization, absenteeism, and workplace productivity. The model nevertheless provides a practical framework that organizations may adapt when seeking to strengthen workplace mental health promotion and support.

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