Visibility of Mental Health in SDG-5: Special Reference to Women-Friendly Villages

Chandaasani

Research Scholar, Department of Women's Studies, Bharathidasan University

A.Jeyanthi

Research Scholar, Department of Women's Studies, Bharathidasan University

PROFS.Suba

Professor, *Department of Women's Studies, Bharathidasan University*

Abstract

World Health Organisation commitment to the definition of health, inclusive of mental health, made by them, "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity", goes back to WHO Constitution 1948. WHO estimates that 'the burden of mental health problems in India is 2443 disability-adjusted life years (DALYs) per 10000 population; the age-adjustedsuiciderateper100000populationis

The economic loss due to mental health conditions, in the year 2012-2030, is estimated at USD 1.03 trillion'.'WHO Status of mental health in India', is quoted, in, Advancing Mental Healthcare in India, Press Release of Ministry of Health & Family Welfare. The Press Release of 9th November 2025 further states 'According to a NIMHANS study from 2019, mental health disorders are more prevalent among women (20%) than men (10%). Women in India are found to be particularly more prone to conditions like depression, anxiety, and somatic complaints compared to their male counterparts' (PIB Headquarters, Understanding Mental Health, 09 NOV 2025).

Sustainable Development Goals (SDG) have seventeen goals. Gender Equality (Goal-5_Fast-Facts) is SDG-5 which is further bifurcated into 9 Themes. Women Friendly Villages is Theme 9 which reflects the premise of the present conference of 'Empowering Communities through Holistic Initiatives'. In the process of localizing the themes other than Global Indicators each of them have indicators for verifying. The Theme 9 indicators were further subdivided into nine components; Crimes, Education, Gender sex Ratio, GP Spending, Health, Income generation, Leadership and Empowerment, Participation and Social Protection, health having the most14 aspects of reference out of 43 total points. With this background, this conceptual Paper will be critically looking at Health Indicators of SDG-5, theme – 9aligned in the line developing women-friendly village sunder localizing SDGs to assess visibility of mental health components with support existing SDGs data sources. This is an attempt to find gaps in the process where integrating mental health components ought to be a vital factor of Women-Friendly Villages.

Keywords: Localizing SDG5, Women Friendly Villages, Mental health, Health Indicators, Visibility.

1. Introduction

A meaningful entry point for examining mental health within the Sustainable Development framework is Sustainable Development Goal 3 (SDG-3: Good Health and Well-Being), which provides the primary global mandate for health-related outcomes. SDG-3 encompasses a wide range of targets, including the reduction of maternal mortality (Target 3.1), ending preventable deaths among newborns and children under five (Target 3.2), and combating communicable diseases such as HIV/AIDS, tuberculosis, malaria, and other epidemics (Target 3.3). It also addresses non-communicable diseases and explicitly calls for the promotion of mental health and well-being (Target 3.4), alongside the prevention and treatment of substance abuse (Target 3.5), reduction of road traffic injuries (Target 3.6), and ensuring universal access to sexual and reproductive health services (Target 3.7). Further, SDG-3 emphasizes universal health coverage (Target 3.8), reduction of health risks from environmental pollution (Target 3.9), and strengthening global health systems through policy frameworks, research, financing, and risk management (Targets 3.A–3.D).Despite this comprehensive scope, mental health receives explicit mention in only one target—Target 3.4—where it is positioned alongside the reduction of premature mortality from non-communicable diseases. This limited visibility highlights a critical gap in the global health agenda, where mental health, though increasingly recognized, remains insufficiently integrated across broader health and development priorities.

The 17 Sustainable Development Goals collectively address interconnected dimensions of development, ranging from poverty eradication and education to environmental sustainability and social justice. Given the conference theme, "Empowering Communities through Holistic Initiatives: Synergizing Sustainable Development Goals, Mental Health, and Social Work," it is evident that multiple SDGs intersect with mental health either directly or indirectly. Among these, SDG-5 (Gender Equality) is particularly significant, as gender-based disparities profoundly influence mental health outcomes, access to care, and overall well-being.

This paper specifically focuses on the localization of SDG-5 through the lens of "Women Friendly Villages," identified as Theme 9 within the localized Sustainable Development Goals (LSDGs) framework. SDG localization refers to the process of adapting global goals to regional and local contexts by developing context-specific targets, indicators, and implementation strategies. This approach ensures that development initiatives are responsive to local needs, strengthens institutional ownership, and promotes multi-stakeholder participation, including local governments, civil society, and community-based organizations. Importantly, localization operationalizes the principle of "leaving no one behind" by addressing ground-level disparities and enabling context-sensitive interventions (Ministry of Panchayati Raj, 2019).

Within the Indian context, the localization of SDGs in Panchayati Raj Institutions has been organized into nine thematic areas, including poverty alleviation, health, child welfare, water security, environmental sustainability, infrastructure, social justice, governance, and gender equality. Theme 9, "Women Friendly Panchayat," envisions the creation of gender-equitable spaces that ensure equal rights, opportunities, and participation for women. It emphasizes access to essential services such as health, education, and nutrition, while also addressing issues of safety, reduction of gender-based violence, and enhanced participation of women in decision-making processes at the grassroots level (Ministry of Panchayati Raj, 2023).

While multiple dimensions such as education, legal rights, and safety intersect with women's well-being, they are also intrinsically linked to health outcomes. However, this paper narrows its analytical focus to health-related indicators within SDG-5 and Theme 9, with particular attention to the visibility and integration of mental health. By doing so, it seeks to critically examine the extent to which mental health is embedded within gender-responsive development frameworks at the local level.

SDG-5 Indicators

5.3.1	Proportion of womenaged20-24yearswho were married or in a union before age 15 and before age 18
5.3.2	Proportion of girls and women aged 15-49 years who have undergone female genital mutilation/cutting, by age
5.6.1	Proportion of women aged 15-49 years who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care
5.6.2	Number of countries with laws and regulations that guarantee full and equal Access to women and menaged15 years and older to sexual and reproductive health care, information and education

Theme-9 Indicators available on 13.06.2024

1. Percentage of currently married women (15-49years) who use any modern family planning methods.

2. Proportion of women (aged 30-49) screened under the Non Communicable Disease (NCD) programme for cervical/breast cancer

3. Percentage of women population (out of total eligible population)receiving social protection benefits under Pradhan Mantri Matritva Vandana Yojana (PMMVY)

4. Percentage of girl children(0-3years) registered under ICDS out of total eligible children (0-3 years)

5. Percentage of girl children (3-6years) registered under ICDS out of total eligible children (3-6 years)

6. Percentage of Pregnant Women and lactating mothers registered under ICDS out of total eligible Pregnant Women and lactating mothers

7. Percentage of births attended by skilled health personnel or institutional delivery (Period 1 year)

8. Percentage of women headed household sunder Aayushman Bharat-Pradhan Mantri Jan Arogya Yojana or any State Govt Health scheme /health insurance.

9. Percentage of girl children under age 5 years who are wasted.

10. Percentage of maternal death to live birth.

11. Under-five mortality rate of girl childrenper1,000 live births.
12. Neonatal girl mortality rate (per1,000 live births).
13. Percentage of pregnant and lactating mothers who are anemic.
14. Percentage of girl Children under 5 years who are anemic.

A random search on virtual space and UN website for SDG provided a few articles on mental health and rural communities. Out of which nine articles that are related to the scope of this paper are being conceptually reviewed.

2. Review of Literature

'Regardless of where you live in, gender equality is a fundamental human right. Advancing gender equality is critical to all areas of a healthy society, from reducing poverty to promoting the health, education, protection and the well-being of girls and boys.'(Goal-5_Fast-Facts.pdf) This statement of SDG-5 does mention 'well-being' and reiterates the basic need for paying attention to this aspect as basis of health. The same website states that it will take 300 years to achieve gender equality. There are respective indicators for each of the target stated to achieve gender equality under Goal -5. One of the two targets taken for health merges with violence against women. A magnifying glass in not needed to state how mental health is affected along with health per sew hen women undergo violence of one form or other, be it child, early or forced marriage or one of the most cruel form of violence 'female genital mutilation' (5.3 Eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation.)

This Goal has two indicators as two different aspects are being addressed. The first part looks at the proportion of women aged 20-24 years who were married or in a union before age 15 and before age 18. The limitation of the age group 20-24 years marginalizes a major chunk of women and their issues and challenges. 'Union before age 15 and before age 18' also creates a similar exclusion for girls being married or in a union before 10 to 14 years. The second indicator covers a much broader age group 15-49, still carries the drawback of exclusion.

The other goal 5.6 that aspires to 'Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences' limits itself to sexual and reproductive health and reproductive rights. This in itself is not a negligible arena but slots women into reproductive agents ignoring the multidimensional identity of women.

This goal also has two indicators, the first about women's informed decision regarding sexual relations, contraceptive use and reproductive health care in the age group 15-49, again excluding other women or creating a norm that only this age group can have sexual relations. The second indicator has a wider scope to both men and women above 15 years access to sexual and reproductive health care, information and education.

Out of 14 Theme -9 Indicators available on 13.06.2024 one reflects the indicator in Goal 5 to limit married women presuming women in reproductive stage in age group 15-49 years who use any modern family planning methods. It is appreciated that 'pregnant and lactating women(mothers)' are not slotted under a marriage status in three indicators, one referring the percentage of pregnant women and lactating mothers, second percentage of births by skilled health personnel (within a year) and the third addresses those who are anemic in this group. One indicator deals with maternal death. One indicator talks about women benefitting from Pradhan Mantri Matritva Vandana Yojana (PMMVY) out of total eligible population. The name itself restricts women who are not mothers and that too there is a criterion for eligibility. Six indicators refer to women in reproductive state. These have exclusion in built in these of all women who do not come in this category, the most important factor and a major health drawback being anemia for women.

Six indicators address health issues of children in percentage, two about registration of 0-3 and 3-6 age group in ICDS, two about girl mortality of neonatal and under-five per 1000 live births, one under-five wasted girl children and one of under girl children who are anemic. The indicators are not addressing adolescent girl children in any way.

Out of the remaining two indicators one deals with Non Communicable Disease (NCD) programme for cervical/breast cancer for women in 30-49 age group, not inclusive of all women and all Non Communicable Diseases (NCD). The other also talks of other government schemes Aayushman Bharat-Pradhan Mantri Jan Arogya Yojana or any State Govt. Health scheme /health insurance which are

general category with invisible strings attached and not exclusive to women.

Conceptual Review of Articles related to mental health

Women-Friendly Village Initiative by NIRDPR

The Women-Friendly Village (WFV) concept, promoted by the National Institute of Rural Development and Panchayati Raj (NIRDPR) as Theme 9 under Localized Sustainable Development Goals (LSDGs), represents a transformative framework for gender-responsive rural governance in India. Aligned with SDG 5 (Gender Equality), it envisions villages where women and girls enjoy equal rights, opportunities, safety, and empowerment, fostering an inclusive environment for their active participation in community life and decision-making.

At its core, WFV prioritizes shifting from women-centric to women-led development. Key objectives include enhancing women's leadership in Gram Panchayats, ensuring safety through mechanisms like helplines and vigilance committees, and promoting economic independence via self-help groups (SHGs), skill development, and access to credit. It emphasizes health and nutrition (e.g., reducing anemia, institutional deliveries), education (high enrollment and retention for girls), sanitation, and social protection schemes. Integration with Gram Panchayat Development Plans (GPDP) enables gender-sensitive budgeting and convergence of programs like Mission Shakti, NRLM, and Beti **Bachao Beti Padhao.**

The initiative's strength lies in its participatory approach: Mahila Sabhas empower women to voice concerns, while indicators track progress in representation (at least 33% women in Panchayats), reduced violence, and economic metrics. Launched amid the Model Women-Friendly Gram Panchayats (MWFGP) effort by the Ministry of Panchayati Raj in 2025, it aims for one model per district, supported by digital monitoring dashboards. WFV addresses entrenched patriarchal norms, bridging gaps in rural gender disparities. By embedding empowerment in local governance, it promises sustainable, equitable rural transformation, contributing to a "Sashakt Bharat" where women thrive as leaders and agents of change.

1. **The Role of Women in Developing a Health-Friendly Village Through Marsirimpa Local Wisdom**

The article by Robert Sibarani, Peninna Simanjuntak, and Mardiana E. Fachry (2020) examines the pivotal yet constrained role of women in fostering a "friendly village for health" in Tipang Village, HumbangHasundutan Regency, North Sumatra Province, Indonesia. Grounded in the Toba Batak local wisdom of *marsirimpa*—a form of mutual cooperation akin to Indonesia's *gotong royong*—the study conceptualizes friendly villages as culturally cohesive communities that combat individualism, social isolation, depression, and related health issues through collective participation.

Employing a qualitative anthropolinguistic approach with an interactive model (data collection, condensation, display, and verification), the authors analyze women's performance, indexicality, and participation using parameters of interconnection, evaluability, and sustainability. *Marsirimpa*en compasses practices like *masiurupan*(mutual help), *rampakmangula*(collective work), and *marsisolisoli*(alternating labor), promoting cohesion, togetherness, and unison. These foster civilized, friendly villages that enhance mental and social health by strengthening community bonds and positive neural pathways.

Central to the framework is gender complementarity: occupational sharing between men and women in village cleaning, beautification, livelihoods, ceremonies, and public works. Women facilitate easier community mobilization and communication, making villages "friendlier." However, the patrilineal Toba Batak system poses socio-cultural handicaps, limiting women's leadership despite their essential participation.

Conceptually, the study bridges local wisdom with public health, arguing that sustaining complementary gender roles in *marsirimpa* empowers women as agents of change, yielding broader health impacts. It highlights empowerment within tradition, countering patriarchal barriers through communicative potentials.

While concise and contextually rich, the paper's brevity limits deeper critique of power dynamics or empirical health outcomes. Nonetheless, it offers valuable insights for integrating indigenous practices into community health strategies, aligning with global discourses on gender-responsive, culturally sensitive development.

2. **Community-Based Mental Health Intervention for Underprivileged Women in Rural India**

The experiential report by KiranRao, Prameela Vanguri, and Smita Premchander (2011), published through Sampark NGO, documents an innovative integration of mental health support within microcredit self-help groups(SHGs) for economically disadvantaged rural women in Koppal district, Karnataka, India. Conceptualized within a developmental framework addressing poverty-linked psychological distress—particularly depression manifesting somatically—the intervention targets gender-specific vulnerabilities: social oppression, low literacy, marital roles, and economic exclusion that exacerbate women's mental health burdens twice that of men.

The core framework embeds mental health into existing SHG livelihoods programs, leveraging microcredit for economic empowerment while adding group-based psychological components. Key elements include fortnightly sessions featuring ventilation (sharing problems for emotional unburdening), reassurance, coping skills training (problem- and emotion-focused), and a simple diaphragmatic breathing relaxation technique. Facilitated initially by trained NGO staff and transitioned to peer leaders for sustainability, sessions use cultural anchors like locally composed songs to foster trust and transition from economic to personal discussions. Pre-intervention health screenings ensure medical issues are addressed, preventing conflation with psychiatric needs.

Qualitative outcomes from focus group discussions reveal multifaceted impacts: reduced distress and somatic complaints (e.g., aches, fatigue), improved sleep (86% reported benefits from relaxation), enhanced social capital through mutual support, and amplified economic agency (higher business start-ups, equitable decision-making). Women described feeling "less alone," with group solidarity breaking isolation and enabling resilience against familial/interpersonal stressors.

The approach exemplifies holistic, community-driven mental health care in resource- scarce settings, aligning with global calls for gender-responsive interventions. By building on SHGs—platforms of trust and reciprocity—it counters stigma, in accessibility, and high dropout in clinical models, while low costs (~$13 per woman) underscore scalability.

Limitations include reliance on qualitative data, small sample, and potential group think in feedback. Nonetheless, the report offers profound insights for integrating mental health into poverty alleviation, emphasizing empowerment as a pathway to psychological well- being in rural India.

3. **In Remote TN, Women Ushering Mental Care**

S. Senthalir's 2023 article chronicles with photographs, the grassroots efforts of women community health workers in remote villages of Kancheepuram district (now Chengalpattu taluk), Tamil Nadu, who serve as vital bridges in delivering mental health care amid profound accessibility gaps. Spotlighting veteran worker Shanthi Sesha, a 61- year-old pioneer with over three decades of service, this piece illustrates how local women, trained under the National Mental Health Programme (NMHP) by the Schizophrenia Research Foundation (SCARF) since the 1980s, identify, support, and rehabilitate individuals with mental illnesses in underserved rural areas.

The intervention embodies a community-based, gender-responsive model that leverages women's insider status for trust-building and stigma reduction. Workers like Shanthi and Selvi traverse challenging terrains—often with infrequent transport—to detect early symptoms (e.g., schizophrenia in cases like Aruna), persuade reluctant families, ensure medication adherence, and facilitate access to scarce professional care. Between 2017-2022, Shanthi alone identified 98 patients, exemplifying scalable impact in regions where buses to remote villages run sporadically.

The framework addresses India's stark mental health disparities: disorders affect 10.6%of adults, with a lifetime prevalence of 13.7%, yet an 83% treatment gap persists, particularly for schizophrenia (60% untreated). By empowering educated-yet- underemployed rural women as volunteers, the approach fosters sustainability, cultural sensitivity, and holistic rehabilitation, countering urban-centric services and patriarchal barriers.

Senthalir underscores personal sacrifices—workers navigating familial duties and societal skepticism—while highlighting broader implications: such women-led initiatives democratize care, prevent institutionalization, and promote recovery in community settings. Though reliant on NGO-driven training, the model offers replicable insights for integrating gender equity into public health, aligning with global calls for localized, de- stigmatizing mental health strategies in low-resource contexts.

4. **Mental Health Awareness in Indian Villages – The Beginning of a Much-Needed Movement**

This article articulates an emergent grassroots movement addressing mental health in rural India, where emotional distress has historically been silenced amid survival priorities and cultural taboos.

Framing mental health as intertwined with livelihood, community stability, and social entitlements, Chandrakant Kumbhani(2025) highlights a paradigm shift toward community-led, informal support systems, aligning with the WHO's Service Organisation Pyramid that prioritizes self-care and local networks over scarce professional interventions.

Central to the conceptual framework is the empowerment of local women—Sakhis and frontline health volunteers—as "emotional first responders." These trusted figures, embedded in rural healthcare ecosystems, are trained by NGOs (notably the Ambuja Foundation) in early recognition of common mental disorders, active listening, problem- solving, behavioral activation, and relaxation techniques. Delivered through home visits, small group sessions, and awareness videos, this model bridges vast service gaps: India's 10.6% prevalence rate affects ~150 million, yet psychiatrist ratios remain critically low (<1 per 100,000), with rural areas largely unreached. Post-COVID exacerbations—job losses, migrant returns—underscored these vulnerabilities, propelling initiativesfrom110 villages across four states to a scaled target of 2,000, training over 600 facilitators.

The approach's strength lies in its cultural resonance, low-cost scalability, and holistic integration: linking psychosocial support with economic schemes to alleviate stressors like debt or crop failure. Outcomes include reduced household conflict, alcohol reliance, and isolation, fostering open dialogues on postpartum depression or farmer anxiety.

Kumbhani positions this women-driven movement as a cultural inflection point, democratizing care in underserved two-thirds of the population. It exemplifies gender- responsive, de-stigmatizing strategies, emphasizing informal networks' efficacy where formal systems falter. While optimistic and practice-oriented, the article could deepen empirical evidence on long-term impacts or gender dynamics in facilitation. Nonetheless, it compellingly advocates sustained investment in panchayat-level integration, signaling a vital evolution toward equitable rural mental well-being.

5. **Women's Rural Livelihood Programme and Mental Health – A Case Study of JEEViKA in Bihar**

The 2023 case study by Lakshmi Pandey and Juli Kumari investigates the intersection of economic empowerment and psychological well-being through Bihar's JEEViKA program—a World Bank-supported rural livelihoods initiative mobilizing poor women into Self-Help Groups (SHGs) for microfinance, social capital building, and socio- economic upliftment. Conceptualized amid India's high burden of female depression and suicide rates, particularly in rural and impoverished contexts, the study posits that anti- poverty interventions targeting women can yield psychosocial benefits beyond financial gains, fostering autonomy, decision-making, and community solidarity.

Employing a comparative design, the authors sampled 100 JEEViKA-affiliated rural women (aged 25-35) against 100 non-SHG counterparts from similar low-literacy, disadvantaged backgrounds. Mental health was assessed via the Hindi PGI General Well- being Scale (Verma & Verma, 1989), a reliable 20-item measure of positive well-being. Results revealed stark disparities: JEEViKA women scored significantly higher ($M=16.41$ vs. 10.79; $t=5.02$, $p<0.01$), with 94% in good/excellent categories versus 89% of non-SHG women in poor/average. This underscores financial inclusion's role in alleviating stressors linked to poverty, echoing prior evidence on SHG-mediated gains in self-efficacy, household agency, and emotional resilience.

The framework bridges livelihood programs with mental health via social capital theory: federated SHGs cultivate networks, trust, and collective action, countering isolation and patriarchal constraints. It aligns with global discourses on gender-responsive development, highlighting empowerment as a buffer against common mental disorders in resource-scarce settings. Strengths include contextual relevance to Bihar's vulnerabilities and empirical linkage of microfinance to well-being. Limitations—cross-sectional design, modest sample, age restriction, and lack of causality—temper generalizability, warranting longitudinal scrutiny. Nonetheless, the study compellingly advocates integrating SHGs into mental health strategies, offering scalable insights for reducing India's rural gender- mental health gap.

6. **Proceedings of the Consultative Workshop on Addressing Mental Health in Rural India: Issues and Challenges**

Edited by Dr. Sucharita Pujari (2024), these proceedings capture the deliberations of a one-day national consultative workshop held on October 23, 2024, at the National Institute of Rural Development and PanchayatiRaj(NIRDPR), Hyderabad. Organized by the Centre for Post Graduate Studies and Distance Education, the event brought together policymakers, academics, practitioners, and NGOs to examine the multifaceted crisis of mental health in rural India, where over 65% of the population resides yet faces profound service deficits.

Conceptually, the framework positions mental health as integral to sustainable rural development, aligning with SDGs 3 (Good Health and Well-Being) and localized goals under Panchayati Raj. Core

issues identified include an 83-90% treatment gap, acute shortages of psychiatrists (0.75 per 100,000 population), pervasive stigma associating illness with weakness or supernatural causes, and exacerbating factors like agrarian distress, migration, debt, and gender-based vulnerabilities—women bearing disproportionate burdens from domestic stress and social norms.

Technical sessions explored ethical/policy gaps, community-based interventions (e.g., ASHA/ANM roles in screening), and innovative models leveraging digital tools and PRI- led awareness. Presentations underscored the need for de-stigmatization through cultural sensitivity, integration with NMHP/DMHP, and convergence with schemes like NRLM SHGs for psychosocial support.

The proceedings advocate a paradigm shift toward decentralized, inclusive care: empowering Gram Panchayats for mental health planning in GPDPs, training frontline workers, and fostering public-private partnerships. Conceptually strong in bridging health with governance, it critiques urban-centric models while proposing scalable, context- specific strategies. Though concise, the document's consultative nature yields actionable insights, though deeper empirical data or follow-up mechanisms could enhance impact. Overall, it reinforces mental health as a rural development imperative, urging systemic reforms for equitable, resilient communities.

7. District Mental Health Programme in TamilNadu

The District Mental Health Programme (DMHP) in Tamil Nadu exemplifies a robust, decentralized framework for community-based mental health care under India's National Mental Health Programme (NMHP), launched nationally in 1996. Initiated in TamilNadu as a pilot in Tiruchirappalli district in 1997, it has expanded to all38 districts—the highest coverage nationwide—leveraging the state's strong public health infrastructure for outreach to rural and underserved populations.

DMHP shifts from asylum-based to integrated primary care models, addressing India's 83-90% treatment gap through early detection, treatment, and rehabilitation at the community level. Objectives encompass providing accessible services(outpatient clinics, satellite centers at block PHCs, 10-bed inpatient facilities), training frontline workers (ASHAs, ANMs), generating awareness to combat stigma, and promoting prevention via targeted interventions like school mental health, college counseling, workplace stress management, and suicide prevention.

Key components include multidisciplinary teams—psychiatrists, clinical psychologists, psychiatric social workers, and nurses—delivering fixed-day outreach clinics, treatment camps, home visits, and follow-up care. Tamil Nadu's implementation stands out for its functionality: regular awareness programs, integration with schemes like Ayushman Bharat Health and Wellness Centres, and coordination with Gram Panchayats for community participation. Special focus on vulnerable groups, including homeless persons with mental illness, aligns with the Mental Healthcare Act 2017's rights-based approach.

The program's strength lies in its public health orientation, fostering sustainability through state-NHM convergence and low-cost scalability. Evaluations highlight Tamil Nadu's model as replicable, yielding reduced institutionalization and enhanced recovery in community settings. Despite challenges like human resource shortages and variable monitoring, DMHP Tamil Nadu conceptualizes mental health as integral to rural development, offering equitable, stigma-reducing care amid agrarian distress and social vulnerabilities.

8. Tamil Nadu Mental Health Care Assessment – Review of District Mental Health Programme (2013)

The 2014 report by GururajG, Ramasubramanian C, and colleagues from NIMHANS, in collaboration with the Government of TamilNadu, presents a comprehensive evaluation of the District Mental Health Programme (DMHP) implementation across selected districts in 2013. Commissioned to assess progress under the National Mental Health Programme(NMHP), this assessment employs a mixed-methods framework—combining quantitative service data, qualitative stakeholder interviews, field observations, and facility audits—to gauge programmatic effectiveness, gaps, and scalability in a state renowned for robust public health infrastructure.

Conceptually, the review reinforces DMHP's paradigm of decentralised, integrated mental health care, shifting from institutional to community-based models. It evaluates core components: outpatient services, outreach clinics, school and workplace interventions, training of primary care staff, and public awareness campaigns. Tamil Nadu's early adoption (pilot in 1997) and expansion to multiple districts by 2013 positioned it as a national benchmark, with functional teams delivering services like follow-up care, crisis intervention, and rehabilitation.

Key findings highlight strengths in outreach (regular camps, ASHA involvement) and inter-sectoral coordination, yielding increased case detection and reduced stigma in pilot areas. However, persistent challenges emerge: human resource deficits (vacant psychiatrist posts, overburdened staff), inadequate funding allocation/utilization, weak monitoring systems, and limited integration with general health services. Gender and vulnerability dimensions—higher untreated burden among rural women due to socio- economic stressors—are noted, underscoring the need for targeted approaches.

The report's conceptual value lies in its evidence-based recommendations: strengthening HR through contractual appointments and training, enhancing budgetary support, developing robust IEC materials, and fostering PRI-NGO partnerships for sustainability. It aligns with evolving rights-based frameworks prefiguring the Mental Healthcare Act 2017. Though dated, the assessment remains pivotal for understanding contextual adaptations in high-performing states, offering transferable insights for addressing India's enduring 80-90% treatment gap through pragmatic, locally attuned strategies.

3. Objectives of the Study

a) To critically review visibility of mental health in the following: The Health Related Indicators of SDG-5 and Theme 9 Secondary Articles of mental health and SDG-5

b) To assess gaps in the SDG-5 and Theme 9 health indicators and secondary source materials in relation to mental health.

4. Methodology

Qualitative analysis is done of secondary sources of mental health and SDG-5. Data collection: Secondary source of information was collected for this research.

Data Analysis: Qualitative critical analysis to assess visibility of mental health in SDG

5. Results/Discussion

NoneoftheindicatorsofSDGandTheme9connectmentalhealthwiththeissuesof health even when it is a major factor related to all indicators. Random search of secondary data shows that mental health is barely addressed in any articles in connection with SDG 5.Work on mental health is done by NGOs

6. Conclusion and Implications

Various innovative works have been going on in rural villages in India and other parts of the world to find out what helps the mental health of the rural women. In some programmes funds are provided by one organization and implemented by another. Some are women's participation that brings change in addressing mental health issues and in some awareness brings perception change. A few examples are cited here.

Tipang Village is an example that shows that women play potential roles in developing friendly village based on local wisdom *marsirimpa* "mutual cooperation". The complementary occupational sharing between men and women when maintained will develop the village. This friendly village will give impact to many health aspects hopefully including mental health (EnfermeríaClínicaVolume 30, Supplement 2, March 2020, Pages 226-228).

A mental health intervention by Sampark organization with the ongoing SHG activity in 12SHGs in two sets of villages (Kolur-Gunnalli and Madanur-Mornal) in Koppal district, Karnataka, provided qualitative evidence that adding the mental health intervention to the ongoing economic activity had made a positive difference in the lives of the women. Addressing mental health concerns along with livelihood initiatives can help to enhance both economic and social capital in rural poor women. Mental health interventions in the context of poor, underserved regions, such as rural India, are particularly challenging. Community-based mental health interventions serve not only to reduce psychological distress, but also strengthen women's social capital. Sampark intends to extend the mental health intervention to all its SHGs and make it an integral component of its poverty alleviation programme.(PMID: 22295190)

In Tamilnadu, District Mental Health Programme was launched in1997 in Trichy on pilot basis and has been extended to all the 32 districts of Tamil Nadu. In order to mitigate suicide rate, 104 Tele-counselling services has been implemented from the year 2018-19. An innovative programme is based on the Dava & Dua Model at Ahmedabad being implemented in the name of "Markkam & Maruthuvam" Pilot Project at EarwadiDhargah Ramnad District (dmhp.pdf). Taking care on mentally ill seems to be the objective of DMHP Tamilnadu.

One study by a women's rural livelihood program, JEEViKA, on women's mental health in one of India's poorest states Bihar shows that financial inclusion and socio economic status link with women

empowerment vis-à-vis women's mental health. The study does not claim to present a complete picture of women's mental health, because the study was conducted among rural women of Bihar. However, the results indicate financial inclusion has a strong positive impact on mental health. (OR5_WOMEN_RURAL_LIVELIHOOD.pdf)

Grassroots efforts of women community health workers in remote villages of Kancheepuram district trained under the National Mental Health Programme (NMHP) by the Schizophrenia Research Foundation (SCARF) since 1980 has been trying to bring a shift of perspective towards women and people affected by mental health issues. 'Things might be different if budgetary allocation for mental health care was not so abysmalin India.' The women workers themselves are on the verge of mental breakdown due to financial crisis (In Remote TN, Women Ushering Mental Care, 2023).

Across India's villages, a quiet but determined movement is emerging —one that places emotional well-being at the centre of community health. This shift is being driven not by psychiatrists or psychologists, but by local women: a network of Sakhis and health volunteers (or field facilitators) who form the backbone of India's rural healthcare system. People are beginning to see that mental health issues are not shameful. When care comes from someone familiar — a neighbour, a friend, a fellow farmer — it feels less like treatment and more like understanding. This is the essence of community-based mental health: support embedded in daily life (Chandrakant KumbhaniOct 10, 2025).

A lot of effort is being taken to address the issue of mental health and women but it is still a drop in the ocean. SDG indicators have to be broadened to include mental health of women within their parameters, especially for Women Friendly Villages, to get closer to gender equality.

7. References

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