THE IMPACT OF INTERPERSONAL THERAPY GROUP (IPT-G) ON THE SOCIAL AND PSYCHOLOGICAL WELLBEING OF THE COMMUNITY IN TAKAJJUNGE VILLAGE, MUKONO, UGANDA

GLORIA KISIBO

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UGANDA CHRISTIAN UNIVERSITY

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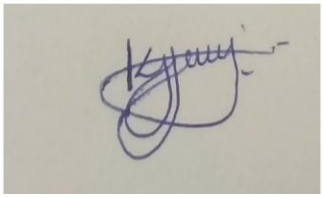
DECLARATION

I KISIBO GLORIA, hereby declare that the dissertation titled "THE IMPACT OF INTERPERSONAL THERAPY GROUP (IPT-G) ON THE SOCIAL AND PSYCHOLOGICAL WELLBEING OF THE COMMUNITY IN TAKAJJUNGE VILLAGE, MUKONO, UGANDA." is my original work, is not plagiarized and has not been submitted to any other institution for any academic award.

All sources of information used in this study have been duly acknowledged.

This dissertation is submitted to Uganda Christian University in partial fulfillment of the requirements for the award of Bachelor's Degree in Social Work and Social Administration.

KISIBO GLORIA



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APPROVAL

This dissertation titled "THE IMPACT OF INTERPERSONAL THERAPY GROUP (IPT-G) ON THE SOCIAL AND PSYCHOLOGICAL WELLBEING OF THE COMMUNITY IN TAKAJJUNGE VILLAGE, MUKONO, UGANDA." Has been submitted to Uganda Christian University for examination with my approval.

Dr. Winfred Naamara

14/5/2026

Supervisor

DEDICATION

I dedicate this work to my family and friends, whose unwavering belief in me provided the emotional anchor I needed to complete this journey. You are my own “support group,” and I carry your love into every page of this work.

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First and foremost, I would like to thank God almighty for the strength, health and opportunity to serve others through this Social Work.

My deepest gratitude goes to the people of Takajjunge, thank you for opening your hearts and your community to me. You allowed a Me to walk and work alongside you and for that I am forever grateful.

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Finally, to the team at Nama Health Impact and the tireless Village Health Teams (VHTs), thank you for your partnership and for the life changing work you do every single day on the frontlines of community health.

LIST OF ACRONYMS AND ABBREVIATIONS.

IPT-G: Interpersonal Therapy Group.

WHO: World Health Organization.

SDG: Sustainable Development Goal.

VHTS: Village Health Teams.

IPT: Interpersonal Psychotherapy.

MoH: Ministry of Health.

RCTs: Randomized Controlled Trials.

KII: Key Informant Interview.

FGD: Focus Group Discussion.

SPSS: Statistics Package for Social Sciences.

REC: Research Ethics Committee.

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ABSTRACT

In the quiet village of Takajjunge, many individuals navigate the heavy weight of social and emotional distress often is made worse by the pressures of poverty and fractured relationships. This study was born from a desire to see if the Interpersonal Therapy Group (IPT-G) model could offer genuine path to healing. The research utilized a mixed methods design, combining quantitative surveys with 43 participants and qualitative data from Focus Group Discussions and Key Informant interviews, reflecting the interconnectedness of social work research (Creswell & Creswell,2018).

Moving beyond simple data, the research listened to the stories of participants through heart-to-heart conversations. The findings tell a story of profound transformation for 88% of those involved, the IPT-G sessions became a "safe haven" where they finally felt seen and heard, echoing the importance of social support in psychological recovery (Weissman et al., 2017). Married participants spoke of rediscovered peace at home, and many found a new family in their fellow group members.

However, the study also uncovered the "graduation/ termination blues" a heartfelt sense of loss when the formal sessions ended and the stark absence of men in these healing spaces. This research aligns with the observation that mental health interventions in low resource settings often face challenges regarding long term sustainability and gender inclusive participation (Bolton et al., 2003; Verdeli et al.,2021). Consequently, this work is a call to action to treat mental health not as a temporary project, but as a temporary project, but as a permanent, community rooted pillar of village life.

CHAPTER ONE:

INTRODUCTION

1.0. Introduction

Chapter one comprises the background study, problem statement, justification, objective and scope.

1.1. Background to the Study

Mental health challenges are increasingly recognized as a major public health concern in Uganda, with depression, anxiety, and trauma-related disorders being prevalent due to social, economic, and cultural stressors. This constitutes a significant public health concern globally and particularly in low- and middle-income countries (WHO, 2016). In Uganda, socioeconomic stressors including poverty, unemployment, domestic conflict, and rapid urbanization have contributed to increasing mental health challenges (Kigozi et al., 2010), Community-based psychosocial interventions have therefore been prioritized to bridge the mental health treatment gap.
Interpersonal Therapy (IPT) is an evidence-based psychological intervention that focuses on improving interpersonal relationships to reduce psychological distress (Klerman et al., 1984). The original framework for IPT focuses on resolving interpersonal problems to alleviate psychological symptoms (Klerman et al., 1984). However, IPT is the foundation of Interpersonal Therapy Group (IPT-G), a group adaptation, that has been proven effective in low-resource settings, specifically in rural Uganda (Bolton et al., 2003). It has emerged as an effective psychosocial intervention designed to address depression and other common mental disorders through structured group-based therapy.

It focuses on improving interpersonal relationships and social functioning. IPT-G was introduced in Uganda by the Ministry of Health (MoH) and the World Health Organization (WHO) as part of the national mental health strategy (Ministry of Health Uganda, 2022;

World Health Organization, 2016), aiming to improve access to community-based mental health services. It is particularly effective in low-resource settings because it relies on trained lay facilitators and utilizes existing social structures within communities.

IPT-G intervention began to raise because it became the most used intervention during the plagiarized COVID-19 period and also as a post covid solution to equip the general population with skills to cope with the drastic changes that had occurred during the COVID-19 and post covid.

Mukono District, is characterized by a mix of urban and rural communities, faces rising mental health concerns linked to poverty, family conflicts, unemployment and post conflict trauma. Despite IPT-G implementation in some areas, limited research has been done to assess its actual impact on community well-being, social relationships, and resilience particularly in peri-urban areas such as Takajjunge village in Mukono District. This study will therefore seek to explore the impact of IPT-G interventions on the social, psychological, and economic wellbeing of individuals and the community of Takajjunge.

1.2 Problem Statement

Mental health services in Uganda still limited, underdeveloped, underfunded and are in a way often affected by stigma making it difficult for many people to seek professional help. In communities such as Takajjunge village found in Mukono district, individuals experiencing psychological distress frequently lack access to appropriate and timely mental health support.

Although Interpersonal Therapy Group (IPT-G) has been introduced as a community-based intervention, there is still little clear evidence showing its long-term impact on people's lives. While some programs have reported positive outcomes, it remains unclear whether IPT-G has significantly improved social relationships, strengthened community support systems, or enhanced individuals' ability to cope with everyday challenges.

This lack of localized and in-depth evidence creates a gap in understanding how effective IPT-G truly is within specific communities like Takajjunge. Without such information, it becomes difficult for policymakers, practitioners, and stakeholders to make informed decisions about expanding or improving mental health interventions. This study therefore aims to address this gap by examining the actual impact of IPT-G on the social and psychological wellbeing of the community.

1.3. Purpose and Objectives of the Study

This section states the main and specific objectives of the study.

1.3.1. Main purpose:

This study will assess the impact of Interpersonal Therapy Group (IPT-G) on the social and psychological wellbeing of the people of Takajjunge community found in Mukono district.

1.3.2. General objectives:

To examine the effectiveness of Interpersonal Therapy Group (IPT-G) on the social and psychological wellbeing of the people of Takajjunge community found in Mukono district.

1.3.3. Specific Objectives:

- To assess the effectiveness of IPT-G in reducing symptoms of depression and psychological distress among participants in Takajjunge village.
- To determine the extent to which IPT-G interventions are strengthening social support and interpersonal functioning among community members.
- To evaluate the role of IPT-G in enhancing coping mechanisms and resilience within the Takajjunge community.
- To give recommendations for informing policy on scaling up IPT-G across Uganda.

1.4 Research Questions

The study will be guided by the following research questions:

- How effective will IPT-G be in reducing symptoms of depression and psychological distress among participants in Takajjunge village?
- To what extent do IPT-G interventions strengthen social support and interpersonal functioning among community members?
- What is the role of IPT-G in enhancing coping mechanisms and resilience within the Takajjunge village?
- What challenges are faced during the implementation of IPT-G?
- What recommendations can be proposed for informing policy on scaling up IPT-G across Uganda?

1.5. Scope of the Study.

The scope of the study will involve: Subject scope, Geographic scope and time scope.

1.5.1. Subject scope:

The study will focus on assessing the impact of Interpersonal Therapy Group (IPT-G) interventions on the social, psychological, and economic wellbeing of individuals and the community.

1.5.2. Geographical Scope:

The study will be carried out in Takajjunge village located in Mukono District. The researcher will choose this area because of easy accessibility and availability of information concerning the impact of IPT-G on the social and psychological well-being of the community of Takajjunge.

1.5.3. Time Scope:

The study will examine the impact of IPT-G programs implemented within the period of two years, from 2022 to 2023 and anything beyond this period will be excluded. This will be due to data and comparison which will be considered a good period for the researcher to acquire the necessary information in line with the case study.

1.6. Justification of the Study

The study is important because it will contribute to a better understanding of IPT-G and how it is influencing and promoting community resilience as well as enhancing social cohesion of Takajjunge as a community. In many cases limited research and insufficient data make it difficult for stakeholders and policy makers to design effective programs that respond to the real needs of communities. Conducting this study will therefore generate evidence that can guide the development of appropriate strategies and interventions.

By focusing on a specific community, this study will generate evidence that reflects the lived experiences of participants and highlights how IPT-G influences their wellbeing. This information will be valuable in guiding the development of more responsive and context specific interventions,

Furthermore, the findings of the study will benefit several stakeholders including social workers, policy makers, community leaders, and researchers. Social workers will gain insights that can improve professional practice and service delivery, while policy makers may use the findings to design policies that address the identified challenges. The study will also contribute to the existing body of knowledge and provide a foundation for research on community based mental health interventions in the field of social work and community development in Uganda.

1.7. Significance of the Study

The study on the impact of Interpersonal Therapy Group (IPT-G) in Takajjunge village holds importance for various stakeholders, such as social workers, researchers, and policymakers, by generating evidence on the effectiveness of this community-based intervention, this research aims to guide the development of appropriate strategies to address mental health challenges.

1.7.1. Significance to Social Work Practice.

The findings will enable social workers to enhance their professional practice and service delivery. This will provide social workers with a better understanding of how IPT-G influences and promotes community resilience.

It will offer evidence-based insights into improving interpersonal functioning and social support, which are core components of social work intervention and identify best practices for integrating psychological interventions within existing social structures and community-based systems and

Identify best practices for integrating psychological interventions within existing social structures and community-based systems.

1.7.2. Significance to Research.

The study will contribute to the academic arena by addressing specific gaps in the existing literature regarding mental health interventions in Uganda. This will include: -

Providing localized research that disaggregates the specific mechanisms of impact within a peri-urban environment like Mukono, which differs from rural settings.

Elevating the body of knowledge by using a mixed-methods approach to provide qualitative depth on how IPT-G generates social cohesion.

establishing the "service delivery gap" regarding the exclusion of men in current models, providing a basis for future research into gender-inclusive mental health programs.

1.7.3. Significance to Policy.

This research is designed to contribute to national mental health strategies and support the achievement of global developmental targets. The policy implications include:

The findings of this research will contribute to Sustainable Development Goal (SDG) 3.4, (UN 2015) which emphasizes promoting mental health and wellbeing for all. The expected outcomes include an improved understanding of IPT-G's role in promoting mental health in low-resource communities, the identification of best practices for scaling up IPT-G across Uganda, and recommendations for integrating IPT-G into community and primary healthcare systems.

Providing evidence to help the Ministry of Health and other stakeholders refine and scale up IPT-G interventions across diverse regional needs in Uganda.

Guiding policymakers in the design of policies that address identified challenges in mental health service delivery, in low resource settings

1.8. Limitations of the Study.

Financial resources may be one of the limitations of the study, this could restrict extensive data collection and a wider geographical area coverage of research activities such as transportation, printing of questionnaires, and data processing may require funds that are sometimes limited for student researchers.

time constraints may be another possible limitation since the research is conducted within a specific academic period. it may limit the amount of time available for data collection and analysis. also, some respondents may be unwilling to provide accurate information due to personal reasons, fear of disclosure, or lack of interest in participating in the study.

However, the researcher will address this by assuring participants of confidentiality and using appropriate data collection methods to obtain reliable information.

1.9. Theoretical/Conceptual Framework

The Conceptual Framework will explore the relationship between the Interpersonal Therapy Group (IPT-G) intervention and the measured outcomes of social and psychological wellbeing in Takajjunge village. The framework will integrate key elements of Interpersonal Psychotherapy Theory (Klerman et al., 1984), which states that mental health symptoms are often connected to the current interpersonal difficulties, relationships and external environment while Social Support Theory, mostly emphasizes the role of a strong social network in mitigating psychological distress.

Systems Theory (Bronfenbrenner, 1979) focuses on the fact that individual behavior is influenced and shaped by interactions within social contexts like family, peers, and community. IPT-G agrees with this by focusing on strengthening social networks to improve wellbeing.

CHAPTER TWO:

LITERATURE REVIEW

2.0. Introduction.

This chapter briefly summarizes and reviews the theoretical and empirical literature needed to evaluate the impact of the Interpersonal Therapy Group (IPT-G) on the social, psychological, and economic wellbeing of the Takajjunge village, Mukono district in Uganda. The review establishes the theoretical underlying of the intervention, details the empirical evidence on its effectiveness including the data from local partnerships like Nama Health Impact and recognizes the critical research and service delivery gap in the current model related to the exclusion of men in the current model.

2.1. Theoretical Framework

The study follows a dual-theoretical approach which incorporates Interpersonal Psychotherapy (IPT) Theory and Social Support Theory. According to Klerman et al. (1984), psychological distress is often associated with and maintained by current difficulties in interpersonal relationships and social roles.

The adaptation into Group Interpersonal Therapy (IPT-G) for low-resource areas builds on Social Support Theory, which suggests that a strong social network acts as a "buffer" against life stressors like poverty and domestic conflict. Furthermore, the study incorporates Systems Theory (Bronfenbrenner, 1979), this ecological perspective places emphasis on the fact that individual behavior is influenced by interactions within social systems like family and community.

2.1.1. Interpersonal Psychotherapy (IPT) and Scaling Mental Health

The study is based on the Interpersonal **Psychotherapy (IPT) theory**, that relates psychological issues especially depression to current difficulties in interpersonal relationships and social roles. IPT is a time-limited intervention that focuses on improving interpersonal functioning within four primary problem areas: grief, role disputes, role transitions, or interpersonal deficits/skills.

The adaptation into Group Interpersonal Therapy (IPT-G) for low-resource settings leverages Social Support Theory, making sure that the group environment itself provides a vital protective social network, enhancing coping mechanisms and long-term resilience by building on its strengths. This model is further supported by the Task-Shifting approach, is promoted by the WHO, which enables non-specialist lay workers to deliver evidence-based psychological interventions, to ensure that its scalable and cost-effective across large populations.

2.1.2. Systems theory

Systems Theory (Bronfenbrenner, 1979) focuses on the fact that individual behavior is influenced and shaped by relationships and interactions within social systems like family, peers, and community. IPT-G is in line with this and aims to build and enhance social connections by strengthening social networks to improve wellbeing.

2.1.3. Social Support Theory

While IPT focuses on the resolution of conflicts, Social Support Theory explains how the group support is important in the intervention (IPT-G) which creates a protective environment. This theory suggests that social resources serve as a "buffer" against life stressors, such as poverty and domestic conflict, which are prevalent in Mukono District. (Cohen and Wills,1985)

Key Dimensions of Social Support in IPT-G:

1. **Emotional Support:** The group setting fosters a safe space for emotional expression and the development of empathy among participants.

2. Social Network Building: IPT-G changes the nature of temporary therapy groups into lasting social support networks, which enhances long-term community resilience.

3. Social Capital and Cohesion: The intervention has the potential to enhance individual interpersonal skills such as social capital and cohesion. The intervention generates "ripple effects," in families such as reducing family conflict and increasing collaborative efforts with in family or community building.

4.Coping Mechanisms: Access to a supportive peer group strengthens an individual's ability to navigate socioeconomic pressures and enhances an individual's coping mechanism, which leads to improved motivation and productivity.

2.2. Empirical Literature Review (Efficacy, Scalability, and Impact.)

Empirical evidence for IPT-G in Uganda is robust, hence moving from initial randomized controlled trials (RCTs) to large-scale, real-world implementation.

Previous studies like (Bolton et al., 2003; WHO, 2016) have shown that IPT-G is effective in reducing depressive symptoms in low-resource settings such as rural Uganda. Participants often report improved self-esteem, emotional control, and strengthened relationships. However, studies have assessed and evaluated IPT-G's long-term community impact beyond individual participants, creating a gap this research intends to fill.

The efficacy of IPT-G in sub-Saharan Africa, specifically Uganda, is supported by a strong body of evidence that validates its use as a task-shifting, community-based intervention.

The efficacy of IPT-G in Uganda is supported by a strong body of evidence that was built on Randomized Controlled Trial (RCT) conducted by Bolton et al. (2003) which demonstrated that adults receiving IPT-G from trained lay health workers experiencing a significantly greater decrease in symptoms of depression compared to a control group. These clinical benefits were shown to be sustainable, with Bass et al. (2006) confirming that lower rates of major depression were largely maintained after six months post-intervention follow up.

2.3. Effectiveness in Reducing Depression Symptoms and Foundational Efficacy.

The foundational study establishing IPT-G's utility in Africa was a Randomized Controlled Trial (RCT) conducted in rural Uganda. Bolton et al. (2003) demonstrated that adults receiving 16 sessions of IPT-G delivered effectively by trained lay health workers experienced a significantly greater reduction in symptoms of depression and functional impairment compared to a control group. This critical finding validated IPT-G as an evidence-based, culturally compatible and appropriate intervention for addressing mental health challenges in low-resource settings.

The outcomes of these results were confirmed in a follow-up study. Bass et al. (2006) reported that the significant clinical benefits were observed immediately in the post-intervention were largely maintained six months later, with the treatment arm maintaining a significantly lower rate of major depression. This evidence underscores the sustainability and long-term impact of the IPT-G model. While the majority of the foundational research is rural, one urban-focused Master's thesis confirmed the general applicability and that the effectiveness of IPT-G in the urban Kampala setting, which in turn noted that challenges differed and varied from the rural context (Tukahiirwa, 2019).

Furthermore, the initial efficacy of IPT-G in Uganda was established by a landmark RCT in rural settings. Bolton et al. (2003) demonstrated that adults receiving 16 sessions of IPT-

G, delivered by trained lay health workers, showed a significantly greater reduction in symptoms of depression and functional impairment compared to a control group. This effect was shown to be durable, with Bass et al. (2006) confirming that substantial clinical benefits and lower rates of major depression were largely maintained six months after the end of the intervention. This foundational work proved IPT-G's cultural compatibility and effectiveness in the region.

2.4. Scaling IPT-G: The Strong Minds Model

The implementation work of Strong Minds Uganda is important and represents a critical development that demonstrates the efficacy of IPT-G at a scale up in both rural and peri-urban contexts, which is highly relevant to the Mukono District.

2.4.1. Clinical Success:

Impact evaluations consistently show high recovery rates, with approximately 67% to 78% of women maintaining their depression-free status 18-24 months post-therapy.

2.4.2. Adaptation and Efficiency:

Strong Minds has innovated by testing a shorter 6-week problem area-concordant IPT-G model, which was confirmed in a recent RCT as noninferior and in some cases superior to the standard 8-week model in reducing depression and improving quality of life.

2.4.3. Wider Population Reach:

The model has successfully been extended beyond adult women to treat adolescents in schools and communities, with reports of improved academic outcomes, including a 63% improvement in grades for treated girls.

2.5. Impact on Social, Economic, and Household Wellbeing.

Strong Minds' data strongly documents the secondary, non-clinical impacts, which directly address the broader wellbeing objectives of this proposal. Research by Strong Minds (2020) and Lewandowski et al. (2015) documents significant "ripple effects" beyond clinical recovery:

2.5.1. Economic Productivity:

Evaluation reports show a substantial increase in economic engagement, including a 34 % increase in clients reporting no significant work missed and a 22% increase in self-employment among participants post-treatment.

2.5.2. Household Stability:

Positive ripple effects on household wellbeing include a 63% increase in the number of women able to save income and a 245% increase in women reporting that their household members ate three meals a day.

2.5.3. Social Cohesion:

Participants consistently report that the therapeutic groups transform into lasting social support networks, directly promoting the study's objective of community resilience. Qualitative studies by Lewandowski et al. (2015) also noted positive community-level "ripple effects." Findings indicated that the intervention successfully improved social dynamics, reporting:

- Greater cohesion among community members.
- Reduced conflict within families.
- The initiation of collaborative efforts in farming and building among group members.

These results indicate that IPT-G successfully facilitates the translation of improved individual interpersonal skills the primary target of the therapy into broader social capital and enhanced community resilience, directly supporting the objectives of this proposal.

2.6. Integration through Local Partnerships (Nama Health Impact.)

To achieve large-scale access, Strong Minds utilizes strategic partnerships with local NGOs, such as the work with Nama Health Impact a presumed local implementing partner. This collaboration is designed to transfer capacity for high-quality depression treatment to local entities, ensuring greater reach and long-term sustainability.

2.6.1. IPT-G STEP BY STEP PROCESS

Interpersonal Psychotherapy Group is a structured, time limited, evidence-based therapy, usually lasting 8 weeks and each session last's 90 minutes. It is an intervention designed to treat depression by improving relationships and social functioning. It commonly focuses on one of four areas such as grief, disagreement/ conflict, life change or interpersonal deficits.

The process generally follows a three-phase structure as explained below:

2.6.2. Pre-group phase and Assessment (individual assessment) week 1

Before the group begins, the facilitator holds an individual session with each prospective member to:

Assess depression by evaluating symptoms using tools like the PHQ9. This tool is used to identify the people who qualify for the IPT-G sessions.

Assessment that confirms their attendance with the help of a PQH4.

Identify problems by mapping interpersonal difficulties to the four IPT-G focus areas.

Establish goals by setting one to three specific goals related to the problem area.

Educate and motivate by explain IPT-G, the connection between mood and relationships, and instill hope.

Assign “sick role” by explain that symptoms are due to a treatable medical condition, not a character flaw.

2.6.3. Initial group phase (week 2-3 initial phase)

The focus is on building trust and rapport among members.

Introductions and norms, in this case members are given a chance to introduce themselves and the group establishes rules to govern the group for instance rules about confidentiality and attendance among others.

Psychoeducation in this case the facilitator explains that depression is a treatable illness and links it to interpersonal functioning.

Reviewing personal problems and in this case, members discuss their problems and goals linking their depression to current interpersonal relationships.

Identifying themes in this case the group identifies common themes and how the group itself can help them learn new skills.

2.6.4. Middle group phase/ midline (week 4-5 midsession)

This is the working phase where members address specific interpersonal issues.

Weekly check ins on the mood/burden score(kagugu) are done in each session which starts with a review of depression symptoms and the past week’s events.

Linking mood to events in this case members connect their depressive moods to specific interpersonal interactions from the previous week.

Active problem solving in which techniques like communication analysis and role playing is used. In this case members practice new behaviors in the safe group environment.

Homework is given in which members practice new skills in their daily lives and report back, addressing interpersonal issues like disputes or transitions.

2.6.5. Termination phase (week 7-8 final session)

The focus is on ending the group and looking forward.

Reviewing progress by evaluating the changes in depression symptoms and improvements in interpersonal relationships.

Consolidating gains by discussing what was learned and how to use these new skills in the future.

Managing relapse by creating a plan for handling future interpersonal challenges that could involve low moods.

Saying goodbye by addressing the feelings associate with ending the group which is particularly crucial for those dealing with grief or loss.

2.7. Role in Enhancing Coping Mechanisms and Productivity.

Empirical literature also connects IPT-G to improved economic and developmental outcomes which in turn contributes to improved coping skills and productivity. The study by Lewandowski et al. (2015) found that as participants experienced remission of depressive symptoms, they became "more hopeful and motivated," which led to tangible improvements in productivity, including:

- Increased productivity in agricultural and animal husbandry activities.

- Improved school attendance for children, as parents were better able to focus on and afford school fees.

This reinforces the concept of the therapeutic model's role as an indirect mechanism or approach for community development, which focuses on enhancing individual coping, motivation, and the capacity for productive engagement (World Health Organization, 2016).

2.8. Synthesis and Research Gap

To conclude, the literature review was a valuable source of information that can be used to establishes IPT-G as a strong, empirically tested, and is a community-friendly intervention for depression in Uganda, which yields positive effects on social functioning, community cohesion, and productivity among people with depression.

This study will target this gap by studying Takajjunge village found in Mukono District, which will provide evidence necessary for the Ministry of Health (Ministry of Health Uganda, 2022) and engage stakeholders by helping them to refine, adapt, and tailor the scale of IPT-G interventions to better suit Uganda's diverse regional needs.

The literature strongly supports IPT-G as an effective, scalable, and economically transformative intervention in Uganda due to the ample evidence from the literature, however, a critical research gap persists.

2.8.1. Mukono-Specific Data:

While an evaluation by Strong Minds (2019-2020) included the Mukono District, there is a lack of independent, in-depth, localized research that disaggregates the specific mechanisms of impact on social and psychological wellbeing unique to Mukono's peri-urban environment.

2.8.2. Contextual Complexity:

Mukono's unique blend of urban and peri-urban pressures like rapid urbanization, unique forms of conflict, economic precarity may produce distinct interpersonal stressors compared to the predominantly rural settings of the foundational studies.

2.8.3. Depth of Analysis:

The existing community impact data is largely programmatic and quantitative. This study proposes a mixed-methods approach to provide the necessary qualitative depth to explain how and why IPT-G generates social cohesion and psychological resilience in the Mukono community.

2.8.4. Service Delivery Gap (Exclusion of Men):

The current model focuses primarily on women and adolescents. There is a critical need to assess how IPT-G services can be effectively expanded to include men, addressing a significant service delivery and research gap. This study will address this gap by providing a mixed-methods, context-specific evaluation of IPT-G's impact in Takajjunge village, generating tailored evidence to optimize service delivery and scaling efforts for the Ministry of Health and its partners.

2.9. Conceptual framework

Independent Variable (IV)	→	Dependent Variable (DV)
Interpersonal Therapy Group (IPT-G) - Group sessions - Skill training - Conflict resolution - Emotional expression		Community Wellbeing - Reduced depression - Improved relationships - Enhanced coping - Social cohesion

Intervening Variables: Age, gender, education level, socio-economic status, and cultural beliefs.

CHAPTER THREE:

METHODOLOGY

3.0. Introduction

This chapter outlines the methodology that will guide the research and this will include Research Design, Study Population, sampling design, sampling size, Sources of data, Data Collection methods and instruments, Data control, Data Analysis, Ethical Considerations and Limitations that will be used to collect and analyze data for the study.

3.1. Research Design

The study will adopt a mixed-methods research design that utilizes both quantitative and qualitative approaches. This design will allow for the measurement of impact known as quantitative while exploring the experiences and perceived changes known as qualitative.

3.2. Area of Study

The research will be conducted in Takajjunge village is situated in Nama Sub- County, located within the Mukono District of Central Uganda. The area is characterized by the following features:

3.2.1. Geographical Location:

Mukono District lies approximately 27 kilometers east of Kampala, Uganda's capital. Nama Sub- County is predominantly rural/peri-urban, with a landscape consisting of plateau land and lush vegetation, which is conducive to mosquito breeding sites.

3.2.2. Demographics and Socio-economics:

The population of Takajjunge primarily engage in agriculture to be exact subsistence farming (growing coffee, bananas, and maize) for the natives and are neighbors with a big

sugarcane plantation for Madivan sugar factory and small-scale trade. Housing often consists of permanent structures consisting of permanent residents who wone property and mobile residents who rent.

3.2.3. Health Infrastructure:

The village is served by the government's tiered health system, specifically relying on Nama Health Center III and a network of Village Health Teams (VHTs). These VHTs act as key outreach informants and also as the primary vehicle for community-based mobilization and distribution of IPT-G, acting as the liaison between the formal health sector and the households.

3.3. Sources of Information:

The study will be based on the primary data collected directly from participants through surveys, interviews, and focus groups that will be used to engage participants.

3.4. Study population:

The target population will include former IPT-G participants their caregivers (family members) will make up the study population and community stakeholders of Takajjunge will be included.

Inclusion Criteria: Participants must have been permanent or semi-permanent residents (those renting) of Takajjunge village during the specific time scope of 2023 to 2024 to ensure they were present for the program's implementation.

Exclusion Criteria: Temporary residents or "floating populations" who stayed in the village for less than six months during the implementation period will be excluded. This prevents Recall Bias or distorted results from individuals who did not receive the full intervention.

3.5. Sampling Techniques and Sample Size.

3.5.1. Sampling Technique:

Purposive sampling for IPT-G participants and facilitators in which I will select participants based on specific, predefined characteristics relevant to the study's objectives while random sampling will be used for general community members. Sampling techniques such as stratified random sampling for quantitative data and purposive sampling for qualitative data like Key Informant Interviews and Focus Group Discussions will be employed.

3.5.2. Sample Size:

Approximately 25 to50 respondents will participate.

3.6. Data Collection Instruments and Procedures

Data Collection Instruments: Data will be collected using a structured survey questionnaire to collect quantitative data on participants 'mental health and social wellbeing, a semi-structured Key Informant Interview (KII) guide, a Focus Group Discussion (FGD) guide and document review to obtain program data and reports.

3.7. Data Processing and Analysis

Quantitative data: will be processed using the Statistical Package for the Social Sciences (SPSS) and analyzed using descriptive and inferential statistics.

Qualitative data: (transcripts from KIIs and FGDs) will be analyzed using thematic content analysis.

3.8. Ethical Considerations

Ethical clearance will be sought from the University Research Ethics Committee (REC). Informed consent will be obtained from all participants, and issues of confidentiality, assent, and anonymity will be strictly adhered to throughout the study process.

3.9. Anticipated Methodological Constraints

Potential constraints, such as limited access to former participants or reluctance to discuss any issues concerning sensitive mental health problems, will be anticipated and mitigation strategies will be outlined.

The study assumes that the following constraints could be a threat to the study and the that following strategies will be implemented to mitigate the arising situations and they are as explained blow:

Limited Access to Participants: There be difficulty in locating former participants of the IPT-G sessions which will be mitigated by collaborating with community health programs and local partners like Nama Wellness to trace records.

Sensitivity of Subject Matter: Reluctance to discuss sensitive mental health issues may come up as a constraint which will be addressed or mitigated by ensuring a safe, confidential environment and obtaining informed consent.

Gender Data Gap: The current model's focus on women may limit male participation in this case the researcher will actively seek to identify any available male cohorts to address the service delivery gap.

Recall Bias: Since the study covers a three-year time scope, participants may struggle with memory in this case the researcher will use semi-structured prompts to help participants recall their experiences.

High Population Mobility: The peri-urban nature of Takajjunge may result in a "loss to follow-up" where former IPT-G participants have moved out of the village since 2023.The researcher will work closely with Village Health Teams (VHTs) and local partners like Nama Wellness to distinguish between permanent residents and those who have moved, focusing data collection on stable residents to ensure the study captures long-term.

CHAPTER FOUR:

FINDINGS

4.0. Introduction

This study employed a mixed method approach to evaluate the inter personal psychotherapy group program in Nama subcounty by combing individual interviews of 48 members with qualitative insights from community members (FDGs) and key informants (KIIs). The report explores how social interventions intercept with cultural norms, economic needs and psychological wellbeing.

It integrates the statistical data from quantitative records with the rich lived experiences in focus group discussions and key informant interviews

4.1. Quantitative findings: - A profile of participation

The quantitative data provides a snapshot of who the program reached and a measurable shift in their wellbeing.

In Takajjunge in Mukono there are four recognized IPT-G groups each consisting of 12 members giving a total of 48 participants eligible for this research. Out of 48 members 43 members participated in the interview process. quantitative findings and data derived from the sample of 43 participants in Takajjunge village were analyzed as below: -

4.1.1. Demographic profile

The study involved a diverse group of participants primarily women with a significant concentration in the middle -aged group of 18 to 46 years.

4.1.2. Age of participants

	18-25 (CODE1)	26-35 (CODE2)	36-45 (CODE3)	46< (CODE4)
NO. of participants	9	18	10	6

The largest participating group was aged 26-35years which is 41.86%, followed closely by the 36-45 years age bracket which is 23.25%, the least participating group was of 18-25 years which is 20.93%. those above 46 but also participating in the IPT-G were 13.96%.

4.1.3. Marital status

A vast majority of participants were married 65.12 %, while 20.93 were single and 11.63%were widowed, with 2.33% separated as shown in the table below:

Years	Single (CODE1)	Married (CODE2)	Widowed (CODE3)	Separated (CODE4)
18-25	3	5	1	
26-35	5	10	2	1
36-45	1	10	0	
46<	0	3	2	

4.1.4. Educational Level

Among the 43 participants 16.28% had no education, 58.14% had primary education and 25.58% had secondary education. Most participants attained a primary level education.

Age bracket	No Education (CODE1)	Primary Edu (CODE2)	Secondary Edu (CODE3)	Tertiary Edu (CODE4)
18-25	1	3	5	
26-35	5	13	0	
36-45	1	6	3	
46<	0	3	3	
TOTAL	7	25	11	

4.2. SOCIAL ECONOMIC STATUS

4.2.1. OCCUPATION OF PARTICIPANTS

Years	NON (CODE1)	FARMER (CODE2)	BUSINESS (CODE3)	HOUSE WIFE (CODE4)
18-25	5	4	1	2
26-35	4	5	6	4
36-45	0	3	1	4
46<	0	2	2	0

Farming is the primary occupation of participants with approximately 32.56% followed by small businesses owners with 23.26% of the participants and house wives also 23.26% those with no occupation at 20.93%.

4.3. PROGRAM IMPACT INDICATORS

- **Safe space and Emotional strength**

Quantitative tabulation shows that a significant number of participants 38 out of 43 tracked in section B felt the sessions provided a safe space.

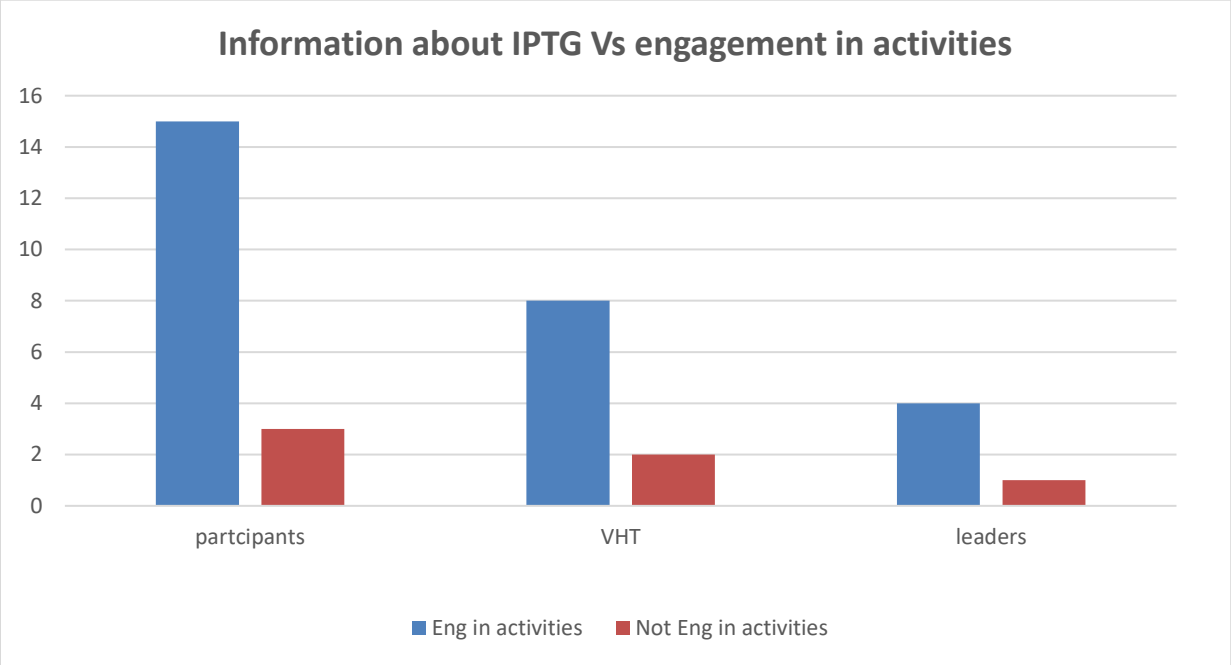
- **Social connectivity**

	participants	VHT	leaders
Engaged in activities	25	8	4
Not Engaged in activities	3	2	1

28 of the participants said their source of information about IPT-G was from peers who participated in the sessions and 10 heard from VHTs while 5 from the local leaders.

Of those who got information from participants 67.57% engaged in the activities while 21.62% of those who got information from the VHT engaged in the activities. While 10.81% the least source of information was the local leaders.

This shows psychological resilience and a sense of belonging and increased engagement in community activities as represented in the graph below.



- **Psychological and social impact**

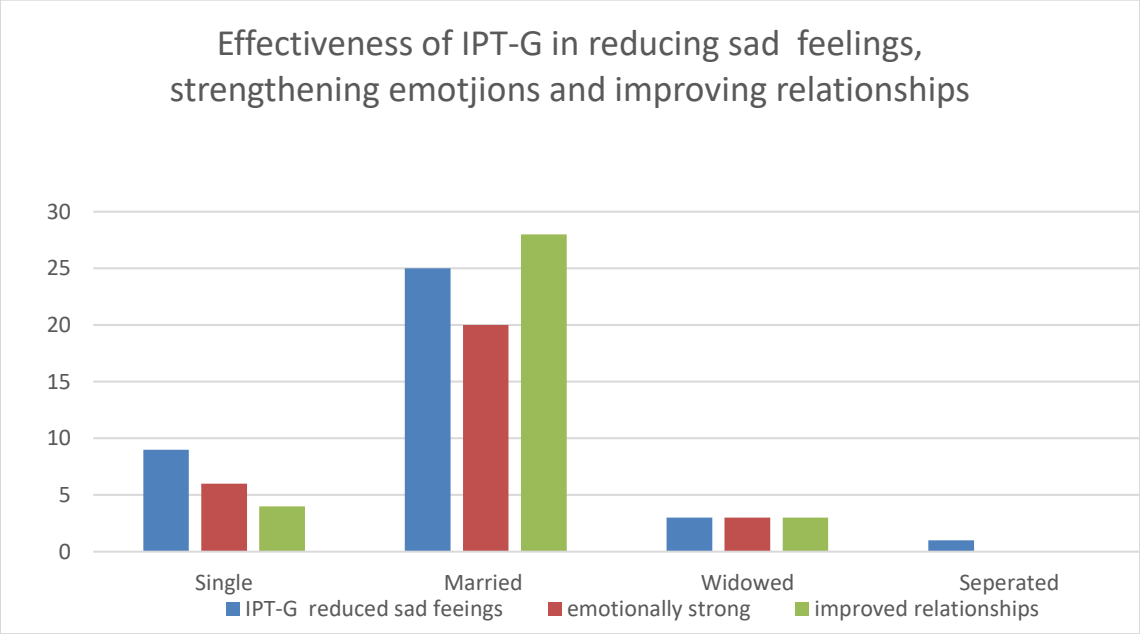
In assessing the effectiveness of IPT-G in reducing symptoms of depression and psychological distress among participants in Takajjunge village. The following data was analyzed

4.3.1. Conflict resolution

Most participants reported improved skills in resolving issues, this is shown especially in the married bracket with 100% of the married having improved relationships, this was achieved by moving away from isolation toward communal engagement.

	Single	**Married**	**Widowed**	**Separated**
IPT-G reduced sad feelings	9	25	3	1
Emotionally strong	6	20	3	0
Improved relationships	4	28	3	0

The graph below shows how effective IPT-G has helped especially married women in conflict resolution by acquiring necessary skills,



Acquisition of conflict resolution skills is a good indicator of psychological resilience; this was reported that the sessions provided a "safe space" and a majority indicated feeling emotionally stronger after the program, improving relationships and reducing sad feelings as shown in the graph above.

4.4. QUALITATIVE FINDING (KIIs &FDGs): THE HUMAN EXPERIENCE

While the numbers show success, the qualitative data reveals the complexities of implementing therapy in community with resource-constrained setting. Qualitative data strongly supports the "sense of belonging" found in the quantitative data, participants highlighted that the group served as a vital networking hub.

In African context mental health is deeply intertwined with social economic and cultural structures. Stressors often operate in a circular way where a social challenge causes psychological distress which in turn hiders the individuals' ability to resolve the challenge.

Qualitative data was collected through focus group discussions (FDGs) involving participants approximately 25-40 and key informant interviews KIIs) with facilitators and community stakeholders.

The thematic analysis of KIIs & FDGs revealed both positive outcome and implementation gaps

4.4.1. Mental health and social stressors

The most common mental health or social stressors in Takajjunge village included: - social economic hardship such as poverty induced stress, unemployment, food insecurity, social isolation and lack of services.

4.4.2. Economic independence

The quantitative data shows high rates of unemployment or subsistence farming. This explains the qualitative finding where participants expected financial benefits. IPT-G is succeeding in social healing, but participants are still under heavy economic pressure.

There was misalignment of expectations, a key finding is the mismatch between the program's psychological goals and the participants' economic needs. Many participants especially single mothers, joined with the hope of tangible financial support or scholarships**.** ***"We expected small benefits like money or connections since most of us where single mothers"***

4.4.3. Social economic hardships

These were reflected in the FGDs that revealed the following information that collarets with the quantitative data on occupation of the participants.

4.4.4. Social support and community networking

The participants in FGDs revealed that the greatest strength of IPT-G wasn't just the curriculum, but the organic support network it created. One member said: -

"When I joined, I didn't have a job but after I shared my issues a group member connected me to a good opportunity" they emphasized that IPTG helped them build new relationships and identify those who needed help. "***We met new people in the community whom we were able to identify as those who needed help'*** this suggests that IPTG strengthens social capital and promotes peer identification of mental health needs.

The quantitative data shows a community struggling with poverty, high farmer/house wife ratios, this directly drives the expectations found in Key informant interviews. Where Single mothers joined IPT-G expecting small benefits like money or scholarships when these didn't materialize, there was a risk of disillusionment, even if psychological gains were made.

Social isolation as a stressor has been overcome by the IPT-G intervention. From the quantitative data majority of the respondents were married, this can be attributed to this intervention. One member said,

"I got some advice from a seasoned group member which helped me save my marriage".

4.4.5. Social sequencing and life transitions

This is a sociological concept used to analyses the order, timing and duration of life events and social interactions. This helps to understand the paths people follow over time. The goal is to help individuals to transition smoothly from one stage of life to another while building cumulative advantages.

Helping community members navigate social sequencing, the strategic timing and ordering of life events is a core part of social work and community development. The goal is to help individuals transition smoothly from one stage of life to the next while building "cumulative advantages".

The facilitators help the community carry out social sequencing by mapping current life styles of the participants willing to join the program This helps them understand the existing patterns in the community. The quantitative data shows that most of the participants stop in secondary level of education, this identifies common disruptions in community girl education.

The participants are helped to Visualize the path, by using life mapping exercise where the participants draw their past and desired future sequences. This helps them see their life as a series of connected steps rather than isolated events.

Encouraging participants to make action plans of "if then plans" in case of a life emergency situation there should be a preplanned sequence.

Another community social sequencing mentioned by the health worker was enhancing social support systems because a successful life sequence rarely happens in a vacuum. It requires a support network. Participants are encouraged to form peer support groups, grouping people in similar life stages which allows them to share resources and social capital. This explains the strong sense of belonging evidenced in quantitative data.

Information accessibility is ensured through participants, VHTs and local leaders. this ensures the community knows the required sequence for specific goals such as the exact steps needed to qualify the government health initiative.

While the quantitative data shows a high sense of belonging, the qualitative data reveals that this feeling is fragile once the formal sessions end. The lack of follow up mentioned by participants suggests that the graduation might be premature for some, hence an existing sustainability gap.

The facilitators help the participants in strengthening transitional points.

The participants are encouraged to engage in bridge programs which create initiatives that act as hand off between systems, where the champion participants mentor others.

The facilitators as one of their social sequencing activities help the participants in building resilience buffers. life sequences can be interrupted by external shocks like illness economic shift and family emergencies. Participants are encouraged to have skill diversification, this helps community members gain transferable skills so that if their primary carrier sequence is blocked, they can resort to secondary sequence without starting from zero.

4.4.6. Validation of emotional gains.

Both the quantitative emotional strength scores and the qualitative success stories from KIIs confirm that IPT-G effectively builds psychological resilience. therefore, mental health integration

helps in providing psychosocial support, which in turn helps individuals maintain their emotional stability needed to stay on truck with their long-term goals despite temporarily setbacks.

4.5. Role of IPT-G in enhancing coping mechanism

A conversation usually goes wrong when the interpersonal connection is sacrificed for clinical efficiency. Examining a difficult conversation is a critical skill in clinical practice often referred to as interpersonal supervisor or process recording. In a group session there is a shift from "what happened" to "how the relationship dynamics impacted the individual's ability to cope". The health workers use the following method to work it out.

This includes use of a framework for deconstructing that conversation as follows: -

1. Mapping the exchange to identify the core interpersonal problem area such as interpersonal disputes, role transitions, grief, or interpersonal deficit. This helps to identify the problem if it was a hidden disagreement, a conversation shadowed by an unresolved loss or a recurring pattern of isolation or social anxiety.
2. Analyzing the communication by evaluating the dialogue to see where the" break" occurred. It is done by identifying the exact sentence where the rapport shifted, when the person becomes defensive, or when the person said they are coping fine while avoiding eye contact. The conversation may have gone wrong because the underlying distress was not named.

Once the conversation is deconstructed, IPT-G principles can guide to help provide better coping tools. This is an enhancement strategy which includes communication analysis to correct "toxic" communication patterns, problem solving which focuses on moving the person to take one small interpersonal action step, and emotional regulation which help members realize that their feelings are signal.

Coping is enhanced when they realize emotions are valid reactions to interpersonal triggers.

After, the health worker takes reflective questions to find the missing link in the recent exchange. Questions about communication analysis, expectation gap, the safety factor. This is because a conversation usually goes wrong when the interpersonal connection is sacrificed for clinical efficiency. By applying an IPT-G Lense the difficulty is not a failure,

but a data point, an opportunity to identify which social support or communication skill needs to be strengthened to improve the participants' future coping capacity.

4.6. The noticeable changes in community cohesion or productivity

From the KIIs the following were the noticeable changes in community cohesion or productivity since the intervention of IPT-G.

On productivity it's been a massive win, it helped staff move through administrative hurdles easily and reduced friction which was a bottleneck moment that stalled work for days. People focused more time on the actual creative roles.

Community cohesion is a human element, where cohesion is a yes and no situation. The participants have formed teams which are collaborating across different villages much more easily. They speak the same language on mental health issues which has brought some distant groups closer together.

Some of those accidental problem-solving sessions and organic connections have slowly disappeared because everything is now optimized and scheduled through the IPT-G framework that lose those human moments that actually build deep trust.

The community is more aligned towards goals but there is need to maintain the actual social fabric of the group. This can bring in more different friction points.

4.7. Issues that prevent more members especially men from joining the group are complex.

From the participant reality, the leakage of information into the broader community caused harm. One participant noted that after a neighborhood argument, their private group disclosures were used against them. "***It made me feel that everyone in the community knew everything about me"***

4.7.1. Gender barriers and cultural taboos

The FDGs & KIIs highlighted that the Nama health impact focuses on maternal and child health, naturally leaning toward female participants. however, this has created a gender vacuum. From men's perspective men avoided the grounds to avoid being seen as weak by peers.

4.7.2. The facilitator gap

Cultura norms make it difficult for men to take instruction from female facilitators. "Some men showed interest but they didn't want to attend a session facilitated by women.

4.7.3. The paradox of the "safe space"

There is a sharp contrast between how facilitators and participants view "safety" from facilitator view (IPT-g sessions provided a safe space). To allow participants express themselves without judgement. However, the community members fear to completely voice their problems for confidentiality purposes.

4.7.4. The challenge of confidentiality in small villages

The quantitative "safe space is high but qualitative data shows that the remaining %, the risk of social stigma is a major barrier in a village like Takajjunge "what stays in the group" does not always stay in the group.

4.7.5. Divergent perspectives on success

There is a notable perception gap between the facilitators (KIIs) and the community members, the facilitators view the program as a successful graduation model where participants are equipped with life skills while the community (participants) value the skills, they expressed a feeling of abandonment post- graduation." after we graduated from the last session the facilitators never came back to check on us."

4.8. Resources or policies needed to ensure IPT-G is a permanent intervention.

To move IPTG from a temporary to a permanent resource in Takajjunge there is need to align the proposal with the Mukono district and Nama subcounty local government who manage finances and health budgets.

Based on the current local government structures and recent budget frameworks for Mukono, the specific resources and policies should “Instead of asking for funding, ask for inclusion in those specific local government budget outputs”.

Considering the primary health care services, for IPTG to become a permanent, it can be considered among the non-wage conditional grants by requesting that a portion of these funds be allocated for VHT supervision specifically for mental health follow-ups.

Another resource needed to ensure continuation of IPTG, there should be a steady supply of local facilitators, which can be achieved if included in the budget output of health system strengthening. In Nama subcounty this budget line often receives external financing like from UNICEF and other partners. If training of trainers for IPTG can be codified here it is a great resource.

There is need for a policy to be proposed at subcounty level to earmark a small percentage of primary health care grants which are sent to the HC IIIs quarterly for community outreach specifically for mental health screenings.

For IPTG to be considered permanent there is need to be written in the district development plan of Mukono district. This makes it a priority intervention allowing the district health officer to allocate resources to it without special permission each time.

There is need for Nama subcounty leadership on social development to draft a local resolution that recognizes mental health as a key pillar of "community mobilization and empowerment "to receive a significant portion of funding from the district.

It is important to integrate mental health sessions in the health management information system (HMIS). Currently many mental health sessions are not recorded in the standard ministry of health form 105. There is need for a local policy requiring Nama health workers to record IPTG attendance in the HMIS as a must. If it is not in the data the government won't see it to fund it.

VHT allowances if enhanced will motivate them to ensure recruitment of men into the groups. Integrating IPTG with OVC programs can link it to funding. Making MOU with Nama HC III formalizes the use of the health center's space and staff for IPTG supervision.

To frame IPTG around these existing "buckets" of money and authority, makes it easier for a local leader to say "yes" because it encourages them to use what they already have more effectively than trying to create something new.

CHAPTER FIVE:

SUMMARY, RECOMMENDATIONS AND CONCLUSION.

5.0. Introduction.

The study sought to evaluate the impact of Interpersonal Therapy Group (IPT-G) on the social and psychological wellbeing of the community of Takajjunge village found in Mukono district. The findings indicate that the intervention is highly effective in building *psychological resilience and social capital* among participants.

Psychological impact: Quantitative data showed that 38 out of 43 participants felt the sessions provided a "safe space," leading to increased emotional strength and a reduction in "sad feelings."

Social and interpersonal impact: There was a significant improvement in conflict resolution skills, particularly among married participants (100% reported improved relationships). The program successfully transformed therapy groups into vital networking hubs, facilitating job connections and communal engagement.

Implementation Gaps: Qualitative analysis revealed a mismatch between the program's psychological goals and the participants' economic expectations, as many joined hoping for financial aid or scholarships. Additionally, a "gender vacuum" exists where men avoid participation due to cultural taboos and a preference for male facilitators.

5.1. Recommendations.

Based on the research findings, the following recommendations are proposed to enhance the effectiveness and sustainability of IPT-G:

Livelihood integration.

Integrated livelihood linking like economic empowerment by linking IPT-G groups since participants are already using groups for job networking therefore formally linking these groups to village savings and loan associations (VSLAs) or small-scale trade initiatives. This in turn addresses the "expectation gap" where participants seek financial stability alongside psychological healing. Also, by using skill diversification which may be done by incorporating basic livelihood skills modules into the therapy framework to build "resilience buffers" against external economic shocks.

Expectation management.

Clearly communicate the scope of the program during the assessments to align community expectation with psychological interventions rather than financial aid.

Strategic male engagement.

This can be done by using gender-inclusive models to develop a specific strategy to recruit men, including the recruitment of professional male facilitators of IPT-G to overcome cultural barriers and the perception that seeking help is a sign of weakness.

5.2. Policy and sustainability measures

Local Government integration: This can be done by encouraging advocacy for the inclusion of IPT-G in the Mukono district development plan and Nama sub-county health budgets.

Data formalization: which can help to ensure that mental health sessions are recorded in the Ministry of health like a Form 105 (HMIS) to provide the necessary data for government funding and prioritization.

Alumni mentor program.

Instead of facilitators leaving after graduation, empower seasoned members to act as local mentors for new groups, ensuring the check-ins continue

Note: participant names have been withheld to maintain confidentiality.

Reinforced confidentiality protocols.

Create a more rigorous community covenant on privacy to prevent the weaponization of share stories in neighborhood disputes.

5.3. Conclusion.

The IPT-G intervention in Takajjunge village has proven to be a robust tool for enhancing community wellbeing by improving interpersonal function and providing a protective social “buffer” against life stressors. While the program excels at individual and social healing, its long-term sustainability is challenged by a lack of post-graduation follow up after termination and the persistent economic pressures faced by the community. For IPT-G to be truly transformative in a peri-urban setting like Mukono, it must evolve from a standalone psychological intervention into a mor integrated model that addresses both the mind and the livelihood of its participants.

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APPENDICES

Appendix 1

RESEARCH INSTRUMENT

1: CONSENT FORM

Wano waliwo nkyusa y'ebiwandiiko bino mu Luganda, okusobola okuyamba abantu b'omu kitundu ky'e Takajjunge okutegeera obulungi n'okuwa olukusa lwabwe mu ngeri etegeerekeka:

EKYUMA KY'OKUKUNGANYIRAKO EBIWANDIIKO: EKIKOLA OMULIMU MU BUJJUVU

Omulamwa gw'Okunoonyereza: Enkola y'Okubudaabuda mu Kibinja (IPT-G) bw'ekwasizzaako embeera z'abantu n'ebirowoozo mu kitundu ky'e Takajjunge, mu disitulikiti y'e Mukono.

Omunoonyereza Omukulu: KISIBO GLORIA, Uganda Christian University

EKITUNDU 1: OKWEYANJULA N'OKUWA OLUKUSA MU BULAMBULUKUFU.

Nze Kisibo Gloria, ndimuyizi asoma eby'Embeera z'Abantu n'Okuddukanya Emirimu (Social Work and Social Administration) ku ssettendekero wa Uganda Christian University.

Nkola okunoonyereza okulina omulamwa ogugamba nti: "Enkola y'Okubudaabuda mu Kibinja (IPT-G) bw'ekwasizzaako embeera z'abantu n'ebirowoozo mu kitundu ky'e Takajjunge, mu disitulikiti y'e Mukono."

Ebirowoozo byo bikulu nnyo mu kutegeera n'okutumbula enkolagana y'abantu mu kyalo Takajjunge. Okwetaba kwo kujja kuyamba mu kuleetawo enkola n'enteekateeka ezijja okunyweza enkolagana n'obuyambi mu kitundu kino.

Okukkiriza mu Bulambulukufu:

Okwetaba kwo mu kunoonyereza kuno kwa kyeyagali.

Ebirowoozo n'ebigambo by'ojja okutuwa bijja kukumibwa nga bya kyama, era bijja kukozesebwa ku nsonga z'okusoma kwokka.

Oli waddembe obutadamu bibuzo byo tayagala n'okubuuzibwa ebibuuzo ekiseera kyonna awatali kubonerezebwa kwonna.

Okkiriza okwetabamu?

Ye (Okkiriza)..... / Nedda.....Omukono/Kinkumu: ..... Olunaku: .....

2: DEMOGRAPHIC QUESTIONNAIRE

Wano waliwo empapula z'ebibuuzo bino nga zivvuunuddwa mu Luganda:

Ekitundu 2: Ebibuuzo eri Abaneetaba mu Kunonyereza

Ebiragiro: Nyoola akabonero kano (✓) ku kidduukirize ekisinga okukiikirira okuddamu kwo.

OKUFUNA: EBINKWATAKO (SECTION A)

1. Ekikula: ☐ Mukazi

2. Emyaka: ☐ 18–25 ☐ 26–35 ☐ 36–45 ☐ 46 n'okweyongerayo

3. Mbeera y'obufumbo: ☐ Sifumbilwanga ☐ Nafumbilwa ☐ Nnamwandu ☐ Twayawukana

4. Mutindo gwa obuyigirize: ☐ Sirina buyigirize bwa mu matendekero ☐ Pulayimale ☐Ssekendule ☐ Ssettendekero/Ttendekero lya waggulu

5. Omulimu gwo: .....

6. Wali weetabyeeko mu nsisira za IPT-G? Ye ..... / Nedda .....

OKUFUNA: EMYEYISA N'ENKOLAGANA N'ABALALA (SECTION B)

1. Otera okukola dduyiro mu biseera byo eby'eddembe? Ye ..... / Nedda .....

(Bwekiba Nedda, genda ku kibuuzo nnamba 2.)

Bwekiba Ye, dduyiro ki guwokola?

.....
.....

2. Wawulirako ku IPT-G? Ye ..... / Nedda .....

Bwekiba Ye, wa gye wabbiwulira?

.....
.....

3.Wali wettabyeko nsisira za IPT-G zonna? Ye ..... / Nedda .....

(Bwekiba Ye, genda ku nnamba 4; bwekiba Nedda, mwaliriza okubulira wano.)

4. Okweetaba mu nsisira za IPT-G kukuwadde ekifo ekikuumi okwogera ku nneewulira yo, ssaako n'okuyiga obukodyo bw'okwebeera?

Ye ..... / Nedda .....

5. Ensisira za IPT-G zikuyambye okukendeeza ku nneewulira y'okunakuwala, okweraliikirira, n'okupampuka kw'omutima?

Ye ..... / Nedda .....

6. Owulira nti kati oli wamanyi mu nneewulira yo era olina essuubi oluvanyuma lw'okweetaba mu nsisira za IPT-G?

Ye ..... / Nedda .....

7. Enkolagana yo n'ab'enganda ssaako n'emikwano gyo eyongedde okutereera okuva lwe watandika okweetaba mu nsisira za IPT-G?

Ye ..... / Nedda .....

8.Owulira nti oli waka /oli muntu ddala mu kitundu kye Takajjunge?

Ye ..... / Nedda .....

OKUFUNA: OKUDDAMU OKWEGIRIRA (SECTION C)

1. Oyizeeyo obukodyo bw'okugonjoolamu okusoomoozebwa kw'obulamu, okugonjoola obukuubagano, n'engeri y'okukwatamu enkyukakyuka z'obuvunaanyizibwa?

   Ye ..... / Nedda .....

   Bwekiba Ye, obugonjoola otya?

   .....
   .....

2. Kusoomoozebwa ki kwe wafuna nga weetaba mu IPT-G?

.....

.....

3. Ku ndowooza yo, abasajja mu kitundu kino bawagira ensisiraza IPT-G oba babiwakanya? Lwaki?

   .....

4. Oli mu bibiina by'abantu bimeka?

   .....

Appendix II

3: KEY INFORMANT INTERVIEW GUIDE.

EKITUNDU 3: EBIBUUZO ERI ABANTU AB'ENJAWULO (KII)

(Eri Abasawo, Abakulembeze b'ebitundu, n'Abatabaazi b'Ebyobulamu (VHTs))

1. Bintu ki ebisinze okuleeta okweraliikirira n'okusoomoozebwa kw'ebirowoozo mu kitundu kye Takajjunge?

.....
..

2. Oyamba otya abantu mu kitundu okukola enteekateeka y'okukolagana n'abalala (social sequencing)?

.....
....

3. Nga omukozi w'ebyobulamu, ogezeza otya okulaba engeri emboozi enzibu gye yafuseemu oba gye vudeyo obubi?

(Okuzuula omugaso gwa IPT-G mu kussaawo engeri y'okwebeera)

.....
.....

4. Olabyeeyo enkyukakyuka yonna mu nkolagana y'ekitundu n'obunyiikivu mu mirimu okuva IPT-G lwe yatandika?

(Nnyonnyola ebisingawo)

.....
.....

5. Kiki ekigaana abantu abangi (nadala abasajja) okwetaba mu bibiina bino ebya IPT-G?

.....
.....

6. Bye bintu ki oba ntekateeka ki ezeetaagisa okukakasa nti IPT-G eyongera okubaawo?

.....

Webale nnyo okugaba endowooza yo mu kunonyereza kuno.

Appendix III

4: **Focus Group Discussion Guide.**

Target group: Community members graduates and current participants.

Purpose: To explore the social dynamics, collective experiences and barriers to long term impact.

Introduction and ice breaker

1. When you first heard about the IPTG sessions what were your expectations?
2. What was your feeling of the group at the beginning compared to the final week?

Social support and networking

3. After meeting new people through the sessions, has anyone her gained a practical benefit like a job, a loan or connection from another member?

4. How has your relationship with your family or neighbors changed since you started these sessions?

Confidentiality and safety

5. We encourage the issue of safe space; do you feel that the things shared in the group truly stay in the group?
6. Has anyone ever felt scared to speak because they feel the information might be used against them in the community?

The graduation experience and sustainability

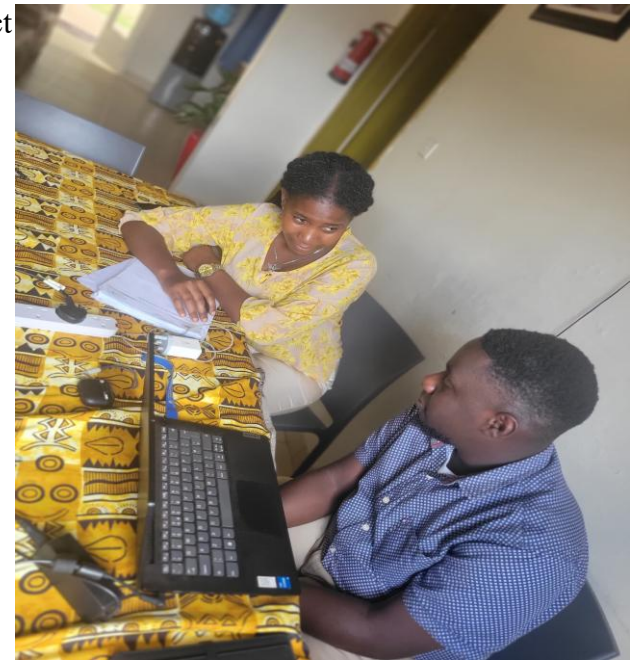
7. After the final sessions were you confident to continue on your own? Why or why not?
8. How did it feel when the facilitators stopped coming to check on you as a group? What did the group do after that?

Gender and community perception

9. Why do men stay away from these IPTG sessions
10. How best do you think this IPTG program can be run?

VHT facilitating an IPT-G Session.

key informant interview with the Nama Health Impact



Facilitator.

Nama Health Impact
P. O. Box 420, Mukono
info@namahealth.org
www.namahealth.org
+256 200 949257

Date: 31st March 2026

Dear Ms. Kisimbo Gloria
Uganda Christian University
P.O. Box 67-173, Mukono

SUBJECT: Acceptance of Research Opportunity - Public Health Department

On behalf of Nama Health Impact, I am pleased to formally accept your request to conduct research within our Public Health Department (Specifically the social work program). We are delighted to welcome you to our team and look forward to the valuable contributions your work will bring to our ongoing efforts in advancing public health.

Your research aligns with our mission to improve health outcomes and address pressing public health challenges. We are confident that your expertise and dedication will enrich our department's initiatives and foster meaningful impact.

Please liaise with our department coordinator to finalize the necessary arrangements and ensure you have access to the resources required for your research. We are committed to supporting you throughout this process.

We look forward to collaborating with you and witnessing the positive outcomes of your research.

Your sincerely,

.....

CHARITY DEBORAH ACHOM
cachom@namahealth.org
FINANCE & ADMINISTRATION MANAGER
NAMA HEALTH IMPACT

Cc: Pauline Picho Keronyai
Cc: Brian Odaga
Cc: Awumba Rogers

nama HEALTH IMPACT
31 MAR 2026
Tel: 0200949257
P.O.Box 420, Mukono - Uganda

"Equitable and quality healthcare services for all"

Nama Wellness
COMMUNITY CENTRE

BURDEN SCALE

1

LIGHT

2

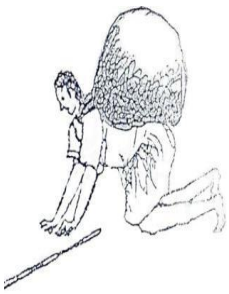
HEAVY

3

VERY HEAVY

4

EXTREMELY HEAVY



5

CAN'T MANAGE ANY MORE

PRE-ASSESSMENT GUIDE FOR IN-PERSON ASSESSMENTS FOR ADULTS

Interview date: _____/_____/_____

Facilitator's name: _____

Are you free to speak with me right now or are you busy with other things?

Yes ☐ No ☐

Are you alone or in a place where you feel you can easily speak openly about yourself and your emotions?

Yes ☐ No ☐

Seeking consent

By signing this document, I acknowledge that I have had an opportunity to discuss any and all questions related to depression and the assessment process. With this understanding, I accept you to carry out this assessment.

Name of client: _____Date ___/__/_____

Signature: _____

BIO DATA

A. Respondent's Name

First Name: _____

Last Name: _____

Other Names: _____

B. Gender (tick appropriate)

Male

2. Female

C. Date of birth (dd-mm-yyyy) _____

Age (years) _____

D. Nationality (tick appropriate)

1. Ugandan

2. Non-Ugandan

E. Residence

Country: _____

District: _____

Parish: _____

Village: _____

F. Marital status (tick appropriate)

1.Married

4.Divorced/ separated

2. Cohabiting 3. Single/Never married 5. Widowed

G. Highest level of education

1. None
2. Primary
3. O-level
4. A-level
5. Vocational
6. University
7. Post graduate

H. Phone Number

_____

Phone ownership: Does this phone number belong to you?

Yes No

If no, who does it belong to

_____

I. Are you leaving with any disability?

Yes No

PHQ 4

This first set of questions helps me determine whether you may need to talk to a community facilitator about your symptoms.

Over the last 2 weeks, how often have you been bothered by the following problems? (Use "✓" to indicate your answer)	Not at all (0-1)	Several days (2-6)	More than half the days (7-11)	Nearly every day 12-14)
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Little interest or pleasure in doing things	0	1	2	3
4. Feeling down, depressed, or hopeless	0	1	2	3

SCORE_____

Total score is determined by adding together the scores of each of the 4 items. Scores are rated as; normal (0-2), mild (3-5), moderate (6-8), and severe (9-12).

Total score ≥3 for first 2 questions suggests anxiety. Total score ≥3 for last 2 questions suggests depression

For clients who score 0-4

Thank you very much for talking to me today. I can tell from your responses that you are unlikely to be suffering from depression or anxiety. Please continue applying tips from our mental health messages. However, should you begin to feel worse, get in touch with us again via 0708914882/ 0753237271

For clients who score above 5

Thank you very much for talking to me today. I can tell from your responses that you need to speak to one of our community facilitators about a further assessment and starting therapy.

Let us agree on a day and time we can come and visit you next week.

Appointment set for _____(date) at _____ (time).

Name of Community Mobilizer: _____ Signature: _____

Telephone contact: _____ Date: _____

KOMO/NAWEC: SECONDARY INDICATOR FORM FOR ADULTS			
Name of Respondent: _____Sex: _____Age (Yrs): _____ Telephone: _____ **Marital status: _____MHF/Data collector: _____Date of interview _____**			
District: _____Subcounty: _____Parish_____Village: _____			
SECTION A: PHYSICAL HEALTH			
S/N	**Question**	**Response**	**Notes**
PH 1	How would you rate your overall physical health?	1=Very good 2=Good 3=Neither good nor bad 4=Poor 5=Very poor	
PH 2	Who usually makes decisions about [healthcare for yourself and dependents]/ [major household purchases]/ [visits to your family or relatives]?	1= Myself 2=My spouse 3= Jointly with my spouse 4=Someone else	

PH 3	If you, your spouse, or your dependents are experiencing any health-related problems. What is the FIRST action that you will take?	1=Visit the health center 2.=Consult a traditional practitioner 3.=Self - medicate	
PH 4	What are the barriers to seeking health care	1= Bad roads 2= High transport costs 3= Decision making 4= Child care 5= Others (specify) ……	**Multiple choices allowed**
PH 5	Have you experienced consistent body or head pain for **more than three** days in the last 7 days?	1 = Yes 0 = No	
PH 5.1	If yes, what do you think was the cause of the pain?	……	
SECTION B: ECONOMIC STATUS			
ES1	What best describes your main source of income?	1=Full time formal employment 2=Part time formal employment	

	**Housework of one's own home should be circled independently as an option*	3= Casual laboring 4=Housework 5=Self-employed (includes farming) 6=Remittances 7=Other (specify)----------	
ES1.2	On average, how much money do you earn every month	1.Less 100,000 Ugx 2. Between 100,000-<200,000Ugx 3. 200,000 - <300,000 4. 300,000 - <500,000 5. 500,000+	
ES1.3	Over the past 7 days did you perform that activity for either a full or part day for **<u>three or more</u>** days?	1 = Yes 0 = No	If "Yes", Skip to **Next Section**
ES1.4	If 'No' above, what were the reason(s)	1=No energy 2=No interest in work 3 =Illness and/or body pain	

		4= Other (specify) …….	
SECTION C: FAMILY AND CHILD WELFARE			
FC W 1	During the last 24 hours how many meals did you and other household members have? ***Note that*** *"Meals" =breakfast, lunch and supper. Porridge by itself alone is NOT a meal*	None----------0 One----------1 Two----------2 Three ----------3 Four ----------4 Five----------5 Six or more----------6	
FC W2	Do you have a household member (child or children) aged 6 – 59 months?	1= Yes 0= No (Skip to FCW2	
FC W3	How many of the food groups listed below did your child 6-59 months eat in the previous day and night?	1) Grains, white roots and tubers, and plantains 2) Pulses like beans, peas and lentils 3) Nuts and seeds including groundnut 4) Dairy	

	(Multiple choice answers allowed)	5) Meat, poultry, and fish 6) Eggs 7) Dark green leafy vegetables 8) Other vitamin A-rich fruits and vegetables 9) Other vegetables 10) Other fruits.	
FC W 4	Were you or any household member not able to eat the kinds of foods you preferred because of a lack of resources? (Foods you preferred might include meat, Chicken, eggs, fish, milk, spaghetti, rice)	1 = Yes 0 = No	
FC W 5	Do you have children in your household who are eligible to attend school? How many	0 = None 1 = Yes	If "None" skip to **Next Section**

	boys? How many girls? *Eligible children are seven years and older **If school is not in session, then rephrase: For the upcoming term, how many children in your household will be eligible to attend school?	Number Boys: _____ Number Girls: _____	
FC W 6	During the previous school week, did any of these children not attend or miss school for any reason? *Exclude holidays **if school was not in session the previous week, ask about last school week in session	1 = Yes 0 = No	If "No" skip to **Next Section**

FC W 7	What is the **main** reason your child or children missed school? **(Circle all reason(s)**	1=Could not pay school fees 2=Child was sick 3=Dropped out 4=Had to work 5=Death in family/funeral 6=Parent refused to send child to school 7=Child did not want to go to school 8……Other	
SECTION D: SOCIAL SUPPORT			
SS 1	Do you have someone in your life to turn to for suggestions about how to deal with a personal problem?	1 = Yes 0 = No	
SS2	Have you participated in any of these community activities in the past 1 month?	0 - None 1 - Community meetings 2 - Burial / funeral activities 3- Self Help Groups	

		4- Weddings 5-Savings Group meetings 6-Religious meetings Specify: _____	
SS3	Did the group continue to meet	1. Yes 2. No	
SS4	If group didn't continue to meet, have you found a support network	1. Yes 2. No	

THANK YOU SO MUCH FOR YOUR TIME!!!

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Thank you so much for taking the time to answer those questions so openly and honestly for me. The second set of questions that I am going to ask you are going to focus on Depression. I want to see if you are feeling any of the symptoms of depression. And, if you are experiencing some symptoms of depression, these questions will help me understand the specific details about what exactly you are feeling and how intense each feeling might be in your life right now.

Over the <u>last 2 weeks</u>, how often have you been bothered by the following problems? *(Use "✓" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things.	0	1	2	3
2. Feeling down, depressed, or hopeless.	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much.	0	1	2	3
4. Feeling tired or having little energy.	0	1	2	3

5. Poor appetite or overeating.	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way.	0	1	2	3
TOTALS				

1. CLIENT LIFE SKILLS ASSESSMENT QUESTIONNAIRE

		Rarely	Sometimes	Almost always
1	I am able to name my emotions when I am feeling okay and when I am not feeling okay	1	2	3
2	I am able to discern how my feelings affect others	1	2	3
3	My feelings are driven by my circumstances	3	2	1
4	I am able to motivate myself when things are not going well	1	2	3
5	I am dependent on what other people say to feel good about myself.	3	2	1
6	I take criticism well	1	2	3
7	I set realistic expectations for myself and others	1	2	3
8	I allow myself to rest	1	2	3
9	I am able to articulate my needs to others	1	2	3
10	I am able to hold difficult conversations about changes that I need to see in my life	1	2	3
11	I am able to communicate when I am hurt by someone's words or actions towards me.	1	2	3

12	I am confident about the decisions I make concerning my life	1	2	3
13	I participate in community activities that build me up.	1	2	3
14	I feel confident around people I do not know	1	2	3
15	I feel like I am in control of my life and my destiny//future	1	2	3
16	Sometimes I find myself overwhelmed and I do not know why	1	2	3
17	I avoid unpleasant feelings all together. I would rather find something to distract me.	3	2	1