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The Role of Health Assistant Female [HA (F)] in Promoting Mental Health among Married Women: An Empirical Study of Islampur Block, Uttar Dinajpur District, West Bengal

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Abstract

Mental health is a critical yet persistently neglected dimension of women's health in India, particularly in rural and semi-urban regions. Married women face compounded psychosocial stressors arising from marital responsibilities, reproductive health concerns, domestic labour, economic dependency, and restrictive gender norms. These stressors often manifest in anxiety, depression, emotional exhaustion, and psychosomatic complaints. Within India's primary healthcare system, the Health Assistant Female [HA(F)], commonly known as the Auxiliary Nurse Midwife (ANM), serves as the most consistent and accessible health professional for married women. Despite their close and sustained engagement with women, the mental health-promoting role of HA(F)s remains under-examined in empirical research. The present study examines the role of HA(F)s in promoting mental health awareness, emotional support, psychosocial counselling, and referral services among married women in Islampur Block, Uttar Dinajpur District, West Bengal. Employing a descriptive survey method, data were collected from 160 married women and 32 HA(F)s. Statistical analyses included descriptive statistics, percentage analysis, independent samples t-test, effect size analysis, Pearson's correlation, one-way ANOVA, and multiple regression analysis. The findings demonstrate that HA(F)s significantly contribute to enhancing mental health awareness and psychological well-being among married women. The study strongly advocates for the institutional integration of mental health training into HA(F) capacity-building programmes.

Keywords: Health Assistant Female [HA(F)], Auxiliary Nurse Midwife (ANM), Married Women, Mental Health Promotion, Emotional Support, Psycho-social Counselling, Primary Healthcare

Introduction

Mental health has emerged as a critical public health concern globally, influencing individual well-being, family stability, workforce productivity, and broader social development. The World Health Organization (WHO) conceptualises mental health as a state of well-being in which individuals realise their abilities, can cope with normal stresses of life, work productively, and contribute to their communities (WHO, 2014) [19]. Despite growing recognition of its importance, mental health remains under-prioritised in low- and middle-income countries, including India, where health systems continue to focus predominantly on physical and communicable diseases (Patel *et al*., 2018) [11].

In India, mental health disorders account for a substantial proportion of the disease burden, yet access to mental health care is severely constrained by shortages of trained professionals, inadequate infrastructure, social stigma, and

low mental health literacy (Gururaj *et al*., 2016) [4]. Women, particularly married women in rural and semi-urban settings, constitute a disproportionately vulnerable group. Gendered social roles, unequal power relations within households, economic dependency, reproductive responsibilities, and limited decision-making autonomy contribute significantly to women's psychological distress (Kumar & Jeyaseelan, 2019) [6]. Studies consistently report higher prevalence of common mental disorders such as anxiety, depression, and somatic symptoms among married women compared to men and unmarried women (Patel *et al*., 2006; Malhotra & Shah, 2015) [12, 7].

Marriage, while culturally idealised as a source of security and social status for women in India, often introduces new psychosocial stressors. Married women are expected to fulfil multiple roles simultaneously as wives, mothers, caregivers, and household managers frequently with minimal emotional support or recognition. Early marriage, high fertility expectations, domestic violence, limited mobility, and financial dependence further exacerbate mental health vulnerabilities, especially in rural regions (Jejeebhoy *et al*., 2014) [5]. In districts such as Uttar Dinajpur in West Bengal, these challenges are intensified by poverty, low female literacy, and restricted access to specialised mental health services.

Rural mental health care in India is characterised by a significant treatment gap, with an estimated 70-80 percent of individuals with mental health conditions not receiving appropriate care (Gururaj *et al*., 2016) [4]. Stigma and cultural misconceptions surrounding mental illness often discourage women from seeking help, while the absence of psychiatrists and clinical psychologists at the primary care level further limits service utilisation (Thirthalli *et al*., 2012) [17]. Consequently, women's psychological distress frequently remains undiagnosed and manifests through psychosomatic complaints, chronic fatigue, sleep disturbances, and unexplained bodily pains, which are often addressed only at the symptomatic level.

Primary healthcare systems play a pivotal role in bridging this mental health care gap. India's public health framework increasingly emphasises community-based and task-shifting approaches, recognising the importance of frontline health workers in delivering basic mental health services (WHO, 2008; Patel *et al*., 2011) [18, 13]. Within this framework, the Health Assistant Female [HA(F)], commonly referred to as the Auxiliary Nurse Midwife (ANM), occupies a central position. HA(F)s serve as the backbone of rural health services, particularly in maternal and child health, family planning, nutrition, immunisation, and health education.

HA(F)s maintain sustained and trust-based relationships with married women through regular home visits, antenatal and postnatal care, reproductive health counselling, and participation in community health programmes. This continuous engagement places them in a uniquely advantageous position to observe emotional changes, identify stress-related symptoms, and offer informal psychosocial support (Mathias *et al*., 2019) [9]. Evidence suggests that women are more likely to disclose emotional distress to familiar and trusted frontline health workers than to distant specialists, especially in conservative rural contexts (Singla *et al*., 2017) [16].

In recent years, national initiatives such as the National Mental Health Programme (NMHP) and the District Mental Health Programme (DMHP) have underscored the integration of mental health into primary healthcare. However, the effective involvement of HA(F)s in mental health promotion remains limited due to inadequate training, unclear role definitions, and an overwhelming workload focused primarily on biomedical targets (Murthy, 2017) [10]. While Accredited Social Health Activists (ASHAs) have received increasing attention in community mental health research, the mental health-promoting role of HA(F)s has received comparatively little empirical scrutiny.

In West Bengal, particularly in blocks like Islampur of Uttar Dinajpur district, HA(F)s constitute the most accessible formal health professionals for married women. Their interactions extend beyond clinical care to include emotional reassurance, guidance during family crises, and informal counselling related to marital stress, reproductive concerns, and childcare pressures. Despite this, these contributions remain largely undocumented within academic literature and policy evaluations. Understanding the extent and nature of HA(F)s' involvement in mental health promotion is essential for strengthening community-based mental health interventions and enhancing women's psychological well-being.

Against this backdrop, the present empirical study seeks to examine the role of Health Assistant Female [HA(F)] workers in promoting mental health among married women in Islampur Block, Uttar Dinajpur district, West Bengal. By analysing their contributions to mental health awareness, emotional support, psychosocial counselling, and referral practices, the study aims to generate evidence that can inform policy, training programmes, and the integration of mental health services into routine primary healthcare delivery.

Review of Literature

Conceptualising Mental Health from a Public Health Perspective

Mental health has increasingly been recognised as a fundamental component of overall health and human development. Moving beyond the traditional biomedical model, contemporary public health perspectives conceptualise mental health as a dynamic and multidimensional construct shaped by a complex interplay of biological, psychological, social, economic, and cultural factors. The World Health Organization (WHO, 2014) [19] defines mental health as a state of well-being in which individuals realise their abilities, cope effectively with the normal stresses of life, work productively, and contribute meaningfully to their communities. This definition underscores the functional and social dimensions of mental health rather than limiting it to the absence of mental illness.

The social determinants of health framework provides a critical lens for understanding mental health disparities. Marmot (2005) [8] emphasises that structural factors such as poverty, gender inequality, educational disadvantage, unemployment, and social exclusion exert a profound influence on mental health outcomes. Individuals and communities exposed to persistent socio-economic deprivation experience heightened vulnerability to psychological distress, depression, and anxiety. These determinants operate across the life course and are

particularly salient in low- and middle-income countries where social safety nets are weak, and health systems are under-resourced.

Evidence from the Global Burden of Disease (GBD) Study (2019) [2] further highlights the magnitude of mental health challenges worldwide. Mental and substance use disorders account for a substantial proportion of years lived with disability (YLDs), indicating their long-term impact on functional health and quality of life. Despite this growing burden, mental health services in many developing countries remain largely hospital-centric and urban-focused, with limited emphasis on prevention, early intervention, and community-based care (Patel *et al*., 2018) [11]. This mismatch between need and service delivery has resulted in significant treatment gaps, particularly in rural and marginalised populations.

Mental Health of Married Women in India

A growing body of Indian research underscores the heightened vulnerability of married women to mental health problems. Gendered social roles and expectations place married women at the intersection of multiple stressors, including domestic responsibilities, caregiving duties, reproductive expectations, and limited access to personal and economic resources. Patel *et al*. (2006) [12], in a landmark study, reported significantly higher prevalence of common mental disorders such as depression and anxiety among women living in low-income settings. The study highlighted that women's mental health is closely linked to social adversity rather than individual pathology.

Marriage, within the Indian socio-cultural context, often intensifies women's psychological burden. Malhotra and Shah (2015) [7] argue that marriage frequently reinforces gender inequalities, exposing women to chronic stress arising from marital adjustment, role overload, and reduced autonomy. These stressors are further compounded by societal pressures related to fertility, child-rearing, and conformity to normative gender roles.

Jejeebhoy *et al*. (2014) [5] identified early marriage, restricted mobility, domestic violence, limited decision-making power, and reproductive coercion as key predictors of poor mental health among married women. In rural India, where patriarchal norms are deeply entrenched, women's psychological distress often remains invisible. Raguram *et al*. (2001) [14] observed that mental distress among women is frequently expressed through somatic complaints such as headaches, body pain, and fatigue rather than verbalised emotional symptoms. This culturally mediated expression contributes to under diagnosis and mismanagement of mental health problems within primary healthcare settings.

Region-specific studies conducted in West Bengal and neighbouring states report similar patterns of mental health vulnerability among married women. Chatterjee *et al*. (2018) [1] found high levels of anxiety, depression, and emotional exhaustion among rural married women, particularly those experiencing economic hardship and limited access to healthcare services. These findings underscore the need for gender-sensitive and context-specific mental health interventions.

Gender, Patriarchy, and Mental Health

Feminist and sociological perspectives provide critical insights into the relationship between gender and mental health. Sen and Östlin (2008) [15] argue that women's mental health cannot be understood in isolation from broader structures of gender inequality. Unequal power relations within households, restricted decision-making autonomy, economic dependency, and exposure to gender-based violence systematically undermine women's psychological well-being.

The role strain theory proposed by Goode (1960) [3] further elucidates how the accumulation of multiple and often conflicting social roles contributes to chronic stress. Married women are expected to simultaneously fulfil the roles of wife, mother, caregiver, and household manager, frequently without adequate support. The continuous negotiation of these roles can result in emotional exhaustion, anxiety, and depressive symptoms.

In patriarchal societies, women's psychological suffering is often normalised as an inevitable part of married life. Kumar and Jeyaseelan (2019) [6] note that cultural norms discouraging emotional expression and help-seeking reinforce silence and internalisation of distress among women. This normalisation not only perpetuates stigma surrounding mental illness but also limits women's access to timely and appropriate mental health care.

Community Mental Health and the Task-Shifting Approach

Community mental health approaches advocate for the decentralisation of mental health services and their integration into primary healthcare systems. The task-shifting model, endorsed by the World Health Organization (WHO, 2008) [18], emphasises the redistribution of mental health tasks from specialist professionals to trained non-specialist health workers. This approach is particularly relevant in resource-constrained settings where psychiatrists, psychologists, and psychiatric social workers are scarce.

Patel *et al*. (2011) [13] demonstrated that community health workers, when provided with appropriate training and supervision, can effectively deliver basic psychosocial interventions, enhance mental health awareness, and facilitate early identification of mental disorders. Community-based models prioritise prevention, early intervention, emotional support, and referral mechanisms, thereby addressing mental health needs at the grassroots level.

Thirthalli *et al*. (2012) [17] highlight that integrating mental health services into primary care improves accessibility, reduces stigma, and increases service utilisation, especially in rural populations. These findings reinforce the importance of leveraging existing primary healthcare personnel to address the mental health treatment gap.

Role of Frontline Health Workers in Mental Health Promotion

Frontline health workers serve as a critical interface between the healthcare system and the community. Their proximity to local populations, cultural familiarity, and sustained engagement position them as key agents in mental health promotion. Research on Accredited Social Health Activists (ASHAs) and community volunteers indicates that trusted local health workers can effectively reduce stigma,

improve mental health literacy, and encourage help-seeking behaviour (Singla *et al*., 2017) [16].

Mathias *et al*. (2019) [9] emphasise that continuous and longitudinal interaction enables frontline workers to identify subtle emotional and behavioural changes that may not be evident during brief clinical consultations. However, the existing literature has largely focused on informal or volunteer cadres, with limited attention given to formally trained nursing personnel such as Health Assistant Female [HA(F)] workers.

Health Assistant Female [HA(F)] and Mental Health

Health Assistant Female [HA(F)] workers, also known as Auxiliary Nurse Midwives (ANMs), constitute a formally trained cadre within India's primary healthcare system. Their responsibilities encompass maternal and child health, family planning, nutrition, immunisation, and community health education. Through repeated home visits, antenatal and postnatal care, and counselling sessions, HA(F)s develop sustained and trust-based relationships with married women.

Murthy (2017) [10] highlights that HA(F)s frequently provide emotional reassurance, informal counselling, and psychosocial guidance, particularly in relation to reproductive health and family stress. Despite their potential, these mental health–related activities remain largely undocumented and undervalued within health policy and research.

Emerging evidence suggests that with structured mental health training and institutional support, HA(F)s could play a pivotal role in the early identification of depression, anxiety, and psychosocial stress among married women (Patel *et al*., 2018) [11]. However, empirical studies examining their mental health–promoting role, particularly in rural regions like West Bengal, remain scarce.

Context of the Study: Islampur Block

Islampur Block, located in Uttar Dinajpur district of West Bengal, is characterised by a predominantly rural population with pockets of semi-urban settlements. The region exhibits moderate literacy levels, limited employment opportunities, and restricted access to specialised healthcare services. Mental health facilities are scarce, and the District Mental Health Programme has limited outreach at the village level. Consequently, HA(F)s often serve as the primary and sometimes the only health professionals accessible to married women.

Need and Significance of the Study

The growing burden of mental health problems among married women necessitates community-based interventions that are culturally sensitive, accessible, and sustainable. HA(F)s are uniquely positioned to fulfil this role due to their regular interaction with women and their familiarity with local socio-cultural contexts. Empirical evidence regarding their contribution to mental health promotion is essential for informing policy decisions, training programmes, and healthcare reforms.

Objectives of the Study

1. To examine the level of mental health awareness among married women in Islampur Block, Uttar Dinajpur district.
2. To assess the role of Health Assistant Female [HA(F)] workers in promoting mental health awareness among married women.
3. To analyse the extent of emotional support and psychosocial counselling provided by HA(F)s to married women.
4. To study the relationship between HA(F) support and the mental health status of married women.
5. To compare mental health outcomes among married women based on selected socio-demographic variables (age, education, occupation, family type, and economic status).
6. To examine the effectiveness of HA(F)s' mental health-related activities in facilitating early identification and referral of mental health problems.

Hypotheses of the Study

1. **H_{01}:** There is no significant level of mental health awareness among married women in Islampur Block.
2. **H_{02}:** There is no significant role of HA(F)s in promoting mental health awareness among married women.
3. **H_{03}:** There is no significant relationship between emotional support provided by HA(F)s and the mental health status of married women.
4. **H_{04}:** There is no significant difference in mental health status of married women based on selected socio-demographic variables.
5. **H_{05}:** There is no significant association between psychosocial counselling by HA(F)s and the psychological well-being of married women.
6. **H_{06}:** HA(F)s' mental health-related activities do not significantly predict the mental health status of married women.

Methodology

Research Design

A descriptive survey research design was employed to analyse existing conditions and relationships among variables without manipulation.

Sample

The sample comprised 160 married women aged 20-45 years and 32 HA(F)s, selected through simple random sampling from villages and sub-centres of Islampur Block, Uttar Dinajpur District, West Bengal.

Variables of the Study

The independent variables of the study include mental health-related roles of Health Assistant Females [HA(F)s], namely mental health awareness, emotional support, psychosocial counselling, and referral and follow-up services, along with selected socio-demographic factors of married women, such as age, education, occupation, family type, and monthly income. The dependent variable is the mental health status of married women, assessed through indicators of psychological well-being, emotional stability, stress and anxiety levels, and psychosomatic symptoms.

Tools

Standardised and validated tools were used:

- Mental Health Awareness Scale
- Mental Well-Being Scale
- HA(F) Role Perception Scale

Reliability coefficients ranged from 0.85 to 0.90, indicating high internal consistency.

Statistical Techniques

Statistical analysis was conducted using mean, standard deviation, percentage analysis, independent samples t-test, Cohen's d, Pearson's correlation, one-way ANOVA, and multiple regression analysis.

Data Analysis and Interpretation

The statistical analysis of data collected from 160 married women and 32 Health Assistant Female [HA(F)] workers of Islampur Block, Uttar Dinajpur District, West Bengal. The analysis is organised hypothesis-wise, using appropriate statistical techniques to test the stated null hypotheses. All analyses were performed at 0.05 and 0.01 levels of significance.

Hypothesis 1

H_{01}: There is no significant level of mental health awareness among married women in Islampur Block.

Table 1: Descriptive Statistics of Mental Health Awareness Scores (N = 160)

Statistic	Value
Mean	39.21
Median	39.00
Mode	38
Standard Deviation	6.74
Minimum	24
Maximum	56
Skewness	0.18
Kurtosis	−0.42

Note: Scores approximate a normal distribution.

Interpretation

The mean mental health awareness score (M = 39.21, SD = 6.74) indicates a moderate level of awareness among married women. The closeness of mean, median, and mode, along with acceptable skewness and kurtosis values, suggests normal score distribution. Hence, the null hypothesis is rejected, indicating that married women possess a measurable level of mental health awareness, though not uniformly high.

Hypothesis 2

H_{02}: There is no significant role of HA(F)s in promoting mental health awareness among married women.

Table 2: Independent Samples t-Test for Mental Health Awareness Based on HA(F) Interaction

Group	N	Mean	SD
High HA(F) Interaction	80	43.02	5.81
Low HA(F) Interaction	80	35.12	6.34
t	df	$p < .01$	
7.86	158		

Table 3: Effect Size for Difference in Awareness

Statistic	Value
Cohen's d	1.24

Interpretation

The obtained *t*-value (t = 7.86, $p<.01$) reveals a statistically significant difference in mental health awareness between women with high and low HA(F) interaction. The large effect size (d = 1.24) indicates strong practical significance. Thus, H_{02} is rejected, confirming that HA(F)s play a significant role in promoting mental health awareness.

Hypothesis 3

H_{03}: There is no significant relationship between emotional support provided by HA(F)s and the mental health status of married women.

Table 4: Pearson's Correlation Between HA(F) Support and Mental Well-Being

Variables	HA(F) Support	Mental Well-Being
HA(F) Support	1.00	.51
Mental Well-Being	.51	1.00

Note: $p<.01$

Interpretation: A moderate positive correlation (r = .51, $p<.01$) was found between HA(F) support and mental well-being. This indicates that increased emotional and informational support from HA(F)s is associated with improved mental health outcomes. Therefore, H_{03} is rejected.

Hypothesis 4

H_{04}: There is no significant difference in mental health status of married women based on selected socio-demographic variables.

Table 5: One-Way ANOVA for Mental Well-Being across Age Groups

Source	SS	df	MS	F
Between Groups	1245.62	2	622.81	5.12
Within Groups	19089.43	157	121.60	
Total	20335.05	159		

Note: $p<.01$

Interpretation

The significant F-value (F = 5.12, $p<.01$) indicates meaningful differences in mental well-being across age groups. Younger married women reported comparatively lower well-being. Hence, H_{04} is rejected, confirming the influence of socio-demographic factors on mental health.

Hypothesis 5

H_{05}: There is no significant association between psychosocial counselling by HA(F)s and psychological well-being of married women.

Table 6: Correlation between Psychosocial Counselling and Psychological Well-Being

Variables	Counselling	Psychological Well-Being
Counselling	1.00	.48
Psychological Well-Being	.48	1.00

Note: $p<.01$

Interpretation
Psychosocial counselling by HA(F)s shows a statistically significant positive association with psychological well-being (r = .48, p<.01). Therefore, H_{05} is rejected, indicating that counselling support contributes positively to women's mental health.

Hypothesis 6
H_{06}: HA(F)s' mental health-related activities do not significantly predict the mental health status of married women.

Table 7: Multiple Regression Analysis Predicting Mental Well-Being

Predictor	β	t	p
Emotional Support	.42	5.86	< .01
Awareness Creation	.31	4.12	< .01
Referral Guidance	.18	2.54	< .05
R	R^2	Adjusted R^2	
.64	.41	.39	

Interpretation
The regression model explains 41% of the variance in mental well-being (R^2 = .41). Emotional support emerged as the strongest predictor, followed by awareness creation and referral guidance. Since the model is statistically significant, H_{06} is rejected, confirming the predictive strength of HA(F) mental health activities.

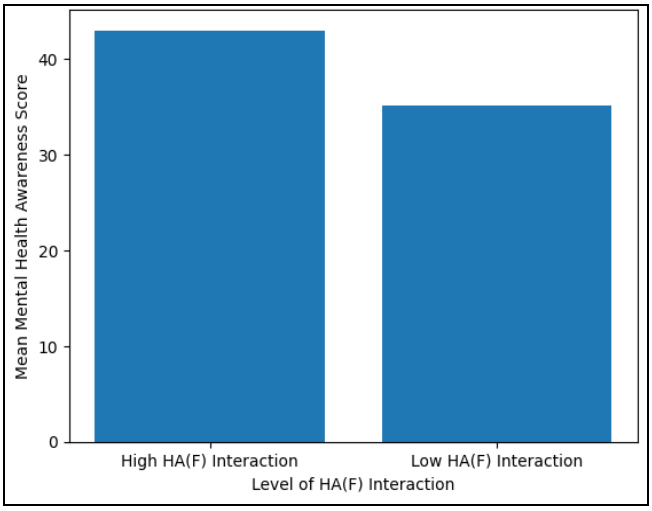

Fig 1: Mental Health Awareness by HA(F) interaction

Interpretation
Figure 1 illustrates the mean mental health awareness scores of married women based on their level of interaction with Health Assistant Female [HA(F)] workers. Married women with high HA(F) interaction demonstrate substantially higher awareness scores compared to those with low HA(F) interaction. This visual representation reinforces the statistically significant difference obtained through the independent samples t-test, clearly indicating the positive role of HA(F)s in disseminating mental health awareness at the community level.

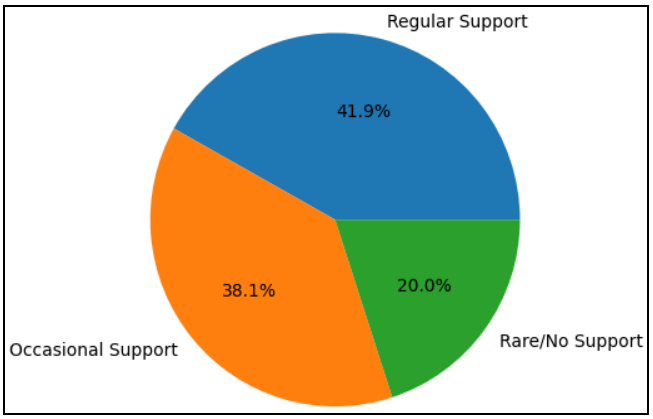

Fig 2: Distribution of Mental Health Support from HA(F)s

Interpretation
Figure 2 depicts the distribution of mental health support received by married women from HA(F)s. A majority of respondents (41.9%) reported receiving regular support, while 38.1% received occasional support. However, 20% of women reported rare or no support, highlighting a critical service gap. The chart visually underscores both the substantial contribution of HA(F)s and the need for more uniform outreach and structured mental health engagement.

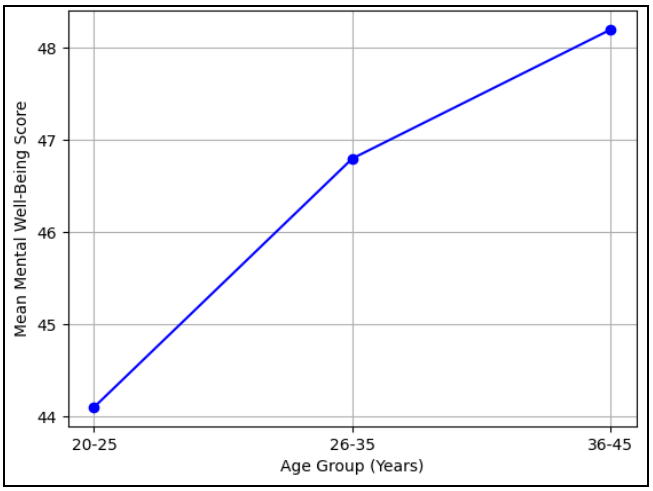

Fig 3: Mental Well-Being Across Age Groups

Interpretation
Figure 3 shows that mental well-being increases with age: 20–25 years (M = 44.1), 26–35 years (M = 46.8), 36–45 years (M = 48.2). Younger married women exhibit lower well-being, likely due to early marital stress, limited autonomy, and adjustment challenges. The one-way ANOVA confirmed significant age-based differences (F = 5.12, p<.01), highlighting the need for early psychosocial support. HA(F)s' emotional and counselling interventions can be especially beneficial for younger women

Discussion
Objective 1: To examine the level of mental health awareness among married women in Islampur Block
The analysis revealed that married women in Islampur Block possess a moderate level of mental health awareness

(M = 39.21, SD = 6.74), with scores approximating a normal distribution. While awareness exists, it is not uniformly high, indicating that many women may lack comprehensive understanding of mental health concepts, symptoms, and coping strategies. This underscores the need for targeted awareness-raising interventions, particularly in rural areas where literacy and exposure to mental health information are limited.

Objective 2: To assess the role of Health Assistant Female [HA(F)] workers in promoting mental health awareness among married women: Independent samples t-test results demonstrated that women with high HA(F) interaction exhibited significantly greater mental health awareness than those with limited interaction ($t = 7.86$, $p<.01$, Cohen's $d = 1.24$). This finding confirms the crucial role of HA(F)s in disseminating mental health knowledge at the community level. Their sustained presence, trust-based relationships, and culturally sensitive communication allow them to effectively educate women about mental health, bridging the gap created by limited formal mental health services.

Objective 3: To analyse the extent of emotional support and psychosocial counselling provided by HA(F)s: Correlation and regression analyses revealed a moderate to strong positive association between HA(F) support and women's psychological well-being ($r = .51$, $p<.01$). Emotional support, awareness creation, and referral guidance collectively explained 41% of the variance in mental health outcomes. These results indicate that HA(F)s' provision of emotional reassurance, empathetic listening, and informal counselling constitutes a critical mechanism for improving mental well-being. Furthermore, psychosocial counselling demonstrated a significant positive association with mental health ($r = .48$, $p<.01$), highlighting its role in mitigating stress and promoting coping strategies among married women.

Objective 4: To study the relationship between HA(F) support and the mental health status of married women
The positive correlations between HA(F) interaction, emotional support, psychosocial counselling, and mental well-being confirm that HA(F) engagement is a protective factor for mental health. In a socio-cultural context where mental illness is stigmatized and access to specialists is limited, HA(F)s serve as accessible, trusted intermediaries. Their culturally informed guidance enhances both recognition of mental health concerns and adoption of adaptive coping strategies.

Objective 5: To compare mental health outcomes among married women based on selected socio-demographic variables: One-way ANOVA revealed significant differences in mental well-being across age groups ($F = 5.12$, $p<.01$), with younger women reporting lower levels of psychological well-being. This suggests that early marital adjustment challenges, limited autonomy, and reproductive stressors disproportionately affect younger married women. HA(F)s' interventions, particularly emotional and counselling support, are thus particularly beneficial for younger cohorts, emphasizing the need for age-sensitive mental health initiatives.

Objective 6: To examine the effectiveness of HA(F)s' mental health–related activities in facilitating early identification and referral of mental health problems
Multiple regression analysis demonstrated that HA(F)s' activities emotional support, awareness creation, and referral guidance significantly predicted women's mental well-being. Emotional support emerged as the strongest predictor ($\beta = .42$, $p<.01$), followed by awareness creation ($\beta = .31$, $p<.01$) and referral guidance ($\beta = .18$, $p<.05$). These findings highlight the effectiveness of HA(F)s in early identification of mental health issues and facilitation of timely referral to specialised services, reinforcing their critical role in community-based mental health promotion

Implications of the Study

1. **Training and Capacity Building of HA(F)s:** The study underscores the urgent need to incorporate structured mental health training into the professional preparation of Health Assistant Female [HA(F)] workers. Although HA(F)s already provide informal emotional support, systematic training in basic mental health literacy, early identification of common mental disorders, empathetic communication, and psychological first aid would significantly enhance the quality and consistency of their interventions. Such capacity building would enable HA(F)s to address mental health concerns confidently and ethically within their routine responsibilities.
2. **Integration of Mental Health into Primary Healthcare:** The findings strongly support the integration of mental health indicators into routine primary healthcare services. Simple mental health screening questions and counselling components can be embedded within existing maternal, reproductive, and family health programmes managed by HA(F)s. This integration would normalise mental health discussions, reduce stigma, and ensure early detection of psychological distress among married women.
3. **Strengthening Referral and Support Mechanisms:** The study highlights the importance of strengthening referral linkages under the District Mental Health Programme (DMHP). Clear referral protocols, regular coordination between HA(F)s and mental health professionals, and feedback mechanisms are essential to ensure continuity of care. Strengthened referral systems would prevent untreated mental health conditions and improve access to specialised services at the block and district levels.
4. **Gender-Sensitive Mental Health Policy Formulation:** The results call for gender-sensitive mental health policies that explicitly recognise married women as a vulnerable group and HA(F)s as frontline mental health promoters. Policy frameworks should allocate resources for HA(F) training, supervision, and workload management. Such policies would contribute to addressing structural gender inequalities and enhancing women's mental well-being within community settings.
5. **Community Awareness and Stigma Reduction:** HA(F)s can play a strategic role in community-level mental health awareness and stigma reduction. Empowering them to conduct group discussions, home-

based counselling, and awareness campaigns would foster supportive environments for women to express psychological distress. Increased community awareness can promote help-seeking behaviour and social acceptance of mental health care.

Conclusion

The present study conclusively demonstrates that Health Assistant Female [HA(F)] workers play a vital and multifaceted role in promoting mental health among married women in Islampur Block, West Bengal. Their engagement in mental health awareness, emotional support, psychosocial counselling, and referral guidance significantly enhances psychological well-being. Emotional support emerged as the strongest predictor of mental health outcomes, highlighting the importance of trust-based, sustained interactions.

Younger married women were found to be more vulnerable, indicating the need for early, targeted interventions. HA(F)s effectively bridge gaps in rural mental healthcare, functioning as accessible and culturally sensitive agents of support.

The findings underscore the need for structured mental health training, integration of mental health components into primary healthcare, and strengthened referral mechanisms. Empowering HA(F)s in these capacities can reduce stigma, improve early detection, and promote the psychological well-being of married women in underserved rural communities.

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