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Feasibility of the use of Group Interpersonal Psychotherapy in schools to treat depression among adolescents in Uganda. A qualitative study

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Abstract

With the increasing burden of depression among young people in resource-constrained settings worldwide, innovative and cost-effective treatments for depression are needed to mitigate its effects, which are known to cascade into adulthood. High levels of poverty, combined with a limited number of mental health providers in low-resource settings, make the timely treatment of depression, especially among young people, complex, necessitating alternative treatments that are cost-effective and rely less on professionals for delivery. The WHO recommends Group Interpersonal Psychotherapy (IPT-G) as a cost-effective treatment for depression. However, although IPT-G is increasingly used in low-resource settings, it typically does not reach adolescents, who spend most of their time at school. Extending IPT-G into schools would offer greater benefits and coverage for young people, but its practicality, viability, and implementability need to be assessed.

We engaged 44 adolescents who had attended IPT-G sessions delivered in school settings in in-depth interviews and Focus Group Discussions, and n = 9 teachers through key informant interviews to explore the feasibility of using IPT-G in schools to treat depression among adolescents, following Bowen's feasibility study framework. Data were collected between October and November 2025 from one rural and one urban district in Uganda. Data were thematically analyzed using both inductive and deductive approaches. The study findings showed that IPT-G was beneficial to adolescents, helping them deal with life challenges and providing an opportunity to share them openly. They considered IPT-G groups safe spaces, and some even attributed improved academic performance to participation in IPT-G sessions. Teachers found the groups easy to mobilize because children were within a single school space, and some considered the program desirable for providing holistic child support.

However, some implementation challenges were identified, including managing sessions alongside tight school schedules, managing teachers' workloads while supporting sessions, and a lack of cooperation from teachers who were not directly involved in the program. Respecting the mental health hour (a gazetted weekly period in the school schedule for mental health care recommended by the Ministry of Education), sensitization across schools, and involving administrators were suggested to improve implementation. Overall, with implementation flexibility, IPT-G is feasible in school settings.

Background

Depression is a major global health concern, particularly among adolescents [1]. Prevalence estimates suggest that nearly 20% of young people experience clinically significant depressive symptoms before reaching the age of eighteen. [2]. The onset of depression during adolescence can result in serious long-term consequences, including difficulties in social functioning, academic performance challenges, an increased risk of substance use, and heightened suicidality [1, 2]. While there has been a growing interest in researching adolescent depression, most evidence-based interventions targeted at addressing depression among young people have primarily been developed and tested in high-income countries [2], limiting their utility in low-income countries where the prevalence of depression is higher [3].

Low-resource settings face several logistical and practical challenges, including limited numbers of mental health providers, the cost of care, and low government funding, which make the implementation of care services, including depression treatment for adolescents, not only costly but also logistically difficult [4, 5]. To bridge the gap between the cost of care and the growing number of adolescents with depression, innovative treatments that may not entirely rely on the few professional care providers but can be delivered by lay providers or even adolescent peers need to be promoted for low-resource settings [6]. Such treatments should, however, be evidence-based, contextually relevant, and easy to use in formats that suit limited-resource settings [7, 8].

Group Interpersonal Psychotherapy (IPT-G) is one known depression treatment that fits a task-shifting approach [9]. IPT-G thrives on group dynamics in which group members share experiences, build skills, and develop resilience to support one another [10]. IPT-G emphasizes the interpersonal aspects of depressive symptoms, enhancing skills in communication, social support, and relationship management —elements critical to adolescent development [10]. The WHO has also classified IPT-G as a cost-effective first-line treatment for depression [11], making it an ideal program for adolescents in resource-constrained environments. IPT-G has also been evaluated in severallow- and middle-income countries (LMICs), including Uganda, where it has primarily been used with adults in community settings [12–14]. However, the use of IPT-G to treat depression among adolescents in Uganda has been limited, with a few available studies conducted among adolescents in humanitarian settings, not in the general population or even in schools [15]. Thus, delivering IPT-G to adolescents in the general setting can help reduce the burden of depression.

The WHO recommends that adolescent-focused mental health promotion programs be delivered in settings that can maximize their presence and convenience [6]. School is an ideal environment where adolescents spend a significant amount of time, and in Uganda, schools serve as critical platforms for delivering mental health interventions [16]. The school context presents both opportunities and challenges for implementing IPT-G. The group-based approach of IPT-G aligns well with classroom dynamics and may engage adolescents who are accustomed to peer interactions. However, obstacles such as school schedules, privacy concerns, and academic pressures may limit consistent participation [17]. Thus, it's essential to explore and understand the implementation aspects of IPT-G in schools to inform scalability. Conducting a comprehensive exploration requires working through a framework to capture all key feasibility components. Bowen et al. (2009) proposed a framework comprising eight elements to be assessed when gauging the feasibility of health interventions: acceptability, demand, expansion, integration, efficacy, implementation, practicality, and adaptation [18]. This study aimed to use Bowen's framework to explore the feasibility of using IPT-G in schools in Uganda to treat depression among adolescents.

Methods

Bowen's feasibility study framework

Implementation and scaling of health promotion interventions require robust evidence of their effectiveness; however, organizing large-scale evaluations, such as randomized trials, is costly, and resources should not be allocated to evaluating programs that may not be relevant, practical, or sustainable. Thus, conducting feasibility studies addresses these questions and may serve as a basis for organizing costly evaluations. Bowen et al. proposed a framework with eight elements as guidelines for assessing the feasibility of interventions [18].

The elements include: (i) *acceptability*, how the targeted users react to the program. In our study, we operationalized it as: 'how school children and teachers responded to IPT-G in school. The level of satisfaction, how they felt about it, intention to use it, and perceived appropriateness for a school setting. (ii) *Demand*, the actual use of the intervention. For this study, demand referred to how children and teachers found IPT-G to help treat depression among children, how they used it, and their willingness to continue using it at school. (iii) *Implementation*: the likelihood that an intervention can be implemented as planned. We operationalized it as the extent to which IPT-G was delivered as initially planned, and any changes made during implementation. (iv) *practicality*, the extent to which an intervention can be delivered when resources are constrained. We defined it as the extent to which IPT-G can continue to be implemented in schools, even when resources are minimal. (v) *adaptation*, changing program content and procedure to be appropriate in a new situation. We operationalized adaptation as the changes made or needed to make IPT-G suitable for use in schools. (vi) *integration*, system changes needed to integrate a new program. We defined it as how well IPT-G fit the school term's program, teachers' workload, students' time, and existing school activities. (vii) *expansion*, potential success of an already successful intervention in a different setting. We operationalized expansion as the reasons why IPT-G can be extended to other children in the school or pushed to other schools, and why it may or may not be easy to introduce it in different schools. Finally, (viii) *efficacy*, if the program shows promise of being successful. We looked at efficacy as whether children who participated got better, what changed in them, what was helpful, and why they think they got better or did not.

Study design, setting, and participants

This exploratory qualitative study was conducted between October 2025 and November 2025 in the two Ugandan districts of Mukono and Kayunga, both in central Uganda. Mukono is an urban district, while Kayunga is a rural district. Thus, both settings were represented. We engaged both schoolchildren and teachers from five primary schools selected in the two districts.

The schools involved in the study were supported by StrongMinds Uganda (SMU), a non-governmental organization dedicated to providing mental health care for individuals experiencing depression. SMU has primarily used IPT-G to treat depression in communities since 2013. By 2024, SMU had treated depression in close to half a million Ugandans [13]. In 2018, SMU, in close collaboration with the Ugandan Ministry of Education, launched a pilot project using IPT-G in schools to treat depression among adolescents, and since then, the program has been running in selected schools. Participants for this study were some of the beneficiaries of this school-based program by SMU.

Participants and sampling strategy

In total, we recruited 51 participants from five schools. SMU provided a list of schools where they operated in the two districts, and we decided to involve all of them. We conducted in-depth interviews with 44 children and six focus group discussions (FGDS) with children. We also conducted nine key informant interviews (KIIs) with teachers. To participate in interviews and FGDS, participants had to be children attending one of the participating schools who had ever participated in IPT-G sessions, could speak either Luganda or English, were willing to assent, and whose parents had provided written consent.

Procedure and data collection

After receiving ethics approval and administrative clearance from all participating schools, recruitment began. A team of trained research assistants conducted the recruitment. The school administrators provided lists of children and teachers who had participated in IPT-G sessions. The recruitment team briefed the children on the study's purpose, obtained their assent to participate, and provided a consent form for their parents to sign. Only those who returned consent forms were included. For the teachers, the team outlined the purpose of the study and explained the consent form, emphasizing their right to voluntary participation—those who agreed to participate signed the consent form. The consent process was conducted in both Luganda and English, depending on the participant's preferred language.

Data collection was guided by semi-structured interview guides derived from the eight components of Bowen's feasibility study framework (Supplementary Files 1). Interviews with children lasted 20–25 minutes, while FGDs sessions lasted about an hour. Each focus group comprised up to 7 participants, most of whom had also participated in interviews. Key informant interviews with teachers lasted 30–45 minutes and were all audio-recorded. All interviews and FGDS sessions were conducted in English or Luganda, depending on the participant's preference.

Data management and analysis

All audio recordings were transcribed verbatim and translated into English by three bilingual research assistants who could speak either Luganda or English. A senior team member sampled some transcripts and verified them against the corresponding audio recordings to ensure no data was lost during transcription and translation. The transcripts were anonymized to protect participant confidentiality before analysis began.

Data were analyzed using a thematic approach in NVivo 14, employing both inductive and deductive methods. Bowen's feasibility framework served as the main analytical framework, while maintaining flexibility to identify new, emerging themes beyond the predefined domains.

The analytic process began with familiarization, during which the research team read and re-read transcripts to gain an in-depth understanding of the data. Three coders read and open-coded three similar transcripts to identify emerging codes. They discussed the meaning, agreed on a final set of codes, organized them into the eight components, and created the analysis framework, which was applied to the remaining transcripts. Coding was conducted by tagging relevant text segments under the eight components of Bowen's framework: Acceptability, demand, practicality, integration, expansion, implementation, efficacy, and adaptation. Related codes were grouped into higher-order themes within and across domains, and emerging subthemes that extended beyond the framework were integrated to capture new insights.

Finally, the team synthesized and interpreted the findings. Triangulation with teachers as key informants enhanced the credibility of interpretations, while reflexive discussions among the research team supported analytic rigor and consistency throughout the process. The emerging codes grouped by each component of Bowen's framework are shown in Table 1.

Table 1
coding framework

Bowen's components	Emerging codes
Acceptability	Beneficial
	Safe space
	Confidential
	Empowering
Demand	Sharing challenges
	Understanding of children
Implementation	Ease of mobilization
	Mental health hour
	Need a designated person.
Practicality	Requires resources
Adaptations	Sensitization
	Involve administrators
	Incentives for children
Integration	Discouragement from teachers
	Disrupt learning
	Competing activities
Expansion	Commonality of problems
	School as a conducive environment
Efficacy	Anger management
	Academic performance
	Improved relations
	Behavioral modification

Results

Most student participants were in the 13–15 age category, male, and attending public schools, while the majority of participating teachers were in the 30–39 age bracket, male, and teaching in public schools, as shown in Table 2.

Table 2
Characteristics of participants

Participants	**Age**		**Gender**		**Nature of School**	
category	*Age group*	*f(%)*	*Male f(%)*	*Female f(%)*	*Public*	*Private*
Students n = 44	10–12	18(40.9)	24 (54.5)	20 (45.5)	33 (75)	11 (25)
	13–15	24(54.6)				
	Above 15	2(4.5)				
Teachers n = 9	20–29	3(33.3)	5 (55.5)	4 (44.5)	7 (77.8)	2 (22.2)
	30–39	4(44.5)				
	40 and above	2(22.2)				

The findings from the feasibility assessment are presented under the eight constructs of Bowen's feasibility study framework: Acceptability, Demand, Implementation, Practicality, Adaptation, Integration, Expansion, and Efficacy, reflecting the voices of both children and teachers.

Acceptability

Relating to how children and teachers responded to the implementation of IPT-G in their schools, particularly focusing on how they felt, their level of satisfaction with the program, and whether they found it helpful. The four most frequently occurring codes that emerged under acceptability were: Beneficial, safe space, confidential, and empowering, as explained below.

Beneficial

Children found IPT-G highly beneficial in schools. They admitted that at first, theydid not see the program as essential and they were therefore hesitant to join. However, after attending some sessions, they recognized it had several benefits considering the circumstances they faced, as shared below.

"In the start, I didn't really take it that seriously, but as time went on, it helped me, and it was beneficial according to the things I was going through." KPS3-FGD4-12-year-old-male

"For me, there's nothing I didn't like because I used to benefit from the sessions". STM2-FGD1-14-year-old-female

Safe space

Secondly, children described participating in IPT-G sessions as 'a safe space'. They felt the sessions provided a place to openly share challenges without fear of judgment or reprimand.

“It’s needed because sometimes children have something they are going through and can't fully express or share it, but with this programme, it gives them space to share and also solve those challenges". STM2-IDI-11-year-old-male.

“I loved the fact that you could talk and they could not tell our secrets out of the group” NPS3-IDI-12-year-old-female.

Confidential

Relatedly, children found the IPT-groups to be confidential. They would openly share secrets without fear, which encouraged them to open up further. They considered each other their keepers. Several reported that the number one reason they loved the groups more was confidentiality.

“We were able to talk truthfully with our friends, and they kept it a secret too”. MBP27-IDI-13-year-old-female

“We had rules like self-control, and one in Luganda called ‘okukuuma emizzi’, which means confidentiality”. KPS14-IDI-12-year-old-female

Empowering

Finally, participants regarded engaging in IPT-G sessions as empowering. Empowerment was reported as feeling confident in using the skills acquired to support others and overcoming previous anxieties, as shared below.

“I didn't like sharing, but now these days I feel empowered, I can share freely. I can talk with my friends and anyone else”. MBP4-FGD5-13-year-old-female.

“My experience now, I can know somebody who is depressed and how to give her some measures to be free.” SPS1-FGD2-12-year-old-male.

Efficacy

For the second construct of Bowen’s framework, we examined the extent to which IPT-G was vital and transformative for the children who participated. The most frequently mentioned codes were: anger management, academic performance, improved relationships, and behavioral modification.

Anger management

Children reported that participation in the IPT-G program helped them learn to manage anger and develop self-control and restraint, which improved their ability to live harmoniously with others. Teachers also observed enhanced emotional well-being among children in IPT groups.

“The goal I achieved was... before the sessions, even though someone steps on me, I get annoyed, and I just either slap or get so annoyed that I even give him or her a punch. But now, after the session, I learned how to overcome anger” SPS4-FGD2-15-year-old-male.

“Yeah, it has improved on, I call it Emotional well-being, their emotions have changed. Those who have been with negative emotions, the anger, the what, now they tell you, I know how I can control the anger, because I know the consequences of it, I can manage it now.” T1-KII-33-year-old-female.

Academic performance

Both children and teachers reported that class performance improved for children attending IPT-G sessions. The improvement was primarily due to improved concentration in class.

“What I liked most in the program was that my performance in class became better, because when I was in class, I used to overthink, but now I no longer do.” MBP3-IDI-12-year-old-female.

“So, when they started coming to the group, some of them performed better than before.” T3-KII-37-year-old-female.

Relationships

Participants also reported that, after taking part in the IPT-G program, their relationships with friends, parents, and teachers improved. The teacher also highlighted this, noting a significant change in children's interactions.

“For me, the program helped me get on good terms with my parents, in a way that when I do something wrong, I come back to the group and ask for advice” MBP4-IDI-12-year-old-female.

“…And you find that there is again a stronger relationship between the teacher and that child” T2-KII-33-year-old-male.

Behavioral change

Lastly, notable changes in behavior and conduct were also reported following participation in IPT-G sessions. These changes were observed not only in improved discipline at school but also through feedback from parents to teachers.

“First of all, behavior changes. They changed their moods towards others. Some of them didn't want to be with others, never wanted to share, used to isolate themselves, but now they don’t.” T5-KII-38-year-old-female.

“Some of their parents tell us that our children are changing their ways, the way they are performing in a class, the way they are behaving at home. There are lots of changes.” T5-KII-38-year-old-female.

Integration

In determining whether IPT-G, as a program, integrated well into the school system, while considering school dynamics, four main themes emerged: disruption to learning, discouragement from teachers, and competing activities.

Disruption of learning

While the program offered several benefits, it disrupted the teaching program. Students reported having to miss classes sometimes to attend sessions, which led to regret, as shared in the quotes below.

"The day I regretted was when I attended the session. I found that the teacher had finished marking the books, and he was already at home." SPS4-FGD2-15-year-old-male.

"Sometimes I was picked up from class when I was still doing some work, and they would tell us to attend to the program" STM31-IDI-13-year-old-female.

Discouragement from teachers

Relatedly, teachers who were not part of the program considered it an inconvenience and thus continued to discourage children from attending sessions. This was reported by both the children and teachers who participated in the interviews.

"What made it hard for me was like the day the teacher was teaching, he refused to let me go for the session." SPS3-FGD2-12-year-old-female.

"Some of them discouraged the children and asked them why they should go? You don't have time." T5-KII-38-year-old-female.

Competing activities

The delivery of IPT-G sessions also competed with other school activities besides class. It mainly affected playtime and lunch, and required postponing the marking of books on the side of teachers, as noted in the quotes below.

"I have sacrificed a lot for the program, I missed marking books, the lessons, I have other activities I do in the school like monitoring other teachers, I sacrificed a lot."- T1-KII-33-year-old-female.

"Sometimes, the program ends when playtime is over. They call you, and by the time you come back, your friends have finished playing football and are going home". STM31-IDI-13-year-old-female.

Implementation

Closely related to integration is implementation. In examining how IPT-G was delivered in schools, focusing on factors that facilitated or hindered its implementation, the following themes emerged: ease of mobilization, a mental health hour, and the need for a designated person.

Ease of mobilization

Having the program run in schools made it easy to implement because mobilizing children was quick and easy, since they are in a confined space.

"Gathering children in groups was very easy because we spent a lot of time with them, so I knew where to find them at any time. I think this would have been difficult in the community". T6-KII-31-year-old-male.

Mental health hour

Having an hour on the timetable reserved for mental health activities created space for implementing IPT-G; however, several teachers do not respect it, resulting in the need to seek time outside the timetable.

"*Though we have that mental health hour, which we were using to do the groups, others don't respect it; they keep teaching even when you talk to them."- T1-KII-33-year-old-female.*

Need for a designated person.

Finally, it was reported that, for the program to be implemented successfully, a designated person is required who has no other school responsibilities. Currently, the task of guiding groups falls to teachers who already have heavy workloads.

"We are very busy with many school activities, sometimes you forget about the sessions because they are not part of your primary work. There should be a person employed to do only this work, as it is a lot of work". T2-KII-33-year-old-male.

Adaptation

When we examined changes to the IPT-G implementation to improve its use in schools, three themes emerged: involving school administrators, sensitization, and offering incentives for participation.

Involving school administrators

The idea of involving school administrators came out strongly. Having administration support could ease implementation, as shared below.

"If the school administration could come in and also support that thing, give us time, and put it on the timetable, I know that will be helpful." T1-KII-33-year-old-female.

"What was hard was that the administration would not take it immediately. Not until I had to convince them that it really makes an impact". T5-KII-38-year-old-female.

Sensitization

The lack of awareness of the program was common in schools, which inadvertently affected IPT-G acceptance; thus, creating awareness is necessary.

"It wasn't easy because even the teachers need sensitization because they think it's useless, and they don't know what it is." T4-KII-29-year-old-male.

Incentives for participation

Finally, some teachers suggested that children participating in IPT-G sessions should be offered small incentives to encourage continued participation. As young people, offering motivation is essential.

“The moment they see a soda, they will run quicker for the session. But the moment there is no soda, they feel they should go and play football”. T6-KII-31-year-old-male.

“They can offer incentives to these kids, like sweets. Like small things.” T3-KII-37-year-old-female.

Demand

When we navigated the actual use of IPT-G in schools, the expression of interest to continue using it, or the degree to which participants found it helpful, three themes emerged: sharing challenges, and understanding children.

Sharing challenges

Participants expressed interest in continuing IPT-G groups in their schools because they offered children an opportunity to share challenges and work through solutions.

“Whenever I have an issue, I can share it with my friends and also solve it, so that’s what I liked most in the program, and I want it to continue.” KPS5-IDI-13-year-old-male.

“Yes, we would also love to continue meeting after because we shared a lot of advice, and sometimes when you get a challenge, you go back to the group, and that’s where you get help from.” SPS-IDI-11-year-old-male.

Understanding of children

For the teachers who participate in the program, IPT-G helped them better understand children. They got a chance to know what children go through even outside school.

“It enables us to learn more about these learners, the environment they come from, and the challenges that they face. T7-KII-46-year-old-male.

Practicality

When we explored how long the program can continue in schools despite limited resources, the central theme that emerged was: it requires resources.

Requires resources.

Participants indicated that while the program is good and relevant for schools, minimal resources are required to sustain it. They noted that many government-owned schools struggle to provide resources for mainstream school activities; thus, any additional demand may not be feasible.

“The resources on the side of the school may be a bit difficult because the government owns these schools, and if the government does not provide the resources, it will not be able to deliver the program”. T7-KII-46-year-old-male.

“We are working in settings where people are really in need, and they need more action than words. It may not be big, but something small can speak”. TI-KII-28-year-old-female.

Expansion

Finally, when we assessed the possibility of expanding IPT-G to other children in schools or to different schools, the most common recurring themes were the commonality of problems and the school as a supportive environment.

Commonality of problems

Participants observed that the problems and challenges faced by children are relatively similar across schools, suggesting that more children with the same issues will be found elsewhere; therefore, expanding the program remains relevant.

Yes, in fact, it should extend to many, many schools. Because these children are going through similar problems. They are going through a lot in their homes; some are going through sexual abuse, some are going through real physical abuse, emotional abuse, so they are going through a lot, and they are not talking.” TI-KII-28-year-old-female.

School as a supportive environment

Additionally, participants recognized that school is the best environment to provide support to children. They viewed the school setting as safe and confidential; therefore, the program should be expanded to include other children within the school context.

“Other children will also benefit because it is easier to support a child in a school environment. They feel safer and cared for than anywhere else.” T6-KII-31-year-old-male.

Discussion

In this study, we explored the practical realities of implementing IPT-G in schools, as efforts to continue scaling are ongoing in Uganda. We used a feasibility framework proposed by Bowen (2009) [18] to categorize support factors and challenges affecting the program’s viability. Overall, the program was perceived positively by both teachers and children, who found it acceptable, beneficial, and easy to expand to other children within the school or to different schools, but it requires flexibility during implementation to fit the contextual realities within schools in LMICs. First, integrating IPT-G into a school system with crowded schedules needs good planning and deliberate respect for the mental

health hour, which is now gazetted in Ugandan schools. Second, limited involvement and commitment from school administrators to the program, along with teachers discouraging children from attending IPT-G sessions, also hinder program implementation. Although studies evaluating IPT-G in Uganda are growing, to the best of our knowledge, this is the first study to assess the feasibility of IPT-G in schools in Uganda, making a significant contribution to both practice and the literature.

Regarding how participants felt about the implementation of IPT-G in schools, the program was well-received and recognized as beneficial and timely, given the high levels of depression among schoolchildren in Uganda. The main benefit was providing children with a safe, confidential space to share their challenges without judgment. Sharing with peers within groups was relieving, encouraging, and essential. Generally, adolescence is a stage of heightened involvement with peers, so a program whose mechanism of operation involves groups and shared activities/challenges among peers will resonate strongly with adolescents, hence being liked and attended. A study by Rose-clerk et al. among adolescents in Nepal found high acceptability of IPT-G in a school setting, as indicated by over 80% attendance at all group sessions and a 95.3% satisfaction rate with the IPT-G school program [19]. However, of particular interest in this study were the privacy concerns raised by participants; in our research, participants showed high levels of trust and a strong sense of confidentiality, possibly reflecting cultural differences.

Efficacy results showed that participating in IPT-G was associated with better anger management, improved relationships, and good academic performance. The findings were based on both self- and teacher-reports, reflecting consistency and believability. While the relationship between IPT-G and self-regulation is not straightforward, opening up and sharing experiences with peers who share similar triggers is likely to lead to social learning and behavioral modeling. Recognizing how others react in similar situations can lead to behavioral replication, thereby activating self-regulation. Relatedly, constructively dealing with life challenges can yield other benefits, such as improved concentration at school and clearer values, which can lead to improved school performance. The findings are consistent with studies showing that IPT-G promotes social learning, behavioral modeling, and self-regulation. [20–22]. Furthermore, previous studies have found that although IPT-G may not directly improve academic performance, it can indirectly affect school functioning by reducing adolescent depression and improving concentration, findings that support our findings. [23].

Although IPT-G in schools was associated with benefits, its scaling will require some adjustments in implementation. First, integrating IPT-G into a formal school program will require flexibility. Schools in Uganda operate a compact school schedule, with children studying from morning until evening; thus, finding time within a congested school timetable to run continuous IPT-G sessions means that the school must respect the mental health hour suggested by the Ministry so that all wellbeing programs can be implemented in that gazzeted time or such programs be run in the evening after class, but competing with other co-curricular activities. Beyond fitting in the tight school schedules, teachers supporting groups also reported that they sometimes compromised schoolwork, such as marking students' work on time, to make time for support sessions. Given that school tasks are the core

components of the teaching job, continuous compromise may create challenges. Relatedly, concerns about workload also emerged. Many public schools in Uganda are understaffed, with teachers carrying a heavy teaching load. Adding the responsibility of supporting groups may strain them. A systematic review of the barriers and facilitators of school-based mental health programs found that integrating mental health programs into schools is challenging because schools already have overloaded curricula and teachers are similarly burdened, findings that align with ours [24, 25].

The practicality of running IPT-G sessions with the limited resources available in schools in low-income contexts may affect the sustainability of the program. While completion of sessions was possible in our study because the program was overseen by StrongMinds, extending and sustaining the program to other schools without a similar arrangement may present a different experience. Although IPT-G is designed to operate with fewer resources, teachers reported that having some minimal resources to cover drinks or snacks during sessions is important for children. Since public schools in Uganda are underfunded and operate on limited budgets, with many obligations, priority when allocating funds is given to what is core to school functioning, and a depression treatment program, such as IPT-G, may not necessarily be on the priority list. Resource constraints are common barriers to implementing school-based mental health programs in low-resource settings. [19, 26].

Finally, the limited involvement of school administrators and the lack of buy-in from some teachers also affect the implementability of IPT-G in schools. Unlike communities, schools run on a hierarchical system with clear leadership that controls resources and authority. Based on the findings, while school administrators welcomed the implementation of IPT-G in their schools, they did not fully commit to supporting the program throughout and often left it in the hands of a few teachers who were supporting groups. Most likely, the administrators were taken up by other competing school priorities, or they may have underestimated their relevance in influencing program uptake. This partly explains why the teachers who participated suggested increased sensitization of both the program and the burden of depression to school administrators, teachers, and parents to increase buy-in. Notably, cases of teachers discouraging children from attending IPT-G sessions were also reported. The priority was mainly on classroom work, and anything that took children away from class was not welcome. These realities reflect what is most likely to happen in other schools since the culture and expectations are uniform across schools. The findings are consistent with a study in which teachers supporting students' mental health reported being left alone without administrative support, making it challenging to sustain mental health promotion programs in schools [27].

Strengths and limitations

The strength of this study is threefold: first, engaging both students (adolescents) and teachers who had either participated in or supported IPT-G sessions enabled us to collect data from program beneficiaries and to triangulate and obtain varied responses, thereby limiting subjectivity. Secondly, working within a framework enabled us to conduct a comprehensive assessment that addressed all aspects of program feasibility. Without a framework, studying constructs like feasibility, which are vast, becomes difficult,

and most likely, essential elements are left out. Finally, we engaged a sizeable number of participants. While generalization is not a goal of qualitative research, engaging more participants using varied approaches improves the quality of findings.

The study also had limitations. First, being purely qualitative, it was subject to potential bias. Participants may have provided feedback they deemed appropriate at the time. Triangulating with different data collection methods, such as interviews and FGDs, helped address this bias. Secondly, while we engaged participants from both urban and rural settings in Uganda, all schools were located in central Uganda, which may not necessarily represent the experience in other regions of the country. However, since central Uganda is diverse and home to people from across the country, it can be considered a representative location compared with other regions in Uganda.

Conclusion

Group Interpersonal Therapy is a feasible solution for treating adolescent depression in Uganda's schools. However, certain provisions must be in place to successfully scale this solution. This includes sensitizing administrators, teachers, parents, and students on depression and the role IPT-G can play in supporting adolescents' mental health. Demand and interest in the program are strong, driven by high levels of depression among school-aged adolescents in Uganda, but practical feasibility depends on addressing key implementation challenges. The biggest hurdle is creating space and time for the six IPT-G sessions within a congested school program. Although Uganda's child and adolescent mental health policy calls for the creation of a mental health hour within schools to enable program like IPT-G, many schools do not yet make such a provision, citing limited time. Adjustments to IPT-G implementation are therefore needed to fit school schedules. Finally, mass sensitization around depression and the potential for IPT-G to treat depression among adolescents will be essential. With greater awareness among administrators, children, and teachers.

Declarations

Ethics approval and consent to participate

The study was approved by the Mildmay Uganda Research and Ethics Committee (MUREC-2024-467) in accordance with the Declaration of Helsinki. The study also received administrative clearance from all the participating schools. Because the study involved minors, we obtained written informed consent from parents and written assent from adolescents before participation. Finally, we obtained written informed consent from the teachers who participated in the key informant interviews.

Consent for publication

All authors have reviewed and approved the manuscript for publication.

Availability of data and materials

All data used to prepare the manuscript is available upon reasonable request to the corresponding author.

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Competing interests

Some authors are employed by StrongMinds, the organization involved in implementing and funding the program evaluated in this study. The authors declare that this affiliation did not influence the analysis, interpretation or reporting of the findings. The authors have no other competing interests to declare.

Authors' contributions

EA, KM, RK, JNS, AF, SN, MN, GMN, HMM, SNG, RDN, KL and CC contributed to the conception and design of the study. EA, KM, RK, SN, MN, GMN, HMM, SNG and RDN supported study implementation, coordination and data acquisition. EA, AF, KM, RK, and JNS contributed to data management, analysis and interpretation of findings. EA drafted the initial manuscript, with substantial input from KM, AF, JNS, RK, KL and CC. All authors critically reviewed the manuscript, contributed intellectual content and approved the final version for submission.

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