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"If I'm unhealthy, then I don't have a place in our school system": Co-creating a gender-transformative, whole-school and school-linked mental health research and learning agenda in Uganda

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ABSTRACT

Schools are increasingly expected to promote mental health, identify distress and connect learners to care, yet evidence from low-resource African education systems remains fragmented. This study examined how school communities and system actors in Uganda understand mental health, the needs of learners and school staff, the capacity of schools to respond, and the research and learning priorities required to build a gender-transformative, whole-school and school-linked mental health system. A qualitative participatory study was conducted in Kampala, Jinja, Gulu and Mbarara. Approximately 200 stakeholders were engaged, including learners, teachers, school leaders, parents, community actors, policy officials, service providers, civil society organisations and research partners. Regional consultative dialogues and co-creation sessions used facilitated discussion, group reflection, participatory ranking and priority-setting. Data were analysed thematically using deductive and inductive approaches, with comparison across regions and stakeholder groups. Mental health was understood broadly as emotional, psychological, social, cognitive and behavioural wellbeing, but these understandings coexisted with stigma, spiritual and moral explanations, gender norms and distrust of school support systems. Learner distress was described as cumulative and shaped by academic pressure, poverty, family instability, bullying, violence, substance use, disability, displacement and weak support structures. Girls faced pressures linked to reproductive health, exploitation and social judgement, while boys were constrained by emotional suppression, risk-taking and reluctance to seek help. Teacher and staff wellbeing was widely neglected despite its importance for learner support. Schools had multiple policy and programme entry points, but implementation was fragmented, under-financed and weakly linked to health, child protection and community services. Stakeholders prioritised policy coherence, learner and staff wellbeing, equity and disability inclusion, school climate, family engagement, gender transformation, mental health literacy, functional services and referral, implementation and financing, and responsible digital innovation. School mental health in Uganda should be treated as an education, health, protection and equity systems issue rather than a narrow counselling function. The co-created agenda provides a sequenced framework for generating actionable evidence and strengthening emotionally safe, inclusive and sustainable school-based and school-linked support.

Keywords: School mental health, gender-transformative research, whole-school approach, co-creation, implementation research, Uganda, adolescent wellbeing.

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INTRODUCTION

Globally, approximately one in eight people lives with a mental health condition, including an estimated 8% of children aged 5–9 and 14% of adolescents aged 10–19 (WHO, 2022). Mental health difficulties may be internalising, including depression and anxiety, or externalising, such as disruptive behaviour and attention difficulties (Ogundele, 2018), while exposure, expression and help-seeking are shaped by sex and gender (Matos et al., 2017; WHO, 2022). These difficulties can undermine concentration, attendance, educational achievement and relationships (Cavioni et al., 2020), making adolescence a critical period for mental health promotion, prevention, early identification and timely care (Barry et al., 2013).

The need is particularly acute in low- and middle-income countries (LMICs), where specialist services, financing and professional capacity remain limited (Qureshi and Eaton, 2020; WHO, 2022). Across sub-Saharan Africa, poverty, conflict, urbanisation, HIV/AIDS, gender-based violence, displacement and weak service systems intensify risks to children and adolescents (Jörns-Presentati et al., 2021; Lwidiko et al., 2018; WHO, 2021). COVID-19 compounded these pressures through school closures, social isolation, learning loss, household poverty, child labour and gendered violence (Datzberger et al., 2023; Nakiyingi et al., 2023; Namatende-Sakwa et al., 2023a, 2023b). Low investment, limited mental health literacy and large treatment gaps further constrain access to appropriate support (Kutcher et al., 2019; Qureshi and Eaton, 2020; Being Initiative, 2024).

Schools are therefore strategic settings for promotion, prevention, early identification and support because they connect learners with peers, families, communities and services. Whole-school approaches are especially relevant because they locate mental health within school culture, relationships, safeguarding, staff wellbeing, family engagement and referral systems rather than treating it solely as an individual counselling concern (Barry et al., 2013; Huang et al., 2015, 2022).

Context of the study

Uganda has a young population and a substantial child and adolescent mental health burden (UNICEF, 2021; Opio et al., 2022; Braathu et al., 2025). These risks are gendered as dominant norms frame boys' distress as indiscipline or weakness, while girls face pressures linked to harassment, menstrual stigma, early pregnancy, gender-based violence and unequal expectations (Namatende-Sakwa, 2018; Namatende-Sakwa et al., 2023a, 2023b; Ssesanga et al., 2024). Poverty, family instability, academic pressure, disability, displacement and stigma compound these vulnerabilities.

Uganda's policy environment includes the *Child and Adolescent Mental Health Policy Guidelines (2017), Mental Health Act (2018), Uganda School Health Policy (2008), Adolescent Health Policy Guidelines and Service Standards (2004), the Ministry of Health Strategic Plan 2025/26–2029/30 and the 2025 Guidelines for Integrating Mental Wellbeing and Psychosocial Support in Education Institution*s. The 2025 Guidelines represent an important advance: they define MHPSS; provide guidance on literacy, prevention, early identification, school-level management and a three-level referral system; include educator wellbeing; assign responsibilities across ministries, districts, institutions, staff, learners and parents; and provide monitoring tools, a school health register and referral form. The policy challenge is therefore increasingly one of dissemination, costing, financing, implementation and accountability rather than policy absence alone.

Implementation capacity nevertheless remains constrained. Professional counselling and specialist child mental health services are scarce (Huang et al., 2014), while limited mental health literacy and cultural or spiritual interpretations delay help-seeking (Wabule, 2025; Kutcher et al., 2016; Skylstad et al., 2019). Ugandan and post-conflict interventions show promise (Huang et al., 2022; Tol et al., 2014), and task-sharing can extend reach when supported by training, supervision, safeguarding and functional referral systems (WHO, 2007).

Existing evidence has largely examined particular interventions, learner mental health concerns or specific school-level barriers. Less attention has been given to how learners, educators, communities, practitioners and policy actors collectively define the requirements for a coherent school mental health system, including the institutional and gendered conditions that shape implementation. This study addresses that gap through participatory consultation and co-creation across four Ugandan districts. Its distinctive contribution is to connect lived and professional experience with a gender-transformative, whole-school and school-linked research and implementation agenda.

Conceptual framework

The study used three complementary analytical lenses: an ecological systems perspective, a gender-transformative lens and a whole-school, school-linked systems approach. The ecological systems perspective locates learner wellbeing within interacting individual, family, peer, school, community and policy environments (Bronfenbrenner, 1979), shifting attention from individual pathology to the relationships and conditions that enable or undermine wellbeing.

The gender-transformative lens examines how norms, roles and unequal power relations produce different risks and constraints for girls, boys, women and men (Pederson et al., 2015). It moves beyond sex-disaggregated

description to ask how expectations of toughness, obedience, caregiving, respectability and emotional control shape exposure to distress, disclosure, help-seeking and the support received. It also requires attention to intersections with disability, poverty, displacement, age and school type.

The whole-school approach treats mental health as part of school culture, leadership, curriculum, relationships, safeguarding, staff development, family engagement and external partnerships rather than as a stand-alone counselling activity (Cavioni et al., 2020; Weare, 2013). Because schools cannot independently provide specialist care, the study extends this perspective to a school-linked model connecting education institutions with health, child protection, social welfare and community systems. Together, these lenses enabled analysis of mental health as simultaneously individual, relational, institutional and systemic.

Purpose of the study

The purpose of the study was to co-create a context-specific evidence base for a coherent, gender-transformative, whole-school and school-linked mental health agenda in Uganda. It examined understandings of mental health, learner and staff needs, school and system capacity, and priorities for research, policy and programming.

Objectives of the study

The study sought to:

1. examine understandings and perspectives of mental health in Ugandan school communities, including beliefs, stigma, gender norms and help-seeking barriers;
2. identify the mental health and psychosocial needs of learners, teachers and other school staff;
3. assess school and system capacity to respond to mental health concerns, including school climate, policies, programmes, resources, referral pathways, family engagement and workforce capacity; and
4. identify research, policy and programming priorities for a gender-transformative, whole-school and school-linked mental health agenda in Uganda.

METHODOLOGY

Study design

This qualitative participatory co-creation study drew on lived and professional experience to examine how school mental health is understood, experienced and addressed and to identify priorities for strengthening school-based and school-linked systems. Regional stakeholder dialogues combined qualitative inquiry with participatory reflection, ranking and priority-setting.

Study setting

The study was conducted in Kampala, Jinja, Gulu and Mbarara, purposively selected to capture geographic and contextual diversity and to connect school- and community-level perspectives with district and national policy actors. Kampala provided an urban and policy-centred setting; Jinja a mixed rural–urban context; Gulu a post-conflict and displacement-affected context; and Mbarara an education and economic hub with urban and rural schools. The sites enabled examination of variation across socio-cultural, institutional and resource environments.

Study population, stakeholder mapping and sampling

Participants were purposively identified through stakeholder mapping and snowball referral across education, health, child protection, disability inclusion, youth development, community support, policy and research. Six stakeholder groups were engaged: government and policy actors; education practitioners; learners and youth representatives; community actors; special-interest groups; and development and research partners. Criterion-based sampling prioritised participants with relevant policy or practice roles, lived or professional experience, representation of populations important to gender-transformative programming, or capacity to influence implementation and uptake. The study planned for 50 participants per district (200 overall), distributed across stakeholder categories as shown in Table 1.

Data collection and co-creation

Data were generated through regional consultative dialogues and co-creation sessions. Facilitators used common guiding questions aligned with the four study objectives while allowing participants to introduce context-specific concerns. Methods included facilitated group discussion, group reflection, participatory ranking, plenary feedback and priority-setting. Sessions were conducted in English and, where necessary, local languages. Notes were taken throughout and sessions were audio-recorded where consent was provided.

The co-creation process moved from problem identification to prioritisation. Participants first discussed meanings of mental health, school and community drivers, available supports and implementation gaps. They then identified research questions, policy needs, feasible programme components and potential evidence products. Priorities generated across the regional sessions were compared and consolidated during analysis.

Table 1. Stakeholder composition per regional convening.

No.	Stakeholder category	Example stakeholders	No per region	Total	Rationale for inclusion
1	Government and policy actors	Ministry of Education and Sports school health and gender units; Ministry of Health Mental Health Division; district education and health officers; local government representatives	5	20	Policy alignment, resource mobilisation and scaling capacity
2	Education practitioners	Headteachers, deputy headteachers, teachers, school counsellors, nurses, health teachers and teacher training institutions	10	40	School-level expertise and practical implementation experience
3	Learners and youth representatives	Student councils and youth-led organisations	18	72	First-hand perspectives from intended beneficiaries and youth leadership in co-design
4	Community actors	Parents' associations, religious leaders, cultural leaders and community-based organisations	6	24	Community buy-in, cultural relevance and grassroots mobilisation
5	Special-interest groups	Organisations for children with disabilities, LGBTQ+ support organisations and refugee education partners	6	24	Representation of marginalised and high-risk groups
6	Development and research partners	NGOs, INGOs, universities, research institutions, UN agencies and mental health advocacy groups	5	20	Evidence-based insights, technical support and partnership opportunities
Total	-	-	**50**	**200**	Diversity of expertise, experience and representation

Data analysis

Data were analysed thematically using deductive and inductive coding. An initial framework was developed from the study objectives and research questions around four domains: understandings of mental health; learner and staff mental health and psychosocial needs; school and system capacity to respond; and research, policy and programming priorities. Inductive coding captured issues emerging beyond these predefined categories, including emotional safety, confidentiality, academic pressure, teacher financial stress, fragmented policy implementation and the symbolic rather than functional use of school clubs and counselling structures.

Analysis involved iterative comparison across regions and stakeholder groups to identify convergence, divergence and contextual variation. The ecological, gender-transformative and whole-school/school-linked lenses guided interpretation of how individual experiences and help-seeking were shaped by gender norms, interpersonal relationships, school practices and wider institutional and policy environments. Empirical findings were then integrated with priorities generated through the co-creation exercises. These priorities were consolidated and mapped against identified evidence gaps, intended users and potential evidence products.

Quality assurance

Credibility and trustworthiness were strengthened through triangulation across stakeholder groups and study regions, iterative comparison of convergent and divergent perspectives, and clarification of emerging issues during plenary discussions. The research team maintained documentation of data collection, coding decisions, emerging themes and agenda-setting discussions. Team review was used to challenge assumptions, resolve discrepancies and strengthen consistency in application of the analytical framework.

For the research and learning agenda, priorities generated during co-creation were documented, compared and consolidated. The final agenda was reviewed to ensure that each priority was grounded in an identified evidence gap and linked to practical evidence needs and potential users. Combining deductive and

inductive analysis with multiple stakeholder perspectives strengthened the contextual relevance of both the findings and the resulting agenda.

Ethical considerations

The study followed principles of informed consent, assent, voluntary participation, confidentiality, respect and minimisation of harm. Adult participants provided consent, while learners participated with assent and required parental or guardian permission. Facilitators emphasised that participants could decline questions or withdraw. Because discussions addressed sensitive experiences, the study identified debriefing and referral options where possible. Ethical approval was obtained from the relevant institutional review committees in Kenya and Uganda.

FINDINGS

Meanings and understandings of mental health

This section highlights two interconnected dimensions: mental health as multidimensional and relational wellbeing, and the norms and beliefs shaping help-seeking and access to support.

Mental health as multidimensional and relational wellbeing

Across the stakeholder and learner dialogues, mental health was understood as a broad and multidimensional concept that goes beyond the presence or absence of mental illness. Participants described it as emotional, psychological, social, cognitive and behavioural wellbeing, and as the capacity to cope, relate to others, make sound judgements and participate meaningfully in everyday life. In Gulu, participants defined mental health as "the emotional, physiological, and psychological well-being of a person," including "their feelings, how they feel about certain things" and "how they interact with others" (Gulu, Day 1 stakeholders).

In Kampala, policy actors and stakeholders described mental health as the "state of one's mind," "emotional psychosocial wellbeing," "mental wellness," and the ability "to cope with everyday emotions" (Kampala, policy actors). Participants also linked mental health to "the function of the brain and associated personal behavior," suggesting that mental health was seen not only as an internal state but also as something expressed in behavior, relationships and daily functioning.

Mbarara participants similarly defined mental health as "psychological, social and emotional wellbeing," "a state of being stable in the mind," and "the ability of a person to have sound judgement" (Mbarara, stakeholders). Learners in Jinja defined it as the "social, emotional and psychological wellbeing of a person." They extended this to mental health support: what someone can do to contribute to another person's emotional, social and psychological wellbeing (Jinja, students). This relational understanding is important because learners did not view mental health as only an individual condition; they also saw it as shaped by friendship, counselling, safe spaces, conversation, peer support, physical activity and opportunities for self-expression.

Participants also connected mental health to the school environment. In Mbarara, emotional safety was defined as "the ability of a school to create a safe space for students when they have emotional and psychological challenges" (Mbarara, stakeholders). This suggests that school mental health programming should not be framed narrowly around illness, treatment or crisis response alone. It should also address emotional literacy, supportive relationships, safe and inclusive school climates, early identification, stigma reduction and the everyday conditions that allow learners and teachers to function well.

Norms, beliefs, stigma and help-seeking

Participants across Kampala, Gulu, Jinja and Mbarara described mental illness as highly stigmatized in schools and wider society. Mental health problems were often interpreted through spiritual, cultural, moral, disciplinary or social lenses rather than as health and wellbeing concerns. These beliefs shape how learners, teachers, parents and communities respond to distress, often delaying support until problems escalate.

A recurring belief was that witchcraft, spirits, curses, ancestral forces or demonic possession cause mental illness. Kampala policy actors reported that schools and communities commonly associate mental illness with "witchcraft," "demon possessed," "family curses" and "generational curses" (Kampala, policy actors). Gulu participants similarly identified beliefs that mental illness is inherited, a curse, caused by ancestral spirits, witchcraft or punishment for sins. One Gulu learner explained that when someone begins behaving differently, some people conclude that the person "was bewitched" and therefore "wouldn't go for psychiatric advice," but would instead "consult spirits" (Gulu, learners).

Moral judgement and blame were also common. Mental illness was associated with laziness, indiscipline, poor upbringing, dullness, attention-seeking, drug use, relationships, peer influence or family background. Mbarara stakeholders noted that panic attacks or distress may be dismissed as "hysteria," with learners seen as "faking it" or "seeking attention" (Mbarara, stakeholders). Kampala policy actors also reported perceptions that depression was "a disease for the rich" or "a disease for white people," with one participant summarizing the view as: "Me who is a poor person do I have the luxury to have

depression? No, it is only you who is rich that has the luxury to have depression" (Kampala, policy actors).

Gender norms were a strong barrier to help-seeking, especially for boys and men. Kampala students explained that boys are told "you have to be strong" and "you're supposed to be like a guy who does not cry," which leads them to bottle up emotions (Kampala, students). Mbarara students made the same point: "men or boys normally look at themselves as people who can handle stress. So even when we are stressed, we try to hide it from the rest that we're okay" (Mbarara, students). These norms affect male learners and male teachers by making emotional disclosure appear weak or inappropriate.

Stigma affected willingness to seek help, as Kampala students said learners feared being judged because "people perceive it as you're going to a counsellor you actually do have a mental disorder," even when the learner is only trying to seek help for a difficult issue (Kampala, students). Gulu participants linked the fear of help-seeking to lack of private counselling spaces, noting that peers may ask, "what were you going to do to the counselor?" (Gulu, stakeholders). Referral sites could also carry stigma. Kampala teachers observed that when "Butabika" [a national mental health referral hospital] is mentioned, "parents are very scared" (Kampala, teachers).

Confidentiality and mistrust of adults by learners were also major barriers. Kampala students reported fear that teachers could judge, quarrel, disclose personal stories or use them as examples in class. Mbarara students identified "insecurity," "lack of privacy," "lack of confidence," "unconducive environment," "lack of space for counsellor's office," "no counsellors" and "stereotypes" as barriers to help-seeking (Mbarara, students). Peer stigma compounded this: learners experiencing distress risked gossip, body shaming, neglect or ridicule.

These beliefs delayed formal care and pushed families toward prayer-only, spiritual, traditional or informal responses. Mbarara stakeholders reported that stigma can lead people to seek spiritual support first and only reach psychiatric care after resources have been depleted. Kampala teachers observed that "some people will pray until somebody dies and then they will say we have prayed" (Kampala, teachers).

Overall, stigma is not only a cultural issue, but it also interacts with weak school systems, limited mental health literacy, inadequate referral structures and lack of confidential spaces. School mental health programming must therefore address stigma directly, including gender norms, while building trusted, confidential and culturally grounded support systems.

Mental health and psychosocial needs of learners, teachers and other school staff

This section highlights the interconnected mental health and psychosocial needs of learners, teachers and other school staff, and the individual, social and institutional pressures shaping their wellbeing and capacity to function within schools.

Learner mental health and psychosocial needs

Student mental health was described as a growing concern shaped by pressures within schools, families, communities and the wider social environment. Prominent concerns raised across discussions included depression, anxiety, stress, low self-esteem, fear, social withdrawal, substance use, bullying-related distress, trauma, anger, academic pressure and poor emotional regulation. In Gulu, stakeholders listed "depression, stress, anxiety, low self-esteem, stigma, fear" among the most pressing issues (Gulu, stakeholders). Kampala teachers similarly identified bullying, peer pressure, social media pressure, performance expectations, corporal punishment, poverty, neglect and weak counselling systems as major concerns affecting learners (Kampala, teachers).

A strong theme was that learner distress is cumulative. Participants did not describe depression, anxiety, stress, trauma and substance use as isolated problems, but as interconnected experiences. Kampala teachers explained that "it all starts with feeling anxious, you develop stress and then this stress causes trauma and then it affects education" (Kampala, teachers). Learners also emphasized academic pressure, noting that "so much of what stresses students is academic pressure and stress" (Kampala, students).

Academic pressure was one of the most consistent drivers of student distress. It was linked to examination anxiety, fear of failure, pressure from parents and teachers, long school days, limited rest and competitive school environments. Mbarara stakeholders described anxiety as linked to "exam fever," and participants connected distress to "high expectations from teachers and parents" where parents set rigid academic standards without considering learners' interests, capacities or emotional state. Some participants also linked distress to lack of sleep, arguing that "some mental issues honestly come from lack of sleep children don't sleep" (Mbarara, stakeholders).

Family and home background were also prominent. Participants linked learner mental health challenges to broken homes, absent parents, single parenthood, domestic violence, poverty, family conflict, parental separation, neglect and limited emotional connection at home. In Gulu, stakeholders identified single parenthood, parenting styles, health status, school fees pressures, gender-based violence, drug and alcohol abuse, early sexual relationships, academic pressure, bullying and harassment as major factors (Gulu, stakeholders). In Jinja, students similarly identified family background, bullying, drug abuse, rejection, peer pressure, stigma, discrimination and past experiences, with one student

explaining that learners from poorer or "humble backgrounds" may feel "out of place" (Jinja, students).

Poverty and inequality were especially visible. Learners and adults linked poverty to low self-esteem, shame, comparison with wealthier peers, inability to meet school expectations, school fees-related stigma and exclusion from peer cultures shaped by phones, clothing, food and social activities. In Gulu, learners reported that low self-esteem was "linked to poverty and comparing oneself to wealthier peers" (Gulu, learners). Kampala parents and community actors also noted that peer comparison around phones and material possessions can affect learners, giving the example that "other people have iPhones and you have an Itel it can affect you" (Kampala, parents/community actors).

Bullying, teasing, humiliation and harsh discipline were also described as major contributors. Kampala teachers noted that corporal punishment persists despite being abolished, and one participant captured its normalization through the saying, "The best ear is from the buttocks" (Kampala, teachers). Mbarara students identified bullying and torture as factors behind stress, anxiety and isolation, and reported that emotionally struggling peers may experience gossip, neglect, body shaming and ridicule (Mbarara, students).

Substance use and addiction were another recurring concern, especially among boys and urban learners. Kampala policy actors listed alcohol and substance use, addiction and peer pressure as major mental health concerns. Gulu learners identified addiction as driven by "peer pressure and continued exposure to drugs/alcohol," while Mbarara students linked drug use to peer influence and the belief that alcohol or drugs temporarily help learners forget problems. One learner cautioned that "drugs like alcohol make you forget the issues," but later create more problems (Mbarara, students).

Girls were seen as vulnerable to poverty, reproductive and menstrual health challenges, sexual exploitation, abuse, body image pressures and fear of embarrassment. Boys were identified as vulnerable to substance use, aggression, peer pressure, emotional suppression and reluctance to seek help, with learners noting that "men are taught not to show emotions" (Gulu, learners).

Participants identified several groups as especially affected: adolescent girls, boys, learners with disabilities and special needs, candidates facing examinations, learners from poor families, orphans, displaced learners, learners from broken or polygamous families, learners in institutional care, newcomers, urban learners exposed to drugs and digital pressures, and adolescents navigating puberty and peer influence. Learners with disabilities were consistently identified as affected by stigma, exclusion, neglect, bullying, isolation, limited trained personnel and weak accessibility of support services.

Overall, learner mental health challenges are produced by overlapping academic, family, economic, social, disciplinary and institutional pressures. Participants' accounts pointed beyond counselling alone towards safer school climates, reduced academic overload, anti-bullying systems, confidential support, disability inclusion, parent engagement, poverty-sensitive interventions, substance use prevention and gender-transformative approaches that attend to distinct vulnerabilities among girls, boys and learners with special needs.

Teacher and staff mental health and psychosocial needs

Teacher mental health emerged as both a direct wellbeing concern and an indirect determinant of learner outcomes. Participants repeatedly argued that teachers cannot effectively support learners if they are unsupported, overworked, underpaid, stigmatized or emotionally distressed. A Kampala participant captured this link clearly: "if a teacher is not happy it affects the learners and therefore it affects the performance of the teacher and the outcome" (Kampala, teachers). In Gulu, a participant made the same point through the metaphor: "by the time, I go to lead a blind man out of the ditch, I must be seeing… I cannot also go when I have problems" (Gulu, stakeholders).

Prominent teacher mental health concerns raised included anxiety, depression, burnout, workload-related stress, emotional distress, low morale, addiction, social media pressure, stigma and, in some discussions, severe mental health conditions such as bipolar disorder and suicide risk. Kampala policy actors linked these issues to low pay, difficult work environments, high employer expectations, violence and domestic violence, and identified urban teachers and private-school teachers as especially affected (Kampala, policy actors).

Financial stress was a prominent reported driver. Participants connected low pay, salary disparities and the social devaluation of teachers to stress, demotivation and lowered professional dignity. Kampala participants noted that salary disparities can divide staff so deeply that "teachers are in different staff rooms, they don't look at each other face to face" (Kampala, teachers). Another participant linked public stereotypes about teachers to emotional harm, noting that "everyone is talking about the policeman and the teacher as the most broke person," and that students internalize this stereotype (Kampala, teachers).

Workload and role overload were also central. Teachers are expected to teach, discipline, counsel, identify mental health concerns, manage parental expectations and compensate for gaps in formal school mental health systems. This expectation is especially problematic where teachers are assigned counselling roles without adequate preparation. Kampala participants criticized the assumption that limited exposure to counselling qualifies a teacher as a counsellor: "You are a teacher? You studied Counselling as one of your course units? You are a

Counsellor now" (Kampala, teachers). Gulu stakeholders similarly argued that teachers who lack mental health knowledge may punish learners who are isolated, aggressive or late rather than asking what is happening in the child's life (Gulu, stakeholders).

Gendered and family-related pressures also emerged. Female teachers, especially single-parent teachers, were identified as vulnerable to family stress, moral judgement and caregiving pressures. One discussion captured stigma toward unmarried or single female teachers through the question: "Where are their husbands and why are they not interested in staying with them?" (Kampala, teachers). Male teachers were also described as vulnerable because norms such as "men don't cry" discourage disclosure and help-seeking (Kampala, teachers). Teachers with disabilities, counsellors, school nurses, matrons, wardens, cleaners, cooks, guards and other non-teaching staff were less visible but should be included in future evidence and support. One Gulu participant argued that "all learners and all staff groups" require attention because "I don't think any should be left out" (Gulu, stakeholders).

Mental health professionals and school counsellors also emerged as a vulnerable staff group. Kampala policy actors raised concerns about financial constraints, lack of recognition, burnout, compassion fatigue and the absence of public service positions, captured in the quote: "There are no jobs in Public Service for Mental Health professionals" (Kampala, policy actors). Another participant emphasized the need to care for those providing support: "whoever has been selected to be the mental health provider in that school should be supported to be cared for" (Kampala, policy actors).

Overall, teacher and non-teaching staff mental health is shaped by financial strain, workload, poor working conditions, gender norms, stigma, weak policy implementation, inadequate training, limited psychosocial support and the expectation that teachers absorb mental health responsibilities without sufficient backing. Across accounts, teachers and non-teaching staff were positioned not only as implementers of learner support, but also as intended beneficiaries of school mental health systems.

School capacity to address mental health

This section examines schools' capacity to address mental health, focusing on school climate and leadership, the policy and programme environment, available resources and referral systems, family engagement, and workforce capacity.

School climate, emotional safety, inclusion and leadership

Schools were generally described as insufficiently emotionally safe and only partially inclusive, with variation by school type, location, resources and leadership commitment. Participants defined emotional safety as an environment where learners can express emotions, disclose distress, make mistakes and seek help without fear of judgement, ridicule, punishment or stigma. Kampala policy actors defined it as "the environment that enables learners to freely express their emotions where they are respected, accepted without being judged" (Kampala, policy actors).

Participant ratings across sites suggested generally weak emotional safety. Kampala parents and community actors rated schools 3 out of 10, saying "emotional safety is low or lacking in most of the schools in Uganda today" and that in many schools "everything that you do is a punishment" (Kampala, parents/community actors). Gulu stakeholders rated emotional safety and inclusion in Northern Uganda at 4 out of 10, noting that many learners simply come to school, study, eat and return home without meaningful support: "We like calling it vegetating. They vegetate and go back home without any clear support" (Gulu, stakeholders). Jinja stakeholders also rated emotional safety and inclusion at 4 out of 10, observing that schools often "deal more with the normal child" while learners with mental health concerns receive limited attention because teachers are "chasing grades" (Jinja, stakeholders).

Kampala education stakeholders rated school inclusivity even lower, at 2 out of 10, arguing that although some upscale schools may prioritize mental health more visibly, emotional safety and inclusion are not fully integrated. Kampala policy actors rated emotional safety and inclusion as 1/10 in government urban and rural schools, 3/10 in private urban schools, and 2/10 in private rural schools. Mbarara stakeholders gave a more mixed assessment, rating safety at 6, trust at 5, structures at 8, inclusion at 6 and involvement at 4. Their explanation was important: "you can have the structures in the school but because of low safety and inclusion the students are not able to take advantage of the services" (Mbarara, stakeholders).

A major reason emotional safety remains weak is the dominance of academic pressure and performance-driven school cultures. Kampala teachers observed that schools "call in more facilitators for academic excellence than they call in someone to come and support for mental health," while parents often ask about grades rather than emotional support (Kampala, teachers). Kampala parents described some schools as "pressure points," where learners fear failure, cut-off marks and expulsion (Kampala, parents/community actors).

Punitive discipline and harsh adult-child interactions also undermined emotional safety. Participants linked unsafe school climates to punishment, ridicule, fear of adults and emotional abuse. Kampala teachers identified "use of heavy words on students worse than the canes," warning that children remember "the ugly word that was said" (Kampala, teachers). Inclusion was also uneven, especially for learners with disabilities, chronic illnesses

and mental health conditions. One Kampala participant stated: “Our school system is designed for healthy children but if I’m unhealthy then I don’t have a place in our school system” (Kampala, teachers/health practitioners).

School leadership was seen as central but uneven. In Gulu, leadership was described as “not very supportive” because headteachers and staff “lack insight” and have not been adequately capacitated to handle mental health challenges (Gulu, stakeholders). Kampala policy actors rated leadership support very low across school types and reported “no mental health consideration” among Boards of Directors, Boards of Governors and School Management Committees, with only minimal consideration among PTAs, school administration and student bodies (Kampala, policy actors). Jinja stakeholders were more positive, rating leadership support at 7 out of 10 because some schools now have counsellors, teachers and psychologists, and “have started… to appreciate the role of counselors and social workers” (Jinja, stakeholders). Mbarara stakeholders rated leadership support around 5 out of 10, noting that some schools recruit counsellors, use spiritual directors, matrons, patrons, senior women/men and guidance teachers, or invite NGOs and motivational speakers (Mbarara, stakeholders).

Overall, schools are important but underprepared spaces for emotional safety and inclusion. The evidence does not suggest that all schools are uniformly unsafe; rather, schools are generally low-capacity, unevenly inclusive and overly academic in orientation. Strengthening emotional safety will require leadership accountability, respectful teacher-student relationships, confidential spaces, disability-sensitive services, learner voice, reduction of punitive discipline, and recognition that mental health is central to learning rather than peripheral to academic performance.

Policy and programme environment

Participants agreed that Uganda has several policies, guidelines, protocols and initiatives relevant to school mental health, but these are fragmented, poorly disseminated, weakly implemented and not yet functioning as a coherent school-based mental health system. The policy environment is therefore not empty; the challenge is translation into practice.

Relevant instruments identified by participants include the *Guidance and Counselling Policy for students, National School Health Policy, National School Health Service Standards and Guidelines, Policy on Prevention of Violence Against Children in Schools, Guidelines on Re-entry and Management of Teenage Pregnancy in Schools, Guidelines on Positive Parenting and Key Family Care Practices, National Teacher Policy* (Kampala, policy actors; Kampala, teachers; Kampala, parents/community actors).

However, participants repeatedly noted weak dissemination. Kampala teachers said, “Government has good policies, but they are hidden somewhere in documentation. They are not actually printed out in hard copies, but they are there on the websites” (Kampala, teachers). Gulu participants similarly noted that “policies regarding mental health are in place, but the policy is not being implemented in those schools because implementers are not equipped and responses are not timely (Gulu, stakeholders). The same participant said that while stakeholders know policies exist, “we do not know what the policies are,” and that in schools “there is nothing like mental health programmes being included into the school programmes,” making policy “very dormant” (Gulu, stakeholders).

Ratings reinforce this gap between availability and effectiveness. Kampala policy actors rated policy/guideline availability at 9/10 and consideration for teachers at 9/10, but rated effectiveness and timeliness at only 2/10 because of gaps in dissemination, implementation, human resources, counsellors and psychologists. Gulu stakeholders rated policies, guidelines and protocols at 3/10. Kampala teachers rated effectiveness around 5/10 mainly because “the policies are there,” not because protocols are fully laid out. Mbarara stakeholders reported that some mechanisms exist, including *Circular 20* on one hour per week for mental health activities, but rated effectiveness very low because implementation is inconsistent.

Several national, regional, school-based and civil society initiatives promote student wellbeing. These include music, dance and drama; games and sports; school debates; guidance and counselling; radio talk shows; mental health clubs; school assemblies; counselling sessions; peer support; safe spaces; school nurses; senior women/men teachers; NGO-supported programmes; and school-linked referral initiatives. Gulu stakeholders listed “music dance and drama,” “games and sports,” “school debates,” “guidance and counselling,” “radio talk shows” (Gulu, stakeholders).

Learners also proposed practical school-based initiatives. Gulu students recommended mental health clubs, trained counsellors, mental health awareness days, mental health books in libraries and access to health practitioners. One student explained that clubs can create awareness because students become curious, join and learn “ways on how to improve on their well-being” (Gulu, learners). Kampala learners described mental health clubs, class-based reflection spaces, counselling sessions, anti-bullying efforts, special needs clubs and learner-led initiatives such as Unshaken (Kampala, students). Jinja participants identified senior women/men teachers, school counsellors, peer counsellors, prefect bodies, chaplains, religious groups, disciplinary committees and house/club patron systems.

Teacher-focused initiatives were less visible. Participants mentioned National Sports and Recreation Initiatives, UNITE continued professional development,

teacher training in mental health, the MHPSS guide for teachers and Ministry of Health tele-counselling. However, these were described as limited, underutilized or poorly institutionalized. Kampala policy actors noted that teacher mental health training exists but "the scope is very limited," the MHPSS guide is "not fully utilized," and the tele-counselling helpline is not effectively used (Kampala, policy actors).

Overall, the policy and programme environment has many entry points but lacks coherence, financing, accountability and systematic implementation. NGO partner support was described as fragmented, duplicated, not standardized, donor dependent and not sustainable. The strongest gap is therefore not complete absence of initiatives, but the absence of a well-resourced, standardized and accountable implementation system that links policy, school practice, teacher support and health/social service referral.

School-based resources, referral pathways and family engagement

Participants identified a range of school-based and school-linked mental health resources, but described them as uneven, under-resourced and more accessible to learners than to teachers. Common resources included school counsellors, guidance and counselling teachers, senior women and senior men teachers, school nurses, matrons, dormitory wardens, peer counsellors, mentors, religious leaders, administrators, mental health clubs, co-curricular activities, school health units, referral links, educational materials and NGO/community services.

Reach was highly uneven as Kampala teachers said access is "limited to urban and semi-urban schools," suggesting that rural and poorly resourced schools were less likely to have meaningful counselling, clubs, professional staff or structured support (Kampala, teachers). Gulu stakeholders reported that counsellors were available in some schools, especially in central Uganda, but rare in Northern Uganda, and that referral to Gulu Regional Referral Hospital existed for urban schools but was "virtually absent for rural schools" (Gulu report).

Participants described mixed perceived effectiveness for students. In schools where services exist, they can be helpful. Kampala teachers reported behaviour change and increased numbers of students seeking counselling where services were available. Gulu students said counsellors and visiting specialists helped learners share emotional issues and reduce distress, though support may not eliminate problems. Mbarara students rated available services 6 out of 10, stating that some students were helped, especially those who opened up, but that services failed when confidentiality was breached. One student said learners may trust someone with a problem but later "come to hear it throughout the school compound" (Mbarara, students).

Participants described teacher-focused support as weaker and less visible. Teachers were expected to support learners, but their own access to counselling and psychosocial support was limited. Kampala teachers observed that teachers rarely sought counselling despite needing it, asking: "How can you give what you do not have?" (Kampala, teachers). Mbarara stakeholders similarly emphasized that "teachers also need to be mentally okay" (Mbarara, stakeholders).

Referral and specialized care pathways exist in some contexts but are not standardized. Partners identified nearby health centers, hospitals, mental health facilities, psychiatric staff, NGOs, churches, community-based organizations, private providers and specialized schools. Kampala parents and community actors mentioned Butabika, Mulago, Naguru for Teens, NGOs and churches (Kampala, parents/community actors). Mbarara stakeholders identified hospitals, Strong Minds organization, churches and shrines as possible support or referral pathways, showing that families may use both biomedical and spiritual/traditional routes (Mbarara, stakeholders).

Students were identified for referral through self-disclosure, teacher observation, peer reports, truancy, behavioural change, attention-seeking, low self-esteem, missing class, declining performance, withdrawal from co-curricular activities and isolation. Kampala teachers listed self-referral, teacher observation, truancy, behaviour change, attention-seeking, self-esteem concerns and peer counsellors (Kampala, teachers). Peer referral was important: Kampala parents reported that cases may begin when "a peer comes and tells you, 'The other child there's something wrong'" (Kampala, parents/community actors).

Timeliness was a major weakness. Kampala teachers said referrals were "usually delayed" because counsellors had long queues and there are few facilities. They illustrated this with a learner referred by a peer when the counsellor already has "a queue of about 30," asking: "At number 31, when will I get attention?" (Kampala, teachers).

Family involvement was essential but inconsistent. Schools involved families through enrolment processes, visiting days, class days, teacher-parent-student conferences, counselling invitations, Parent Teacher Associations (PTAs), annual general meetings, circulars, home visits and direct contact with parents. Kampala teachers noted that conferencing was often framed as disciplinary rather than supportive, while inviting parents for counselling was described as "a hard one" (Kampala, teachers). Mbarara stakeholders recommended greater involvement of fathers.

Family receptiveness was mixed. Gulu participants said, "some are, and some are not," with some parents telling schools: "I sent my child to school to you… when he is in school, he is your responsibility" (Gulu, stakeholders). Kampala teachers said some parents "do not see value in mental health" and think their only role is "to pay fees,"

while others do not believe therapy works (Kampala, teachers). Kampala parents and community actors described family receptiveness as limited by superstitious beliefs, cost, inaccessibility, fear of stigma, skepticism and ignorance, including fear that people will say “my child is stupid” (Kampala, parents/community actors).

Overall, schools have some resources and partnerships, but the support ecosystem is not yet reliable or equitable. The main gaps are limited funding, few trained counsellors, poor counsellor-student ratios, inadequate private spaces, weak confidentiality, stigma, limited rural reach, uneven referral pathways, weak follow-up, parental resistance and minimal teacher-focused support.

Workforce capacity and professional support

Teachers, headteachers, health practitioners and school counsellors described school-based mental health as urgent but under-supported. Prominent challenges raised were limited technical skills, inadequate resources, weak referral pathways, teacher stress and burnout, poor teacher-student ratios, lack of clear school-level protocols, stigma, parental resistance and limited access to specialized mental health professionals.

Limited mental health knowledge is a major challenge. In Gulu, one participant stated, “One of them is lack of technical skills, very, very important. Most of us lack the knowledge” (Gulu, stakeholders). The consequences are practical: teachers may not know what to do when a learner has an episode, withdraws, becomes aggressive or shows signs of distress. Mbarara stakeholders said it is “very difficult for us generally to identify the mentally ill cases,” and argued that if everyone had the basics of identifying how mental illness presents, schools could “arrest the situation early enough” (Mbarara, stakeholders).

Some training exists, but it is uneven and inadequate. Kampala policy actors identified teacher mental health training by the Ministry of Education and Sports, integration into teacher training, CSO-led capacity building, mental health clubs, basic MHPSS training, continuous professional development, internal supervision, Ministry monitoring, external supervision and governance oversight. However, they also noted a major quality gap: “There is no standardized training material each CSO is using different materials” (Kampala, policy actors).

Kampala teachers said staff are trained only “to a very less extent,” with some teachers relying on elementary university knowledge, books or informal sources such as TikTok. Gulu participants gave the most direct response to ongoing training: “normally none” (Gulu, stakeholders). Some inclusion training exists, including training on learners with special needs, but this was not described as broad school mental health training for all staff. Kampala teachers recommended that at least one afternoon per month be dedicated to child protection and mental health, and that CPD be scheduled with prepared content so that teachers do not “digress” (Kampala, teachers). Kampala teachers recommended continuous supervision and professional support for school mental health practitioners so that they can reflect, learn, maintain standards and improve practice. They also called for trauma-informed training for all teachers so they can recognize signs of trauma, understand behavioural responses and create supportive classrooms (Kampala, teachers).

Hiring and retaining qualified mental health professionals is a major structural challenge. Kampala policy actors identified financial constraints, lack of recognition and the absence of public service positions: “There are no jobs in Public Service for Mental Health professionals” (Kampala, policy actors). Gulu students noted that hiring specialists is expensive: “when hiring these specialists who deal with mental health, it is so costly” (Gulu, learners).

Even when schools appointed counsellors, quality is not guaranteed. Mbarara students observed that many schools had counsellors because “the government says you must have a counsellor in school,” but some counsellors are not actually doing the work or are not qualified (Mbarara, students). Gulu students added that some counsellors lacked adequate knowledge or the personality and approachability needed to gain students’ trust (Gulu, learners). Moreover, retention of counsellors was affected by burnout, emotional strain, lack of supervision, poor remuneration and poor workspaces. Kampala policy actors noted “burnout and compassion fatigue,” adding that mental health work is draining and that school mental health providers must be cared for. Kampala teachers also noted that there is often “no counselling space available for counsellors” and called for “cozy spaces” that are safe and private (Kampala, teachers).

Overall, workforce capacity was one of the central bottlenecks in school mental health. Teachers are expected to identify and respond to learner distress, but many lack the skills, time, resources and referral support to do so. Qualified professionals are scarce, under-recognized and difficult to retain. Participants prioritised standardised training materials, routine continuous professional development, supervision, professional counsellor posts, funded school mental health roles, private counselling spaces and care for teachers and mental health providers themselves.

Research, policy and programming priorities

This section outlines stakeholder priorities for strengthening school mental health through context-relevant research, coherent policy, sustainable programming and integrated research and learning agenda.

Research priorities

Priority research areas include the burden and patterning of common learner mental health conditions such as anxiety, depression, stress, trauma, low self-esteem, substance use, behavioural difficulties and academic pressure. Participants also prioritized violence, bullying, corporal punishment, peer relationships, school climate, digital exposure, substance use, poverty, family instability, bereavement, identity, teacher-student relationships and student-student relationships. Gulu participants identified the need for culturally relevant assessment tools for identifying adolescent distress rather than relying only on imported frameworks (Gulu report).

Learner groups requiring more evidence include adolescents generally; learners aged 10–18; learners with disabilities, special needs, chronic illnesses or learning impairments; learners from poor households; displaced learners; refugees; child-headed households; orphans; learners in boarding schools; learners from broken or dysfunctional homes; rural girls; urban boys; teenage mothers; candidates; and learners affected by grief, substance use, violence, bullying or digital exposure. Staff groups requiring more evidence include teachers, headteachers, deputies, counsellors, nurses, non-teaching staff, mental health professionals, teachers with disabilities, teachers with chronic illness, less motivated teachers, teachers dealing with burnout, teachers of candidate classes and staff working closely with vulnerable learners.

Policy priorities

Participants recommended a dedicated school mental health policy or framework that is anchored in education but linked to health, child protection, social protection and community systems. Kampala policy actors cautioned that schools may not have the infrastructure or personnel to manage mental health alone, arguing that the model should be “school-linked or school-affiliated” because “we don’t even have the infrastructure of the personnel so the schools cannot stand on their own” (Kampala, policy actors).

The policy should define roles, referral steps, minimum service standards, confidentiality requirements, data systems, crisis response procedures, school-level reporting lines, budget responsibilities and coordination between education, health and community services. It should also ring-fence financing for school mental health, because stakeholders repeatedly noted that implementation will not happen without budget allocations. Kampala parents asked how structures can be facilitated “without a budget,” while policy actors suggested dedicated financing, potentially through a conditional grant model (Kampala, parents/community actors; Kampala, policy actors).

Teacher wellbeing should be a policy objective. Mbarara stakeholders emphasized that “teachers cannot give what they don’t have,” and that good mental health is important for teachers “in and of themselves,” not only to support learners (Mbarara, stakeholders). The policy should therefore include care for the carer, teacher psychosocial support, staff referral options, manageable workloads and support for non-teaching staff.

Programming priorities

Programming should prioritize prevention, early identification and referral. One Kampala participant summarized the prevention argument clearly: “Prevention is very cheap, but treatment is very expensive. I normally add that Butabika [a mental health referral hospital in Uganda] is full” (Kampala, policy actors). Schools should have permanent counselling structures staffed by qualified professionals. Kampala teachers were emphatic: “This should be non-negotiable. There should be an office permanently dealing with counselling for the children” (Kampala, teachers).

Programming should also include functional mental health clubs, structured life skills and guidance sessions, mental health awareness days, peer support, anti-bullying work, parent engagement, disability inclusion, confidential safe spaces, links to health facilities and community actors, and culturally grounded stigma-reduction campaigns. Gulu stakeholders cautioned that clubs should not be symbolic: “You don’t just put a club and say in our school we have a club. Is it functioning? That is the point” (Gulu, stakeholders).

Finally, programming should move from fragmented projects to sustainable systems. NGO and partner initiatives should align with national standards, district coordination mechanisms, referral directories and shared training materials. Monitoring and evaluation should track not only activities delivered, but also counselling access, referral completion, learner and teacher satisfaction, confidentiality, stigma reduction, violence prevention, teacher wellbeing, inclusion of vulnerable groups and implementation quality. The central implication is that mental health should not remain an optional activity, one-off talk or NGO-driven project. It should become a core part of how schools protect learners and teachers, support learning and build emotionally safe and inclusive school communities.

Priority research and learning agenda

Drawing on the stakeholder consultations and study findings, the following agenda identifies priority areas for generating actionable evidence to strengthen a gender-transformative, whole-school and school-linked mental health system in Uganda. The sequence reflects the

prioritization recorded during the co-creation process; priority 8 is presented as two closely connected strands because mental health literacy and help-seeking must be developed alongside functional school-based services and referral pathways. The priorities should be treated as interdependent rather than as stand-alone topics.

Table 2. Co-created research and learning agenda for school mental health in Uganda.

Priority domain	Core research and learning questions	Illustrative evidence products and uses
1. Policy coherence, governance and accountability	Where are the gaps, overlaps and implementation bottlenecks across education, health, protection and adolescent wellbeing policies? What roles, standards, financing and accountability arrangements are required for a dedicated school-based and school-linked framework?	Policy and implementation-gap analysis; governance role map; minimum standards; policy options brief.
2. Learner mental health and psychosocial needs	What is the distribution of common mental health and psychosocial concerns? How do needs and access vary by gender, age, region, school type, boarding status, disability, poverty and displacement?	Learner wellbeing survey; school mental health profiles; disaggregated evidence briefs; contextually validated assessment tools.
3. Teacher and staff wellbeing	What pressures affect teachers, leaders, counsellors, nurses and other staff? How do workload, pay, burnout, family pressures, working conditions and training affect wellbeing and capacity to support learners? Which supports are feasible?	Staff wellbeing study; support-needs assessment; workplace intervention pilot; teacher wellbeing policy brief.
4. Equity, disability inclusion and marginalised learners	Who is least likely to access timely support and why? What barriers affect learners with disabilities, displaced and refugee learners, teenage parents, bereaved learners and those from poor or disrupted households?	Equity audit; inclusive referral protocol; disability-sensitive psychosocial guidance; lived-experience brief.
5. School climate, emotional safety and relationships	How do bullying, punitive discipline, humiliation, harassment, academic pressure and relationships affect wellbeing and help-seeking? What practices make learners and staff feel safe and included? How prepared are schools for crises?	School climate tool; anti-bullying and positive-discipline study; learner voice brief; emergency preparedness framework.
6. Family and community engagement	How do parents, caregivers, religious and cultural leaders influence literacy, stigma, disclosure, referral and follow-up? Which family-school engagement models, including father involvement, are acceptable and effective?	Family-school partnership study; parent engagement model; community dialogue toolkit; accountability guidance.
7. Gender-transformative school mental health	How do gender norms and power relations shape exposure, emotional expression, disclosure and access? How should programmes address harassment, reproductive-health stigma, early parenthood, caregiving, boys' emotional suppression and social judgement?	Gender norms study; programming framework; gender-transformative indicators; practical school guidance.
8a. Mental health literacy, stigma and help-seeking	Which cultural, spiritual, moral and gendered beliefs shape recognition and response? Which messages, messengers and channels reduce stigma and increase appropriate help-seeking? How do trust and confidentiality affect disclosure?	Literacy intervention pilot; message testing; help-seeking strategy; training and awareness package.
8b. School-based and school-linked services, referral and workforce	How functional and accessible are counselling, senior teacher roles, nursing, clubs, peer support and safe spaces? What competencies, supervision and confidentiality standards are needed? Where do referral pathways break down?	School readiness and service map; minimum package; workforce competency framework; referral audit and tracking pilot.

Table 2. Continues.

9. Implementation, financing, cost and sustainability	Which models are feasible, acceptable and effective within workforce and financing constraints? What does a minimum package cost? What determines adoption, reach, quality, adaptation and sustainability?	Implementation and realist evaluation; costing and cost-effectiveness; political economy and financing analysis; scale-up roadmap.
10. Digital technology and responsible innovation	How can digital tools support literacy, training, identification, referral, follow-up and specialist advice? What privacy, safeguarding, exclusion, bias and misinformation risks must be addressed?	Digital readiness assessment; responsible innovation framework; feasibility pilot; data governance and safeguarding guidance.

Overall, the agenda should be implemented through participatory, gender-transformative and intersectional approaches that center learners and school staff, prioritise equity, safeguarding and confidentiality, and account for variation across social and institutional contexts. Evidence generation should also be closely linked to implementation, financing and uptake so that it identifies not only the scale of need, but what works, for whom, under what conditions and at what cost.

DISCUSSION

This study examined how diverse school-community and policy stakeholders understand school mental health, the needs of learners and staff, and the capacity of existing school and service systems to respond. Across settings, mental health was framed as relational and multidimensional, while distress and help-seeking were shaped by academic pressure, poverty, family instability, bullying, punitive discipline, stigma, disability, gender norms, weak confidentiality and limited access to appropriate services. Four implications are especially important: school mental health is a whole-school and school-linked systems issue; gender transformation requires attention to norms and power rather than sex differences alone; teacher wellbeing is integral to system functioning; and Uganda's policy challenge is increasingly one of implementation.

School mental health as a whole-school and school-linked systems issue

The findings reinforce perspectives that locate mental health within relationships and institutional environments rather than solely within individual learners. Participants connected distress to interacting academic, social, family and school conditions, consistent with evidence that effective school mental health approaches must address both individual needs and the environments that shape wellbeing (Edyburn et al., 2023; Cavioni et al., 2020; Fazel et al., 2014). Recent guidance similarly positions education systems as important settings for creating safe and inclusive environments, reducing risks and connecting learners with appropriate psychosocial support (WHO, 2025).

The findings also clarify the limits of a school-only model. Schools are strategically positioned for promotion, prevention, early identification and basic support, but cannot reasonably function as self-contained mental health services. LMIC evidence highlights both the potential of school-based interventions and persistent implementation challenges relating to workforce capacity, cultural adaptation, resources and sustainability (Carlson et al., 2021; Fazel et al., 2014; Harte and Barry, 2024). Uganda-specific work similarly underscores the importance of designing interventions around existing school resources and implementation capacity (Huang et al., 2014; Huang et al., 2022; Laurenzi et al., 2024). The present findings therefore support a whole-school and school-linked model in which schools provide promotion, prevention, early identification and basic support while maintaining functional links with health, child protection, social welfare and community services.

Mental health literacy is integral to this system. Participants described biomedical and psychosocial understandings alongside spiritual, cultural, moral and disciplinary explanations that shaped recognition, disclosure and pathways to care. Mental health literacy encompasses not only knowledge but also beliefs influencing recognition, management, prevention and help-seeking (Kutcher et al., 2016). Evidence from secondary-school adolescents in Kampala similarly found low-to-moderate mental health knowledge, stigma and reluctance to seek support from some adults within schools (Nantumbwe et al., 2026). The present findings add that knowledge alone is unlikely to improve help-seeking where confidentiality, trust and fear of judgement remain unresolved. Cultural and spiritual explanations should therefore be engaged rather than treated simply as knowledge deficits, including through appropriately linked cultural and religious actors, safeguarding structures and professional services (Harte and Barry, 2024).

Gender transformation requires attention to norms, power and institutional practices

Gender shaped exposure to distress, emotional

expression, disclosure and access to support. Boys were expected to demonstrate toughness, suppress emotions and manage distress independently, while girls faced pressures linked to harassment, reproductive health, violence and social judgement. These patterns are socially produced through gender norms and unequal power relations rather than representing fixed differences between girls and boys (Ninsiima et al., 2018; Pederson et al., 2015; Smith et al., 2018). Adolescence is particularly important because gender identities and expectations become increasingly salient alongside changing peer, educational and social pressures (Blakemore and Mills, 2014; Campbell et al., 2021; Greene and Patton, 2020).

Cross-national evidence documents substantial gender differences in adolescent mental health while also showing variation across countries and dimensions of wellbeing (Campbell et al., 2021; Rice et al., 2021). This cautions against universalising girls' and boys' experiences. Smith et al. (2018) further caution that conventional distinctions between female internalising and male externalising distress may obscure underlying difficulties among boys and men when masculine norms discourage emotional disclosure and help-seeking.

A gender-transformative response must therefore move beyond describing differences to examining the relations and institutional practices that reproduce them. In this study, those practices included expectations of masculine toughness, moral judgement of female teachers and learners, gendered exposure to violence and reproductive-health stigma, and school environments in which disclosure can carry social costs. School mental health interventions should create conditions that enable boys to express vulnerability and seek support while addressing violence, unequal expectations and structural pressures affecting girls and women. Gender must also be examined intersectionally with disability, poverty, displacement, age and school type.

Teacher wellbeing is integral to school mental health

Teacher and staff wellbeing emerged as both a substantive mental health concern and a condition for effective learner support. Participants described financial strain, workload, burnout, stigma, family demands and limited psychosocial support among teachers, while simultaneously expecting them to identify learner distress, counsel students and facilitate referral. This is consistent with evidence linking teacher wellbeing with teacher–student relationships, staff retention and student-related outcomes (Burić et al., 2019; Fourie and de Klerk, 2024; McLean and Sandilos, 2022; Moens et al., 2026).

These findings challenge approaches that position teachers primarily as instruments for improving learner wellbeing. Teachers and other school staff are themselves rights-holders and beneficiaries of a whole-school mental health system. This is especially important where task-sharing is used to extend access in settings with few specialists. Task-sharing can improve reach, but requires clear roles, competency-based training, supervision and functional referral arrangements (Babatunde et al., 2020; Mælan et al., 2020; Zabek et al., 2023). Previous work in low-resource Ugandan schools similarly highlights the need for implementation support when using existing school personnel (Huang et al., 2014; Huang et al., 2022). Expanding teachers' mental health responsibilities without addressing workload, competence, supervision and their own wellbeing risks transferring responsibility for an under-resourced system onto an already constrained workforce.

From policy commitments to integrated implementation and learning

Uganda's school mental health challenge is increasingly one of implementation rather than policy absence. Existing education structures recognise guidance, counselling and psychosocial support, while the *2025 Guidelines for Integrating Mental Wellbeing and Psychosocial Support in Education Institutions* provide a clearer framework for action (MoES, 2025), consistent with WHO guidance on integrating mental health into education-sector leadership, financing, safe learning environments and support systems (WHO, 2025). Participants nevertheless described weak dissemination, limited financing, workforce shortages, fragmented coordination and inconsistent implementation. These concerns mirror wider LMIC evidence that sustainability depends on leadership, resources, workforce capacity, contextual adaptation and implementation processes (Harte and Barry, 2024; Heinrich et al., 2023; Margaretha et al., 2023).

The policy priority is therefore to translate commitments into functional roles, minimum service standards, referral pathways, financing, monitoring and accountability. The co-created research and learning agenda extends this implementation focus across learner and staff wellbeing, equity, school climate, family engagement, mental health literacy, workforce capacity, governance, referral and responsible digital innovation (Fazel et al., 2014; Harte and Barry, 2024). Research should move progressively from documenting need and system gaps to co-designing, testing and scaling contextually appropriate responses, while examining reach, accessibility, acceptability, quality, cost and sustainability and asking what works, for whom, under what conditions and at what cost (Fazel et al., 2014; Harte and Barry, 2024).

Implications for strengthening school mental health in Uganda

The findings suggest that Uganda can move from fragmented activities towards a coherent approach anchored in education and functionally linked to health,

protection and community systems. This direction is consistent with emerging national policy developments and international guidance emphasising coordinated education-sector approaches to mental health and wellbeing (MoES, 2025; WHO, 2025).

The immediate priority is not simply to introduce additional interventions, but to strengthen the conditions through which interventions become functional and sustainable: emotionally safe and inclusive schools; supported and competent staff; trusted and confidential services; meaningful learner and family participation; effective referral pathways; sustainable financing; and clear implementation accountability. Mental health should therefore be treated as integral to the purpose and functioning of education rather than as an additional service at its margins. A gender-transformative, whole-school and school-linked approach provides a basis for addressing mental health simultaneously through people, relationships, institutions and the wider systems that structure school life.

Study limitations

The findings should be interpreted in light of the study design. Participants were purposively selected through stakeholder mapping and snowball referral, and the four study districts were selected for contextual diversity rather than statistical representativeness; the findings therefore should not be interpreted as prevalence estimates or as nationally representative of all Ugandan schools. The study primarily captures participant perceptions and experiences and does not independently measure the effectiveness of services, programmes or policies. Group-based dialogue may also have been influenced by social desirability, uneven participation or reluctance to disclose sensitive experiences in the presence of others. In addition, the co-created priorities represent the perspectives generated within these consultations rather than a nationally validated consensus. These limitations are partly offset by the breadth of stakeholder groups, cross-regional comparison, triangulation and participatory validation embedded in the study design.

CONCLUSION

School mental health in Uganda is not simply a matter of identifying distressed learners or expanding counselling. The findings point to a systems challenge shaped by school climate, gender relations, teacher wellbeing, family and community beliefs, workforce capacity, referral infrastructure, financing and policy implementation. The study's principal contribution is a co-created agenda that connects these domains within a gender-transformative, whole-school and school-linked framework. Translating this agenda into practice will require implementation research and sustained investment in the institutional conditions that make school mental health support accessible, trusted, equitable and sustainable.

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